APPENDIX

Exhibit 1: CVS_HJC_00000228 Cease-and-desist letter sent to Dearborn Hills Pharmacy 5
Exhibit 2: CVS_HJC_00000247 Cease-and-desist letter sent to NMB Pharmacy 8
Exhibit 3: CVS_HJC_00000283 Cease-and-desist letter sent to Southwood Pharmacy 12
Exhibit 4: CVS_HJC_00000362 Termination notice sent to Market 32 Pharmacy 16
Exhibit 5: CVS_HJC_00000367 Breach of contract notice sent to Market 32 Pharmacy 22
Exhibit 6: CVS_HJC_00000370 Cease-and-desist letter sent to Med Cart Specialty Pharmacy ...26
Exhibit 7: CVS_HJC_00000375 Cease-and-desist letter sent to Nomi Pharma LLC 32
Exhibit 8: CVS_HJC_00000396 Cease-and-dAesist letter sent to Sav-On Pharmacy 36
Exhibit 9: CVS_HJC_00000406 Cease-and-desist letter sent to Village Fertility Pharmacy 42
Exhibit 10: CVS_HJC_00000424 Response to final notice sent from CVS to White Drug 46
Exhibit 11: CVS_HJC_00000427 Response to final notice sent from White Drug's counsel to CVS 50
Exhibit 12: CVS_HJC_00000541 CVS Caremark 2024 Provider Manual 53
Exhibit 13: CVS_HJC_00000659 Salesforce entry related to Shell USA's pharmacy audit requests 168
Exhibit 14: CVS_HJC_00000664 Salesforce entry related to the Commonwealth of Kentucky's pharmacy audit requests 173
Exhibit 15: CVS_HJC_00000667 Salesforce entry related to Neighborhood Health Plan of Rhode Island's pharmacy audit requests 177
Exhibit 16: CVS_HJC_00000681 Salesforce entry related to the State of Oklahoma's pharmacy audit requests 182
Exhibit 17: CVS_HJC_00000785 Email exchange between Market 32 Pharmacy and CVS requesting permission to work with Blink Rx 187
Exhibit 18: CVS_HJC_00000840 Portion of the CVS Caremark 2022 Provider Manual related to working with hub pharmacies 194
Exhibit 19: CVS_HJC_00000889 Email exchange between Albertsons and CVS 213
Exhibit 20: CVS_HJC_00000931 Response to cease-and-desist sent from Village Fertility Pharmacy to CVS 219
Exhibit 21: CVS_HJC_00000934 CVS Caremark 2022 Provider Manual 223
Exhibit 22: CVS_HJC_00001058 CVS Caremark 2020 Provider Manual 348
Exhibit 23: CVS_HJC_00002411 Letter allowing 986 Specialty Pharmacy 2 to work with Blink Rx 491
Exhibit 24: CVS_HJC_00002417 Letter allowing Med Cart Specialty Pharmacy to work with Blink Rx 493

Exhibit 25: CVS_HJC_00002425 Letter allowing Market 32 Pharmacy to work with Blink Rx 495
Exhibit 26: CVS_HJC_00006885 Internal email highlighting changes to the provider manual....497
Exhibit 27: CVS_HJC_00008402 Internal email thread investigating hub pharmacy activity 499
Exhibit 28: CVS_HJC_00008671 Internal email thread investigating claims of fraud, waste, and abuse 510
Exhibit 29: CVS_HJC_00008885 Internal email thread discussing changes to the provider manual.....519
Exhibit 30: CVS_HJC_00009552 Internal email thread discussing changes to the provider manual.....523
Exhibit 31: CVS_HJC_00009576 Internal email thread investigating hub pharmacy activity 527
Exhibit 32: CVS_HJC_00009579 Internal email thread discussing changes to the provider manual.....531
Exhibit 33: CVS_HJC_00009621 Internal email thread investigating pharmacy dispensing patterns.....534
Exhibit 34: CVS_HJC_00009754 Internal email thread discussing changes to the provider manual.....537
Exhibit 35: CVS_HJC_00010046 Internal email thread investigating pharmacy dispensing patterns.....540
Exhibit 36: CVS_HJC_00010635 Internal email thread investigating hub pharmacy activity 545
Exhibit 37: CVS_HJC_00010909 Internal email thread investigating hub pharmacy activity 554
Exhibit 38: CVS_HJC_00010969 Internal CVS Caremark business presentation.....561
Exhibit 39: CVS_HJC_00011011 Internal CVS Caremark business presentation developing the plan to create an in-house hub pharmacy.....597
Exhibit 40: CVS_HJC_00011061 Industry research about Blink Rx.....638
Exhibit 41: CVS_HJC_00011092 Internal research about Blink Rx.....655
Exhibit 42: CVS_HJC_00011094 Internal email thread between David Joyner and others discussing Blink Rx 657
Exhibit 43: CVS_HJC_00011257 Internal email thread discussing Blink Rx's application to become a certified software vendor 660
Exhibit 44: CVS_HJC_00011347 BlueCross BlueShield Association audit report 664
Exhibit 45: CVS_HJC_00011370 Internal email thread discussing how Carepoint Pharmacy worked with Blink Rx.....676
Exhibit 46: CVS_HJC_00011411 Internal email thread discussing changes to the provider manual.....679
Exhibit 47: CVS_HJC_00011857 Cease-and-desist letter sent to White Drug 684

Exhibit 48: CVS_HJC_00011886 Internal email thread discussing White Drug's compliance with the cease-and-desist letter 687
Exhibit 49: CVS_HJC_00011904 Internal email thread discussing hub pharmacy activities.....690
Exhibit 50: CVS_HJC_00012275 Internal email thread discussing White Drug's compliance with the cease-and-desist letter 694
Exhibit 51: CVS_HJC_00012313 Internal email thread discussing White Drug's compliance with the cease-and-desist letter 699
Exhibit 52: CVS_HJC_00012329 Internal email thread discussing a CVS audit of an independent pharmacy.....702
Exhibit 53: CVS_HJC_00012411 Internal email thread discussing a CVS audit of an independent pharmacy.....708
Exhibit 54: CVS_HJC_00012459 Internal email thread discussing sending a cease-and-desist letter to an independent pharmacy 716
Exhibit 55: CVS_HJC_00012600 Email thread between White Drug's counsel and CVS discussing White Drug's compliance with the cease-and-desist letter 724
Exhibit 56: CVS_HJC_00012614 Internal email thread discussing a CVS audit of an independent pharmacy.....732
Exhibit 57: CVS_HJC_00012693 Email thread between Carepoint Pharmacy and CVS discussing Carepoint's compliance with the cease-and-desist letter.....739
Exhibit 58: CVS_HJC_00012783 Internal email thread discussing Blink Rx 742
Exhibit 59: CVS_HJC_00012791 Internal email thread discussing Blink Rx 745
Exhibit 60: CVS_HJC_00012799 Internal email thread discussing Blink Rx 748
Exhibit 61: CVS_HJC_00012827 Internal email discussing which medications are associated with Blink Rx.....751
Exhibit 62: CVS_HJC_00012860 Audit file for Postmeds Inc (January 24, 2019) 753
Exhibit 63: CVS_HJC_00012924 Audit file for Sterling Specialty Pharmacy 756
Exhibit 64: CVS_HJC_00012953 Audit file for White Drug (August 17, 2021).....760
Exhibit 65: CVS_HJC_00012979 Audit file for Postmeds Inc (September 28, 2021).....764
Exhibit 66: CVS_HJC_00013296 Audit file for White Drug (January 24, 2023).....771
Exhibit 67: CVS_HJC_00013336 Audit file for Carepoint Pharmacy (July 18, 2022).....774
Exhibit 68: CVS_HJC_00013373 Audit file for Nomi Pharma LLC.....778
Exhibit 69: CVS_HJC_00013451 Audit file for Postmeds Inc (January 9, 2024) 782
Exhibit 70: CVS_HJC_00013583 Audit file for Southwood Pharmacy.....785
Exhibit 71: CVS_HJC_00013600 Audit file for Deadborn Hills Pharmacy 788
Exhibit 72: CVS_HJC_00013637 Audit file for Carepoint Pharmacy (February 2, 2022).....791

Exhibit 73: CVS_HJC_00013689 Audit file for Sav-On Pharmacy.....795
Exhibit 74: CVS_HJC_00014043 Audit file for Smartscripts.....798
Exhibit 75: CVS_HJC_00014054 Audit file for Village Fertility Pharmacy.....802
Exhibit 76: CVS_HJC_00014149 Draft of the 2020 CVS Caremark Provider Manual 802
Exhibit 77: CVS_HJC_00019525 Audit file for Market 32 Pharmacy 894
Exhibit 78: CVS_HJC_00020368 Internal email thread discussing the “no hubs” language in CVS’s provider manual.....899
Exhibit 79: CVS_HJC_00020700 Internal email thread discussing hub pharmacy activities.....902

Exhibit 1: CVS_HJC_00000228 Cease-and-desist letter sent to Dearborn Hills Pharmacy

CVS/caremark 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

August 25, 2022

VIA UPS AND FACSIMILE 313-915-5415

HILLS COMMUNITY PHARMACY INC D/B/A DEARBORN HILLS PHARMACY
24755 FORD RD
DEARBORN, MI 48128

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP: 2377073 NPI: 1356699888

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between HILLS COMMUNITY PHARMACY INC D/B/A (DEARBORN HILLS PHARMACY) and philRx, Carepoint Pharmacy and/or aspn pharmacies for Trudhesa® prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> .....
>
> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

Caremark has reviewed prescriptions for our Plan Sponsors and determined DEARBORN HILLS PHARMACY is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands DEARBORN HILLS PHARMACY immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000228

REQUIRED ACTIONS

Caremark requires that DEARBORN HILLS PHARMACY:

1. Immediately cease allowing an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity; and
3. Reverse **ALL** Trudhesa® prescription claims submitted to Caremark for payment

DEARBORN HILLS PHARMACY's signed acknowledgement must be received by Caremark via facsimile **at (401) 404-6332 within two weeks of receipt of this letter (on or before September 08, 2022).** DEARBORN HILLS PHARMACY's failure to comply with the terms of this letter may result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with DEARBORN HILLS PHARMACY regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

_____	_____	_____
Signature of Pharmacy Owner	Print Name and Title	Date

CONFIDENTIAL TREATMENT REQUESTED

Exhibit 2: CVS_HJC_00000247 Cease-and-desist letter sent to NMB Pharmacy

9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

November 11, 2022

VIA UPS and FACSIMILE 305-768-9828

NCPDP: 5737703 NPI: 1467959783
NMB PHARMACY INC D/B/A NMB PHARMACY INC
1203 NE 163 RD ST STE 103, N MIAMI BEACH, FL 33162

Re: CVS Caremark® Provider Agreement – Final Notice- Cease and Desist

Dear NMB Pharmacy:

On August 25, 2022, CVS Caremark® ("Caremark") notified NMB Pharmacy ("NMB") that the pharmacy was submitting claims in breach of your Provider Agreement. For reference, the August 25, 2022 Cease and Desist letter is attached to this second notice. On September 8, 2022, NMB acknowledged and agreed to the required actions. To date, NMB has failed to comply with:

1. Reverse **ALL** Trudhesa® prescription claims submitted to Caremark for payment

This letter serves as the Final Notice and a reminder that failure to comply will result in termination of NMB's Provider Agreement (and participation in our pharmacy networks). Failure to comply by December 9, 2022, will result in Caremark instituting termination of your Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Regards,

CVS Caremark
Pharmacy Performance

CONFIDENTIAL TREATMENT REQUESTED

CVS caremark™

9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

August 25, 2022

VIA UPS AND FACSIMILE 305-768-9828

NMB PHARMACY INC D/B/A NMB PHARMACY INC
1203 NE 163 RD ST STE 103
N MIAMI BEACH, FL 33162

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP: 5737703 NPI: 1467959783

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between NMB PHARMACY INC D/B/A (NMB PHARMACY INC) and philRx, Carepoint Pharmacy and/or aspn pharmacies for Trudhesa® prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> .....
> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

Caremark has reviewed prescriptions for our Plan Sponsors and determined NMB PHARMACY INC is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands NMB PHARMACY INC immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

REQUIRED ACTIONS

Caremark requires that NMB PHARMACY INC:

CONFIDENTIAL TREATMENT REQUESTED

1. Immediately cease allowing an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity; and
3. Reverse **ALL** Trudhesa® prescription claims submitted to Caremark for payment

NMB PHARMACY INC's signed acknowledgement must be received by Caremark via facsimile **at (401) 404-6332 within two weeks of receipt of this letter (on or before September 08, 2022).** NMB PHARMACY INC's failure to comply with the terms of this letter may result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with NMB PHARMACY INC regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

Signature of Pharmacy Owner	Print Name and Title	Date

CONFIDENTIAL TREATMENT REQUESTED

Exhibit 3: CVS_HJC_00000283 Cease-and-desist letter sent to Southwood Pharmacy

CVS/caremark 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

September 24th, 2024

VIA UPS AND FACSIMILE 732-651-7685

SOUTHWOOD PHARMACY
15 RT 516
OLD BRIDGE, NJ 08857

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP #**3159452** NPI #**1609580489**

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between **SOUTHWOOD PHARMACY** and hub pharmacies for prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

The Caremark Provider Manual states in **3.03.03 Coupons and Other Programs**:

> *Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:*

a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program; or

b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location

Caremark has reviewed claims for our Plan Sponsors and determined **SOUTHWOOD PHARMACY** is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands **SOUTHWOOD PHARMACY** immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

REQUIRED ACTIONS

Caremark requires that **SOUTHWOOD PHARMACY**:

1. Immediately cease allowing an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity; and
3. Immediately cease allowing **all** pharmaceutical hubs to submit claims using Pharmaceutical Manufacturer Coupons to reduce member copayments; and
4. Immediately cease submitting test claims for benefit verification without a valid prescription; and
5. Immediately conduct a review of claims to determine which claims were test claims and where those claims are in paid status, reverse all outstanding paid test claims.
6. Provide Caremark with a Corrective Action Plan (CAP) using the following documentation guidelines.

Documentation Guidelines

CVS Caremark ***REQUIRES*** the following documentation to be provided by the pharmacy:

- ***Cover Letter*** – A letter signed by the pharmacy that describes what occurred and the plan to resolve the findings that resulted in the need for corrective action. Include the pharmacy name, address, name of contact person, and telephone number with your submitted documents; and
- ***Policy and Procedure Document*** –The policy and procedure document must contain the following elements:
    - Header - List the document title, number, approver, type, and relative dates.
    - Purpose - Explain the rationale of the policy.

  - Scope - List to whom the policy applies to (e.g. pharmacy manager, all pharmacy personnel, etc.).
  - Policy - Explain the Medicare Part D program requirement and/or other discrepancy that is being addressed in the document.
  - Procedures - List in logical format the steps to take explaining how the policy is implemented by the pharmacy, with specificity.
  - Review and Revision History - List any document revision dates and numbers. Also, include the reason for the update and the specific sections that were affected by the revision; and
- ***Training Attestation Document*** – Review and train pharmacy personnel on the pharmacy's policy. Once training has been conducted, the pharmacy should have all applicable employees sign a training attestation document confirming their understanding and adherence to the policy.
- ***Attachments*** – Other supporting documentation may be provided (including but not limited to Fraud, Waste, and Abuse training certificates and logs, Office of Inspector General internet search results, etc.) demonstrating methodology to prevent findings described above from future reoccurrence.

SOUTHWOOD PHARMACY'S signed acknowledgement and CAP must be received by Caremark via facsimile **at FAX # 480-661-2787 within two weeks of receipt of this letter (on or before October 8th, 2024). SOUTHWOOD PHARMACY'S** failure to comply with the terms of this letter may result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with **SOUTHWOOD PHARMACY** regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

_____	_____	_____
Signature of Pharmacy Owner	Print Name and Title	Date

Exhibit 4: CVS_HJC_00000362 Termination notice sent to Market 32 Pharmacy

CVS caremark™ 9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719 | 480-391-4359

September 5, 2023

Via UPS

Frier Levitt
[redacted]
84 Bloomfield Avenue
Pine Brook, NJ 07058

RE: Notice of Termination
Market 32 Pharmacy Store #244
NCPDP: 2245024
NPI: 1659754208

Dear [redacted]

CVS Caremark ("Caremark") is notifying you that Caremark will terminate the Provider Agreement of The Golub Corporation's Market 32 Pharmacy Store #244 (NCPDP 2245024) ("Market 32") pursuant to terms of the Provider Agreement effective 11/09/2023. Caremark has been in contact with you regarding its audit of Market 32. As a result of the audit findings, Caremark's Pharmacy Membership Review Committee ("PMRC") has examined Market 32's audit history, other aspects of the pharmacy's performance, and common ownership. During the December 5, 2022 audit ("The Audit"), which covered the time frame of August 1, 2021 through August 31, 2022 ("Audit Period"), Caremark discovered The Golub Corporation to be outsourcing pharmacy processes to Blink Health ("Blink") for Xhance® prescriptions, which is a direct violation of the Provider Agreement with Caremark.

Confirmation of the breach of contract was made by The Golub Corporation in an email to Caremark on November 21, 2022:

> *As requested, a report of the shipping amount of Xhance to the pharmacy under audit along with the requested signed attestation.*
>
> *In response to the rest of the inquiry, you've asked for information relating to who performs the following functions in the filling of Xhance prescriptions. Our responses are below:*
>
> 1. ***Bill claims to Caremark.*** *The dispensing pharmacy, Price Chopper/Market 32 Pharmacy Store #244 in Sutton, MA, bills the claim to Caremark.*
> 2. ***Apply Coupons or Other Offsets to the Adjudicated Patient Pay Amount.*** *Blink Health coordinates applying coupons to the patient pay amount pursuant to a Shared Services Agreement.*
> 3. ***Inform Patients of Patient Pay Responsibility****. Blink Health performs that function under the previously mentioned Shared Services Agreement.*
> 4. *Collect Copayments from Patients. Similarly, pursuant to that Shared Services Agreement, Blink Health directly collects copayments from the patient. Price Chopper Pharmacy subsequently invoices Blink Health for the collected copayment amount.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

And **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> 1. *Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> 2. *The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> 3. *Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> 4. *Provider is not allowed to submit claims on behalf of another entity;*
> 5. *Provider must only submit claims it intends to dispense; and*
> 6. *Provider may not act on behalf of another entity regardless of ownership structure.*

The Golub Corporation, in their November 21, 2022 email acknowledged their violation of the Caremark Provider Agreement and Provider Manual requirements and further indicated their intentional inappropriate pharmaceutical hub practices would stop pending Caremark's written authorization.

...

> *Please be advised that we are aware that revisions that have been made to the Provider Manual in recent years contain certain requirements on who and where patient pay amounts are to be collected and similar requirements relevant to coupons and other offsets. Please consider this a formal request for Caremark's authorization to continue with the process as outlined above. We will also submit a more formal request to this effect. Please also be advised that we have officially paused the process outlined above for copayments and coupons with respect to CVS/Caremark claims until we have CVS/Caremark's written authorization to proceed.*

Golub's request to continue their intentional violation of the Caremark Provider Agreement by continuing its pharmaceutical hub practices with Blink was expressly denied by Caremark on November 30, 2022, as communicated to you via email.

December 5, 2022

Caremark's December 5, 2022 audit identified $976,900.18 in discrepant claims billed by Market 32 to Caremark's plan sponsors.

Other - OTH

For claims marked discrepant as "Other" or "OTH", per Caremark's Initial Discrepancy List, "Pharmacy outsourced collection of copayments to third-party, which is specifically prohibited by contract."

An Appeal of Initial Audit Findings letter dated 01/31/2023, was submitted by you, on behalf of Market 32. This submission was reviewed as follows:

- Attorney Statements
  - Reference was made to two hundred eight (208) OTH discrepancies, with explanation that the adjudicated copayment amount for these claims was $0.00. It was further stated that Caremark could not maintain the discrepancies for claims that did not require any patient pay amount. Correlating adjudication screenshots were provided to support the statements made.

- A statement provided indicated the pharmacy dispensed and patients received the prescription medications and as such Caremark should reverse the Initial Findings including the discrepant dollar amount.

The audit finalized with two thousand sixty-two (2,062) OTH discrepancies. In addition, while Caremark denied The Golub Corporation's request on November 30, 2022 to continue pharmaceutical hub practices with Blink, Caremark discovered the pharmacy failed to comply.

Caremark received the Issue with Final Findings email communication, dated 02/20/2023. In addition, Caremark received a PowerPoint deck including additional documents, dated 03/14/2023. This information was reviewed as follows:

- Claims with $0.00 Patient Paid Amount
  - Statements were made regarding claims with $0.00 patient paid amount, indicating since no copays were due or collected, it cannot be asserted that a third-party collected copays on behalf of the pharmacy.
- Manufacturer Credit Card Claims
  - Three hundred twenty-six (326) claims were addressed, in part, with the following statement:

    These claims were processed the same as any other manufacturer assistance program. The Pharmacy received the single-use credit card information and charged the credit cards at the point of sale to collect patient copay amounts. These copays were not collected by a third-party, and were collected by the Pharmacy, at the Pharmacy.

    The statements made in the 03/14/2023 submission are concerning to Caremark as they contradict the explanations offered in the 11/21/2022 email communication provided by Market 32, "Similarly, pursuant to that Shared Services Agreement, Blink Health directly collects copayments from the patient. Price Chopper Pharmacy subsequently invoices Blink Health for the collected copayment amount."
  - Market 32 provided examples of receipts
    - The receipts provided represented forty-eight (48) unique dates between 08/02/2021-10/05/2021. Caremark's analysis of the documentation was as follows:
      1. Instances where the same credit card is used for different members
         Example 1:
         Rx 171938 – date of receipt 08/03/2021, Mastercard used, last four (4) digits of card: **6128**
         Rx 159588 – date of receipt 09/13/2021, Mastercard used, last four (4) digits of card: **6128**
         Example 2:
         Rx 172259 – date of receipt 09/07/2021, Mastercard used, last four (4) digits of card: **9764**
         Rx 169199 – date of receipt 08/13/2021, Mastercard used, last four (4) digits of card: **9764**
      2. The same sequence number is listed on the receipts for multiple members
      3. Instances where multiple transactions occurred on the same date, at the same time, and in the same lane for different members
      4. Receipts time stamped **after** the pharmacy's operating hours

5. Instances when the last four (4) digits of the credit card number listed in the transfer document submitted during the audit, does **not** match the last four (4) digits of the credit card number reflected in the corresponding receipt provided in the 03/14/2023 submission

- Blink
  - Market 32 asserts that it stopped utilizing Blink for any Caremark claims in early November. There is mention by Market 32 of six (6) "isolated" incidents where claims bypassed Market 32's security measures. While Market 32 ceased allowing Blink to adjudicate claims under their NCPDP using Blink's software certification ID ("cert ID"), the pharmacy continued to intentionally violate its agreement with Caremark by allowing Blink to directly submit test claims with Market 32's cert ID. Caremark's records indicate from November 1, 2022 through March 13, 2023, a total of one thousand nine hundred forty-two (1,942) claims were submitted by Blink utilizing Market 32's cert ID.
- Additional Security Measures
  - Market 32 explained the pharmacy "engaged its switch vendor to implement additional security measures" to prevent the six (6) isolated incidents from reoccurring in the future, including having a "hard stop" in place to prevent Caremark claims from being processed.

Caremark received the Notice of Dispute Appeal of Final Findings, dated 06/08/2023. This was reviewed as follows:

- Claims with $0.00 Patient Paid Amount
  - Statements were made indicating Caremark agreed to reverse each claim in the Final Findings for which no patient pay amounts were due at the point of sale.
  - Caremark credited two hundred seventy-one (271) OTH discrepancies
- Copay Collection at the Pharmacy
  - Approximately three hundred twenty (320) claims are addressed with duplicate statements previously provided, explaining Market 32 "charged, processed, and collected copays at the Pharmacy's physical location." Caremark reiterates that this explanation contradicts statements submitted in the 11/21/2022 communication provided by Market 32.
- Manufacturer Credit Card Claims – Caremark's concerns regarding the receipts provided in the 03/14/2023 submission are addressed as follows:
  - Single use credit cards
    - It's stated that it should be expected that certain cards contain the same last four (4) digits on rare occasions as there are only a limited number of possible combinations. In addition, the pharmacy only identified two (2) instances where single-use credit cards contained the same last four (4) digits.
  - Reference/Sequence Numbers
    - It's explained that the pharmacy's review of the receipts did not show repetition of a single reference/sequence.
  - Time Stamps on Receipts
    - Statements provided indicate the time stamps on the receipts submitted range from 9:02 AM to 8: 20 PM. It's claimed only six (6) of the over three hundred (300) receipts submitted include time stamps after 8:00 PM. Explanations are offered, stating one (1) receipt has a time stamp of 8:01 PM while the remaining five (5) were a result of an unannounced routine compliance inspection, causing the pharmacy to stay open late.
- The Golub Corporation's Cease and Desist to Blink
  - Attorney Statements
    - It was revealed that Market 32 met with Blink on 04/20/2023. During this meeting, Blink confirmed that it had "inadvertently not fully complied with the Pharmacy's

request to cease providing services for Caremark patients and, unbeknownst to the Pharmacy, was submitting test claims for purposes of eligibility identification."

- A Cease and Desist Notice to Blink was issued on 04/21/2023, demanding that Blink cease all services, including the submission of test claims.
- Market 32 and Blink met again on 05/08/2023. In this call, Blink indicated a "hard stop" was in place in their system to prevent running any claims, including test claims, for Caremark claims; however, after this call Blink admitted an error occurred resulting in some test claims being submitted with Caremark members.

After the credit of the two hundred seventy-one (271) OTH discrepancies, the audit was re-finalized with one thousand seven hundred ninety-one (1,791) OTH discrepancies remaining

On 06/15/2023 Caremark received an email communication stating The Golub Corporation provided Blink with an official Notice of Termination of the Participating Pharmacy Agreement.

PMRC Review

In a letter dated 02/24/2023 Caremark notified Market 32 that it would be presented to PMRC for review and possible termination. In that letter, Caremark requested Market 32 submit any additional documentation for PMRC's review by 03/10/2023. Several extensions were requested and permitted. On 06/15/2023, Caremark received an email communication stating The Golub Corporation provided Blink with an official Notice of Termination of the Participating Pharmacy Agreement. In addition, Caremark received the Supplemental Response for PMRC Review letter, dated 06/23/2023. All information submitted was reviewed and taken into consideration by the PMRC Committee.

After careful review, the PMRC concluded that Market 32 is not in compliance with its Caremark Provider Agreement. As such, the PMRC voted to terminate Market 32's Provider Agreement with cause for a two (2) year period. Additionally, to the extent not otherwise precluded by applicable law, Caremark has also elected to terminate the Provider Agreement without cause under the terms of the Caremark Provider Manual.

Market 32 will be terminated from the Caremark network effective 11/09/2023 and can apply for reinstatement after 11/09/2025. Should Market 32 choose to re-apply for network enrollment at the end of their two (2) year termination, Market 32's request will be presented to the PMRC for evaluation. At such time Market 32 will be required to submit credentialing documentation as requested as well as a robust Corrective Action Plan that specifically identifies processes and procedures that if followed will reasonably assure Caremark that Market 32 will operate in conformity with the terms of the Provider Agreement. If approved for reinstatement, Market 32 will be required to successfully complete the standard enrollment process.

Regards,

CVS Caremark
Pharmacy Performance

cc: The Golub Corporation, [redacted] / 461 Nott Street / MB#202 / Schenectady, NY 12308
[redacted]
Steven McCall RPh, VP, Network Performance
Jackie Terrel PharmD, Director, Pharmacy Performance
Jennifer Thomas CPhT, Senior Manager, Pharmacy Performance

Exhibit 5: CVS_HJC_00000367 Breach of contract notice sent to Market 32 Pharmacy

9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719 | 480-391-4359

CVS caremark™

2/24/2023

The Golub Corporation
[redacted]
461 Nott Street MB#202
Schenectady, NY 12308

Via Email: [redacted] **and UPS**

Re: Notice of Review of Breach of Contract – The Golub Corporation

Dear [redacted]

As you are aware, CVS Caremark ("Caremark") has recently concluded an audit, dated **December 5, 2022,** of The Golub Corporation ("Golub"). Caremark's audit identified $1,143,441.02 in discrepant claims at Golub's Market 32 Pharmacy Store #244 ("Market 32") (NCPDP 2245024). The entirety of these discrepancies are due to Golub outsourcing pharmacy processes to Blink Health ("Blink") for Xhance® prescriptions, which is a direct violation of your Provider Agreement with Caremark.

Confirmation this breach of contract was made by Golub in an email to Caremark on November 21, 2022:

> *As requested, a report of the shipping amount of Xhance to the pharmacy under audit along with the requested signed attestation.*
>
> *In response to the rest of the inquiry, you've asked for information relating to who performs the following functions in the filling of Xhance prescriptions. Our responses are below:*
>
> > *1. Bill claims to Caremark. The dispensing pharmacy, Price Chopper/Market 32 Pharmacy Store #244 in Sutton, MA, bills the claim to Caremark.*
> > *2. Apply Coupons or Other Offsets to the Adjudicated Patient Pay Amount. Blink Health coordinates applying coupons to the patient pay amount pursuant to a Shared Services Agreement.*
> > *3. Inform Patients of Patient Pay Responsibility. Blink Health performs that function under the previously mentioned Shared Services Agreement.*
> > *4. Collect Copayments from Patients. Similarly, pursuant to that Shared Services Agreement, Blink Health directly collects copayments from the patient. Price Chopper Pharmacy subsequently invoices Blink Health for the collected copayment amount.*
>
> ...

The Caremark Provider Manual **3.03.01 Collection of Patient Pay Amounts states**:

> .....
>
> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for*

CVS caremark™

which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.

And **4.12 Dispensing Pharmacy NPI/NCPDP**:

Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.
1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;
2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;
3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;
4. Provider is not allowed to submit claims on behalf of another entity;
5. Provider must only submit claims it intends to dispense; and
6. Provider may not act on behalf of another entity regardless of ownership structure.

Golub acknowledged understanding these Provider Manual requirements in their November 21, 2022 email and further indicated the inappropriate pharmaceutical hub practices would stop pending Caremark's written authorization.

...

Please be advised that we are aware that revisions that have been made to the Provider Manual in recent years contain certain requirements on who and where patient pay amounts are to be collected and similar requirements relevant to coupons and other offsets. Please consider this a formal request for Caremark's authorization to continue with the process as outlined above. We will also submit a more formal request to this effect. Please also be advised that we have officially paused the process outlined above for copayments and coupons with respect to CVS/Caremark claims until we have CVS/Caremark's written authorization to proceed.

Golub's request to continue their pharmaceutical hub practices with Blink was expressly denied by Caremark on November 30, 2022, as communicated to you via email. Regrettably, Golub has continued using Blink as a pharmaceutical hub for billing Xhance after being notified of Caremark's denial. Therefore, Golub is not in compliance with the above listed provisions of the Caremark Provider Manual.

As a result of the continued and intentional non-compliance, and the egregious audit findings, Golub will be presented to our Pharmacy Membership Review Committee (PMRC). The PMRC will review the practices between Golub and Blink, the audit findings, past audit results (if applicable), pharmacies under common ownership and/or management, and your non-compliance with the Provider Agreement. The PMRC committee will render a decision concerning your pharmacy membership in the Caremark network.

If the PMRC terminates your Provider Agreement, its decision will be final.

CVS caremark™

All information you provided to Caremark during the course of the audit will be presented; however, if you have any documentation not presented during the audit to dispute the audit findings provided to you in the FINAL AUDIT DISCREPANCY LIST, you must submit those immediately to the address below in order for the documentation to be included in the PMRC's review.

Sincerely,

CVS Caremark
Pharmacy Performance
9501 E Shea Boulevard MC 020
Scottsdale, AZ 85260

DOCUMENTATION DEADLINE FOR PMRC CONSIDERATION: 03/10/2023.
Information and documents received after that date will not be considered or presented to the PMRC.

cc: Frier Levitt: [redacted]

Exhibit 6: CVS_HJC_00000370 Cease-and-desist letter sent to Med Cart Specialty Pharmacy

DocuSign Envelope ID: B5B4C6EB-543A-4C67-8E90-94B9E0EFFF53

CVS/caremark

9501 E. Shea Blvd Scottsdale AZ 85260 Phone (480) 391-4600

Fax

To:		**From:**	Expanded Audit
Fax:	[redacted]	**Fax:**	
Company:		Voice:	
Date:	March 06, 2023	Pages:	5
Subject:	Med Cart Specialty Pharmacy C & D		

Comments:

Thank you

| Pharmacy Performance, CVS Caremark
9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260
[CVS]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

CONFIDENTIALITY NOTICE:
This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or it's contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

DocuSign Envelope ID: B5B4C6EB-543A-4C67-8E90-94B9E0EFFF53

DocuSign Envelope ID: B5B4C6EB-543A-4C67-8E90-94B9E0EFFF53



DocuSign Envelope ID: B5B4C6EB-543A-4C67-8E90-94B9E0EFFF53

CVS/caremark 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

Monday March 6, 2023

VIA UPS AND FACSIMILE 734-762-6601
CC: New Albertsons, Inc. (CC 2196)

Med Cart Specialty Pharmacy
32131 Industrial Road
Livonia, MI 48150

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP 2374445 NPI 1225343221

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between Med Cart Specialty Pharmacy, Blink Rx, Carepoint Pharmacy and/or other hub pharmacies for prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

Caremark has reviewed prescriptions for our Plan Sponsors and determined Med Cart Specialty Pharmacy is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands Med Cart Specialty Pharmacy immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

REQUIRED ACTIONS

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000373

DocuSign Envelope ID: B5B4C6EB-543A-4C67-8E90-94B9E0EFFF53

CVS/caremark 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

Caremark requires that Med Cart Specialty Pharmacy :

1. Immediately cease allowing an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease allowing **all** pharmaceutical hubs including those using the following CERT ID's to submit test claims using your NPI number and NCPDP number.

Wellsky	D012000045
Digital Simplistics	D012000047
CarePoint	D012000149
	D012500011

3. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity

Med Cart Specialty Pharmacy signed acknowledgement must be received by Caremark via facsimile **at (480) 661-2787 within two weeks of receipt of this letter (on or before March 20, 2023).** Med Cart Specialty Pharmacy failure to comply with the terms of this letter may result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with Med Cart Specialty Pharmacy regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

DocuSigned by:
[redacted]

Signature of Pharmacy Owner | [redacted] Print Name and Title | 03-17-2023 | 10:29:44 PDT Date

CONFIDENTIAL TREATMENT REQUESTED

Exhibit 7: CVS_HJC_00000375 Cease-and-desist letter sent to Nomi Pharma LLC

CVS caremark™ 9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719 | 480-391-4359

November 8, 2024

VIA UPS AND FACSIMILE 385-375-6563

Nomi Pharma LLC
3696 West 2100 S
Salt Lake City, UT 84120

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP # 4615223 NPI # 1669123279

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between **Nomi Pharma LLC** and **ASPN** and/or other HUB pharmacies for prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

The Caremark Provider Manual states in **3.03.03 Coupons and Other Programs**:

> *Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:*

a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program; or

b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location

Caremark has reviewed claims for our Plan Sponsors and determined **Nomi Pharma LLC** is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands **Nomi Pharma LLC** immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

REQUIRED ACTIONS

Caremark requires that **Nomi Pharma LLC**

1. Immediately cease allowing **all** pharmaceutical hubs including **ASPN** to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity; and
3. Immediately cease allowing **all** pharmaceutical hubs to submit claims using Pharmaceutical Manufacturer Coupons to reduce member copayments; and
4. Immediately cease submitting test claims for benefit verification without a valid prescription; and
5. Immediately conduct a review of claims to determine which claims were test claims and where those claims are in paid status, reverse all outstanding paid test claims.
6. Provide Caremark with a Corrective Action Plan (CAP) using the following documentation guidelines.

Documentation Guidelines

CVS Caremark ***REQUIRES*** the following documentation to be provided by the pharmacy:

- ***Cover Letter*** – A letter signed by the pharmacy that describes what occurred and the plan to resolve the findings that resulted in the need for corrective action. Include the pharmacy name, address, name of contact person, and telephone number with your submitted documents; and
- ***Policy and Procedure Document*** –The policy and procedure document must contain the following elements:
  - Header - List the document title, number, approver, type, and relative dates.
  - Purpose - Explain the rationale of the policy.
  - Scope - List to whom the policy applies to (e.g. pharmacy manager, all pharmacy personnel, etc.).

  - Policy - Explain the Medicare Part D program requirement and/or other discrepancy that is being addressed in the document.
  - Procedures - List in logical format the steps to take explaining how the policy is implemented by the pharmacy, with specificity.
  - Review and Revision History - List any document revision dates and numbers. Also, include the reason for the update and the specific sections that were affected by the revision; and
- ***Training Attestation Document*** – Review and train pharmacy personnel on the pharmacy's policy. Once training has been conducted, the pharmacy should have all applicable employees sign a training attestation document confirming their understanding and adherence to the policy.
- ***Attachments*** – Other supporting documentation may be provided (including but not limited to Fraud, Waste, and Abuse training certificates and logs, Office of Inspector General internet search results, etc.) demonstrating methodology to prevent findings described above from future reoccurrence.

Nomi Pharma LLC signed acknowledgement and CAP must be received by Caremark via facsimile **at 480-661-2787 within two weeks of receipt of this letter (on or before December 20, 2024).**

Caremark takes this breach of contract very seriously and **Nomi Pharma LLC** failure to comply with the terms of this letter will result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with **Nomi Pharma LLC** regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

_____	_____	_____
Signature of Pharmacy Owner	Print Name and Title	Date

Exhibit 8: CVS_HJC_00000396 Cease-and-desist letter sent to Sav-On Pharmacy

CVS Health®

Fax

To: [redacted]
Fax:
Company:
Date: Thursday, September 7, 2023 11:57:10 AM

From: **Tran, Cindy L**
Fax:
Voice:
Pages: 05

Subject:

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Hello Sav-On's Pharmacy,

Please see attached.

Thank you,
Cindy Tran | Sr Business Analyst, Pharmacy Management, CVS/Caremark
[redacted]
9501 East Shea Blvd, MC-020, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

CVS/caremark 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

September 7, 2023

VIA UPS AND FACSIMILE 714-960-6828
CC: Chain Contact Chain Code: 2029

SAV-ON PHARMACY 0110
7201 YORKTOWN AVE
HUNTINGTON BEACH, CA 92648

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP **# 0535724** NPI **#1487600037**

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between **SAV-ON PHARMACY 0110** and hub pharmacies for prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**: **1487600037/0535724**

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

The Caremark Provider Manual states in **3.03.03 Coupons and Other Programs**:

> *Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:*
>
> *a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program; or*

b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location

Caremark has reviewed claims for our Plan Sponsors and determined **SAV-ON PHARMACY 0110** is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands **SAV-ON PHARMACY 0110** immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

REQUIRED ACTIONS

Caremark requires that **SAV-ON PHARMACY 0110**:

1. Immediately cease allowing an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease allowing **all** pharmaceutical hubs including those using the following CERT ID's to submit test claims using your NPI number and NCPDP number; and

CERT ID's: D012000149, D012000047 D012500011

3. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity; and
4. Immediately cease allowing **all** pharmaceutical hubs to submit claims using Pharmaceutical Manufacturer Coupons to reduce member copayments; and
5. Immediately cease submitting test claims for benefit verification without a valid prescription; and
6. Immediately conduct a review of claims to determine which claims were test claims and where those claims are in paid status, reverse all outstanding paid test claims.
7. Provide Caremark with a Corrective Action Plan (CAP) using the following documentation guidelines.

Documentation Guidelines

CVS Caremark ***REQUIRES*** the following documentation to be provided by the pharmacy:

- ***Cover Letter*** – A letter signed by the pharmacy that describes what occurred and the plan to resolve the findings that resulted in the need for corrective action. Include the pharmacy name, address, name of contact person, and telephone number with your submitted documents; and
- ***Policy and Procedure Document*** –The policy and procedure document must contain the following elements:
  - Header - List the document title, number, approver, type, and relative dates.
  - Purpose - Explain the rationale of the policy.
  - Scope - List to whom the policy applies to (e.g. pharmacy manager, all pharmacy personnel, etc.).
  - Policy - Explain the Medicare Part D program requirement and/or other discrepancy that is being addressed in the document.
  - Procedures - List in logical format the steps to take explaining how the policy is implemented by the pharmacy, with specificity.

  - Review and Revision History - List any document revision dates and numbers. Also, include the reason for the update and the specific sections that were affected by the revision; and
- ***Training Attestation Document*** – Review and train pharmacy personnel on the pharmacy's policy. Once training has been conducted, the pharmacy should have all applicable employees sign a training attestation document confirming their understanding and adherence to the policy.
- ***Attachments*** – Other supporting documentation may be provided (including but not limited to Fraud, Waste, and Abuse training certificates and logs, Office of Inspector General internet search results, etc.) demonstrating methodology to prevent findings described above from future reoccurrence.

Pharmacy Name signed acknowledgement and CAP must be received by Caremark via facsimile **at FAX #** 480-661-2787 **within two weeks of receipt of this letter (on or before DATE). SAV-ON PHARMACY 0110** failure to comply with the terms of this letter may result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with **SAV-ON PHARMACY 0110** regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

_____ _____

Signature of Pharmacy Owner Print Name and Title Date

Exhibit 9: CVS_HJC_00000406 Cease-and-desist letter sent to Village Fertility Pharmacy

CVS caremark™
9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719 | 480-391-4359

November 8, 2024

VIA UPS AND FACSIMILE 877-334-1602

Village Fertility Pharmacy
335 Bear Hill Road
Waltham, MA 02451

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP # 2238005 NPI # 1225182595

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between **Village Fertility Pharmacy** and **Blink RX** and/or other HUB pharmacies for prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

The Caremark Provider Manual states in **3.03.03 Coupons and Other Programs**:

> *Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:*

a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program; or

b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location

Caremark has reviewed claims for our Plan Sponsors and determined **Village Fertility Pharmacy** is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands **Village Fertility Pharmacy** immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

REQUIRED ACTIONS

Caremark requires that **Village Fertility Pharmacy**

1. Immediately cease allowing **all** pharmaceutical hubs including **BLINK RX** to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity; and
3. Immediately cease allowing **all** pharmaceutical hubs to submit claims using Pharmaceutical Manufacturer Coupons to reduce member copayments; and
4. Immediately cease submitting test claims for benefit verification without a valid prescription; and
5. Immediately conduct a review of claims to determine which claims were test claims and where those claims are in paid status, reverse all outstanding paid test claims.
6. Provide Caremark with a Corrective Action Plan (CAP) using the following documentation guidelines.

Documentation Guidelines

CVS Caremark ***REQUIRES*** the following documentation to be provided by the pharmacy:

- ***Cover Letter*** – A letter signed by the pharmacy that describes what occurred and the plan to resolve the findings that resulted in the need for corrective action. Include the pharmacy name, address, name of contact person, and telephone number with your submitted documents; and
- ***Policy and Procedure Document*** –The policy and procedure document must contain the following elements:
  - Header - List the document title, number, approver, type, and relative dates.
  - Purpose - Explain the rationale of the policy.
  - Scope - List to whom the policy applies to (e.g. pharmacy manager, all pharmacy personnel, etc.).

  - Policy - Explain the Medicare Part D program requirement and/or other discrepancy that is being addressed in the document.
  - Procedures - List in logical format the steps to take explaining how the policy is implemented by the pharmacy, with specificity.
  - Review and Revision History - List any document revision dates and numbers. Also, include the reason for the update and the specific sections that were affected by the revision; and
- ***Training Attestation Document*** – Review and train pharmacy personnel on the pharmacy's policy. Once training has been conducted, the pharmacy should have all applicable employees sign a training attestation document confirming their understanding and adherence to the policy.
- ***Attachments*** – Other supporting documentation may be provided (including but not limited to Fraud, Waste, and Abuse training certificates and logs, Office of Inspector General internet search results, etc.) demonstrating methodology to prevent findings described above from future reoccurrence.

Village Fertility Pharmacy's signed acknowledgement and CAP must be received by Caremark via facsimile **at 480-661-2787 within two weeks of receipt of this letter (on or before November 22, 2024).**

Caremark takes this breach of contract very seriously and **Village Fertility Pharmacy's** failure to comply with the terms of this letter will result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with **Village Fertility Pharmacy's** regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

_____	_____	_____
Signature of Pharmacy Owner	Print Name and Title	Date

Exhibit 10:
CVS_HJC_00000424 Response to final notice sent from CVS to White Drug

CVS caremark™
9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719

Amy K. Lyster
Senior Counsel
[redacted]

VIA EMAIL

August 22, 2024

Thrifty White Stores d/b/a White Drug #061
706 38th Street North
Suite A
Fargo, ND 58102

RE: Final Notice - Response
NCPDP 3504138 NPI 1003906942

Dear Attorney [redacted]:

By this letter, CVS Caremark ("Caremark") hereby notifies your client Thrifty White Stores d/b/a White Drug #0061 ("White Drug") that it has received White Drug's final notice response dated July 26, 2024. White Drug states in its response:

> ...
> *To be clear, no third party has permission to utilize White Drug's information to submit claims to Caremark.*
> ...
> *White Drug has vigorously endeavored to put the actions in place that were outlined in its May 23, 2024 response to Caremark and believed such actions had resolved the issue.*

However, Caremark's data analytics continue to show submitted test or eligibility claims utilizing White Drug's NCPDP or NPI number. The details of these identified claims are summarized below:

PHMCY_NM	NCPDP_PRVDR_ID	DRUG_LBL_NM	RX_NBR	FILL_DT
WHITE DRUG	3504138	AUVI-Q 2 PK KIT 0.3MG	916124157	**10/20/2024**
WHITE DRUG	3504138	AUVI-Q 2 PK KIT 0.3MG	916784952	**8/16/2032**

It appears that White Drug's response on this issue continues to be less than forth coming.

Caremark also made the following outreaches to White Drug concerning claims for ACCRUFeR® and Miebo® that raised additional concerns:

- **White Drug 61 (3504138) – Rx# 4292609**
  - On June 5, 2024, during Caremark's conversation with White Drug to correct the days' supply on a submitted ACCRUFeR® claim, the pharmacy staff responded, *"they have to call BLINK program and ask them to eat the cost for 120 tablets per insurance will only allow 30 days."*

- **White Drug 61 (3504138) – Rx# 4250787**
  - On July 2, 2024, during Caremark's conversation with White Drug to correct the days' supply on a submitted ACCRUFeR® claim, the pharmacy staff responded, *"it was processed through BLINK program."*

- **White Drug 61 (3504138) – Rx# 4548267**
  - On July 30, 2024, during Caremark's conversation with White Drug on a Miebo® claim, the pharmacy staff stated, *"Pharmacy uses second party billing – BLINK."* The call continued on August 8, 2024 and Caremark was told, *"They emailed BLINK, but BLINK has not responded."* Lastly, on August 13, 2024, White Drug's staff stated, *"They have reached out to BLINK with no response."*

These actions demonstrate your client's continued violations of the Caremark Provider Agreement and Provider Manual including, but not limited to, Sections 4.03, 4.12, and 4.16.

Due to the persistent failure of White Drug to comply with its contractual obligations, the pharmacy must correct the record, implement appropriate controls to stop the submission of test or eligibility claims, and remedy their noncompliance as indicated in the **Required Actions** section of this letter **immediately**. This is White Drug's **FINAL WARNING** on this matter.

REQUIRED ACTIONS

1. An explanation of why test or eligibility claims continue to be submitted and identified by Caremark despite White Drug's representations that it endeavors to cease the submission of these claims;
2. An understanding of why Caremark was told the BLINK program continues to be involved in the submission of White Drug's claims;
3. Full compliance with the provisions of the Provider Agreement and Provider Manual including, but not limited to, Sections 4.03, 4.12, and 4.16 referenced in the original Cease and Desist letter;
4. Listing of all vendors/partners/service providers/non-owned pharmacies and/or intermediary entities that send prescriptions to White Drug (directly or indirectly) other than the original prescriber;
5. Production to Caremark of all documents concerning White Drug's relationship with BlinkRx; and
6. Production of all documents related to other third parties that may be forwarding prescriptions to White Drug for activity, including dispensing.

Caremark requires that White Drug provide its responses in writing.

Should White Drug fail to respond to this **FINAL NOTICE** by **September 5, 2024**, it may be deemed in further violation of the Provider Agreement and Provider Manual and Caremark may immediately exercise all available rights and remedies, including and up to termination of White Drug from the

Caremark networks. Caremark otherwise reserves all rights and remedies available to it under contract and other applicable Law.

Sincerely,

Amy K. Lyster

Amy K. Lyster
Senior Counsel

Exhibit 11:
CVS_HJC_00000427 Response to final notice sent from White Drug's counsel to CVS

BAKER DONELSON
BEARMAN, CALDWELL & BERKOWITZ, PC

901 K STREET, N.W.
SUITE 900
WASHINGTON, D.C. 20001

PHONE: [redacted]
FAX: [redacted]

www.bakerdonelson.com

[redacted] SHAREHOLDER
Direct Dial: [redacted]
Direct Fax: [redacted]
E-Mail Address: [redacted]

September 11, 2024

VIA E-MAIL

Amy Lyster
Senior Counsel
CVS Caremark
9501 E. Shea Blvd
Scottsdale, AZ 85260

Re: Thrifty White Stores d/b/a White Drug #061
NCPDP: 3504138
NPI: 1003906942

Dear Attorney Lyster:

As you know, this firm represents White Drug #061 located in Fargo, North Dakota ("White Drug or Pharmacy). White Drug is in receipt of your August 22, 2024 correspondence entitled "*Final Notice – Response*" ("Notice").

The Notice states, in part, that "Caremark's data analytics continue to show submitted test or eligibility claims utilizing White Drug's NCPDP or NPI number." Two claims are referenced as examples. However, the fill dates for these two claims are listed by Caremark as 10/20/2024 and 8/16/2032 - neither of which have occurred. The Pharmacy researched the matter and has found no evidence that these two claims were submitted within the past year. We once again request more information regarding these claims.

The Notice seeks an explanation as to "why test or eligibility claims continue to be submitted and identified by Caremark despite White Drug's representations that it endeavors to cease the submission of these claims." Further, the Notice cites Sections 4.03, 4.12, and 4.16 referenced in the original Cease and Desist Letter. The Pharmacy complies with these provisions. As highlighted in prior correspondence to Caremark, White Drug has undertaken extensive efforts to prevent third parties from submitting test or eligibility claims utilizing its NCPDP or NPI number. This includes working with RelayHealth, Change Healthcare and RedSail to ensure edits are placed into their system to block such possibility. Change Healthcare and RelayHealth have informed the Pharmacy that blocks are active and in place. To be clear, no third party is authorized to use the White Drug's NPI number, NCPDP number or other identifier to submit a claim to Caremark.

CONFIDENTIAL TREATMENT REQUESTED

The Notice further seeks information regarding third parties that send prescriptions to White Drug. The Pharmacy has been in business for over 20 years and may receive transfers to fill prescriptions. However, no third party has the authority to submit claims to Caremark.

The Notice references BlinkRx and suggests that Blink "continues to be involved in the submission of White Drug's claims." White Drug has no knowledge or evidence of any such claim submissions by Blink. Further, Blink has no authority whatsoever to submit claims on behalf of the Pharmacy. In fact, the Pharmacy has acted to prevent such behavior from being possible. Once again, the Pharmacy has worked with Change Healthcare and RelayHealth to prevent third parties, including Blink, from submitting claims with the Pharmacy's information. We assume that the Notice would have included evidence of Blink claim submissions had they been occurring.

White Drug looks forward to continuing its longstanding relationship with Caremark. Should Caremark see any evidence of third-party claim submissions in the future, the Pharmacy again requests that it be informed immediately so that they can identify and take appropriate action against the perpetrator.

Please contact me should you have any additional questions. The Pharmacy will continue to be vigilant on this matter.

Sincerely,

[redacted]

Enclosure

cc: White Drug #061
[redacted]

Exhibit 12:
CVS_HJC_00000541 CVS Caremark 2024 Provider Manual

CONFIDENTIAL AND PROPRIETARY – FOIA EXEMPT – DO NOT DISCLOSE

2024 CVS Caremark Provider Manual

Provider Manual

CVS caremark®

Table of Contents

1. General Information 5

1.01 Proprietary Statement 5
1.02 Requirement to Adhere to Provider Agreement and Provider Manual 5
1.03 Contacting Caremark 5
1.04 Pharmacy Help Desk 5
1.05 Contact Information and Additional Resources 5
1.06 Pharmacy Communications 5
1.07 CVS Caremark Pharmacy Portal 6
1.07.01 Pharmacy Portal Terms of Use 6
1.08 Questions Asked by Providers 7
1.08.01 Pharmacy Audit and Pharmacy Compliance 7
1.08.02 Network Contract Rates/Terms 8
1.08.03 Provider Enrollment, Credentialing, Change of Ownership 8
1.08.04 Claims Processing and Benefit Plan Design 8

2. Credentialing 11

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

3. Pharmacy Services and Standards 20

3.01 Providing Pharmacy Services to Eligible Persons 20
3.01.01 Professional Judgment and Conduct 20
3.01.02 Verification of Eligible Persons 20
3.01.03 Identification Cards 20
3.01.04 Nondiscrimination 20
3.01.05 Eligible Person Solicitation 20
3.01.06 Eligible Person Complaints 21
3.01.07 Patient Receipts and Insurance Profiles 21
3.01.08 Educational Materials and Efforts 21
3.02 Dispensing Requirements 21
3.02.01 Hours of Operation 21
3.02.02 Drug Stock and Inventory 21
3.02.03 Aberrant Practices and Trends 21
3.02.04 Dispensing Covered Items to Eligible Person's Agent 22
3.02.05 Performance Initiatives 22
3.02.06 Dispensing Errors 22
3.03 Patient Pay 22
3.03.01 Collection of Patient Pay Amounts 22
3.03.02 Usual and Customary Price 23
3.03.03 Coupons and Other Programs 23
3.03.04 Proof of Payment 24
3.03.05 Excess Collections 24
3.03.06 Limitation on Collection 24
3.03.07 Patient Inducements 24
3.03.08 Waivers 25
3.03.09 Financial Hardship Program 25
3.03.10 Documentation 25
3.03.11 Violations 25
3.04 Standards of Operation 26
3.04.01 Other Standards of Operations 26

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000542

TABLE OF CONTENTS

3.05 Records 27
3.05.01 Documents and Records Maintenance 27
3.05.02 Signature Log – Hard Copy or Electronic 27
3.05.03 Prescription Information 28
3.06 Referrals 28
3.06.01 Referral Fees 28
3.06.02 Referrals to Non-Retail Participating Providers 28

4. Claims Submission 29

4.01 Payer Sheets and Reject Codes 29
4.02 General Claim Submission Policies 29
4.03 Other Claim Submission Requirements 30
4.04 Dispense as Written Codes 32
4.05 Usual and Customary Validation 32
4.06 Over-the-Counter Products 33
4.07 Multi-Ingredient Compound Processing 33
4.08 Overrides 35
4.09 Natural Disasters 36
4.10 Coordination of Benefits 36
4.10.01 Multiple Transaction Coordination of Benefits 36
4.10.02 Single Transaction Coordination of Benefits 36
4.11 Long-Term Care Billing 37
4.12 Dispensing Pharmacy NPI/NCPDP 37
4.13 Prescriber Identification; Prescriptive Authority 37
4.14 Transaction Fees 37
4.15 Electronic Submission, Reversal, and Processing Windows 38
4.15.01 Universal Claim Form Requirement 38
4.16 Software Certification 38
4.17 Schedule of Claims Systems Maintenance 38
4.17.01 Additional Required Procedures 39
4.18 Provider Taxes 39

5. Clinical Programs, Services and Related Messages 40

5.01 Drug Utilization Review 40
5.02 DUR Conflict Codes and Messaging 40
5.03 Refill-Too-Soon or Excessive Utilization Reject 40
5.04 Drug-Drug Interaction Reject Program 41
5.05 Formularies 41
5.06 Prior Authorization 41
5.07 Managed Drug Limitations/Quantity vs. Time 42
5.08 Dose Optimization 42
5.09 Step Therapy 43
5.10 Plan Sponsor Programs 43
5.11 Federal Regulatory Quality Assurance Programs 43
5.12 Clinical Studies/Trials 43
5.13 Vaccines and Medication Administration 44

6. Network Participation and Payment 45

6.01 Network Participation 45
6.02 Provider Payment 45
6.02.01 General Reimbursement 45
6.02.02 Multi-Ingredient Compound Reimbursement 46
6.02.03 Vaccine and Non-Vaccine Injectable Administration Reimbursement 46
6.02.04 Adjustments to Reimbursement 46
6.02.05 Post-Adjudication Settlements 46
6.02.06 Other Entity Adjudication 47
6.03 Changes to Average Wholesale Price 47
6.04 Maximum Allowable Cost 47
6.05 Eligible Person Fees and Amounts 48
6.06 Claims Payment and Other Fees 48
6.06.01 Remittance Advices 48
6.06.02 Disputed Claims, Collected Fees, Amounts, or Recoupments 48
6.06.03 Claims Adjustment 49
6.07 Recoupment and Adjustments 49
6.08 Workers' Compensation 49
6.09 Consumer Card 50
6.10 Provider Suspension 50
6.11 Directories 50
6.12 Collection of Regulatory or Other Governmental Agency Assessment 50

7. Compliance Reviews 51

7.01 Non-Compliance Fees 52
7.02 Additional Information Regarding Compliance Reviews 52

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000543

TABLE OF CONTENTS

8. Professional Audits 53

8.01 Types of Audits 53
8.01.01 On-site Audits 53
8.01.02 Expanded Audits 53
8.01.03 Desktop Audits 53
8.01.04 Audits by Government Agencies 53
8.02 Professional Audits Rights 54
8.03 Documents and Records Production Related to Audits 54
8.04 Documents and Records Subject to Audit 55
8.05 Supply of Covered Items; Purchase Invoices 56
8.05.01 Invoice Documents and Records Maintenance 57
8.06 Medicare Part D Requirements 57
8.07 On-Site and Expanded Audit Resolution – Appeals Process 58
8.08 Corrective Action Plan 59
8.09 Potentially Fraudulent Activity 59

9. Medicaid 60

9.01 Compliance with State and Federal Laws 60
9.02 Enrollment with State Medicaid 60
9.03 Medicaid Credentialing 60
9.04 Fraud, Waste and Abuse Compliance Program 60
9.05 Inspection and Audit of Records and Access to Facilities 61
9.06 Claims Submission Requirements for Medicaid 61
9.07 Medicaid Coordination of Benefits 61
9.08 Prior Authorization 61
9.09 Denial of Services 61
9.10 Cultural Competency 61
9.11 Home Delivery 61
9.12 Directories 61

10. Medicare Part D 62

10.01 Medicare Part D Network Standards 62
10.01.01 Network Participation 62
10.01.02 Compliance with Laws 62
10.01.03 Delegated Activity 63
10.01.04 Offshore Subcontracting 63
10.01.05 Marketing 63
10.01.06 Fraud, Waste and Abuse Program 63
10.01.07 Pharmacy Compliance and FWA Training 63
10.01.08 Information on CMS-10147 Pharmacy Notice 63
10.01.09 Performance Monitoring 64
10.02 General Information 64
10.02.01 Part D Reference Information for Pharmacists 64
10.02.02 Medicare Part D Calls to the Pharmacy Help Desk 64
10.03 Credentialing 64
10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies 64
10.03.02 Federal Health Care Programs Participation Exclusion 65
10.04 Pharmacy Services and Standards 66
10.04.01 Plan Identification Cards 66
10.04.02 General Procedures for Acknowledgement of Enrollment Letters 66
10.04.03 Best Available Evidence 66
10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS 67
10.04.05 Auto-Ship Refill Programs 67
10.05 Claims Submission 67
10.05.01 Unique RXBIN/RXPCN Requirement - Medicare Part D 67
10.05.02 Payment of Clean Claims 68
10.05.03 Electronic Prescribing 68
10.05.04 Prescription Origin Code and Fill Number 68
10.05.05 Improving Drug Utilization Review Controls 68
10.05.06 Medicare Part D Claims Requiring Overrides 70
10.05.07 General Medicare Part D Submission Requirements for COB 70
10.05.08 Formulary Transition Fill Process 71
10.05.09 Insulin Coverage 72
10.05.10 Pro-Rated Daily Cost Share 72
10.05.11 Medicare Part B and Medicare Part D Drug Coverage Determinations 72
10.05.12 End Stage Renal Disease Claim Processing 73
10.05.13 Prescriber Identification for Medicare Part D Claims 73

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000544

TABLE OF CONTENTS

10.05.14 Claims Submission Window for Medicare Part D 74
10.05.15 Medicare Part D Claims Adjustment 75
10.05.16 Medicare Part D Transaction Fees 75
10.06 Network Participation and Payment 75
10.06.01 Drug Pricing 75
10.06.02 Pharmacy Service Type and Patient Residence Requirements 75
10.07 Special Instructions for Participating LTC Providers 76
10.07.01 Pharmacies Serving LTC Facilities 76
10.07.02 LTC Pharmacies Timely Claim Submission 76
10.07.03 LTC Appropriate Days' Supply Short Cycle Billing 77
10.07.04 LTC Days' Supply Limitations 78
10.07.05 LTC Transition Fill 78
10.07.06 Special Package Indicator 79
10.07.07 LTC Override Requests 79
10.07.08 Medicare Part A and Medicare Part D Drug Coverage Determinations 81
10.08 Retail Addendum to the Caremark Provider Agreement 82

11. Medicare Advantage 85

12. Medicare-Medicaid Plan 87

12.01 Medicare-Medicaid Networks Standards 87
12.02 Compliance with State and Federal Laws 87

13. Qualified Health Plans 88

14. Intellectual Property, Confidentiality and Proprietary Rights 89

14.01 Advertising and Trademarks 89
14.02 Non-Disparagement 89
14.03 Confidentiality 89
14.04 Non-Solicitation and Non-Interference 90
14.05 Proprietary Rights 90
14.06 Remedies 91

15. Miscellaneous 92

15.01 Assignment 92
15.02 Independent Contractors and Third-Party Beneficiaries 92
15.03 Court Orders, Subpoenas or Governmental Requests 92
15.04 Notices 92
15.05 Termination 93
15.05.01 Termination for Cause 93
15.05.02 Termination Without Cause 94
15.05.03 Rights and Remedies in the Event of Termination or Breach 94
15.06 Survival of Certain Provisions 94
15.07 Amendments 95
15.08 Enforceability 95
15.09 Arbitration 95
15.09.01 Discovery Limitations 96
15.09.02 Expenses of Arbitration 96
15.09.03 Anti-Class; Anti-Consolidation of Claims in Arbitration 96
15.09.04 Confidentiality of Arbitration 97
15.09.05 No Collateral Estoppel/Precedential Impact of Award 97
15.09.06 Waiver of Right to Confirm Award Upon Payment 97
15.09.07 Dispute Resolution Procedures 97
15.09.08 Severability 98
15.10 Force Majeure 98
15.11 Anti-Kickback Statute, Stark Law and Caremark Compliance Program 98
15.12 Rebate Programs 98
15.13 Eligible Person Communications 98

16. Federal and State Laws and Regulations 99

16.01 Compliance with Laws 99

Appendix A - CMS Form No. 10147 (English) 100

Appendix A1 - CMS Form No. 10147 (Spanish) 101

Appendix B - Appeals Process Documentation Guidelines 102

Glossary of Terms 108

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000545

1. General Information

Caremark appreciates the role that network Providers play in delivering quality care to Eligible Persons. The 2024 Caremark Provider Manual ("Provider Manual") contains the policies and procedures to which network Providers must adhere to provide quality care to Caremark Eligible Persons. The Provider Manual and all payer sheets are part of the Provider Agreement and are incorporated into the Provider Agreement pursuant to the terms thereof. This Provider Manual supersedes and replaces all previous versions of the Provider Manual. As a network Provider, you are responsible for monitoring and complying with all changes to the Provider Manual. Capitalized terms used in the Provider Manual not defined in the **Glossary of Terms** in the Provider Manual shall have the same meaning as in the Provider Agreement.

1.01 Proprietary Statement

The Provider Agreement (which includes the Provider Manual) constitutes Confidential Caremark Information and is provided to Provider for business purposes only. Provider must maintain in confidence the Provider Manual, and must not disclose, sell, assign, transfer, or give to any third party the Provider Manual or any of its contents without Caremark's prior written consent. Refer to section **14.03 Confidentiality** of the Provider Manual.

1.02 Requirement to Adhere to Provider Agreement and Provider Manual

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda, and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

1.03 Contacting Caremark

Caremark strives to ensure that Providers receive prompt and courteous assistance with questions that may arise. Caremark's Pharmacy Help Desk Representatives are available every day of the year. The Interactive Voice Response (IVR) system is available 24 hours a day, 7 days a week, excluding downtime for maintenance and service.

1.04 Pharmacy Help Desk

Pharmacy Help Desk phone numbers and associated Banking Identification Numbers (RXBIN) are found at **caremark .com/pharminfo**. Pharmacy Help Desk representatives will use reasonable efforts to assist Providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with respect to the provision of Pharmacy Services. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, or non-compliance).

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

1.05 Contact Information and Additional Resources

Unless otherwise specified in the Provider Manual, Providers must send inquiries and grievances in writing to:
CVS Caremark
Attn: Network Management, MC 080
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

- Information and FAQs
- Forms and Guides
- Medicare and Medicaid Compliance Training
- Provider Credentialing
- NCPDP Payer Sheets [A payer sheet provides information necessary to electronically submit Pharmacy Point-of-Sale (POS) claims. This includes NCPDP Telecommunication Standard vD.0 Segments, Fields, and ECL values that CVS Caremark requires for claim adjudication.]

1.06 Pharmacy Communications

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

- Provider Manual and Provider Manual Amendments
- Plan Sponsor implementation notices

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000546

- Formulary updates
- Clinical/vaccine information
- Pharmacy audit tips
- Medicare Part D or other government or regulatory guidance
- Network initiatives
- Industry standard changes
- Emergency procedures
- Plan Sponsor initiatives
- Point-of-service issues
- Network Enrollment Forms or other contract updates
- Pharmacy audit documents

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

It is Provider's responsibility to promptly notify Caremark of any changes to Provider's contact information, including street address, mailing address, phone number, fax number, or email address. Provider's failure to update its contact information with Caremark, or refusal to accept delivery of a communication from Caremark, shall not relieve Provider of any obligations to comply with the information communicated. Refer to sections **2.05.01 Notification of Change in Documentation and Other Information** and **15.04 Notices** of the Provider Manual.

1.07 CVS Caremark Pharmacy Portal

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

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

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

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

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

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

1.07.01 Pharmacy Portal Terms of Use

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

The Pharmacy Portal may provide authorized users with various analytical tools (such as MAC Price Lookup, MAC Appeals, MAC Future Pricing, etc.). The Pharmacy Portal, and its content, are the property of Caremark and users are strictly prohibited from using Pharmacy Portal content or information for any purpose other than for the purposes

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000547

of fulfilling the Provider's obligations under the Provider Agreement. Users are strictly prohibited from accessing the Pharmacy Portal using automated means (such as harvesting bots, robots, spiders, or scrapers). Caremark reserves the right to remove content from the Pharmacy Portal at its sole and absolute discretion. Improper use or unauthorized access of the Pharmacy Portal may result in termination of Pharmacy Portal use privileges and pursuit of all other remedies available to Caremark.

1.08 Questions Asked by Providers

1.08.01 Pharmacy Audit and Pharmacy Compliance

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

   If your pharmacy received notice of an impending pharmacy audit, please refer to the letter you received which includes contact information for the pharmacy auditor that will be conducting the audit. Please reach out to the pharmacy auditor directly and in a timely fashion as travel and other arrangements may not be flexible.

2. **What are the preferred invoices and invoice date ranges needed to demonstrate inventory that aligns with my claims submissions and dispensing to Caremark Eligible Persons?**

   Invoices predated not more than thirty (30) days before audit date range and invoices reflecting inventory purchased during the audit date range are typically accepted by Caremark.

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

   Your pharmacy is allowed a set amount of time to provide complete documentation for the potential discrepancies to address the items that can be resolved, as outlined in the correspondence your pharmacy received with the initial discrepancy list. The time period granted is typically thirty (30) days to give your pharmacy the opportunity to research and collect documentation and provide it to Caremark for further review. If your pharmacy needs additional time, reach out to the contact listed in the correspondence to inquire if your pharmacy can be granted a short extension.

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

   Some common audit findings, such as missing prescription(s) for example, may be addressed by contacting the Prescriber and requesting a duplicate prescription as well as a copy of the medical records demonstrating a prescriber-patient relationship to document and send to Caremark to enable Caremark to evaluate whether credit will be allowed. For additional detail, consult **Appendix B – Appeals Process Documentation Guidelines** of the Provider Manual.

5. **My pharmacy just received a final discrepancy list from a recent pharmacy audit. Can I request an extension?**

   No, unless otherwise authorized by applicable Law, when your pharmacy receives a final discrepancy list from Caremark, by definition, the list is final and complete. Your pharmacy was granted time during the initial discrepancy list notification to resolve outstanding proof of documentation which included an opportunity to request an extension prior to the distribution of a final discrepancy list.

6. **Can adverse findings result in my pharmacy being terminated?**

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

7. **I received my final audit findings; what are my next steps if I do not agree?**

   Refer to section **8.07 On-site and Expanded Audit Resolution – Appeals Process** of the Provider Manual for additional information and instructions.

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

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

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

   If your pharmacy elects to ship, mail, or deliver Covered Items by common carrier/courier/employee/contractor or other means, it is your pharmacy's responsibility to ensure your selected distribution channel has documented

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000548

procedures in place to limit potential liability as delivery confirmation may not constitute member receipt of the medication or ensure that timely/appropriate manufacturer handling instructions regarding Covered Items have been met. In the event of an Eligible Person dispute, your pharmacy may be deemed responsible for lost/missing Covered Items or Covered Items not received by the Eligible Person. Notwithstanding the Plan Sponsor's authorization for an emergency override, the Provider retains all liability for the initial Covered Items not received by the Eligible Person. Caremark may reverse claims at its sole discretion. Provider may not seek reimbursement from Eligible Person for non-received Covered Items (refer to section **3.03.06 Limitation on Collection** of the Provider Manual).

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

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

1.08.02 Network Contract Rates/Terms

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

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

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

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

1.08.03 Provider Enrollment, Credentialing, Change of Ownership

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

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

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

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

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

Refer to section **2.01 Steps to Become a Provider** of the Provider Manual.

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

Refer to sections **2.01 Steps to Become a Provider** and **1.07 CVS Caremark Pharmacy Portal** of the Provider Manual.

1.08.04 Claims Processing and Benefit Plan Design

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

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000549

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

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

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

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

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

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

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

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

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

6. May I waive Eligible Person copays?

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

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

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

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

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

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

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

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

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

11. How do I know if the Plan allows Coordination of Benefits (COB)?

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000550

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

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

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

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

14. If I am a long-term care (LTC) pharmacy and an LTC/Assisted Living Facility (ALF) patient returns home, but I am still dispensing Covered Items and providing clinical care to the patient at home, what codes do I use to submit claims?

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000551

2. Credentialing

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

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

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

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

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

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

IMPORTANT:

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000552

2.01 Steps to Become a Provider

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

2.01.01 Review Credentialing Requirements

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

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

1. Prior to beginning step two of section **2.01 Steps to Become a Provider** (2. Complete the "Pharmacy Pre-Enrollment Questionnaire"), Provider must:
   a. be open for business and actively operating as a pharmacy in accordance with applicable Law relating to the practice of the pharmacy;
   b. be reachable by mail, telephone, and fax during Provider's hours of operation based on the contact information provided;
   c. have an active NPI and NCPDP Provider ID;
   d. have an active DEA Certificate of Registration and state-controlled substance registration, where applicable; and
   e. have active general and professional liability insurance, including malpractice (see bullet #9 of this section for additional information).
2. Provider must maintain in good standing all federal, state, and local licenses; permits; certifications; and maintain an active NPI and NCPDP Provider ID.
3. Provider must maintain at all times current and valid licensure as issued by the appropriate state agency(ies) in which Provider operates to dispense medications and, where applicable, into which it ships medications. Additionally, Provider must meet all standards of operation as described in federal, state, and local laws. Any Pharmacy Services provided during a period where Provider does not possess all required active and valid licenses and/or permits under applicable Law shall be deemed to be invalid and subject to chargeback.
4. All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist or Dispensing Practitioner (as applicable and according to applicable Law) and in accordance with applicable Prescriber directions and applicable Law.
5. Provider must require and verify that all personnel employed by or contracted with Provider are licensed and qualified to perform their professional duties and that they act only within the scope of their licensure. Provider shall make inquiry and document all past employment associations of all personnel with respect to third-party payor audit history.
6. Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable federal, state, and local laws (including any local laws and regulations) in performing its Pharmacy Services under the Agreement including, but not limited to, the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395nn); Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Parts 160, 162, and 164; and the Controlled Substance Act (21 U.S.C. 801-971).
7. Provider must require and verify that Provider and all personnel employed by or contracted with Provider have not been excluded or debarred by any federal or state program. Provider must check the applicable state and federal exclusion lists upon initial hire/contract and on a monthly (or more frequent) basis thereafter to verify that no employees or contractors are on the list. Provider further agrees that any claim submitted to and paid by Caremark in violation of this section is subject to chargeback.
8. Provider must require and verify that any individual for whom there has been a restriction, suspension, revocation, probation, or any other disciplinary action taken by a licensing or other oversight agency, does not provide any Pharmacy Services to Caremark or its Eligible Persons. Provider agrees that any claim submitted to and paid by Caremark in violation of this section is subject to chargeback.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000553

9. Provider must maintain, at its cost and expense, policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services or failure to perform Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate, unless otherwise agreed to by Caremark or such greater amount as required by Law.
    a. Provider must furnish copies of said policies upon enrolling as a Provider with Caremark and as requested by Caremark thereafter. Failure to maintain the minimum coverage may result in immediate termination.
    b. Provider must notify Caremark immediately in writing if its insurance is canceled, lapsed, or otherwise terminated. Failure to notify Caremark in writing of any such termination of insurance coverage may result in immediate termination.
    c. Provider must notify Caremark of any changes to the policy including, but not limited to, the location schedule.
10. Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.
11. Provider agrees that Caremark, at its sole discretion, may obtain and use Provider credentialing and recredentialing information from third-party vendors that store Provider's information. This does not relieve Provider of its responsibility to notify pharmacy of changes as required by the Provider Agreement.

2.01.02 Complete the "Pharmacy Pre-Enrollment Questionnaire"

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

1. Access the "Pharmacy Pre-Enrollment Questionnaire" at **caremark.com/pharminfo** and select "Pharmacy Pre-Enrollment Questionnaire".
2. Supply the required information as outlined in the "Pharmacy Pre-Enrollment Questionnaire". It is important for all Providers to complete the form accurately and in its entirety as Caremark relies on this information in making enrollment determinations.
3. Submit the online questionnaire. Upon successful completion of the "Pharmacy Pre-Enrollment Questionnaire" and approval by Caremark, instructions for creating an online Pharmacy Portal account will be sent to the applicant which will include any fees, where permitted by applicable Law (refer to section **2.01.03 Create a Pharmacy Portal Account to Submit Enrollment Application**).

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

2.01.03 Create a Pharmacy Portal Account to Submit Enrollment Application

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

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

Fee payment is due and payable at the time of application submission.

1. To the extent permitted by applicable Law, Caremark charges non-refundable fees. The amount of such fees will be communicated to the pharmacy.
2. Payment must be submitted to Caremark in the form of a cashier's check or money order, made payable to "CVS Health" and mailed to the address below. Failure to submit payment, where applicable, within twenty-one (21) days of the date the enrollment application was initiated will result in the denial of the enrollment application and, if applicable, termination of the existing Provider Agreement.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000554

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

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

2.01.04 Complete and Submit Your Application

Once the applicant submits the online enrollment application, the applicant will be notified in writing by Caremark if any required documentation or information is missing or incomplete. Caremark will reach out by email and telephone call to obtain missing items. Failure to provide all required enrollment information and documentation within twenty-one (21) days of the first outreach may result in the denial of the enrollment application and, if applicable, termination of the existing Provider Agreement. Caremark, where permitted by applicable Law, may charge a $75 fee per pharmacy location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application.

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

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

If Provider's pharmacy is located in or near a designated strike force location*, in addition to meeting requirements outlined in section **2.01.01 Review Credentialing Requirements**, Provider must:

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

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

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

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

2.01.06 Additional Application Requirements for Dispensing Practitioners

In addition to meeting requirements outlined in section **2.01.01 Review Credentialing Requirements**, the Dispensing Practitioner must meet the minimum requirements below:

1. Be open for business and actively operating in accordance with applicable Law relating to the practice of the pharmacy at the time of application submission, participate in a site visit where applicable (see section **2.01.05 Additional Application Requirements for Pharmacies Located in a Strike Force Location**), and fulfill enrollment requirements.
2. Dispense medications within the Dispensing Practitioner's scope of professional practice. The Dispensing Practitioner will comply with this requirement through computerized edits and purchase of appropriate Covered Items from licensed and authorized distributors/wholesalers/manufacturers.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000555

3. Support Caremark audits. Audits may be conducted in the form of an on-site audit, expanded audit, or desktop audit and require access to the Dispensing Practitioner's records and documents, facility, and practices as Caremark reasonably determines are necessary to evaluate Dispensing Practitioner's compliance with the Provider Agreement and applicable Law. There are other compliance reviews that Caremark may conduct as described in chapter **7. Compliance Reviews** of the Provider Manual.
4. Send applicable fee; payment is due at the time of application submission. To the extent permitted by applicable Law, Caremark charges non-refundable fees. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. This fee is non-refundable and does not guarantee the application will result in enrollment.

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

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

2.02 Steps to Become a Complex Compound Provider

Providers are not authorized to submit claims for complex compounds without first obtaining written approval from Caremark and maintaining ongoing compliance with Caremark's requirements. In order to become an approved Provider to submit non-sterile complex compound claims to Caremark and dispense non-sterile complex compounds that are Covered Items to Eligible Persons, Provider must first be currently enrolled with Caremark (refer to section **2.01 Steps to Become a Provider** of the Provider Manual) and accurately complete, in its entirety, the Caremark Compound Application.

Providers wishing to submit claims for complex compounds must:

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

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

8. Wait for approval letter before submitting complex compound claims.

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000556

2.03 Plan Sponsor Networks

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

2.04 Recredentialing

Caremark will periodically recredential Providers as required by contract or Law. When requested, Provider will be required to submit requested information and/or documentation to Caremark in the communicated time period. Failure to supply the information and/or documentation in the requested manner and time period may result in suspension, probation, or termination. Caremark may assess against Provider a $475 fee for the initial failure of the Provider to provide the requested recredentialing information and/or documentation within the timeframe requested, and Caremark may increase the fee in $475 increments for subsequent failures of the Provider to provide the requested recredentialing information and/or documentation (i.e., $475, $950, $1,425) until such time as the request is complete in lieu of other available actions.

2.05 Notification to Caremark

2.05.01 Notification of Change in Documentation and Other Information

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

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

To notify Caremark of a change, Provider must complete and submit an online "Pharmacy Change Form" found online at **caremark.com/pharminfo**. Click on "Forms and Guidelines", select "Pharmacy Enrollment Self Service" and then select "Pharmacy Change Form".

2.05.02 Notification of Closure

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

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

2.06 Change in Ownership

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

The current Provider, who entered into the Provider Agreement with Caremark, is responsible for notifying Caremark in writing of any change in ownership or control, as defined above, as required by applicable Law, Plan Sponsor or program

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000557

requirement, or Network Agreement no later than within ten (10) business days of the change. Failure to notify Caremark may be considered for future Network eligibility and liability of the new owners' financial obligations to Caremark.

The Buyer (defined as any successor in interest to an owner or operator) must notify Caremark in writing of a change in ownership or control, as defined above, no later than ten (10) business days of the change. Changes in pharmacy provider ownership are subject to Caremark's standard pre-enrollment credentialing review process and fee assessment (refer to section **2.01 Steps to Become a Provider** of the Provider Manual). Prior to initiating the change in ownership enrollment process, Buyer must satisfy all outstanding monetary obligations due to CVS Caremark including any pending audit findings, associated with either the Buyer or Seller, or with any individual associated with the ownership of the Buyer or Seller or any individual in a management position with the Buyer or Seller. In order to initiate the change in ownership enrollment process, Provider may submit a "Pharmacy Pre-Enrollment Questionnaire" found at **caremark.com/pharminfo**. Click on "Forms and Guides" and select "Pharmacy Pre-Enrollment Questionnaire". Complete your information on page one and then select enroll type of "Change of Ownership" on page two. Upon successful submission of the "Pharmacy Pre-Enrollment Questionnaire", instructions for the creation of an online Pharmacy Portal account will be sent to applicant via email.

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

1. Where the Buyer has no existing relationship with Caremark:
    a. It must execute a new Provider Agreement and meet all of Caremark's credentialing requirements, including completion of the "Pharmacy Pre-Enrollment Questionnaire", in order to initiate the credentialing process for the acquired pharmacy or pharmacies. Refer to section **2.01 Steps to Become a Provider** of the Provider Manual.
    b. Caremark, in its sole discretion, may allow assignment of the Provider Agreement for the acquired pharmacy to the Buyer.
    c. A change of ownership is not effective until a decision is rendered by Caremark and communicated in writing by Caremark.
2. In the event that the Buyer has an ownership interest or operating rights in an existing Provider, Caremark may elect to:
    a. Apply in whole or in part the terms of the acquired pharmacy's Provider Agreement to the acquired pharmacy or pharmacies; or
    b. Apply in whole or in part the terms of the Buyer's Provider Agreement to the acquired pharmacy or pharmacies; or
    c. Require Buyer to complete credentialing and execute a new Provider Agreement for the acquired pharmacies.

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

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000558

2.07 Reporting of Investigations and Disciplinary Actions

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

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

Provider must notify Caremark in writing to:
CVS Caremark
Attn: Provider Enrollment, MC 129
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

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

2.08 Criminal Offense Related to Federal Health Care Programs

2.08.01 Pharmacy Criminal Offense

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

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

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000559

in a First Offender, deferred adjudication, pardon program, or other arrangement or program where a judgment of conviction has been withheld.

2.08.02 Prescriber Criminal Offense

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

2.09 Federal Health Care Programs Participation Exclusion: Pharmacy

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

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

Provider hereby certifies that:

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

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

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

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000560

3. Pharmacy Services and Standards

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

Pharmacies are an important part of Caremark's services and our goal to help people on their path to better health. Our Plan Sponsors, which include insurance companies, managed care organizations, third-party administrators, federal and state entities, employers, and union-sponsored benefit plans, entrust us with serving their diverse membership and we are committed to providing them with innovative and quality services and measures to control health care spending and improve health outcomes. Through our health services, plans, and community pharmacists, we are pioneering a bold new approach to total health, making quality care more affordable, accessible, simple and seamless, to not only help people get well, but help them *stay* well in body, mind and spirit.

3.01 Providing Pharmacy Services to Eligible Persons

3.01.01 Professional Judgment and Conduct

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

3.01.02 Verification of Eligible Persons

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

3.01.03 Identification Cards

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

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

3.01.04 Nondiscrimination

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

3.01.05 Eligible Person Solicitation

Provider must not directly or indirectly obtain prescriptions for Eligible Persons via marketing activities including, but not limited to, (1) contacting Eligible Person or Prescriber without a previously existing relationship; (2) obtaining an Eligible Person's primary care provider or billing information through unsolicited methods; and/or (3) contacting or offering to contact a Prescriber on an Eligible Person's behalf without the Eligible Person's express knowledge and authorization for each specific claim. Provider shall not obtain a prescription from a Prescriber not expressly requested by the Eligible Person or by suggesting to an Eligible Person that their Prescriber or health plan wants the Eligible Person to receive the medication without the Prescriber's express knowledge and authorization. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives including, but not limited to, adherence initiatives, gaps-in-care management, or comprehensive medication reviews with Eligible Persons.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000561

3.01.06 Eligible Person Complaints

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

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

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

3.01.07 Patient Receipts and Insurance Profiles

Provider may print the Usual and Customary (U&C) Price and Patient Pay Amount on receipts and insurance profiles provided to an Eligible Person. Provider reimbursement pricing information and prices paid to Provider for individual claims under this Provider Agreement are Confidential Caremark Information and may not be disclosed on patient receipts or insurance profiles, subject to applicable Law. Refer to section **14.03 Confidentiality** of the Provider Manual.

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

3.01.08 Educational Materials and Efforts

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

Caremark may educate Provider about products, programs, and services as well as distribute Plan Sponsor announcements. Educational materials may be distributed through various means, including email, fax, mail, or posted on one of the Caremark websites or the Pharmacy Portal. Refer to sections **1.06 Pharmacy Communications** and **1.07 CVS Caremark Pharmacy Portal** of the Provider Manual.

3.02 Dispensing Requirements

3.02.01 Hours of Operation

Provider must maintain hours of operation that meet the needs of the community, but in all circumstances in accordance with applicable Law. Provider must communicate those hours of operation to Caremark upon enrollment and upon any changes. Refer to sections **2.05.01 Notification of Change in Documentation and Other Information** and **2.06 Change in Ownership** of the Provider Manual. Provider must be reachable by telephone or fax during Provider's hours of operation (except as described in section **15.10 Force Majeure** of the Provider Manual).

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

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

3.02.02 Drug Stock and Inventory

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

3.02.03 Aberrant Practices and Trends

Caremark has implemented programs to address aberrant Provider practices or trends in Caremark retail networks. Providers participating in a Caremark network(s) must not engage in aberrant practices or trends including, but not limited to:

1. Dispensing:
    a. aberrant quantities of a Covered Item and/or disparate volume of claims within a therapeutic category (e.g., topicals, dermatologicals), as measured by number of claims, quantity dispensed and/or dollars;

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000562

b. limited medications and/or therapeutic categories (e.g., topicals products, diabetic test products, skin care products);

c. drug products inconsistent with the habits of local Prescribers or Plan Sponsor formularies, at Caremark's sole determination.

2. Demonstrating purchasing practices (e.g., higher cost drug products) that are not in keeping with the aligned goal of safeguarding both the health and financial welfare of Eligible Persons and Plan Sponsors.
3. Disregarding Eligible Persons' private and confidential identification information by using or misusing member data for Provider's own use (e.g., submitting test claims with no subsequent paid claims – also known as "negative" claims) and/or without Prescriber prescription authorization.
4. Participating in actions, programs and/or business models that result in the selection and dispensing of drug products that increase the amount billed to Plan Sponsors for Covered Items to Eligible Persons.
5. Engaging in practices that focus on Provider's welfare rather than best practices of providing clinical, cost-effective solutions for Eligible Persons and Plan Sponsors.

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

3.02.04 Dispensing Covered Items to Eligible Person's Agent

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

3.02.05 Performance Initiatives

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

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

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

3.02.06 Dispensing Errors

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

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

3.03 Patient Pay

3.03.01 Collection of Patient Pay Amounts

Patient Pay Amounts (e.g., Copayments, Coinsurance) is an extremely important tool to help align the needs of Eligible Persons with those of the Plan Sponsor. The disclosure of the Patient Pay Amount to the Eligible Person is an important step in the adjudication and dispensing process of a Covered Item as it can assist with ensuring the necessity of a specific medication. The patient, or Eligible Person, may choose to find a more cost-effective alternative that is therapeutically equivalent, resulting in cost savings for the Plan Sponsor while maintaining quality patient care. Provider must disclose

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000563

to each Eligible Person the Patient Pay Amount prior to dispensing the prescription so the Eligible Person has the opportunity to make an informed decision. Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system and in accordance with section **4.05 Usual and Customary Validation** of the Provider Manual. Provider must keep evidence of the collection of Patient Pay Amount for review.

Provider has the right to provide an Eligible Person with information about the cost of their medication including lower-cost alternatives to assist the Eligible Person in finding affordable, clinically appropriate, alternative medications.

Failure to collect Patient Pay Amounts is prima facie evidence of a Fraud, Waste and Abuse (FWA) practice. All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.

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

3.03.02 Usual and Customary Price

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

3.03.03 Coupons and Other Programs

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

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

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

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

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

accessdata.fda.gov/scripts/cder/ob/index.cfm

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000564

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

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

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

accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm

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

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

3.03.04 Proof of Payment

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

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

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

3.03.05 Excess Collections

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

3.03.06 Limitation on Collection

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

3.03.07 Patient Inducements

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000565

3.03.08 Waivers

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

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

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

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

3.03.09 Financial Hardship Program

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

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

3.03.10 Documentation

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

3.03.11 Violations

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000566

3.04 Standards of Operation

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

Not considered "Retail Pharmacies":

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

1. Whose number of claims submitted to Caremark for prescriptions that were delivered to Eligible Persons (including common carriers such as USPS, FedEx, UPS or other delivery service) exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. Caremark further reserves the right to charge back any improper or excessive payments made to Provider based upon its misrepresentation as a Retail Pharmacy.
2. Whose number of claims submitted to Caremark for specialty drugs exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy.
3. Who is owned by a 340B covered entity or whose volume of claims filled using 340B Drug Pricing Program acquired or replenished drugs is the basis for any pharmaceutical manufacturer denying pharmaceutical rebates for claims submitted by Provider, is not considered a Retail Pharmacy. All Providers must maintain their NCPDP online provider ID profile services question on 340B (i.e., "Physical Location 340B Status") so that it is accurate and up to date.

If Provider has misrepresented itself as a Retail Pharmacy and/or modifies its operations such that it no longer meets the definition of a Retail Pharmacy, in addition to all other rights and remedies available to Caremark, Caremark reserves the right to exclude Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or to apply unique terms and conditions to such Provider's participation in any retail network(s) in which the Provider is participating or any new retail network(s) established, for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing, and to terminate Provider from Caremark networks. Any Provider that is not considered a "Retail Pharmacy" as described above, may be subject to other reimbursement, terms and conditions relevant to its non-standard retail pharmacy model. Providers are not allowed to engage in marketing activities to Eligible Persons or Prescribers of Eligible Persons for the purpose of gaining dispensing opportunities that limit the Eligible Persons' right to use their participating retail pharmacy of choice including, but not limited to, business models that engage in internet, third-party marketing, telehealth, texting and/or hub-type of activities, without Eligible Persons' knowledge and/or understanding that their pharmacy choices are not restricted to the non-standard retail pharmacy business model.

3.04.01 Other Standards of Operations

1. Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.
2. Provider must furnish Pharmacy Services to Eligible Persons consistent with the requirements of all Caremark Documents. Shipping Covered Items by mail or other common carrier as a routine business practice in excess of the percentage allowed by Caremark without the express written permission of Caremark is a violation of the terms of the Provider Agreement. Payment for claims involving unauthorized mail or other common carrier is subject to chargeback.
3. Providers who utilize an internet site as a routine business practice in the provision of Pharmacy Services (except for refill requests) must maintain Verified Internet Pharmacy Practice Sites (VIPPS) certification through the National Association of Boards of Pharmacy (NABP) but must also otherwise comply with the terms of this subsection.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000567

4. Provider must maintain a process to identify and detect prescriptions prescribed by, or claims for items or services furnished by, an excluded or debarred Prescriber and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment.
5. No third-party consultant is permitted to represent Provider, nor will Caremark communicate with a third-party consultant unless written consent is provided by Caremark. Provider must provide written documentation describing the business relationship with the third-party consultant upon request.

3.05 Records

3.05.01 Documents and Records Maintenance

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

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

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

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

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

3.05.02 Signature Log – Hard Copy or Electronic

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

1. Contains a signature which can be individualized or directly related to each prescription dispensed (e.g., prescription number)
    a. For each claim adjudicated through the claims adjudication system, Provider must obtain the signature of the Eligible Person (or their authorized representative) on a dated third-party signature log to confirm that they have received the medication recorded.
    b. Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.
2. Maintains the date of the receipt of Covered Item by the Eligible Person
3. Maintains the quantity received by the Eligible Person
4. Maintains a disclosure to Eligible Person of insurance billing
5. Retrievable for the purposes of audit

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000568

3.05.03 Prescription Information

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

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

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

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

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy, electronic prescription record, physicians order, or Provider systems where it can be readily retrievable. In the case of a long-term care pharmacy's standing medication order, Provider must maintain written record of the prescriber's review and continuation of the standing order within one (1) year prior to the fill date, or such shorter period as required by applicable Law.

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

3.06 Referrals

3.06.01 Referral Fees

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

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

3.06.02 Referrals to Non-Retail Participating Providers

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000569

4. Claims Submission

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

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

4.01 Payer Sheets and Reject Codes

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

Caremark utilizes NCPDP reject codes. A list of potential reject codes can be found at **caremark.com/pharminfo**. Providers can also refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online. In addition, Providers can contact their software vendor to learn more about submission reject codes.

4.02 General Claim Submission Policies

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000570

9. Provider must display all NCPDP messaging to the dispensing pharmacist. It is imperative that Provider review the claim response in its entirety, including all messages (e.g., primary and secondary). This may require viewing additional screens.
10. Any changes to a prescription including, but not limited to, the Covered Item being prescribed or directions for use, must be approved by the Prescriber prior to dispensing. Provider must date and document the Prescriber approval on the prescription hard copy or electronic prescription record.
11. To protect the health and safety of the Eligible Person, Provider must review and act upon DUR messages received from Caremark. As well as reviewing and acting upon Caremark's DUR messages, Provider must perform an internal DUR on each claim to monitor for safety concerns such as drug-to-drug interactions and drug allergy monitoring. Refer to chapter **5. Clinical Programs, Services and Related Messages** of the Provider Manual.
12. Providers must inform Eligible Persons about the proper storage, dosing, utilization, side effects, potential interactions, and use of the Covered Item dispensed within professional practice guidelines.
13. Provider must submit the precise eleven (11) digit Product Identifier for the Covered Item dispensed as defined by the NCPDP Product Identifiers Standard. Claim submissions utilizing a Product Identifier other than the Product Identifier of the Covered Item dispensed are subject to audit review and chargeback and are not eligible for reimbursement.

4.03 Other Claim Submission Requirements

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000571

prescription hard copy. For additional information regarding Medicare Part D Claims, refer to chapter **10. Medicare Part D** of the Provider Manual.

4. **Dosage Form and Package Size:** Provider is obligated to use available dosage form and package size that results in the lowest reimbursement.
5. **Ophthalmic Products:** Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists.
6. **Drugs with Unusual Submission Requirements:** Claims for some drug products frequently result in incorrect reimbursement. To avoid audit chargebacks, refer to the pharmacy audit tips posted on the Pharmacy Portal at **rxservices.cvscaremark.com**. Provider will be responsible for monitoring and reviewing pharmacy audit tips on the Pharmacy Portal. Refer to sections **1.06 Pharmacy Communications** and **1.07 CVS Caremark Pharmacy Portal** of the Provider Manual.
7. **Repackaging:** Claims for repackaged, relabeled NDCs submitted to Caremark that result in higher reimbursement than claims for non-repackaged, relabeled NDCs may be subject to recoupment.
8. **Non-Covered Items:** Claims submitted to Caremark in accordance with a Plan Sponsor program to allow limited dispensing of a non-covered item (e.g., 3-days' supply approved for a drug on prior authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable day supply.
9. **Federal Health Care Programs Prescriber Participation Exclusion:** Provider must not submit any claim to Caremark for a prescription prescribed by, or item or service furnished by, a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other Federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions and claims for items or services furnished by an excluded or debarred Prescriber and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.
10. **Auto-Ship Refill Programs:** Claims submitted for auto-refill programs must only be for medications used in a maintenance therapy. Refer to section **10.04.05 Auto-Ship Refill Programs** of the Provider Manual.
11. **Fill Date:** The fill date is the date on which the Covered Item is prepared and readied for dispensing to the Eligible Person or, in the case of vaccine administration or other professional service, the date the service was administered/performed. Each prescription claim transmitted must indicate the fill date in the Date of Service field. Billing of claims must not be pre-dated or post-dated. The fill date may also be the date a subsequent payer began coverage following Part A expiration in a long-term care setting only.
12. **Prescription Not Received; Reversal of Claim:** All Covered Items must be received by the Eligible Person within seven (7) days of the fill date and Provider is solely responsible for ensuring a Covered Item is received by Eligible Person in a manner that meets or exceeds requirements of Law. Covered Items not received by an Eligible Person must be reversed by Provider within fourteen (14) days from the fill date through the claims adjudication system. Provider must ensure that an accepted reversal response is received from the claims adjudication system for each claim where the Covered Item was not received by the Eligible Person in accordance with this section. Upon discovery of a Covered Item not received by an Eligible Person in accordance with this section, Caremark in its sole discretion may reverse the claim. Refer to section **4.15 Electronic Submission, Reversal, and Processing Windows** of the Provider Manual.
13. **Pre-Printed Prescriptions:** Provider must not use pre-printed prescriptions that result in the dispensing of Covered Items that are not the most cost-effective even if they are different salts, bases, release characteristics, or additional drugs in combination.
14. **Test Claims:** Unless otherwise authorized in writing by Caremark, Provider must not submit test claims when a prescription order does not exist (e.g., to determine reimbursement rates or benefit coverage). Provider must also not submit test claims acting as a hub service provider unless given written consent by Caremark.
15. **Vaccine and Non-Vaccine Injectable Administration:** When administering vaccines or non-vaccine injectables, submit 'MA' (for Medication Administration) in the Professional Service Code (NCPDP field #440-E5) of the DUR/PPS Segment along with a positive incentive fee amount in the Incentive Amount Submitted (NCPDP field #438-E3) of the Pricing Segment. Provider's submitted Usual and Customary (U&C) must include the charge to administer the vaccine.
16. **No-Cost Vaccines:** When submitting a claim for a vaccine acquired by the Provider at no cost, Provider must submit $0.00 as the Ingredient Cost Submitted (NCPDP field #409-D9) and a value of "15" in the Basis of Cost Determination (NCPDP field #423-DN), unless otherwise communicated by Caremark. Provider's U&C must not include a charge for the vaccine but may include a charge to administer the vaccine.
17. **Durable Medical Equipment (DME):** Provider must only submit DME claims that are payable under the Plan Sponsor's pharmacy benefit. Provider must submit a valid Product Identifier for the DME. If no Product Identifier exists for a DME Provider must not submit a claim.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000572

4.04 Dispense as Written Codes

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

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

DAW 0—No Product Selection Indicated

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

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

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

DAW 2—Substitution Allowed—Patient Requested Product Dispensed

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

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed

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

DAW 4—Substitution Allowed—Generic Not In Stock

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

DAW 5—Substitution Allowed—Brand Dispensed As Generic

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

DAW 6—This Value Is Used As Communicated By Caremark

DAW 7—Substitution Not Allowed—Brand Mandated By Law

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

DAW 8—Substitution Allowed—Generic Not Available In Marketplace

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

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

- Use DAW 9 when the Prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the Plan Sponsor's formulary requests the brand product.

4.05 Usual and Customary Validation

Provider is required to submit accurate Usual and Customary (U&C) Prices for all claims, including U&C Prices which are part of a standard set price generic program offered by Provider (i.e., program that is open and requires no enrollment).

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000573

Upon request, Provider must submit a record of each transaction involving a cash paying customer where, on the same fill date, an identical drug or device was also dispensed to an Eligible Person. Provider may redact confidential patient health information from the record in accordance with applicable Law, but the record must contain the patient charge amount. Caremark has the right to review and audit documentation and records as detailed in this section to validate that Provider's submitted U&C is in accordance with the Agreement.

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

4.06 Over-the-Counter Products

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

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

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

4.07 Multi-Ingredient Compound Processing

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

1. All compounds must be submitted online in accordance with the most current applicable payer sheet(s), found online at **caremark.com/pharminfo**.
2. Provider must submit the accurate dosage form of the final compounded product dispensed in the compound dosage form description code field in the compound segment (must be a valid NCPDP compound segment dosage form value).
3. Enter the total quantity of the final product dispensed in the quantity dispensed field in the claim segment.
4. Enter the calculated cost of the complete compound as the ingredient cost submitted. This calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the level of effort (LOE). Caremark, in its sole discretion, will have final determination of professional allowance attributed to claim above the cost.
5. Calculated cost shall not include cost of drug product associated with waste. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
6. Enter the actual Product Identifier (e.g., NDC or UPC in the Product/Service ID NCPDP field #407-D7) of each active and inactive item used in the preparation of the compound in the compound segment, including any consumable item (e.g., capsule). Each applicable Product Identifier must be entered accurately. Incorrect submission of any ingredient(s) may result in chargeback of the entire claim.
7. Submit the actual Product Identifier (e.g., NDC or UPC) of each Covered/non-Covered Item. For any items in the compound, such items are only reimbursable if Provider provides, upon Caremark's request, evidence that each of the active and inactive items in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to chargeback.
8. For compounds that require a delivery device as a component of the final medication product, the device must be submitted as an item in the compound only when the device has a Product Identifier and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.
9. When required, submit the accurate Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) value for the final compounded product in the route of administration field in the claim segment.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000574

10. Enter the applicable LOE value in the DUR/PPS Segment. The LOE value must reflect the compound types which are referenced in **Figure 1 – Level of Effort Table**, unless otherwise communicated by Caremark. Provider must not program one code for all compounds.

Figure 1 – Level of Effort Table

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

*Using bulk (powder) APIs

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000575

items or ingredients used in the creation of the compounded product. In an effort to protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.

19. Compounds that have a commercially available product are not reimbursable.
    a. In the event a commercially available product becomes unavailable (e.g., product is on backorder, drug shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
    b. If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount.
20. Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.
21. Compounding must be performed by a qualified person as defined by applicable Law.
22. Outsourcing any portion of Pharmacy Services for compounded medications not approved in advance and in writing by Caremark is prohibited.
23. Refer to section **7.02 Additional Information Regarding Compliance Reviews** of the Provider Manual for documentation requirements.

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

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

4.08 Overrides

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

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual for contact information.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000576

4.09 Natural Disasters

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

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual for contact information.

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

4.10 Coordination of Benefits

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

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

Claim submissions with incorrect COB values are subject to chargeback.

4.10.01 Multiple Transaction Coordination of Benefits

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

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

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

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

4.10.02 Single Transaction Coordination of Benefits

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000577

4.11 Long-Term Care Billing

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

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

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

4.12 Dispensing Pharmacy NPI/NCPDP

Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, Software Vendor/Certification ID (NCPDP field #110-AK), or other identifier to submit a claim (including a test claim) to Caremark.

1. Claims submitted must include the NPI that is linked to the NCPDP (as provided to Caremark) of the Dispensing Pharmacy in the Service Provider ID (NCPDP field #201-B1), defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;
2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;
3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's NPI or any other identifiers;
4. Provider is not allowed to submit claims on behalf of another entity;
5. Provider must only submit claims for Pharmacy Services it intends to perform and, at the time of submission, is authorized by the Eligible Person and applicable Law to perform such Pharmacy Services;
6. Provider may not act on behalf of another entity regardless of ownership structure; and
7. Provider is permitted to utilize a switch that has established connectivity directly with Caremark to facilitate the transport of the claims it submits to Caremark and the responses Caremark provides.

4.13 Prescriber Identification; Prescriptive Authority

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

4.14 Transaction Fees

Caremark charges network Providers, and Provider agrees to pay, transaction fees that represent pharmacy network management services Caremark provides to network Providers. For every single transaction Provider transmits to Caremark, Caremark may deduct such amounts for the transaction fee from amounts payable to Provider. A single transaction is defined as each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims adjudication system. Each transaction within a multi-claim transmission will be subject to individual transaction fees.

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000578

4.15 Electronic Submission, Reversal, and Processing Windows

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

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

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

Except as otherwise required by applicable Law, or in the event of an urgent need to provide service to an Eligible Person while the claims system is unavailable (refer to section **4.17 Schedule of Claims Systems Maintenance** of the Provider Manual), Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (e.g., cartridge, CD-ROM, tape, batch, or paper) unless prior written approval is received from Caremark or Plan Sponsor. Caremark charges a handling fee of $2.50 per claim in those situations in which Caremark or Plan Sponsor agree in writing to non-electronic submission or reversal of claims.

4.15.01 Universal Claim Form Requirement

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

4.16 Software Certification

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

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

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

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

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

4.17 Schedule of Claims Systems Maintenance

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

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

From time to time, unscheduled system maintenance or other circumstances may occur when the adjudication platform(s) may not be available to adjudicate claims for a limited time. At any time, a Provider may contact the Pharmacy Help Desk

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000579

for assistance or information regarding any claim processing related question. Pharmacy Help Desk Representatives are available 24 hours a day, 7 days a week. Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual.

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

4.17.01 Additional Required Procedures

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

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

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

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

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

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

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

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual.

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

4.18 Provider Taxes

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

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000580

5. Clinical Programs, Services and Related Messages

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

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

5.01 Drug Utilization Review

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

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

The functions of the DUR program are to:

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

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

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

5.02 DUR Conflict Codes and Messaging

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

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

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

5.03 Refill-Too-Soon or Excessive Utilization Reject

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000581

Examples of extenuating circumstances include:

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

5.04 Drug-Drug Interaction Reject Program

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

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

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

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

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

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

   A secondary message will include the PA contact number

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

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

5.05 Formularies

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

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

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

Product Not on Formulary

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

NF! Form <<XXX>>

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

5.06 Prior Authorization

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000582

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

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

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

PRIOR AUTHORIZATION REQUIRED

MD Call <<XXX-XXX-XXXX>>

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

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

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

Fax: 1-800-408-2386

Phone: 1-800-414-2386

(Hours: Monday through Friday, 8 a.m. to 7 p.m. CT)

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

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

5.07 Managed Drug Limitations/Quantity vs. Time

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

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

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

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

*If prescribed quantity exceeds the plan parameters, call the Pharmacy Help Desk to verify if Prior Authorization is available.

5.08 Dose Optimization

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000583

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

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

5.09 Step Therapy

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

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

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

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

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

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

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

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

5.10 Plan Sponsor Programs

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

5.11 Federal Regulatory Quality Assurance Programs

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

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

5.12 Clinical Studies/Trials

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000584

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

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

Requests for approval can be sent to the following address:

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

The requirements of section **5.12 Clinical Studies/Trials** do not apply to FDA-approved clinical trials.

5.13 Vaccines and Medication Administration

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000585

6. Network Participation and Payment

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

6.01 Network Participation

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

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

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

Plan Sponsors may make determination about network participation.

6.02 Provider Payment

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

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

6.02.01 General Reimbursement

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000586

6.02.02 Multi-Ingredient Compound Reimbursement

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

- The applicable Dispensing Fee plus the applicable amount based on the level of effort*, if submitted, plus for each ingredient that is a Covered Item, the lesser of (1) applicable Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type (2) MAC or (3) compound ingredient drug cost submitted; or
- Ingredient cost submitted plus the applicable Dispensing Fee plus the applicable amount based on the level of effort, if submitted (provided Provider accurately submits the ingredient cost submitted in accordance with the Provider Manual); or
- Provider's U&C Price; or
- Plan Sponsor-specific reimbursement; or
- Provider's submitted "gross amount due" (as defined by NCPDP); or
- For worker's compensation claims, the reimbursement amount prescribed by applicable Law.

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

6.02.03 Vaccine and Non-Vaccine Injectable Administration Reimbursement

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

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

6.02.04 Adjustments to Reimbursement

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

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

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

6.02.05 Post-Adjudication Settlements

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

- Performance Payments
- Network processing fees
- Supplemental dispensing fee payments

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000587

- Effective rate reconciliation
- Other fees

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

6.02.06 Other Entity Adjudication

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

6.03 Changes to Average Wholesale Price

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

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

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

6.04 Maximum Allowable Cost

Maximum Allowable Cost (MAC) is a commonly used tool to control drug costs by establishing a fair but competitive unit price generally at a product level, regardless of supplier. MAC pricing incents pharmacies to buy generic products in the most cost-effective manner, including volume discounts, in order to keep overall prices down for Eligible Persons and Plan Sponsors. Caremark does not have visibility to individual pharmacy arrangement with wholesalers; however, it is generally known in the industry that pharmacies do receive purchase discounts and rebates. It is not possible for Caremark to know what every pharmacy pays for every drug; however, Caremark may utilize aggregate information from wholesalers and third-party sources in order to establish MAC prices and, because MAC prices are reviewed continuously and updated frequently, our MAC prices reflect our best understanding of the marketplace pricing and product availability.

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

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

Provider may access the Pharmacy Portal to obtain current MAC prices and upcoming MAC prices based on Caremark's MAC price update schedule, including for Medicare Part D plans. To locate current or upcoming MAC price information, utilize the "MAC Price Look Up" feature of the Pharmacy Portal available through a secure website: **rxservices.cvscaremark.com**. Providers can also request a MAC list by clicking on the "Pharmacists & Medical Professionals" link found online at **caremark.com** and submitting a Pharmacy MAC List Request form to **MACInquiries@CVSHealth.com**.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000588

6.05 Eligible Person Fees and Amounts

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

6.06 Claims Payment and Other Fees

6.06.01 Remittance Advices

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

If Provider or authorized agent of Provider requires additional remittance reports, the following service fees apply:

SERVICE TYPE	MINIMUM SERVICE FEE
Paper remittance reprint	$150/NPI/cycle
Copy of Performance Network Program report	$150/report
Internet, network data mover (NDM), data recreate, etc.	$500/item/NPI/cycle
Research fee associated with no change in reimbursement	$150/hour
Documentation request/research	$150/hour
Check trace/stop payment	$150/check
EFT Bank Account change	$150/NPI
835 Vendor change	$150/NPI
Provider claim adjustment request	$10/claim

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

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

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

6.06.02 Disputed Claims, Collected Fees, Amounts, or Recoupments

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000589

Notifications may be mailed to:
CVS Caremark
Attn: Network Services, MC 023
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

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

6.06.03 Claims Adjustment

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

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

Claims adjustment requests may be mailed to:
CVS Caremark
Attn: Adjustment Services, Pharmacy Corrections, MC 019
9501 East Shea Boulevard
Scottsdale, AZ 85260

Providers may be required to submit claim adjustment requests electronically.

6.07 Recoupment and Adjustments

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

6.08 Workers' Compensation

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000590

6.09 Consumer Card

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

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

6.10 Provider Suspension

Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider if required by applicable Law, or if Caremark has reason to believe Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; (4) is a breach of the Provider Agreement; (5) alters the dispensing patterns of the Provider sufficiently to indicate potential fraud, waste or abuse; or (6) constitutes potential fraud, waste, or abuse. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement.

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

6.11 Directories

Caremark and Plan Sponsors may list Provider in directories and databases for distribution to, and use by, Eligible Persons, Plan Sponsors, and others as Caremark or a Plan Sponsor determines are necessary. Additionally, Caremark may display Provider, if applicable, in preferred provider performance initiatives in paper, web-based directories, or Plan Sponsor reporting. Refer to section **14.01 Advertising and Trademarks** of the Provider Manual.

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

6.12 Collection of Regulatory or Other Governmental Agency Assessment

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000591

7. Compliance Reviews

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

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

Compliance Reviews include, but are not limited to:

- Concurrent/Daily Review
- Medicare/Medicaid Review
- Telephone or Fax Inquiries
- Provider Tax determinations and legal basis for calculation of such Provider Tax

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

1. Submitting incorrect data in the claims submission;
2. Failing to provide documents or information by the specified deadline requested by Caremark pursuant to the Agreement;
3. Refusing to accept an identification card for an Eligible Person;
4. Refusing to service an Eligible Person because of the reimbursement rate;
5. Failing to submit a claim for a Covered Item for an Eligible Person;
6. Disclosing Confidential Caremark Information;
7. Submitting the incorrect applicable DAW code;
8. Submitting inaccurate Usual and Customary (U&C) Prices or ingredient costs;
9. Submitting a Product Identifier of a Covered Item that does not match the product dispensed to the Eligible Person or submitting a Product Identifier that does not match the product used to prepare the compounded product dispensed to the Eligible Person;
10. Non-adherence to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual;
11. Not dispensing an emergency supply of a Covered Item to an Eligible Person as required by applicable Law;
12. Non-adherence to section **4.16 Software Certification** of the Provider Manual; and
13. Blocking, avoiding, evading, failing, or otherwise refusing to accept telephone calls or fax transmissions from Caremark during Provider's hours of operation.

Provider must not separate cash and third-party prescription business or own, operate, or affiliate with a non-participating Provider to manipulate Eligible Person prescription claims processing or pricing. Providers not in compliance with Caremark Documents may be subject to assessment of non-compliance fees (refer to section **7.01 Non-Compliance Fees** of the Provider Manual) as well as subject to audit review and chargeback for non-compliance actions (e.g., modifying a U&C Price or ingredient cost, submitting a Product Identifier other than actual product dispensed).

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000592

7.01 Non-Compliance Fees

Caremark may find it necessary to perform claims review. Provider agrees that Caremark may review submitted claims and charge a reasonable amount to the Provider consistent with the resources required to perform the review. These reviews may be performed on all claims submitted by the Provider and may include, but not be limited to, consulting with the Prescriber or Eligible Person; review of copayment collection evidence, original prescription, prior authorization documentation, etc.; and other reviews to confirm compliance with the Provider Manual and applicable Law.

Caremark may assess against Provider a $475 administration fee for an initial occurrence of non-compliance or for each non-compliant submitted claim, increasing in $475 increments for subsequent non-compliant events (e.g., $475, $950, $1,425). Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for charges for non-compliance pursuant to the Provider Agreement or any Third-Party Agreement, or claims submitted in breach of the Agreement. Provider also may receive a corrective action required (CAR) notice, with additional requirements and remedial measures, as outlined in section **8.08 Corrective Action Plan** of the Provider Manual.

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

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

7.02 Additional Information Regarding Compliance Reviews

1. Provider must be reachable by Caremark during hours of operation communicated by Caremark pursuant to section **3.02.01 Hours of Operation** of the Provider Manual and based on the contact information (as updated) that Provider specified to Caremark as part of enrollment or credentialing. It is essential that Provider keep contact information up to date to ensure reminders and other important communications are received. Refer to section **2.05 Notification to Caremark** of the Provider Manual. See also section **6.10 Provider Suspension** of the Provider Manual.
2. Documents and records subject to review include, but are not limited to, the following:
    a. Prescription hard copies – scanned images must include both the front and back images of the original and the original must be retained and retrieved if requested (refer to section **3.05.03 Prescription Information** of the Provider Manual)
    b. Computer records/documentation
    c. Dispensing records that include quantities and dates dispensed
    d. Signature logs (refer to section **3.05.02 Signature Log – Hard Copy or Electronic** of the Provider Manual)
    e. Delivery logs with tracking information for mailed or home/business delivered prescriptions (refer to section **3.05.02 Signature Log – Hard Copy or Electronic** of the Provider Manual)
    f. Prescription label and dispensing label
    g. Compound record and subformulations, which must include at minimum, actual Product Identifiers of all items used, lot numbers, expiration dates, compounding instruction, final compounded dosage form, signature of verifying pharmacist, and certificate of analysis. Provider must keep compound records for the same time period as required for prescription hard copies. Refer to chapter **4. Claims Submission** of the Provider Manual
    h. Evidence of copay collection including proof of financial transaction. Refer to chapter **3. Pharmacy Services and Standards** of the Provider Manual
    i. Methodology used to determine appropriate beyond-use date
    j. Claim reversal records, including confirmation of reversal acceptance from Caremark
3. For claim submission requirements refer to chapter **4. Claims Submission** of the Provider Manual.
4. Caremark from time to time supplies network Providers with basic information on the appropriate billing of medications to help prevent audit discrepancies and non-compliance with the Caremark Provider Manual. Pharmacy audit tips are posted on the Pharmacy Portal at **rxservices.cvscaremark.com**. Provider will be responsible for monitoring and reviewing pharmacy audit tips on the portal. Refer to sections **1.06 Pharmacy Communications** and **1.07 CVS Caremark Pharmacy Portal** of the Provider Manual.
5. For additional claim processing information, refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.
6. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance). For audit purposes, Provider must always maintain accurate documentation consistent with Caremark requirements to support overrides submitted, including overrides recommended by Pharmacy Help Desk representatives.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000593

8. Professional Audits

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

8.01 Types of Audits

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

8.01.01 On-site Audits

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

8.01.02 Expanded Audits

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

8.01.03 Desktop Audits

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

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

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

8.01.04 Audits by Government Agencies

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000594

other documentation to Caremark within the timeframe as notified by Caremark based upon the Government Agency Audit, and agrees that Caremark has the right to produce such Provider's books, records, prescription records, and other documentation in Caremark's possession.

8.02 Professional Audits Rights

During the term of the Provider Agreement and for two (2) years following the termination of the Provider Agreement (or such time permitted under applicable Law), Caremark has the right to audit Provider's records and documents, facility, and practices as Caremark reasonably determines are necessary to evaluate Provider's compliance with the Provider Agreement and applicable Law. Caremark's audit may cover any claim submitted by Provider or Eligible Person to Caremark or Plan Sponsor for adjudication, regardless of the method of submission. To the extent allowed by Law, if there is a conflict between the Provider Manual and applicable Law with respect to an audit of Provider, the audit is subject to the stricter provision.

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

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

Throughout the audit process:

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

Provider authorizes Caremark to release Provider's information, records, and documents to governmental authorities (and their agents), Plan Sponsors, and wholesalers upon request. Refer to section **8.01.04 Audits by Government Agencies** of the Provider Manual. Caremark reserves its rights under section **14.03 Confidentiality** of the Provider Manual.

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

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

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

8.03 Documents and Records Production Related to Audits

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

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000595

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

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

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

8.04 Documents and Records Subject to Audit

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

- Prescription hard copies - scanned images must include both the front and back images of the prescription hard copy and the prescription hard copy must be retained and retrieved if requested. Prescription hard copies or scanned images of prescription hard copies must be legible by Caremark
- Signature logs
- Delivery logs with tracking information for mailed or home/business delivered prescriptions
- Daily prescription logs
- Wholesaler, manufacturer, and distributor invoices (with NDC, drug names, quantity, package size, etc.)
- Transaction Statement, Transaction History, and Transaction Information and Documentation as defined in section **8.05 Supply of Covered Items; Purchase Invoices** of the Provider Manual
- Refill information
- Prescriber information
- Patient profiles/Prescriber orders
- Records to validate U&C
- Prescription label and dispensing label
- Provider system report of Pharmacy Services reversed, returned to stock, or not dispensed with confirmation of reversal of the claim submission
- Recorded diagnosis on prescription hard copy or maintained in the computer system for all Medicare Part B Pharmacy Services dispensed under a Medicare Part D plan
- Record of Eligible Person location (e.g., skilled nursing facility, assisted living facility) when claim is dispensed
- Records of transfer/sale between providers of drugs and devices used for Pharmacy Services
- Records of prescription transfers, including evidence of Eligible Person's express permission to Provider to transfer their prescription to another pharmacy
- Medication pricing brochures for cash customers (e.g., paper pamphlet, promotional signage, internet listing)
- Patient consent and administration record of vaccine claims (combination vaccine/administration)
- Evidence of copay collection including proof of financial transaction [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash]. If the Patient Pay Amount is reduced due to a coordination of benefits (COB), Provider must provide evidence of the claim adjudication to other payer(s)
- Documents pertaining to individualized determination of financial need or exhaustion of reasonable Patient Pay Amount collection efforts. Refer to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual
- Proof of completion of annual Medicare Part D Fraud, Waste and Abuse (FWA) training and General Compliance Training (GCT)
- Verification that Provider has reviewed the Office of Inspector General (OIG), List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) exclusion list as required by section **2.09 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual
- Prescription record documentation for Medicare Part D Enrollees with diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD)
- Signed Prescriber or patient attestation legitimizing the dispensing of the prescription if a prescription hard copy, medication order, patient signature log or patient delivery log is not retrievable. Prescriber attestations must be written on the Prescriber's business letterhead or on the Prescriber's prescription. Attestations provided by the Prescriber must clearly indicate the source of the attestation (i.e., clearly visible fax signature that the attestation originated from the Prescriber's office or Prescriber's stamp on the attestation)
- All records acquired in the purchase of a pharmacy or in the purchase of pharmacy files
- Documentation substantiating transmission of submission clarification codes (SCC) or override codes

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000596

- Evidence of verification of legitimate Prescriber/patient relationship if Provider knows or reasonably should know that there is not a legitimate Prescriber/patient relationship
- Collaborative practice agreement(s)
- Credit Card Merchant Account Report including evidence of settlement and payment through bank records
- Policies and procedures related to all Provider operations including, but not limited to, collection of Patient Pay Amounts and inventory controls
- Documents to evidence that Provider is compliant with their own policies and procedures and/or CAP
- Any document deemed necessary by Caremark to determine network provider's compliance with any terms and conditions set forth within this Provider Manual
- Refer to section **7.02 Additional Information Regarding Compliance Reviews** of the Provider Manual for required Multi-Ingredient Compound Documents

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

8.05 Supply of Covered Items; Purchase Invoices

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

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

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

The parties hereby designate manufacturers of diabetes testing products as third-party beneficiaries of this Section 8.05 of this agreement having the right to enforce the paragraphs related to the requirement to purchase from the manufacturer directly or from its Authorized Distribution Network.

Provider's receipt of Covered Items when Provider knows, or reasonably should have known, that the Covered Item is suspect may result in chargeback of claims and other remedies available to Caremark including, but not limited

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000597

to, termination of the Agreement. For purposes of this section "suspect" means a Covered Item that is potentially counterfeit, diverted, or stolen; is potentially intentionally adulterated such that the Covered Item would result in serious adverse health consequences or death to humans; is potentially the subject of a fraudulent transaction; or appears otherwise unfit for distribution such that the Covered Item would result in serious adverse health consequences or death to humans.

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

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

8.05.01 Invoice Documents and Records Maintenance

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

8.06 Medicare Part D Requirements

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

- Long-term care billing
- Correct use of valid Patient Residence Code values (the term "correct" means, for example, submitting the actual Patient Residence code for patients where they physically reside rather than a Patient Residence Code for a recognized LTC/ALF where the patient previously resided). Refer to section **10.07 Special Instructions for Participating LTC Providers** of the Provider Manual
- Correct use of Pharmacy Service Type values. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual
- Compliance with "CMS-10147 Medicare Prescription Drug Coverage and Your Rights" pharmacy notification
- Documentation to establish coverage determinations (e.g., Hospice, Part B vs. Part D, ESRD)
- Documentation to prove that Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **2.09 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual to confirm that no Prescriber transmitted on a Medicare Part D claim is on any exclusion list
- Documentation or information requested which relates to a Medicare Part D claim dispensed by Provider but reimbursed directly to other parties, including the Part D Enrollee
- Documentation substantiating any submission clarification codes (SCC) or override codes transmitted on a Medicare Part D claim

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000598

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

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

8.07 On-Site and Expanded Audit Resolution – Appeals Process

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

If Provider chooses to appeal the initial discrepancies Provider must respond to Caremark in writing within thirty (30) days, or other timeframe required by applicable Law, with supporting documentation for the discrepant claim in accordance with the documentation guidelines or the Provider Manual. Documentation must be transmitted to Caremark via certified mail, fax, Federal Express, United Parcel Service, or any other certified carrier (with delivery confirmation) and must be received by the due date specified by Caremark. Provider may contact the Pharmacy Performance department at **1-866-488-4709** prior to the documentation due date to request an extension of the documentation due date. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date. Late documentation will not be accepted.

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

Any documentation submitted after the documentation due date may be considered by Caremark as part of Caremark's evaluation of the remedies to be taken by Caremark to address the audit findings but will not impact the final chargeback amount owed to Caremark.

Refer to section **15.09 Arbitration** of the Provider Manual for the dispute resolution process once the final audit discrepancy report is complete.

The parties agree that Caremark will incur operating costs and expenses arising out of or related to conducting audits that are difficult to reasonably estimate; as such, if the final audit chargeback exceeds $10,000, Provider must also reimburse Caremark twenty percent (20%) of the total final audit chargeback for operating costs and expenses arising out of or related to conducting the audit and collecting the final audit chargebacks, where consistent with applicable Law. Provider agrees that this twenty percent (20%) audit costs and expenses reimbursement represents a reasonable method to estimate the operating costs and expenses arising out of or relating to conducting audits.

Provider must notify Caremark of Provider's appeal of an initial discrepancy report in writing to:
CVS Caremark – Audit Manager
Attn: Pharmacy Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

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

Once Provider is on notice of an on-site or expanded audit Provider must not during the audit process adjust or reverse claims that are the subject of the audit as Caremark will perform appropriate adjustments and reversals at the conclusion of the audit process.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000599

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

8.08 Corrective Action Plan

A corrective action required (CAR) notice may be sent to Provider requiring Provider to submit to Caremark a corrective action plan (CAP) that in detail describes Provider's plans to resolve identified issues such as audit findings, dispensing errors, failure to respond to audit requests, failure to correct repeated verbal and/or written warnings regarding non-standard retail pharmacy model practices, or as may be required by applicable Law. Provider must respond to any request for information and action in a CAR notice. Provider's response must be submitted by the date provided on the CAR and must include a CAP. Provider's CAP must include applicable documentation and policies and procedures as specified in the CAR notice to support Provider's CAP. As part of the CAP process, Provider may be assessed a per claim review fee where permitted by applicable Law for oversight claim activity during the CAP period (refer to section **7.01 Non-Compliance Fees** of the Provider Manual). If Provider fails to fully respond to a CAR notice or any other request for information and action as part of the CAR/CAP process, fails to follow the CAP, or requires a CAR/CAP for the same or similar issues, Caremark reserves the right to exercise its termination rights under the Provider Agreement, along with other available remedies.

8.09 Potentially Fraudulent Activity

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

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

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000600

9. Medicaid

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

Provider is responsible to review and comply with state requirements which may include additional provisions from Federal Medicaid/Medicare Part D Program requirements.

9.01 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicaid Eligible Person is made, in whole or in part, from state and federal funds, which subjects Provider to laws, such as but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable Laws including minimum standards of pharmacy practice. Refer to section **16. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda (located on the Pharmacy Portal, at **rxservices.cvscaremark.com**). Provider agrees to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions. [42 C.F.R. 438.230(c)(2)]. Provider acknowledges that Provider's ability to provide Pharmacy Services under the Agreement for Medicaid Eligible Persons may be revoked if it is determined that Provider has not performed satisfactorily [42 C.F.R. 438.230(c)(1)(iii)].

9.02 Enrollment with State Medicaid

Pursuant to 42 C.F.R. 438.602(b), Provider shall ensure that it is enrolled with each state Medicaid agency for which Provider provides Pharmacy Services under the Agreement. Provider agrees that if it is not enrolled with the applicable state Medicaid program, it may not provide Pharmacy Services under the Agreement for that state Medicaid program's enrollees.

9.03 Medicaid Credentialing

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

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

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

9.04 Fraud, Waste and Abuse Compliance Program

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000601

9.05 Inspection and Audit of Records and Access to Facilities

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

9.06 Claims Submission Requirements for Medicaid

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

9.07 Medicaid Coordination of Benefits

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

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

9.08 Prior Authorization

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

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

9.09 Denial of Services

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

9.10 Cultural Competency

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

9.11 Home Delivery

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

9.12 Directories

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000602

10. Medicare Part D

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

10.01 Medicare Part D Network Standards

To the extent Provider provides Pharmacy Services to a Part D Enrollee, Provider must comply with the following terms contained in section **10.01 Medicare Part D Network Standards** of the Provider Manual. Unless specifically indicated otherwise, these terms apply to all Providers who provide Pharmacy Services to a Part D Enrollee (including retail, home infusion, long-term care (LTC), and Indian Health Services/Tribal/Urban Providers). Provider acknowledges that CVS Caremark Part D Services, L.L.C. together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this section) are responsible for providing Part D services on behalf of Part D Plan Sponsors. All capitalized terms used in section **10.01 Medicare Part D Network Standards** of the Provider Manual will have the same meaning as in the applicable **Addendum to the Caremark Provider Agreement: Terms of Participation in Medicare Part D,** or the **Glossary of Terms** in the Provider Manual.

10.01.01 Network Participation

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

The terms of section **10.01.01 Network Participation** of the Provider Manual supersede and amend any inconsistent or contrary provision in the Provider Agreement, including section **15.05.02 Termination Without Cause** of the Provider Manual, but will only apply to the extent that this section is consistent with a Part D Plan Sponsor requirement.

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

10.01.02 Compliance with Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Part D Enrollee is made, in whole or in part, from federal funds and subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Provider must comply with minimum standards of pharmacy practice under applicable state Law. Refer to chapter **16. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Pharmacy Portal, refer to section **1.07 CVS Caremark Pharmacy Portal** of the Provider Manual.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000603

10.01.03 Delegated Activity

Provider must obtain prior written approval from Caremark if Provider wishes to delegate any activity or responsibility related to its Pharmacy Services to a subcontractor. Upon Caremark's written approval of such delegation, Provider must obtain written agreement from such subcontractor that the subcontractor will comply with all of the terms and conditions of the Provider Agreement (which includes the Provider Manual) applicable to Provider including, but not limited to, the requirement to comply with the contractual obligations specified for downstream entities in 42 C.F.R. 423.505(i)(2) and (i)(3) that relate to, among other things, retention of books and records, including prescription records, for at least ten (10) years or longer as specified in 42 C.F.R. 505(i)(2); section **2.09 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual; and chapters **4. Claims Submission** and **8. Professional Audits** of the Provider Manual. Provider's written agreement with subcontractor must provide that the agreement and/or delegated activities may be revoked (or specify other remedies) in instances when CMS, Part D Plan Sponsor, or Caremark, or any of Caremark's subsidiaries or affiliates determines that the subcontractor has not performed satisfactorily. In the event that any subcontractor is terminated by CMS or Part D Plan Sponsor, Provider must immediately notify Caremark of such termination.

10.01.04 Offshore Subcontracting

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

10.01.05 Marketing

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

10.01.06 Fraud, Waste and Abuse Program

Provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Compliance Program Guidelines to prevent, detect, and correct Fraud, Waste and Abuse (FWA). Provider also agrees to comply with Part D Plan Sponsor's policies and procedures, and any corrective action plans imposed by Part D Plan Sponsors or Caremark related to the Part D Program. Provider must submit copies of Provider's policies and procedures, and corrective actions related to Part D activities as requested by Caremark. Provider must cooperate fully with a Part D Plan Sponsor's FWA investigative activities including providing copies of prescriptions, signature logs, and other requested documentation to support FWA investigations.

10.01.07 Pharmacy Compliance and FWA Training

The following training is available for all pharmacies and staff on the pharmacy website, **caremark.com/pharminfo,** under "Medicare and Medicaid Compliance Training":

- CVS Health Code of Conduct
- Medicare Part C and D General Compliance Training
- CMS Combating FWA Training

Note: For more information about Medicare Parts C and D Compliance Program requirements, please visit: **cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance**

10.01.08 Information on CMS-10147 Pharmacy Notice

CMS-10147 - Medicare Prescription Drug Coverage and Your Rights

1. CMS requires that Caremark distribute the "Medicare Prescription Drug Coverage and Your Rights" form (Pharmacy Notice – CMS 10147) to Providers on an annual basis. This form is used to instruct Part D Enrollees to contact their Part D Plan to obtain a coverage determination (prior authorization) or ask for a formulary or tiering exception if the Part D Enrollee disagrees with Plan claim response information provided to the Pharmacy.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000604

2. Pharmacies must provide the Part D Notice of Appeal Rights directly to Part D Enrollees any time the following reject(s) and related messaging occurs on a claim:

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

3. This notice is provided in **Appendix A** of the Provider Manual in English and Spanish. This is a standard notice and Provider may not deviate from the content of the notice. Note that the OMB control number [APPROVED OMB #0938-0975] and the expiration date must be displayed in the upper right corner of the notice.
4. This document is distributed to Providers annually by Caremark and is also posted at: **cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html**
5. Distributing this notice fulfills the requirements at 42 C.F.R. § 423.562(a)(3).

10.01.09 Performance Monitoring

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

10.02 General Information

10.02.01 Part D Reference Information for Pharmacists

Refer to **cms.gov/Medicare/Medicare** which contains helpful information on a variety of Medicare Part D topics for Providers. CMS frequently updates this website so check periodically for the latest information.

10.02.02 Medicare Part D Calls to the Pharmacy Help Desk

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

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

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

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

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

10.03 Credentialing

10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies

Provider agrees to comply with the following provisions:

1. Provider has reviewed the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) exclusion list as required by section **10.03.02 Federal Health Care Programs Participation Exclusion** of the Provider Manual.
2. Provider has a record retention policy in place that complies with CMS's minimum of 10-year record retention requirement and with other applicable state Law.
3. Provider has in place and provides FWA training to all employees and managers (who are directly or indirectly involved with the administration of delivery of Part D benefits) within thirty (30) days of their date of hire and annually thereafter.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000605

4. Provider tracks employee and manager attendance for any training conducted.
5. Provider must provide a copy of the training materials upon request.
6. Provider attests that if any services that support the Provider Agreement or if any of its subsidiaries or affiliates are delegated, the performance of those services is monitored by Provider to ensure compliance with the applicable Medicare Part D requirements.
7. Provider has entered into written arrangements with its subcontractors which provide for revocation of the delegation activities or specify other remedies in instances when CMS or Caremark or any of its subsidiaries or affiliates has determined that the parties have not performed satisfactorily.
8. Provider certifies that it is free of any conflicts of interest (within the meaning of the CMS Prescription Drug Benefit Manual, Chapter 9) in administering or delivering its Pharmacy Services, and will require its managers, officers, and directors responsible for the administration or delivery of Pharmacy Services for Part D Enrollees to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer, or director is free from any such conflict of interest.

10.03.02 Federal Health Care Programs Participation Exclusion

A. Prescriber

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

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

Reject A1 <<Prescriber is Federally Excluded>>

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

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

B. Precluded Prescriber

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

Reject 929 <<Prescriber ID is precluded>>

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000606

C. Pharmacy Provider

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

10.04 Pharmacy Services and Standards

10.04.01 Plan Identification Cards

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

10.04.02 General Procedures for Acknowledgement of Enrollment Letters

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

An acknowledgement letter is a letter that qualified Part D Enrollees receive from their Part D Plan in advance of the distribution of Part D Plan identification cards. The letter should contain sufficient information in order to verify a Part D Enrollee's eligibility and to submit claims to the appropriate location in order for adjudication to occur. Note, letters confirming initial information was received but has yet to be confirmed or processed may not constitute a Part D acknowledgement letter.

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

1. If a Part D Enrollee's eligibility cannot be verified, send an E1 transaction to the Transaction Facilitator (RelayHealth) to verify the Part D Enrollee eligibility and to obtain information necessary to process claims. It is Provider's responsibility to verify Part D Enrollee is the Part D Enrollee identified in the response. For more information on E1 transactions visit RelayHealth at **medifacd.mckesson.com/e1/**.
2. If a Part D Enrollee's eligibility cannot be verified in Step 1 but Caremark is the processor, contact the appropriate Pharmacy Help Desk phone number. Refer to sections **1.04 Pharmacy Help Desk** and **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual.
3. If a Part D Enrollee's eligibility cannot be verified in Step 2, call **1-800-MEDICARE** to verify the Part D Plan under which the Part D Enrollee is enrolled, and if possible, verify the Part D Enrollee's eligibility information.

10.04.03 Best Available Evidence

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

1. Provider should initiate the BAE process in order for a change to a Part D Enrollee's low-income status to occur if Provider is presented with one or more of the following acceptable forms of evidence from Part D Enrollees:
   a. A copy of the Part D Enrollee's Medicaid card which includes the Part D Enrollee's name and an eligibility date during the discrepant period;
   b. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title, and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
   c. A copy of a state document that confirms active Medicaid status during the discrepant period;
   d. A printout from the State electronic enrollment file showing Medicaid status during the discrepant period;
   e. A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
   f. Other documentation provided by the State showing Medicaid status during the discrepant period.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000607

2. In addition, any one of the following forms of evidence from Part D Enrollees may establish that they are institutionalized and qualify for zero cost-sharing:
   a. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
   b. A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
   c. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.
3. Acceptable documents that may be used as BAE for demonstrating receipt of Home and Community-Based Services (HCBS) include:
   a. A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the Part D Enrollee's name and HCBS eligibility date during a month after June of the previous calendar year;
   b. A copy of a State-approved HCBS Service Plan that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year;
   c. A copy of a State-issued prior authorization approval letter for HCBS that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year; or
   d. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year.
4. Once Provider has the required acceptable form(s) of evidence, Provider should either:
   a. Contact the Pharmacy Help Desk for appropriate Plan Sponsor contact information; or
   b. Consult the annual Caremark Medicare Part D Plan Sponsor chart distributed to Providers annually.

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

10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS

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

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

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

10.04.05 Auto-Ship Refill Programs

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

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

10.05 Claims Submission

10.05.01 Unique RXBIN/RXPCN Requirement - Medicare Part D

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000608

10.05.02 Payment of Clean Claims

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

10.05.03 Electronic Prescribing

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

10.05.04 Prescription Origin Code and Fill Number

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

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

1 = Written

2 = Telephone

3 = Electronic

4 = Facsimile

5 = Pharmacy

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

00 = Original dispensing

01 to 99 = Refill number

10.05.05 Improving Drug Utilization Review Controls

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000609

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

CONFIDENTIAL TREATMENT REQUESTED

Edit Name and Description	Reject Message	Reason for Service Code	PPS Professional Service Code	Result of Service Code
7 Day Opioid Naïve Edit: Designed to identify Part D Enrollees with no history of an opioid in the past 108 days and limit their initial supply to 7 days or less.	Reject 925: IF OPIOID/ CANCER HISTORY, RPH USE SCC 10 OR SUBMIT 7 DS OR CALL XXX-XXX-XXXX	Submit SCC "10"	N/A	N/A

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

10.05.06 Medicare Part D Claims Requiring Overrides

A. Natural Disasters

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

B. Network Access

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

C. Refill-Too-Soon and Excessive Utilization Rejects

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

10.05.07 General Medicare Part D Submission Requirements for Coordination of Benefits

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

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

For Medicare Secondary Payer (MSP) claims, the primary Medicare Part D RXBIN/RXPCN/RXGRP combinations should be submitted on the coordination of benefits (COB) claim (refer to the Caremark Plan Sponsor grid within the Pharmacy Portal at **rxservices.cvscaremark.com**.

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000611

10.05.08 Formulary Transition Fill Process

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

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

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

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

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

<<Paid under Transition Fill - PA required>>

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

The following drugs are not TF eligible:

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

For submitted claims not eligible for TF,

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

is intended to remind Providers to provide the required Part D Notice of Appeal Rights directly to Part D Enrollees should they want to appeal rejected claims with Part D Plans. Notice must be given directly to Part D Enrollees any time this reject occurs on a claim.

The Transition Supply is an approved month's supply for both the outpatient and the long-term care patient. No changes were made to the long-term care Emergency Supply, which remains a 31-day supply.

Outpatient Transition Fill

Transition Fill Condition	Description	Allowed TF Supply for the Retail Setting
Part D Enrollee who is newly enrolled in Plan	• Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one plan to another after start of contract year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first 90 days of coverage in the new Plan

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000612

Transition Fill Condition	Description	Allowed TF Supply for the Retail Setting
Some renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within the look-back period (established by the plan) from date of claim and previous claim not TF for the same reason • If Part D Enrollee has not transitioned before beginning of new Plan benefit year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first 90 days of coverage effective at the beginning of the new contract year
Part D Enrollee requesting exception and decision still pending	Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days' supply exhausted	Contact the Pharmacy Help Desk for Transition Extension Overrides under this Condition

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

10.05.09 Insulin Coverage

Medicare Part D Plans cover injectable insulin not used with a durable medical equipment (DME) insulin infusion pump. Medicare Part B covers most external insulin pumps and the insulin that the device uses under durable medical equipment. Medicare Part D covers disposable insulin infusion pumps.

10.05.10 Pro-Rated Daily Cost Share

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

Caremark will apply a daily cost-sharing rate for a Covered Part D Drug that is dispensed for less than the plan-defined one-month supply. If a claim applies a daily cost-sharing rate Provider may receive the following message:

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

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

- Solid oral doses of antibiotics
- Solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance
- Non-Part D drugs, unless the Part D Plan has specified that copay proration extends to covered drugs that are treated as non-Part D under their benefit plans
- Drugs dispensed by out-of-network providers

10.05.11 Medicare Part B and Medicare Part D Drug Coverage Determinations

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000613

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

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

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

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

When Provider receives a reject with secondary messaging and calls the number included in the reject, the Pharmacy Help Desk representative, who is specifically trained to handle Part B vs. Part D determinations, will present a series of criteria to Provider. Based on the information obtained from the pharmacist, the Pharmacy Help Desk representative will be able to promptly assist Provider with processing the Part D claim, if appropriate. This process only applies to certain drug categories and select Part D Plans. For drugs not handled by the Pharmacy Help Desk, the reject message will indicate that a Prior Authorization is required and include the number for initiating a coverage determination.

10.05.12 End Stage Renal Disease Claim Processing

ESRD "Always" Drugs

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

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

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

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

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

10.05.13 Prescriber Identification for Medicare Part D Claims

For all Medicare Part D claims, accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claims adjudication, clinical services, Plan Sponsor initiatives, and audits. In addition, CMS requires a valid and active individual Prescriber National Provider Identifier (NPI) on all claims. Failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI, DEA number, or any other number or identifier (e.g., hospital, clinic, or pharmacy identification number) in the prescriber identification field which does not represent an individual Prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate submission clarification code (SCC) to bypass the reject. Per CMS, Part D Plan Sponsors are required to only report Type 1 (Individual) NPIs on PDE records. Type 2 (group/organizational identifier) NPIs are not accepted for Prescribers. Providers must obtain an individual NPI. Any claim submitted with an invalid NPI will reject with the following or similar reject message:

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000614

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

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

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

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

10.05.14 Claims Submission Window for Medicare Part D

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

RXBINs 004336, 610591, 610415:

Medicare Part D
PO Box 52066
Phoenix, AZ 85072-2066

Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:

Aetna Medicare Part D and LTC
PO Box 52446
Phoenix, AZ 85072-2446

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000615

RXBINs 020115, 020388

CarelonRx Medicare Part D and LTC
Claims Department – Part D Services
PO Box 52077
Phoenix, AZ 85072-2077

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

10.05.15 Medicare Part D Claims Adjustment

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

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

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

10.05.16 Medicare Part D Transaction Fees

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

10.06 Network Participation and Payment

10.06.01 Drug Pricing

Notwithstanding anything to the contrary, Caremark utilizes Medi-Span as reference for drug prices. Drug price files are updated every business day. An initial update to the drug price file occurs on January 1, or the following business day each year. Point-of-service claims are adjudicated, and Provider is reimbursed in accordance with these updates.

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

10.06.02 Pharmacy Service Type and Patient Residence Requirements

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000616

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

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

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

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

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

As recommended by NCPDP, Caremark accepts the below values to ensure appropriate adjudication and reimbursement. Provider must be in the specific Medicare Part D network in order to submit these codes and receive appropriate payment. Provider must not intentionally or unintentionally submit values that do not accurately represent either Pharmacy Service Type, Patient Residence, or both. Home infusion and LTC claims must meet the CMS qualifications (e.g., skilled nursing unit) in order to submit these codes and receive appropriate payment.

Administrative Codes:

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

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

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

10.07 Special Instructions for Participating LTC Providers

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

10.07.01 Pharmacies Serving LTC Facilities

Prescription Drug Benefit Manual – Section 40.3.1

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

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

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

10.07.02 LTC Pharmacies Timely Claim Submission

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000617

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

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

RXBINs 004336, 610591, 610415:

Long-term Care (LTC) Claims:
Attn: Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:

Aetna Long-term Care (LTC) Claims
Attn: Aetna Medicare Part D LTC
PO Box 14023
Lexington, KY 40512-4023

10.07.03 LTC Appropriate Days' Supply Short Cycle Billing

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

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

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

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

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

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

Submission Clarification Codes:

NCPDP Field #420-DK	
Code	**Description**
21	LTC dispensing: 14 days or less not applicable (N/A) – 14 days or less dispensing is N/A due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e., vacation supply, leave of absence, e-kit, spitter dose). Medication quantities are dispensed as billed
22	LTC dispensing: 7 days – Pharmacy dispenses medication in 7-days' supply
23	LTC dispensing: 4 days – Pharmacy dispenses medication in 4-days' supply
24	LTC dispensing: 3 days – Pharmacy dispenses medication in 3-days' supply
25	LTC dispensing: 2 days – Pharmacy dispenses medication in 2-days' supply
26	LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1-days' supply
27	LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4-days', then 3-days' supply
28	LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2-days', then 2-days', then 3-days' supply
29	LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekends
30	LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes)
31	LTC dispensing: Per med pass dispensing – Remote dispensing per med pass

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000618

NCPDP Field #420-DK	
Code	**Description**
32	LTC dispensing: PRN on demand – Remote dispensing on demand as needed
33	LTC dispensing: 7 days or less cycle not otherwise represented
34	LTC dispensing: 14 days – Pharmacy dispenses medication in 14-days' supply
35	LTC dispensing: 8-14 days dispensing not listed above – 8-14-days dispensing cycle not otherwise represented
36	LTC dispensing: dispensed outside of short cycle. Medicare Part D coverage was determined post dispensing

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

10.07.04 LTC Days' Supply Limitations

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

10.07.05 LTC Transition Fill

Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills must be submitted with the appropriate LTC Pharmacy Service Type and Patient Residence values. See additional information in the table below.

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000619

Transition Fill Condition	Description	Allowed TF Supply
*Part D Enrollee residing in LTC facility (Emergency Supply)	• LTC Emergency Supply	• Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense drugs with a first fill of a maximum of a 31-day supply, or less if the prescription is written for fewer days. • Submit SCC 420-DK Value "7" Emergency Supply. • Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes. If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance.
Part D Enrollee requesting exception and decision still pending	• Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days' supply exhausted	Contact the Pharmacy Help Desk for overrides under this condition.

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

10.07.06 Special Package Indicator

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

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

10.07.07 LTC Override Requests

Emergency Supply:

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000620

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

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

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

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

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

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

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

Utilization Management Rules:

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

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

Emergency Supply Situations:

- **Emergency Kit Dispensing:** Emergency Kit/Box (E-Box) medications for emergency treatment until standard supply can be dispensed
- **First Fill Following Emergency Kit Dose:** Follow-up fill after emergency dose has been dispensed. This prescription should be filled for the fully prescribed amount minus the emergency dosing
- **LOA (Leave of Absence) Medications:** Separate dispensing of small quantities of medications for take-home use allowing Part D Enrollees to leave facility for weekend visits, holidays, etc.
- **Medication Spit Out:** Medication has been "spit out"
- **Emergency Supply:** Emergency supply of non-formulary drugs and formulary with PA or Step Therapy Requirements
- **LTC Admission/Level of Care Change:** Newly admitted due to clinical status change

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000621

1. Medications may have:
   a. Been filled at retail pharmacy prior to admit;
   b. Been filled prior to transfer and discontinued;
   c. Not followed Part D Enrollee to new facility due to regulatory and compliance issues and same medications reordered upon re-admit
2. New Admission/Level of Care Change:
   a. Valid within 31 days of New Admission/Level of Care change
   b. Up to 34-days' supply* with multiple fills
   c. Day Supply of 34 includes those claims where SCC 18 is not used

*based on plan design

Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills are submitted with the Pharmacy Service Type (PST) and Patient Residence (PR) that designate LTC.

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

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

10.07.08 Medicare Part A and Medicare Part D Drug Coverage Determinations

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

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

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

Reject 75 <<Prior Authorization Required>>

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000622

IMPORTANT:

1. As specified in the Social Security Act, Section 1861(dd), and Federal Regulations (42 C.F.R. Section 418 *et seq.*), hospice programs must provide individuals under hospice care with drugs and biologicals related to the palliation and management of the terminal illness as defined in the hospice plan of care.
2. Stand-alone prescription drug Plan Sponsors cannot easily identify and prevent Part D payment for hospice drugs. Provider should work with LTC facilities in which their patients reside or hospice providers to identify any Part D Enrollees who have elected hospice care and ensure hospice drugs are not billed to Part D.
3. For those Plan Sponsors utilizing Caremark coverage determination services, if the treatment is unrelated to the terminal condition, the Pharmacy Help Desk will direct the Provider to ask the hospice provider to fax the form to the Coverage Determinations and Appeal Department and provide the written documentation for the Part D exception. Provider must provide the Pharmacy Help Desk with the hospice provider's contact information to help expedite the process. Caremark's Prior Authorization department will handle the documentation requests and inform Provider if an approval will be made.
4. For Part D Plan Sponsors not utilizing Caremark for coverage determinations, the telephone number in the message will direct Provider to the Part D Plan Sponsor's coverage determination department to initiate the process.
5. Per CMS guidance, for Part D Enrollees and/or caregivers who state they are no longer in hospice, Caremark requires written documentation prior to overriding the hospice reject. The four acceptable forms are outlined as the Best Available Evidence below. The documentation can be faxed to Caremark at **1-844-242-0904**. Caremark requires a retail and LTC pharmacy to provide the hospice contact information to the Pharmacy Help Desk. Part D Enrollees and/or caregivers may ask Providers to fax the documentation to Caremark.

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

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

10.08 Retail Addendum to the Caremark Provider Agreement

Terms of Participation in Medicare Part D

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

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000623

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000624

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000625

11. Medicare Advantage

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000626

12. Provider must comply with the Plan Sponsor's policies and procedures and written standards, which in accordance with 42 C.F.R. 422.112(a)(6) require:
    a. Timely access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services are continuously monitored to ensure compliance and that Caremark and Plan Sponsor will take corrective action as necessary;
    b. Compliance with the Plan Sponsor's coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations; and
    c. Provider consideration of Part D Enrollee's input into Provider's proposed treatment plan.
13. Provider must ensure that its Pharmacy Services are available 24 hours a day, 7 days a week, when medically necessary. 42 C.F.R. 422.112(a)(7)(ii).
14. Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. 422.112(a)(8).
15. Provider must provide effective and continuous patient care and quality review and maintain health records in accordance with standards established by the Plan Sponsor, taking into account professional standards and that there is appropriate and confidential exchange of information with other network Providers. 42 C.F.R. 422.112(b)(4)(ii)-(iii).
16. Provider must establish procedures to ensure that Eligible Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health, and systems to address barriers to Eligible Person compliance. 42 C.F.R. 422.112(b) (5) and (6).
17. Nothing in the Agreement shall be construed as requiring Provider to indemnify Caremark or Plan Sponsor against any civil liability for damage caused to an Eligible Person as a result of a Plan Sponsor's denial of medically necessary care to such Eligible Person. 42 C.F.R. 422.212.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000627

12. Medicare-Medicaid Plan

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

A Medicare-Medicaid Plan (MMP), or dual demonstration plan, is a program administered by Centers for Medicare and Medicaid Services (CMS) and a particular state Medicaid agency that integrates the services provided by both the Medicare and Medicaid programs into one plan provided to eligible MMP Eligible Persons. Provider is responsible to review and comply with state requirements which may include additional provisions from Federal Medicaid/Medicare Part D Program requirements.

12.01 Medicare-Medicaid Networks Standards

To the extent Provider provides Pharmacy Services to an MMP Eligible Person, and without limiting any other provision in the Agreement, Provider must comply with CMS Medicare Part D and applicable state Medicaid requirements, including the components of the three-way contract between CMS, an individual state Medicaid agency, and a specific Plan Sponsor.

12.02 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for an MMP Eligible Person is made, in whole or in part, from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Provider must comply with applicable state laws including minimum standards of pharmacy practice. Refer to chapter **16. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda posted on the Pharmacy Portal. For instructions on how to access the Pharmacy Portal, refer to section **1.07 CVS Caremark Pharmacy Portal** of the Provider Manual.

CONFIDENTIAL TREATMENT REQUESTED

13. Qualified Health Plans

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

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

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

For QHP Eligible Persons eligible for health benefits under a QHP offered by a QHP Issuer on a State-based Exchange including, but not limited to, **Arkansas, California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington,** Provider agrees:

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000629

14. Intellectual Property, Confidentiality and Proprietary Rights

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

14.01 Advertising and Trademarks

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

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

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

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

14.02 Non-Disparagement

Provider and/or its agents, including outside counsel acting on its behalf, may not place in a false light, disparage, defame, nor make any damaging, derogatory, or unfavorable public statements regarding Caremark, Caremark's products, programs, services, employees, personnel, and brands in any manner. Provider will provide appropriate and adequate training to ensure compliance with these requirements. Provider's obligations hereunder shall survive termination of the Agreement.

14.03 Confidentiality

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

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

Provider agrees to protect the security of Confidential Caremark Information and to ensure that it is used and disclosed only as permitted herein. Provider must notify Caremark in writing within five (5) business day after it becomes aware

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000630

of any unauthorized use of Confidential Caremark Information. Provider is responsible to Caremark for any breach of this section by its employees, agents, consultants, or authorized representatives, including outside counsel acting on its behalf.

A notice pursuant to the requirements herein must be in writing, be delivered in person by certified mail, courier, or first-class mail, and be addressed to Network Management at Caremark at the address below:
CVS Caremark
Attn: Network Management, MC 080
9501 E. Shea Boulevard
Scottsdale, AZ 85260

Such notice to Caremark must also be addressed and delivered to:
CVS Caremark
Attn: General Counsel, MC 035
9501 E. Shea Boulevard
Scottsdale, AZ 85260

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

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

This **Confidentiality** section applies to the extent consistent with applicable Law.

14.04 Non-Solicitation and Non-Interference

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

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

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

14.05 Proprietary Rights

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

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000631

14.06 Remedies

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

Accordingly, if Provider should fail to abide by the provision and terms set forth in chapter **14. Intellectual Property, Confidentiality and Proprietary Rights** of the Provider Manual, Caremark will be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and to judgment for damages (including reasonable attorneys' fees and costs) caused by the breach, and all other remedies provided by the Provider Agreement and applicable Law, including termination of the Provider Agreement or Provider's participation in any Caremark network or Plan Sponsor network.

CONFIDENTIAL TREATMENT REQUESTED

15. Miscellaneous

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

15.01 Assignment

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

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

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

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

15.02 Independent Contractors and Third-Party Beneficiaries

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

Except as otherwise provided for in the Provider Agreement including, but not limited to, the **Indemnification** section of the Provider Agreement and section **15.09 Arbitration** of the Provider Manual, no term or provision in the Provider Agreement is for the benefit of any person who is not a party to the Provider Agreement and no such party shall have any right or cause of action under the Provider Agreement.

15.03 Court Orders, Subpoenas or Governmental Requests

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

If Provider is requested or required to disclose any Confidential Caremark Information, whether by oral questions, interrogatories, requests for information or documents, subpoenas, or other processes, Provider must promptly provide Caremark with written notice of any such request or requirement so that Caremark may seek an appropriate protective order or other appropriate remedy. If such protective order or other remedy is not obtained, Provider will disclose only that portion of the Confidential Caremark Information as to which it has been advised by legal counsel that disclosure is required by Law; and Provider must exercise its best efforts to obtain reliable assurances that confidential treatment will be accorded to the Confidential Caremark Information that is disclosed in response to such requests or requirements.

15.04 Notices

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

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

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000633

Any notice to Caremark must also be addressed and delivered to:
CVS Caremark
Attn: General Counsel, MC 035
9501 East Shea Boulevard
Scottsdale, AZ 85260

A notice pursuant to the Provider Agreement to Provider must be in writing, delivered in person by certified mail, courier, or first-class mail, at the street, mailing, or check mailing address set forth in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark. Notwithstanding the foregoing, Caremark may give notice to Provider (1) via the claims adjudication system; (2) by fax via the Provider's fax number or by email via the email address provided by Provider in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark; or (3) via the Pharmacy Portal.

Notices are deemed received on the date of delivery to the other party when delivered in person (by certified mail, courier, or first-class mail), by email, by fax, by secure electronic message, or when posted via the Pharmacy Portal. If notice is sent by first-class mail, the notice is deemed received on the third business day after the date such notice was mailed. It is Provider's responsibility to promptly notify Caremark of any changes to Provider's contact information including, but not limited to, street address, mailing or check mailing address, phone number, fax number, or email address. Provider's failure to update its contact information with Caremark, or refusal to accept delivery of a notice from Caremark, shall not relieve Provider of any obligations to comply with the information communicated in the notice and may subject Provider to termination at Caremark's sole discretion. Refer to section **2.05.01 Notification of Change in Documentation and Other Information** of the Provider Manual.

Where Caremark has responded to Provider's communication and a subsequent communication from Provider is duplicative of the communication just resolved, additional information must be sent to Caremark to reopen that communication. Once additional information is received, Caremark will research the concerns expressed in the communication.

By participating as a provider in Caremark's networks, Provider acknowledges that it has a prior express business relationship with Caremark and consents to receive fax communications as well as automated messages from Caremark. Refer to section **1.06 Pharmacy Communications** of the Provider Manual.

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

15.05 Termination

15.05.01 Termination for Cause

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda, and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in any Caremark network or Plan Sponsor network) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity. Refer to chapter **7. Compliance Reviews** of the Provider Manual.

Caremark may immediately terminate the Provider Agreement if:

1. To the extent consistent with applicable Law, Provider makes an assignment for the benefit of creditors, files a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property, or, in Caremark's sole discretion, a proceeding is commenced against Provider or any principal who holds an ownership interest in Provider which will impair its ability to perform the Provider Agreement.
2. Any court, governmental, or regulatory agency issues to Provider an order to cease and desist from providing Pharmacy Services.
3. (a) There is any change in who holds (directly or indirectly) the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (b) The right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party.
4. A levy, writ of garnishment, attachment, execution, or similar item is served upon Provider and not removed within ten (10) days from the date of service.
5. Caremark reasonably determines that Provider is no longer active.
6. Provider fails to satisfy amounts or other obligations owed to Caremark. Certain remedies may apply, including termination of the Provider Agreement and any other available remedies.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000634

7. Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which:
   a. Appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or general public;
   b. Implies a failure to maintain proper licensure and related requirements for licensure;
   c. Otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement;
   d. Is a breach of the Agreement. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement, including termination of pharmacies found to have a direct or indirect relationship with Provider or its affiliates based upon common officers, directors, Pharmacists-in-Charge/responsible pharmacist, managing employees, current/former employees, owners (direct or indirect); or
   e. Constitutes fraud, waste or abuse.

The termination rights set forth in this section are in addition to any and all other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity. The effective date of a termination shall be determined by Caremark and as in accordance with applicable Law.

For any Provider with multiple locations, Caremark retains the right to terminate one or any number of Provider's pharmacy locations without terminating the Provider Agreement.

15.05.02 Termination Without Cause

Unless precluded by applicable Law, Caremark may at any time terminate the Provider Agreement without cause or terminate Provider from providing Pharmacy Services to specific Plans without cause upon a notice to Provider, regardless of the network(s) in which Provider participates.

Unless precluded by applicable Law, Provider may terminate the Provider Agreement without cause upon one hundred fifty (150) days' prior written notice to Caremark provided, however, that if applicable Law or a Caremark network or a Plan Sponsor network requires a longer notice period, the Provider Agreement shall not terminate until the expiration of such longer period.

Unless precluded by applicable Law, Provider may terminate participation in any Caremark network or a Plan Sponsor network upon one hundred fifty (150) days' prior written notice to Caremark, specifying the date of termination and the names of the Caremark network(s) or Plan Sponsor network(s) in which Provider will no longer participate, provided, however, that if applicable Law or a Caremark network or Plan Sponsor network requires a longer notice period, the termination will not take effect until the expiration of such longer period. Absent the prior written consent of Caremark, Provider who has notified Caremark of its intent not to participate in any Caremark network or a Plan Sponsor network may not elect to subsequently participate in such Caremark network or a Plan Sponsor network for thirty (30) days after the termination date, or until the next solicitation period for that Caremark network or Plan Sponsor network, whichever is longer, to the extent consistent with applicable Law.

The terms of this **Termination Without Cause** section apply notwithstanding any other provision in the Provider Agreement. For termination without cause by Provider from a Medicare Part D network, refer to section **10.01.01 Network Participation** of the Provider Manual.

15.05.03 Rights and Remedies in the Event of Termination or Breach

In the event of a termination of the Provider Agreement for any reason, Provider must (upon Caremark's request) surrender the Provider Agreement, Provider Manual, other Caremark Documents, other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control.

In the event Provider breaches any provision of the Provider Agreement or fails, subsequent to Caremark's written demand to surrender the Provider Agreement, Provider Manual, other Caremark Documents, or other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control, in addition to all other termination rights, Caremark shall have the right, to the extent not contrary to Law, to (1) suspend any and all obligations of Caremark, including payment to Provider, under and in connection with the Provider Agreement, (2) impose reasonable handling, investigation and/or improper use fees, and/or (3) in whole or in part, offset against any amounts owed to Provider under the Provider Agreement or under any other agreement between Caremark and Provider, any amounts required to be paid by Provider to Caremark. These rights and remedies are not exclusive and are in addition to any other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

15.06 Survival of Certain Provisions

Termination of the Provider Agreement or Caremark or Plan Sponsor network will have no effect upon the rights and obligations of the parties accruing prior to the effective date of termination.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000635

15.07 Amendments

From time to time, and notwithstanding any other provision in the Provider Agreement (which includes the Provider Manual), Caremark may amend the Provider Agreement, including the Provider Manual or other Caremark Documents, by giving notice in accordance with applicable Law to Provider of the terms of the amendment and specifying the date the amendment becomes effective. If Provider submits claims to Caremark after the effective date of any notice or amendment, the terms of the notice or amendment is accepted by Provider and is considered part of the Provider Agreement.

15.08 Enforceability

In the event that any provision or term set forth in the Provider Agreement is determined invalid or unenforceable, such invalidity and unenforceability will not affect the validity or enforceability of any other provision or term set forth in the Provider Agreement.

15.09 Arbitration

Any dispute, claim or controversy between Provider and Caremark [including Caremark's current, future, or former employees, parents, subsidiaries, affiliates, agents, and assignees (collectively referred to in this **Arbitration** section as "Caremark") including, but not limited to, disputes in connection with, arising out of, or relating in any way to, the Provider Agreement or to Provider's participation in one or more Caremark networks or exclusion from any Caremark networks, including any disputes regarding the interpretation, validity, scope, or applicability of this agreement to arbitrate, will be exclusively settled by arbitration. This arbitration provision applies to any dispute arising from events that occurred before, on, or after the effective date of this Provider Manual. Any dispute otherwise arbitrable hereunder shall be deemed waived, and no such dispute shall be made or raised unless a Dispute Notice has been given to Caremark or Provider, or arbitration filed, as provided below. Unless otherwise agreed to in writing by the parties, the arbitration shall be administered by JAMS pursuant to its then applicable Comprehensive Arbitration Rules and Procedures ("JAMS Rules") including the rule governing Emergency Relief Procedures (available from JAMS). For purposes of clarity, any arbitration initiated shall be administered by JAMS regardless of whether a Dispute Notice was issued before that date. If any provision of this Provider Manual conflicts with any provision of the JAMS Rules, the Provider Manual's provision shall control.

In no event may the arbitrator(s) award indirect, consequential, or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, injury to reputation, or loss of customers or business, except as required by Law.

The arbitrator(s) shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of the agreement to arbitrate including, but not limited to, any claim that all or part of the agreement to arbitrate is void or voidable for any reason. The arbitrator(s) must follow the rule of Law, and the award of the arbitrator(s) will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. Any such arbitration must be conducted in Scottsdale, Arizona and Provider agrees to such jurisdiction, unless otherwise agreed to by the parties in writing. The arbitrator(s) may construe or interpret the agreement to arbitrate but shall not ignore any term of this Provider Manual and shall be bound by controlling law.

In arbitrations where a dispute, claim, controversy, or counterclaim involves at least $1,000,000, and the parties are unable to agree upon the number of arbitrators, a panel of three arbitrators rather than a single arbitrator shall hear and determine the case. If the parties are unable to agree on the number of arbitrators and the disputes, claims, controversies, or counterclaims involve less than $1,000,000, one arbitrator shall hear and determine the case. If during the course of the arbitration, the amount in controversy changes or is amended to exceed $1,000,000, a single arbitrator shall not have authority to conduct a hearing on the merits or issue an award until a panel of three arbitrators is appointed.

If the arbitration is to be conducted by a sole arbitrator, the arbitrator must be a retired judge. If the arbitration is to be conducted by a panel of three arbitrators, then (a) one of the arbitrators must be a retired judge, and (b) the chair must be a retired judge or previously have served as chair or sole arbitrator in at least ten (10) arbitrations where an award was rendered following a hearing on the merits.

The parties hereby agree that in any underlying award issued by a panel of three arbitrators, as opposed to a single arbitrator, the JAMS Optional Arbitration Appeal Procedures ("Appellate Procedures") shall apply and either party may invoke those appeal procedures. The underlying award shall not be considered final until after the time for filing the notice of appeal pursuant to the Appellate Procedures has expired. Appeals must be initiated within fourteen (14) days after an award has become final, as set forth in the Appellate Procedures, by filing a Notice of Appeal with the JAMS Case Manager and on the opposing party(ies).

Section **15.09 Arbitration** of the Provider Manual and its applicable subsections are applicable to any final awards issued by the appellate tribunal.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000636

15.09.01 Discovery Limitations

Discovery shall be limited to documents and information for which there is a direct, substantial, and demonstrable need, and where such documents and information can be located and produced at a cost that is reasonable in the context of all surrounding facts and circumstances.

Document requests shall (1) be limited to documents that are directly relevant to the matters in dispute or to its outcome; (2) be reasonably restricted in terms of time frame, subject matter, and persons or entities to which the requests pertain; and (3) not include broad phraseology such as "all documents directly or indirectly related to." Requests shall not be encumbered with extensive "definitions" or "instructions." The arbitrator may edit or limit the number of requests.

E-discovery shall be limited as follows: (1) there shall be production of electronic documents only from sources used in the ordinary course of business. Absent a showing of compelling need, no such documents are required to be produced from backup servers, tapes or other media; (2) absent a showing of compelling need, the production of electronic documents shall normally be made on the basis of generally available technology in a searchable format that is usable by the requesting Party and convenient and economical for the producing party. Absent a showing of compelling need, the Parties need not produce metadata, with the exception of header fields for email correspondence; (3) the description of custodians from whom electronic documents may be collected should be narrowly tailored to include only those individuals whose electronic documents may reasonably be expected to contain evidence that is material to the dispute; and (4) where the costs and burdens of e-discovery are disproportionate to the nature of the dispute or to the amount in controversy, or to the relevance of the materials requested, the arbitrator may either deny such requests or order disclosure on the condition that the requesting Party advance the reasonable cost of production to the other side, subject to the allocation of costs in the final Award.

There shall be no interrogatories or requests to admit absent agreement of the parties.

Each Party may take one deposition of an opposing Party or of one individual under the control of the opposing Party. Each deposition shall be subject to a four-hour time limit. The necessity of additional depositions shall be determined by the arbitrator based upon the reasonable need for the requested information, the availability of other discovery options and the burdensomeness of the request on the opposing parties and the witness.

Discovery shall be limited to the Provider initiating the dispute and no other Provider. Provider expressly agrees not to seek discovery concerning other Providers, disputes, or arbitration matters not involving the Provider at issue. Provider agrees that an arbitrator(s) shall have no authority hereunder to order discovery related to other Providers, disputes, or arbitration matters not involving the Provider at issue. Any attempt by Provider to seek discovery on other Providers, disputes, or arbitration matters shall be deemed a violation of this provision, as well as chapter **14. Intellectual Property, Confidentiality and Proprietary Rights** of the Provider Manual, and subject Provider to the penalties outlined in those provisions.

In the event a party that initiates an action for emergency or interim relief does not prevail and subsequently foregoes a final hearing on the merits, the emergency arbitrator's order shall be deemed as the final award and the emergency arbitrator shall retain jurisdiction for the purposes of awarding the expenses of arbitration, including reasonable attorney's fees, against the party that initiated the request for emergency or interim relief.

15.09.02 Expenses of Arbitration

The expenses of arbitration, including reasonable attorney's fees, will be paid for by the party against whom the final award of the arbitrator(s) is rendered, except as otherwise required by Law.

15.09.03 Anti-Class; Anti-Consolidation of Claims in Arbitration

Arbitration with respect to a dispute is binding and neither Provider nor Caremark will have the right to litigate that dispute through a court. In arbitration, Provider and Caremark will not have the rights that are provided in court, including the right to a trial by judge or jury. All of these rights are waived and disputes must be resolved through arbitration.

No dispute between Provider and Caremark may be pursued or resolved as part of a class action, private attorney general, or other representative action or proceeding (hereafter all included in the term "Class Action"). All disputes are subject to arbitration on an individual basis, not on a class or representative basis, or through any form of consolidated proceedings, and the arbitrator(s) will not resolve Class Action disputes and will not consolidate arbitration proceedings without the express written permission of all parties to the Provider Agreement. Provider and Caremark agree that each may pursue or resolve a dispute against the other only in its individual capacity, and not as a plaintiff or class member in any purported Class Action. Further, disputes with a Provider are limited to a single NCPDP number per arbitration. A Provider may not consolidate or aggregate the claims of multiple NCPDP numbers into a single arbitration. The parties agree that any arbitration ruling by an arbitrator(s) allowing class-action arbitration or requiring a consolidated arbitration (including consolidating multiple NCPDPs into a single proceeding) would be contrary to the parties' intent and such decisions are subject to immediate judicial review.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000637

15.09.04 Confidentiality of Arbitration

Except as may be required by Law, a party, its employees, agents, consultants, authorized representatives, counsel, or arbitrator(s) shall not disclose the existence, content, or results of any dispute or arbitration hereunder without the prior written consent of both parties. In the event a Provider is required by Law to make such a disclosure, Provider shall notify Caremark five (5) business days in advance of such disclosure. Notwithstanding the confidentiality provisions contained herein, Caremark may notify any of its Plan Sponsor clients of any pending arbitration or the results thereof that may impact the Plan Sponsor. That notice may include disclosing the underlying documents in the arbitration, including, but not limited to, the statement of claim and the opinion rendered in the case. Provider acknowledges and agrees that any breach of this provision would cause Caremark immediate and irreparable injury or loss that cannot be fully remediated by monetary damages. Accordingly, if Provider, its agents, counsel, or arbitrator fail to abide by the terms and conditions set forth in this **Arbitration** section of the Provider Manual, Caremark shall be entitled to (a) specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and to judgment for damages (including reasonable attorneys' fees and costs) caused by the breach; (b) an option to void the dispute resolution or arbitration award; and (c) all other legal and equitable remedies available to Caremark, including termination of the Provider Agreement or Provider's participation in any Caremark network or Plan Sponsor network.

15.09.05 No Collateral Estoppel/Precedential Impact of Award

The decision of the arbitrator is final and binding to the claims raised in the arbitration but is neither *res judicata* nor collateral estoppel to any other claim or suit. The decision is conclusive only of the issues in the matter submitted to the arbitrator and only as to the parties to the arbitration. The decision shall not have any precedential impact on any other proceeding.

15.09.06 Waiver of Right to Confirm Award Upon Payment

If a final award is rendered awarding a party monetary damages, the party against whom the final award was rendered shall have thirty (30) days to pay the monetary award. During this thirty (30) day period, the party in whose favor the monetary award was rendered shall not have the right to seek confirmation or enforcement of the award. If the monetary relief in the final award is paid within this thirty (30) day period, the party in whose favor the monetary award was rendered shall have no right to seek confirmation of the final award under the Federal Arbitration Act, 9 U.S.C. §9, nor under any applicable state arbitration Law.

In addition to the foregoing, the parties will use all reasonable efforts to maintain the confidentiality of any petitions they file to confirm, modify, or vacate an arbitration award under Federal Arbitration Act, 9 U.S.C. §§ 9-11. To the extent the parties initiate an action to confirm, modify, or vacate an arbitration award, the parties shall file such a petition under seal. Unless ordered by the court, the parties expressly agree to not take any action to unseal any (1) filings relating to the petition to confirm, modify or vacate the award or (2) filings or documents relating to the underlying arbitration, including the underlying arbitration award.

15.09.07 Dispute Resolution Procedures

Prior to a party initiating an arbitration, such party shall request in writing to the other party ("Dispute Notice") a meeting of authorized representatives of the parties for the purpose of resolving the dispute. An action must be commenced within two (2) years from the date on which the facts giving rise to the dispute first arose. The parties agree that, within fourteen (14) business days after issuance of the Dispute Notice, each party shall designate a representative to participate in dispute resolution discussions which will be held at a mutually acceptable time and place (or by telephone) for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner. If despite the good faith efforts of the parties, the authorized representatives of the parties are unable to resolve the dispute within forty-five (45) business days after the issuance of the Dispute Notice, or if the parties fail to meet within such forty-five (45) business days, either party may, by written notice to the other party, submit the dispute to binding arbitration, provided, however, that any demand for arbitration must be filed within six (6) months from the date of the issuance of the Dispute Notice. The above notwithstanding, nothing in this provision shall prevent either party from utilizing the JAMS's procedures for emergency relief to seek preliminary injunctive relief to halt or prevent a breach of this Provider Agreement.

Any party initiating an arbitration pursuant to this **15.09 Arbitration** section of the Provider Manual shall place in escrow (the alleged amount at issue) for the benefit of the opposing party an amount to be determined as sufficient to cover the estimated attorney's fees, forecasted amount of potential claims that could be submitted by Provider based on Provider's historical Caremark adjudicated paid claims experience (e.g., previous rolling twelve months), and other expenses of arbitration that will be incurred in defense of the arbitration action, which shall in no event be less than $50,000. Such funds will be released upon the entry of a final award of the arbitrator(s), with any excess reimbursed to the initiating party. Failure to place such funds in escrow will constitute a material breach of this Arbitration section.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000638

The terms of this **15.09 Arbitration** section of the Provider Manual apply notwithstanding any other or contrary provision in the Provider Agreement including, but not limited to, any contrary language in any Third-Party Beneficiary provision. This **15.09 Arbitration** section of the Provider Manual survives the termination of the Provider Agreement and the completion of the business relationship between Provider and Caremark. This arbitration agreement is made pursuant to a transaction involving interstate commerce, and any arbitration conducted pursuant to the terms of this Provider Agreement shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

15.09.08 Severability

In the event any provision of this **15.09 Arbitration** section of the Provider Manual shall be judged, declared, held or ruled to be invalid, illegal or unenforceable, in whole or in part, such provision shall be deemed severable, and it shall not invalidate or impair the **15.09 Arbitration** section of the Provider Manual as a whole.

15.10 Force Majeure

Caremark and Provider are excused from performance under the Provider Agreement to the extent that either Caremark or Provider is prevented from performing all or any part of the Provider Agreement as a result of causes that are beyond the affected party's reasonable control including, but not limited to, fire, flood, earthquakes, tornadoes, other acts of God, war, work strikes, civil disturbances, power or communications failure, court order, government intervention, a change in Law, a significant change in the industry, or third-party nonperformance.

15.11 Anti-Kickback Statute, Stark Law and Caremark Compliance Program

Each party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C § 1320a-7b(b) ("Anti-Kickback Statute"), or the federal "Stark Law," set forth at 42 U.S.C § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Provider Agreement. In addition, Caremark's Code of Conduct and policies and procedures on the Anti-Kickback Statute and Stark Law may be accessed at **caremark.com/pharminfo.**

15.12 Rebate Programs

Caremark has the right to submit all prescriptions relating to the Provider Agreement to pharmaceutical companies in connection with Caremark's rebate programs and any similar programs. Provider must not submit any of the prescriptions relating to the Provider Agreement to any pharmaceutical company for the purpose of receiving any rebate, discount or the like, except as authorized by Caremark in writing.

15.13 Eligible Person Communications

Provider understands and acknowledges that Caremark may communicate with Eligible Persons as required by Plan Sponsor, applicable Law, or as Caremark determines is necessary regarding matters such as plan benefits, network design and composition, formulary and clinical issues, and manufacturer recalls.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000639

16. Federal and State Laws and Regulations

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of their Provider Agreement.

16.01 Compliance with Laws

Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable Laws (including any implementing regulations) in performing its Pharmacy Services under the Agreement including, but not limited to: applicable state and federal pharmacy Laws, the False Claims Act (31 U.S.C. 3729 et seq.), the Anti-kickback statute (42 U.S.C. 1320a-7b(b), Stark Law (42 U.S.C. 1395 nn), Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (45 C.F.R. Parts 160, 162, and 164) and the Controlled Substance Act (21 U.S.C. 801-971); and Caremark must comply with all applicable Laws (including any implementing regulations) in performing its duties under the Agreement, provided, however, that in the event that Provider alleges that Caremark has not complied with an applicable Law, Provider shall not be entitled to a private right of action unless expressly permitted under the underlying applicable Law, and Provider shall not be entitled to any contract damages or other contract remedies against Caremark other than as specified by such underlying applicable Law. The foregoing notwithstanding, the parties agree this provision shall not be construed to bestow on either party a private right of action or other remedy not otherwise available under existing law.

Federal and state specific addenda, as updated from time to time to reflect regulatory changes, are set forth in the Pharmacy Portal at **rxservices.cvscaremark.com** and are incorporated herein by reference. Refer to section **1.07 CVS Caremark Pharmacy Portal** of the Provider Manual.

Provider shall develop and administer processes and protocols to ensure compliance with the Telephone Consumer Protection Act (TCPA), as may be amended, for all landline and mobile telephonic (including text message) outreach to Eligible Persons under this Agreement, including outreach by subcontractors.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000640

Appendix A - CMS Form No. 10147 (English)

Enrollee's Name (Optional):

Drug and Prescription Number (Optional):

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call **1-800-MEDICARE** for more information.

PRA Disclosure Statement 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 collection is 0938-0975. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: **1-800-MEDICARE**.

Form CMS-10147 *OMB Approval No. 0938-0975 (Expires: 02/28/2025)*

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000641

Appendix A1 - CMS Form No. 10147 (Spanish)

Nombre del beneficiario (opcional):

Número de receta y de medicamento (opcional):

La cobertura de Medicare de las recetas médicas y sus derechos

Sus derechos si tiene Medicare

Usted **tiene el derecho de solicitar una determinación de cobertura** de su plan Medicare de recetas médicas si está en desacuerdo con la información proporcionada por la farmacia. También tiene **el derecho de solicitar una determinación de cobertura especial conocida como "excepción"** si piensa que:

- Necesita un medicamento que no está en la lista de su plan. A la lista de medicamentos cubiertos se le conoce como "formulario".
- Una regla de cobertura (como la autorización previa o un límite de cantidad) no debe aplicarse debido a su problema médico; o
- Necesita tomar un medicamento no preferido y usted quiere que su plan lo cubra al precio de un medicamento preferido.

Lo qué necesita hacer

Usted o la persona que le ha recetado el medicamento pueden pedirle al plan una determinación de cobertura, llamando al número gratis que aparece en la parte de atrás de la tarjeta del plan, o visitando el sitio web del plan. Usted o su médico puede pedir una determinación acelerada (24 horas) si su salud pudiera estar en peligro si tiene que esperar 72 horas para obtener la respuesta. Usted tendrá que informarle al plan:

1. El nombre del medicamento que no pudo obtener, la dosis y concentración si lo sabe.
2. El nombre de la farmacia donde intentó obtener el medicamento.
3. La fecha en que intentó obtenerlo.
4. Si solicita una excepción, el médico que lo recetó tiene que enviarle a su plan una declaración explicándole el motivo por el cual usted necesita el medicamento que no está en el formulario, el medicamento no preferido o no se debe aplicar una regla de cobertura a usted.

Su plan Medicare de medicamentos recetados le comunicará su decisión por escrito. Si no aprueban la cobertura, la carta del plan le explicará el motivo y cómo apelar la decisión si no está de acuerdo.

Si desea más información, consulte los materiales del plan o llame al **1-800-MEDICARE**.

Declaración sobre la Ley para la Reducción de Trámites De acuerdo con la Ley para la Reducción de Trámites de 1995 (PRA en inglés), las personas no están obligadas a responder una recopilación de información a menos que se exhiba un número de control de la oficina de Gerencia y Presupuesto (OMB en inglés) válido. El número de control OMB válido para esta recopilación de información es 0938-0972. El tiempo necesario para responder esta recopilación de información es de aproximadamente 1 minuto por respuesta, incluido el tiempo para revisar instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, llame al **1-800-MEDICARE** o envíe un correo electrónico a: **AltFormat@cms.hhs.gov**.

Formulario de CMS-10147-Spanish *Número de OMB 0938-0975 (Expiración: 02/28/2025)*

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000642

Appendix B - Appeals Process Documentation Guidelines

***Plan Sponsor-specific information may apply as communicated by Caremark or Plan Sponsor.**

*****Please Read Thoroughly Prior To Obtaining and Sending Documentation*****

1. Introduction:

   The enclosed report lists discrepancies found as indicated on the Pharmacy Audit Acknowledgement signed by the pharmacy staff on duty at the time of the audit or submitted to you by Caremark. You have an opportunity to provide documentation to support your pharmacy's claims that are currently considered discrepant. Ensure all documentation provided for each discrepancy type is correct and relevant. Your immediate attention is important. All documentation must be **RECEIVED** by Caremark no later than the **due date** indicated on your cover letter.

2. Documentation Procedures:
   a. Pharmacy Auditing Discrepancy List: The enclosed report lists discrepant claims by prescription number and date of fill. The D1 and D2 columns list the code for the discrepancy type.
   b. Documentation Guidelines: The enclosed guidelines describe the discrepancy types and the acceptable documentation required to support a potential resolution of the identified discrepancies.
   c. **ALL** acceptable documentation is required to include:
      i. Pharmacy NCPDP number
      ii. Prescription number as listed on the Discrepancy List
      iii. Date of fill listed on the Discrepancy List
      iv. Patient's full name and address
      v. For any document signed electronically, the signature audit log from the electronic signature vendor must be provided with the electronically signed document

3. Mailing Instructions:
   a. All documentation must be sent by the documentation **due date** indicated on the cover letter and in one package via **Certified, Express, Express with tracking, or regular USPS mail.** Address your correspondence to:
      CVS Caremark
      Attn: Audit Documentation
      Pharmacy Performance MC 020
      9501 East Shea Boulevard
      Scottsdale, AZ 85260-6719
   b. Caremark recommends sending documentation with tracking and maintaining a copy of all documentation sent.
   c. If the documentation is less than fifty (50) pages, the documentation can be faxed to **1-866-310-4135** instead of mailed; however, the images must be legible (e.g., documents on tamper resistant prescription pads may not be legible when faxed).
   d. If you need additional help, call Caremark Pharmacy Performance at **1-866-488-4709**.

4. Conclusion:
   a. All documentation received on or before the due date will be reviewed by Caremark and a Final Audit Discrepancy List will be mailed upon completion of review.

   Plan Sponsor-specific information may apply as communicated by Caremark or Plan Sponsor.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000643

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION
CMP	COMPOUND	Original prescription hard copy, prescription dispensing label, and compound formulation record (recipe) cannot be found during the audit	1. Legible copy of the original compound formulation record (recipe) that was signed by the verifying pharmacist and that includes the names of all active and inactive ingredients, NDC numbers, and quantity used; (billing statements will not be accepted); **AND** 2. A copy of the prescription hardcopy; **AND** 3. The prescription label with directions for use for each date of fill (if written "use as directed", follow Sig. documentation guidelines). **COMPUTER GENERATED, TELEPHONE RXs, OR TRANSFER RXs WILL NOT BE ACCEPTED.**
COU	COUPON	Coupon or another inappropriate program was used to reduce patient pay amount	This discrepancy does not require further documentation.
CPY	COPAY	Copays are required to be collected by pharmacy, where applicable by Law, and cannot be waived, reduced, increased, or discounted	A copy of a patient invoice showing the member copay amount along with evidence the copay was paid in full, such as a signed member statement listing the RX, date of fill (DOF), and copay paid amount; **AND (one of the following)**: If a credit card was used to pay the copay, provide credit card receipt showing copay amount, last four digits of the credit card number, authorization # and merchant report; **OR** If a check was used to pay the copay, provide a copy of the front and back of member's check; **OR** If cash was used to pay the copay, provide a member attestation indicating the amount paid in cash and bank deposits for copay amounts with documentation that correlates with the date of fill and date the copay was collected.
DAW	DISPENSE AS WRITTEN	DAW code submitted was different than the DAW instructions on the prescription	This discrepancy does not require further documentation.
DDB	DIFFERENT DRUG BILLED	Pharmacy billed a different medication and/or NDC than the one dispensed to the patient	This discrepancy does not require further documentation.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000644

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION
DIS	DRUG INVOICE SHORTAGE	Drug wholesaler invoices were not sufficient to support quantities billed	1. A summary report of drug purchases and returns directly from all wholesale distributors; **OR** 2. A copy of the original drug wholesale distributor invoices, if found; **OR** 3. Documentation of drug purchases via other sources consistent with DSCSA documentation requirements. **All documentation provided for Drug Invoice Shortage discrepancies must include at a minimum NDC, product name, quantity, invoice number, and dates of purchase.** Further verification of these documents may be required and communicated by Caremark, such as, but not limited to, proof of payment for stock transfers, payment history, copies of checks for drug stock buy-out, bill of sale, payment invoices.
DPC	DUPLICATE PAID CLAIM	Multiple claims for the same prescription fill were submitted but only one medication was dispensed to the member	This discrepancy does not require further documentation.
DWC	DATE WRITTEN CORRECTION	The written date submitted by the pharmacy does not match the date written on the prescription hardcopy	This discrepancy does not require further documentation. The claim will be reprocessed for the correct date written.
ETL	EXCEEDS TIME LIMIT	Prescription was filled or refilled for a time period longer than that allowed by the Plan or applicable regulations	This discrepancy does not require further documentation.
INV	INVALID	The prescription and/or claim was invalid at the time the medication was dispensed to the Eligible Persons. Reasons for an Invalid discrepancy type include, but are not limited to, non-compliance with state and/or federal regulations, REMS, RMP, prohibited waiver of the Patient Pay Amount, circumvention of plan design or adjudication edits, altered RX, etc.	This discrepancy does not require further documentation.
MIF	MISFILL	Prescription dispensed was filled with incorrect drug, strength, directions, or patient	This discrepancy does not require further documentation.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000645

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION
MP	MISSING PRESCRIPTION	Original hard copy prescription or computer-based prescription image cannot be found during the audit	1. Send a copy of the prescriber's original written prescription, if found; **OR** 2. Send a signed statement from the prescriber on prescriber's business letterhead with clearly visible sourcing which includes medication, quantity, Sig, original fill date and authorized refill dates; **OR** 3. A prescriber attestation on their prescription Rx pad, including medication, quantity, Sig., original fill date and authorized refill dates. **The prescriber may fax their documentation to the pharmacy; however, prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **AND YOU MUST INCLUDE:** 4. A copy of the dispensing label. If a prescription indicates "Use As Directed", follow Sig. documentation guidelines. **COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs WILL NOT BE ACCEPTED.**
NPI	INACCURATE PRESCRIBER ID	NPI/DEA number on the prescription did not match the NPI/DEA/ prescriber identification number on the claim. The NPI/DEA number is required to be accurate on all controlled substances	This discrepancy does not require further documentation.
NSL	NO SIGNATURE LOG	The signature documenting receipt of the prescription drug cannot be found in the signature logs or the electronic database	1. Send a copy of the signature log with the signature highlighted, if found; **OR** 2. Send a signed statement from the patient verifying receipt of the medication; **OR** 3. Send a signed pharmacy patient profile from the patient including patient's address, phone number, Rx number and date(s) of fill. Each Rx must be initialed by the patient and dated. **AND**, in addition to the documentation in 1. or 2. or 3. above, if the medication is delivered in any manner other than directly at the Provider's location (e.g., to a home or business address of the patient) by carrier other than an employee of the provider, Provider must also provide: a. shipping method; b. shipment manifest; c. documentation of the prescription number(s) and Covered Item(s) delivered; and d. tracking documentation that the Covered Item was delivered.

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION
OBC	OVER BILLED COMPOUND	One or more individual components within the compound claim is over billed	This discrepancy does not require further documentation.
OBQ	OVER BILLED QUANTITY	Quantity billed exceeded the amount authorized by the prescriber, the quantity allowed under the plan, or the quantity dispensed exceeds the days' supply submitted	This discrepancy does not require further documentation.
OTH	OTHER	A miscellaneous discrepancy type	Documentation must address the concern expressed on each claim in the Comments field on the initial discrepancy report.
PRD	PRESCRIBER DENIED	Prescription was denied by the prescriber that was submitted on the claim	1. Send a copy of the prescriber's original written prescription, if found; **OR** 2. Send a signed statement from the prescriber on prescriber's business letterhead with clearly visible sourcing which includes medication, quantity, Sig., original fill date and authorized refill dates; **OR** 3. Send a prescriber attestation on their prescription Rx pad, including medication, quantity, Sig., original fill date and authorized refill dates. **The prescriber may fax their documentation to the pharmacy, however, prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs WILL NOT BE ACCEPTED.**
PTD	PATIENT DENIED	Patient denied requesting and/ or receiving the prescription	1. Send a copy of the signature log with the signature highlighted, if found; **OR** 2. Send a signed statement from the patient verifying receipt of the medication including patient's address, phone number, Rx number and date of fill.; **OR** 3. Send a signed pharmacy patient profile (signed by the patient) including patient's address, phone number, Rx number and date of fill. Each Rx must be initialed and dated by the patient.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000647

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION
RTS	REFILL TOO SOON	Prescription was refilled sooner than appropriate due to an incorrect days' supply on the previous fill date. If Provider dispenses the smallest commercially available package size and enters a day supply based on plan limits, Provider maintains responsibility to adhere to appropriate refill intervals	This discrepancy does not require further documentation.
SIG	INSUFFICIENT DIRECTIONS FOR USE	Hard-copy prescription does not include sufficient information to justify the quantity and days' supply billed	1. Obtain specific dosing instructions from the prescriber. If dosing is PRN, specify patient's maximum weekly or monthly usage. Documentation outlining the patient's dose must be obtained from the prescriber on prescriber's business letterhead; **OR** 2. A prescriber attestation on their prescription Rx pad, including medication, quantity, Sig., original fill date and authorized refill dates. **The prescriber may fax their documentation to the pharmacy, however, prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **NOTES OR VERBAL CONVERSATIONS WITH THE PRESCRIBER OR OFFICE STAFF WILL NOT BE ACCEPTED.**
UAR	UNDOCUMENTED AUTHORIZATION OF REFILL	The number of refills billed exceeds the number authorized by the prescriber	Send a signed statement from the prescriber on prescriber's business letterhead or on a written Rx from the prescriber, authorizing the dispensing. This must include medication, quantity, directions for use, original fill date and authorized refill dates. **The prescriber may fax their documentation to the pharmacy, however, prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **COMPUTER GENERATED, TELEPHONE PRESCRIPTIONS, TRANSFER RXs, WILL NOT BE ACCEPTED.**
VAF	VACCINE ADMININSTRATION FEE	No documentation that a vaccine was administered	1. Send a copy of a vaccine administration log with the signature highlighted, if found; OR 2. Send a signed statement from the patient verifying the vaccine was administered.
WP	WRONG PATIENT	Patient identified on a hard copy prescription is not the same patient on the claim	Send a signed statement from the cardholder indicating that the patient whose name is on the prescription is covered by the indicated plan.

Glossary of Terms

Caremark Documents means the Provider Agreement, schedules thereto, addenda, the Provider Manual and all attachments thereto including this Glossary of Terms, Federal Laws and Regulations, State Laws and Regulations, information transmitted by Caremark to Provider through the claims adjudication system, information transmitted by Caremark to Provider specifically designated by Caremark as a "Caremark Document" which may include educational materials related to products, programs, services, and Plan Sponsor announcements, and such other communications by Caremark to Providers through the CVS Caremark Pharmacy Portal.

Administration Fee means the administration fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a Network Enrollment Form, the claims adjudication system, which may be reduced to the Incentive Amount Submitted (NCPDP field #438-E3) by the Provider.

AWP or Average Wholesale Price means a Price Type including AWP, AAWP and GEAP, published by Medi-Span (with supplements), a Price Type published by MICROMEDEX, or other similar nationally recognized reference which Caremark may select from time to time.

AWP Discount means the AWP percentage discount that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Chargeback means collection by Caremark of amounts paid to a Provider, in whole or in part, that were determined to be owed, including but not limited to, amounts for discrepant claim(s), claim(s) submitted in breach of the Agreement, or identified overpayment(s).

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

Covered Item means any drug, device, or service covered, in whole or in part, in accordance with and subject to the terms of a Plan covering an Eligible Person.

Dispensing Fee means the dispensing fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Dispensing Pharmacy means the pharmacy that is giving or delivering the Covered Item to the Eligible Person.

Dispensing Practitioner means a duly licensed and established practitioner (e.g., MD, DO, RN, NPA, and RPh) operating under a medical license or other appropriate license and that dispenses and sells Covered Items to Eligible Persons through in-person hand delivery at the point of care, solely to the dispensing practitioner's patients in the regular course of the practitioner's practice.

Eligible Person means a person or animal entitled to a Covered Item pursuant to a Plan.

Law means any Federal, State, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, sub-regulatory guidance (including but not limited to, model contracts between the State Medicaid Agency and managed care organizations, and other guidance from State Medicaid Agencies, such as Medicaid Manuals, Bulletins, and other issuances), order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) a condition of granting any applicable permit, license or approval required by Caremark, Provider, or a Plan Sponsor, or other legislative or administrative action of the United States of America, or state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

Licensed Pharmacist means a pharmacist licensed in the United States (including U.S. territories).

MAC or Maximum Allowable Cost means a unit price that has been established as the reimbursement amount to Provider for certain multiple-source drugs without regard to the specific manufacturer whose drug is dispensed.

Medical Foods: The term medical food, as defined in section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000649

Patient Pay Amount means the amount an Eligible Person must pay to Provider at the time a Covered Item is dispensed as indicated by the claims adjudication system, which may include but is not limited to copayments, coinsurance, deductibles, transaction fees, access fees, and/or taxes.

Pharmacy Services/Provider Services means all services including the provision of prescription drugs usually and customarily rendered by a Provider and Licensed Pharmacist or Dispensing Practitioner licensed to provide pharmacy services in the normal course of business, including services mandated by applicable Law. Pharmacy Services may include, but not be limited to: the maintenance of Eligible Person profiles; the interpretation of prescriptions; the selection of medications and medical devices; the sale of compounding or dispensing of medications and medical devices (also includes over-the-counter medications [OTCs] and supplies covered by or used in conjunction with a pharmacy benefit); the counseling of Eligible Persons, which may consist of information about the proper storage, dosing, side effects, potential interactions and use of the medication dispensed; the monitoring of appropriate drug use; and the implementation of drug utilization review programs and other clinical programs and services.

Plan means that portion of a Plan Sponsor's pharmacy benefit plan that relates to Covered Items with respect to a group of Eligible Persons.

Plan Sponsor means the entity that contracts with Caremark or any of Caremark Rx, L.L.C.'s affiliates for pharmacy benefit management services, which entity could be, among other things, an insurance company, self-insured group, health maintenance organization, preferred provider organization, multi-employer trust or third party administrator.

Prescriber means a physician, dentist, physician's assistant, optometrist or other health care professional authorized by law to write prescriptions for prescription drugs within the scope of practice as designated by regulatory agency.

Price Type means a price of a given product for the fill date submitted at the time of claim adjudication as published by a Pricing Source and loaded into the claims adjudication system. Price Type may include, but is not limited to, AWP (Average Wholesale Price), WAC (Wholesale Acquisition Cost), NADAC (National Average Drug Acquisition Cost), ASP (Average Sales Price), FUL (Federal Upper Limit), state-specific AAC (Actual Acquisition Cost), Average AWP (AAWP), Generic Equivalent Average Price (GEAP), etc.

Pricing Source means either a nationally recognized reference that Caremark may reasonably select from time to time or for Plan-specific pricing, a Plan Sponsor, state or other third-party publisher of pricing data supplied to Caremark.

Product Identifier means a series of numerical or alphanumerical digits managed by various organizations and published by Medi-Span, FirstDataBank, MICROMEDEX or other nationally recognized reference which Caremark may reasonably select from time to time, that are used to identify a specific product that, where applicable, is used and formatted according to the NCPDP Product Identifiers Standard. The Food and Drug Administration (FDA) National Drug Code (NDC) as published by Medi-Span and formatted to the 11-digit format defined by NCPDP is an example of a Product Identifier.

Provider means a provider of Pharmacy Services that is the signatory to the Agreement and who must provide all services including the provision of prescription drugs usually and customarily rendered by a provider, Licensed Pharmacist or Dispensing Practitioner licensed to provide such Pharmacy Services in the normal course of business, including services mandated by applicable Law.

Retail Pharmacy means a duly licensed and established community pharmacy or dispensing practitioner that serves walk-in patients and that dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. Participation in Caremark's retail networks is limited to pharmacies (or dispensing practitioners) that are a "Retail Pharmacy". Refer to section **3.04 Standards of Operation** of the Provider Manual.

Third-Party Agreement means an agreement between Caremark and a Caremark client in which Caremark serves as an auditor for that client's participating network pharmacies.

Usual and Customary Price or U&C means the lowest price Provider would charge to a particular customer if such customer were paying cash for an identical prescription on that particular day at that particular location. This price must include any applicable dispensing fee and/or level of effort. This price must include any applicable discounts offered to attract customers.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000650

THIS PAGE INTENTIONALLY LEFT BLANK

THIS PAGE INTENTIONALLY LEFT BLANK

THIS PAGE INTENTIONALLY LEFT BLANK



CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark. If you are not the intended recipient, you have received this Provider Manual in error and any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.

©2024 CVS Caremark. All rights reserved.

108-7223001-092223

Exhibit 13:
CVS_HJC_00000659
Salesforce entry related to Shell USA's pharmacy audit requests

Case: 09493953

Custom Links

General Case Knowledge | General Case Chatter Group | General Case Category/Owner SME List

Basic Information

Subject	2436_Shell USA_SmartLight Pharmacy Referrals	**Case Number**	09493953 [View Hierarchy]
Description	Smartlight is a client vendor that analyzes potential pharmacy malpractices. Please see the attached referrals and let us know if any of these pharmacies are under investigation or warrant investigation. Thank you, Natalie	**Portal Case**	☐
Case Status	Closed	**Case Owner**	Amy Smith
Account Name	Shell USA, Inc.	**Parent Case**	
Category Business Area	Networks	**Expected Completion Date**	8/16/2024
Category	Retail Pharmacy Audit	**Within SLA?**	Yes
Case Type	Research	**Priority**	Normal
Case Origin	Email	**Escalation Reason**	
		Escalation Reason Text	
		Issue/Request?	Request
		Issue Identified	Client

Case Categorization - Administration

SubCategory		**# of times completion date revised**	
Frequency	Unique	**Completion Date Change Reason**	
Welcome Season	☐	**Completion Date Reason Text**	
Major Project	No Major Project	**Reporting Field 1**	
General Case Effective Date		**Reporting Field 2**	
Project ID		**Reporting Field 3**	
PHI/PII Information	☐	**Current Time Spent (hrs)**	
Related Aetna Medicaid Issue Request		**Total Time Spent (hrs)**	
Issue Previously Reported	☐		

Case Source

Contact Name		Client Notified Date	
Vendor Name		Medical Integrator	
Vendor Contact Info		Multi-Client SW Integrated Accums (MI)	
Issue Discovery Date		Parent SW Number	
Issue Discovered By		Client Audit Record ID	
How Issue Discovered			

Global Case Details

Assigned To		Outbound Calls	☐
Project Start Date		Service Warranty	☐
IT Fix	☐	Communication	☐
		Letters	☐

Case Resolution - High Level Root Cause

Root Cause Group		Attestation	☑
Root Cause Issue Type	Research Completed - No Issue Found	Root Cause Notes	root cause analysis not applicable to this case type
Root Cause Category			
Root Cause Sub-Category			
Problem Statement			

Impact

Impacts Multiple Clients	☐	Member Impact	
Issue Start Date		Member Experience	
Issue End Date		Client Experience	
		# of Lives Affected	
		Claim Impact	

Quality Monitoring

QM Issue Status		PA#	
QM Process		User ID	
QM Issue Category		Drug Name	
QM Code Fix Date		QM Issue Type	
QM Paid Claim Date		QM Outreach Date	
		Claim Count	
		Claim Number	
		QM Area of Impact	

IT Information

IT Incident ID	
IT Incident Owner	
IT Incident Journal Entries	

System Information

Created By	Natalie Mitchell, 8/13/2024 1:51 PM	**Date/Time Opened**	8/13/2024 1:51 PM
Last Modified By	Amy Smith, 8/16/2024 3:23 PM	**Date/Time Closed**	8/16/2024 3:23 PM
		Date/Time Re-Opened	

Attachments

Referral - Document - White Drug Company.pdf

Size	**61KB**
Ownership	**Natalie Mitchell**
View	**View file**
Last Modified	**8/13/2024 1:52 PM**

Referral - Document - Anchor Plus.pdf

Size	**59KB**
Ownership	**Natalie Mitchell**
View	**View file**
Last Modified	**8/13/2024 1:52 PM**

Referral - Document - Care Med Group_Maxcare.pdf

Size	**59KB**
Ownership	**Natalie Mitchell**
View	**View file**
Last Modified	**8/13/2024 1:52 PM**

Case Comments

8/16/2024 3:23 PM

User	**Amy Smith**
Public	☐
Comment	**Regarding MaxCare Pharmacy - Caremark has historically conducted audits on this pharmacy; however, no discrepancies were identified for Shell members. That said, Caremark will continue to monitor this pharmacy for a potential future audit. However, it is also recommended to conduct member survey's and/or prescriber investigations to determine if marketers are involved.**

8/16/2024 3:18 PM

User	**Amy Smith**
Public	☐
Comment	**Regarding the referral for Anchor Plus Pharmacy - Caremark conducted an expanded audit within the past year; this audit finalized with no discrepant claims. Regarding the concern with member steerage, it is recommended that the plan conduct member survey's to see if the claim(s) in question were sent to this pharmacy without the member's knowledge. Additionally, medications like Wegovy and other GLP-1 products were and are frequently moved between pharmacies by physicians and members due to ongoing shortages.**

8/16/2024 3:13 PM

User	**Amy Smith**
Public	☐
Comment	**regarding the referral of White Drug - this pharmacy was recently referred for an invoice reconciliation audit. The attached referrals has been forwarded to that auditor for inclusion in the audit file. Invoice audits can take approximately 4-6 months for completion; if your client has any identified discrepancies within this audit, they will receive notice of such on their standard reporting.**

Case History

8/16/2024 3:23 PM

User	**Amy Smith**
Connection	
Action	**Changed Case Status from Open to Closed.**

8/16/2024 3:14 PM

User	**Amy Smith**
Connection	
Action	**Changed Attestation from false to true.**

8/14/2024 9:35 PM

User	**Amy Smith**
Connection	
Action	**Changed Case Owner from Unassigned General Case to Amy Smith.**

8/14/2024 9:35 PM

User **Amy Smith**
Connection
Action **Changed Expected Completion Date to 8/16/2024.**

8/13/2024 1:51 PM

User **Natalie Mitchell**
Connection
Action **Changed Owner (Assignment) from Amy Smith to Unassigned General Case. Created.**

Copyright © 2000-2024 salesforce.com, inc. All rights reserved.

Exhibit 14:
CVS_HJC_00000664
Salesforce entry related to the Commonwealth of Kentucky's pharmacy audit requests

Case: 09487002

Custom Links

General Case Knowledge | General Case Chatter Group | General Case Category/Owner SME List

Basic Information

Subject	Pharmacy Audit Request	Case Number	09487002 [View Hierarchy]
Description	Voquenza potential issue brought by client consultant. details in attachment.	Portal Case	☐
Case Status	Closed	Case Owner	Amy Smith
Account Name	Commonwealth of Kentucky	Parent Case	
Category Business Area	Networks	Expected Completion Date	8/16/2024
Category	Retail Pharmacy Audit	Within SLA?	Yes
Case Type	Research	Priority	Normal
Case Origin	Meeting	Escalation Reason	
		Escalation Reason Text	
		Issue/Request?	Request
		Issue Identified	

Case Categorization - Administration

SubCategory		# of times completion date revised	
Frequency	Unique	Completion Date Change Reason	
Welcome Season	☐	Completion Date Reason Text	
Major Project		Reporting Field 1	
General Case Effective Date		Reporting Field 2	
Project ID		Reporting Field 3	
PHI/PII Information	☐	Current Time Spent (hrs)	
Related Aetna Medicaid Issue Request		Total Time Spent (hrs)	
Issue Previously Reported	☐		

Case Source

Contact Name		Client Notified Date	
Vendor Name		Medical Integrator	
Vendor Contact Info		Multi-Client SW Integrated Accums (MI)	
Issue Discovery Date		Parent SW Number	

Issue Discovered By		Client Audit Record ID	
How Issue Discovered			

Global Case Details

Assigned To		Outbound Calls	☐
Project Start Date		Service Warranty	☐
IT Fix	☐	Communication	☐
		Letters	☐

Case Resolution - High Level Root Cause

Root Cause Group		Attestation	☑
Root Cause Issue Type	Research Completed - No Issue Found	Root Cause Notes	root cause analysis not applicable to this case type
Root Cause Category			
Root Cause Sub-Category			
Problem Statement			

Impact

Impacts Multiple Clients	☐	Member Impact	
Issue Start Date		Member Experience	
Issue End Date		Client Experience	
		# of Lives Affected	
		Claim Impact	

Quality Monitoring

QM Issue Status		PA#	
QM Process		User ID	
QM Issue Category		Drug Name	
QM Code Fix Date		QM Issue Type	
QM Paid Claim Date		QM Outreach Date	
		Claim Count	
		Claim Number	
		QM Area of Impact	

IT Information

IT Incident ID	
IT Incident Owner	
IT Incident Journal Entries	

System Information

Created By	Justin Emerson, 8/9/2024 4:21 PM	Date/Time Opened	8/9/2024 4:21 PM
Last Modified By	Amy Smith, 8/16/2024 2:03 PM	Date/Time Closed	8/16/2024 2:03 PM
		Date/Time Re-Opened	

Attachments

Voquenza Pharmacy Issue from Client Consultant.docx

Size **16KB**
Ownership **Justin Emerson**
View **View file**
Last Modified **8/9/2024 4:25 PM**

Case Comments

8/16/2024 2:02 PM

User **Amy Smith**
Public

Comment

White Drug was recently referred for an invoice reconciliation audit to be conducted. I will forward this client's concerns to have the claims for Voquenza included in the invoice reconciliation.

Regarding your clients concern with the drug spend for the medication in question, please review plan benefit designs and formulary. Plan Edits is the most proactive way to assist in the prevention of high drug spend in relation to these medications.

Case History

8/16/2024 2:03 PM

User **Amy Smith**
Connection
Action **Changed Attestation from false to true. Changed Case Status from Open to Closed.**

8/14/2024 9:35 PM

User **Amy Smith**
Connection
Action **Changed Case Owner from Unassigned General Case to Amy Smith.**

8/14/2024 9:35 PM

User **Amy Smith**
Connection
Action **Changed Expected Completion Date to 8/16/2024.**

8/9/2024 4:21 PM

User **Justin Emerson**
Connection
Action **Changed Owner (Assignment) from Justin Emerson to Unassigned General Case. Created.**

Copyright © 2000-2024 salesforce.com, inc. All rights reserved.

Exhibit 15:
CVS_HJC_00000667
Salesforce entry related to Neighborhood Health Plan of Rhode Island's pharmacy audit requests

- Close Window
- Print This Page
- Expand All | Collapse All

Case: 09474892

Custom Links

General Case Knowledge | General Case Chatter Group | General Case Category/Owner SME List

Basic Information

Subject	NHPRI: White Drug 61	**Case Number**	09474892 [View Hierarchy]
Description	Dave at NHPRI sent the request below. Hi CVS, On the May 2024 Drug Trend Analysis, CMS listed Miebo as a potential drug of concern stating "High-cost brand name ophthalmic medications have been of concern due to invoice discrepancies and potential phantom billing. Plan sponsors are encouraged to conduct invoice audits to identify potential shortages or fraudulent billing." I identified that White Drug 61 Pharmacy (NPI 1003906942) has billed us almost exclusively for Miebo in the past 12 months. What is this pharmacy's audit history with CVS Caremark?	**Portal Case**	☐
Case Status	Closed	**Case Owner**	Amy Smith
Account Name	NHPRI MMP H9576	**Parent Case**	
Category Business Area	Networks	**Expected Completion Date**	8/16/2024
Category	Retail Pharmacy Audit	**Within SLA?**	Yes
Case Type	Research	**Priority**	Normal
Case Origin	Client Center	**Escalation Reason**	
		Escalation Reason Text	
		Issue/Request?	Request
		Issue Identified	Client

Case Categorization - Administration

SubCategory		**# of times completion date revised**	
Frequency		**Completion Date Change Reason**	
Welcome Season	☐	**Completion Date Reason Text**	
Major Project	No Major Project	**Reporting Field 1**	
General Case Effective Date		**Reporting Field 2**	
Project ID		**Reporting Field 3**	

PHI/PII Information	☐	Current Time Spent (hrs)	
Related Aetna Medicaid Issue Request		Total Time Spent (hrs)	
Issue Previously Reported	☐		

Case Source

Contact Name		Client Notified Date	
Vendor Name		Medical Integrator	
Vendor Contact Info		Multi-Client SW Integrated Accums (MI)	
Issue Discovery Date		Parent SW Number	
Issue Discovered By		Client Audit Record ID	
How Issue Discovered			

Global Case Details

Assigned To		Outbound Calls	☐
Project Start Date		Service Warranty	☐
IT Fix	☐	Communication	☐
		Letters	☐

Case Resolution - High Level Root Cause

Root Cause Group		Attestation	✓
Root Cause Issue Type	Research Completed - No Issue Found	Root Cause Notes	root cause analysis not applicable to this case type
Root Cause Category			
Root Cause Sub-Category			
Problem Statement			

Impact

Impacts Multiple Clients	☐	Member Impact	
Issue Start Date		Member Experience	
Issue End Date		Client Experience	
		# of Lives Affected	
		Claim Impact	

Quality Monitoring

QM Issue Status		PA#	
QM Process		User ID	
QM Issue Category		Drug Name	
QM Code Fix Date		QM Issue Type	
QM Paid Claim Date		QM Outreach Date	
		Claim Count	
		Claim Number	

QM Area of Impact

IT Information

IT Incident ID	
IT Incident Owner	
IT Incident Journal Entries	

System Information

Created By	Allyson Zavala, 8/6/2024 1:24 PM	Date/Time Opened	8/6/2024 1:24 PM
Last Modified By	Amy Smith, 8/16/2024 1:26 PM	Date/Time Closed	8/16/2024 1:26 PM
		Date/Time Re-Opened	

Attachments

Claims Detail White Drug 61.xlsx

Size	**22KB**
Ownership	**Allyson Zavala**
View	**View file**
Last Modified	**8/6/2024 1:25 PM**

Case Comments

8/16/2024 1:26 PM

User	**Amy Smith**
Public	☐
Comment	**Caremark has conducted onsite audits in the past; however, invoice reconciliation has not be part of those audits. Due to NHPRI's concerns, and what appears to be exposure/claims activity that mirrors the CMS memo, Caremark will refer this pharmacy for an invoice reconciliation audit. Updates will be available on standard reporting as this audit progresses.**

Case History

8/16/2024 1:26 PM

User	**Amy Smith**
Connection	
Action	**Changed Case Status from Open to Closed.**

8/8/2024 7:20 PM

User	**Amy Smith**
Connection	
Action	**Changed Case Owner from Unassigned General Case to Amy Smith.**

8/8/2024 7:20 PM

User	**Amy Smith**
Connection	
Action	**Changed Expected Completion Date to 8/16/2024.**

8/6/2024 1:24 PM

User	**Allyson Zavala**
Connection	
Action	**Changed Owner (Assignment) from Amy Smith to Unassigned General Case. Created.**

Copyright © 2000-2024 salesforce.com, inc. All rights reserved.

Exhibit 16:
CVS_HJC_00000681
Salesforce entry related to the State of Oklahoma's pharmacy audit requests

- Close Window
- Print This Page
- Expand All | Collapse All

Case: 07016689

Custom Links

General Case Knowledge | General Case Chatter Group | General Case Category/Owner SME List

Basic Information

Subject	Request for Retail Pharmacy Audit	Case Number	07016689 [View Hierarchy]
Description	The client's consultant AON has come to us with a list of several pharmacies they would like the State's claims to be reviewed for issues. Attached is the email and list of pharmcies.	Portal Case	☐
Case Status	Closed	Case Owner	Amy Smith
Account Name	State of Oklahoma - Commercial	Parent Case	
Category Business Area	Networks	Expected Completion Date	4/15/2022
Category	Retail Pharmacy Audit	Within SLA?	Yes
Case Type	Research	Priority	Normal
Case Origin	Email	Escalation Reason	
		Escalation Reason Text	
		Issue/Request?	Request
		Issue Identified	Client

Case Categorization - Administration

SubCategory		# of times completion date revised	
Frequency	Unique	Completion Date Change Reason	
Welcome Season	☐	Completion Date Reason Text	
Major Project	No Major Project	Reporting Field 1	
General Case Effective Date		Reporting Field 2	
Project ID		Reporting Field 3	
PHI/PII Information	☐	Current Time Spent (hrs)	
Related Aetna Medicaid Issue Request		Total Time Spent (hrs)	
Issue Previously Reported	☐		

Case Source

Contact Name		Client Notified Date	
Vendor Name		Medical Integrator	

Vendor Contact Info		Multi-Client SW Integrated Accums (MI)	
Issue Discovery Date		Parent SW Number	
Issue Discovered By		Client Audit Record ID	
How Issue Discovered			

Global Case Details

Assigned To		Outbound Calls	☐
Project Start Date		Service Warranty	☐
IT Fix	☐	Communication	☐
		Letters	☐

Case Resolution - High Level Root Cause

Root Cause Group		Attestation	☑
Root Cause Issue Type	Research Completed - No Issue Found	Root Cause Notes	root cause analysis not applicable to this case type
Root Cause Category			
Root Cause Sub-Category			
Problem Statement			

Impact

Impacts Multiple Clients	☐	Member Impact	
Issue Start Date		Member Experience	
Issue End Date		Client Experience	
		# of Lives Affected	
		Claim Impact	

Quality Monitoring

QM Issue Status		PA#	
QM Process		User ID	
QM Issue Category		Drug Name	
QM Code Fix Date		QM Issue Type	
QM Paid Claim Date		QM Outreach Date	
		Claim Count	
		Claim Number	
		QM Area of Impact	

IT Information

IT Incident ID	
IT Incident Owner	
IT Incident Journal Entries	

System Information

Created By	Lara Clower, 3/25/2022 8:40 PM	**Date/Time Opened**	3/25/2022 8:40 PM
Last Modified By	Amy Smith, 4/4/2022 8:04 PM	**Date/Time Closed**	4/4/2022 8:04 PM
		Date/Time Re-Opened	

Attachments

State of Oklahoma Pharmacies to Review 3_25_22.docx

Size	**17KB**
Ownership	**Lara Clower**
View	**View file**
Last Modified	**3/25/2022 8:41 PM**

Case Comments

4/6/2022 7:35 PM

User: **Lara Clower**
Public: ☐
Comment: **Thank you so very much for this thourough review and response back so quickly! I greatly appreciate your teams assistance!**

4/4/2022 8:02 PM

User: **Amy Smith**
Public: ☐
Comment: **The following pharmacies will be referred over for an expanded audit. Updates will be available upon request; however please allow approximately 2-4 months prior to requesting any updates. Update requests can be sent via email to Amy Smith and Stormie Lindsey. Please include the pharmacy identifiers and client information when requesting an update. Updates are only available based on client exposure and identified discrepancies within the audited time frame.**

1. 5903491 - DFW Wellness Pharmacy
2. 1098121 - Procare Pharmacy Care
3. 3729160 - ASPCares

4/4/2022 7:28 PM

User: **Amy Smith**
Public: ☐
Comment: **Audits have recently been conducted on the following pharmacies with no findings for this client and minimal findings overall. No immediate audit activities to commence.**

1. 3504138 - White Drug
2. 2643321 - Optime Care Inc.

4/4/2022 7:16 PM

User: **Amy Smith**
Public: ☐
Comment: **The portion of this request that is asking Caremark to review the client specific data to determine if next steps are appropriate will need to be addressed by the client's clinical team or account management team. The Retail Pharmacy Audit department does not review client specific data until a specific concern is addressed. Requests to review the pharmacies listed will be reviewed against Caremark's BOB.**

4/4/2022 8:04 PM

User: **Amy Smith**
Public: ☐
Comment: **The following pharmacies are being referred for an onsite audit. Updates will be available upon request; however please allow approximately 2-4 months prior to requesting any updates. Update requests can be sent via email to Amy Smith and Stormie Lindsey. Please include the pharmacy identifiers and client information when requesting an update. If there are any identified discrepancies within the onsite audit, those results will be available via the Sum Detail Report. Please include the pharmacy identifiers and client information when requesting an update.**

1. 1712606 Haysville Health Mart
2. 3723435 walgreens
3. 3714335 Sooner Pharmacy
4. 3729261 APS Pharmacy
5. 3729956 RiteScripts Pharmacy
6. 3728346 Tribex LTC LLC
7. 3725302 Evans Express Pharmacy

4/4/2022 8:01 PM

User: **Amy Smith**
Public: ☐
Comment: **Review of the following pharmacies does not warrant audit activity at this time:**

1. 3721912 - Thifty Pharmacy Edmond
2. 3061657 - Performix Specialty
3. 3729526 - Mustang Drug
4. 3727724 - Olympia Pharmacy
5. 3724499 - McBride Orthopedic Hsp
6. 3720201- Medic Pharmacy & gifts

4/4/2022 7:19 PM

User: **Amy Smith**
Public: ☐
Comment: **The following pharmacies have been removed from Caremark's networks and further review will not commence:**

1. 5912527 DFW Wellness Pharmacy Out of Business 05/20/2019
2. 4551277 Rite Care Pharmacy Inactivity Termed 10/14/2021
3. 2512893 Davidson Discount Pharmacy Inactivity Termed 06/09/2020
4. 3727320 Metro Pharmacy Inactivity Termed 06/08/2021
5. 0131893 HPC International OI-Federal Exclusion

01/30/2022
6. 3719260 Broadway Corner Drug Inactivity Termed 02/18/2021
7. 5913264 Macarthur health mart pharmacy Contract Violation Termed 05/13/2019

Case History

4/4/2022 8:04 PM

User **Amy Smith**
Connection
Action **Changed Attestation from false to true. Changed Case Status from In Progress to Closed.**

4/4/2022 7:16 PM

User **Amy Smith**
Connection
Action **Changed Case Status from Open to In Progress.**

3/29/2022 7:04 PM

User **Amy Smith**
Connection
Action **Changed Case Owner from Unassigned General Case to Amy Smith.**

3/25/2022 8:40 PM

User **Lara Clower**
Connection
Action **Changed Owner (Assignment) from Lara Clower to Unassigned General Case. Created.**

Copyright © 2000-2024 salesforce.com, inc. All rights reserved.

Exhibit 17: CVS_HJC_00000785 Email exchange between Market 32 Pharmacy and CVS requesting permission to work with Blink Rx

From: Mccall, Steven D. [redacted]

Sent: 11/30/2022 7:13:54 PM

To: [redacted]; Thomas, Jennifer A [redacted]; Mills, Joy [redacted]

CC: [redacted]; Murphy, Michael S. [redacted] Terrel, Jaclyn [redacted]

Subject: RE: Price Chopper Follow Up

Hi [redacted]:

At this point we are not granting your request to waive the Provider Manual requirements. At the conclusion of the final audit review including results of the pharmacy(s) that were in breech you may resubmit.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]

Sent: Monday, November 21, 2022 3:41 PM

To: Thomas, Jennifer A [redacted]; Mccall, Steven D. [redacted]; Mills, Joy [redacted]

Cc: [redacted]

Subject: [EXTERNAL] RE: Price Chopper Follow Up

Importance: High

****** External Email - Use Caution ******

Hello Jennifer.

As requested, a report of the shipping amount of Xhance to the pharmacy under audit along with the requested signed attestation.

In response to the rest of the inquiry, you've asked for information relating to who performs the following functions in the filling of Xhance prescriptions. Our responses are below:

1. **Bill claims to Caremark.** The dispensing pharmacy, Price Chopper/Market 32 Pharmacy Store #244 in Sutton, MA, bills the claim to Caremark.
2. **Apply Coupons or Other Offsets to the Adjudicated Patient Pay Amount.** Blink Health coordinates applying coupons to the patient pay amount pursuant to a Shared Services Agreement.
3. **Inform Patients of Patient Pay Responsibility.** Blink Health performs that function under the previously mentioned Shared Services Agreement.
4. **Collect Copayments from Patients.** Similarly, pursuant to that Shared Services Agreement, Blink Health directly collects copayments from the patient. Price Chopper Pharmacy subsequently invoices Blink Health for the collected copayment amount.

Please be advised that we are aware that revisions that have been made to the Provider Manual in recent years contain certain requirements on who and where patient pay amounts are to be collected and similar requirements relevant to coupons and other offsets. Please consider this a formal request for Caremark's authorization to continue with the process as outlined above. We will also submit a more formal request to this effect. Please also be advised that we have officially paused the process outlined above for copayments and coupons with respect to CVS/Caremark claims until we have CVS/Caremark's written authorization to proceed.

Please do not hesitate to contact me if you have any questions or if a discussion is helpful.

Regards,
[redacted]

[redacted]
Pharmacy Third Party Administrator
HIPAA Privacy Officer
The Golub Corporation
Market 32
Price Chopper & House Calls Pharmacy
461 Nott Street, MB#202
Schenectady, NY 12308-1812
[redacted]

The information being provided within this email may contain protected health information as defined by Federal Law and regulations. This information is intended only for the use of the individual or entity named above. You are obligated to maintain it in a safe and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties under Federal and State law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this email in error, please notify the sender immediately to arrange for the return of these documents.

From: Thomas, Jennifer A [redacted]
Sent: Monday, November 21, 2022 1:31 PM
To: Mccall, Steven D. [redacted]; [redacted]
Cc: [redacted] Mills, Joy [redacted]
Subject: RE: Price Chopper Follow Up

[EXTERNAL]

[redacted]

I just wanted to follow up on the 11/11 request from Steve. Do you have the information he requested?

Thank you

Jennifer Thomas, CPhT | Sr. Manager Pharmacy Audit • Investigations • CVS Caremark
[redacted]
CVS Health | 9501 East Shea, MC 020 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Mccall, Steven D. [redacted]
Sent: Friday, November 11, 2022 11:50 AM
To: [redacted]
Cc: [redacted] Thomas, Jennifer A [redacted]
Mills, Joy [redacted]
Subject: RE: Price Chopper Follow Up

Hi [redacted]

So for Xhance and the other hub drugs please provide the information for the medications going into the warehouse. A report of the shipping amount to the pharmacy under audit along with a signed attestation to the veracity of the report will be acceptable. I will be out of the office at a conference next week, so Joy will resume being your primary contact.

Please see the other questions that are pending:

- Drugs from the specific manufacturer/distributor that ships you Xhance to the location under audit
- Information relating to the exact folks performing the following actions
  - Bill claims to Caremark
  - Apply coupons or any other offset to the adjudicated patient pay amount
  - Inform patients of patient pay responsibility
  - Collect copayments from patients

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Tuesday, November 8, 2022 9:17 AM
To: Mccall, Steven D. [redacted]
Cc: [redacted] Thomas, Jennifer A [redacted]
Subject: [EXTERNAL] RE: Price Chopper Follow Up

****** External Email - Use Caution ******

Good morning, Steve.

I am not sure where the confusion arose, but if you understood our conversation to mean that the distributor ships Xhance direct to the specific location, then allow me to clarify. Zembrace is shipped direct from the manufacturer to this location. This report has been provided to Caremark direct from the manufacturer. Xhance, on the other hand, is not shipped from the manufacturer direct to this location. Xhance is submitted from our warehouse to our pharmacies. This location is not unique. You should be able to see that other Price Chopper Pharmacy locations are filling for Xhance products.

As noted, we would be happy to provide you a report of what was shipped from our warehouse to the store in question, if that would be helpful.

[redacted]

[redacted]
Pharmacy Third Party Administrator
HIPAA Privacy Officer
The Golub Corporation
Market 32
Price Chopper & House Calls Pharmacy
461 Nott Street, MB#202
Schenectady, NY 12308-1812
[redacted]

The information being provided within this email may contain protected health information as defined by Federal Law and regulations. This information is intended only for the use of the individual or entity named above. You are obligated to maintain it in a safe and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties under Federal and State law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this email in error, please notify the sender immediately to arrange for the return of these documents.

From: Mccall, Steven D. [redacted]
Sent: Monday, November 7, 2022 3:47 PM
To: [redacted]
Cc: [redacted] Thomas, Jennifer A [redacted]
Subject: RE: Price Chopper Follow Up

[EXTERNAL]

During our call, you indicated that Xhance was shipped by the distributor directly to the specific location under audit. Did you mis-speak? Price Chopper indicated that this situation was unique because it was the only location dispensing.

Please clarify, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication end any attachments.

From: [redacted]
Sent: Monday, November 7, 2022 1:45 PM
To: Mccall, Steven D. [redacted]
Cc: [redacted]
Subject: [EXTERNAL] RE: Price Chopper Follow Up

**** External Email - Use Caution ****

Steve,
To clarify, Exhance is shipped to our warehouse and we ship it to our pharmacies. We, Price Chopper, can give you a report of what was shipped from our warehouse from the warehouse to this store in question. Is that what you are looking for?

[redacted]
Pharmacy Third Party Administrator
HIPAA Privacy Officer
The Golub Corporation
Market 32
Price Chopper & House Calls Pharmacy
461 Nott Street, MB#202
Schenectady, NY 12308-1812
[redacted]

The information being provided within this email may contain protected health information as defined by Federal Law and regulations. This information is intended only for the use of the individual or entity named above. You are obligated to maintain it in a safe and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties under Federal and State law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this email in error, please notify the sender immediately to arrange for the return of these documents.

From: Mccall, Steven D. [redacted]
Sent: Monday, November 7, 2022 1:57 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Price Chopper Follow Up

[EXTERNAL]

I had some action items down for you as follows:

- Drugs from the specific manufacturer/distributor that ships you Xhance to the location under audit
- Information relating to the exact folks performing the following actions
  - Bill claims to Caremark
  - Apply coupons or any other offset to the adjudicated patient pay amount
  - Inform patients of patient pay responsibility
  - Collect copayments from patients

We will respond with the narrowed list for wholesalers upon receiving the answer to the first bullet. If you can get that one over to us today, it would be appreciated.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Wednesday, November 2, 2022 8:56 AM
To: Mccall, Steven D. [redacted]
Cc: [redacted]
Subject: [EXTERNAL] Price Chopper Follow Up
Importance: High

****** External Email - Use Caution ******

Steve,
As a follow up to our call on Monday, as we discussed, we are holding off on pulling together any additional documentation related to prescription records or wholesaler records/purchases subject to your confirmation on what, if anything, further is required from CVS/Caremark's perspective.

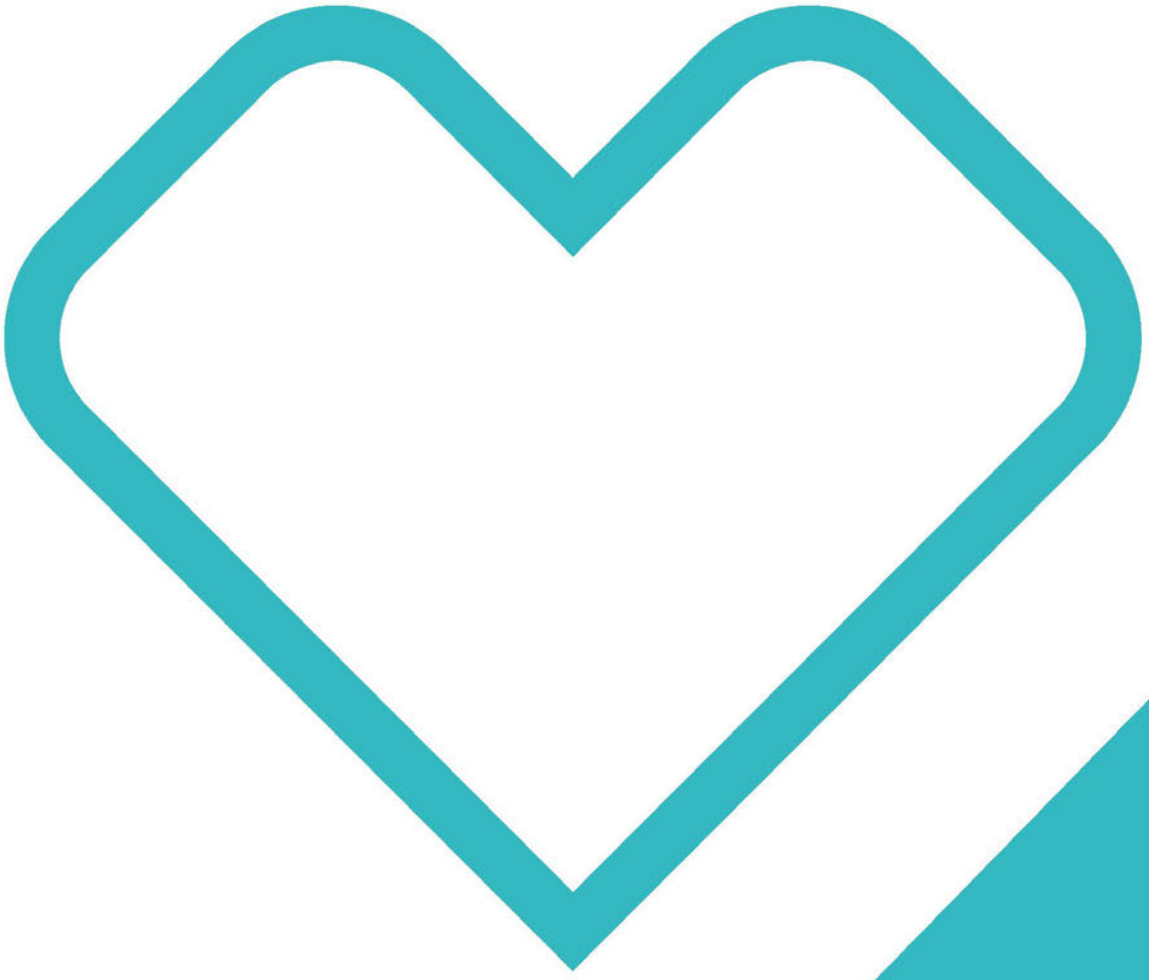
Thank you.
[redacted]

[redacted]
Pharmacy Third Party Administrator
HIPAA Privacy Officer
The Golub Corporation
Market 32
Price Chopper & House Calls Pharmacy
461 Nott Street, MB#202
Schenectady, NY 12308-1812
[redacted]

The information being provided within this email may contain protected health information as defined by Federal Law and regulations. This information is intended only for the use of the individual or entity named above. You are obligated to maintain it in a safe and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties under Federal and State law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this email in error, please notify the sender immediately to arrange for the return of these documents.

Exhibit 18: CVS_HJC_00000840 Portion of the CVS Caremark 2022 Provider Manual related to working with hub pharmacies

Provider Manual



2022 CVS Caremark Provider Manual

CVS caremark®

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

2. Demonstrating purchasing practices (e.g., higher cost drug products) that are not in keeping with the aligned goal of safeguarding both the health and financial welfare of Eligible Persons and Plan Sponsors.
3. Disregarding Eligible Persons' private and confidential identification information by using or misusing member data for Provider's own use (e.g., submitting test claims with no subsequent paid claims – also known as "negative" claims) and/or without Prescriber prescription authorization.
4. Participating in actions, programs and/or business models that result in the selection and dispensing of drug products that increase the amount billed to Plan Sponsors for Covered Items to Eligible Persons.
5. Engaging in practices that focus on Provider's welfare rather than best practices of providing clinical, cost-effective solutions for Eligible Persons and Plan Sponsors.

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

3.02.04 Dispensing Covered Items to Eligible Person's Agent

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

3.02.05 Performance Initiatives

Provider must support all Caremark performance initiatives such as, but not limited to, performance network programs (which may include adherence and drug therapy gap alerts), retrospective safety review alerts, formularies, Prior Authorization programs, Managed Drug Limitations programs, generic incentive programs, Dose Optimization programs, Step Therapy programs (refer to chapter **5. Clinical Programs, Services and Related Messages** of the Provider Manual for a further description of these initiatives) and any criteria in such performance initiatives.

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

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

3.02.06 Dispensing Errors

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

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

3.03 Patient Pay

3.03.01 Collection of Patient Pay Amounts

Patient Pay Amounts (e.g. Copayments, Coinsurance, etc.) is an extremely important tool to help align the needs of Plan Participants with those of the Plan Sponsor. The disclosure of the Patient Pay Amount to the patient is an important step in the adjudication and dispensing process of a Covered Item as it can assist with ensuring the necessity of a specific medication. The patient, or Eligible Person, may choose to find a more cost-effective alternative that is therapeutically equivalent, resulting in cost savings for the Plan Sponsor while maintaining quality patient care. Provider must disclose to each Eligible Person the Patient Pay Amount prior to dispensing the prescription so the Eligible Person has the opportunity to make an informed decision. Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system and in accordance with section **4.05 U&C Validation** of the Provider Manual. Provider must keep evidence of the collection of Patient Pay Amount for review.

Provider has the right to provide an Eligible Person with information about the cost of his or her medication including lower-cost alternatives to assist the Eligible Person in finding affordable, clinically appropriate, alternative medications.

All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.

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

3.03.02 Usual and Customary Price

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

3.03.03 Coupons and Other Programs

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

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

1. Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:
   a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program; or
   b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location; or
   c. The Covered Item is not a compounded drug, 510(k) cleared medical device, or Medical Food.
2. In addition, only certain Covered Items may have Pharmaceutical Manufacturer Coupons applied to reduce the amount the Eligible Person is required to pay. The following categories of Covered Items are the only ones where a coupon may be used.
   a. The Covered Item is approved by the U.S. Food and Drug Administration (FDA) through a New Drug Application (NDA) or Abbreviated New Drug Application (ANDA), and is published in the Approved Drug Products with Therapeutic Equivalence Evaluations (or commonly known as the "Orange Book"); or
   b. The Covered Item has a Biologics License Application (BLA), including drugs classified as biosimilars approved under section 351(k) of the Public Health Service Act, and is published in the Lists of Licensed Biological Products (or commonly referred to as the "Purple Book"); or
   c. The Covered Item is an Over-the-Counter (OTC) Covered Item marketed under an official final OTC monograph; or
   d. The Covered Item is a grandfathered drug marketed pre-1938 or pre-1962, or is otherwise Generally Recognized as Safe and Effective (GRASE) by the FDA.

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

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

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

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

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

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

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

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

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

3.03.04 Proof of Payment

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

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

If the Patient Pay Amount is reduced due to a coordination of benefits (COB), Provider must provide evidence of the COB claim payment by other payer(s), which shall be subject to Caremark audit and/or compliance review.

3.03.05 Excess Collections

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

3.03.06 Limitation on Collection

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

3.03.07 Patient Inducements

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

3.03.08 Waivers

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

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

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

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

3.03.09 Financial Hardship Program

Waivers based on an individualized determination of financial need under a Financial Hardship Program must meet the following requirements.

1. The terms of the Financial Hardship Program must be set forth in a formal written policy adopted by Provider. The policy must specify the documentation required to establish financial need, the criteria for determining eligibility for financial hardship relief and the level of relief to be provided, the application review and approval process, and recordkeeping requirements.
2. Eligible Persons seeking relief under the Financial Hardship Program must submit an application and provide reasonable and objective documentation of financial need that includes federal tax returns and other appropriate documentation.
3. The criteria for determining eligibility for financial hardship relief and the level of relief to be provided must be reasonable.
4. Written notice of qualification for financial relief under the Financial Hardship Program must be provided in writing to the Eligible Person. This notice must specify the amount or portion of the Patient Pay Amount that is being waived and the period of the waiver.
5. Eligibility for continued financial relief under the Financial Hardship Program must be reviewed on at least an annual basis. This review shall be based on an updated application and updated supporting documentation provided by the Eligible Person.
6. Records must be maintained for each Eligible Person receiving financial hardship relief under the Financial Hardship Program. The records must include, at a minimum, the application and supporting documentation submitted by the Eligible Person and a copy of the notice of qualification sent to the Eligible Person.
7. Provider personnel providing final financial hardship approval must be employed by Provider and shall not be contractors or agents of Provider. The identity of the personnel granting approval must be documented and provided as requested by Caremark.
8. The Financial Hardship Program may not be advertised or promoted.
9. The Financial Hardship Program may not be funded, in whole or in part, by any third party.
10. The Financial Hardship Program must meet all requirements and restrictions of applicable Law.

3.03.10 Documentation

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

3.03.11 Violations

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

3.04 Standards of Operation

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

Not considered "Retail Pharmacies":

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

1. Whose number of claims submitted to Caremark for prescriptions that were delivered to Eligible Persons (including common carriers such as USPS, FedEx, UPS or other delivery service) exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. Caremark further reserves the right to charge back any improper or excessive payments made to Provider based upon its misrepresentation as a Retail Pharmacy.
2. Whose number of claims submitted to Caremark for specialty drugs exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy.
3. Who is owned by a 340B covered entity or whose volume of claims filled using 340B Drug Pricing Program acquired or replenished drugs is the basis for any pharmaceutical manufacturer denying pharmaceutical rebates for claims submitted by Provider, is not considered a Retail Pharmacy. All Providers must maintain their NCPDP online provider ID profile services question on 340B (i.e., "Physical Location 340B Status") so that it is accurate and up to date.

If Provider has misrepresented itself as a Retail Pharmacy and/or modifies its operations such that it no longer meets the definition of a Retail Pharmacy, in addition to all other rights and remedies, Caremark reserves the right to exclude Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or to apply unique terms and conditions to such Provider's participation in any retail network(s) in which the Provider is participating or any new retail network(s) established, for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing. Any Provider that is not considered a "Retail Pharmacy" as described above, may be subject to other reimbursement, terms and conditions relevant to its non-standard retail pharmacy model.

Providers are not allowed to engage in marketing activities to Eligible Persons or Prescribers of Eligible Persons for the purpose of gaining dispensing opportunities that limit the Eligible Persons' right to use their participating retail pharmacy of choice including, but not limited to, business models that engage in internet, third-party marketing, telehealth, texting and/or hub-type of activities, without Eligible Persons' knowledge and/or understanding that their pharmacy choices are not restricted to the non-standard retail pharmacy business model.

3.04.01 Other Standards of Operations

1. Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.
2. Provider must furnish Pharmacy Services to Eligible Persons consistent with the requirements of all Caremark Documents. Shipping Covered Items by mail or other common carrier as a routine business practice in excess of the percentage allowed by Caremark without the express written permission of Caremark is a violation of the terms of the Provider Agreement. Payment for claims involving unauthorized mail or other common carrier is subject to chargeback.
3. Providers who utilize an internet site as a routine business practice in the provision of Pharmacy Services (except for refill requests) must maintain Verified Internet Pharmacy Practice Sites (VIPPS) certification through the National Association of Boards of Pharmacy (NABP), but must also otherwise comply with the terms of this subsection.
4. Provider must maintain a process to identify and detect prescriptions prescribed or claims for items or services furnished by an excluded or debarred Prescriber and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment.
5. No third-party consultant is permitted to represent Provider nor will Caremark communicate with a third-party consultant unless written consent is provided by Caremark. Provider must provide written documentation describing the business relationship with the third-party consultant upon request.

3.05 Records

3.05.01 Documents and Records Maintenance

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

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

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

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

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

3.05.02 Signature Log – Hard Copy or Electronic

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

1. Contains a signature which can be individualized or directly related to each prescription dispensed (e.g. prescription number)
    a. For each claim adjudicated through the claims adjudication system, Provider must obtain the signature of the Eligible Person (or his or her authorized representative) on a dated third-party signature log to confirm that he or she has received the medication recorded.
    b. Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.
2. Maintains the date of the receipt of Covered Item by the Eligible Person
3. Maintains a disclosure to Eligible Person of insurance billing
4. Retrievable for the purposes of audit

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

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

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

3.05.03 Prescription Information

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

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

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

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

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy, electronic prescription record, or Provider systems where it can be readily retrievable. In the case of a long-term care pharmacy's standing medication order, Provider must maintain written record of the prescriber's review and continuation of the standing order within one (1) year prior to the fill date, or such shorter period as required by applicable Law.

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

3.06 Referrals

3.06.01 Referral Fees

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

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

3.06.02 Referrals to Non-Retail Participating Providers

Provider must refer Eligible Persons to mail order, specialty, and/or other specified pharmacies for certain Pharmacy Services as appropriate for his or her plan benefit design and in compliance with applicable Law.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000847

4. Claims Submission

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

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

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

4.01 Payer Sheets and Reject Codes

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

Caremark utilizes NCPDP reject codes. A list of reject codes can be found at **www.caremark.com/pharminfo**. Providers can also refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online. In addition, Providers can contact their software vendor to learn more about submission reject codes.

4.02 General Claim Submission Policies

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

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

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

4.03 Other Claim Submission Requirements

1. **Quantity Dispensed and Days Supply:** Provider must submit the accurate days supply and quantity on all claims prior to dispensing.
   a. Provider must submit only the quantity indicated on the prescription. Provider must enter the exact metric decimal quantity dispensed (no rounding) on all claim transactions. Provider must submit the quantity based on product description (e.g., kit, volume of medication in milliliters, weight in grams, eaches, number of capsules/tablets). If the quantity is uncertain, Provider must contact the Prescriber to determine the appropriate amount to dispense and notate on the prescription hard copy or electronic prescription record.
   b. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
   c. Provider must not adjust the quantity dispensed to circumvent adjudication edits, reimbursement structure, prior authorization edits, clinical program or benefit design edits based on day supply.
   d. If the Prescriber indicates ambiguous direction such as "use as directed" or "as needed," (e.g., a drug that may be administered on a sliding scale such as insulin or a topically applied drug), the Provider must obtain the dosing schedule, dosing range, area of application, frequency, and any other information necessary or applicable to determine the days supply for the quantity dispensed. For example, with topical products, the FTU (fingertip-unit) chart is a common reference used to estimate the amount of topical product required based on the area of coverage.
   e. Directions and/or area of application may be obtained from either the Eligible Person or the Prescriber and must be notated on the prescription hard copy or electronic prescription record.
   f. Provider must not combine Prescriber authorized refills.
   g. Provider must consider product expiration and manufacturer storage recommendations when calculating days supply for claim transmission.
2. **Strength Dispensed:** The strength of the medication identified on the claim must be an accurate reflection of that which was prescribed or documentation of the unavailability of the prescribed strength will be required. Provider must utilize the strength originally prescribed by the Prescriber or use an available higher strength single dose of the same medication as described in section **5.08 Dose Optimization** of the Provider Manual. Provider must not utilize a lesser strength in an increased quantity without documentation of unavailability of the prescribed strength.
3. **Plan Limitations Exceeded:** Claims submitted to Caremark that exceed Plan limits for the days supply or quantity dispensed will reject with the message, "Plan Limitations Exceeded". The reject message includes the actual limits such as, "Maximum Days Supply = 34" or "Quantity Limit = 100". Any claims resubmitted must be entered with the accurate quantity and days supply; however, if the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-day supply), and rejects as stated, it is allowable for Provider to resubmit the claim utilizing that quantity and the maximum days supply as provided in the reject messaging. Provider maintains responsibility to adhere to appropriate refill intervals based on the quantity dispensed and actual days supply (based on the prescribed dosing schedule). The Pharmacy Help Desk is available for Provider to request a Plan Limitation Exceeded override; if approved, based on Plan Sponsor parameters, Provider must resubmit the claim with accurate approved quantity and days supply. Provider must document the details of the override granted by the Pharmacy Help Desk on the prescription hard copy. For additional information regarding Medicare Part D Claims, refer to chapter **10. Medicare Part D** of the Provider Manual.
4. **Ingredient Cost and Package Size:** Provider is obligated to submit claims using the lowest ingredient cost dosage form and the lowest cost package size container available that results in the lowest reimbursement.
5. **Ophthalmic Products:** Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. A chart to assist in calculating the appropriate days supply for a claim is provided in **Appendix A – Drug Submission Requirements** of the Provider Manual.

6. **Drugs with Unusual Submission Requirements**: Claims for some drug products frequently result in incorrect reimbursement. To avoid audit chargebacks, refer to the examples in **Appendix A – Drug Submission Requirements** of the Provider Manual.
7. **Repackaging**: Claims for repackaged, relabeled NDCs submitted to Caremark that result in higher reimbursement than claims for non-repackaged, relabeled NDCs may be subject to recoupment.
8. **Non-Covered Items**: Claims submitted to Caremark in accordance with a Plan Sponsor program to allow limited dispensing of a non-covered item (e.g., 3-day supply approved for a drug on prior authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable day supply.
9. **Federal Health Care Programs Prescriber Participation Exclusion**: Provider must not submit any claim to Caremark for a prescription prescribed or item or service furnished by a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other Federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions and claims for items or services furnished by an excluded or debarred Prescriber and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.
10. **Auto-Ship Refill Programs**: Claims submitted for auto-refill programs must only be for medications used in a maintenance therapy. Refer to section **10.04.05 Auto-Ship Refill Programs** of the Provider Manual.
11. **Fill Date**: The fill date is the date on which the Covered Item is prepared and readied for dispensing to the Eligible Person or, in the case of vaccine administration or other professional service, the date the service was administered/performed. Each prescription claim transmitted must indicate the fill date in the Date of Service field. Billing of claims must not be pre-dated or post-dated. The fill date may also be the date a subsequent payer began coverage following Part A expiration in a long-term care setting only.
12. **Prescription Not Received; Reversal of Claim**: All Covered Items must be received by the Eligible Person within seven (7) days of the fill date and Provider is solely responsible for ensuring a Covered Item is received by Eligible Person in a manner that meets or exceeds requirements of Law. Covered Items not received by an Eligible Person must be reversed by Provider within fourteen (14) days from the fill date through the claims adjudication system. Provider must ensure that an accepted reversal response is received from the claims adjudication system for each claim where the Covered Item was not received by the Eligible Person in accordance with this section. Upon discovery of a Covered Item not received by an Eligible Person in accordance with this section, Caremark in its sole discretion may reverse the claim. Refer to section **4.16 Electronic Submission, Reversal, and Processing Windows** of the Provider Manual.
13. **Pre-Printed Prescriptions**: Provider must not use pre-printed prescriptions that result in the dispensing of Covered Items that are not the most cost-effective even if they are different salts, bases, release characteristics, or additional drugs in combination.
14. **Test Claims**: Unless otherwise authorized in writing by Caremark, Provider must not submit test claims when a prescription order does not exist (e.g., to determine reimbursement rates). Provider must also not submit test claims acting as a hub service provider unless given written consent by Caremark.
15. **Vaccine and Non-Vaccine Injectable Administration**: When administering vaccines or non-vaccine injectables, submit 'MA' (for Medication Administration) in the Professional Service Code field (440-E5) of the DUR/PPS Segment along with a positive incentive fee amount in the Incentive Amount Submitted field (438-E3) of the Pricing Segment. Provider's submitted U&C must include the charge to administer the vaccine.
16. **No-Cost Vaccines**: When submitting a claim for a vaccine acquired by the Provider at no cost Provider must submit $0.00 as the Ingredient Cost Submitted (NCPDP field 409-D9) and a value of "15" in the Basis of Cost Determination (NCPDP field 423-DN), unless otherwise communicated by Caremark. Provider's U&C must not include a charge for the vaccine but may include a charge to administer the vaccine.
17. **Durable Medical Equipment (DME)**: Provider must only submit DME claims that are payable under the Plan Sponsor's pharmacy benefit. Provider must submit a valid Product Identifier for the DME. If no Product Identifier exists for a DME Provider must not submit a claim.

4.04 Dispense as Written Codes

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

To ensure proper payment to Provider and the correct Patient Pay Amount of Eligible Persons, Provider must submit all claims with the accurate Dispense as Written (DAW) code, unless otherwise specifically directed by Caremark. Provider must select from the following codes:

DAW 0—No Product Selection Indicated

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

DAW 1—Physician Requested Product Dispensed As Written

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

DAW 2—Substitution Allowed—Patient Requested Product Dispensed

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

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed

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

DAW 4—Substitution Allowed—Generic Not In Stock

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

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

- Use DAW 5 when dispensing a branded version of a multi-source product as a generic.

DAW 6—This Value Is Used As Communicated By Caremark

DAW 7—Substitution Not Allowed—Brand Mandated By Law

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

DAW 8—Substitution Allowed—Generic Not Available

- Use DAW 8 when generic substitution is permitted and the brand product is dispensed because the generic is not currently manufactured, distributed, or is unavailable in the marketplace.

DAW 9—Substitution Allowed By Prescriber But Plan Requests Brand

- Use DAW 9 when the Prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the Plan Sponsor's formulary requests the brand product.

4.05 U&C Validation

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

Provider must not modify its U&C, "gross amount due" (as defined by current NCPDP standards), or ingredient cost claimed on individual claims to bypass plan edits or Provider Agreement requirements.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000851

4.06 Over-the-Counter Products

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

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

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

4.07 Multi-Ingredient Compound Processing

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

1. All compounds must be submitted online in accordance with the most current Caremark payer sheets, which can be found online at **www.caremark.com/pharminfo**.
2. Provider must submit the accurate dosage form of the final compounded product dispensed in the compound dosage form description code field in the compound segment (must be a valid NCPDP compound segment dosage form value).
3. Enter the total quantity of the final product dispensed in the quantity dispensed field in the claim segment.
4. Enter the calculated cost of the complete compound as the ingredient cost submitted. This calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the Level of Effort (LOE). Caremark, in its sole discretion, will have final determination of professional allowance attributed to claim above the cost.
5. Calculated cost shall not include cost of drug product associated with waste. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
6. Enter the actual Product/Service ID (e.g., NDC or UPC) of each active and inactive item used in the preparation of the compound in the compound segment, including any consumable item (e.g., capsule). Each applicable Product/Service ID must be entered accurately. Incorrect submission of any single or multiple ingredient(s) may result in chargeback of the entire claim.
7. Submit the actual Product/Service ID (e.g., NDC or UPC) of each Covered/non-Covered Item. For any items in the compound, such items are only reimbursable if Provider provides, upon Caremark's request, evidence that each of the active and inactive items in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to chargeback.
8. For compounds that require a delivery device as a component of the final medication product, the device must be submitted as an item in the compound only when the device has a Product/Service ID (e.g., NDC or UPC) and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.
9. When required, submit the accurate Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) value for the final compounded product in the route of administration field in the claim segment.
10. Enter the LOE in the DUR/PPS Segment. The LOE must reflect the compound types which are referenced in **Figure 1 – Level of Effort Table**, unless otherwise communicated by Caremark. Provider must not program one code for all compounds.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000852

Figure 1 – Level of Effort Table

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

*Using bulk (powder) APIs

11. Coverage determination is performed on each and every item in the compound.
12. Provider may receive a rejected response for a compound claim when item(s) within the compound are not reimbursable; Caremark accepts Submission Clarification Code (SCC) "08" (Process Compound for Approved Ingredients) which will result in an adjudicated response on all Covered Items.
13. Non-Covered Item(s) within a compound are not reimbursable.
14. Compounds may be a Covered Part D Drug for Medicare Part D Enrollees provided the compound contains at least one Covered Part D Drug. The item cost must only include components which satisfy the definition of a Covered Part D Drug as defined in 42 C.F.R. § 423.100. Components that are not Covered Part D Drugs as defined by the Centers for Medicare and Medicaid Services (CMS) may be included in the creation of the product, but may not be included in the calculation of the item cost submitted (e.g., sterile water, compounding bulk powders, vitamins, components not utilized for a diagnosis recognized in the compendia). Provider must, however, include all items used in the creation of the compounded product on the multi-ingredient claim transmission.
15. If compounded claims reject for pricing edits (e.g., exceeds maximum cost for the Plan), Provider must not alter the quantity or identity of the individual components submitted to inappropriately enable reimbursement. Provider must not alter the quantity of, or omit an item dispensed, to circumvent Caremark's reimbursement structure, such as providing only 83 days of a 90-day supply prescription or dispensing monthly but billing weekly.
16. Provider must not manipulate claims pricing or the compound indicator for inappropriate financial gain or cause a claim to inappropriately pay.
17. The Caremark adjudicated claim response indicates the total payment for the compound claim. Provider must not balance bill an Eligible Person if prohibited by applicable Law.
18. When a compounded product is dispensed to an Eligible Person, Provider must bill Caremark a single claim for the final compounded product using multi-ingredient functionality (including all active and inactive items used in the creation of the compounded product) and must not bill separate claims to Caremark for individual items or ingredients used in the creation of the compounded product. In an effort to protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.

19. Compounds that have a commercially available product are not reimbursable.
    a. In the event a commercially available product becomes unavailable (e.g., product is on backorder, drug shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
    b. If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount.
20. Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.
21. Compounding must be performed by a qualified person as defined by applicable Law.
22. Outsourcing any portion of Pharmacy Services for compounded medications not approved in advance and in writing by Caremark is prohibited.
23. Refer to section **7.02 Additional Information Regarding Compliance Reviews** of the Provider Manual for documentation requirements.

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

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

4.08 Overrides

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

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual for contact information.

4.09 Natural Disasters

Caremark is dedicated to assisting Providers and Eligible Persons in response to emergencies resulting from natural disasters, severe weather, government declared states of emergency, etc. where medical records are either destroyed or not accessible. In the event of an applicable federal or state executive (or other appropriate federal or state governmental agency's) emergency declaration, Caremark, consistent with the scope of the declaration, may allow a specific submission clarification code to override the refill-too-soon edit for Eligible Persons impacted within the disaster area, e.g., a value of "13" in the Submission Clarification Code (SCC) field, 420-DK, and the

displaced Eligible Person's impacted ZIP code (do not enter the ZIP code in which the Eligible Person is temporarily residing as a result of the disaster) in the Patient ZIP/Postal Code field, 325-CP, will allow an override without requiring a call to the Pharmacy Help Desk. On the prescription hard copy or electronic prescription record, document the specific declared disaster (e.g., tornado, flood, wildfire), how the member was impacted (e.g., medication damaged, temporary relocation) and the date the disaster override was utilized. Permission may vary by Plan Sponsor. If you need assistance, call the Pharmacy Help Desk.

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual for contact information.

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

4.10 Coordination of Benefits

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

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

Claim submissions with incorrect COB values are subject to chargeback.

4.10.01 Multiple Transaction Coordination of Benefits

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

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

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

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

4.10.02 Single Transaction Coordination of Benefits

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

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

4.11 Long-Term Care Billing

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

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

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

4.12 Dispensing Pharmacy NPI/NCPDP

Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.

1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;
2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;
3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;
4. Provider is not allowed to submit claims on behalf of another entity;
5. Provider must only submit claims it intends to dispense; and
6. Provider may not act on behalf of another entity regardless of ownership structure.

4.13 Prescriber Identification; Prescriptive Authority

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

4.14 Transaction Fees

Caremark charges network Providers, and Provider agrees to pay, transaction fees that represent pharmacy network management services Caremark provides to network Providers. For every single transaction Provider transmits to Caremark, Caremark may deduct such amounts for the transaction fee from amounts payable to Provider. A single transaction is defined as each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims adjudication system. Each transaction within a multi-claim transmission will be subject to individual transaction fees.

4.15 Transaction Submission Resolution Management Service Fees

Caremark charges network Providers, and Provider agrees to pay, fees for Caremark's resolution of transactions submitted by Provider including, but not limited to, rejected claim resolution, pharmacy compliance, and claims information quality improvement. The fee charged to Provider will be commensurate to the amount of resolution management services Caremark is required to expend based on Provider's claims submissions, as measured comparatively to all other Providers on a retrospective monthly basis. Caremark will determine how the fee will be measured and assessed, as communicated to network Providers in writing accordingly. The Transaction Submission Resolution Management Service Fee charged will be charged per transaction, and Provider has the opportunity to reduce the amount of fees charged based on the degree of resolution of transactions required by Caremark for Provider as compared to all other Providers. Caremark may deduct the fee amount from amounts payable to Provider. Providers will be charged for either a Transaction Fee (as described in section **4.14 Transaction Fees** of the Provider Manual) or a Transaction Submission Resolution Management Service Fee, but not both for the same transaction.

4.16 Electronic Submission, Reversal, and Processing Windows

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

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

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

Except as otherwise required by applicable Law, or in the event of an urgent need to provide service to an Eligible Person while the claims system is unavailable (refer to section **4.18 Schedule of Claims Systems Maintenance** of the Provider Manual), Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (e.g., cartridge, CD-ROM, tape, batch, or paper) unless prior written approval is received from Caremark or Plan Sponsor. Caremark charges a handling fee of $2.50 per claim in those situations in which Caremark or Plan Sponsor agree in writing to non-electronic submission or reversal of claims.

4.16.01 UCF Requirement

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

4.17 Software Certification

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

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

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

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

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

4.18 Schedule of Claims Systems Maintenance

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

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000857

Exhibit 19: CVS_HJC_00000889 Email exchange between Albertsons and CVS

From: [redacted]
Sent: 10/6/2023 6:48:58 PM
To: Mccall, Steven D. [redacted]; Harris, Stephanie [redacted]
CC: [redacted]; Terrel, Jaclyn [redacted]; Thomas, Jennifer A [redacted]; Lynch, John H [redacted]; [redacted]; Grosso, Lauren A. [redacted]
Subject: [EXTERNAL] RE: EXTERNAL EMAIL: RE: Secure

****** External Email - Use Caution ******

Thank you Steve. I appreciate it.
We will hold off on the CAP then unless I hear otherwise from you. If you are able to confirm the audit for store 110 will not be negatively impacted with the information contained below without the CAP, I would greatly appreciate it.
Thank you!
[redacted]

From: Mccall, Steven D. [redacted]
Sent: Friday, October 6, 2023 11:08 AM
To: [redacted]; Harris, Stephanie [redacted]
Cc: [redacted] Terrel, Jaclyn [redacted] Thomas, Jennifer A [redacted]; Lynch, John H [redacted] Grosso, Lauren A. [redacted]
Subject: RE: EXTERNAL EMAIL: RE: Secure

[redacted]:

I just wanted to send a thanks. IT ran a scan and your controls look to be working to prevent the issues from occurring. I can't thank you enough for getting this fixed.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Monday, September 25, 2023 10:33 AM
To: Mccall, Steven D. [redacted] Harris, Stephanie [redacted]
Cc: [redacted] Terrel, Jaclyn [redacted] Thomas, Jennifer A [redacted] Lynch, John H [redacted]; [redacted]
Subject: [EXTERNAL] RE: EXTERNAL EMAIL: RE: Secure

****** External Email - Use Caution ******

Good morning Steve
As we have been working hard to pull all of the documentation for the recent audits, we have also been thoroughly reviewing our practices and establishing additional protocols to ensure we are following the provider manual hence the delayed response.

I want to reply to your questions and the highlighted sections of the provider manual you provided.

- Has the pharmacy in question (Med Cart NCPDP 2374445) ceased all hub activity? We are compliant with the protocols outlined in the Provider Manual
- If so what date? ACI responded to a March 6th Cease and Desist and took immediate action to correct. We confirmed compliance on March 17th, 2023.
- What controls have you placed to prevent any other entity from submitting claims on behalf of the pharmacy? Our switch established an edit that blocks claims submitted by an outside entity using our NPI. It then alerts us to respond appropriately.

Provider Manual Sections

- Provider must not participate in programs that increase amount billed to Plan Sponsors for Covered Items.
  - ACI complies with CRK formulary and does not control what the Plan sponsor is charged. If a product requires Prior Authorization, ACI works with the prescriber and only fills if the PA is approved by CRK. If a drug is not on formulary ACI will work with patient and prescriber to use an alternative product that is approved by CRK.
  - Please elaborate and provide examples to support your assertion that ACI is increasing costs to health plans, including taxpayer funded programs. Please also address how this occurs when ACI follows CRK's formularies and properly addresses CRK's PA requests as well as various other CRK adjudication responses.
- Collection of Patient Pay amounts
  - All collections of Patient Pay amounts are collected by ACI .
- Application of Pharmaceutical Manufacturer Coupon performed by another entity and disallowance of pharmacy specific manufacturer coupons.
  - When permissible, MedCart may use a publicly available manufacturer coupon to assist patients with copayments. ACI does not restrict or imply that patients must use our pharmacies. Patients are made aware that the prescription is being filled by an Albertsons owned pharmacy and patients confirm that they want prescriptions filled by us.
- Providers are not allowed to engage in marketing activities.
  - MedCart receives new, refill and transferred prescriptions. All patients are notified MedCart will be fulfilling their order.
- Test Claims
  - MedCart does not allow non-ACI entities to submit claims, including test claims, on its behalf or use its NPI, NCPDP, software certification ID, or any other identifier.
  - Our switch established an edit that blocks claims submitted by an outside entity using our NPI. It then alerts us to respond appropriately.
- Dispensing Pharmacy NPI/NCPDP
  - Claim submission must utilize NPI or NCPCP of Dispensing pharmacy.
    - MedCart is submitting all claims.
  - Provider that submits the claim must be the same that dispenses
    - MedCart is submitting all claims.
  - Provider must not allow an entity to submit a claim on their behalf
    - MedCart is submitting all claims and no other entity is using their NPI/NCPDP.
  - Provider must submit only claims it intends to dispense
    - MedCart intends to dispense all claims it submits unless there is rejection for some reason.
  - Provider may not act on behalf of another entity
    - MedCart acts on behalf of Albertsons Companies.

Thank you, Steve. Our pharmacies are following the protocols laid out in the Provider Manual. If there are any additional concerns, please bring to our attention and we will address accordingly. We are happy to discuss further and want to partner with you and if needed, have more in-depth discussions around this.

Thank you

[redacted]

From: Mccall, Steven D. [redacted]
Sent: Monday, August 28, 2023 12:06 PM
To: [redacted] Harris, Stephanie [redacted]
Cc: [redacted] Terrel, Jaclyn [redacted] Thomas, Jennifer A [redacted] Lynch III, John H [redacted]
Subject: RE: EXTERNAL EMAIL: RE: Secure

Hi [redacted]

Ok to grant a two week extension.

Has the pharmacy in question (Med Cart – NCPDP 2374445) ceased all hub activity? If so, what date? What controls have you placed to prevent any other entity from submitting claims on behalf of the pharmacy?

I have attached and highlighted some of the relevant sections of the Provider Manual that appear to have been potentially materially breached (this may not be an all-inclusive list). I spoke with Joe and explained we have clients that are concerned including taxpayer funded programs including contemplating next steps.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Monday, August 28, 2023 8:27 AM
To: Mccall, Steven D. [redacted]; Harris, Stephanie [redacted]
Cc: [redacted] Terrel, Jaclyn [redacted]
Subject: [EXTERNAL] RE: EXTERNAL EMAIL: RE: Secure

****** External Email - Use Caution ******

Good morning Steve
Just checking in the request for an extension.
Thank you
[redacted]

From: Mccall, Steven D. [redacted]
Sent: Wednesday, August 23, 2023 1:28 PM
To: [redacted] Harris, Stephanie [redacted]
Cc: [redacted] Terrel, Jaclyn [redacted]
Subject: EXTERNAL EMAIL: RE: Secure

Hi [redacted]

I sent over to the group to review. I also owe [redacted] an email as it appears the location is in violation of the HUB requirement of the provider manual. I will put together information, but this is a very vocal area of concern by plan sponsors and viewed as questionable spend.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Wednesday, August 23, 2023 12:21 PM
To: Mccall, Steven D. [redacted] Harris, Stephanie [redacted]
Cc: [redacted]
Subject: [EXTERNAL] FW: Secure
Importance: High

****** External Email - Use Caution ******

Good afternoon Steven and Stephanie
I am requesting some assistance on two audits. The first one is in reference to the email below. Because of the large amount of information we are pulling for several audits currently, we are requesting an extension through 9/8. I greatly appreciate any help on this front.
The second request is in regards to an audit appeal. I am working with Gary Domond on this audit and sent the attached email. I wanted to ensure this was received and being reviewed as we believe through our calculations, we have accounted for the inventory.

I greatly appreciate your assistance with both of these items.
Thank you
[redacted]
-----Original Message-----
From: Alegria, Kimberly E [redacted]
Sent: Wednesday, August 16, 2023 1:28 PM
To: Pharmacy Audits <pharmaudits@albertsons.com>
Subject: EXTERNAL EMAIL: CVS/Caremark REQUEST FOR CLAIM INFORMATION. PLEASE RESPOND BY 08/24/2023 SECUREMAIL

Hello,
Following up on the requested missing items. This is a 2nd attempt to complete the requested documents for co-pay information and the associated prior authorization information. Please provide the requested documentation by 08/24/2023 or let us know if you have any questions or need any additional information.
Please email [redacted] or fax [redacted]

Thank you,

Kimberly Alegria | Clinical Assistant, CVS Caremark
4755 S. 44th Pl., MC 113, Phoenix, AZ 85040 [redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

-----Original Message-----
From: Alegria, Kimberly E
Sent: Friday, August 4, 2023 8:48 AM
To: pharmaudits@albertsons.com
Cc: Alegria, Kimberly E <Kimberly.Alegria[redacted]
Subject: CVS/Caremark REQUEST FOR CLAIM INFORMATION. PLEASE RESPOND BY 08/14/2023 SECUREMAIL

Hello [redacted]
Thank you for sending in the requested documents. Unfortunately I do not see the requested Co-pay information or the associated prior authorization information. Please provide the requested documentation by 08/14/2023 or let us know if you have any questions or need any additional information.

Warning: All e-mail sent to this address will be received by the corporate e-mail system, and is subject to archival and review by someone other than the recipient. This e-mail may contain proprietary information and is intended only for the use of the intended recipient(s). If the reader of this message is not the intended recipient(s), you are notified that you have received this message in error and that any review, dissemination, distribution or copying of this message is strictly prohibited. If you have received this message in error, please notify the sender immediately.

Warning: All e-mail sent to this address will be received by the corporate e-mail system, and is subject to archival and review by someone other than the recipient. This e-mail may contain proprietary information and is intended only for the use of the intended recipient(s). If the reader of this message is not the intended recipient(s), you are notified that you have received this message in error and that any review, dissemination, distribution or copying of this message is strictly prohibited. If you have received this message in error, please notify the sender immediately.

Warning: All e-mail sent to this address will be received by the corporate e-mail system, and is subject to archival and review by someone other than the recipient. This e-mail may contain proprietary information and is intended only for the use of the intended recipient(s). If the reader of this message is not the intended recipient(s), you are notified that you have received this message in error and that any review, dissemination, distribution or copying of this message is strictly prohibited. If you have received this message in error, please notify the sender immediately.

Warning: All e-mail sent to this address will be received by the corporate e-mail system, and is subject to archival and review by someone other than the recipient. This e-mail may contain proprietary information and is intended only for the use of the intended recipient(s). If the reader of this message is not the intended recipient(s), you are notified that you have received this message in error and that any review, dissemination, distribution or copying of this message is strictly prohibited. If you have received this message in error, please notify the sender immediately.

Exhibit 20: CVS_HJC_00000931 Response to cease-and-desist sent from Village Fertility Pharmacy to CVS

VFP PHARMACY GROUP

Village Fertility - Boston
Village Fertility - Chicago
Integrity Rx - Phoenix
Integrity Rx - Los Angeles

www.VFPpharmacyGroup.com

November 22, 2024

Via facsimile (480-661-2787) and email (expandedaudit@cvshealth.com)

CVS Caremark
9501 E. Shea Boulevard
Scottsdale, AZ 85260-6719

Re: ***Cease and Desist – Pharmaceutical Hub Practices***
NCPDP # 2238005 NPI # 1225182595

To Whom It May Concern:

Please consider this Village Fertility Pharmacy's ("VFP") response to CVS Caremark's ("Caremark") Cease and Desist letter of November 8, 2024 ("Letter"). In that letter, Caremark suggested that VFP is not in compliance with several provisions of the Caremark Provider Agreement because of its relationship with BlinkRx. We place tremendous importance on our relationship with Caremark and have evaluated with great care the concerns expressed in your letter. We are certain, however, that those concerns are misplaced because VFPVFP's operations fully comply with each Provider Manual provision identified in your Letter. In light of VFP's compliance with each provision of the Provider Agreement and Caremark's Provider Manual, we ask that Caremark please withdraw its Letter.

Below is an explanation of VFP's relationship with BlinkRx and how it complies with the Provider Manual. Also addressed is each specific provision of the Provider Manual cited in Caremark's Letter with an explanation of how VFP is in compliance with that provision.

Partnership with BlinkRx

VFP is committed to supporting comprehensive medication access solutions to patients nationwide. To further that goal, VFP has partnered with BlinkRx to improve patients' medication access and affordability. As part of the relationship between VFP and BlinkRx, where applicable, BlinkRx transfers prescriptions to VFP so VFP can provide comprehensive pharmacy services, including but not limited to VFP running claims and dispensing the medication to the patient. Together, the partnership enables VFP to help patients navigate the complexities of the prescription drug experience and improve health.

Provider Manual Compliance

Having carefully reviewed each of the specific provisions identified in Caremark's Letter and correlating aspects of VFP's operations, VFP is confident that it is in compliance with each provision.

§ 4.12 Dispensing Pharmacy NPI/NCPDP

Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.

1. *Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
2. *The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
3. *Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
4. *Provider is not allowed to submit claims on behalf of another entity;*
5. *Provider must only submit claims it intends to dispense; and*
6. *Provider may not act on behalf of another entity regardless of ownership structure.*

VFP's partnership with BlinkRx complies with § 4.12 of the Provider Manual. In particular, VFP's business with BlinkRx in no way permits BlinkRx to use VFP's identifiers or to submit claims on VFP's behalf. BlinkRx does not use VFP's NPI or any other VFP identifier to submit claims. *See* Provider Manual § 4.12(1)–(4), (6). Rather, BlinkRx transfers prescriptions to VFP. Once VFP has received a prescription transfer, VFP then submits claims to Caremark and other payers using VFP's NPI, and VFP dispenses the medication to the eligible patient. VFP also does not permit BlinkRx to submit "test claims," and VFP does not itself submit test claims. Provider Manual § 4.12(5). In all cases, VFP acts on its own behalf to run claims and dispense medications to patients that VFP is serving and for whom VFP has valid prescription orders on file. For the avoidance of doubt, VFP also does not permit any other HUB pharmacy or third party to use its NPI number or other identifier to submit claims (including test claims) on VFP's behalf or otherwise violate any provisions of § 4.12 of the Provider Manual.

§ 3.03.01 Collection of Patient Pay Amounts

All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.

VFP's partnership with BlinkRx complies with § 3.03.01 of the Provider Manual because VFP does not "outsource" the collection of Patient Pay Amounts to a third party, including BlinkRx, nor does VFP submit claims for which the collection of Patient Pay Amounts was performed by any other entity. All Patient Pay Amounts are paid directly by patients to VFP. For the avoidance of doubt, VFP have already provided proof of receipt of such copay and Patient Pay Amount collections to Caremark. In addition, VFP appreciates the importance of collecting (and not waiving) Patient Pay Amounts, and we have policies and procedures in place to ensure all Patient Pay Amounts are appropriately collected.

§ 3.03.03 Coupons and Other Programs

Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:

CONFIDENTIAL TREATMENT REQUESTED

a. *The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program; or*
b. *The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location.*

VFP's partnership with BlinkRx fully complies with § 3.03.03 of the Provider Manual. In compliance with paragraph (a), VFP applies Pharmaceutical Manufacturer Coupons only in full compliance with the terms of the applicable program, including prohibitions related to medications reimbursed by government healthcare programs. In compliance with paragraph (b), it is VFP—not BlinkRx—that applies any Pharmaceutical Manufacturer Coupons if a patient is eligible, and any such application by VFP occurs at VFP's location and is done within VFP's pharmacy software system. Further, in compliance with § 3.03.04 of the Provider Manual, if a Patient Pay Amount is reduced due to a Pharmaceutical Manufacturer Coupon, VFP conducts a standard coordination of benefits transaction and maintains evidence of the Pharmaceutical Manufacturer Coupon as the secondary payer. For the avoidance of doubt, VFP also does not permit any other HUB pharmacy or third party to apply Pharmaceutical Manufacturer Coupons on its behalf.

* * *

In sum, VFP are confident that its business practices comply with the Provider Manual, including the provisions that Caremark shared in its Letter. VFP therefore respectfully requests that Caremark withdraw its Letter to avoid any complications in our valued relationship or in our relationship with BlinkRx.

Thank you allowing us to address the concerns raised in your Letter in this response. Please let us know if Caremark has any remaining questions, as we would be happy to meet or to provide further materials that demonstrate VFP's compliance with the Provider Manual. We look forward to continuing our partnership and to maintaining exemplary patient care.

Sincerely,

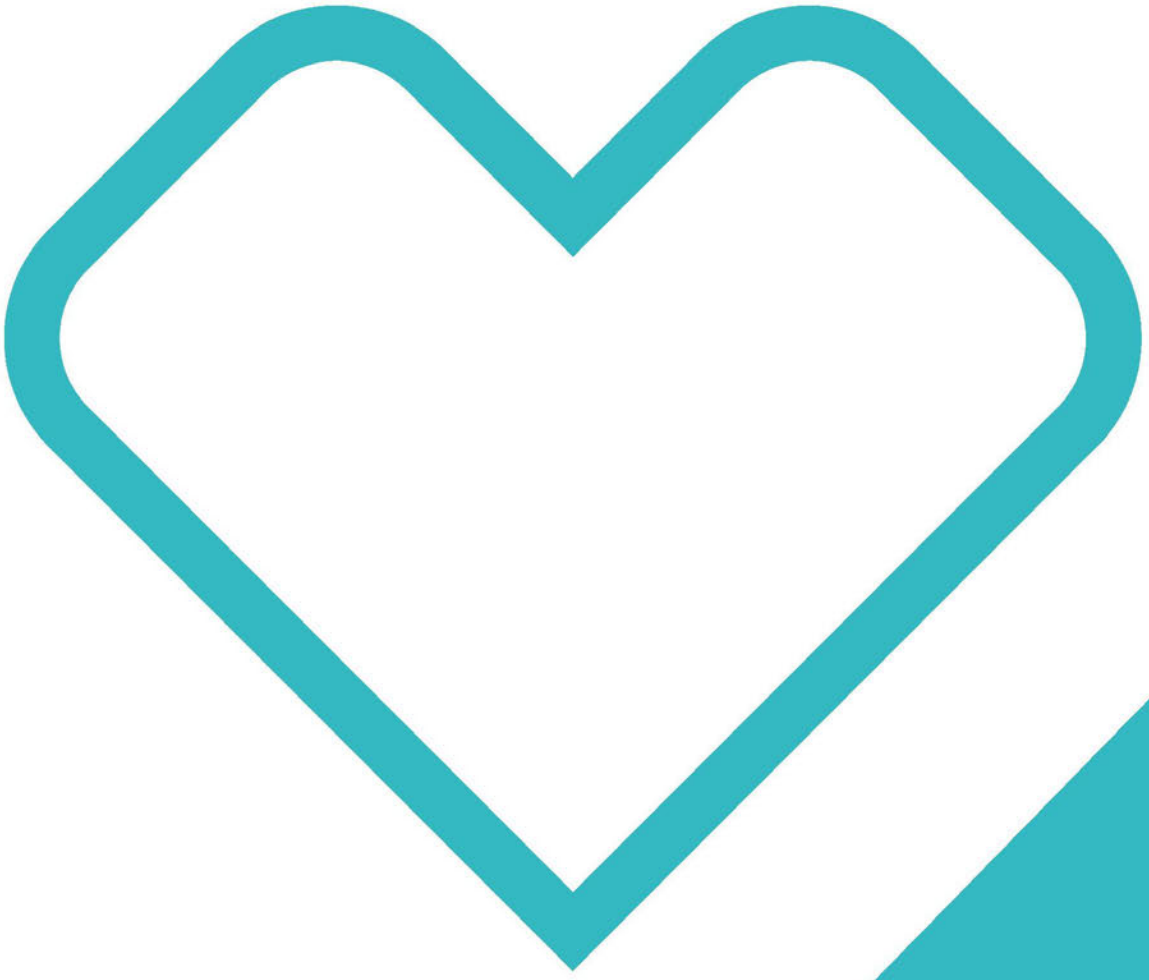
[redacted]

[redacted]
President

CONFIDENTIAL TREATMENT REQUESTED

Exhibit 21:
CVS_HJC_00000934 CVS Caremark 2022 Provider Manual

Provider Manual



2022 CVS Caremark Provider Manual

CVS caremark®

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

CONFIDENTIAL TREATMENT REQUESTED

Table of Contents

1. General Information 5

1.01 Proprietary Statement
1.02 Requirement to Adhere to Provider Agreement and Provider Manual
1.03 Contacting Caremark
1.04 Pharmacy Help Desk
1.05 Contact Information
1.06 Pharmacy Communications
1.07 Caremark Pharmacy Portal
1.07.01 Pharmacy Portal Terms of Use
1.08 Questions Asked by Providers
1.08.01 Pharmacy Audit and Pharmacy Compliance
1.08.02 Network Contract Rates/Terms
1.08.03 Provider Enrollment, Credentialing, Change of Ownership
1.08.04 Claims Processing and Benefit Plan Design

2. Credentialing 11

2.01 Steps to Become a Provider
2.01.01 Review Credentialing Requirements
2.01.02 Complete the "Pharmacy Pre-Enrollment Questionnaire"
2.01.03 Create a Pharmacy Portal Account to Submit Enrollment Application
2.01.04 Complete and Submit Your Application
2.01.05 Additional Application Requirements for Pharmacies Located in a Strike Force Location
2.01.06 Additional Application Requirements for Dispensing Practitioners
2.02 Steps to Become a Complex Compound Provider
2.03 Plan Sponsor Networks
2.04 Re-Credentialing
2.05 Notification to Caremark
2.05.01 Notification of Change in Documentation and Other Information
2.05.02 Notification of Closure
2.06 Change in Ownership
2.07 Reporting of Investigations and Disciplinary Actions
2.08 Criminal Offense Related to Federal Health Care Programs
2.08.01 Pharmacy Criminal Offense
2.08.02 Prescriber Criminal Offense
2.09 Federal Health Care Programs Participation Exclusion: Pharmacy

3. Pharmacy Services and Standards 20

3.01 Providing Pharmacy Services to Eligible Persons
3.01.01 Professional Judgment and Conduct
3.01.02 Verification of Eligible Persons
3.01.03 Identification Cards
3.01.04 Nondiscrimination
3.01.05 Eligible Person Solicitation
3.01.06 Eligible Person Complaints
3.01.07 Patient Receipts and Insurance Profiles
3.01.08 Educational Materials and Efforts
3.02 Dispensing Requirements
3.02.01 Hours of Operation
3.02.02 Drug Stock and Inventory
3.02.03 Aberrant Practices and Trends
3.02.04 Dispensing Covered Items to Eligible Person's Agent
3.02.05 Performance Initiatives
3.02.06 Dispensing Errors
3.03 Patient Pay
3.03.01 Collection of Patient Pay Amounts
3.03.02 Usual and Customary Price
3.03.03 Coupons and Other Programs
3.03.04 Proof of Payment
3.03.05 Excess Collections
3.03.06 Limitation on Collection
3.03.07 Patient Inducements
3.03.08 Waivers
3.03.09 Financial Hardship Program
3.03.10 Documentation
3.03.11 Violations
3.04 Standards of Operation
3.04.01 Other Standards of Operations
3.05 Records
3.05.01 Documents and Records Maintenance
3.05.02 Signature Log – Hard Copy or Electronic
3.05.03 Prescription Information
3.06 Referrals
3.06.01 Referral Fees
3.06.02 Referrals to Non-Retail Participating Providers

4. Claims Submission 29

4.01 Payer Sheets and Reject Codes
4.02 General Claim Submission Policies
4.03 Other Claim Submission Requirements
4.04 Dispense as Written Codes
4.05 U&C Validation
4.06 Over-the-Counter Products

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000936

Table of Contents

4.07 Multi-Ingredient Compound Processing
4.08 Overrides
4.09 Natural Disasters
4.10 Coordination of Benefits
4.10.01 Multiple Transaction Coordination of Benefits
4.10.02 Single Transaction Coordination of Benefits
4.11 Long-Term Care Billing
4.12 Dispensing Pharmacy NPI/NCPDP
4.13 Prescriber Identification; Prescriptive Authority
4.14 Transaction Fees
4.15 Transaction Submission Resolution Management Service Fees
4.16 Electronic Submission, Reversal, and Processing Windows
4.16.01 UCF Requirement
4.17 Software Certification
4.18 Schedule of Claims Systems Maintenance
4.18.01 Additional Required Procedures
4.19 Taxes

5. Clinical Programs, Services and Related Messages 40

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

6. Network Participation and Payment 45

6.01 Provider Payment
6.02 General Reimbursement
6.02.01 Multi-Ingredient Compound Reimbursement
6.02.02 Vaccine and Non-Vaccine Injectable Administration Reimbursement
6.02.03 Adjustments to Reimbursement
6.02.04 Post-Adjudication Settlements
6.03 Changes to AWP
6.04 Maximum Allowable Cost
6.05 Eligible Person Fees and Amounts
6.06 Claims Payment and Other Fees
6.06.01 Remittance Advices
6.06.02 Disputed Claims, Collected Fees, Amounts, or Recoupments
6.06.03 Claims Adjustment
6.07 Recoupment and Adjustments
6.08 Workers' Compensation
6.09 Provider Suspension
6.10 Directories

7. Compliance Reviews 51

7.01 Non-Compliance Fees
7.02 Additional Information Regarding Compliance Reviews

8. Professional Audits 53

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

9. Medicaid 60

9.01 Compliance with State and Federal Laws
9.02 Enrollment with State Medicaid
9.03 Medicaid Credentialing

Table of Contents

9.04 Fraud, Waste and Abuse Compliance Program
9.05 Inspection and Audit of Records and Access to Facilities
9.06 Claims Submission Requirements for Medicaid
9.07 Medicaid Coordination of Benefits
9.08 Prior Authorization
9.09 Denial of Services
9.10 Cultural Competency
9.11 Home Delivery
9.12 Directories

10. Medicare Part D 62

10.01 Medicare Part D Network Standards
10.01.01 Network Participation
10.01.02 Compliance with Laws
10.01.03 Delegated Activity
10.01.04 Offshore Subcontracting
10.01.05 Marketing
10.01.06 Fraud, Waste and Abuse (FWA) Program
10.01.07 Pharmacy Compliance and FWA Training
10.01.08 Information on CMS-10147 Pharmacy Notice
10.01.09 Performance Monitoring
10.02 General Information
10.02.01 Part D Reference Information for Pharmacists
10.02.02 Medicare Part D Calls to the Pharmacy Help Desk
10.03 Credentialing
10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies
10.03.02 Federal Health Care Programs Participation Exclusion
10.04 Pharmacy Services and Standards
10.04.01 Plan Identification Cards
10.04.02 General Procedures for Acknowledgement of Enrollment Letters
10.04.03 Best Available Evidence
10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS
10.04.05 Auto-Ship Refill Programs
10.05 Claims Submission
10.05.01 Unique RXBIN/RXPCN Requirement - Medicare Part D
10.05.02 Payment of Clean Claims
10.05.03 Electronic Prescribing
10.05.04 Prescription Origin Code and Fill Number
10.05.05 Improving Drug Utilization Review Controls
10.05.06 Medicare Part D Claims Requiring Overrides
10.05.07 General Medicare Part D Submission Requirements for COB
10.05.08 Formulary Transition Fill Process
10.05.09 Insulin Coverage
10.05.10 Pro-Rated Daily Cost Share
10.05.11 Medicare Part B and Medicare Part D Drug Coverage Determinations
10.05.12 End Stage Renal Disease Claim Processing
10.05.13 Prescriber Identification for Medicare Part D Claims
10.05.14 Claims Submission Window for Medicare Part D
10.05.15 Medicare Part D Claims Adjustment
10.06 Network Participation and Payment
10.06.01 Drug Pricing
10.06.02 Pharmacy Service Type and Patient Residence Requirements
10.07 Special Instructions for Participating LTC Providers
10.07.01 Pharmacies Serving LTC Facilities
10.07.02 LTC Pharmacies Timely Claim Submission
10.07.03 LTC Appropriate Day Supply Short Cycle Billing
10.07.04 LTC Days Supply Limitations
10.07.05 LTC Transition Fill
10.07.06 Special Package Indicator
10.07.07 LTC Override Requests
10.07.08 LTC Overrides for Current Part D Enrollees
10.07.09 Medicare Part A and Medicare Part D Drug Coverage Determinations
10.08 Retail Addendum to the Caremark Provider Agreement

11. Medicare Advantage 87

12. Medicare-Medicaid Plan 89

12.01 Medicare-Medicaid Networks Standards
12.02 Compliance with State and Federal Laws

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000938

Table of Contents

13. Qualified Health Plans 90

14. Intellectual Property, Confidentiality and Proprietary Rights 91

14.01 Advertising and Trademarks
14.02 Non-Disparagement
14.03 Confidentiality
14.04 Non-Solicitation and Non-Interference
14.05 Proprietary Rights
14.06 Remedies

15. Miscellaneous 94

15.01 Assignment
15.02 Independent Contractors and Third-Party Beneficiaries
15.03 Court Orders, Subpoenas or Governmental Requests
15.04 Notices
15.05 Termination
15.05.01 Termination for Cause
15.05.02 Termination Without Cause
15.05.03 Rights and Remedies in the Event of Termination or Breach
15.06 Survival of Certain Provisions
15.07 Amendments
15.08 Enforceability
15.09 Arbitration
15.09.01 Discovery Limitations
15.09.02 Expenses of Arbitration
15.09.03 Anti-Class; Anti-Consolidation of Claims in Arbitration
15.09.04 Confidentiality of Arbitration
15.09.05 No Collateral Estoppel/Precedential Impact of Award
15.09.06 Waiver of Right to Confirm Award Upon Payment
15.09.07 Dispute Resolution Procedures
15.09.08 Severability
15.10 Force Majeure
15.11 Anti-Kickback Statute, Stark Law, and Caremark Compliance Program
15.12 Rebate Programs
15.13 Eligible Person Communications

16. Federal and State Laws and Regulations 100

16.01 Compliance with Laws

Appendix A - Drug Submission Requirements 101

Appendix B - CMS Form No. 10147 (English) 110

Appendix B1 - CMS Form No. 10147 (Spanish) 111

Appendix C - Appeals Process Documentation Guidelines 112

Glossary of Terms 116

1. General Information

Caremark appreciates the role that Network Providers play in delivering quality care to Eligible Persons. The 2022 Caremark Provider Manual ("Provider Manual") contains the policies and procedures to which network Providers must adhere to provide quality care to Caremark Eligible Persons. The Provider Manual and all Payer Specification Sheets are part of the Provider Agreement and are incorporated into the Provider Agreement pursuant to the terms thereof. This Provider Manual supersedes and replaces all previous versions of the Provider Manual. As a network Provider, you are responsible for monitoring and complying with all changes to the Provider Manual. Capitalized terms used in the Provider Manual not defined in the Glossary of Terms shall have the same meaning as in the Provider Agreement.

1.01 Proprietary Statement

The Provider Agreement (which includes the Provider Manual) constitutes Confidential Caremark Information and is provided to Provider for business purposes only. Provider must maintain in confidence the Provider Manual, and must not disclose, sell, assign, transfer, or give to any third party the Provider Manual or any of its contents without Caremark's prior written consent. Refer to section **14.03 Confidentiality** of the Provider Manual.

1.02 Requirement to Adhere to Provider Agreement and Provider Manual

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda, and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

1.03 Contacting Caremark

Caremark strives to ensure that Providers receive prompt and courteous assistance with questions that may arise. Caremark's Pharmacy Help Desk Representatives are available every day of the year. The Interactive Voice Response (IVR) system is available 24 hours a day, 7 days a week, excluding downtime for maintenance and service.

1.04 Pharmacy Help Desk

Following are the phone numbers corresponding with the appropriate Bank Identification Numbers (BINs):

Caremark System	RXBIN	Pharmacy Help Desk Number*
Legacy ADV	004336**	1-800-364-6331
Legacy PCS	610415**	1-800-345-5413
FEP	610239	1-800-345-5413
Caremark	610591	As communicated by plan or refer to ID card
Aetna	610502	1-800-238-6279
IngenioRx (Anthem)	020099 020115 020107	1-833-296-5037
IngenioRx	020123 020388 020396	1-833-296-5038

Secondary RXBINs and Plan sponsor-specific RXBINs and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at:

www.caremark.com/pharminfo

*Or as communicated on Eligible Person's Card or claim response

**Puerto Rico Providers call toll-free 1-800-842-7331

Pharmacy Help Desk representatives will use reasonable efforts to assist Providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with respect to the provision of Pharmacy Services.

Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

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

1.05 Contact Information

Unless otherwise specified in the Provider Manual, Providers must send inquiries and grievances in writing to:

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

1.06 Pharmacy Communications

Caremark may communicate to Providers, and Provider agrees to receive pharmacy communications, via email messaging, fax, telephoning pharmacies directly, UPS (or other carrier), USPS, and secure messages through the CVS Caremark Pharmacy Portal. Many Pharmacy Communications are distributed via fax or email and may require an action by Provider in response to the communication. Pharmacy Communications include but are not limited to:

- Provider Manual and Provider Manual Amendments
- Plan Sponsor Implementation Notices
- Formulary Updates
- Clinical/Vaccine Information
- Pharmacy Audit Tips
- Medicare Part D or other government or regulatory guidance
- Network Initiatives
- Industry Standard Changes
- Emergency Procedures
- Plan Sponsor Initiatives
- Point-of-Service Issues
- Network Enrollment Forms or other Contract Updates

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

It is Provider's responsibility to promptly notify Caremark of any changes to Provider's contact information, including street address, mailing address, phone number, fax number, or email address. Provider's failure to update its contact information with Caremark, or refusal to accept delivery of a communication from Caremark, shall not relieve Provider of any obligations to comply with the information communicated. Refer to sections **2.05.01 Notification of Change in Documentation and Other Information** and **15.04 Notices** of the Provider Manual.

1.07 Caremark Pharmacy Portal

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

Provider may access the Pharmacy Portal to obtain information and other services Caremark may make available. Provider acknowledges that the Pharmacy Portal is an effective medium for communicating Caremark Documents. Provider is required to frequently log in to the Pharmacy Portal to review important information to ensure awareness of Caremark requirements including, but not limited to, Provider Manual Amendments, Performance Network Program, vaccine requirements, Medicare Part D regulations, and Medicaid/state regulations.

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

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

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

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

1.07.01 Pharmacy Portal Terms of Use

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

The Pharmacy Portal may provide authorized users with various analytical tools (such as MAC Price Lookup, MAC Appeals, MAC Future Pricing, etc.). The Pharmacy Portal, and its content, are the property of Caremark and users are strictly prohibited from using Pharmacy Portal content or information for any purpose other than for the purposes of fulfilling the Provider's obligations under the Provider Agreement. Users are strictly prohibited from accessing the Pharmacy Portal using automated means (such as harvesting bots, robots, spiders, or scrapers). Caremark reserves the right to remove content from the Pharmacy Portal at its sole and absolute discretion. Improper use or unauthorized access of the Pharmacy Portal may result in termination of Pharmacy Portal use privileges and pursuit of all other remedies available to Caremark.

1.08 Questions Asked by Providers

1.08.01 Pharmacy Audit and Pharmacy Compliance

1. **My pharmacy has received notice of an upcoming pharmacy audit. How do I request an extension to the audit date?**
   If your pharmacy received notice of an impending pharmacy audit, please refer to the letter you received which includes contact information for the pharmacy auditor that will be conducting the audit. Please reach out to the pharmacy auditor directly and in a timely fashion as travel and other arrangements may not be flexible.
2. **What are the preferred invoices and invoice date ranges needed to demonstrate inventory that aligns with my claims submissions and dispensing to Caremark Eligible Persons?**
   Invoices predated not more than thirty (30) days before audit date range and invoices reflecting inventory purchased during the audit date range are typically accepted by Caremark.
3. **My pharmacy just received an initial discrepancy list from a recent pharmacy audit. Can I request a post-audit extension? What are my next steps?**
   Your pharmacy is allowed a set amount of time to provide documentation for some of the potential discrepancies to address the items that can be resolved, as outlined in the correspondence your pharmacy received with the initial discrepancy list. The time period granted is typically thirty (30) days to give your pharmacy the opportunity to research and collect documentation and provide it to Caremark for further review. If your pharmacy needs additional time, reach out to the contact listed in the correspondence to inquire if your pharmacy can be granted a short extension.
4. **How can I address the initial discrepancies from my pharmacy's recent audit?**
   Some common audit findings, such as missing prescription(s) for example, may be addressed by contacting the Prescriber and requesting a duplicate prescription for documentation to send to Caremark to receive credit within the timeframe allowed. Other discrepancies such as refill-too-soon or overbilled quantities are point-in-time issues that cannot be addressed.
5 **My pharmacy just received a final discrepancy list from a recent pharmacy audit. Can I request a post-audit extension?**
   No, when your pharmacy receives a final discrepancy list from Caremark's post-audit review area, by definition, the list is final and complete. Your pharmacy was granted a set amount of time during the initial discrepancy list notification to resolve outstanding proof of documentation which included an opportunity to request an extension prior to the distribution of a final discrepancy list.
6. **Can adverse findings result in my pharmacy being terminated?**
   Yes. Pharmacies that have adverse findings may be presented to an internal review committee that may determine to terminate your pharmacy from a Caremark network(s) or elect to terminate your pharmacy Provider Agreement.
7. **My pharmacy just received notice of a payment suspension/adjudication suspension. What does this mean?**
   Please engage the Caremark pharmacy audit team to inquire about potential next steps. The notice your pharmacy received includes pharmacy audit contact information.
8. **I received my final audit findings; what are my next steps if I do not agree?**
   Refer to section **8.07 On-site and Investigational Audit Resolution – Appeals Process** for additional information and instructions.

9. **I am thinking about using a new distributor. What are some best practices that I should use when making the decision?**

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

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

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

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

    Yes, where required by applicable Law for Eligible Persons residing or located in that jurisdiction.

1.08.02 Network Contract Rates/Terms

1. **I participate in a Caremark Network with Performance Network Program (PNP) measures. Where can I access my PNP reports?**
   Caremark provides online access to PNP information via the Pharmacy Portal at **rxservices.cvscaremark.com**. Provider may access the Pharmacy Portal to obtain PNP reports spanning the last eighteen (18) months for both Medicare Part D and non-Medicare Part D plans. Information on how to read and understand your pharmacy's PNP reports is included.
2. **I am reviewing a Caremark Network contract and I don't know if I want to participate. What are various factors I should consider?**
   It is important for your pharmacy to make a business decision on every network opportunity that is presented to your pharmacy. Your pharmacy should review the terms and conditions and only enroll in networks in which your pharmacy agrees the terms and conditions are reasonable and relevant to your business model prior to enrolling. Consider your pharmacy's business goals and decide if the opportunities align with those of your pharmacy. If your pharmacy does not or cannot meet the requirements, or requirements do not align with your pharmacy's business goals, there are instructions that explain how to accept or decline each network opportunity.

1.08.03 Provider Enrollment, Credentialing, Change of Ownership

1. **I am a new provider owner. Am I responsible for the liabilities and obligations of the previous owner?**
   Refer to section **2.06 Change in Ownership** of the Provider Manual.
2. **I am selling my pharmacy. Do I have any obligations under the Provider Agreement?**
   Yes. Refer to section **2.06 Change in Ownership** of the Provider Manual. You also should inform the new owner of any obligations to Caremark that may have been incurred.
3. **I am interested in enrolling as a participating Caremark Provider (or I have a new pharmacy I would like to enroll), what steps do I take?**
   Refer to section **2.01 Steps to Become a Provide**r of the Provider Manual.
4. **When will I have access to the enrollment information in the Pharmacy Portal? What other information is on the Caremark Pharmacy Portal?**
   Refer to sections **2.01 Steps to Become a Provider** and **1.07 Caremark Pharmacy Portal** of the Provider Manual.

1.08.04 Claims Processing and Benefit Plan Design

1. **What date of birth, sex and/or person code do you have on file for this Eligible Person?**
   Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable attempts/efforts to obtain the necessary information for claim submission. In the event a Plan Sponsor has incorrect eligibility information (e.g., incorrect date of birth), when a Provider submits a claim using the correct eligibility information (e.g., correct date of birth) the claim will reject. In most cases, Caremark will be able to assist the Provider at the point of service with any discrepancies with eligibility information, such as date of birth and sex. However, you should advise your Eligible Person that he or she should inform his or her Plan Sponsor of the incorrect eligibility information and that until it is corrected claims will continue to reject.
2. **What is the identification number for this Eligible Person?**
   Provider must request to see the identification card for the Eligible Person to ensure that the prescription is written by the Prescriber for an Eligible Person.
3. **Are person code and patient relationship code required for claim submission?**
   Person code (as printed on the identification card) and patient relationship code data fields are required for submission as outlined in the Caremark Payer Sheets. Many times, person code is printed on the identification card. It is important that this information is submitted accurately to Caremark for appropriate Drug Utilization Review (DUR) for that individual to occur.
4. **What Banking Identification Number (RXBIN) do I use for all Caremark Eligible Persons?**
   Provider should submit claims utilizing the corresponding RXBIN which, in most cases, is illustrated on the identification card.
5. **Is a Processor Control Number (RXPCN) required for claim submission?**
   Provider must request to see the identification card for the Eligible Person and examine the identification card to determine if RXPCN information is available. Submit the RXPCN information as it appears on the identification card. If no RXPCN appears on the identification card, submit the default RXPCN according to the RXBIN as outlined in the Caremark Payer Sheets found online at **www.caremark.com/pharminfo.**

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000944

6. **What is the Group (RXGRP) number for this Eligible Person?**
   The RXGRP number is located on the Eligible Person's identification card. Refer to section **3.01.03 Identification Cards** of the Provider Manual.

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

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

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

10. **Is this Eligible Person eligible to receive a vacation supply?**
    Many Plan Sponsors allow for Eligible Persons to secure an early refill for vacation supply. If the Eligible Person states that he or she is eligible for an early refill for vacation supply, Provider must submit the claim as usual. If the claim rejects, Provider should contact the appropriate Pharmacy Help Desk for coverage verification. If the Plan Sponsor does allow for an early refill for vacation supply, the representative from the Pharmacy Help Desk will enter an override.

11. **What is the prior authorization procedure for this Eligible Person?**
    Caremark administers Prior Authorization programs for some of its Plan Sponsors. Therefore, Provider should note the adjudication response which generally includes the online retransmission instruction or appropriate contact information and telephone numbers.

12. **What are the plan limits for this Eligible Person?**
    Provider must submit the claim through the claims adjudication system to receive the adjudicated response which will include messaging about plan coverage. The representatives at the Pharmacy Help Desk cannot release plan limitation information due to the variables that may impact the coverage for a given drug.

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

14. **Do I need to bill the specific National Drug Code dispensed?**
    Yes. Submitted claims information must be accurate and complete. This includes, but is not limited to, billing the actual National Drug Code (NDC) used for each item within a prescription for compound recipe.

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

16. **If I am an LTC pharmacy and an LTC/ALF patient returns home, but I am still dispensing Covered Items and providing clinical care to the patient at home, what codes do I use to submit claims?**
    If a patient is returned to a non-LTC/non-ALF residence (at home patient), your pharmacy must submit value "01" for Pharmacy Service Type and value "01" Patient Residence Type. If other values are submitted that indicate the patient is still residing in an LTC or ALF when the patient is not residing in an LTC or ALF your pharmacy may be subject to chargebacks, non-compliance fees, or other remedies. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

For additional claim processing information, refer to the Caremark Payer Sheets at: **www.caremark.com/pharminfo.**

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

2. Credentialing

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

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

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

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

- Approval of enrollment
- Denial of enrollment
- Approval of enrollment with limited services (e.g., vaccines, complex compounds)
- The right to terminate the Provider Agreement

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

1. Any non-compliance with the terms of the Provider Agreement, serious and/or significant audit findings, or adverse actions by a governmental regulatory or enforcement entity or agency against:
   a. Provider; or
   b. Another provider with any common association, ownership, or relationship to Provider; or
   c. Any of Provider's respective owners (direct or indirect), officers, directors, Pharmacists-in-Charge/responsible pharmacist, managing employees, employees, or affiliated personnel. This also includes Providers that have billed for other entities or that have billed for claims that were previously found to have migrated from other Providers removed from the network.
2. Any conduct that may adversely impact Caremark's relationship with, or Caremark's contractual duties to, a Plan Sponsor.
3. Any conduct that may pose a risk to the health, welfare, safety, or financial well-being of Eligible Persons or the general public.
4. Any other conduct that Caremark, in its sole discretion, determines would adversely affect Provider's ability to fulfill the requirements of the Provider Agreement.
5. If Caremark believes, in its sole discretion, that the Provider may pose an undue risk of potential Fraud, Waste, and/or Abuse.
6. Failure to fulfill any outstanding financial obligations to Caremark and/or Plan Sponsors.

IMPORTANT:

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

2.01 Steps to Become a Provider

1. Review Credentialing Requirements
2. Complete the "Pharmacy Pre-Enrollment Questionnaire"
3. Create a Pharmacy Portal account
4. Complete and submit an application, which includes attestation to Provider Agreement

2.01.01 Review Credentialing Requirements

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

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

1. Provider must maintain in good standing all federal, state, and local licenses; permits; certifications; and maintain an active NPI and NCPDP Provider ID.
2. Provider must maintain at all times current and valid licensure as issued by the appropriate state agency(s) in which Provider operates to dispense medications and, where applicable, into which it ships medications. Additionally, Provider must meet all standards of operation as described in federal, state, and local laws. Any Pharmacy Services provided during a period where Provider does not possess all required active and valid licenses and/or permits under applicable Law shall be deemed to be invalid and subject to chargeback.
3. All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist or Dispensing Practitioner (as applicable and according to applicable Law) and in accordance with applicable Prescriber directions and applicable Law.
4. Provider must require and verify that all personnel employed by or contracted with Provider are licensed and qualified to perform their professional duties and that they act only within the scope of their licensure.
5. Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable federal, state, and local laws (including any local laws and regulations) in performing its Pharmacy Services under the Agreement including, but not limited to, the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395nn); Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Parts 160, 162, and 164; and the Controlled Substance Act (21 U.S.C. 801-971).
6. Provider must require and verify that Provider and all personnel employed by or contracted with Provider have not been excluded or debarred by any federal or state program. Provider must check the applicable state and federal exclusion lists upon initial hire/contract and on a monthly (or more frequent) basis thereafter to verify that no employees or contractors are on the list. Provider further agrees that any claim submitted to and paid by Caremark in violation of this section is subject to chargeback.
7. Provider must require and verify that any individual for whom there has been a restriction, suspension revocation, probation, or any other disciplinary action taken by a licensing or other oversight agency does not provide any Pharmacy Services to Caremark or its Eligible Persons. Provider agrees that any claim submitted to and paid by Caremark in violation of this section is subject to chargeback.
8. Provider must maintain, at its cost and expense, policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services or failure to perform Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate, unless otherwise agreed to by Caremark or such greater amount as required by Law.
    a. Provider must furnish copies of said policies upon enrolling as a Provider with Caremark and as requested by Caremark thereafter. Failure to maintain the minimum coverage may result in immediate termination.
    b. Provider must notify Caremark immediately in writing if its insurance is canceled, lapsed, or otherwise terminated. Failure to notify Caremark in writing of any such termination of insurance coverage may result in immediate termination.
    c. Provider must notify Caremark of any changes to the policy including, but not limited to, the location schedule.
9. Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

2.01.02 Complete the "Pharmacy Pre-Enrollment Questionnaire"

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

1. Access the "Pharmacy Pre-Enrollment Questionnaire" at **www.caremark.com/pharminfo** and select "Pharmacy Pre-Enrollment Questionnaire".
2. Supply the required information as outlined in the "Pharmacy Pre-Enrollment Questionnaire". It is important for all Providers to complete the form accurately and in its entirety as Caremark relies on this information in making enrollment determinations.
3. Submit the online questionnaire. Upon successful completion of the "Pharmacy Pre-Enrollment Questionnaire" and approval by Caremark, instructions for creating an online Pharmacy Portal account will be sent to the applicant which will include any fees, where permitted by applicable Law (refer to section **2.01.03 Create a Pharmacy Portal Account to Submit Enrollment Application**).

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

2.01.03 Create a Pharmacy Portal Account to Submit Enrollment Application

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

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

Fee payment is due and payable at the time of application submission.

1. To the extent permitted by applicable Law, Caremark charges non-refundable fees. The amount of such fees will be communicated to the pharmacy.
2. Payment must be submitted to Caremark in the form of a cashier's check or money order, made payable to "CVS Health" and mailed to the address below. Failure to submit payment, where applicable, within twenty-one (21) days of the date the enrollment application was initiated will result in the denial of the enrollment application and, if applicable, termination of the existing Provider Agreement.

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

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

2.01.04 Complete and Submit Your Application

Once the applicant submits the online enrollment application, the applicant will be notified in writing by Caremark if any required documentation or information is missing or incomplete. Caremark will reach out by email and telephone call to obtain missing items. Failure to provide all required enrollment information and documentation within twenty-one (21) days of the first outreach may result in the denial of the enrollment application and, if applicable, termination of the existing Provider Agreement. Caremark, where permitted by applicable Law, may charge a $75 fee per pharmacy location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application.

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

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

If Provider's pharmacy is located in or near a designated strike force location*, in addition to meeting requirements outlined in section **2.01.01 Review Credentialing Requirements**, Provider must:

1. Be open for business and actively operating as a pharmacy in accordance with applicable Law relating to the practice of the pharmacy at the time of application submission, site visit, and enrollment.
2. Agree to an unannounced site visit to inspect the pharmacy before enrollment.
3. Send fee; payment is due at the time of application submission. To the extent permitted by applicable Law, Caremark charges non-refundable fees. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. This fee is non-refundable and in no way guarantees the pharmacy's application will result in enrollment.

   Mail Cashier's checks or money order to:
   CVS Caremark
   ATTN: Provider Enrollment, MC 129
   9501 E. Shea Boulevard
   Scottsdale, AZ 85260

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

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

2.01.06 Additional Application Requirements for Dispensing Practitioners

In addition to meeting requirements outlined in section **2.01.01 Review Credentialing Requirements**, the Dispensing Practitioner must meet the minimum requirements below:

1. Dispense medications within the Dispensing Practitioner's scope of professional practice. The Dispensing Practitioner will comply with this requirement through computerized edits and purchase of appropriate Covered Items from licensed and authorized distributors/wholesalers/manufacturers.
2. Support Caremark audits. Audits may be conducted in the form of an on-site audit, investigational audit, or desktop audit and require access to the Dispensing Practitioner's records and documents, facility, and practices as Caremark reasonably determines are necessary to evaluate Dispensing Practitioner's compliance with the Provider Agreement and applicable Law. There are other compliance reviews that Caremark may conduct as described in chapter **7. Compliance Reviews** of the Provider Manual.
3. Send fee; payment is due at the time of application submission. To the extent permitted by applicable Law, Caremark charges non-refundable fees. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below.

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

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

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000949

2.02 Steps to Become a Complex Compound Provider

Providers are not authorized to submit claims for complex compounds without first obtaining written approval from Caremark and maintaining ongoing compliance with Caremark's requirements. In order to become an approved Provider to submit non-sterile complex compound claims to Caremark and dispense non-sterile complex compounds that are Covered Items to Eligible Persons, Provider must first be currently enrolled with Caremark (refer to section **2.01 Steps to Become a Provider** of the Provider Manual) and accurately complete, in its entirety, the Caremark Compound Application.

Providers wishing to submit claims for complex compounds must:

1. Contact Caremark at **CompoundApplicationTeam@CVSHealth.com**. In the body of the email, include the Provider's name, the corresponding NPI and NCPDP numbers, the contact name, the telephone number, and the request for a Caremark Compound Application.
2. Be an established non-sterile complex compound pharmacy able to provide a list of top ten compounds dispensed.
3. Offer a variety of dosage forms.
4. Be in good standing with Caremark.
5. Avoid relationships with any pharmacy staff (including the Pharmacist in-charge), officers, directors, owner(s), and other parties not currently in good standing with Caremark.

Steps to become a non-sterile complex compound Provider:

1. Complete the Caremark Compound Application and return with all applicable supporting documents to **CompoundApplicationTeam@CVSHealth.com**.
2. Send fee; payment is due at the time of application submission. Caremark, where permitted by applicable Law, charges non-refundable fees. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. The submission of an application and non-refundable fee in no way authorizes the Provider to submit complex compounds to Caremark or participate in a Caremark or Plan Sponsor network.

   Mail cashier's check or money order to:
   CVS Caremark
   ATTN: Provider Enrollment, MC 129
   9501 E. Shea Boulevard
   Scottsdale, AZ 85260
3. Wait for approval letter before submitting complex compound claims.

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

2.03 Plan Sponsor Networks

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

2.04 Re-Credentialing

Caremark will periodically re-credential Providers. When requested, Provider will be required to submit requested information/documentation to Caremark. Failure to supply the information/documentation in the requested manner and time period may result in suspension, probation, or termination. Caremark reserves the right to increase the transaction fee to a minimum fee of $0.99 per transaction transmitted for failure to provide the requested re-credentialing documentation until such time as the request is complete.

2.05 Notification to Caremark

2.05.01 Notification of Change in Documentation and Other Information

Unless otherwise specified, Provider must notify Caremark in writing within ten (10) business days of any change in Provider's credentials, documentation, and other information provided to Caremark in connection with its most recent enrollment as a Provider, or re-credentialing including, but not limited to, change in credentialing information (e.g., change in "Pharmacy Pre-Enrollment Questionnaire" information, change in enrollment application), name, contact information, services, hours of operation, or 24-hour status. Caremark has a requirement to maintain accurate directories of Providers so that Eligible Persons can quickly find in-network locations to fill their prescriptions. Therefore, as determined at Caremark's sole discretion, Provider's credentials may be updated without Provider's confirmation using alternative data sources.

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

Provider must send such notification to Caremark using one of the following options:

- Fax to **480-661-3054**
- Mail to:

  CVS Caremark
  Attn: Provider Enrollment, MC 129
  9501 E. Shea Boulevard
  Scottsdale, AZ 85260

- Submit an online "Pharmacy Change Form" located at **www.caremark.com/pharminfo**, select "Pharmacy Enrollment Self Service" and then select "Pharmacy Change Form".

2.05.02 Notification of Closure

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

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

2.06 Change in Ownership

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

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

The Buyer (defined as any successor in interest to an owner or operator) must notify Caremark in writing of a change in ownership or control, as defined above, no later than ten (10) business days of the change. Changes in pharmacy provider ownership are subject to Caremark's standard pre-enrollment credentialing review process and fee assessment (refer to section **2.01 Steps to Become a Provider** of the Provider Manual). In order to initiate the

change in ownership enrollment process, Provider may submit a "Pharmacy Pre-Enrollment Questionnaire" found at **www.caremark.com/pharminfo** and select "Pharmacy Pre-Enrollment Questionnaire", wherein the enroll type of "change of ownership" is selected. Upon successful submission of the "Pharmacy Pre-Enrollment Questionnaire", instructions for the creation of an online Pharmacy Portal account will be sent to applicant via email.

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

1. Where the Buyer has no existing relationship with Caremark:
   a. It must execute a new Provider Agreement and meet all of Caremark's credentialing requirements, including completion of the "Pharmacy Pre-Enrollment Questionnaire", in order to initiate the credentialing process for the acquired pharmacy or pharmacies. Refer to section **2.01 Steps to Become a Provider** of the Provider Manual.
   b. Caremark, in its sole discretion, may allow assignment of the Provider Agreement for the acquired pharmacy to the Buyer.
   c. A change of ownership is not effective until a decision is rendered by Caremark and communicated in writing by Caremark.
2. In the event that the Buyer has an ownership interest or operating rights in an existing Provider, Caremark may elect to:
   a. Apply in whole or in part the terms of the acquired pharmacy's Provider Agreement to the acquired pharmacy or pharmacies; or
   b. Apply in whole or in part the terms of the Buyer's Provider Agreement to the acquired pharmacy or pharmacies; or
   c. Require Buyer to complete credentialing and execute a new Provider Agreement for the acquired pharmacies.

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

Current Provider and potential new Provider shall inform Caremark in writing no later than ten (10) business days after the sale of any prescription files.

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

Mail change of ownership notification to:

CVS Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

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

2.07 Reporting of Investigations and Disciplinary Actions

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

1. Any of Provider's licenses or permits that are required under applicable Law for Provider to provide Pharmacy Services is, or is in jeopardy of being, suspended or revoked;
2. There are proceedings related to Pharmacy Services that may lead to an adverse action against Provider or affiliate of Provider, or any of their respective officers, directors, current/former employees, or owners (direct or indirect);
3. Any adverse action is taken against (a) Provider; (b) officer, director, current/former employee, owner (direct and indirect) of Provider or affiliate of Provider including, but not limited to, action taken by a Board of Pharmacy, Officer of Inspector General (OIG), System for Award Management (SAM), law enforcement, Drug Enforcement Administration (DEA), or other regulatory body;

4. There is a subpoena of records, issuance of a civil investigative demand letter, plea of no contest, or a filing of a civil lawsuit against a Provider related to Pharmacy Services or Provider's business practices;
5. There is a seizure by law enforcement of Provider's prescription records, computer systems, financial records, accounts, or real property;
6. Provider or affiliate of Provider, or any of their respective officers, directors, Pharmacists-in-Charge/responsible pharmacist, managing employees, employees, or owners (direct and indirect) enters into a settlement agreement, Corporate Integrity Agreement, or consent order with a governmental or regulatory agency relating to Pharmacy Services or Provider's business practices, even if there is no admission of liability; or
7. Provider is terminated from a third-party payer's (including a pharmacy benefit manager) network based on cause.

Provider must notify Caremark in writing to:

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

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

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

2.08 Criminal Offense Related to Federal Health Care Programs

2.08.01 Pharmacy Criminal Offense

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

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

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

2.08.02 Prescriber Criminal Offense

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

2.09 Federal Health Care Programs Participation Exclusion: Pharmacy

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

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

Provider hereby certifies that:

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

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

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

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

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

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

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

3. Pharmacy Services and Standards

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Pharmacies are an important part of Caremark's services and our goal to help people on their path to better health. Our Plan Sponsors, which include insurance companies, managed care organizations, third-party administrators, federal and state entities, employers, and union-sponsored benefit plans, entrust us with serving their diverse membership and we are committed to providing them with innovative and quality services and measures to control healthcare spending and improve health outcomes. Through our health services, plans, and community pharmacists, we are pioneering a bold new approach to total health, making quality care more affordable, accessible, simple and seamless, to not only help people get well, but help them stay well in body, mind and spirit.

3.01 Providing Pharmacy Services to Eligible Persons

3.01.01 Professional Judgment and Conduct

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

3.01.02 Verification of Eligible Persons

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

3.01.03 Identification Cards

In most cases, the identification card will be produced in the most current NCPDP format and will contain the Eligible Person's identification number, RXBIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information.

An identification card may show coverage for the Eligible Person only or it may show coverage for the Eligible Person and his or her dependents.

3.01.04 Nondiscrimination

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

3.01.05 Eligible Person Solicitation

Provider must not directly or indirectly obtain prescriptions for Eligible Persons via marketing activities including, but not limited to, (1) contacting Eligible Person or Prescriber without a previously existing relationship; (2) obtaining an Eligible Person's primary care provider or billing information through unsolicited methods; and/or (3) contacting or offering to contact a Prescriber on an Eligible Person's behalf without the Eligible Person's express knowledge and authorization for each specific claim. Provider shall not obtain a prescription from a Prescriber not expressly requested by the Eligible Person or by suggesting to an Eligible Person that his or her Prescriber or health plan wants the Eligible Person to receive the medication without the prescriber's express knowledge and authorization. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives including, but not limited to, adherence initiatives, gaps-in-care management, or comprehensive medication reviews with Eligible Persons.

3.01.06 Eligible Person Complaints

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

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

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

3.01.07 Patient Receipts and Insurance Profiles

Provider may print Usual and Customary (U&C) and Patient Pay Amount on receipts and insurance profiles provided to an Eligible Person. Provider reimbursement pricing information and prices paid to Provider for individual claims under this Provider Agreement are Confidential Caremark Information and may not be disclosed on patient receipts or insurance profiles, subject to applicable Law. Refer to section **14.03 Confidentiality** of the Provider Manual.

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

3.01.08 Educational Materials and Efforts

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

Caremark may educate Provider about products, programs, and services as well as distribute Plan Sponsor announcements. Educational materials may be distributed through various means, including e-mail, fax, mail, or posted on one of the Caremark websites or the Caremark Pharmacy Portal. Refer to sections **1.06 Pharmacy Communications** and **1.07 Caremark Pharmacy Portal** of the Provider Manual.

3.02 Dispensing Requirements

3.02.01 Hours of Operation

Provider must maintain hours of operation that meet the needs of the community, but in all circumstances in accordance with applicable Law. Provider must communicate those hours of operation to Caremark upon enrollment and upon any changes. Provider must be reasonably reachable by telephone or fax during Provider's hours of operation (except as described in section **15.10 Force Majeure** of the Provider Manual).

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

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

3.02.02 Drug Stock and Inventory

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

3.02.03 Aberrant Practices and Trends

Caremark has implemented programs to address aberrant Provider practices or trends in Caremark retail networks. Providers participating in a Caremark network(s) must not engage in aberrant practices or trends including, but not limited to:

1. Dispensing:
   a. aberrant quantities of a Covered Item and/or disparate volume of claims within a therapeutic category (e.g., topicals, dermatologicals), as measured by number of claims, quantity dispensed and/or dollars;
   b. limited medications and/or therapeutic categories (e.g., topicals products, diabetic test products, skin care products, etc.);
   c. drug products inconsistent with the habits of local Prescribers or Plan Sponsor formularies, at Caremark's sole determination.

2. Demonstrating purchasing practices (e.g., higher cost drug products) that are not in keeping with the aligned goal of safeguarding both the health and financial welfare of Eligible Persons and Plan Sponsors.
3. Disregarding Eligible Persons' private and confidential identification information by using or misusing member data for Provider's own use (e.g., submitting test claims with no subsequent paid claims – also known as "negative" claims) and/or without Prescriber prescription authorization.
4. Participating in actions, programs and/or business models that result in the selection and dispensing of drug products that increase the amount billed to Plan Sponsors for Covered Items to Eligible Persons.
5. Engaging in practices that focus on Provider's welfare rather than best practices of providing clinical, cost-effective solutions for Eligible Persons and Plan Sponsors.

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

3.02.04 Dispensing Covered Items to Eligible Person's Agent

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

3.02.05 Performance Initiatives

Provider must support all Caremark performance initiatives such as, but not limited to, performance network programs (which may include adherence and drug therapy gap alerts), retrospective safety review alerts, formularies, Prior Authorization programs, Managed Drug Limitations programs, generic incentive programs, Dose Optimization programs, Step Therapy programs (refer to chapter **5. Clinical Programs, Services and Related Messages** of the Provider Manual for a further description of these initiatives) and any criteria in such performance initiatives.

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

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

3.02.06 Dispensing Errors

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

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

3.03 Patient Pay

3.03.01 Collection of Patient Pay Amounts

Patient Pay Amounts (e.g. Copayments, Coinsurance, etc.) is an extremely important tool to help align the needs of Plan Participants with those of the Plan Sponsor. The disclosure of the Patient Pay Amount to the patient is an important step in the adjudication and dispensing process of a Covered Item as it can assist with ensuring the necessity of a specific medication. The patient, or Eligible Person, may choose to find a more cost-effective alternative that is therapeutically equivalent, resulting in cost savings for the Plan Sponsor while maintaining quality patient care. Provider must disclose to each Eligible Person the Patient Pay Amount prior to dispensing the prescription so the Eligible Person has the opportunity to make an informed decision. Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system and in accordance with section **4.05 U&C Validation** of the Provider Manual. Provider must keep evidence of the collection of Patient Pay Amount for review.

Provider has the right to provide an Eligible Person with information about the cost of his or her medication including lower-cost alternatives to assist the Eligible Person in finding affordable, clinically appropriate, alternative medications.

All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.

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

3.03.02 Usual and Customary Price

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

3.03.03 Coupons and Other Programs

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

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

1. Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:
   a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program; or
   b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location; or
   c. The Covered Item is not a compounded drug, 510(k) cleared medical device, or Medical Food.
2. In addition, only certain Covered Items may have Pharmaceutical Manufacturer Coupons applied to reduce the amount the Eligible Person is required to pay. The following categories of Covered Items are the only ones where a coupon may be used.
   a. The Covered Item is approved by the U.S. Food and Drug Administration (FDA) through a New Drug Application (NDA) or Abbreviated New Drug Application (ANDA), and is published in the Approved Drug Products with Therapeutic Equivalence Evaluations (or commonly known as the "Orange Book"); or
   b. The Covered Item has a Biologics License Application (BLA), including drugs classified as biosimilars approved under section 351(k) of the Public Health Service Act, and is published in the Lists of Licensed Biological Products (or commonly referred to as the "Purple Book"); or
   c. The Covered Item is an Over-the-Counter (OTC) Covered Item marketed under an official final OTC monograph; or
   d. The Covered Item is a grandfathered drug marketed pre-1938 or pre-1962, or is otherwise Generally Recognized as Safe and Effective (GRASE) by the FDA.

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

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

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

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

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

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

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

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

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

3.03.04 Proof of Payment

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

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

If the Patient Pay Amount is reduced due to a coordination of benefits (COB), Provider must provide evidence of the COB claim payment by other payer(s), which shall be subject to Caremark audit and/or compliance review.

3.03.05 Excess Collections

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

3.03.06 Limitation on Collection

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

3.03.07 Patient Inducements

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

3.03.08 Waivers

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

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

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

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

3.03.09 Financial Hardship Program

Waivers based on an individualized determination of financial need under a Financial Hardship Program must meet the following requirements.

1. The terms of the Financial Hardship Program must be set forth in a formal written policy adopted by Provider. The policy must specify the documentation required to establish financial need, the criteria for determining eligibility for financial hardship relief and the level of relief to be provided, the application review and approval process, and recordkeeping requirements.
2. Eligible Persons seeking relief under the Financial Hardship Program must submit an application and provide reasonable and objective documentation of financial need that includes federal tax returns and other appropriate documentation.
3. The criteria for determining eligibility for financial hardship relief and the level of relief to be provided must be reasonable.
4. Written notice of qualification for financial relief under the Financial Hardship Program must be provided in writing to the Eligible Person. This notice must specify the amount or portion of the Patient Pay Amount that is being waived and the period of the waiver.
5. Eligibility for continued financial relief under the Financial Hardship Program must be reviewed on at least an annual basis. This review shall be based on an updated application and updated supporting documentation provided by the Eligible Person.
6. Records must be maintained for each Eligible Person receiving financial hardship relief under the Financial Hardship Program. The records must include, at a minimum, the application and supporting documentation submitted by the Eligible Person and a copy of the notice of qualification sent to the Eligible Person.
7. Provider personnel providing final financial hardship approval must be employed by Provider and shall not be contractors or agents of Provider. The identity of the personnel granting approval must be documented and provided as requested by Caremark.
8. The Financial Hardship Program may not be advertised or promoted.
9. The Financial Hardship Program may not be funded, in whole or in part, by any third party.
10. The Financial Hardship Program must meet all requirements and restrictions of applicable Law.

3.03.10 Documentation

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

3.03.11 Violations

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

3.04 Standards of Operation

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

Not considered "Retail Pharmacies":

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

1. Whose number of claims submitted to Caremark for prescriptions that were delivered to Eligible Persons (including common carriers such as USPS, FedEx, UPS or other delivery service) exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. Caremark further reserves the right to charge back any improper or excessive payments made to Provider based upon its misrepresentation as a Retail Pharmacy.
2. Whose number of claims submitted to Caremark for specialty drugs exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy.
3. Who is owned by a 340B covered entity or whose volume of claims filled using 340B Drug Pricing Program acquired or replenished drugs is the basis for any pharmaceutical manufacturer denying pharmaceutical rebates for claims submitted by Provider, is not considered a Retail Pharmacy. All Providers must maintain their NCPDP online provider ID profile services question on 340B (i.e., "Physical Location 340B Status") so that it is accurate and up to date.

If Provider has misrepresented itself as a Retail Pharmacy and/or modifies its operations such that it no longer meets the definition of a Retail Pharmacy, in addition to all other rights and remedies, Caremark reserves the right to exclude Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or to apply unique terms and conditions to such Provider's participation in any retail network(s) in which the Provider is participating or any new retail network(s) established, for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing. Any Provider that is not considered a "Retail Pharmacy" as described above, may be subject to other reimbursement, terms and conditions relevant to its non-standard retail pharmacy model.

Providers are not allowed to engage in marketing activities to Eligible Persons or Prescribers of Eligible Persons for the purpose of gaining dispensing opportunities that limit the Eligible Persons' right to use their participating retail pharmacy of choice including, but not limited to, business models that engage in internet, third-party marketing, telehealth, texting and/or hub-type of activities, without Eligible Persons' knowledge and/or understanding that their pharmacy choices are not restricted to the non-standard retail pharmacy business model.

3.04.01 Other Standards of Operations

1. Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.
2. Provider must furnish Pharmacy Services to Eligible Persons consistent with the requirements of all Caremark Documents. Shipping Covered Items by mail or other common carrier as a routine business practice in excess of the percentage allowed by Caremark without the express written permission of Caremark is a violation of the terms of the Provider Agreement. Payment for claims involving unauthorized mail or other common carrier is subject to chargeback.
3. Providers who utilize an internet site as a routine business practice in the provision of Pharmacy Services (except for refill requests) must maintain Verified Internet Pharmacy Practice Sites (VIPPS) certification through the National Association of Boards of Pharmacy (NABP), but must also otherwise comply with the terms of this subsection.
4. Provider must maintain a process to identify and detect prescriptions prescribed or claims for items or services furnished by an excluded or debarred Prescriber and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment.
5. No third-party consultant is permitted to represent Provider nor will Caremark communicate with a third-party consultant unless written consent is provided by Caremark. Provider must provide written documentation describing the business relationship with the third-party consultant upon request.

3.05 Records

3.05.01 Documents and Records Maintenance

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

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

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

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

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

3.05.02 Signature Log – Hard Copy or Electronic

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

1. Contains a signature which can be individualized or directly related to each prescription dispensed (e.g. prescription number)
   a. For each claim adjudicated through the claims adjudication system, Provider must obtain the signature of the Eligible Person (or his or her authorized representative) on a dated third-party signature log to confirm that he or she has received the medication recorded.
   b. Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.
2. Maintains the date of the receipt of Covered Item by the Eligible Person
3. Maintains a disclosure to Eligible Person of insurance billing
4. Retrievable for the purposes of audit

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

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

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

3.05.03 Prescription Information

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

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

Documentation for a vaccine claim transaction, which includes vaccine administration, must be maintained on the prescription hard copy or electronic prescription record, or in the form of a vaccination administration record (when the administration was included within the claim transaction). Documentation must include:

- Detail regarding the administration (e.g., lot number, expiration)
- Date of the administration
- Name and NPI of Provider directly responsible for administration of the vaccine (if the Provider does not have an NPI, provide the NPI of the pharmacy)
- NPI of the Prescriber of the vaccine, following applicable state and federal Law (this may be the same as the Provider administering the vaccine where applicable Law allows)
- Acknowledgement that confirms the Eligible Person received both the medication and the administration

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy, electronic prescription record, or Provider systems where it can be readily retrievable. In the case of a long-term care pharmacy's standing medication order, Provider must maintain written record of the prescriber's review and continuation of the standing order within one (1) year prior to the fill date, or such shorter period as required by applicable Law.

During an audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, Caremark recommends that Provider document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the Caremark auditor or help to resolve an audit discrepancy.

3.06 Referrals

3.06.01 Referral Fees

Provider shall not offer or pay to any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback, or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referrals of patients or other individuals to Provider for the provision of any pharmacy or other healthcare service.

Provider shall not solicit or receive from any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback, or other consideration, whether in the form of money or otherwise, as compensation or inducement for Provider's referral of patients or other individuals for the provision of any pharmacy or other healthcare service.

3.06.02 Referrals to Non-Retail Participating Providers

Provider must refer Eligible Persons to mail order, specialty, and/or other specified pharmacies for certain Pharmacy Services as appropriate for his or her plan benefit design and in compliance with applicable Law.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000963

4. Claims Submission

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Notwithstanding anything to the contrary in the Agreement, by participating in a Caremark network Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Agreement unless professional judgment dictates otherwise. Provider agrees that any violation of this chapter is subject to audit chargeback, non-compliance fees, and/or possible termination as a Provider.

A paid claim as indicated through the claims adjudication system is not an indication by Caremark of Provider's compliance with the Agreement.

4.01 Payer Sheets and Reject Codes

The Caremark Payer Specification Sheets and NCPDP Version D.Ø Payer Sheets can be found at **www.caremark.com/pharminfo**. Please carefully review the appropriate Payer Sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

Caremark utilizes NCPDP reject codes. A list of reject codes can be found at **www.caremark.com/pharminfo**. Providers can also refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online. In addition, Providers can contact their software vendor to learn more about submission reject codes.

4.02 General Claim Submission Policies

The following are general Provider claim submission policies that are applicable to all claim submissions:

1. Each claim constitutes a representation by Provider to Caremark that the Pharmacy Services were provided to the Eligible Person and that the information transmitted is correct and complete. Submission of incomplete, false, or fraudulent claims is a willful misrepresentation and intentional misconduct by Provider.
2. Unless required by Law or regulation, Provider must not submit claims to any other administrator when documentation confirms Eligible Person's eligibility with Caremark.
3. Unless otherwise permitted by applicable Law, each claim submitted must result from a prescription for a Covered Item that was written by a Prescriber and for which Pharmacy Services for a Covered Item were provided to the Eligible Person for whom the prescription was written.
4. If Provider knows or reasonably should know that a prescription did not result from a legitimate Prescriber/patient relationship, Provider must verify the Prescriber/patient relationship prior to dispensing a Covered Item and maintain a record of such verification.
5. Provider must only submit claims to Caremark for Covered Items requested by an Eligible Person. When providing a Covered Item to an Eligible Person through any means other than the in-person receipt of the Covered Item by the Eligible Person or Eligible Person's designee on Provider's premises, Provider must receive and document Eligible Person's request prior to submitting each claim for (a) a Covered Item pursuant to a new prescription received by Provider from a party other than the Eligible Person and (b) a Covered Item pursuant to an available refill of an existing prescription.
6. Provider must submit all claims for a Covered Item for Pharmacy Services via the Caremark adjudication system to ensure that plan design, quality, and professional practice standards are met and that safety and drug utilization review (DUR) are applied.
7. All claims must be submitted online using a current HIPAA-named version of the NCPDP Telecommunication Standard and in compliance with the Provider Agreement, the Payer Sheets, the Provider Manual, and all applicable Laws, rules, and regulations. Caremark may require additional information to process a claim.
8. Provider must not take any steps to circumvent plan design or claims edits. Provider must not modify any claim data fields (e.g., reduce quantities or increase days supply) to bypass plan edits or Provider Agreement requirements; and Provider must not use an SCC value to inappropriately override a reject.
9. Provider must display all NCPDP messaging to the dispensing pharmacist. It is imperative that Provider review the claim response in its entirety, including primary and secondary messages. This may require viewing additional screens.
10. Any changes to a prescription including, but not limited to, the Covered Item being prescribed or directions for use, must be approved by the Prescriber prior to dispensing. Provider must date and document the Prescriber approval on the prescription hard copy or electronic prescription record.

11. To protect the health and safety of the Eligible Person, Provider must review and act upon DUR messages received from Caremark. As well as reviewing and acting upon Caremark's DUR messages, Provider must perform an internal DUR on each claim to monitor for safety concerns such as drug-to-drug interactions and drug allergy monitoring. Refer to chapter **5. Clinical Programs, Services and Related Messages** of the Provider Manual.
12. Providers must inform Eligible Persons about the proper storage, dosing, utilization, side effects, potential interactions, and use of the medication dispensed within professional practice guidelines.
13. Provider must submit the precise eleven (11) digit Product Identifier for the Covered Item dispensed as defined by the NCPDP Product Identifiers Standard. Claim submissions utilizing a Product Identifier other than the Product Identifier of the Covered Item dispensed are subject to audit review and chargeback and are not eligible for reimbursement.

4.03 Other Claim Submission Requirements

1. **Quantity Dispensed and Days Supply:** Provider must submit the accurate days supply and quantity on all claims prior to dispensing.
   a. Provider must submit only the quantity indicated on the prescription. Provider must enter the exact metric decimal quantity dispensed (no rounding) on all claim transactions. Provider must submit the quantity based on product description (e.g., kit, volume of medication in milliliters, weight in grams, eaches, number of capsules/tablets). If the quantity is uncertain, Provider must contact the Prescriber to determine the appropriate amount to dispense and notate on the prescription hard copy or electronic prescription record.
   b. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
   c. Provider must not adjust the quantity dispensed to circumvent adjudication edits, reimbursement structure, prior authorization edits, clinical program or benefit design edits based on day supply.
   d. If the Prescriber indicates ambiguous direction such as "use as directed" or "as needed," (e.g., a drug that may be administered on a sliding scale such as insulin or a topically applied drug), the Provider must obtain the dosing schedule, dosing range, area of application, frequency, and any other information necessary or applicable to determine the days supply for the quantity dispensed. For example, with topical products, the FTU (fingertip-unit) chart is a common reference used to estimate the amount of topical product required based on the area of coverage.
   e. Directions and/or area of application may be obtained from either the Eligible Person or the Prescriber and must be notated on the prescription hard copy or electronic prescription record.
   f. Provider must not combine Prescriber authorized refills.
   g. Provider must consider product expiration and manufacturer storage recommendations when calculating days supply for claim transmission.
2. **Strength Dispensed:** The strength of the medication identified on the claim must be an accurate reflection of that which was prescribed or documentation of the unavailability of the prescribed strength will be required. Provider must utilize the strength originally prescribed by the Prescriber or use an available higher strength single dose of the same medication as described in section **5.08 Dose Optimization** of the Provider Manual. Provider must not utilize a lesser strength in an increased quantity without documentation of unavailability of the prescribed strength.
3. **Plan Limitations Exceeded:** Claims submitted to Caremark that exceed Plan limits for the days supply or quantity dispensed will reject with the message, "Plan Limitations Exceeded". The reject message includes the actual limits such as, "Maximum Days Supply = 34" or "Quantity Limit = 100". Any claims resubmitted must be entered with the accurate quantity and days supply; however, if the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-day supply), and rejects as stated, it is allowable for Provider to resubmit the claim utilizing that quantity and the maximum days supply as provided in the reject messaging. Provider maintains responsibility to adhere to appropriate refill intervals based on the quantity dispensed and actual days supply (based on the prescribed dosing schedule). The Pharmacy Help Desk is available for Provider to request a Plan Limitation Exceeded override; if approved, based on Plan Sponsor parameters, Provider must resubmit the claim with accurate approved quantity and days supply. Provider must document the details of the override granted by the Pharmacy Help Desk on the prescription hard copy. For additional information regarding Medicare Part D Claims, refer to chapter **10. Medicare Part D** of the Provider Manual.
4. **Ingredient Cost and Package Size:** Provider is obligated to submit claims using the lowest ingredient cost dosage form and the lowest cost package size container available that results in the lowest reimbursement.
5. **Ophthalmic Products:** Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. A chart to assist in calculating the appropriate days supply for a claim is provided in **Appendix A – Drug Submission Requirements** of the Provider Manual.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000965

6. **Drugs with Unusual Submission Requirements**: Claims for some drug products frequently result in incorrect reimbursement. To avoid audit chargebacks, refer to the examples in **Appendix A – Drug Submission Requirements** of the Provider Manual.
7. **Repackaging**: Claims for repackaged, relabeled NDCs submitted to Caremark that result in higher reimbursement than claims for non-repackaged, relabeled NDCs may be subject to recoupment.
8. **Non-Covered Items**: Claims submitted to Caremark in accordance with a Plan Sponsor program to allow limited dispensing of a non-covered item (e.g., 3-day supply approved for a drug on prior authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable day supply.
9. **Federal Health Care Programs Prescriber Participation Exclusion**: Provider must not submit any claim to Caremark for a prescription prescribed or item or service furnished by a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other Federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions and claims for items or services furnished by an excluded or debarred Prescriber and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.
10. **Auto-Ship Refill Programs**: Claims submitted for auto-refill programs must only be for medications used in a maintenance therapy. Refer to section **10.04.05 Auto-Ship Refill Programs** of the Provider Manual.
11. **Fill Date**: The fill date is the date on which the Covered Item is prepared and readied for dispensing to the Eligible Person or, in the case of vaccine administration or other professional service, the date the service was administered/performed. Each prescription claim transmitted must indicate the fill date in the Date of Service field. Billing of claims must not be pre-dated or post-dated. The fill date may also be the date a subsequent payer began coverage following Part A expiration in a long-term care setting only.
12. **Prescription Not Received; Reversal of Claim**: All Covered Items must be received by the Eligible Person within seven (7) days of the fill date and Provider is solely responsible for ensuring a Covered Item is received by Eligible Person in a manner that meets or exceeds requirements of Law. Covered Items not received by an Eligible Person must be reversed by Provider within fourteen (14) days from the fill date through the claims adjudication system. Provider must ensure that an accepted reversal response is received from the claims adjudication system for each claim where the Covered Item was not received by the Eligible Person in accordance with this section. Upon discovery of a Covered Item not received by an Eligible Person in accordance with this section, Caremark in its sole discretion may reverse the claim. Refer to section **4.16 Electronic Submission, Reversal, and Processing Windows** of the Provider Manual.
13. **Pre-Printed Prescriptions**: Provider must not use pre-printed prescriptions that result in the dispensing of Covered Items that are not the most cost-effective even if they are different salts, bases, release characteristics, or additional drugs in combination.
14. **Test Claims**: Unless otherwise authorized in writing by Caremark, Provider must not submit test claims when a prescription order does not exist (e.g., to determine reimbursement rates). Provider must also not submit test claims acting as a hub service provider unless given written consent by Caremark.
15. **Vaccine and Non-Vaccine Injectable Administration**: When administering vaccines or non-vaccine injectables, submit 'MA' (for Medication Administration) in the Professional Service Code field (440-E5) of the DUR/PPS Segment along with a positive incentive fee amount in the Incentive Amount Submitted field (438-E3) of the Pricing Segment. Provider's submitted U&C must include the charge to administer the vaccine.
16. **No-Cost Vaccines**: When submitting a claim for a vaccine acquired by the Provider at no cost Provider must submit $0.00 as the Ingredient Cost Submitted (NCPDP field 409-D9) and a value of "15" in the Basis of Cost Determination (NCPDP field 423-DN), unless otherwise communicated by Caremark. Provider's U&C must not include a charge for the vaccine but may include a charge to administer the vaccine.
17. **Durable Medical Equipment (DME)**: Provider must only submit DME claims that are payable under the Plan Sponsor's pharmacy benefit. Provider must submit a valid Product Identifier for the DME. If no Product Identifier exists for a DME Provider must not submit a claim.

4.04 Dispense as Written Codes

Provider must dispense a generic drug whenever permitted and in accordance with applicable Law. Provider must use its best efforts to carry out Caremark and Plan Sponsor mandatory generic programs. In doing so, Provider must contact the Prescriber to encourage a change to a generic substitute when the prescription contains a "dispense as written" signature for a multi-source brand medication.

To ensure proper payment to Provider and the correct Patient Pay Amount of Eligible Persons, Provider must submit all claims with the accurate Dispense as Written (DAW) code, unless otherwise specifically directed by Caremark. Provider must select from the following codes:

DAW 0—No Product Selection Indicated

- Use DAW 0 when dispensing a generic; that is, when no party (e.g., neither Prescriber, pharmacist, nor Eligible Person) requests the branded version of a multi-source product.
- Use DAW 0 when dispensing a single-source brand product.
- Generic pricing may be applied to claims for multi-source products submitted with DAW 0.

DAW 1—Physician Requested Product Dispensed As Written

- Use DAW 1 only when the Prescriber specifies the branded version of a multi-source product on the prescription hard copy or in the verbally communicated instructions (must be evidenced on the prescription hard copy – original and updated); this documentation must occur prior to Pharmacy Services being rendered.
- Computer systems that default to DAW 1 may result in discrepancies and chargebacks.
- Prescription must follow state substitution laws.

DAW 2—Substitution Allowed—Patient Requested Product Dispensed

- Use DAW 2 when the Eligible Person requests the branded version of a multi-source product even though a generic is available and the Prescriber has authorized (or not prohibited) a generic, or when the Eligible Person requests that Provider contact the Prescriber to obtain approval for a branded version when neither the original prescription nor the verbally communicated instructions specified the branded version.

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed

- Use DAW 3 when the Prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed.

DAW 4—Substitution Allowed—Generic Not In Stock

- Use DAW 4 when the Prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy.

DAW 5—Substitution Allowed—Brand Dispensed As Generic, Priced As Generic

- Use DAW 5 when dispensing a branded version of a multi-source product as a generic.

DAW 6—This Value Is Used As Communicated By Caremark

DAW 7—Substitution Not Allowed—Brand Mandated By Law

- Use DAW 7 when prevailing law prohibit generic substitution for a brand product even though generic versions of the product may be available in the marketplace.

DAW 8—Substitution Allowed—Generic Not Available

- Use DAW 8 when generic substitution is permitted and the brand product is dispensed because the generic is not currently manufactured, distributed, or is unavailable in the marketplace.

DAW 9—Substitution Allowed By Prescriber But Plan Requests Brand

- Use DAW 9 when the Prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the Plan Sponsor's formulary requests the brand product.

4.05 U&C Validation

Provider is required to submit accurate U&C Prices for all Caremark claims, including U&C Prices which are part of a standard set price generic program offered by Provider (i.e., program that is open and requires no enrollment). Upon request, Provider must submit a record of each transaction involving a cash paying customer where, on the same fill date, an identical drug or device was also dispensed to an Eligible Person. Provider may redact confidential patient health information from the record in accordance with applicable Law, but the record must contain the patient charge amount. Caremark has the right to review and audit documentation and records as detailed in this section to validate that Provider's submitted U&C is in accordance with the Agreement.

Provider must not modify its U&C, "gross amount due" (as defined by current NCPDP standards), or ingredient cost claimed on individual claims to bypass plan edits or Provider Agreement requirements.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000967

4.06 Over-the-Counter Products

Caremark requires a prescription for Over-the-Counter (OTC) products submitted for reimbursement, except in OTC programs as stated below, and Provider must label and dispense the OTC product in accordance with the prescription and applicable Law. All OTC Covered Items dispensed pursuant to a prescription that are provided to an Eligible Person as prescribed by a Prescriber must be labeled for the Eligible Person. The requirements in chapters **7. Compliance Reviews, 8. Professional Audits** and section **4.13 Prescriber Identification; Prescriptive Authority** of the Provider Manual are applicable to all OTC claims.

Some Plan Sponsors elect to offer a program where Covered Items include certain OTC products to be dispensed without a prescription. These programs may incorporate a monthly or quarterly maximum; in which case, in the event Eligible Persons reach the allowed maximum amount covered by the Plan, per time period, Eligible Persons are responsible for any amount over the allowed maximum including cusp claims and claims submitted after the allowed maximum is exhausted for that time period.

Upon notification of approval from Caremark, Provider may submit claims for Plan Sponsor OTC programs that do not require a prescription and do not require labeling of the Covered Item by Provider. Provider, however, must maintain a computer-generated label for the OTC product for Caremark's audit purposes. Unless otherwise specified by Caremark, Provider may submit Provider's NPI as the Prescriber identification for these Plan Sponsor programs for OTC products which, by Law, do not require a prescription.

4.07 Multi-Ingredient Compound Processing

The following are submission policies for multi-ingredient compound processing.

1. All compounds must be submitted online in accordance with the most current Caremark payer sheets, which can be found online at **www.caremark.com/pharminfo**.
2. Provider must submit the accurate dosage form of the final compounded product dispensed in the compound dosage form description code field in the compound segment (must be a valid NCPDP compound segment dosage form value).
3. Enter the total quantity of the final product dispensed in the quantity dispensed field in the claim segment.
4. Enter the calculated cost of the complete compound as the ingredient cost submitted. This calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the Level of Effort (LOE). Caremark, in its sole discretion, will have final determination of professional allowance attributed to claim above the cost.
5. Calculated cost shall not include cost of drug product associated with waste. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
6. Enter the actual Product/Service ID (e.g., NDC or UPC) of each active and inactive item used in the preparation of the compound in the compound segment, including any consumable item (e.g., capsule). Each applicable Product/Service ID must be entered accurately. Incorrect submission of any single or multiple ingredient(s) may result in chargeback of the entire claim.
7. Submit the actual Product/Service ID (e.g., NDC or UPC) of each Covered/non-Covered Item. For any items in the compound, such items are only reimbursable if Provider provides, upon Caremark's request, evidence that each of the active and inactive items in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to chargeback.
8. For compounds that require a delivery device as a component of the final medication product, the device must be submitted as an item in the compound only when the device has a Product/Service ID (e.g., NDC or UPC) and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.
9. When required, submit the accurate Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) value for the final compounded product in the route of administration field in the claim segment.
10. Enter the LOE in the DUR/PPS Segment. The LOE must reflect the compound types which are referenced in **Figure 1 – Level of Effort Table**, unless otherwise communicated by Caremark. Provider must not program one code for all compounds.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000968

Figure 1 – Level of Effort Table

DUR/PPS (Field 474-8E) Level of Effort	Compound Type
11	Single ingredient capsule Any combination of commercially available products
12	Two ingredient capsule/suppository Transdermal gel
13	Three or less ingredient cream/ointment/gel* Three ingredient capsule/suppository* Two or less ingredient troche* Non-complex suspension Tablet triturate*
14	Topical containing controlled substance Three or more ingredient troche* Four or more ingredient cream/ointment/gel* Four or more ingredient capsule/suppository* Complex suspensions (e.g., pediatric/altering PH/base to salt conversion) Chemotherapy cream/ointment/gel* Hormone therapy (capsules/troches/suppositories)
15	Sterile products - limited to aqueous bronchial and nasal inhalations (does not include nasal sprays or irrigations), injections, irrigations for wounds, and ophthalmic drops and ointments per USP <797>

*Using bulk (powder) APIs

11. Coverage determination is performed on each and every item in the compound.
12. Provider may receive a rejected response for a compound claim when item(s) within the compound are not reimbursable; Caremark accepts Submission Clarification Code (SCC) "08" (Process Compound for Approved Ingredients) which will result in an adjudicated response on all Covered Items.
13. Non-Covered Item(s) within a compound are not reimbursable.
14. Compounds may be a Covered Part D Drug for Medicare Part D Enrollees provided the compound contains at least one Covered Part D Drug. The item cost must only include components which satisfy the definition of a Covered Part D Drug as defined in 42 C.F.R. § 423.100. Components that are not Covered Part D Drugs as defined by the Centers for Medicare and Medicaid Services (CMS) may be included in the creation of the product, but may not be included in the calculation of the item cost submitted (e.g., sterile water, compounding bulk powders, vitamins, components not utilized for a diagnosis recognized in the compendia). Provider must, however, include all items used in the creation of the compounded product on the multi-ingredient claim transmission.
15. If compounded claims reject for pricing edits (e.g., exceeds maximum cost for the Plan), Provider must not alter the quantity or identity of the individual components submitted to inappropriately enable reimbursement. Provider must not alter the quantity of, or omit an item dispensed, to circumvent Caremark's reimbursement structure, such as providing only 83 days of a 90-day supply prescription or dispensing monthly but billing weekly.
16. Provider must not manipulate claims pricing or the compound indicator for inappropriate financial gain or cause a claim to inappropriately pay.
17. The Caremark adjudicated claim response indicates the total payment for the compound claim. Provider must not balance bill an Eligible Person if prohibited by applicable Law.
18. When a compounded product is dispensed to an Eligible Person, Provider must bill Caremark a single claim for the final compounded product using multi-ingredient functionality (including all active and inactive items used in the creation of the compounded product) and must not bill separate claims to Caremark for individual items or ingredients used in the creation of the compounded product. In an effort to protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.

19. Compounds that have a commercially available product are not reimbursable.
    a. In the event a commercially available product becomes unavailable (e.g., product is on backorder, drug shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
    b. If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount.
20. Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.
21. Compounding must be performed by a qualified person as defined by applicable Law.
22. Outsourcing any portion of Pharmacy Services for compounded medications not approved in advance and in writing by Caremark is prohibited.
23. Refer to section **7.02 Additional Information Regarding Compliance Reviews** of the Provider Manual for documentation requirements.

The following must not be billed as a multi-ingredient compound:

1. A combination of products which are not combined to make one final medication for use (e.g., a kit of individual products designed to be used independently)
2. A combination of Covered Items which do not have a medical purpose in combination other than convenient dosage form
3. Any product that contains an item or substance that is classified as a dietary supplement as defined by the Dietary Supplement Health and Education Act (DSHEA) of 1994
4. A commercially available compound kit or commercially available product which is represented by a unique assigned NDC and contains all the items of the final product as such (e.g., kit containing a base and active items and directives for mixture)
5. Compounds dispensed for human consumption or application which include items that are not approved for human use
6. Medications requiring reconstitution prior to dispensing (e.g., powdered oral antibiotics, topical acne preparations, injectable medications)
7. Flavoring of a commercially available product prior to dispensing (e.g., addition of flavor to powdered oral antibiotics), nor should the item cost submitted include flavoring cost
8. Covered Items that are in a ready-to-use form that are transferred from one container to another for use (e.g., pre-filling insulin syringes, transferring multiple bottles into a single IV bag)
9. Any compound that contains a drug product that has been withdrawn or removed from the market because the drug product or components of the drug product have been found to be unsafe or not effective as defined in section 21 C.F.R. § 216.24 of the Code of Federal Regulations

4.08 Overrides

Caremark has developed general prior authorization numbers for some Plan Sponsors for claims that reject. A Pharmacy Help Desk representative can provide information if the Plan Sponsor allows for an override to allow the claim to adjudicate. In addition, some Medicaid Plan Sponsors provide temporary coverage of non-formulary medications. If this is the case, the claim may reject with a message that includes the temporary days supply that will be covered and the Prior Authorization/Medical Certification (PA/MC) code to enter into the NCPDP prior authorization number field in order for the claim to adjudicate. Provider must calculate the appropriate quantity for a Covered Item accordingly to correspond with prescription instructions and temporary days supply. Provider must maintain documentation to substantiate any overrides applied to a claim.

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual for contact information.

4.09 Natural Disasters

Caremark is dedicated to assisting Providers and Eligible Persons in response to emergencies resulting from natural disasters, severe weather, government declared states of emergency, etc. where medical records are either destroyed or not accessible. In the event of an applicable federal or state executive (or other appropriate federal or state governmental agency's) emergency declaration, Caremark, consistent with the scope of the declaration, may allow a specific submission clarification code to override the refill-too-soon edit for Eligible Persons impacted within the disaster area, e.g., a value of "13" in the Submission Clarification Code (SCC) field, 420-DK, and the

displaced Eligible Person's impacted ZIP code (do not enter the ZIP code in which the Eligible Person is temporarily residing as a result of the disaster) in the Patient ZIP/Postal Code field, 325-CP, will allow an override without requiring a call to the Pharmacy Help Desk. On the prescription hard copy or electronic prescription record, document the specific declared disaster (e.g., tornado, flood, wildfire), how the member was impacted (e.g., medication damaged, temporary relocation) and the date the disaster override was utilized. Permission may vary by Plan Sponsor. If you need assistance, call the Pharmacy Help Desk.

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual for contact information.

Refer to chapter **10. Medicare Part D** of the Provider Manual for additional information.

4.10 Coordination of Benefits

Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any Coordination of Benefits (COB) requirements, and must engage in appropriate COB activities to the extent required by Caremark or applicable Law.

Provider must not engage in COB activities with drug discount programs when prohibited by Caremark or applicable Law. Unless approved in advance and in writing by Caremark, Provider may not submit claims to Caremark where a prior claim to a drug discount program, coupon, or other non-insurance payer type is included in the COB segment.

Claim submissions with incorrect COB values are subject to chargeback.

4.10.01 Multiple Transaction Coordination of Benefits

For most plans, Caremark utilizes a typical multiple transaction COB process. Multiple transaction COB consists of one claim submitted to the primary payer followed by one or more claims submitted to the supplemental payer(s). Specific COB RXBINs exist to differentiate between claims that are supplemental to Medicare Part D and claims that are supplemental to non-Medicare Part D coverage.

For COB claims that are supplemental to Medicare Part D, Provider must submit RXBIN 012114 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of Plan-specific claims processing information.

For COB claims that are NOT supplemental to Medicare Part D, Provider must submit RXBIN 013089 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of Plan-specific claims processing information.

Refer to chapter **10. Medicare Part D** of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets found at **www.caremark.com/pharminfo**. Please carefully review the appropriate Payer Sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

4.10.02 Single Transaction Coordination of Benefits

Caremark may utilize a Single Transaction Coordination of Benefits (STCOB) process whereby Provider sends one transaction to Caremark and the Claim adjudicates against both primary and secondary plans before returning one final response to Provider. Single Transaction COB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for Eligible Persons. When STCOB is utilized, it is not necessary for Provider to submit a separate COB claim in order to coordinate these benefits.

Refer to chapter **10. Medicare Part D** of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets found at **www.caremark.com/pharminfo**. Please carefully review the appropriate Payer Sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

4.11 Long-Term Care Billing

For information related to Medicare Part D LTC billing, refer to chapter **10. Medicare Part D** of the Provider Manual.

For Providers providing home health care or Long-term Care (LTC) Covered Items to Eligible Persons, each NDC of the individual drug dispensed must be billed only once to Caremark during any 30-day period unless authorized by the Plan Sponsor. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws. Provider must submit claims to Caremark's claims adjudication system for LTC Pharmacy Services.

Provider must bill Caremark once during any 30-day period for medications dispensed continuously over the course of a month for an Eligible Person. One dispensing fee will be paid based on the monthly quantity dispensed of a single drug of a single strength for an Eligible Person. When the medical needs of the Eligible Person require a change in the medication order or the medication provided has a documented medical necessity for limited dispensing (including but not limited to, expiration of product) requiring an additional dispensing of the same drug, Provider may receive one dispensing fee for each new medication order or dispensed quantity limited by medical necessity. Provider must include within documentation of medical necessity for limited dispensing the diagnosis/clinical reason for the patient need from the Prescriber on the Prescriber's letterhead or prescription pad/form.

4.12 Dispensing Pharmacy NPI/NCPDP

Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.

1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;
2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;
3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;
4. Provider is not allowed to submit claims on behalf of another entity;
5. Provider must only submit claims it intends to dispense; and
6. Provider may not act on behalf of another entity regardless of ownership structure.

4.13 Prescriber Identification; Prescriptive Authority

Accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claims adjudication, clinical services, Plan Sponsor initiatives, and audits. A valid and active individual Prescriber National Provider Identifier (NPI) is required on all claims, and failure to submit a valid and active Prescriber NPI may result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable to utilize an invalid or inactive NPI, DEA number, or any other number or identifier (e.g. hospital, clinic, or pharmacy identification number) in the Prescriber ID field which does not represent the individual Prescriber, except when directed by Caremark in writing to use the Provider's NPI as the Prescriber's NPI. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate submission clarification code (SCC) to bypass the reject.

4.14 Transaction Fees

Caremark charges network Providers, and Provider agrees to pay, transaction fees that represent pharmacy network management services Caremark provides to network Providers. For every single transaction Provider transmits to Caremark, Caremark may deduct such amounts for the transaction fee from amounts payable to Provider. A single transaction is defined as each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims adjudication system. Each transaction within a multi-claim transmission will be subject to individual transaction fees.

4.15 Transaction Submission Resolution Management Service Fees

Caremark charges network Providers, and Provider agrees to pay, fees for Caremark's resolution of transactions submitted by Provider including, but not limited to, rejected claim resolution, pharmacy compliance, and claims information quality improvement. The fee charged to Provider will be commensurate to the amount of resolution management services Caremark is required to expend based on Provider's claims submissions, as measured comparatively to all other Providers on a retrospective monthly basis. Caremark will determine how the fee will be measured and assessed, as communicated to network Providers in writing accordingly. The Transaction Submission Resolution Management Service Fee charged will be charged per transaction, and Provider has the opportunity to reduce the amount of fees charged based on the degree of resolution of transactions required by Caremark for Provider as compared to all other Providers. Caremark may deduct the fee amount from amounts payable to Provider. Providers will be charged for either a Transaction Fee (as described in section **4.14 Transaction Fees** of the Provider Manual) or a Transaction Submission Resolution Management Service Fee, but not both for the same transaction.

4.16 Electronic Submission, Reversal, and Processing Windows

Unless otherwise agreed in writing and to the extent consistent with applicable Law, all claims must be submitted electronically. Failure to submit a claim within ninety (90) days of the fill date may result in non-payment of such claim to the extent consistent with applicable Law. Failure to timely submit claims will preclude Provider from seeking reimbursement from Eligible Person.

All prescriptions not received by an Eligible Person must be returned to stock and claim must be reversed within fourteen (14) days from original submission through the electronic claims system using data elements as defined by Caremark's payer sheets (found online at **www.caremark.com/pharminfo**) or as directed by Caremark.

Reversals and resubmits must occur within ninety (90) days of the claim's original submission date, or such other time period as communicated by Caremark or required by applicable Law. For reversals, Provider can reverse up to ninety (90) days from the date on which the claim was originally submitted, including Plan Sponsor-specific payment cycles. For Medicare Part D processing windows, refer to chapter **10. Medicare Part D** of the Provider Manual.

Except as otherwise required by applicable Law, or in the event of an urgent need to provide service to an Eligible Person while the claims system is unavailable (refer to section **4.18 Schedule of Claims Systems Maintenance** of the Provider Manual), Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (e.g., cartridge, CD-ROM, tape, batch, or paper) unless prior written approval is received from Caremark or Plan Sponsor. Caremark charges a handling fee of $2.50 per claim in those situations in which Caremark or Plan Sponsor agree in writing to non-electronic submission or reversal of claims.

4.16.01 UCF Requirement

Caremark reserves the right to require Provider to submit claims via a UCF, along with all supporting documentation that Caremark may require to support the claim including, but not limited to, medical records and Eligible Person attestations, at Caremark's sole discretion.

4.17 Software Certification

Provider must utilize software certified by Caremark and adhere to the NCPDP standards in compliance with HIPAA. Provider must support NCPDP updates as requested from time to time by Caremark. Provider is responsible for and assumes all risk arising from or related to Provider's selection and use of its software. Provider, where not precluded by applicable Law, must indemnify Caremark and its affiliates from and against any claim, cause of action, liability, loss, damage, cost, fines, charges, and/or expenses arising from or related to Provider's selection and use of its software.

Caremark may provide reasonable technical support to assist Provider in complying with Caremark requirements and industry standards for submitting claims through the claims system. Provider may be assessed a fee by Caremark if Provider submits claims that are not in accordance with current requirements, industry standards or in compliance with government program requirements.

Provider must submit all claims with the software certification ID in field 110-AK. Each software certification ID is assigned by Caremark to a unique vendor and/or software product. Provider must not release their software certification ID to be used by any other entity nor can a Provider use a software certification ID to submit a transaction from a system other than the vendor and/or software product associated with the software certification ID submitted. Any violation of this rule may result in a reject of the transaction as well as the assessment of an administration fee. Refer to chapter **7. Compliance Reviews** of the Provider Manual.

If Provider is not submitting claims in accordance with HIPAA-mandated data and/or standards, Caremark may reject the transaction and/or charge a minimum fee of $0.99 per transaction. In addition, Provider is required to provide Eligible Person(s) a bridge supply of medication(s) until such time occurs when Provider is compliant with HIPAA-mandated data and/or current NCPDP standard, and the claim(s) can be adjudicated.

Refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online.

4.18 Schedule of Claims Systems Maintenance

Maintenance of the claims systems may be scheduled between 11 p.m. and 6 a.m. Eastern Standard Time (EST) every Friday or Saturday as necessary. During the scheduled maintenance, Providers will receive the message, "HOST UNAVAILABLE." If this message displays, Providers must resubmit claims after maintenance is completed.

If maintenance is not needed, Providers will be able to submit claims as usual during those hours. If any other scheduled maintenance is required outside of the published hours listed above, Caremark may notify Provider in advance.

From time to time, unscheduled system maintenance or other circumstances may occur when the adjudication platform(s) may not be available to adjudicate claims for a limited time. At any time, a Provider may contact the Pharmacy Help Desk for assistance or information regarding any claim processing related question. Pharmacy Help Desk Representatives are available 24 hours a day, 7 days a week. Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual.

Note: Providers are reminded that, pursuant to the Provider Agreement, Providers must render services unless professional judgment dictates otherwise.

4.18.01 Additional Required Procedures

1. If the claims adjudication system indicates a host processing error or unexpected reject has occurred, Provider should attempt to resubmit within a few minutes. If the status continues to indicate a host processing error (downtime circumstance), Provider should hold the transaction and attempt to process it again within the next two (2) hours.

   If two (2) hours have elapsed and the same host processing error or unexpected reject continues to occur, call the Pharmacy Help Desk for additional information regarding system availability and other assistance that may be available at that time. The Pharmacy Help Desk is equipped to assist in guiding the pharmacy through the claim resubmission process when the system becomes available.

2. To ensure that each Eligible Person receives his or her Covered Items, Provider must make reasonable attempts to obtain information necessary to fill a script.

   Provider is requested to serve the Eligible Person by establishing/confirming eligibility/coverage:

   a. If the Eligible Person is available, ask for the ID card. Call the Customer Care number on the ID card to verify eligibility, drug coverage, formulary status, and associated Patient Pay Amount.

   b. If the Eligible Person is not available, call the Pharmacy Help Desk.

3. Provider should provide a bridge supply, typically covering three (3) days, for those Eligible Persons in urgent need of medication so that the Eligible Person is not delayed at the pharmacy counter during a system downtime event, or provide service to the Eligible Person and submit a Universal Claim Form (UCF) within the required timeframe.

Refer to section **1.04 Pharmacy Help Des**k of the Provider Manual.

4.19 Taxes

For purposes of this Section, the term "Provider Taxes" shall include any provider fees, assessments, sales taxes, transaction privilege taxes, occupation taxes, or similar fees/taxes imposed by any federal, state, or local governmental authority.

Provider is responsible for submitting requests for reimbursement/payment of Provider Taxes for claims requiring such inclusion at the time of the claims submission. In no event shall Caremark be responsible for any Provider Taxes or other liability that may be imposed on Provider. Provider shall be responsible for timely filing any reports or returns and for timely paying all Provider Taxes with the appropriate governmental authorities. Provider is responsible for submitting accurate and authorized claims for Provider Taxes though adjudication and providing support upon written request. Caremark is not responsible for confirming such Provider Tax amounts through adjudication. Reimbursement of Provider Tax is not confirmation or validation. Provider is responsible for any Caremark or Plan Sponsor losses due to incorrect Provider Taxes submitted for claim adjudication.

To the extent permitted under the terms of its agreement with the Plan Sponsor or as required by Law, Caremark agrees to seek reimbursement/payment from the Plan Sponsor for any timely and accurately submitted claim for Provider Taxes incurred by or imposed on Provider by any governmental authority on account of, or based upon, the provision of Pharmacy Services or Covered Items. Caremark is not responsible for correcting claims for Provider Taxes for which Provider failed to submit Provider Taxes.

An Eligible Person may be liable, in addition to any applicable copayment, coinsurance, or deductible, for Provider Taxes, unless specifically prohibited under applicable Law; provided, however, that if the applicable governmental authority otherwise compensates Provider or makes Provider whole for any such Provider Taxes, Eligible Person shall have no obligation to reimburse Provider for the amount of Provider Taxes so compensated.

In no event does this section give Provider any additional rights than those allowed by Law.

5. Clinical Programs, Services and Related Messages

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Provider must support all clinical programs and services and utilize software that will display all messages related to clinical programs and services and that provide for the recording of Eligible Person drug and medical information where utilized by Caremark and as allowed by applicable Law. Provider is required to uphold the same clinical standards of professional judgment relating to and including, but not limited to, seeking cost-effective clinical solutions that benefit the Eligible Person and Plan Sponsor in terms of health and financial welfare of both and refrain from participating in programs that are designed to increase either the Eligible Person or Plan Sponsor's drug spend.

Subject to applicable Law, Provider must provide Caremark any and all reasonably available information that Caremark needs to perform such clinical programs and services, and conduct drug utilization review accordingly. Provider must act upon all messages related to clinical programs subject to professional judgment.

5.01 Drug Utilization Review

Inappropriate drug therapy can cause Eligible Person injury and can lead to additional health care costs. In an effort to reduce the number of situations where an Eligible Person may receive inappropriate drug therapy, Caremark implemented a concurrent Drug Utilization Review (DUR) program that detects a potential therapeutic problem at the point of service.

In order to ensure that Provider receives and acts upon all DUR messages, which appear in the claim response, Provider must adhere to the claims submission requirements outlined in chapter **4. Claims Submission** of the Provider Manual.

The functions of the DUR program are to:

- Analyze prescriptions submitted through Caremark
- Screen prescriptions for several types of therapeutic drug problems
- Provide clinical information related to the claim

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional judgment of the Provider or Prescriber. The Provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims system and for performing Pharmacy Services in each jurisdiction consistent with the scope of their respective licenses.

Additional information regarding DUR review controls for Medicare Part D claims may apply as specified by Caremark.

5.02 DUR Conflict Codes and Messaging

All DUR messages appear in the claim response. The Provider must view all screens necessary to receive the message detail and act upon all such messages subject to the professional judgment of Provider.

Provider will receive DUR messaging in a format consistent with its software vendor. Provider may need to consult with the software vendor for help with identifying or accessing DUR messages. Caremark, in accordance with current NCPDP standards, returns up to nine (9) DUR messages that can be received on the same claim and requires Provider to have the capability to accept up to nine (9) DUR messages on the same claim.

Refer to the NCPDP standard at **member.ncpdp.org/Standards-Lookup**. Membership to NCPDP is required to view this information online.

5.03 Refill-Too-Soon or Excessive Utilization Reject

Provider must call the Pharmacy Help Desk if extenuating circumstances justify payment for a claim that was denied for excessive utilization (Refill-Too-Soon). Provider can enter Submission Clarification Codes (SCC) in field# 420-DK to override a refill-too-soon reject for Eligible Persons without requiring a call to the Pharmacy Help Desk. Provider must document on the prescription hard copy or electronic prescription record the details of any situation requiring an override. Permission may vary by Plan Sponsor.

Examples of extenuating circumstances include:

- Lost or stolen prescriptions (SCC 04)
- Damaged prescriptions, dropped or broken prescription bottle containing liquid (SCC 04)

- Vacation supplies (SCC 03)
- Increase in dosing/therapy change (SCC 05)
- Circumstances such as natural disasters. Refer to section **4.09 Natural Disasters** of the Provider Manual.
- Extra supply for school or similar circumstances (e.g., rescue inhalers or epinephrine auto-injectors)

If you need assistance, call the Pharmacy Help Desk.

5.04 Drug-Drug Interaction Reject Program

The Drug-Drug Interaction Reject Program is a point-of-sale claim reject for selected high-risk drug combinations. The reject will occur if the current drug being submitted and another drug that was dispensed to the Eligible Person are one of the high-risk drug combinations included in the program.

When a claim is rejected for a high-risk drug-drug interaction, a standard drug-drug interaction warning message will be transmitted with the claim reject response. In addition, a secondary message will be transmitted that provides instructions regarding override options.

Depending on the types of overrides that the Plan Sponsor has authorized, one of the following override option messages will be transmitted:

1. **PPS Code REQD: <<Reject Message>>**

   In this case, Provider may resubmit the claim with the indicated PPS code to override the reject, based on the professional judgment of Provider and in consultation with the Prescriber.

2. **PA REQD: <<Reject Message>>**

   A secondary message will include the PA contact number

   In this case, a Prior Authorization (PA) is required to override the reject. The message will provide further instructions on how to obtain an override.

Provider must contact the Prescriber to discuss the drug-drug interaction that has been identified for the current prescription based on the Eligible Person's other active drug therapy. If the Prescriber determines that the prescribed therapy is warranted despite the drug-drug interaction risk, or if the interacting drug has been discontinued, the Provider must pursue an override according to the instructions provided in the claim response message. Otherwise, Provider should obtain a new prescription for an alternative therapy.

5.05 Formularies

Plan Sponsor formularies determine how drugs are covered (e.g., preferred, non-preferred, excluded) for drug therapy selections. The final choice of specific drug selection for an Eligible Person rests solely with the Prescriber.

Provider must support all formulary initiatives and inform Eligible Persons when a non-formulary drug has been prescribed. Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider agrees that for all Plan Sponsors and Eligible Persons, therapeutic programs and formularies take precedence over any agreements or programs to which Provider is a party. Provider also agrees not to implement any substitution programs for Eligible Persons that are inconsistent with such therapeutic programs and formularies.

When a claim is submitted for a non-formulary drug and the Plan has a closed formulary, it may reject with:

Product Not on Formulary

or a similar message, which may include a customized drug alternative.

When a claim is submitted for a non-formulary drug and the Plan has an open formulary, the response may include the message:

NF! Form <<XXX>>

In many cases, the Patient Pay Amount may be higher for a non-formulary medication.

5.06 Prior Authorization

For some Plans, certain medications will require prior authorization. For prior authorization, the Prescriber is required to supply additional documentation to Caremark or the Plan Sponsor to determine whether certain criteria are met for the drug to be covered under the Plan.

Provider must follow Caremark and Plan Sponsor requirements for the prior authorization process including, but

not limited to, obtaining a Prescriber's signature on a prior authorization form if a Prescriber signature is required. In no event may Provider represent itself as a Prescriber or a member of Prescriber's staff as part of the prior authorization process.

If a medication is designated for prior authorization, the claim may reject with the following or similar message:

PRIOR AUTHORIZATION REQUIRED
MD Call <<XXX-XXX-XXXX>>

In most cases, the claims system response will also provide the correct contact information in the subsequent message.

If, in the Prescriber's professional judgment, the drug is medically necessary, Prescriber will need to call the number provided in the claim message to initiate coverage.

For Aetna RXBIN 610502 only: If no contact number is provided in the messaging, Provider should contact the Prescriber and ask him or her to contact the Precertification Unit for precertification and medical exception requests. The Precertification Unit contact information for RXBIN 610502 is:

Fax: 1-800-408-2386
Phone: 1-800-414-2386
(Hours: Monday through Friday, 8 a.m. to 7 p.m. CT)

Provider must support all clinical programs and services and inform Eligible Persons when a drug designated for prior authorization has been prescribed. Provider must use its best efforts to contact the Prescriber to inform on prior authorization messaging.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

5.07 Managed Drug Limitations/Quantity vs. Time

Some Plan Sponsors implement managed drug limitations (MDL) or quantity vs. time (QVT) programs. MDL or QVT programs allow an Eligible Person to receive up to a set amount of medication per designated timeframe.*

If an Eligible Person presents a prescription for an amount greater than the set amount or has accumulated an amount greater than the set amount within the designated timeframe, the claim will reject with one of the following or similar messages:

PLAN LIMITS EXCEEDED <<# of quantity left>>*
or
MAX QUANTITY XX PER XX DAYS

If there is a remaining quantity within the designated look-back period and within the Plan parameters, Provider can resubmit the claim after the appropriate amount of time has passed using an amount equal to or less than the amount stated in the message.

*If prescribed quantity exceeds the plan parameters, call the Pharmacy Help Desk to verify if Prior Authorization is available.

5.08 Dose Optimization

Dose Optimization is a point-of-service claim reject for selected drugs where multiple daily doses of the drug are prescribed and where a higher strength single daily dose is available and clinically appropriate (e.g., Lipitor® 10 mg 2 tabs/day could be optimized to Lipitor 20 mg 1 tab/day).

For a drug subject to Dose Optimization, the claim will reject with the following or similar message:

MISSING/INVALID DAYS SUPPLY <<use higher strength one per day>>

In the event there is an override option, the subsequent message will list next steps:

CALL HELP DESK <<or a specific Plan Sponsor telephone number>>

Provider must contact Prescriber for a new prescription of a higher strength at the once-daily dosing regimen, then resubmit the claim with the higher strength. If this cannot or should not be done based on the professional judgment of Provider or the Prescriber is unwilling to change the prescription, review Provider messaging for further instructions.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000977

5.09 Step Therapy

Step Therapy requires that a set quantity of certain medication(s) be in an Eligible Person's drug history within a given timeframe before a claim will adjudicate for another drug in a specified therapeutic category. If Provider submits a claim for a Step Therapy and the conditions are not met, the claim will reject with a message similar to the below:

NDC NOT COVERED SUBOPTIMAL REGIMEN
USE <<XXXX>> 1ST
MD CALL <<XXX-XXX-XXXX>> FOR PRIOR AUTHORIZATION

If Provider receives this message, discuss the alternatives with the Prescriber. If, in the Prescriber's professional judgment, the originally prescribed drug is medically necessary, Prescriber will need to initiate a request for prior authorization.

A qualification period may also be in place for the targeted drug. Once an Eligible Person satisfies the Step Therapy requirements, he or she may obtain the targeted drug for a specific time period (e.g., 60 days). When the qualification period has been exceeded, the Eligible Person must requalify for the prescribed drug by repeating the Step Therapy requirements.

Some Plan Sponsors may choose to give Eligible Persons additional flexibility in choosing not to follow the recommended Step Therapy. A copayment option may be available for some Eligible Persons which allows them to obtain the originally prescribed drug without requiring the Prescriber to call for an override. The Eligible Person may make the decision and obtain the original drug simply by paying a higher copayment.

If this option is in place, claims not meeting the required conditions will reject with the following or similar message:

NDC NOT COVERED SUBOPTIMAL REGIMEN
COPAY = <<XX.XX>>
TO ACCEPT, SUBMIT PA - 99999999999

If you receive this message, discuss the alternatives with the Eligible Person and advise that the originally prescribed drug can be obtained by paying the copayment indicated in the message. If the Eligible Person accepts the copayment, resubmit the claim to Caremark using PA code 99999999999.

5.10 Plan Sponsor Programs

Provider must participate in Plan Sponsor programs as requested by Caremark and/or Plan Sponsors. Provider must maintain internal procedures for compliance with such programs and furnish an outline of such procedures to Caremark upon request. Providers are encouraged to engage in and support Plan Sponsor electronic prescribing initiatives in accordance with applicable Law.

5.11 Federal Regulatory Quality Assurance Programs

Caremark recommends Provider adhere to Federal Regulatory Quality Assurance Programs, such as but not limited to:

- Medication Errors Reporting Program (MERP) through the Institute for Safe Medication Practices (ISMP); more information can be found on the website **www.ISMP.org**
- MedWatch program through the Food & Drug Administration (FDA); more information can be found by calling **1-800-FDA-1088** or on the web-site **www.FDA.gov**

5.12 Clinical Studies/Trials

To the extent Provider participates, or is involved, in a study, directly and indirectly, for which Provider submits claims to Caremark for adjudication and payment for prescriptions obtained by study participants (e.g., Eligible Persons), Provider must obtain prior written approval from Caremark. If prior Caremark written approval is not obtained, claims submitted to Caremark for study participants are subject to chargeback. Caremark's review of the study will be administrative in nature to determine Provider's compliance with the terms of the Provider Agreement such as, but not limited to, determining whether any compensation paid to study participants has the effect of waiving the participant's Patient Pay Amounts under the Plan (which Provider has an obligation to collect in accordance with the Provider Manual – see section **3.03.01 Collection of Patient Pay Amounts**) or whether study premises result in changes in drug regimens that have the effect of increasing Plan Sponsor costs.

Provider requests for approval must include all of the following details:

- Study overview
  - Study duration
  - Number of subjects
  - Study locations
  - Medications involved
  - Costs for participants and Plan Sponsors
- Details of insurance for study
- Credentials of study investigators
- Source of funding for the study
- Consideration paid to all study participants, providers, and prescribers
- Copies of all documentation submitted to ethics committees, review boards, or governmental agencies
- Disclosure of any potential conflicts of interest

Requests for approval can be sent to the following address:

CVS Caremark
ATTN: Pharmacy IRB Study Review
9501 E. Shea Boulevard, MC 020
Scottsdale, AZ 85260

The requirements of section **5.12 Clinical Studies/Trials** do not apply to FDA-approved clinical trials.

5.13 Vaccines and Medication Administration

1. Plan Sponsors may include coverage for the administration of vaccines, non-vaccine injectable products, or other Covered Items as part of a Plan. Provider is required to comply with applicable Law when administering a Covered Item. Provider is required to:
   a. Train all personnel and comply with all applicable storage, dispensing, and administration requirements for dispensing and administration of Covered Items as normally implemented by members of their health care profession in good standing in the community.
   b. Comply with the requirements of the Vaccine Injury Compensation Program (VICP) or other compensation program, where applicable, when administering vaccines.
   c. Implement a system capable of reporting the administration to a state or governmental immunization reporting registry, the Eligible Person's primary care provider (or prescriber), and public health agencies.
   d. Provide Eligible Persons with a written or electronic record of the Covered Item's administration and, where applicable, with any documentation provided by the manufacturer intended for patient use [e.g., vaccine information statement (VIS) or a state or governmental immunization registry].
   e. Report vaccine administration errors and adverse events to the Vaccine Adverse Event Reporting System (VAERS) and to any revised safety reporting requirements as required.
2. When administering a Covered Item that requires multiple doses, including a maintenance medication, Provider must monitor the interval between administered doses for clinical appropriateness. Accordingly, Provider must:
   a. Maintain an accurate accounting of the number of doses that the Eligible Person has received from Provider and the date administered. If Eligible Person has received a previous dose from another provider, Provider must make reasonable efforts to document when Eligible Person has received a previous dose, which may include the use of a vaccine registry or other accessible records, or verbal information provided by the Eligible Person, Prescriber, or prior provider.
   b. Implement and utilize a program that encourages the Eligible Person to receive subsequent doses of a Covered Item when necessary, including a multiple dose vaccine, within the expected timeframe outlined in the FDA approval, EUA, or as prescribed. Provider agrees to provide a copy of the Policy and Procedure or Work Instructions regarding tracking of multiple doses, their administration date, and the program to encourage Eligible Person compliance when requested by Caremark.

6. Network Participation and Payment

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Caremark, on its own behalf, or on behalf of a Plan Sponsor, reserves the right to limit Provider's participation in a network to certain Plan Sponsors based on Plan Sponsor network design or contractual rights to determine network participation including, but not limited to, suspension or termination of the Provider Agreement upon a determination by a Plan Sponsor in their sole discretion that Provider has not performed satisfactorily, unless otherwise precluded by applicable Law.

Caremark will reimburse Providers for Pharmacy Services for Covered Items provided as set forth in the Provider Agreement, including any amendments, Network Enrollment Forms, exhibits, and this Provider Manual. Even if Provider has not signed a rate schedule, Provider is deemed to have accepted reimbursement and participation terms, including the finalization of any applicable post-adjudication settlement, in the Caremark or Plan Sponsor network in which Provider submits and Caremark does not reject the claim for an Eligible Person in that network, in accordance with applicable Law. Notwithstanding anything to the contrary in the Provider Agreement, by participating in a Caremark network, Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Provider Agreement unless professional judgment dictates otherwise; provided that Caremark, or Caremark on behalf of a Plan Sponsor, reserves the right to limit Provider's participation in a network to certain Plan Sponsors based upon Plan Sponsor network design.

Plan Sponsors may make determination about network participation.

Caremark may from time to time enter into an arrangement with a Plan Sponsor ("Other Entity") pursuant to which Provider's Provider Agreement (including reimbursements terms and schedules) with Caremark will be utilized by such Other Entity and such Other Entity's pharmacy benefit manager ("Other PBM") on the Other PBM's adjudication platform, as communicated by Caremark. Provider agrees to cooperate with Caremark, Other Entity, and Other PBM as needed to support such arrangement.

6.01 Provider Payment

Notwithstanding any other provision in the Provider Agreement, in the event of a conflict between the reimbursement rate indicated through the claims adjudication system and a Network Enrollment Form or addendum or any other agreement, the claims adjudication system reimbursement rate will apply provided there is no error in the claims adjudication system resulting in overpayment to Provider or to Eligible Person. In addition, any post-adjudication settlements applicable to the claim or network will apply.

6.02 General Reimbursement

The applicable Price Type(s), percentage added to or subtracted from the Price Type, Dispensing Fee(s), and other reimbursement terms will be set forth in a Network Enrollment Form, network addendum, or transmitted online via the claims adjudication system.

Notwithstanding any other provision in the Provider Agreement, claims submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network may be reimbursed at the lower of the following less the applicable Patient Pay Amount:

- Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee (or if applicable Price Type is unavailable for a given drug, Caremark will pay Provider based upon an alternate Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type plus the applicable Dispensing Fee); or
- Maximum Allowable Cost (MAC) plus the applicable Dispensing Fee; or
- Ingredient cost submitted by Provider plus the applicable Dispensing Fee; or
- Provider's U&C Price; or
- Provider's submitted "gross amount due" (as defined by NCPDP); or
- For worker's compensation claims, the reimbursement amount prescribed by applicable Law; or
- For Coordination of Benefit claims, Provider's submitted Other Payer Patient Responsibility Amount(s).

6.02.01 Multi-Ingredient Compound Reimbursement

Multi-Ingredient compound medications submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of the following less the applicable Patient Pay Amount:

- The applicable Dispensing Fee plus the applicable amount based on the Level of Effort*, if submitted, plus for each ingredient that is a Covered Item, the lesser of (1) applicable Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type (2) Maximum Allowable Cost (MAC) or (3) compound ingredient drug cost submitted; or
- Ingredient cost submitted plus the applicable Dispensing Fee plus the applicable amount based on the Level of Effort, if submitted (provided Provider accurately submits the ingredient cost submitted in accordance with the Provider Manual); or
- Provider's U&C Price; or
- Plan Sponsor-specific reimbursement; or
- Provider's submitted "gross amount due" (as defined by NCPDP); or
- For worker's compensation claims, the reimbursement amount prescribed by applicable Law.

*Refer to "Figure 1 – Level of Effort Table" in section **4.07 Multi-Ingredient Compound Processing** of the Provider Manual.

6.02.02 Vaccine and Non-Vaccine Injectable Administration Reimbursement

Covered vaccines and non-vaccine injectable products dispensed and administered to Eligible Person submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of the following less any applicable Patient Pay Amount:

- Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee, plus applicable Administration Fee (or if the applicable Price Type is unavailable for a given Covered Item, Caremark will pay Provider based upon an alternate Price Type plus applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee, plus the applicable Administration Fee); or
- Maximum Allowable Cost (MAC), plus the applicable Dispensing Fee, plus the applicable Administration Fee; or
- Applicable reimbursement amount for the Covered Item, dispensing and administration described in a Network Enrollment Form, network addendum, or transmitted online via the adjudication claims adjudication system; or
- Ingredient cost submitted by Provider, plus the applicable Dispensing Fee, plus the applicable Administration Fee; or
- Provider's U&C Price; or
- Provider's submitted "gross amount due" (as defined by NCPDP)

6.02.03 Adjustments to Reimbursement

All calculated reimbursement to Provider may be adjusted by any of the following:

- Applicable Patient Pay Amount
- Applicable Provider taxes
- Incentive amount(s) paid
- Other amount(s) paid (e.g., delivery fee)
- For coordination of benefits claims, by all applicable other payer(s) amounts paid
- For consumer card networks, by the applicable consumer card administration fee

Unless otherwise required by a Plan, including a consumer card Plan, Caremark may increase one or more components of the calculated reimbursement above to cause a zero-balance due (in lieu of a negative) once the applicable Patient Pay Amount is subtracted.

6.02.04 Post-Adjudication Settlements

Many Caremark and Plan Sponsor networks include additional financial terms that will be calculated and settled between Caremark and Provider post-adjudication subject to applicable Law. The terms of any post-adjudication settlement will be set forth in a Network Enrollment Form, network addendum or other Caremark Document. Post adjudication settlements include, but are not limited to:

- Performance Network Rebates ("PNR")
- Performance Payments
- Network processing fees
- Network management fees
- Supplemental dispensing fee payments
- Effective rate reconciliation
- Other fees

Where a post-adjudication settlement is applicable to a Caremark or Plan Sponsor network, Provider's consideration for participation in such network includes the post-adjudication settlement. Accordingly, Provider's acceptance of reimbursement for a claim processed for a network where a post-adjudication settlement applies obligates Provider to finalize the post-adjudication settlement.

6.03 Changes to AWP

In the event Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) discontinues the reporting of Average Wholesale Price (AWP) or changes the manner in which AWP is calculated, then Caremark reserves the right to modify the pricing terms of the Provider Agreement, notwithstanding any other provision in the Provider Agreement. Such modification may include:

- Modification of the AWP unit price reported by Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) by applying the Wholesale Average Cost (WAC) Mark-Up factor (in use before the effective date of a change in the calculation of AWP) to the WAC unit price reported by Medi-Span ("Pre-Settlement AWP Discount");
- Utilization of a modified AWP Discount ("Post-Settlement AWP Discount"); and/or
- Utilization of alternate Price Type other than AWP.

Nothing herein shall limit Caremark's rights and abilities to establish additional networks at reimbursement terms as determined by Caremark.

6.04 Maximum Allowable Cost

Maximum Allowable Cost (MAC) is a commonly used tool to control drug costs by establishing a fair but competitive unit price generally at a product level, regardless of supplier. MAC pricing incents pharmacies to buy generic products in the most cost-effective manner, including volume discounts, in order to keep overall prices down for Eligible Persons and Plan Sponsors. Caremark does not have visibility to individual pharmacy arrangement with wholesalers; however, it is generally known in the industry that pharmacies do receive purchase discounts and rebates. It is not possible for Caremark to know what every pharmacy pays for every drug; however, Caremark may utilize aggregate information from wholesalers and third-party sources in order to establish MAC prices and, because MAC prices are reviewed continuously and updated frequently, our MAC prices reflect our best understanding of the marketplace pricing and product availability.

Caremark determines Maximum Allowable Cost generally at a product level for generic and multi-source brand products. This determination includes a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span, MAC lists published by CMS, National Average Drug Acquisition Cost (NADAC) published by CMS, Predictive Acquisition Cost (PAC) developed by Glass Box Analytics, and if available, wholesalers and retail pharmacies. MAC prices are subject to change, which can occur at least on a weekly basis and are based on marketplace trends and dynamics and price fluctuations. MAC price lists and/or pricing formulas are Caremark confidential and proprietary information.

For MAC paid claim appeals and as in accordance with Law, as applicable, Provider may appeal the MAC price paid by Caremark at a product level. Submission of a paid claim by Provider is required for this process. Provider must notify Caremark within the period required by applicable Law and provide all of the following information: fill date, prescription number, Provider name, Pharmacy NCPDP number, chain/affiliation code, phone number, email address, and RXBIN. Chain and Pharmacy Services Administration Organization (PSAO) pharmacies may submit MAC paid claim appeals through their respective chain or PSAO headquarters, which will then submit appropriate data to Caremark. Chain, PSAO pharmacies, and Independent pharmacies (those which are not affiliated with a PSAO for contracting purposes) may also submit MAC paid claim appeals using the Pharmacy Portal at **rxservices.cvshealth.com**.

Provider may access the Pharmacy Portal to obtain current MAC prices and upcoming MAC prices based on Caremark's MAC price update schedule, including for Medicare Part D plans. To locate current or upcoming MAC price information, utilize the "MAC Price Look Up" feature of the Pharmacy Portal available through a secure website: **rxservices.cvscaremark.com**. Providers can also request a MAC list by clicking on the "Pharmacists & Medical Professionals" link located at **caremark.com** and submitting a Pharmacy MAC List Request form to **MACPRICE@cvshealth.com.**

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000982

6.05 Eligible Person Fees and Amounts

Unless otherwise authorized by Caremark in writing, Provider must collect at the point of service from Eligible Persons any administrative, transaction, access, or other types of such fees or amounts, when applicable. The total amount to collect from the Eligible Person for providing Pharmacy Services, including any such fee or amount, will be communicated through the claims adjudication system and may be debited from Provider's claims payment account. Refer to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual.

6.06 Claims Payment and Other Fees

6.06.01 Remittance Advices

Provider will receive a remittance advice for claim transactions within a payment cycle. Paper remittance reports are distributed by mail; 835s are posted to a secure portal. Caremark payments to Provider may reflect adjustments for claims reversals, resubmissions, or amounts owed by Provider to a Plan Sponsor under a Provider Agreement between Provider and a Plan Sponsor.

If Provider or authorized agent of Provider requires additional remittance reports, the following service fees apply:

SERVICE TYPE	MINIMUM SERVICE FEE
Paper remittance reprint	$150/NPI/cycle
Copy of Performance Network Program report (when no longer available online)	$150/report
Internet, network data mover (NDM), data recreate, etc.	$500/item/NPI/cycle
Research fee associated with no change in reimbursement	$150/hour
Documentation request/research	$150/hour
Check trace/stop payment	$150/check
EFT Bank Account change	$150/NPI
835 Vendor change	$150/NPI
Provider claim adjustment request	$10/claim

If Provider receives remittance reports electronically, Provider must adhere to HIPAA regulations which mandate ASCX12N 835 and updates as required. Providers with questions regarding the testing, creation, and receipt of the 835 data file should contact Caremark at the following address:

CVS Caremark
Attn: Finance MC 019
9501 East Shea Boulevard
Scottsdale, AZ 85260

All adjudicated claims detailed in a remittance advice are paid to Provider at one hundred percent (100%) of the reimbursement rate as in accordance with the Provider Agreement, pending audit by Caremark. All claims are subject to completion of audit. Prior to reimbursement, Caremark reserves the right to require additional documentation by Provider to validate a claim(s) including, but not limited to, submission of medical records and Eligible Persons attestations.

6.06.02 Disputed Claims, Collected Fees, Amounts, or Recoupments

Provider is required to review remittance advices and Performance Network Program reports received from Caremark. Notwithstanding any provision in the Provider Agreement, if Provider disputes a claim, collected fees, amounts, or recoupments due to failure to pay the contractual reimbursement amount, Provider must notify Caremark in writing within one hundred eighty (180) days of the fill date, date of collected fees, amounts, or recoupments, receipt of Performance Network Program report assessing network variable rates, or within a longer period required by applicable Law, listing details of the disputed claim or payment, collected fees, amounts, or recoupments. For claim disputes regarding a remittance advice, Provider's notification of a disputed claim, collected fees, amounts, or recoupments must include the fill date, prescription number, Eligible Person ID number, and Provider NPI or NCPDP. For disputes regarding a Performance Network Program report, Provider's notification of a disputed network fee must include the specific fee and network at issue. Provider should include a copy of the remittance advice or Performance Network Program report, if possible, and must provide the specific reason for the dispute. If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims, collected fees, amounts, or recoupments as set forth in the remittance advice or assessment of fees in the Performance Network Program report for the applicable cycle or trimester, except for any overpayments made to Provider. Notifications may be mailed to:

CVS Caremark
Attn: Network Services, MC 023
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark may charge a research fee of $150/hour for any request in which Provider was accurately reimbursed. Caremark is not obligated to reimburse Provider for a claim, collected fee, amount, or recoupment if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim, collected fee, amount, or recoupment.

Refer to section **6.04 Maximum Allowable** Cost of the Provider Manual for additional information regarding MAC appeals.

6.06.03 Claims Adjustment

Notwithstanding any provision in the Provider Agreement, if Provider requests an adjustment to a claim (e.g., to correct claims information submitted by Provider), Provider must notify Caremark in writing within one hundred eighty (180) days of the fill date, or within a longer period required by applicable Law. If Provider fails to notify Caremark in a timely manner or in the manner required Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle. A $2.50 per claim assessment, where permitted by applicable Law, will be applied where Caremark or Plan Sponsor in writing agree to Provider's request for non-electronic submission or reversal of claims.

Claims adjustment requests must list the fill date, prescription number, Eligible Person ID number, Provider NPI or NCPDP, Refill Code and Authorization Number, the specific reason for the claim adjustment requested, and the information necessary to make the requested adjustment. To request a copy of the Claims Adjustment template, or for questions regarding data submission, contact the Pharmacy Help Desk. Claims adjustment requests may be mailed to:

Caremark
Attn: Adjustment Services, Pharmacy Corrections, MC 019
9501 East Shea Boulevard
Scottsdale, AZ 85260
Providers may be required to submit claim adjustment requests electronically.

6.07 Recoupment and Adjustments

Caremark is not obligated to reimburse Provider for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider. Refer to chapter **8. Professional Audits** of the Provider Manual for additional information on audits. Provider agrees and acknowledges that Caremark may, to the fullest extent allowed by law, recoup, charge back, offset, withhold, or otherwise adjust payments due to Provider or any affiliate of Provider for claims improperly submitted by Provider or paid by Caremark.

6.08 Workers' Compensation

Notwithstanding anything to the contrary, Caremark may utilize non-Medicare Part D networks for workers' compensation claims. To the extent Caremark utilizes a non-Medicare Part D network for workers' compensation claims and Provider participates in such network, the reimbursement for such workers' compensation claim shall be as reflected in the applicable non-Medicare Part D network addendum (to the extent such network addendum does not conflict with the claims adjudication system) and the following additional terms will apply:

- Section 4.3 or Schedule A, whichever is applicable, of the Provider Agreement, is amended to add "(vi) the reimbursement amount prescribed by a Law for workers' compensation (unless otherwise permitted by such Law), if applicable for workers' compensation claims reimbursement."
- Caremark may utilize a third-party vendor for certain portions of Caremark's network services including, but not limited to, claims processing and pharmacy payments for workers' compensation claims.

6.09 Provider Suspension

Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider if required by applicable Law, or if Caremark has reason to believe Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; (4) is a breach of the Provider Agreement; (5) alters the dispensing patterns of the Provider sufficiently to indicate potential

CONFIDENTIAL AND PROPRIETARY

fraud, waste or abuse; or (6) constitutes potential fraud, waste, or abuse. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement.

If Caremark is unable to reach Provider through any contact method that Provider provided to Caremark as part of the enrollment or credentialing process (e.g., mail, telephone, fax), Caremark reserves the right to immediately suspend Provider. Caremark may elect to perform re-credentialing and/or audit and may leave the suspension in place until such time as these processes are complete.

6.10 Directories

Caremark and Plan Sponsors may list Provider in directories and databases for distribution to, and use by, Eligible Persons, Plan Sponsors, and others as Caremark or a Plan Sponsor determines are necessary. Additionally, Caremark may display Provider, if applicable, in preferred provider performance initiatives in paper, web-based directories, or Plan Sponsor reporting. Refer to section **14.01 Advertising and Trademarks** of the Provider Manual.

Caremark has a requirement to maintain accurate directories of Dispensing Pharmacies so that Eligible Persons can quickly find pharmacies to fill their prescriptions. Therefore, Providers that have no dispensing activity of Covered Items for a period of time may be immediately removed from the network as determined at CVS Caremark's sole discretion. Additionally, at Caremark's sole discretion, Provider's credentials may be updated without Provider's confirmation using alternative data sources. Refer to Section **2.05.01 Notification of Change in Documentation and Other Information** of the Provider Manual for more information.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000985

7. Compliance Reviews

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

In order to determine Provider's compliance with the terms of the Provider Agreement and applicable Law, Caremark has the right to examine Provider records (and obtain a copy as necessary) and pharmacy practices as Caremark reasonably determines are necessary. Provider must comply with such examination within the timeframe indicated by Caremark on the notice of the examination and without charge to Caremark. Caremark conducts examinations in accordance with the Provider Agreement and applicable Law and Caremark may, in accordance with applicable Law, refer Provider's non-compliance to local/state/federal investigative and law enforcement agencies as appropriate.

Submission of false or misleading records and documentation may result in chargeback for all claims reviewed and any other remedies available to Caremark including, but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies. If clarification of documentation is requested by Caremark, Provider is required to submit unaltered original documentation.

Compliance Reviews include, but are not limited to:

- Concurrent/Daily Review
- Medicare/Medicaid Review
- Telephone or Fax Inquiries
- Provider Tax determinations and legal basis for calculation of such Provider Tax

To the extent consistent with applicable Law, non-compliance of the Agreement includes, but is not limited to,

1. Submitting incorrect data in the claims submission;
2. Failure to provide documents requested by Caremark pursuant to the Agreement;
3. Refusing to accept an identification card for an Eligible Person;
4. Refusing to service an Eligible Person because of the reimbursement rate;
5. Failing to submit a claim for a Covered Item for an Eligible Person;
6. Disclosing Confidential Caremark Information;
7. Submitting the incorrect applicable DAW code;
8. Submitting inaccurate U&C Prices or ingredient costs;
9. Submitting a Product Identifier of a Covered Item that does not match the product dispensed to the Eligible Person or submitting a Product Identifier that does not match the product used to prepare the compounded product dispensed to the Eligible Person;
10. Non-adherence to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual;
11. Not dispensing an emergency supply of a Covered Item to an Eligible Person as required by applicable Law; and
12. Non-adherence to section **4.17 Software Certification** of the Provider Manual.

Provider must not separate cash and third-party prescription business or own, operate, or affiliate with a non-participating Provider to manipulate Eligible Person prescription claims processing or pricing. Providers not in compliance with Caremark Documents may be subject to assessment of non-compliance fees (refer to section **7.01 Non-Compliance Fees** of the Provider Manual) as well as subject to audit review and chargeback for non-compliance actions (e.g., modifying a U&C Price or ingredient cost, submitting a Product Identifier other than actual product dispensed, etc.).

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000986

7.01 Non-Compliance Fees

Caremark may find it necessary to perform claims review. Provider agrees that Caremark may review submitted claims and charge a reasonable amount to the Provider consistent with the resources required to perform the review. These reviews may be performed on all claims submitted by the Provider and may include, but not be limited to, consulting with the Prescriber or Eligible Person; review of copayment collection evidence, original prescription, prior authorization documentation, etc.; and other reviews to confirm compliance with the Provider Manual and applicable Law.

Caremark may assess against Provider a $475 administration fee for an initial occurrence of non-compliance or for each non-compliant submitted claim, increasing in $475 increments for subsequent non-compliant events (e.g., $475, $950, $1,425). Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for charges for non-compliance pursuant to the Provider Agreement or any Third-Party Agreement, or claims submitted in breach of the Agreement. Provider also may receive a Corrective Action Required (CAR) notice, with additional requirements and remedial measures, as outlined in section **8.08 Corrective Action Plan** of the Provider Manual.

Provider is liable for all fees, interest, penalties, damages, withholds, judgments, financial obligations, or other charges imposed upon Caremark as a result in whole or in part from Provider's non-compliance or omissions of any act or responsibility assumed by Provider under the Agreement.

Caremark's rights under this section survive the termination of the Provider Agreement.

7.02 Additional Information Regarding Compliance Reviews

1. Provider must be reachable by Caremark based on the contact information (as updated) that Provider specified to Caremark as part of enrollment or credentialing. It is essential that Provider keep contact information up to date to ensure reminders and other important communications are received. Refer to section **2.05 Notification to Caremark** of the Provider Manual.
2. Documents and records subject to review include, but are not limited to, the following:
    a. Prescription hard copies – scanned images must include both the front and back images of the original and the original must be retained and retrieved if requested
    b. Computer records/documentation
    c. Signature logs
    d. Delivery logs with tracking information for mailed or home/business delivered prescriptions
    e. Prescription label and dispensing label
    f. Compound Record and subformulations, which must include at minimum, actual Product Identifiers of all items used, lot numbers, expiration dates, compounding instruction, final compounded dosage form, signature of verifying pharmacist, and certificate of analysis. Provider must keep Compound Records for the same time period as required for prescription hard copies. Refer to chapter **4. Claims Submission** of the Provider Manual
    g. Evidence of copay collection including proof of financial transaction. Refer to chapter **3. Pharmacy Services and Standards** of the Provider Manual
    h. Methodology used to determine appropriate beyond-use date
3. For claim submission requirements refer to chapter **4. Claims Submission** of the Provider Manual.
4. For specific drug submission requirements, refer to **Appendix A – Drug Submission Requirements** of the Provider Manual. Audit Tip Communications may be sent to Providers periodically to advise of drug submission requirement updates.
5. For additional claim processing information, refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.
6. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance). For audit purposes, Provider must always maintain accurate documentation consistent with Caremark requirements to support overrides submitted, including overrides recommended by Pharmacy Help Desk representatives.

8. Professional Audits

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

As a service to its Plan Sponsors and Eligible Persons, and to educate Providers in complying with the Provider Agreement, Caremark engages in an on-going audit program. The audit program also serves to protect against fraud, waste, and abuse. As part of this program, Caremark may conduct reviews and audits of claims prior to payment to ensure compliance with the Provider Agreement. Caremark may also audit the claim post-payment. The positive adjudication of any claim does not limit or preclude Caremark's ability to review or otherwise audit or recoup that claim.

8.01 Types of Audits

Audits may be conducted in the form of an on-site audit, investigational audit, or desktop audit. There are other compliance reviews that Caremark may conduct as described in chapter **7. Compliance Reviews** of the Provider Manual.

8.01.01 On-site Audits

Caremark performs routine on-site audits. Caremark as a routine business practice may notify Provider two (2) weeks prior to a scheduled audit date or as required by applicable Law. For an on-site audit, auditors will generally review specific documents and records related to claims paid to Provider by Caremark during the previous twenty-four (24) months, unless otherwise required by applicable Law.

8.01.02 Investigational Audits

For an investigational audit, Provider is contacted via telephone, fax, or through the mail, and asked to provide specific documents and records related to claims paid to Provider or Eligible Person by Caremark during a specified period. Documentation may include, but not be limited to, prescription hard copies, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications.

8.01.03 Desktop Audits

For a desktop audit, Provider is contacted via telephone, fax, or through the mail to satisfy records and documentation requirements for limited reviews (e.g., MEDIC requests, CMS audits, Plan Sponsor audit inquiries, and compliance audits). Records and documentation requested must be provided in a timely manner not to exceed ten (10) days or according to applicable Law. Failure to submit all the required documentation by the due date may result in claim reversal, non-compliance fees, submission of a Corrective Action Plan (CAP), or potential termination from the provider network.

8.01.04 Audits by Government Agencies

Provider agrees that state and federal government agencies and their respective duly authorized representatives or designees, including, but not limited to, the Department of Health and Human Services and CMS (collectively "Government Auditors") have the right, for the period allowed by Law, to review, audit, examine, and reproduce Provider's books, records, prescription records, and other documentation, to the extent such Government Agency Audit is required by Law or under the asserted authority of the Government Auditor ("Government Agency Audit"), and Provider will cooperate in good faith with such Government Agency Audit. To the extent the Government Auditor requests either of Caremark's or Plan Sponsor's Provider books, records, prescription records, and other documentation as part of the Government Agency Audit, Provider agrees that it will provide such Provider's books, records, prescription records, and other documentation to Caremark within the timeframe as notified by Caremark based upon the Government Agency Audit, and agrees that Caremark has the right to produce such Provider's books, records, prescription records, and other documentation in Caremark's possession.

8.02 Professional Audits Rights

During the term of the Provider Agreement and for two (2) years following the termination of the Provider Agreement (or such time permitted under applicable Law), Caremark has the right to audit Provider's records and documents, facility and practices as Caremark reasonably determines are necessary to evaluate Provider's compliance with the

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000988

Provider Agreement and applicable Law. Caremark's audit may cover any claim submitted by Provider or Eligible Person to Caremark or Plan Sponsor for adjudication (regardless of the method of submission), claims for Covered Items, and U&C submissions. To the extent allowed by Law, if there is a conflict between the Provider Manual and applicable Law with respect to an audit of Provider, the audit is subject to the stricter provision.

Nothing in this **Professional Audits** chapter prohibits Caremark from conducting an audit of Provider that does not follow the established audit procedures set forth in this **Professional Audits** chapter to determine Provider's compliance with the terms of the Agreement, but in all cases compliant with applicable Law. Refer to chapter **7. Compliance Reviews** of the Provider Manual for other rights.

Unless unusual circumstances exist, Caremark will schedule an audit in advance and work with Provider to accommodate reasonable schedule change requests made prior to the audit date to a mutually agreeable time. Notice of an audit may be communicated to Provider via, telephone, fax, or mail.

Throughout the audit process:

- Provider is expected to be an active participant to ensure audit findings are accurate. Provider may designate an employee to facilitate the audit on behalf of Provider.
- Provider must provide the Caremark auditor with a clutter-free work area that does not disrupt the provision of Pharmacy Services, but with ease of access to records and documents required for the audit.
- Provider must maintain proper staffing during the audit to ensure that Provider is reasonably available for questions and the retrieval of records. If possible and requested by Provider, the Caremark auditor will wait a reasonable amount of time (10-15 minutes) while Provider locates any missing records and documents not found during the course of the audit.
- Provider must provide access to a Plan Sponsor (and its representatives or agents) to examine, audit, and copy Provider records and documents pursuant to its authority under contract with Caremark or by applicable Law.

Provider authorizes Caremark to release Provider's information, records, and documents to governmental authorities (and their agents), Plan Sponsors, and wholesalers upon request. Refer to section **8.01.04 Audits by Government Agencies** of the Provider Manual. Caremark reserves its rights under section **14.03 Confidentiality** of the Provider Manual.

If the Caremark auditor is denied access to Provider's records, documents, or facility, Provider is deemed non-compliant. Caremark has the right to recoup one hundred percent (100%) of the amount for the claims in question, with such amount becoming immediately due and owing to Caremark. Caremark has the right to offset the amounts due to Caremark against any amount due to Provider. Caremark may also exercise all remedies available to it including, but not limited to, payment suspension (in accordance with the terms of the Provider Manual) until the audit is completed or termination of the Agreement. In addition to other remedies, Caremark reserves the right to charge Provider for the costs of travel and expenses associated with the audit and additional resources needed to address audit non-compliance.

Caremark audits do not employ extrapolation unless required under applicable Law.

Provider must notify Caremark in the event of a change in the pharmacy's physical location prior to the change. Refer to section **2.05 Notification to Caremark** of the Provider Manual.

8.03 Documents and Records Production Related to Audits

Provider must provide Caremark with all requested documents and records as Caremark reasonably determines are necessary to evaluate Provider's compliance with the terms of the Provider Agreement and applicable Law, and Provider must fully comply with such requests, including the delivery of all requested documents and records to Caremark by the specified due date and without charge to Caremark. If Provider fails to provide requested documents and records, the entire amount of the paid claim for which documents and records were not provided are due and owing. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date.

Submission of false or misleading records and documentation may result in chargeback for all claims audited and any other remedies available to Caremark including, but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies. If clarification of documentation is requested by Caremark, Provider is required to submit unaltered original documentation.

Documents and records must be readily retrievable at the Dispensing Pharmacy.

Caremark reserves the right to not consider Provider actions (and documentation of such actions) that take place

after Provider is notified of an audit as a demonstration of compliance with the Agreement. Refer also to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual.

Provider's failure to comply with document and records requests as required under the Agreement is a breach of the Agreement and is subject to remedies available to Caremark including termination of the Agreement.

8.04 Documents and Records Subject to Audit

Documents and records subject to audit include, but are not limited to, the following:

- Prescription hard copies - Scanned images must include both the front and back images of the prescription hard copy and the prescription hard copy must be retained and retrieved if requested. Prescription hard copies or scanned images of prescription hard copies must be legible by Caremark
- Signature logs
- Delivery logs with tracking information for mailed or home/business delivered prescriptions
- Daily prescription logs
- Wholesaler, manufacturer, and distributor invoices (with NDC, drug names, quantity, package size, etc.)
- Transaction Statement, Transaction History, and Transaction Information and Documentation as defined in section **8.05 Supply of Covered Items; Purchase Invoices** of the Provider Manual
- Refill information
- Prescriber information
- Patient profiles/Prescriber orders
- Records to validate U&C
- Prescription label and dispensing label
- Provider system report of Pharmacy Services reversed, returned to stock, or not dispensed with confirmation of reversal of the claim submission
- Recorded diagnosis on prescription hard copy or maintained in the computer system for all Medicare Part B Pharmacy Services dispensed under a Medicare Part D plan
- Record of Eligible Person location (e.g., skilled nursing facility, assisted living facility) when claim is dispensed
- Records of transfer/sale between providers of drugs and devices used for Pharmacy Services
- Records of prescription transfers, including evidence of Eligible Person's express permission to Provider to transfer his or her prescription to another pharmacy
- Medication pricing brochures for cash customers (e.g., paper pamphlet, promotional signage, internet listing)
- Patient consent and administration record of vaccine claims (combination vaccine/administration)
- Evidence of copay collection including proof of financial transaction [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash]. If the Patient Pay Amount is reduced due to a coordination of benefits, Provider must provide evidence of the claim adjudication to other payer(s)
- Documents pertaining to individualized determination of financial need or exhaustion of reasonable Patient Pay Amount collection efforts. Refer to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual
- Proof of completion of annual Medicare Part D FWA training and General Compliance Training (GCT)
- Verification that Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **2.09 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual
- Prescription record documentation for Medicare Part D Enrollees with diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD)
- Signed Prescriber or patient attestation legitimizing the dispensing of the prescription if a prescription hard copy, medication order, patient signature log or patient delivery log is not retrievable. Prescriber attestations must be written on the Prescriber's business letterhead or on the Prescriber's prescription. Attestations provided by the Prescriber must clearly indicate the source of the attestation (i.e., clearly visible fax signature that the attestation originated from the Prescriber's office or Prescriber's stamp on the attestation)

- All records acquired in the purchase of a pharmacy or in the purchase of pharmacy files
- Documentation substantiating transmission of submission clarification codes (SCC) or override codes
- Evidence of verification of legitimate Prescriber/patient relationship if Provider knows or reasonably should know that there is not a legitimate Prescriber/patient relationship
- Collaborative practice agreement(s)
- Credit Card Merchant Account Report including evidence of settlement and payment through bank records
- Policies and procedures related to all Provider operations including, but not limited to, collection of Patient Pay Amounts and inventory controls
- Documents to evidence that Provider is compliant with their own policies and procedures and/or corrective action plan
- Any document deemed necessary by Caremark to determine Network Provider's compliance with any terms and conditions set forth within this Provider Manual
- Refer to section **7.02 Additional Information Regarding Compliance Reviews** of the Provider Manual for required Multi-Ingredient Compound Documents

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 C.F.R. 164.502 and 45 C.F.R. 154.501). Provider further acknowledges that in order to receive payment from Caremark, Provider is required to allow Caremark to conduct audits of its prescription and other pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws. Additionally, Provider recognizes that Caremark audit staff may be exposed to or otherwise become aware of certain confidential, protected, and individually identifiable health information of patients who are not Eligible Persons during the course of the audit review, and that such disclosures by Provider to Caremark are incidental to the payment disclosures and are therefore permitted by HIPAA under 45 C.F.R. 164.502(a)(iii) provided that reasonable safeguards are implemented by Provider to limit such incidental disclosures. Caremark will maintain confidentiality of this information and will not disclose, publish, or otherwise reveal any of this confidential information except as necessary to conduct its audit pursuant to applicable Law.

8.05 Supply of Covered Items; Purchase Invoices

All Covered Items used by Provider to fill prescriptions or otherwise meet requests of Eligible Persons must be sourced from an Authorized Trading Partner [which includes manufacturers, distributors, wholesalers, and other pharmacies, and as defined under the Drug Supply Chain Security Act 21 U.S.C.A § 360eee ("DSCSA")] that is subject to regulatory oversight and duly licensed under all applicable Law including, but not limited to, the Food and Drug Administration, Drug Enforcement Administration and state Boards of Pharmacy. For those Covered Items that are regulated by the DSCSA and any regulations promulgated under the DSCSA, Provider must maintain the Transaction Statement, Transaction History, and Transaction Information that it receives from the Authorized Trading Partner as set forth in this section.

For those Covered Items for which a Transaction Statement, Transaction History and Transaction Information are not required by the DSCSA, Provider must maintain records of the exact quantities purchased, name of the Authorized Trading Partner, Covered Item name(s), NDC(s), date(s) of purchase, and proof of payment [e.g. copies of credit card receipts, canceled checks (front AND back)] (collectively "Documentation"). For those Covered Items received from other pharmacies, where permitted by and consistent with Law, Provider must obtain and maintain the entire Transaction Statement, Transaction History, and Transaction Information from the selling entities. Failure to acquire and maintain records will result in the Covered Items received from other pharmacies being ineligible to be dispensed to Eligible Persons. Unless permitted by applicable Law, Provider must not use Covered items which are foreign-sourced, samples, returned, recalled, expired, or otherwise "suspect", as defined below, to dispense to or otherwise provide for Eligible Persons under the Provider Agreement. For diabetic testing supplies, Provider must use diabetic products that have been sourced either from within the manufacturer's authorized distribution channel or purchased directly from the manufacturer.

It is the sole responsibility of Provider to ensure that all wholesalers, manufacturers, distributors, or other pharmacies that Provider utilizes to source Provider's purchases of Covered Items are Authorized Trading Partners, or in the case of diabetic test strips, sourced from within the manufacturer's authorized distribution network. As a means to identify the authorized distribution network, Provider must search the manufacturer's website and print the listing of authorized distributors from the manufacturer's website and maintain this document in Provider's records to demonstrate compliance. Provider must check the authorized manufacturer's website (no less than annually) to ensure that it is utilizing the most current information in order to protect patient safety.

Provider's receipt of Covered Items when Provider knows, or reasonably should have known, that the Covered Item

is suspect may result in chargeback of claims and other remedies available to Caremark including, but not limited to, termination of the Agreement. For purposes of this section "suspect" means a Covered Item that is potentially counterfeit, diverted, or stolen; is potentially intentionally adulterated such that the Covered Item would result in serious adverse health consequences or death to humans; is potentially the subject of a fraudulent transaction; or appears otherwise unfit for distribution such that the Covered Item would result in serious adverse health consequences or death to humans.

Provider must make available to Caremark Transaction Statement, Transaction History, and Transaction Information and Documentation as part of Caremark's audits. Provider must fully cooperate with Caremark in audits or in the course of investigation of suspect or reported violations of this section. Caremark's audit may involve selecting a date range for aggregate purchase invoice review. Provider's purchases occurring within the date range of the aggregate purchase invoice review, or thirty (30) days prior thereto, must be sufficient to support the total quantity dispensed by Provider (or provided to Eligible Persons) as reflected in the claims billed to Caremark during the same date range of the aggregate purchase invoice review. Caremark will not accept purchases occurring outside of thirty (30) days prior to the selected date range unless: (1) Provider notifies Caremark in writing of its intent to make a bulk purchase (i.e., more than thirty (30) days of inventory) of a Covered Item within seven (7) days prior to the purchase; and (2) Caremark approves the bulk purchase in writing. If Provider has not purchased sufficient Covered Items to substantiate the quantity of claims billed, those claims may be subject to chargeback and other remedial action. If Provider fails to timely provide all the requested Documentation in accordance with this section, one hundred percent (100%) of the amount for the paid claims audited is subject to chargeback and other remedies available to Caremark including, but not limited to, termination of the Agreement.

Mail bulk purchase notification to:
CVS Caremark
Attn: Bulk Purchase Notification, MC 020
9501 E. Shea Blvd.
Scottsdale, AZ 85260

8.05.01 Invoice Documents and Records Maintenance

Provider must maintain any Transaction Statement, Transaction History, and Transaction Information provided to Provider pursuant to the DSCSA and any regulations promulgated under the DSCSA for the period required by applicable Law and any Documentation during the term of the Agreement and for two (2) years after the termination of the Agreement.

8.06 Medicare Part D Requirements

Provider must provide documentation to demonstrate compliance with all Medicare Part D requirements (as stated in the Provider Manual, Caremark Medicare Part D Addenda, CMS guidance, or under applicable Law) including, but not limited to:

- Long-term Care billing
- Correct use of valid Patient Residence Code values (the term "correct" means, for example, submitting the actual Patient Residence code for patients where they physically reside rather than a Patient Residence Code for a recognized LTC/ALF where the patient previously resided). Refer to section **10.07 Special Instructions for Participating LTC Providers** of the Provider Manual
- Correct use of Pharmacy Service Type values. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual
- Compliance with "CMS-10147 Medicare Prescription Drug Coverage and Your Rights" pharmacy notification
- Documentation to establish coverage determinations (e.g., Hospice, Part B vs. Part D, ESRD)
- Documentation to prove that Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **2.09 Federal Health Care Programs Participation Exclusion: Pharmacy of the Provider Manual to confirm that no Prescriber transmitted on a Medicare Part D claim is on any exclusion list**
- Documentation or information requested which relates to a Medicare Part D claim dispensed by Provider but reimbursed directly to other parties, including the Part D Enrollee
- Documentation substantiating any submission clarification codes (SCC) or override codes transmitted on a Medicare Part D claim

Documentation submitted must comply with guidance set forth by CMS or any other applicable regulatory body or its designated auditor.

If a copy of a prescription or signature log is not retrievable after sufficient effort, Provider must obtain either Prescriber or Eligible Person attestations.

For further requirements refer to Chapter 10. Medicare Part D of the Provider Manual.

8.07 On-Site and Investigational Audit Resolution – Appeals Process

As part of an audit, Caremark may identify claim discrepancies. If Caremark identifies claim discrepancies Caremark will send Provider an initial discrepancy report along with Documentation Guidelines (refer to **Appendix C – Appeals Process Documentation Guidelines** of the Provider Manual) that show how Provider may address an initial discrepancy and validate the audited claim through a written appeals process.

If Provider chooses to appeal the initial discrepancies Provider must respond to Caremark in writing within thirty (30) days, or other timeframe required by applicable Law, with supporting documentation for the discrepant claim in accordance with the Documentation Guidelines or the Provider Manual. Documentation must be transmitted to Caremark via certified mail, fax, Federal Express, United Parcel Service, or any other certified carrier (with delivery confirmation) and must be received by the due date specified by Caremark. Provider may contact the Pharmacy Performance department at **1-866-488-4709** prior to the documentation due date to request an extension of the documentation due date. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date. Late documentation will not be accepted.

Upon review of Provider's appeal documentation, or at the end of the thirty (30) day appeal period if Provider has not submitted appeal documentation, Caremark will issue a final audit report. Discrepant claims that are not documented and validated in accordance with the Documentation Guidelines or the Provider Manual are detailed in the final discrepancy report and are due and owing to Caremark as of the expiration of the thirty (30) day appeal period or other timeframe required by applicable Law; however, Caremark has the right to offset, if consistent with applicable Law, against amounts owed to Provider before the expiration of the thirty (30) day period, or other time period required by Law, for any discrepant claims as allowed for under section **6.09 Provider Suspension** of the Provider Manual. Audit discrepancies are detailed in a final audit discrepancy report.

Any documentation submitted after the documentation due date may be considered by Caremark as part of Caremark's evaluation of the remedies to be taken by Caremark to address the audit findings but will not impact the final chargeback amount owed to Caremark.

Refer to section **15.09 Arbitration** of the Provider Manual for the dispute resolution process once the final audit discrepancy report is complete.

If the final audit chargeback exceeds $10,000, Provider must also reimburse Caremark twenty percent (20%) of the total final audit chargeback for operating costs and expenses arising out of or related to conducting the audit and collecting the final audit chargebacks, where consistent with applicable Law.

Provider must notify Caremark of Provider's appeal of an initial discrepancy report in writing to:

CVS Caremark – Audit Manager
Attn: Pharmacy Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for audited discrepant claims, audit-related costs pursuant to the Provider Agreement or any Third-Party Agreement, claims submitted in breach of the Agreement, or any audit conducted by a third-party auditor on behalf of a Plan Sponsor. If the Provider fails to satisfy amounts owed related to an audit finding, certain remedies may apply, including termination of the Provider Agreement and any other available remedies.

When Caremark collects from Provider amounts due as a result of audit discrepancies Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an Eligible Person or Plan Sponsor in relation to such adjustment or chargeback.

Once Provider is on notice of an on-site or investigative audit Provider must not during the audit process adjust or reverse claims that are the subject of the audit as Caremark will perform appropriate adjustments and reversals at the conclusion of the audit process.

Caremark may report its audit findings to Plan Sponsors and local/state/federal investigative and law enforcement agencies (and their agents).

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000993

8.08 Corrective Action Plan

A corrective action required (CAR) notice may be sent to Provider requiring Provider to submit to Caremark a corrective action plan (CAP) that in detail describes Provider's plans to resolve identified issues such as audit findings, dispensing errors, failure to respond to audit requests, failure to correct repeated verbal and/or written warnings regarding non-standard retail pharmacy model practices, or as may be required by applicable Law. Provider must respond to any request for information and action in a CAR notice. Provider's response must be submitted by the date provided on the CAR and must include a CAP. Provider's CAP must include applicable documentation and policies and procedures as specified in the CAR notice to support Provider's CAP. As part of the CAP process, Provider may be assessed a per claim review fee where permitted by applicable Law for oversight claim activity during the CAP period (refer to section **7.01 Non-Compliance Fees** of the Provider Manual). If Provider fails to fully respond to a CAR notice or any other request for information and action as part of the CAR/CAP process, fails to follow the CAP, or requires a CAR/CAP for the same or similar issues, Caremark reserves the right to exercise its termination rights under the Provider Agreement, along with other available remedies.

8.09 Potentially Fraudulent Activity

If Provider suspects that potentially fraudulent prescriptions are being presented or that other improprieties regarding claims are occurring Provider must notify Caremark by telephone at **1-877-841-1851** or by written correspondence at:

CVS Caremark
Attn: Network Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Provide the Eligible Person's name and identification number, the Prescriber's name and identification number, a detailed description of the suspected fraudulent activity and any related supporting documentation.

Examples of potentially fraudulent activity that warrant notification to Caremark may include, but not be limited to:

- Eligible Person presenting a forged or altered prescription
- Eligible Person presenting a prescription not written by the Prescriber identified
- Eligible Person calling in his or her own prescription
- Eligible Person presenting a prescription indicating a medication which is not consistent with the practice or specialty of the Prescriber
- Eligible Person presenting a prescription for an ineligible person or fictitious family member

Provider may also consider notifying the Drug Enforcement Administration (DEA) or other related regulatory agencies.

9. Medicaid

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

To the extent Provider provides Pharmacy Services to a Medicaid Eligible Person and without limiting any other provision in the Agreement (including the Provider Manual), Provider must, at minimum, comply with the following terms.

9.01 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicaid Eligible Person is made, in whole or in part, from state and federal funds, which subjects Provider to laws, such as but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable Laws including minimum standards of pharmacy practice. Refer to the **Federal and State Laws and Regulations** section of the Provider Manual (located on the Pharmacy Portal, at **rxservices.cvscaremark.com**), including state-specific addenda. Provider agrees to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions. [42 C.F.R. 438.230(c)(2)]. Provider acknowledges that Provider's ability to provide Pharmacy Services under the Agreement for Medicaid Eligible Persons may be revoked if it is determined that Provider has not performed satisfactorily [42 C.F.R. 438.230(c)(1)(iii)].

9.02 Enrollment with State Medicaid

Pursuant to 42 C.F.R. 438.602(b), Provider shall ensure that it is enrolled with each state Medicaid agency for which Provider provides Pharmacy Services under the Agreement. Provider agrees that if it is not enrolled with the applicable state Medicaid program, it may not provide Pharmacy Services under the Agreement for that state Medicaid program's enrollees.

9.03 Medicaid Credentialing

Provider shall comply with Caremark's credentialing requirements. Failure to do so impacts Plan Sponsors in terms of compliance to their governing body(ies) and impacts Eligible Persons in terms of Eligible Persons' ability to locate Provider's physical location or contact information in a prompt manner. Provider must provide Caremark with documentation and other information that is required to comply with "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E); otherwise, Provider may be subject to termination or other available remedies. Provider is required to notify Caremark and, where applicable, the Plan Sponsor and provide updated, accurate information such as physical address, city, state, ZIP code, telephone number and fax number; changes to location, and contact information in a timely manner not to exceed ten (10) days or according to applicable Law or enrollment agreement. Failure to submit updates of the required information by the due date may result in non-compliance fees, CAR (Corrective Action Required), and CAP (Corrective Action Plan) to be submitted, or potential termination from the provider network. Refer to chapter **2. Credentialing** of the Provider Manual for additional information.

Provider must allow CMS, its agents, its designated contractors (e.g., recovery audit contractors), or the applicable state Medicaid agency to conduct unannounced on-site inspections of Provider's location(s). 42 C.F.R. § 455.432.

9.04 Fraud, Waste and Abuse Compliance Program

Provider shall maintain a compliance program in accordance with 42 C.F.R. 438.608 to detect fraud, waste, and abuse.

9.05 Inspection and Audit of Records and Access to Facilities

Pursuant to 42 C.F.R. 438.3(h), Provider shall allow a state Medicaid program, CMS, the DHSS Office of the Inspector General, the Comptroller General, and their designees, to, at any time, inspect and audit any records or documents of Provider, and inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for ten (10) years from the final date of the Agreement or from the date of completion of any audit, whichever is later. See also 42 C.F.R. 438.230(c)(3).

9.06 Claims Submission Requirements for Medicaid

Additional Plan Sponsor-specific information, such as claims submission requirements for 340B drugs, may apply as specified in notices to Provider or in the Caremark Payer Sheets. Refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.

9.07 Medicaid Coordination of Benefits

By Law, Medicaid is typically the payer of last resort, which pays after any other applicable primary programs have been billed. Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider first must submit its claim to the appropriate payer as required by and in accordance with any Coordination of Benefits (COB) requirements, and must engage in appropriate COB activities to the extent required by Caremark, or applicable by Law.

Refer to section **4.10 Coordination of Benefits** of the Provider Manual. For complete technical information on COB, refer to the Payer Specification Sheets located at **www.caremark.com/pharminfo**.

9.08 Prior Authorization

Where permitted by applicable state Law and the Plan Sponsor, Provider is authorized to dispense a limited number days supply of medically necessary Covered Items if the Prescriber is unavailable to process a prior authorization request within a reasonable time period. Plan Sponsor-specific processes and contact information may apply as indicated in Caremark Documents.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

9.09 Denial of Services

Provider must not deny services to an Eligible Person on account of such individual's inability to pay the Patient Pay Amount to the extent consistent with applicable Law.

9.10 Cultural Competency

Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. § 438.206(c)(2).

9.11 Home Delivery

A Medicaid beneficiary may not be charged for the expense, or any portion of an expense, as the result of a prescription medication being mailed, shipped, or delivered (including curbside delivery), etc.

9.12 Directories

Provider shall provide Caremark with all information that may be needed in connection with Caremark's initiatives to comply with 42 C.F.R. 438.10 concerning pharmacy directories. Additionally, at Caremark's sole discretion, Provider's credentials may be updated without Provider's confirmation using alternative data sources.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00000996

10. Medicare Part D

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

10.01 Medicare Part D Network Standards

To the extent Provider provides Pharmacy Services to a Part D Enrollee, Provider must comply with the following terms contained in this **Medicare Part D Network Standards** section of the Provider Manual. Unless specifically indicated otherwise, these terms apply to all Providers who provide Pharmacy Services to a Part D Enrollee (including retail, home infusion, long-term care, and Indian Health Services/Tribal/Urban Providers). Provider acknowledges that CVS Caremark Part D Services, L.L.C. together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this section) are responsible for providing Part D services on behalf of Part D Plan Sponsors. All capitalized terms used in this **Medicare Part D Network Standards** section will have the same meaning as in the applicable **Addendum to the Caremark Provider Agreement: Terms of Participation in Medicare Part D**, or the **Glossary of Terms** in the Provider Manual.

10.01.01 Network Participation

For any Part D plan year, and to ensure adequate access to retail network pharmacies for Part D Enrollees, Provider must provide Caremark with written notice by no later than March 31 of the prior calendar year, or other time as specified in the cover letter accompanying Medicare Part D network enrollment form solicitations, if Provider will not be participating in a Medicare Part D network including, but not limited to, the retail, long-term care, and home infusion networks for that plan year. For example, if Provider will not be participating in the Medicare Part D retail pharmacy network for the 202X plan year, it must notify Caremark in writing by no later than the specified date indicated in the solicitation for that Medicare Part D network enrollment form. If such timely written notice is not given, Provider must participate in such Medicare Part D network for the entire Part D plan year unless Provider terminates with cause its participation in accordance with the Provider Agreement. If Provider elects to participate, either passively or by signing and returning the network enrollment form (as applicable), and does not terminate from a Medicare Part D network, Provider is deemed to be in agreement to all terms and conditions (including reimbursement), as reasonable and relevant, regardless of the business model or dispenser type in which Provider identifies. Additionally, if the network enrollment forms incorporate a performance program, Provider must support all performance initiatives in keeping with the accepted terms and conditions and acknowledges that no additional dispenser-type definitions apply to a pharmacy participating in a Medicare Part D retail pharmacy network, in accordance with CMS guidance.

The terms of this **Network Participation** section supersede and amend any inconsistent or contrary provision in the Provider Agreement, including section **15.05.02 Termination Without Cause** of the Provider Manual, but will only apply to the extent that this section is consistent with a Part D Plan Sponsor requirement.

The deadlines set forth in chapter **6. Network Participation and Payment** of the Provider Manual do not apply to Medicare Part D network solicitations to participate in a new Medicare Part D network for which the deadline for participation will be as stated in such Caremark written solicitation.

10.01.02 Compliance with Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Part D Enrollee is made, in whole or in part, from federal funds and subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with minimum standards of pharmacy practice under applicable state Law. Refer to chapter **16. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Pharmacy Portal, refer to section **1.07 Caremark Pharmacy Portal** of the Provider Manual.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00000997

10.01.03 Delegated Activity

Provider must obtain prior written approval from Caremark if Provider wishes to delegate any activity or responsibility related to its Pharmacy Services to a subcontractor. Upon Caremark's written approval of such delegation, Provider must obtain written agreement from such subcontractor that the subcontractor will comply with all of the terms and conditions of the Provider Agreement (which includes the Provider Manual) applicable to Provider including, but not limited to, the requirement to comply with the contractual obligations specified for downstream entities in 42 C.F.R. 423.505(i)(2) and (i)(3) that relate to, among other things, retention of books and records, including prescription records, for at least ten (10) years or longer as specified in 42 C.F.R. 505(i)(2); and section **2.09 Federal Health Care Programs Participation Exclusion: Pharmacy**, and chapters **4. Claims Submission**, and **8. Professional Audits** of the Provider Manual. Provider's written agreement with subcontractor must provide that the agreement and/or delegated activities may be revoked (or specify other remedies) in instances when CMS, Part D Plan Sponsor, or Caremark, or any of Caremark's subsidiaries or affiliates determines that the subcontractor has not performed satisfactorily. In the event that any subcontractor is terminated by CMS or Part D Plan Sponsor, Provider must immediately notify Caremark of such termination.

10.01.04 Offshore Subcontracting

If Provider or any of Provider's subcontractors (or downstream subcontractors) receive, process, transfer, handle, store, or access Protected Health Information (PHI) of Part D Enrollees outside the United States or one of the United States Territories, Provider agrees to notify Caremark and to comply (and to require any downstream subcontractors to comply, as applicable) with the requirements specified in CMS memorandum of July 23, 2007, entitled "Sponsor Activities Performed Outside of the United States (Offshore Subcontracting)." Further, Provider agrees to submit to Caremark information to enable Caremark or Caremark's Part D Plan Sponsors to provide the "Attestation Concerning the Use of Offshore Contractors" form contained in the July 23, 2007, CMS memorandum, which includes, but is not limited to, providing to Caremark information of Provider's own or Provider's offshore subcontractor operations, safeguards to protect PHI, and auditing to ensure protection of PHI.

10.01.05 Marketing

Provider must conduct marketing activity in a manner consistent with the Medicare regulation and guidelines, including the Medicare Communications and Marketing Guidelines. Provider must remain neutral when assisting Part D Enrollees with enrollment decisions in an objective assessment of his or her needs and potential options to meet those needs.

10.01.06 Fraud, Waste and Abuse (FWA) Program

Provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Compliance Program Guidelines to prevent, detect, and correct Fraud, Waste and Abuse (FWA). Provider also agrees to comply with Part D Plan Sponsor's policies and procedures, and any corrective action plans imposed by Part D Plan Sponsors or Caremark related to the Part D Program. Provider must submit copies of Provider's policies and procedures, and corrective actions related to Part D activities as requested by Caremark. Provider must cooperate fully with a Part D Plan Sponsor's FWA investigative activities including providing copies of prescriptions, signature logs, and other requested documentation to support FWA investigations.

10.01.07 Pharmacy Compliance and FWA Training

The following training is available for all pharmacies and staff on the pharmacy website, **www.caremark.com/pharminfo**, under "Medicare Compliance Training for Pharmacy Staff":

- CVS Health Code of Conduct
- CMS General Compliance (.pdf)
- CMS Combating FWA Training (.pdf)

Note: For more information about Medicare Parts C and D Compliance Program requirements, please visit **www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/CompliancePrograмPolicyandGuidance**.

10.01.08 Information on CMS-10147 Pharmacy Notice

CMS-10147 - Medicare Prescription Drug Coverage and Your Rights

1. CMS requires that Caremark distribute the "Medicare Prescription Drug Coverage and Your Rights" form (Pharmacy Notice – CMS 10147) to Providers on an annual basis. This form is used to instruct Part D Enrollees to contact their Part D Plan to obtain a coverage determination (prior authorization) or ask for a formulary or tiering exception if the Part D Enrollee disagrees with Plan claim response information provided to the Pharmacy.
2. Pharmacies must provide the Part D Notice of Appeal Rights directly to Part D Enrollees any time the following reject(s) and related messaging occurs on a claim:

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

3. This notice is provided in **Appendix B** of the Provider Manual in English and Spanish. This is a standard notice and Provider may not deviate from the content of the notice. Note that the OMB control number [APPROVED OMB #0938-0975] must be displayed in the upper right corner of the notice.
4. This document is distributed to Providers annually by Caremark and is also posted at: **www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html**
5. Distributing this notice fulfills the requirements at 42 C.F.R. § 423.562(a)(3).

10.01.09 Performance Monitoring

Provider understands that Caremark and Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis. Provider must cooperate with Caremark and Part D Plan Sponsor as necessary to support Caremark and Part D Plan Sponsor monitoring strategies including, but not limited to, allowing Caremark and Part D Plan Sponsor to inspect, evaluate, and audit Provider's operations, documents, and records.

10.02 General Information

10.02.01 Part D Reference Information for Pharmacists

Refer to the following website: **www.cms.gov/Medicare/Medicare.html** which contains helpful information on a variety of Medicare Part D topics for Providers. CMS frequently updates this website, so check periodically for the latest information.

10.02.02 Medicare Part D Calls to the Pharmacy Help Desk

The Pharmacy Help Desk interactive voice response (IVR) system immediately routes Medicare Part D inquiries to appropriate information/pharmacy service representatives through an initial request/prompt to discover if Provider is calling on behalf of a Part D Enrollee or about a Medicare Part D Claim.

Provider will be routed to a specialized team prepared to handle and resolve Medicare Part D inquiries. If the Part D Enrollee does not have an ID card available, ask for an acknowledgement letter. If an acknowledgement letter is not available, call **1-800-MEDICARE (1-800-633-4227).** Only if needed, Provider can submit an enhanced E1 transaction to determine the processing information.

The Pharmacy Help Desk numbers are provided below:

Caremark System	RXBIN	Pharmacy Help Desk Number	Point-of-Service Assistance B vs D
Legacy ADV	004336*	1-866-693-4620	
Caremark	610591	As communicated by plan or refer to ID card	
SilverScript	004336*	1-866-693-4620	1-855-503-6054
Non-SilverScript	004336*	As communicated by plan or refer to ID card	1-855-238-9379
NEJE (New England Joint Enterprise)	004336*	1-866-693-4620	1-844-635-3407
IngenioRx (Anthem)	020115	1-833-377-4266	
IngenioRx	020388	1-833-377-4266	
Aetna	610502	1-800-238-6279	

Secondary RXBINS and Plan sponsor-specific RXBINs and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at **www.caremark.com/pharminfo**.

*Puerto Rico Providers call toll-free **1-800-842-7331**.

Pharmacy Help Desk representatives will use reasonable efforts to assist Providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with the respect to the provision of Pharmacy Services. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

10.03 Credentialing

10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies

Provider agrees to comply with the following provisions:

1. Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **10.03.02 Federal Health Care Programs Participation Exclusion** of the Provider Manual.
2. Provider has a record retention policy in place that complies with CMS's minimum of 10-year record retention requirement and with other applicable state Law.
3. Provider has in place and provides FWA training to all employees and managers (who are directly or indirectly involved with the administration of delivery of Part D benefits) within thirty (30) days of their date of hire and annually thereafter.
4. Provider tracks employee and manager attendance for any training conducted.
5. Provider must provide a copy of the training materials upon request.
6. Provider attests that if any services that support the Provider Agreement or if any of its subsidiaries or affiliates are delegated, the performance of those services is monitored by Provider to ensure compliance with the applicable Medicare Part D requirements.
7. Provider has entered into written arrangements with its subcontractors which provide for revocation of the delegation activities or specify other remedies in instances when CMS or Caremark or any of its subsidiaries or affiliates has determined that the parties have not performed satisfactorily.
8. Provider certifies that it is free of any conflicts of interest (within the meaning of the CMS Prescription Drug Benefit Manual, Chapter 9) in administering or delivering its Pharmacy Services, and will require its managers, officers, and directors responsible for the administration or delivery of Pharmacy Services for Part D Enrollees to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer, or director is free from any such conflict of interest.

10.03.02 Federal Health Care Programs Participation Exclusion

A. Prescriber

In accordance with CMS requirements, Part D Plan Sponsors must have policies and procedures in place to implement a comprehensive program to detect, prevent, and control fraud, waste, and abuse, including a process to identify any claims that were submitted for drugs that were prescribed by an excluded Prescriber, and a process to report and properly repay any overpayments resulting from inaccurate payments in accordance with CMS policy. The guidance also states that Part D Plan Sponsors must not pay for drugs prescribed by a Prescriber excluded by either the Health and Human Services-Office of Inspector General (HHS-OIG) or System for Award Management (SAM).

Caremark implemented an automated point-of-sale process to deny Part D Claims for drugs prescribed by excluded Prescribers. Provider may receive the following reject:

Reject A1 <<Prescriber is Federally Excluded>>

If Provider receives this electronic message, do not resubmit the claim for processing unless, in Provider's professional judgment, it is an emergency situation. If it is an emergency situation, call the appropriate Pharmacy Help Desk contact number referenced in this section.

The Caremark point-of-sale reject is intended to assist Provider in the identification of excluded Prescribers, but does not serve as a substitute for the Provider's own comprehensive program to identify claims for drugs prescribed by excluded Prescribers. Provider must maintain a comprehensive program to identify claims for drugs prescribed by an excluded Prescriber in the event that a point-of-sale reject does not occur.

B. Precluded Prescriber

In accordance with CMS guidance, claims prescribed by an individual on the Preclusion List will reject with the following or similar reject:

Reject 929 <<Prescriber ID is precluded>>

The Preclusion List includes prescribers who meet one of the following conditions:

- Prescribers that are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Prescribers that have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but is not limited to, felony convictions and Office of Inspector General (OIG) exclusions.

There is no override for this reject. Impacted Part D Enrollees that have concerns or need assistance finding a new Prescriber should contact Medicare's toll-free customer care operations at **1-800-MEDICARE (1-800-633-4227)**.

C. Pharmacy Provider

Pharmacy Provider must review the OIG LEIE and the SAM Excluded Prescriber lists. Provider must not submit any claim to Caremark for a prescription written by an excluded Prescriber, nor should a Pharmacy Provider submit claims if Provider is excluded or debarred from participation in any Federal health care program. Provider agrees that any claim submitted in violation of this section is subject to chargeback. Refer to section **4.03 Other Claim Submission Requirements**, (bullet 9. **Federal Health Care Programs Prescriber Participation Exclusion**) of the Provider Manual.

10.04 Pharmacy Services and Standards

10.04.01 Plan Identification Cards

Provider must submit claims to the claims adjudication system whenever the Part D Enrollee's plan identification card is presented to or on file with Provider, unless the Part D Enrollee expressly requests that a particular claim not be submitted.

10.04.02 General Procedures for Acknowledgement of Enrollment Letters

In order to comply with CMS requirements, Providers should honor Part D Enrollee acknowledgement of enrollment letters if presented to Provider in place of identification cards.

An acknowledgement letter is a letter that qualified Part D Enrollees receive from their Part D Plan in advance of the distribution of Part D Plan identification cards. The letter should contain sufficient information in order to verify a Part D Enrollee's eligibility and to submit claims to the appropriate location in order for adjudication to occur. Note, letters confirming initial information was received but has yet to be confirmed or processed may not constitute a Part D acknowledgement letter.

If there is insufficient/inaccurate information on the letter or if the claim rejects, the following steps may be useful whether the information was obtained from an acknowledgement letter, an identification card, or from the Part D Enrollee directly:

1. If a Part D Enrollee's eligibility cannot be verified, send an E1 transaction to the Transaction Facilitator (RelayHealth) to verify the Part D Enrollee eligibility and to obtain information necessary to process claims. It is Provider's responsibility to verify Part D Enrollee is the Part D Enrollee identified in the response. For more information on E1 transactions visit RelayHealth at **medifacd.mckesson.com/e1/**.
2. If a Part D Enrollee's eligibility cannot be verified in Step 1 but Caremark is the processor, contact the appropriate Pharmacy Help Desk phone number. Refer to sections **1.04 Pharmacy Help Desk** and **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual.
3. If a Part D Enrollee's eligibility cannot be verified in Step 2, call **1-800-MEDICARE** to verify the Part D Plan under which the Part D Enrollee is enrolled, and if possible, verify the Part D Enrollee's eligibility information.

10.04.03 Best Available Evidence

CMS created the Best Available Evidence (BAE) policy requiring Part D Plans to establish the appropriate cost-sharing for low-income Part D Enrollees when presented with evidence that the Part D Enrollee's information was not accurate. As a result, a CMS best practice is for Providers and Part D Plans to work to resolve these issues at the point of sale when Part D Enrollees present appropriate evidence of correct low-income status.

1. Provider should initiate the BAE process in order for a change to a Part D Enrollee's low-income status to occur if Provider is presented with one or more of the following acceptable forms of evidence from Part D Enrollees:
   a. A copy of the Part D Enrollee's Medicaid card which includes the Part D Enrollee's name and an eligibility date during the discrepant period;

b. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title, and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
c. A copy of a state document that confirms active Medicaid status during the discrepant period;
d. A printout from the State electronic enrollment file showing Medicaid status during the discrepant period;
e. A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
f. Other documentation provided by the State showing Medicaid status during the discrepant period.

2. In addition, any one of the following forms of evidence from Part D Enrollees may establish that they are institutionalized and qualify for zero cost-sharing:
   a. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
   b. A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
   c. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.
3. Acceptable documents that may be used as BAE for demonstrating receipt of Home and Community-Based Services (HCBS) include:
   a. A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the Part D Enrollee's name and HCBS eligibility date during a month after June of the previous calendar year;
   b. A copy of a State-approved HCBS Service Plan that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year;
   c. A copy of a State-issued prior authorization approval letter for HCBS that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year; or
   d. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year.
4. Once Provider has the required acceptable form(s) of evidence, Provider should either:
   a. Contact the Pharmacy Help Desk for appropriate Plan Sponsor contact information; or
   b. Consult the annual Caremark Medicare Part D Plan Sponsor chart distributed to Providers annually.

If urgent, Caremark will work with Provider and Plan Sponsor to update eligibility and resolve the situation; otherwise, Provider should work directly with the Plan Sponsor to submit the acceptable BAE in order for a change to a Part D Enrollee's low-income status to occur through standard protocol.

10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS

In order to avoid any interruptions to receiving drug therapy for Part D Low-Income Subsidy (LICS/LIS) eligible Part D Enrollees who have received a notification from CMS indicating a status change, the Part D Enrollee must apply/re-apply through the Social Security Administration, or he or she may have adjusted copayment and premium liabilities in the future. Providers are encouraged to assist these Part D Enrollees by:

- Helping the Part D Enrollee submit LICS/LIS applications
- Referring the Part D Enrollee to the Social Security Administration at:

1-800-772-1213
www.ssa.gov/medicareoutreach2/index.htm

10.04.05 Auto-Ship Refill Programs

Providers may offer Part D Enrollees the option of enrolling in automatic refill programs. Providers must offer such programs in compliance with CMS requirements, including (a) permitting Part D Enrollees to opt-out of auto-ship refill program at any time; (b) providing Part D Enrollees with two (2) shipping reminders prior to shipping; and (c) granting Part D Enrollees a refund for any unwanted fill.

Provider must provide the Part D Enrollee with two (2) shipping reminders before each auto-ship refill order to give the Part D Enrollee sufficient time to cancel or make changes to an order. Shipping reminders must include an approximate shipping date range, information on how to obtain the cost-share for an upcoming auto-ship refill order, and instructions on how to cancel an order. CMS allows Provider to send the shipping reminder based on the Part D Enrollee's preferred method of communication that includes phone, email, text, direct mailing, or other comparable means of communication.

10.05 Claims Submission

10.05.01 Unique RXBIN/RXPCN Requirement - Medicare Part D

Provider must include RXBIN, RXPCN, and RXGRP values on submitted claims. Part D Enrollee profiles must be updated accordingly. Caremark will continue to communicate unique RXBIN/RXPCN/RXGRP combinations of Plan Sponsors. Refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.

10.05.02 Payment of Clean Claims

In accordance with 42 C.F.R. § 423.520, payment for clean claims (that have been determined to be eligible for payment) will be made to Provider within fourteen (14) days (for electronically submitted claims), or thirty (30) days (for non-electronically submitted claims) from the date the claim is received. A clean claim is defined as a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. Claims from a Provider whose participation status has been suspended, in accordance with section **6.09 Provider Suspension** of the Provider Manual, are not eligible for payment unless and until such time as Provider's suspension has been lifted and any offset against amounts owed to Caremark has been processed.

10.05.03 Electronic Prescribing

Providers engaged in e-prescribing must do so in accordance with all CMS and Part D E-Prescribing standards and requirements. Refer to the following web address for specific e-prescribing requirements and their applicable compliance dates: **www.cms.hhs.gov/EPrescribing/**. Additional information is also available in Section 50 of Chapter 7 of the Medicare Part D Prescription Drug Manual, **cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/dwnlds/Chapter7pdf.**

10.05.04 Prescription Origin Code and Fill Number

Provider must use the Prescription Origin Code when submitting all Medicare Part D claims. Original fill claims submitted without one of the values below will reject.

The Prescription Origin Code should be placed in the 419-DJ field, and the following values should be used:

1 = Written

2 = Telephone

3 = Electronic

4 = Facsimile

5 = Pharmacy

The Fill Number should be placed in the 403-D3 field, and the following values should be used:

ØØ= Original dispensing

Ø1 to 99 = Refill number

10.05.05 Improving Drug Utilization Review Controls

CMS discusses the need for Medicare Part D Plan Sponsors to employ more effective concurrent and retrospective DUR programs to address overutilization of medications in order to protect Part D Enrollees and to comply with drug utilization management requirements at 42 C.F.R. § 423.153, et seq.

Claims adjudication system edits have been implemented to improve control at the point of sale and ensure that DUR processes comply with CMS requirements for all classes of drugs.

The chart below describes the DUR reject edits and associated Professional Service (PPS) Codes that may be used to override the reject when applicable. Enhanced reject messaging will return to help clarify the reason for the reject. Be sure to review the entire DUR message for instructions which may require viewing additional screens in your software. Since a single claim may trigger more than one concurrent DUR reject, Providers will need to enter the corresponding PPS codes documenting the action for each reject.

The chart below may be used to assist with entering the appropriate PPS Codes.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00001003

Edit Name and Description	Reject Message	Reason for Service Code	PPS Professional Service Code	Result of Service Code
Buprenorphine/Opioid: Identifies opioid use after treatment with a buprenorphine product.	Reject 88- PPS CODE REQD: HX BUPENORP; EXCL OPIOID	"DM"	**MØ -** Prescriber consulted **PØ -** Patient consulted **PM -** Patient monitoring **RØ -** Pharmacist consulted other source	1B - RHP determines alert is not relevant for the Rx and member 1C - Filled with a different dose 1D - Filled with different directions 1F - Filled with a different quantity 1G - Filled with a Prescriber approval 2A - RPH determines Rx should not be filled as written 4B - Dispensed, Palliative Care 4C - Dispensed, Hospice 4D - Dispensed, Cancer Treatment
Cumulative APAP Check: Checks for excessive cumulative acetaminophen (cAPAP) utilization across multiple prescriptions.	Reject 88– PPS CODE REQD: APAP EXCEEDS 4GM/DAY	"AT"		
Cumulative Morphine Milligram Equivalent (cMME): Checks for excessive opioid utilization via cumulative morphine equivalent dose (cMED) across multiple drugs and prescriptions.	Soft Reject 922/88- EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD. Hard Reject 922/G4/88 – EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD. PRESCRIBER MUST CALL XXX-XXX-XXXX WHEN CLINICAL EXCEPTION APPLIES	"HC"		
Excessive Controlled Substance Enhancement: Intended to capture multiple controlled substance (CS) claims (for the same drug or different controlled substances) within the past thirty (30) days.	Reject 88– PPS CODE REQD: MULT CII-V IN LAST 30 DAYS	"DM"		
Dose Check - Max Dose Multiplier: Intended to identify claims with excessively high doses. Applies to all drugs.	Reject 88– PPS CODE REQD: MAX DOSE EXCEEDED – 5X MAX	"HD"		
Multiple Pharmacies: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class at four or more pharmacies. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PHARMACIES/ SAME DRUG CLASS	"DM"		
Multiple Prescribers: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class prescribed by four or more prescribers. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PRESCRIBERS/ SAME DRUG CLASS	"DM"		
Multiple Long Acting Opioids: Designed to identify Part D Enrollees on two or more long acting opioids.	Reject 88 – PPS CODE REQD: 2 OR MORE LA OPIOIDS	"TD"		
Opioid/Benzodiazepine Drug Interaction: Designed to identify Part D Enrollees receiving a medication from both classes of drugs.	Reject 88 – PPS CODE REQD: DRUG INT OPIOIDS AND BENZO	"DD"		
7 Day Opioid Naïve Edit: Designed to identify Part D Enrollees with no history of an opioid in the past 108 days and limit their initial supply to 7 days or less.	Reject 925: IF OPIOID/CANCER HISTORY, RPH USE SCC 10 OR SUBMIT 7 DS OR CALL XXX-XXX-XXXX	Submit SCC "10"	N/A	N/A

Do not save PPS and Result of Service Codes on any prescriptions that have previously rejected for DUR. For an initial fill or any refills, Provider cannot pre-empt the reject by entering PPS Codes prior to the first submission of the claim. Allow the reject to occur and then enter the appropriate PPS Codes on resubmission. Entering PPS Codes prior to allowing the claim to reject will cause the claim to continue to reject.

10.05.06 Medicare Part D Claims Requiring Overrides

A. Natural Disasters

Caremark is dedicated to assisting Providers and Part D Enrollees in response to emergencies resulting from natural disasters, severe weather, etc., where medical records are either destroyed or not accessible. Refer to section **4.09 Natural Disasters** of the Provider Manual. Refer to section **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual for contact information.

B. Network Access

Some Part D Enrollees are allowed by their Part D Plan to obtain prescriptions at out-of-network pharmacies. However, Part D Enrollees may be required to submit paper claims for reimbursement for eligible out-of-network expenses and provide documentation as to why the claims were filled at an out-of-network pharmacy. There are no changes to this process for Part D Enrollees residing in the emergency area.

C. Refill-Too-Soon and Excessive Utilization Rejects

CMS will ensure that rules preventing early refills are waived. This will assist those Part D Enrollees who left or lost their prescription during emergencies. The pharmacy may utilize the Submission Clarification Code (SCC) 13 and the displaced Eligible Person's impacted ZIP code to bypass the refill-too-soon reject message. Refer to section **4.09 Natural Disasters** of the Provider Manual.

10.05.07 General Medicare Part D Submission Requirements for COB

Provider must not hold an Eligible Person who is dually eligible for both Medicare and Medicaid liable for Medicare Part A and B Patient Pay Amounts when Medicaid is responsible for paying such amounts for Qualified Medicare Beneficiaries; Provider must accept Caremark's payment as payment in full or bill the appropriate Medicaid plan.

For Medicare Secondary Payer (MSP) claims, the primary Medicare Part D RXBIN/RXPCN/RXGRP combinations should be submitted on the COB claim (refer to the Caremark Plan Sponsor grid within the Pharmacy Portal, login required, at **rxservices.cvscaremark.com**).

For COB claims that are supplemental to Medicare Part D, Provider must submit the corresponding RXBIN (refer to chapter **1. General Information** of the Provider Manual) unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs or RXGRPs as communicated or printed on ID cards. Providers may receive notice of plan-specific claims processing information.

For primary Part D Plan Sponsors who have implemented STCOB, the claim adjudicates against both primary and secondary plans before returning one final response to Provider. Caremark may return a message in the pharmacy response indicating STCOB was used. STCOB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for eligible Part D Enrollees.

Refer to the Caremark Payer Sheets found at **www.caremark.com/pharminfo** for additional details on how to submit Medicare Part D COB claims. Please carefully review the appropriate Payer Sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

10.05.08 Formulary Transition Fill Process

All Part D Plans are required by CMS to provide a formulary transition plan for Part D Enrollees who are eligible for a transition supply. The intent of the transition plan is to ensure immediate short-term coverage for Part D Enrollees who are either new to a Part D Plan or who otherwise qualify for a Transition Fill (TF). Providers are required to submit TF-eligible claims for eligible Part D Enrollees to ensure these Enrollees are able to receive the TF's to which they are entitled. This will allow Part D Enrollees to continue ongoing therapies while either transitioning to an equivalent formulary drug, or pursuing prior authorizations or formulary exceptions. Drugs excluded under Part D are not eligible for TF.

Caremark provides TF coverage to eligible Part D Enrollees under the circumstances indicated in the "Transition Fill Plan" below when Part D drugs:

- are non-formulary; or
- are formulary and require prior authorization or step therapy under a plan's utilization management rules; or
- have quantity limits or daily dose limits that are not safety related.

TF-eligible claims will process and pay upon initial submission and messages will indicate when claims have paid under TF rules. Providers do not need to resubmit a TF Prior Authorization code for TF-eligible claims to adjudicate upon initial submission. The messages listed below will return with paid TF claims so Providers can remind Part D Enrollees of actions that should be taken to ensure access to prescription drugs in accordance with Part D formularies and benefits. Provider will receive one of the following messages with the paid claim under TF rules:

<<Paid under Transition Fill - Non-formulary>>

<<Paid under Transition Fill - PA required>>

<<Paid under Transition Fill - Other Reject>> (Note: other rejects represented by this message include Step Therapy, Quantity Limits, Daily Dose, etc.)

The following drugs are not TF eligible:

- Drugs not covered under Part D
- Drugs that are dispensed for reasons other than medically accepted indications
- Drugs that are dispensed outside of safe utilization recommendations

For submitted claims not eligible for TF,

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

is intended to remind Providers to provide the required Part D Notice of Appeal Rights directly to Part D Enrollees should he or she want to appeal rejected claims with Part D Plans. Notice must be given directly to Part D Enrollees any time this reject occurs on a claim.

The Transition Supply is an approved month's supply for both the outpatient and the long-term care patient. No changes were made to the long-term care Emergency Supply, which remains a 31-day supply.

Outpatient Transition Fill

Transition Fill Condition	Description	Allowed TF Supply for the Retail Setting
Part D Enrollee who is newly enrolled in Plan	• Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one plan to another after start of contract year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage in the new Plan
Some renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within the look-back period (established by the plan) from date of claim and previous claim not TF for the same reason • If Part D Enrollee has not transitioned before beginning of new Plan benefit year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage effective at the beginning of the new contract year
Part D Enrollee requesting exception and decision still pending	Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted	Contact the Pharmacy Help Desk for Transition Extension Overrides under this Condition

For questions, concerns or issues related to Transition Fill claim processing, refer to section **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual for the appropriate telephone number to call.

10.05.09 Insulin Coverage

Medicare Part D Plans cover injectable insulin not used with a durable medical equipment (DME) insulin infusion pump. Medicare Part B covers most external insulin pumps and the insulin that the device uses under durable medical equipment. Medicare Part D covers disposable insulin infusion pumps.

10.05.10 Pro-Rated Daily Cost Share

For applicable plans with a copayment benefit, Part D Plan Sponsors must establish and apply a daily cost-sharing rate whenever certain prescriptions (depending on the drug) are dispensed by Provider for less than the Part D Plan Sponsor's defined one-month supply in accordance with 42 C.F.R. § 423.153(b)(4)(i).

Caremark will apply a daily cost-sharing rate for a Covered Part D Drug that is dispensed for less than the plan-defined one-month supply. If a claim applies a daily cost-sharing rate Provider may receive the following message:

> **<<Ø23 – Prorated copayment applied based on days supply. Plan has prorated the copayment based on days supply>>**

The daily cost-sharing rate applies if the drug (brand or generic) is in the form of a solid oral dose and is dispensed for a days supply less than the plan-defined one-month supply under applicable Law, except for the following types of drugs:

- Solid oral doses of antibiotics
- Solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance
- Non-Part D drugs, unless the Part D Plan has specified that copay proration extends to covered drugs that are treated as non-Part D under their benefit plans
- Drugs dispensed by out-of-network providers

10.05.11 Medicare Part B and Medicare Part D Drug Coverage Determinations

For specific rejects addressing (1) drugs excluded from Part D coverage as mandated by the Medicare Modernization Act; and (2) drugs that are covered under Medicare Part B for the designated Part D Enrollee, refer to the NCPDP Payer Sheets at **www.caremark.com/pharminfo**.

Provider must enter an appropriate Patient Residence Code for all Part B vs. Part D claims. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

Caremark uses the following reject codes for drugs that may be covered under Medicare Part B for the designated Medicare beneficiary:

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A6	This Product/Service May Be Covered Under Part B

Secondary messaging may also be returned. The secondary message is as follows:

<<B vs D Inquiry RPH Call XXX-XXX-XXXX>>

When Provider receives a reject with secondary messaging and calls the number included in the reject, the Pharmacy Help Desk representative, who is specifically trained to handle Part B vs. Part D determinations, will present a series of criteria to Provider. Based on the information obtained from the pharmacist, the Pharmacy Help Desk representative will be able to promptly assist Provider with processing the Part D claim, if appropriate. This process only applies to certain drug categories and select Part D Plans. For drugs not handled by the Pharmacy Help Desk, the reject message will indicate that a Prior Authorization is required and include the number for initiating a coverage determination.

10.05.12 End Stage Renal Disease Claim Processing

ESRD "Always" Drugs

CMS guidance requiring Part D Plans to impose a prior authorization edit for the four categories of drugs that are "always" used to treat End Stage Renal Disease (ESRD) remains in effect. CMS states that if the "always" drug was used to treat ESRD, it is payable under the Medicare Part B Bundled Payment to the dialysis center, regardless of whether or not dialysis treatment was received on the date the drug was prescribed or dispensed. Provider must maintain prescription record documentation for Part D Enrollees which contains the diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD).

For the ESRD "Always" Drugs, Caremark uses the following reject codes for drugs that may be covered under Medicare Part B Bundled Payment for ESRD:

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A4	This Product May Be Covered Under the Medicare B Bundled Payment to an ESRD Dialysis Facility

In addition to these rejects, **secondary messaging** will be returned. The secondary message is as follows:

<<Part B vs D: To Resolve RPh Call XXX-XXX-XXXX>>

10.05.13 Prescriber Identification for Medicare Part D Claims

For all Medicare Part D claims, accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claims adjudication, clinical services, Plan Sponsor initiatives, and audits. In addition, CMS requires a valid and active individual Prescriber National Provider Identifier (NPI) on all claims. Failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI, DEA number, or any other number or identifier (e.g., hospital, clinic, or pharmacy identification number) in the prescriber identification field which does not represent an individual Prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate submission clarification code (SCC) to bypass the reject. Per CMS, Part D Plan Sponsors are required to only report Type 1 (Individual) NPIs on PDE records. Type 2 (group/organizational identifier) NPIs are not accepted for Prescribers. Providers must obtain an individual NPI. Any claim submitted with an invalid NPI will reject with the following or similar reject message:

Reject Code	Reject Message
A2	Plan's Prescriber database indicates Prescriber ID submitted is associated with a deceased Prescriber and the Fill Date of the claim is one year after the deceased date for a non-controlled substance or the Fill Date of the claim is 180 days after the deceased date for controlled substance
42	Plan's Prescriber database indicates the Prescriber ID submitted is inactive or expired
43	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID is inactive
44	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID is not found
46	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID does not allow this drug DEA class
56	Plan's Prescriber database indicates the Prescriber ID submitted is not found
619	Plan's Prescriber database indicates the Prescriber qualifier is not equal to 01

Below are the various SCC values that may be submitted for the invalid Prescriber ID rejects once Provider has confirmed the ID submitted is valid and the reject for invalid Prescriber ID is not appropriate (the claim is still subject to audit review and chargeback):

Reject Code	SCC Value
A2	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
42	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
43	43 - Prescriber's DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule
44	43 - Prescriber's DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule
46	46 - Prescriber's DEA has prescriptive authority for this drug DEA Schedule
56	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
619	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated

For additional information on identification of a foreign Prescriber, refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo.**

10.05.14 Claims Submission Window for Medicare Part D

Providers have ninety (90) days from fill date to receive paid transactions including submissions, reversals, and resubmissions of Medicare Part D Claims. Provider Universal Claim Forms (UCFs) will be accepted and processed up to March 31 after the close of the previous plan year in which the fill date occurred when accompanied by a reasonable explanation why the Medicare Part D Claim could not be submitted and processed online. This timely filing window aligns with the CMS processing windows. Provider UCFs should be clearly identified as "Medicare Part D" claims and should be mailed to the following address:

RXBINs 004336, 610591, 610415:

Medicare Part D
PO Box 52066
Phoenix, AZ 85072-2066

Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:

Aetna Medicare Part D and LTC
PO Box 52446
Phoenix, AZ 85072-2446

RXBINs 020115, 020388

IngenioRx Medicare Part D and LTC
Claims Department – Part D Services
PO Box 52077
Phoenix, AZ 85072-2077

Refer to section **10.07.02 LTC Pharmacies Timely Claim Submission** of the Provider Manual regarding timely submission of Medicare Part D LTC claims.

10.05.15 Medicare Part D Claims Adjustment

Caremark may adjust paid claims to correct errors or reflect changes in eligibility of Part D Enrollee, to the extent consistent with applicable Law. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider.

Provider must charge Part D Enrollees the correct cost-sharing amount in accordance with the Part D Plan benefit and as required by CMS. For all LTC claims submitted by Providers for Part D Enrollees, and therefore, for whom Caremark has assessed cost-sharing that has been borne by Provider, Caremark will reimburse Provider for such amounts. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

1. Provider agrees that by accepting payment from Caremark for these amounts assessed against Part D Enrollees, Provider is certifying that:
   a. Provider has not collected or otherwise waived such amounts from such Part D Enrollees or their representatives;
   b. Provider is in fact carrying a debt for the amounts charged to such Part D Enrollee; and
   c. The amounts reimbursed by Caremark are appropriate, owed, and payable.
2. In cases where Part D Enrollees claims are retroactively identified as inappropriate overpayments to Provider, Caremark will adjust Provider for such amounts. Provider is responsible for:
   a. Collecting outstanding Patient Pay Amount balances from Part D Enrollees; and
   b. Accurately debiting and/or crediting Part D Enrollees to help maintain accurate True Out-of-Pocket (TrOOP) balances for these retroactively identified claims.

10.06 Network Participation and Payment

10.06.01 Drug Pricing

Notwithstanding anything to the contrary, Caremark utilizes Medi-Span as reference for drug prices. Drug price files are updated every business day. An initial update to the drug price file occurs on January 1, or the following business day each year. Point-of-service claims are adjudicated, and Provider is reimbursed in accordance with these updates.

Provider may access the Pharmacy Portal at rxservices.cvscaremark.com to receive advance notice of changes to MAC for Medicare Part D Claims. Refer to section **6.04 Maximum Allowable Cost** of the Provider Manual.

10.06.02 Pharmacy Service Type and Patient Residence Requirements

To ensure appropriate adjudication and reimbursement, Providers must submit valid Pharmacy Service Type and Patient Residence values on all claims. Approved Part D Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) values must be submitted accurately to identify claim type. Refer to the NCPDP Payer Sheets at **www.caremark.com/pharminfo**. Intentional or unintentional misrepresentation of valid Pharmacy Service Type, and/or Patient Residence codes that are not aligned with Provider's Pharmacy Service Type as it relates to the patient, or Patient's residence type is not representative of where the patient is physically residing, or aligned with CMS guidelines, constitutes an invalid use of one or more values and claims may be subject to chargeback.

CMS Acceptable Code Values	
Pharmacy Service Type – Field 147-U7	01-08 and 99
Patient Residence – Field 384-4X	00, 01, 03, 04, 06, 09, 11

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply.

The only valid claim submission values for Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) are the supported values listed in the NCPDP External Code List (ECL). Submitted values not supported in the ECL will cause the claim to reject with:

Reject U7: <<M/I Pharmacy Service Type>> or

Reject 4X: <<M/I Patient Residence>> respectively.

A blank value will not be allowed in either field for Medicare Part D claims.

As recommended by NCPDP, Caremark accepts the below values to ensure appropriate adjudication and reimbursement. Provider must be in the specific Medicare Part D network in order to submit these codes and receive appropriate payment. Provider must not intentionally or unintentionally submit values that do not accurately represent either Pharmacy Service Type, Patient Residence value, or both. Home infusion and Long-term Care Claims must meet the CMS qualifications (e.g., skilled nursing unit) in order to submit these codes and receive appropriate payment.

Administrative Codes:

- Patient Residence Code on the claim submission must represent the true and actual residence of the Part D Enrollee; documentation must support the code that was used on the claim.
- Pharmacy Service Type code on the claim submission must represent the true and actual service type provided by the pharmacy; documentation must support the code that was used on the claim.

Pharmacy Type	Claim/Service Type	Pharmacy Service Type (Field 147-U7)	Patient Residence (Field 384-4X)
Retail	Retail	01	01
Home Infusion	HIF	03	01
Home Infusion	ALF	03	04
Long-term Care	LTC	05	03
Long-term Care	ICF/IID	05	09
Assisted Living Facility	ALF	05	04

For Claims submitted for LTC Part D Enrollees with a Patient Residence of 03, an SCC value in field 420-DK is required for brand oral solids. The above table does not include all Patient Residence and Pharmacy Service Type combinations.

10.07 Special Instructions for Participating LTC Providers

The following information is applicable to Providers participating in the Caremark and Part D Plan-specific LTC Medicare Part D networks, unless specified otherwise.

10.07.01 Pharmacies Serving LTC Facilities

Prescription Drug Benefit Manual – Section 40.3.1

Given the unique circumstances of the LTC setting, Part D Enrollees will generally not present the prescription to Provider. In most instances, either the treating Prescriber or his or her authorized agent sends the prescription to Provider. If there is an issue with a requested prescription, Provider is required to contact the treating Prescriber or his or her authorized agent and the Prescriber determines what course of action is appropriate (e.g., the Prescriber may prescribe a different medication or request an exception).

If Provider is off-site, Provider must send (fax or deliver) the CMS-10147 Pharmacy Notice to the location in the LTC facility designated to accept such notices.

If Provider is on-site, Provider must deliver the notice to the location in the LTC facility designated to accept such notices. The LTC facility staff is responsible for providing the Part D Enrollee (or the Part D Enrollee's appointed representative) and the Part D Enrollee's treating Prescriber with the notice. A copy of the notice should be placed in the Part D Enrollee's file at the LTC facility (refer to **Appendix B** for a copy of the notice in English and Spanish).

10.07.02 LTC Pharmacies Timely Claim Submission

Participating LTC Providers will have no less than thirty (30) days, and no more than ninety (90) days to submit claims (42 C.F.R. 423.505(b)(20)) from the original fill date. This includes electronically submitted claims and non-electronically submitted claims from original fill date. Non-participating LTC Providers have three (3) years from the original fill date to file claims.

The requirement above does not eliminate the requirement specified in CMS policy memo dated May 25, 2007, for Part D Plan Sponsors to provide new timely claims filing period for claims incurred by dual-eligible Part D Enrollees during a period of retroactive Part D enrollment.

Provider UCFs should be clearly identified as "Medicare Part D LTC" claims, include the appropriate Pharmacy Service Type and Patient Residence values, and should be mailed to the following address:

RXBINs 004336, 610591, 610415:

Long-term Care (LTC) Claims:
Attn: Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:

Aetna Long-term Care (LTC) Claims
Attn: Aetna Medicare Part D LTC
PO Box 14023
Lexington, KY 40512-4023

10.07.03 LTC Appropriate Day Supply Short Cycle Billing

Provider must dispense certain brand oral solid Covered Part D Drugs in quantities of fourteen (14) days or less, unless an exemption applies. Caremark has implemented a dispensing fee incentive for those LTC Part D brand and generic drugs in accordance with CMS regulations. Provider agrees to submit claims to Caremark's claim adjudication system for LTC Pharmacy Services. Provider must bill Caremark immediately after dispensing or within thirty (30) days after the dispensing event. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws.

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply. "Brand oral solids" are limited to brand products with the following exceptions to the appropriate days supply (ADS) dispensing rule:

- Generic drugs (ANDA/non-specified)
- Solid oral doses of antibiotics
- Solid oral doses in packaging that cannot be broken (e.g., oral contraceptives)

Other exceptions—Providers, Part D Enrollees and coverage situations—include:

- Assisted Living Facilities (ALF)
- Medicare as a Secondary Payer (MSP)
- Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) and Institutes for Mental Disease (IMD)
- Indian Health Service, Tribal 638, and Urban Indian Health (I/T/U)

Three fields have been utilized to accommodate ADS dispensing requirements: Patient Residence Code, Submission Clarification Codes (SCC) and Special Package Indicator (SPI).
Submission Clarification Codes:

NCPDP Field 420-DK	
Code	**Description**
21	LTC dispensing: 14 days or less not applicable (N/A) – 14 days or less dispensing is N/A due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e., vacation supply, leave of absence, e-kit, spitter dose). Medication quantities are dispensed as billed
22	LTC dispensing: 7 days – Pharmacy dispenses medication in 7-day supplies

NCPDP Field 420-DK	
Code	**Description**
23	LTC dispensing: 4 days – Pharmacy dispenses medication in 4-day supplies
24	LTC dispensing: 3 days – Pharmacy dispenses medication in 3-day supplies
25	LTC dispensing: 2 days – Pharmacy dispenses medication in 2-day supplies
26	LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1-day supplies
27	LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4-day, then 3-day supplies
28	LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2-day, then 2-day, then 3-day supplies
29	LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekends
30	LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes)
31	LTC dispensing: Per med pass dispensing – Remote dispensing per med pass
32	LTC dispensing: PRN on demand – Remote dispensing on demand as needed
33	LTC dispensing: 7 days or less cycle not otherwise represented
34	LTC dispensing: 14 days – Pharmacy dispenses medication in 14-day supplies
35	LTC dispensing: 8-14 day dispensing not listed above – 8-14-day dispensing cycle not otherwise represented
36	LTC dispensing: dispensed outside of short cycle. Medicare Part D coverage was determined post dispensing

Refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online.

10.07.04 LTC Days Supply Limitations

As per CMS guidance, LTC Providers in the LTC Medicare Part D networks are only allowed to dispense up to a 31-day supply of medication for Part D Enrollees. In the event that a medication being provided is the smallest commercially available package size and exceeds the allowable 31-day supply, the quantity may be submitted utilizing the quantity of the single package with the corresponding day supply. Refer to section **10.07.03 LTC Billing** of the Provider Manual.

10.07.05 LTC Transition Fill

(NOTE: Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills must be submitted with the appropriate LTC Pharmacy Service Type and Patient Residence Codes. See additional information in the table below).

Transition Fill Condition	Description	Allowed TF Supply
Part D Enrollee who is newly enrolled in Plan	• Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one plan to another after start of contract year	• Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage in the new Plan.
Renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within 180 days from date of claim and previous claim not TF • If Part D Enrollee has not transitioned before beginning of new Plan benefit year	• Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage effective at the beginning of the new contract year.
*Part D Enrollee residing in LTC facility (New Patient Admission)	• LTC New Patient Admission/Level of Care Change within past 30 days	• Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. Multiple fills are allowed within 31 days of admission or change of care. • Submit SCC 420-DK Value "18". • Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes. • If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance.

Transition Fill Condition	Description	Allowed TF Supply
*Part D Enrollee residing in LTC facility (Emergency Supply)	• LTC Emergency Supply	• Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense drugs with a first fill of a maximum of a 31-day supply, or less if the prescription is written for fewer days. • Submit SCC 420-DK Value "7". • Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes. If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance.
Part D Enrollee requesting exception and decision still pending	• Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted	Contact the Pharmacy Help Desk for overrides under this condition.

*Refer to section **10.07.03 LTC Appropriate Day Supply Short Cycle Billing** of the Provider Manual for exceptions.

10.07.06 Special Package Indicator

NCPDP has created an additional field for Special Package Indicator (SPI). Caremark does not require SPI Codes at this time but will accept the values shown below if submitted. At such time Caremark requires SPI Codes, Caremark will provide Provider with written notice.

NCPDP Field 429-DT	
Code	**Description**
0	Not specified
1	Not Unit Dose - product is not being dispensed in special unit dose packaging
2	Manufacturer Unit Dose - a distinct dose as determined by the manufacturer
3	Pharmacy Unit Dose - when the pharmacy has dispensed the drug in a unit-of-use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose
4	Pharmacy Unit Dose Patient Compliance Packaging - Unit dose blister, strip, or other packaging designed in compliance-prompting formats that help people take their medications properly
5	Pharmacy Multi-drug Patient Compliance Packaging - Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration
6	Remote Device Unit Dose - Drug is dispensed at the facility, via a remote device, in a unit-of-use package
7	Remote Device Multi-drug Compliance - Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration
8	Manufacturer Unit-of-Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in LTC claims only (as defined in Telecommunication Editorial Document)

10.07.07 LTC Override Requests

Emergency Supply:

Note the following text from Chapter 6 of the Medicare Part D manual. The requirement states to allow emergency fill(s) while an exception or prior authorization is being processed (after the 90-day transition period has expired) for up to 31 days of medication unless the prescription is written for less than 31 days.

If the prescription in question was written for less than 31 days, it is within CMS guidelines to restrict to one fill. According to CMS regulations, standard prior authorization requests must be decisioned within 72 hours. Standard exception requests must be decisioned within 72 hours of receiving the Prescriber's supporting statement.

Provider shall not apply Emergency Supply overrides to situations outside the defined scenario(s) that CMS describes in the Prescription Drug Benefit Manual below.

Chapter 6 of CMS Prescription Drug Benefit Manual states the following:

> **Section 30.4.6 - Emergency Supply for Current Enrollees in the LTC Setting**
> ***(Rev. 18, Issued: 01-15-16, Effective: 01-15-16; Implementation: 01-15-16)***
>
> Since, as a matter of general practice, LTC facility residents must receive their medications as ordered without delay, Part D sponsors must also cover emergency supplies of non-formulary Part D drugs for LTC facility residents after the transition period.
>
> During the first ninety (90) days after enrollment, the Part D Enrollee will receive a transition supply as described in section 30.4. However, to the extent that a Part D Enrollee in an LTC setting is outside his or her 90-day transition period, the Plan Sponsor must still provide an emergency supply of non-formulary Part D drugs while an exception or prior authorization request is being processed. These emergency supplies of non-formulary Part D drugs must be for at least 31 days of medication, regardless of dispensing increments, unless the prescription is written by a Prescriber for less than 31 days. In cases where the smallest available marketed package size is not available for less than a 31-day supply, the Plan Sponsor must still provide an emergency supply when required. Part D Sponsors and their processors must determine how best to process claims in such cases. Multiple 14-day or less supplies can be supplied for brand name drugs to meet a minimum of a 31-day emergency supply requirement. A Plan Sponsor is not expected to provide more than a one-time 31-day emergency fill of a particular drug per LTC stay.
>
> **Section 30.4.7 - Level of Care Changes (excerpt)**
> ***(Rev. 10, Issued: 02-19-10, Effective/Implementation Date: 03-01-10)***
>
> In addition to circumstances impacting new Part D Enrollees who may enter a plan with a medication list that contains non-formulary Part D drugs, other circumstances exist in which unplanned transitions for current Part D Enrollees could arise and in which prescribed drug regimens may not be on sponsor formularies. These circumstances usually involve level of care changes in which a Part D Enrollee is changing from one treatment setting to another. For example, Part D Enrollees who enter LTC facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary with very short-term planning taken into account (often under eight hours). Similar situations may exist, for example, for Part D Enrollees who are discharged from a hospital to a home; for Part D Enrollees who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; for Part D Enrollees who give up hospice status to revert to standard Medicare Part A and B benefits; for Part D Enrollees who end an LTC facility stay and return to the community; and for Part D Enrollees who are discharged from psychiatric hospitals with drug regimens that are highly individualized.

Below are Part D Plan Sponsor's utilization management rules to LTC Part D Enrollees for LTC emergency supplies and LTC admissions/level of care changes.

1. An emergency supply must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days.
2. Transition supplies of non-formulary Part D drugs for LTC admission/level of care changes must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days.
3. Provider must maintain documentation substantiating any SCC values or override codes transmitted on a Medicare Part D claim.

Emergency Supply Situations:

- **Emergency Kit Dispensing:** Emergency Kit/Box (E-Box) medications for emergency treatment until standard supply can be dispensed
- **First Fill Following Emergency Kit Dose:** Follow-up fill after emergency dose has been dispensed. This prescription should be filled for the fully prescribed amount minus the emergency dosing
- **LOA (Leave of Absence) Medications:** Separate dispensing of small quantities of medications for take-home use allowing Part D Enrollees to leave facility for weekend visits, holidays, etc.
- **Medication Spit Out:** Medication has been "spit out"
- **Emergency Supply:** Emergency supply of non-formulary drugs and formulary with PA or Step Therapy Requirements
- **LTC Admission/Level of Care Change:** Newly admitted due to clinical status change

  1. Medications may have:
     a. Been filled at retail pharmacy prior to admit;
     b. Been filled prior to transfer and discontinued;
     c. Not followed Part D Enrollee to new facility due to regulatory and compliance issues and same medications reordered upon re-admit
  2. New Admission/Level of Care Change:
     a. Valid within 31 days of New Admission/Level of Care change
     b. Up to 34-day supply* with multiple fills
     c. Day Supply of 34 includes those claims where SCC 18 is not used

*based on plan design

Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills are submitted with the Pharmacy Service Type (PST) and Patient Residence (PR) that designate LTC (for RXBINs 004336, 012320 and 610591 only).

- For LTC Emergency Supply: Use SCC [NCPDP Field # 420-DK] Value "07"
- For LTC New Patient Admission/Level of Care Change: Use SCC [NCPDP Field # 420-DK] Value "18"

10.07.08 LTC Overrides for Current Part D Enrollees

D.Ø NCPDP FIELD	D.Ø VALUE/CODE	SITUATION	ALLOWANCES
SCC 420-DK	16	Emergency Kit (Emergency Dose)	5-day supply
SCC 420-DK	17	First Fill Following Emergency Kit Dose	Written Rx Less E.R. Kit Dose given
SCC 420-DK	14 (use value 3 for ALF)	Leave of Absence Vacation supply	5-day supply
SCC 420-DK	15	Patient "Spit Out"	Not applicable

D.Ø NCPDP FIELD	D.Ø VALUE/CODE	SITUATION	ALLOWANCES
SCC 420-DK	07	Emergency Supply (only as defined in this section)	31-day supply
SCC 420-DK	18	LTC Admission/ Level of Care Change	Up to 34-day supply with multiple fills within 31 days of admission or change of care, day supply includes claims where no SCC 18 is used after New Admission/Level of Care Change
SCC 420-DK	19	Partial Payment under Medicare Part A	Not applicable

Refer to the NCPDP Payer Sheets at **www.caremark.com/pharminfo**.

10.07.09 Medicare Part A and Medicare Part D Drug Coverage Determinations

LTC Providers should consult their Caremark LTC Addendum regarding clarification on Medicare Part A and Medicare Part D drug coverage determinations.

Hospice care is a Medicare Part A benefit and, therefore, drugs provided by hospice and covered under the Medicare Part A payment to the hospice program are not covered under Part D. Only drugs which are used primarily for relief of pain and symptom control related to an individual's terminal illness are covered by the hospice program. When a Medicare Part D claim rejects due to hospice validation, the claim will also reject with:

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

Reject 75 <<Prior Authorization Required>>

Reject A3 <<This Product May Be Covered Under Hospice – Medicare A>>

In addition to the above rejects, secondary messaging is returned. The secondary message is as follows:

<<Hospice drugs not covered under Part D. If unrelated to terminal diagnosis, call XXX-XXX-XXXX>>.

The reject message will direct the pharmacy to the Pharmacy Help Desk. The Pharmacy Help Desk representative will verify if the Part D Enrollee is in hospice and inform Provider that written termination documentation from hospice or Part D Enrollee is required before an override can be placed. If the Part D Enrollee has confirmed with the Provider, and the Provider confirms on the recorded line, that the Part D Enrollee has never been cared for/or resided in hospice care, the Pharmacy Help Desk representative may place a one-time override not to exceed a 12-month period.

IMPORTANT:

1. As specified in the Social Security Act, Section 1861(dd), and Federal Regulations (42 C.F.R. Section 418 et seq.), hospice programs must provide individuals under hospice care with drugs and biologicals related to the palliation and management of the terminal illness as defined in the hospice plan of care.
2. Stand-alone prescription drug Plan Sponsors cannot easily identify and prevent Part D payment for hospice drugs. Provider should work with LTC facilities in which their patients reside or hospice providers to identify any Part D Enrollees who have elected hospice care and ensure hospice drugs are not billed to Part D.
3. For those Plan Sponsors utilizing Caremark coverage determination services, if the treatment is unrelated to the terminal condition, the Pharmacy Help Desk will direct the Provider to ask the hospice provider to fax the form to the Coverage Determinations and Appeal Department and provide the written documentation for the Part D exception. Provider must provide the Pharmacy Help Desk with the hospice provider's contact information to help expedite the process. Caremark's Prior Authorization department will handle the documentation requests and inform Provider if an approval will be made.
4. For Part D Plan Sponsors not utilizing Caremark for coverage determinations, the telephone number in the message will direct Provider to the Part D Plan Sponsor's coverage determination department to initiate the process.
5. Per CMS guidance, for Part D Enrollees and/or caregivers who state they are no longer in hospice, Caremark requires written documentation prior to overriding the hospice reject. The four acceptable forms are outlined

as the Best Available Evidence below. The documentation can be faxed to Caremark at **1-844-242-0904**. Caremark requires a retail and LTC pharmacy to provide the hospice contact information to the Pharmacy Help Desk. Part D Enrollees and/or caregivers may ask Providers to fax the documentation to Caremark.

The following valid documents can be provided as Best Available Evidence of hospice disenrollment or discharge:

1. Written statement from Part D Enrollee to hospice indicating date revocation is to be effective: Applies when Part D Enrollee has chosen to no longer continue with hospice benefits.
2. Notice of Medicare Non-Coverage (NOMNC): Hospice initiates discharge because Part D Enrollee is no longer considered terminally ill.
3. Discharge summary (provided by hospice to a facility or physician): Hospice discharged Part D Enrollee for cause, or because Part D Enrollee is no longer within the hospice service area.
4. NCPDP form: Submitted by hospice or physician indicating date of discharge.

10.08 Retail Addendum to the Caremark Provider Agreement

Terms of Participation in Medicare Part D

By entering into the Provider Agreement, Provider agrees to comply with the following terms (as noted in this Retail Addendum to the Caremark Provider Agreement) to the extent Provider provides Pharmacy Services to a Part D Enrollee and Provider is a Retail Pharmacy as that term is defined in 42 C.F.R. § 423.100. In the event any provision in this Retail Addendum to the Caremark Provider Agreement ("Retail Addendum") conflicts with the terms of the Provider Agreement (including the Provider Manual), the terms of this Retail Addendum shall govern. Provider acknowledges that CVS Caremark Part D Services, L.L.C., together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this Retail Addendum) are responsible for providing Part D services on behalf of Part D Plan Sponsors.

To the extent that Provider shall provide Pharmacy Services to a Part D Enrollee, Provider agrees to comply with any applicable Part D requirements for participation in Part D as a Dispensing Pharmacy.

Without limiting the generality of the foregoing, and notwithstanding anything in the Provider Agreement to the contrary, Provider agrees as follows:

1. Provider agrees to participate as, and perform the functions of, a Part D Retail Dispensing Pharmacy, including any reporting functions required to Part D Plan Sponsors, in accordance with the terms and conditions set forth in this Retail Addendum.
2. Provider agrees to perform its services under this Retail Addendum in a manner that is consistent with, and encompasses the services required to support Part D and in compliance with the contractual obligations of a Part D Plan Sponsor to CMS.
3. Provider agrees not to hold any Part D Enrollee liable for payment of any fees that are the responsibility of Caremark or a Part D Plan Sponsor.
4. Provider and Caremark agree that Provider is not required to accept Insurance Risk as a condition of participation as a Dispensing Pharmacy for Part D, and in the Medicare Part D Retail Network.
5. Provider agrees to comply with all applicable federal and state laws and regulations, CMS guidance or instructions relating to Part D, and any minimum standards for Provider practice established by the States in which Provider is licensed. Provider agrees to comply with all applicable state and federal privacy and security requirements, including the confidentiality and security requirements set forth in 42 C.F.R. § 423.136, the Privacy Rule, Security Rule, and Transactions Standards.
6. Provider agrees to make its books and records available in accordance with, and for the period required by 42 C.F.R. § 423.505(i)(2), which gives HHS, the Comptroller General, or their designees (collectively, "Government Parties"), the right to audit, evaluate, collect, and inspect any books, contracts, records, computers, or other electronic systems, including medical records, and documentation of Provider involving transactions related to CMS' contract with a Part D Plan Sponsor (collectively, "Records"), and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor's contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the ten (10) year retention period. In the case of a request by a Government Party for the direct disclosure by Provider to the Government Party of Records, Provider shall (a) provide Caremark with prompt written notice of the Government Party's request so that Caremark can object or intervene as it deems proper; (b) take all appropriate steps to protect the confidentiality of the Records, including labeling it "CONFIDENTIAL AND PROPRIETARY – FOIA EXEMPT" and

attaching a statement provided by Caremark explaining the application to the Records of any Freedom of Information Act or other exemptions to disclosure; and (c) provide Caremark with the opportunity to review the Records that is subject to disclosure to the Government Party prior to Provider's release of same to the Government Party. Provider also agrees to maintain records and provide access in accordance with 42 C.F.R. § 423.505(b)(10).

7. Provider agrees that, upon a Part D Plan Sponsor delegating any activity or responsibility to Caremark and Caremark in turn delegating that activity or responsibility to Provider pursuant to this Retail Addendum, that activity or responsibility may be revoked if CMS, the Part D Plan Sponsor, or Caremark determines that Provider has not performed satisfactorily. CMS, the Part D Plan Sponsor, or Caremark may also exercise anyremedies available at Law or under the Provider Agreement in lieu of revocation. Further, Provider agrees that such activity or responsibility shall be in accordance with 42 C.F.R. § 423.505(i)(3).
8. Provider agrees that Caremark and any Part D Plan Sponsor (with respect to its Part D Enrollees only) each has the right to approve, suspend, or terminate the Agreement in their sole discretion at any time.
9. Provider agrees that Caremark and the Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis.
10. Provider agrees to provide Part D Enrollees with access to Negotiated Prices for Covered Part D Drugs as required by and in accordance with 42 C.F.R. § 423.104(g).
11. Provider agrees to submit Claims to Caremark's real-time claims adjudication system.
12. Provider agrees that when it dispenses a Covered Part D Drug to a Part D Enrollee, it will inform such Part D Enrollee at the point of sale of the lowest-priced, generically-equivalent version of that Covered Part D Drug, if one exists for the Part D Enrollee's prescription, as well as any associated differential in price in accordance with 42 C.F.R. § 423.132.
13. Provider agrees to implement a method for maintaining up-to-date Part D Enrollee information such as, but not limited to, demographic and allergy (drug) information, and such other information as CMS may require.
14. Provider agrees to implement such utilization management and quality assurance programs, including concurrent drug utilization review, generic substitution and/or therapeutic interchange programs, as Caremark may require, and as consistent with and in compliance with 42 C.F.R. § 423.153(b), (c) and (d). Provider agrees to offer patient counseling to Part D Enrollees, where appropriate and/or required by Law.
15. Provider agrees to fill a prescription for a 90-day supply of Covered Part D drugs for Part D Enrollees at the appropriate cost-sharing and Negotiated Price as communicated by Caremark to Provider through the real-time claims adjudication process, including that which applies to individuals qualifying for the low-income subsidy.
16. Provider agrees to charge/apply the correct cost-sharing amount, including that which applies to individuals qualifying for the low-income subsidy.
17. Part D Claims may be priced using the Provider Agreement, the Caremark Medicare Part D Retail Network, or other Caremark or Plan Sponsor specific network.
18. INTENTIONALLY BLANK
19. Provider acknowledges that it is not a mail order pharmacy and it is a "retail pharmacy" as defined in 42 C.F.R. § 423.100.
20. Entire Agreement. This Retail Addendum, the Provider Agreement, the Provider Manual, and the Medicare Network Enrollment form, and all other applicable enrollment forms, constitute the entire agreement between Provider and Caremark for the purposes of Provider's participation as a Medicare Part D Network Provider, all of which are incorporated by this reference as if fully set forth herein and referred to collectively as the "Provider Agreement" or "Agreement". Any prior agreements, promises, negotiations, or representations related to the terms of this Retail Addendum are terminated and of no force and effect. Provider's non-compliance with any of the provisions of this Retail Addendum will be a breach of the Provider Agreement. All pricing terms are considered to be Caremark's confidential and proprietary information and may not be shared with any third party without express written consent from Caremark.
21. The following terms and phrases, when capitalized and when used in this Retail Addendum, have the meanings

set forth below. All other capitalized terms and conditions shall have the meaning set forth in the Provider Agreement.

a. "Claims" means those claims processed through the Caremark online, real-time claims adjudication system.

b. "CMS" means the Centers for Medicare and Medicaid Services under the Department of Health and Human Services.

c. "Covered Part D Drug(s)" has the same meaning as that term as defined in 42 C.F.R. § 423.100.ß.

d. "Dispensing Fee" has the same meaning as such term is defined in 42 C.F.R. § 423.100 which states that dispensing fee means costs that are incurred at the point of sale and pay for costs in excess of the ingredient cost of a Covered Part D Drug each time a Covered Part D Drug is dispensed, and includes only pharmacy costs associated with ensuring the possession of the appropriate Covered Part D Drug is transferred to a Part D Enrollee.

e. "HHS" means the Department of Health and Human Services.

f. "Insurance Risk" has the same meaning as such term as defined in 42 C.F.R. § 423.4.

g. "Medicare Part D Retail Network" means Claims priced for a Part D Enrollee pursuant to the Retail Addendum to the Caremark Provider Agreement entitled "Caremark Medicare Part D Retail Pharmacy Network."

h. "Negotiated Prices" has the same meaning as such terms as defined 42 C.F.R. § 423.100.

i. "Part D" means Part D of Title XVIII of the Social Security Act, which establishes the Voluntary Prescription Drug Benefit Program under Medicare.

j. "Part D Enrollee" means an individual covered by a Part D Plan.

k. "Part D Plan" has the same meaning as such term as defined in § 423.4, but limited to those Part D Plans that have contracted with SilverScript, L.L.C. to use pharmacy providers that have contracted with Caremark to provide Pharmacy Services to Part D Enrollees.

l. "Part D Plan Sponsor" has the same meaning as such term as defined in 42 C.F.R. § 423.4, but limited to those Part D Plan Sponsors that offer Part D Plans.

m. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

n. "Security Rule" shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. parts 160, 162 and 164, subpart C. Notwithstanding anything to the contrary in the Agreement, any requirements related to the Security Rule shall be effective no earlier than the applicable Compliance Date for the Security Rule.

o. "Transactions Standard" means the Standards for Electronic Transactions under 45 C.F.R. parts 160 and 162, subparts I et.seq.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00001021

11. Medicare Advantage

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

To the extent Provider provides Pharmacy Services for an Eligible Person for a claim covered by a Plan Sponsor that is a Medicare Advantage plan, Provider must comply with the following terms, if applicable:

1. The Department of Health and Human Services, the Comptroller General or their designees have the right to audit, evaluate, collect, and inspect any pertinent information including books, contracts, computer or other electronic systems, including medical records, and documentation related to CMS' contract with Plan Sponsor for a period of ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. 42 C.F.R. 422.504(i) (2)(i)-(ii) and (iv).
2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (a) abiding by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, (b) ensuring that medical information is released only in accordance with applicable federal or state law or pursuant to court orders or subpoenas, (c) maintaining the records and information in an accurate and timely manner, and (d) ensuring timely access by Part D Enrollees to the records and information that pertain to him or her, including 42 C.F.R. 422.118; 42 C.F.R. 422.504(a)(13).
3. Provider may not hold an Eligible Person liable for payment of fees that are the legal obligation of the Plan Sponsor to fulfill. Such provision will apply, but will not be limited to, insolvency of Caremark or Plan Sponsor, contract breach, and Provider billing. 42 C.F.R. 422.504(g)(1)(i); 422.504(i)(3)(i); MMA Manual Chapter 11, Section 100.
4. Any services performed in accordance with a contract are consistent and comply with the Plan Sponsor's contractual obligations to CMS. 42 C.F.R. 422.504(i)(3)(iii).
5. Provider will be paid in compliance with the requirements of 42 C.F.R. 422.520(b).
6. Caremark and Plan Sponsor may approve, suspend, or terminate the Agreement with respect to Provider's provision of Pharmacy Services for a Medicare Advantage Plan Sponsor. 42 C.F.R. 422.504(i)(5).
7. Caremark and Plan Sponsor have the right to revoke the Provider Agreement with respect to delegated activities performed or to seek other remedies in lieu of termination as provided in the Provider Agreement if Caremark, CMS, or the Plan Sponsor determines that Provider has not performed its obligations satisfactorily. Caremark and Plan Sponsor will monitor Provider's performance hereunder on an ongoing basis. 42 C.F.R. 422.504(i)(4)(ii) and (iii).
8. Caremark and Plan Sponsor will review the credentials of medical professionals affiliated with Provider. Caremark and Plan Sponsor will also review and approve the credentialing process, including audits of the credentialing process on an ongoing basis. 42 C.F.R. 422.504(i)(4)(iv).
9. Provider must comply with applicable Medicare laws and regulations and CMS instructions and to allow audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of ten (10) years. 42 C.F.R. 422.504(i)(4)(v) and MMA Manual, Chapter 11, Section 100.4.
10. Provider agrees that Caremark and Plan Sponsor oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations. MMA Manual, Chapter 11, Section 100.4.
11. Provider must not discriminate in the furnishing of benefits on the basis of any factor that is related to health status including, but not limited to: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (g) disability. 42 C.F.R. 422.110(a).
12. Provider must comply with the Plan Sponsor's policies and procedures and written standards, which in accordance with 42 C.F.R. 422.112(a)(6) require:
    a. Timely access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services are continuously monitored to ensure compliance and that Caremark and Plan Sponsor will take corrective action as necessary;

b. Compliance with the Plan Sponsor's coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations; and

c. Provider consideration of beneficiary input into Provider's proposed treatment plan.

13. Provider must ensure that its Pharmacy Services are available 24 hours a day, 7 days a week, when medically necessary. 42 C.F.R. 422.112(a)(7)(ii).

14. Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. 422.112(a)(8).

15. Provider must provide effective and continuous patient care and quality review and maintain health records in accordance with standards established by the Plan Sponsor, taking into account professional standards and that there is appropriate and confidential exchange of information with other network providers. 42 C.F.R. 422.112(b)(4)(ii)-(iii).

16. Provider must establish procedures to ensure that Eligible Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and systems to address barriers to Eligible Person compliance. 42 C.F.R. 422.112(b)(5) and (6).

17. Nothing in the Agreement shall be construed as requiring Provider to indemnify Caremark or Plan Sponsor against any civil liability for damage caused to an Eligible Person as a result of a Plan Sponsor's denial of medically necessary care to such Eligible Person. 42 C.F.R. 422.212.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00001023

12. Medicare-Medicaid Plan

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

A Medicare-Medicaid Plan (MMP), or dual demonstration plan, is a program administered by CMS and a particular state Medicaid agency that integrates the services provided by both the Medicare and Medicaid programs into one plan provided to eligible Medicare-Medicaid Eligible Persons.

12.01 Medicare-Medicaid Networks Standards

To the extent Provider provides Pharmacy Services to a Medicare-Medicaid Plan Eligible Person, and without limiting any other provision in the Agreement, Provider must comply with CMS Medicare Part D and applicable state Medicaid requirements, including the components of the Three-Way contract between CMS, an individual state Medicaid agency, and a specific Plan Sponsor.

12.02 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicare-Medicaid Plan Eligible Person is made, in whole or in part, from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable state laws including minimum standards of pharmacy practice. Refer to chapter **16. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Caremark Pharmacy Portal, refer to section **1.07 Caremark Pharmacy Portal** of the Provider Manual.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00001024

13. Qualified Health Plans

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

For Qualified Health Plan ("QHP") Eligible Persons eligible for health benefits under a QHP ("Eligible Person") offered by a QHP Issuer (as defined in 45 C.F.R. 155.20), or "Plan Sponsor", on the Federally-facilitated Exchange or a State Partnership Exchange, Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and the Department of Health and Human Services ("HHS") guidance including, but not limited to, 45 C.F.R. 156.340(a), to the extent relevant to the Pharmacy Services provided.
2. To permit access by HHS and the Office of Inspector General ("OIG"), or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations in accordance with 45 C.F.R. 156.340(a), until ten (10) years after the final date of the Provider Agreement period.
3. For purposes of clarity, delegated activities and reporting responsibilities as described in 45 C.F.R. 156.340(b), if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.
4. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.
5. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer or Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.
6. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

For QHP Eligible Persons eligible for health benefits under a QHP offered by a QHP Issuer on a State-based Exchange including, but not limited to, **Arkansas**, **California**, **Colorado**, **Connecticut**, **District of Columbia**, **Idaho**, **Kentucky**, **Maine**, **Maryland**, **Massachusetts**, **Minnesota**, **Nevada**, **New Jersey**, **New Mexico**, **New York**, **Oregon**, **Pennsylvania**, **Rhode Island**, **Vermont**, **Virginia**, and **Washington**, Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and guidance issued by HHS, a State-based Exchange or other applicable regulatory body, to the extent relevant to the Pharmacy Services provided.
2. To perform Pharmacy Services in a manner consistent with and in compliance with the QHP Issuer's contractual obligations to the State-based Exchange or other applicable regulatory body.
3. To permit access by HHS, the OIG, the State-based Exchange or other applicable regulatory body, or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations until ten (10) years after the final date of the Provider Agreement period.
4. For purposes of clarity, delegated activities and reporting responsibilities, if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.
5. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.
6. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer, State-based Exchange, applicable regulatory body, Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.
7. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

14. Intellectual Property, Confidentiality and Proprietary Rights

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

14.01 Advertising and Trademarks

CVS Caremark®, or its affiliates, retains exclusive rights to, and in, the names "CVS Caremark" and "Caremark®" together with other distinctive trademarks or service marks that have been used by Caremark or may be adopted or used by Caremark in the future.

Provider must not advertise or use any name, symbol, trademark, or service mark of Caremark or Plan Sponsor in advertising or any other promotional information other than as specifically permitted by the Provider Agreement without prior written consent of Caremark and/or Plan Sponsor respectively, where applicable.

Caremark or Plan Sponsors may, or where required by Law: (1) use the name, logos, address(es) of Provider in directories, informational brochures, or other publications provided to Plan Sponsors or Eligible Persons; (2) use the information regarding Provider's services that is provided to Caremark by Provider in publications provided to Plan Sponsors or Eligible Persons; and (3) provide Plan Sponsors or Eligible Persons with credentialing information.

Upon termination for any reason, Provider must immediately discontinue the use of any name, symbol, trademark, or service mark of Caremark and/or Plan Sponsor in advertising or any other promotional information authorized by Caremark or Plan Sponsor.

14.02 Non-Disparagement

Provider and/or its agents, including outside counsel acting on its behalf, may not place in a false light, disparage, defame, nor make any damaging, derogatory, or unfavorable public statements regarding Caremark, Caremark's products, programs, services, employees, personnel, and brands in any manner. Provider will provide appropriate and adequate training to ensure compliance with these requirements. Provider's obligations hereunder shall survive termination of the Agreement.

14.03 Confidentiality

"Confidential Caremark Information" is defined as any non-public information or data of Caremark and includes, but is not limited to, (1) Caremark's products, programs, services, designs, inventions, business practices, policies and procedures, customer list, information related to a Plan Sponsor, trade secrets; (2) MAC lists; (3) reimbursement rates and terms; (4) the Provider Agreement, the Provider Manual, network enrollment forms and other addenda, and other Caremark Documents; and (5) other information relating to Caremark's business.

Provider and/or its agents, including outside counsel acting on its behalf, must maintain in confidence and may not disclose, sell, assign, transfer, or give to any third party including, a Plan Sponsor or Eligible Person, Confidential Caremark Information without Caremark's prior written consent. Provider may use Confidential Caremark Information only for the purpose of carrying out its obligations under the Provider Agreement. Provider may disclose Confidential Caremark Information to its employees, agents, consultants, or authorized representatives who have a bona-fide need to know the Confidential Caremark Information in order to carry out Provider's obligations under the Provider Agreement and who (1) have been informed of the confidential and proprietary nature of the Confidential Caremark Information, and (2) have agreed in writing not to disclose the Confidential Caremark Information to others and to treat the Confidential Caremark Information in accordance with the requirements of this section. In doing so, Provider agrees that any of its representatives including, but not limited to, its employees, agents, consultants, or authorized representatives (e.g., legal counsel, business associates, third party representatives) are bound by the same confidential provisions; non-compliance to this provision can lead up to and include termination of Provider. Provider must provide Caremark a copy of any signed written non-disclosure agreement within five (5) business days of Caremark's written request to Provider.

Provider agrees to protect the security of Confidential Caremark Information and to ensure that it is used and disclosed only as permitted herein. Provider must notify Caremark in writing within five (5) business day after it becomes aware of any unauthorized use of Confidential Caremark Information. Provider is responsible to Caremark for any breach of this section by its employees, agents, consultants, or authorized representatives, including outside counsel acting on its behalf.

A notice pursuant to the requirements herein must be in writing, be delivered in person by certified mail, courier, or first class mail, and be addressed to Network Management at Caremark at the address below:

CVS Caremark
Attn: Network Management, MC 080
9501 E. Shea Blvd.
Scottsdale, AZ 85260

Such notice to Caremark must also be addressed and delivered to:

CVS Caremark
Attn: General Counsel, MC 035
9501 E. Shea Blvd.
Scottsdale, AZ 85260

No Confidential Caremark Information may be quoted or attributed to Provider or Caremark without the prior written consent of Caremark.

Provider agrees to protect the confidentiality and security of an Eligible Person's personal information (which includes any information that identifies or can be used to identify an Eligible Person), as required by applicable Law, and to use and disclose such information only as permitted by and in accordance with applicable Law.

This **Confidentiality** section applies to the extent consistent with applicable Law.

14.04 Non-Solicitation and Non-Interference

Provider must not (directly or indirectly): (1) communicate with any current Plan Sponsor about terminating its agreement with Caremark; (2) interfere with the relationship or potential relationship between Caremark and a Plan Sponsor or Eligible Person; (3) use or disclose Confidential Caremark Information for the purpose of soliciting a Plan Sponsor or Eligible Person or for any other purpose not in furtherance of the Agreement; (4) communicate with a Plan Sponsor regarding Provider network participation status or network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor; (5) provide inaccurate plan benefit design information to an Eligible Person; or (6) communicate with any Plan Sponsor or potential Plan Sponsor about entering into an agreement for pharmacy benefit management services with any person other than Caremark.

Provider must not (directly or indirectly): (1) communicate with any Eligible Person or a Plan Sponsor's group(s) about person or group terminating its agreement with the Plan Sponsor; (2) interfere with negotiations that a Plan Sponsor is conducting for the provision of health benefits, including pharmacy benefits, to Eligible Persons or groups; (3) use or disclose to any third party Eligible Person or Plan Sponsor group information acquired during the term of the Agreement for the purpose of soliciting Eligible Persons or Plan Sponsor groups or for any other purpose not in furtherance of the Agreement; or (4) communicate with a Plan Sponsor's group regarding Provider's network participation status or the network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor or group.

Nothing contained herein shall prevent Provider from disclosing any information required by Law to be disclosed or otherwise required to be disclosed to an Eligible Person in the fulfillment of the Provider's professional responsibilities for an Eligible Person.

14.05 Proprietary Rights

Provider has no right to use, reproduce, or adapt any information, data, work, compilation, computer program, manual, process, or invention obtained from, provided by, or owned by Caremark or Plan Sponsor (including but not limited to, products, programs, services, business practices, procedures), without Caremark's prior written consent.

Provider agrees that the information contained in the claims adjudication system that was obtained by and through the administration and adjudication of a claim by Provider is the property of Caremark and Provider agrees not to claim any right, title, or interest in said information.

Caremark and its affiliates have the right to use, reproduce, and adapt any information or data obtained from Provider in any manner deemed appropriate, even if such use is outside the scope of the Provider Agreement, provided such use is in accordance with applicable Law.

14.06 Remedies

Provider acknowledges that any unauthorized disclosure or use of information or data obtained from or provided by Caremark would cause Caremark immediate and irreparable injury or loss that cannot be fully remedied by monetary damages.

Accordingly, if Provider should fail to abide by the provision and terms set forth in chapter **14. Intellectual Property, Confidentiality, and Proprietary Rights** of the Provider Manual, Caremark will be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and judgment for damages (including reasonable attorneys' fees and costs) caused by the breach, and all other remedies provided by the Provider Agreement and applicable Law, including termination of the Provider Agreement or Provider's participation in any Caremark network or Plan Sponsor network.

15. Miscellaneous

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

15.01 Assignment

Neither party may assign the Agreement without the prior written consent of the other party; provided, however, that Caremark may, without consent, assign the Agreement to any direct or indirect parent, subsidiary, or affiliated company, or to a successor company.

Any permitted assignee shall assume all obligations of its assignor under the Agreement. The Agreement shall inure to the benefit of and be binding upon each party, its respective successors, and permitted assignees.

If Provider's proposed assignment is approved by Caremark, Provider covenants that Provider shall enter into an agreement with such permitted successor or permitted assignee assigning Provider's rights and obligations under the Agreement in form and substance acceptable to Caremark, including naming Caremark as an express third-party beneficiary thereof. Notwithstanding an approved assignment and a permitted successor's or permitted assignee's assumption of Provider's liabilities and obligations under the Agreement, Provider will remain jointly liable for any liabilities and obligations under the Agreement until such permitted successor or permitted assignee satisfies such liabilities and obligations in full.

The terms of this **Assignment** section apply notwithstanding any other provision in the Agreement.

15.02 Independent Contractors and Third-Party Beneficiaries

Caremark and Provider are considered independent contractors and shall have no other legal relationship under or in connection with the Provider Agreement. Neither party will act as or be deemed a representative of the other party for any reason whatsoever.

Except as otherwise provided for in the Provider Agreement including, but not limited to, the **Indemnification** section of the Provider Agreement and section **15.09 Arbitration** of the Provider Manual, no term or provision in the Provider Agreement is for the benefit of any person who is not a party to the Provider Agreement and no such party shall have any right or cause of action under the Provider Agreement.

15.03 Court Orders, Subpoenas or Governmental Requests

If Caremark receives a court order, subpoena, or governmental request relating solely to Provider, Caremark may comply with such order, subpoena, or request, and Provider must indemnify and hold harmless Caremark for, from, and against any and all costs (including reasonable attorneys' fees and costs), losses, damages, or other expenses Caremark may suffer or incur in connection with the responding to such order, subpoena, or request.

If Provider is requested or required to disclose any Confidential Caremark Information, whether by oral questions, interrogatories, requests for information or documents, subpoenas, or other processes, Provider must promptly provide Caremark with written notice of any such request or requirement so that Caremark may seek an appropriate protective order or other appropriate remedy. If such protective order or other remedy is not obtained, Provider will disclose only that portion of the Confidential Caremark Information as to which it has been advised by legal counsel that disclosure is required by Law; and Provider must exercise its best efforts to obtain reliable assurances that confidential treatment will be accorded to the Confidential Caremark Information that is disclosed in response to such requests or requirements.

15.04 Notices

A notice pursuant to the Provider Agreement to Caremark must be in writing, be delivered in person by certified mail, courier, or first class mail, and be addressed to Network Management at Caremark at the address below:

CVS Caremark
Attn: Network Management, MC 080
9501 East Shea Boulevard
Scottsdale, AZ 85260

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00001029

Any notice to Caremark must also be addressed and delivered to:

CVS Caremark
Attn: General Counsel, MC 035
9501 East Shea Boulevard
Scottsdale, AZ 85260

A notice pursuant to the Provider Agreement to Provider must be in writing, delivered in person by certified mail, courier, or first class mail, at the street, mailing, or check mailing address set forth in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark. Notwithstanding the foregoing, Caremark may give notice to Provider (1) via the claims adjudication system; (2) by fax via the Provider's fax number or by e-mail via the e-mail address provided by Provider in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark; or (3) via Caremark's Pharmacy Portal.

Notices are deemed received on the date of delivery to the other party when delivered in person, by courier, by e-mail, by fax, by secure electronic message, by certified mail, or when posted via Caremark's Pharmacy Portal. If notice is sent by first class mail, the notice is deemed received on the third business day after the date such notice was mailed. It is Provider's responsibility to promptly notify Caremark of any changes to Provider's contact information including, but not limited to, street address, mailing or check mailing address, phone number, fax number, or email address. Provider's failure to update its contact information with Caremark, or refusal to accept delivery of a notice from Caremark, shall not relieve Provider of any obligations to comply with the information communicated in the notice and may subject Provider to termination at Caremark's sole discretion. Refer to section **2.05.01 Notification of Change in Documentation and Other Information** of the Provider Manual.

By participating as a provider in Caremark's networks, Provider acknowledges that it has a prior express business relationship with Caremark and consents to receive facsimile communications as well as automated messages from Caremark. Refer to section **1.06 Pharmacy Communications** of the Provider Manual.

The terms of this **Notices** section apply notwithstanding any other provision in the Provider Agreement.

15.05 Termination

15.05.01 Termination for Cause

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda, and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in any Caremark network or Plan Sponsor network) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity. Refer to chapter **7. Compliance Reviews** of the Provider Manual.

Caremark may immediately terminate the Provider Agreement if:

1. To the extent consistent with applicable Law, Provider makes an assignment for the benefit of creditors, files a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property, or, in Caremark's sole discretion, a proceeding is commenced against Provider or any principal who holds an ownership interest in Provider which will impair its ability to perform the Provider Agreement.
2. Any court, governmental, or regulatory agency issues to Provider an order to cease and desist from providing Pharmacy Services.
3. (a) There is any change in who holds (directly or indirectly) the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (b) The right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party.
4. A levy, writ of garnishment, attachment, execution, or similar item is served upon Provider and not removed within ten (10) days from the date of service.
5. Caremark reasonably determines that Provider is no longer active.
6. Provider fails to satisfy amounts or other obligations owed to Caremark. Certain remedies may apply, including termination of the Provider Agreement and any other available remedies.
7. Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which:
   a. Appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or general public;
   b. Implies a failure to maintain proper licensure and related requirements for licensure;

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00001030

c. Otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement;

d. Is a breach of the Agreement. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement, including termination of pharmacies found to have a direct or indirect relationship with Provider or its affiliates based upon common officers, directors, Pharmacists-in-Charge/responsible pharmacist, managing employees, current/former employees, owners (direct or indirect); or

e. Constitutes fraud, waste or abuse.

The termination rights set forth in this section are in addition to any and all other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity. The effective date of a termination shall be determined by Caremark and as in accordance with applicable Law.

For any Provider with multiple locations, Caremark retains the right to terminate one or any number of Provider's pharmacy locations without terminating the Provider Agreement.

15.05.02 Termination Without Cause

Unless precluded by applicable Law, Caremark may at any time terminate the Provider Agreement without cause or terminate Provider from providing Pharmacy Services to specific Plans without cause upon a notice to Provider, regardless of the network(s) in which Provider participates.

Unless precluded by applicable Law, Provider may terminate the Provider Agreement without cause upon one hundred fifty (150) days' prior written notice to Caremark provided, however, that if applicable Law or a Caremark network or a Plan Sponsor network requires a longer notice period, the Provider Agreement shall not terminate until the expiration of such longer period.

Unless precluded by applicable Law, Provider may terminate participation in any Caremark network or a Plan Sponsor network upon one hundred fifty (150) days' prior written notice to Caremark, specifying the date of termination and the names of the Caremark network(s) or Plan Sponsor network(s) in which Provider will no longer participate, provided, however, that if applicable Law or a Caremark network or Plan Sponsor network requires a longer notice period, the termination will not take effect until the expiration of such longer period. Absent the prior written consent of Caremark, Provider who has notified Caremark of its intent not to participate in any Caremark network or a Plan Sponsor network may not elect to subsequently participate in such Caremark network or a Plan Sponsor network, for thirty (30) days or until the next solicitation period for that Caremark network or Plan Sponsor network, whichever is longer, to the extent consistent with applicable Law.

The terms of this **Termination Without Cause** section apply notwithstanding any other provision in the Provider Agreement. For termination without cause by Provider from a Medicare Part D network, refer to section **10.01.01 Network Participation** of the Provider Manual.

15.05.03 Rights and Remedies in the Event of Termination or Breach

In the event of a termination of the Provider Agreement for any reason, Provider must (upon Caremark's request) surrender the Provider Agreement, Provider Manual, other Caremark Documents, other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control.

In the event Provider breaches any provision of the Provider Agreement or fails, subsequent to Caremark's written demand to surrender the Provider Agreement, Provider Manual, other Caremark Documents, or other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control, in addition to all other termination rights, Caremark shall have the right, to the extent not contrary to Law, to (1) suspend any and all obligations of Caremark, including payment to Provider, under and in connection with the Provider Agreement, (2) impose reasonable handling, investigation and/or improper use fees, and/or (3) in whole or in part, offset against any amounts owed to Provider under the Provider Agreement or under any other agreement between Caremark and Provider, any amounts required to be paid by Provider to Caremark. These rights and remedies are not exclusive and are in addition to any other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

15.06 Survival of Certain Provisions

Termination of the Provider Agreement or Caremark or Plan Sponsor network will have no effect upon the rights and obligations of the parties accruing prior to the effective date of termination.

15.07 Amendments

From time to time, and notwithstanding any other provision in the Provider Agreement (which includes the Provider Manual), Caremark may amend the Provider Agreement, including the Provider Manual or other Caremark Documents, by giving notice to Provider of the terms of the amendment and specifying the date the amendment becomes effective. If Provider submits claims to Caremark after the effective date of any notice or amendment, the terms of the notice or amendment is accepted by Provider and is considered part of the Provider Agreement.

15.08 Enforceability

In the event that any provision or term set forth in the Provider Agreement is determined invalid or unenforceable, such invalidity and unenforceability will not affect the validity or enforceability of any other provision or term set forth in the Provider Agreement.

15.09 Arbitration

Any and all disputes between Provider and Caremark [including Caremark's current, future, or former employees, parents, subsidiaries, affiliates, agents, and assigns (collectively referred to in this **Arbitration** section as "Caremark")] including, but not limited to, disputes in connection with, arising out of, or relating in any way to, the Provider Agreement or to Provider's participation in one or more Caremark networks or exclusion from any Caremark networks, will be exclusively settled by arbitration. This arbitration provision applies to any dispute arising from events that occurred before, on, or after the effective date of this Provider Manual. Any dispute otherwise arbitrable hereunder shall be deemed waived, and no such dispute shall be made or raised unless a Dispute Notice has been given to Caremark, or arbitration filed, as provided below. Unless otherwise agreed to in writing by the parties, the arbitration shall be administered by the American Arbitration Association ("AAA") pursuant to the then applicable AAA Commercial Arbitration Rules and Mediation Procedures including the rule governing Emergency Measures of Protection (available from the AAA). In no event may the arbitrator(s) award indirect, consequential, or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, injury to reputation, or loss of customers or business, except as required by Law.

The arbitrator(s) shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of the agreement to arbitrate including, but not limited to, any claim that all or part of the agreement to arbitrate is void or voidable for any reason. The arbitrator(s) must follow the rule of Law, and the award of the arbitrator(s) will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. Any such arbitration must be conducted in Scottsdale, Arizona and Provider agrees to such jurisdiction, unless otherwise agreed to by the parties in writing.

15.09.01 Discovery Limitations

Discovery shall be limited to documents and information for which there is a direct, substantial, and demonstrable need, and where such documents and information can be located and produced at a cost that is reasonable in the context of all surrounding facts and circumstances.

Discovery shall be limited to the Provider initiating the dispute and no other Provider. Provider expressly agrees not to seek discovery concerning other Providers, disputes or arbitration matters not involving the Provider at issue. Provider agrees that an Arbitrator(s) shall have no authority hereunder to order discovery related to other Providers, disputes or arbitration matters not involving the Provider at issue. Any attempt by Provider to seek discovery on other Providers, disputes or arbitration matters shall be deemed a violation of this provision, as well as Section 14, and subject Provider to the penalties outlined in those provisions.

Further, when the cost and burden of e-discovery are disproportionate to the likely importance of the requested materials, the arbitrator may deny the requests or require that the requesting party advance the reasonable cost of production to the other side. Absent a showing of exceptional circumstances, as determined by the arbitrator(s), the parties shall be limited to one corporate representative deposition per party with each deposition subject to a four-hour time limit.

In the event a party that initiates an action for emergency or interim relief, does not prevail, and subsequently foregoes a final hearing on the merits, the emergency arbitrator's order shall be deemed as the final award and the emergency arbitrator shall retain jurisdiction for the purposes of awarding the expenses of arbitration, including reasonable attorney's fees, against the party that initiated the request for emergency or interim relief.

15.09.02 Expenses of Arbitration

The expenses of arbitration, including reasonable attorney's fees, will be paid for by the party against whom the final award of the arbitrator(s) is rendered, except as otherwise required by Law.

15.09.03 Anti-Class; Anti-Consolidation of Claims in Arbitration

Arbitration with respect to a dispute is binding and neither Provider nor Caremark will have the right to litigate that dispute through a court. In arbitration, Provider and Caremark will not have the rights that are provided in court, including the right to a trial by judge or jury. In addition, the right to discovery and the right to appeal are limited or eliminated by arbitration. All of these rights are waived and disputes must be resolved through arbitration.

No dispute between Provider and Caremark may be pursued or resolved as part of a class action, private attorney general, or other representative action or proceeding (hereafter all included in the term "Class Action"). All disputes are subject to arbitration on an individual basis, not on a class or representative basis, or through any form of consolidated proceedings, and the arbitrator(s) will not resolve Class Action disputes and will not consolidate arbitration proceedings without the express written permission of all parties to the Provider Agreement. Provider and Caremark agree that each may pursue or resolve a dispute against the other only in its individual capacity, and not as a plaintiff or class member in any purported Class Action. Further, disputes with a Provider are limited to a single NCPDP number per arbitration. A Provider may not consolidate or aggregate the claims of multiple NCPDP numbers into a single arbitration.

15.09.04 Confidentiality of Arbitration

Except as may be required by Law, a party, its employees, agents, consultants, authorized representatives, counsel, or arbitrator(s) shall not disclose the existence, content, or results of any dispute or arbitration hereunder without the prior written consent of both parties. In the event a Provider is required by law to make such a disclosure, Provider shall notify Caremark five (5) business days in advance of such disclosure. Provider acknowledges and agrees that any breach of this provision would cause Caremark immediate and irreparable injury or loss that cannot be fully remediated by monetary damages. Accordingly, if Provider, its agents, counsel, or arbitrator fail to abide by the terms and conditions set forth in this Arbitration section of the Provider Manual, Caremark shall be entitled to (a) specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and to judgment for damages (including reasonable attorneys' fees and costs) caused by the breach; (b) an option to void the dispute resolution or arbitration award; and (c) to all other legal and equitable remedies available to Caremark, including termination of the Provider Agreement or Provider's participation in any Caremark network or Plan Sponsor network.

15.09.05 No Collateral Estoppel/Precedential Impact of Award

The decision of the arbitrator is final and binding to the claims raised in the arbitration, but is neither res judicata nor collateral estoppel to any other claim or suit. The decision is conclusive only of the issues in the matter submitted to the arbitrator and only as to the parties to the arbitration. The decision shall not have any precedential impact on any other proceeding.

15.09.06 Waiver of Right to Confirm Award Upon Payment

If a final award is rendered awarding a party monetary damages, the party against whom the final award was rendered shall have thirty (30) days to pay the monetary award. During this thirty (30) day period, the party in whose favor the monetary award was rendered shall not have the right to seek confirmation or enforcement of the award. If the monetary relief in the final award is paid within this thirty (30) day period, the party in whose favor the monetary award was rendered shall have no right to seek confirmation of the final award under the Federal Arbitration Act, 9 U.S.C. §9, nor under any applicable state arbitration Law.

In addition to the foregoing, Provider will use all reasonable efforts to maintain the confidentiality of any petitions it files to confirm, vacate, or modify an arbitration award under Federal Arbitration Act, 9 U.S.C. §§ 9-11. To the extent Provider initiates an action to confirm, modify, or vacate an arbitration award, Provider shall file such a petition under seal. Unless ordered by the court, Provider expressly agrees to not take any action to unseal any (i) filings relating to the petition to confirm, modify or vacate the award or (ii) filings or documents relating to the underlying arbitration, including the underlying arbitration award.

15.09.07 Dispute Resolution Procedures

Prior to a party initiating an arbitration, such party shall request in writing to the other party ("Dispute Notice") a meeting of authorized representatives of the parties for the purpose of resolving the dispute. Disputes must be filed within the following timeframes: (a) for audit related disputes, within six (6) months from the date of the final audit findings; (b) for termination related disputes, within six (6) months from the date of the notification of termination; and (c) for all other disputes, within six (6) months from the date on which the facts giving rise to the dispute first arose. The parties agree that, within fourteen (14) business days after issuance of the Dispute Notice, each party shall designate a representative to participate in dispute resolution discussions which will be held at a mutually acceptable time and place (or by telephone) for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner. If despite the good faith efforts of the parties, the authorized representatives of the parties are unable to resolve the dispute within forty-five (45)

business days after the issuance of the Dispute Notice, or if the parties fail to meet within such forty-five (45) business days, either party may, by written notice to the other party, submit the dispute to binding arbitration provided, however, that any demand for arbitration must be filed within six (6) months from the date of the issuance of the Dispute Notice. The above notwithstanding, nothing in this provision shall prevent either party from utilizing the AAA's procedures for emergency relief to seek preliminary injunctive relief to halt or prevent a breach of this Provider Agreement.

Any party initiating an arbitration pursuant to this Arbitration section shall place in escrow (the alleged amount at issue) for the benefit of the opposing party an amount to be determined as sufficient to cover the estimated attorney's fees, forecasted amount of potential claims that could be submitted by Provider based on Provider's historical Caremark adjudicated paid claims experience (e.g., previous rolling twelve months), and other expenses of arbitration that will be incurred in defense of the arbitration action, which shall in no event be less than $50,000. Such funds will be released upon the entry of a final award of the arbitrator(s), with any excess reimbursed to the initiating party. Failure to place such funds in escrow will constitute a material breach of this Arbitration section.

The terms of this Arbitration section apply notwithstanding any other or contrary provision in the Provider Agreement including, but not limited to, any contrary language in any **Third-Party Beneficiary** provision. This Arbitration section survives the termination of the Provider Agreement and the completion of the business relationship between Provider and Caremark. This arbitration agreement is made pursuant to a transaction involving interstate commerce, and shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

15.09.08 Severability

In the event any provision of this **15.09 Arbitratio**n section of the Provider Manual shall be judged, declared, held or ruled to be invalid, illegal or unenforceable, in whole or in part, such provision shall be deemed severable, and it shall not invalidate or impair the **15.09 Arbitration** section as a whole.

15.10 Force Majeure

Caremark and Provider are excused from performance under the Provider Agreement to the extent that either Caremark or Provider is prevented from performing all or any part of the Provider Agreement as a result of causes that are beyond the affected party's reasonable control including, but not limited to, fire, flood, earthquakes, tornadoes, other acts of God, war, work strikes, civil disturbances, power or communications failure, court order, government intervention, a change in Law, a significant change in the industry, or third-party nonperformance.

15.11 Anti-Kickback Statute, Stark Law, and Caremark Compliance Program

Each party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C § 1320a-7b(b) ("Anti-Kickback Statute"), or the federal "Stark Law," set forth at 42 U.S.C § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Provider Agreement. In addition, Caremark's Code of Conduct and policies and procedures on the Anti-Kickback Statute and Stark Law may be accessed at **www.caremark.com/pharminfo.**

15.12 Rebate Programs

Caremark has the right to submit all prescriptions relating to the Provider Agreement to pharmaceutical companies in connection with Caremark's rebate programs and any similar programs. Provider must not submit any of the prescriptions relating to the Provider Agreement to any pharmaceutical company for the purpose of receiving any rebate, discount or the like, except as authorized by Caremark in writing.

15.13 Eligible Person Communications

Provider understands and acknowledges that Caremark may communicate with Eligible Persons as required by Plan Sponsor, applicable Law, or as Caremark determines is necessary regarding matters such as plan benefits, network design and composition, formulary and clinical issues, and manufacturer recalls.

16. Federal and State Laws and Regulations

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

16.01 Compliance with Laws

Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable Laws (including any implementing regulations) in performing its Pharmacy Services under the Agreement including, but not limited to: the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395 nn); Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (45 C.F.R. Parts 160, 162, and 164), and the Controlled Substance Act (21 U.S.. 801-971); and Caremark must comply with all applicable Laws (including any implementing regulations) in performing its duties under the Agreement, provided however that in the event that Provider alleges that Caremark has not complied with an applicable Law, Provider shall not be entitled to a private right of action unless expressly permitted under the underlying applicable Law, and Provider shall not be entitled to any contract damages or other contract remedies against Caremark other than as specified by such underlying applicable Law.

Federal and state specific addenda, as updated from time to time to reflect regulatory changes, are set forth in the Pharmacy Portal at **rxservices.cvscaremark.com** and are incorporated herein by reference. Refer to section **1.07 Caremark Pharmacy Portal** of the Provider Manual.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00001035

Appendix A - Drug Submission Requirements

Note: This section contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Caremark.

OPHTHALMIC PRODUCTS

Ophthalmic Drops (solutions and suspensions)

Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. Acute therapy may be submitted for Prescriber-specified days (e.g., ciprofloxacin eye drops for 5 days – enter 5 days supply). Information in the chart below is based on total drops per day being utilized in the prescribed directions and the bottle size being dispensed.

15 gtt/mL Total Drops Per Day	2.5 mL	5 mL	10 mL	15 mL	20 mL	30 mL	40 mL	45mL
One	37 (30/34 acceptable)	75	150	225	300			
Two	18	37 (30/34 acceptable)	75	112 (90/100 acceptable)	150	225	300	337
Three	12	25	50	75	100 (90 acceptable)	150	200	225
Four	9	18	37 (30/34 acceptable)	56	75	112 (90/100 acceptable)	150	168
Six	6	12	25	37 (30/34 acceptable)	50	75	100 (90 acceptable)	112 (90/100 acceptable)
Eight	4	9	18	28	37 (30/34 acceptable)	56	75	84

	NDC	Billing Unit	Common Dosage	Common Day Supply	Common Errors
Restasis® Multi-dose™	00023-5301-05	Per mL	1 drop in both eyes twice daily	5.5 mL = 30-day supply	Commonly misbilled for incorrect quantity and day supply (e.g., 5.5 mL for 20 days). Per manufacture one bottle is a 30 day-supply

Ophthalmic Ointments

Eye ointments are typically dispensed as one package per prescription. It is rare for Prescribers to write for more than one tube per prescription. Should a prescription be presented for multiple packages or for quantity unavailable, the pharmacy staff should clarify the prescribed quantity and directions for use to support the prescription and days supply entered on the claim.

Ophthalmic Single-Use Vials

Single-use vial ophthalmics should be calculated based on directions for use and the dosage units available within the single-dose vial and packaging. Note: Single dose vials are commonly used in both eyes during a single dosage application.

	NDC	How Supplied	Common Dosage	Common Day Supply	Common Errors
Restasis®	00023-9163-30	30 single-use vials/package	1 drop 2 times daily in each eye	60 for a 30-day supply	Commonly misbilled as 120 for 30 days. Single-use vial can be utilized for both eyes.
Xiidra®	00078-0911-12	60 single-use containers	1 drop 2 times daily in each eye	60 for a 30-day supply	Commonly misbilled as 120 for 30 days. Single-use vial can be utilized for both eyes.
Zioptan®	17478-0609-30 17478-0609-90	30 single-use containers 90 single-use containers	1 drop in each eye every night 1 drop in each eye every night	30 for a 30-day supply 90 for a 90-day supply	Commonly misbilled as 60 for 30 days. Single-use vial can be utilized for both eyes. Commonly misbilled as 90 for 45 days. Single-use vial can be utilized for both eyes.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00001036

PROPER BILLING FOR ORAL INHALERS

Refer to section **4. Claims Submission** of the Provider Manual for a list of claim submission requirements.

ORAL INHALER CHART

Inhaler Name	Billing Pkg Size	Total Inhalations Per Box	Manufacturer Recommended Adult Max Daily Dose	Product Expiration Once Opened	TOTAL # of Inhalations Used Per Day					
					1	2	4	6	8	10
					Day Supply ( ) Indicates Acceptable Day Supply					
Advair® Diskus 100/50 mcg, 250/50 mcg, 500/50 mcg	60 ea	60	2	1 month	30	30	-	-	-	-
Advair® HFA 45/21 mcg, 115/21 mcg, 230/21 mcg	12 gm	120	4	N/A	120	60	30	-	-	-
Alvesco® 80 mcg	6.1 gm	60	8	N/A	60	30	15	10	7	-
Alvesco® 160 mcg	6.1 gm	60	4	N/A	60	30	15	-	-	-
Anoro Ellipta 62.5/25 mcg	60 ea	30	1	6 weeks	30	-	-	-	-	-
Arnuity® Ellipta® 100 mcg	30 ea	30	2	6 weeks	30	15	-	-	-	-
Arnuity® Ellipta® 200 mcg	30 ea	30	1	6 weeks	30	-	-	-	-	-
Asmanex® Twisthaler 220 mcg	1 ea	30	4	45 days	30	15	7	-	-	-
Asmanex® Twisthaler 220 mcg	1 ea	60	4	45 days	45	30	15	-	-	-
Asmanex® Twisthaler 220 mcg	1 ea	120	4	45 days	45	45	30	-	-	-
Asmanex® HFA 110 mcg, 200 mcg	13 gm	120	4	N/A	120	60	30	-	-	-
Atrovent® HFA 17 mcg	12.9 gm	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Bevespi Aerosphere® 9 mcg/4.8 mcg	10.7 gm	120	4	3 months	90	60	30	-	-	-
Breo® Ellipta® 100/25 mcg, 200/25 mcg	60 ea	30	1	6 weeks	30	-	-	-	-	-
Combivent® Respimat® 20/100 mcg	4 gm	120	6	3 months	90	60	30	20	-	-
Dulera® 100/5 mcg, 200/5 mcg	13 gm	120	4	N/A	120	60	30	-	-	-
Flovent® Diskus 100 mcg	60 ea	60	20	2 months	60	30	15	10	7	6
Flovent® Diskus 250 mcg	60 ea	60	8	2 months	60	30	15	10	7	-
Flovent® HFA 44 mcg	10.6 gm	120	20	N/A	120	60	30	20	15	12
Flovent® HFA 110 mcg, 220 mcg	12 gm	120	8	N/A	120	60	30	20	15	-
Incruse Ellipta 62.5 mcg	30 ea	30	1	6 weeks	30	-	-	-	-	-
ProAir® HFA 90 mcg	8.5 gm	200	12	N/A	200	100 (90)	50	33 (30)	25	20
ProAir® RespiClick 90 mcg	1 ea	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Proventil® HFA 90 mcg	6.7 gm	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Pulmicort Flexhaler® 90 mcg	1 ea	60	16	N/A	60	30	15	10	7	6
Pulmicort Flexhaler® 180 mcg	1 ea	120	8	N/A	120	60	30	20	15	-
QVAR RediHaler™® 40 mcg	10.6 gm	120	16	N/A	120	60	30	20	15	12
QVAR RediHaler™ 80 mcg	10.6 gm	120	8	N/A	120	60	30	20	15	-
Seebri™ Neohaler® 15.6 mcg	60 ea	60	2	N/A	60	30	-	-	-	-
Serevent® Diskus® 50 mcg	60 ea	60	2	6 weeks	42	30	-	-	-	-
Spiriva® HandiHaler® 18 mcg	30 ea	30	1	Use capsule immediately	30	-	-	-	-	-

ORAL INHALER CHART

Inhaler Name	Billing Pkg Size	Total Inhalations Per Box	Manufacturer Recommended Adult Max Daily Dose	Product Expiration Once Opened	TOTAL # of Inhalations Used Per Day					
					1	2	4	6	8	10
					Day Supply ( ) Indicates Acceptable Day Supply					
Spiriva® Respimat® 1.25 mcg, 2.5 mcg	4 gm	60	2	3 months	60	30	-	-	-	-
Symbicort® 80/4.5 mcg, 160/4.5 mcg	6 gm	120	4	N/A	120	60	30	20	15	-
Trelegy Ellipta 100/62.5/25 mcg, 200/62.5/25 mcg	60 ea	30	1	6 weeks	30	-	-	-	-	-
Wixela™ Inhub™ 100/50 mcg, 250/50 mcg, 500/50 mcg	60 ea	60	2	1 month	60	30	-	-	-	-

PROPER BILLING FOR NASAL SPRAYS

Refer to section **4. Claims Submission** of the Provider Manual for a list of claim submission requirements.

NASAL SPRAY CHART

Drug Name	Billing Package Size	Total Sprays per Box	Manufacturer Recommended Adult Max Daily Dose	Product Expiration Once Opened	TOTAL # of Sprays Used Per Day					
					1	2	4	6	8	10
					Day Supply ( ) Indicates Acceptable Day Supply					
Astepro® (azelastine) 0.15%	30 mL	200	8	N/A	200	100 (90)	50	33 (30)	25	-
azelastine 0.1%	30 mL	200	8	N/A	200	100 (90)	50	33 (30)	25	-
Beconase® AQ 42 mcg	25 gm	180	8	N/A	180	90	45	30	22	-
DDAVP™ (desmopressin) 0.01%	5 mL	50	4	N/A	50	25	12	-	-	-
Dymista™ 137 mcg/50 mcg	23 gm	120	4	N/A	120	60	30	-	-	-
Flonase® (fluticasone) 50 mcg	16 gm	120	4	N/A	120	60	30	-	-	-
Flonase® Sensimist 27.5 mcg	15.8 mL	120	4	N/A	120	60	30	-	-	-
flunisolide 0.025%	25 mL	200	16	N/A	200	100 (90)	50	33 (30)	25	20
ipratropium bromide 0.03%	30 mL	345	12	N/A	345	172	86	57	43	34 (30)
ipratropium bromide 0.06%	15 mL	165	16	N/A	165	82	41	27	20	16
Miacalcin® (calcitonin/salmon) 200 unit	3.7 mL	30	1	35 days	30	-	-	-	-	-
Narcan® 4 mg/0.1 mL	2 ea	2	N/A	N/A	2	1	-	-	-	-
Nasacort® Allergy 24HR (triamcinolone) 55 mcg	16.9 mL	120	4	N/A	120	60	30	-	-	-
Nasalcrom® (cromolyn) 5.2 mg	26 mL	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Nasonex™ (mometasone) 50 mcg	17 gm	120	4	N/A	120	60	30	-	-	-
Omnaris™ 50 mcg	12.5 gm	120	4	4 months	120	60	30	-	-	-
Qnasl™ 80 mcg	8.7 gm	120	4	N/A	120	60	30	-	-	-
Patanase® (olopatadine) 665 mcg	30.5 gm	240	8	N/A	240	120	60	40	30	-
Rhinocort Aqua™ (budesonide) 32 mcg	8.6 gm	120	8	N/A	120	60	30	20	15	-
Sprix® 15.75 mg/act.	5 ea	40	4	24 hours	5	5	5	5	5	-
Stimate™ (desmopressin) 1.5 mg/mL	2.5 mL	25	2	6 months	25	12	-	-	-	-
Zetonna™ 37 mcg	6.1 gm	60	2	N/A	60	30	-	-	-	-

CONFIDENTIAL TREATMENT REQUESTED

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

PROPER BILLING FOR COMMON MEDICATIONS

DRUG NAME	BILLING UNIT	COMMON DIRECTIONS	COMMON DAY SUPPLY	COMMENTS
Oral Tablets/Capsules				
Benicar®, Crestor® (Rosuvastatin), Dexilant, Januvia®, Lipitor® (Atorvastatin), Pravachol® (Pravastatin), Singulair® (Montelukast), Synthroid® (Levothyroxine), Tirosint®, Tricor® (Fenofibrate), Zetia®	Per tablet/capsule	One tablet/capsule daily	30 tablets/capsules = 30-day supply	Commonly billed for incorrect day supply (e.g., 1 tablet daily billed for 90 tablets for a 30-day supply).
Boniva® (Ibandronate)	Per tablet	One tablet every month	One tablet = 28-day supply	Commonly billed for incorrect quantity and day supply (e.g., more than one tablet in 28 days).
Contraceptives (various) 28-day	Per tablet (one pack contains 28 tablets)	One active tablet daily for twenty-one days followed by 21 and 7 days of inactive tablets	28 tablets = 28-day supply	Commonly billed for incorrect quantity (e.g., 84 for a 28-day supply instead of 28 for a 28-day supply). Commonly misbilled when pack does not contain inactive tablets (for continuous use).
Methotrexate	Per tablet	2.5 mg tablets, various quantities, typically dosed weekly	Varies	Commonly misfilled for incorrect directions.
Prempro®	Per tablet (one pack contains 28 tables)	One tablet every day	28 tablets = 28-day supply	Commonly billed for incorrect quantity and day supply (e.g 30 for 30-day supply).
Ubrelvy®	Per tablet	Take one tablet and may repeat in 2 hours if needed for migraine	Varies	Commonly billed for incorrect quantity and day supply outside of safety guidelines without supporting documentation.
Oral Suspensions/Solutions				
Miralax™ Packets (Polyethylene Glycol 3350)	Per Packet	One packet (17 gm) per day	30 packets = 30-day supply	Commonly billed for incorrect billing unit (e.g., grams instead of number of packets).
MoviPrep® Powder for Solution	Per box	Mix with water and drink as directed prior to procedure	One box = 1 or 2-day supply	Commonly billed for incorrect billing unit (e.g., milliliters instead of per box).
Suprep® Bowel Prep	Per mL (one box = 354 mL)	Mix with water and drink as directed prior to procedure	354 mL = 1 or 2-day supply	Commonly incorrectly billed for greater than 354 mL (1 box).
Rectal/Vaginal				
Annovera®	Per vaginal system	Insert ring for 3 weeks, remove for 1 week; repeat for up to 13 cycles	One ring = 364 days or plan max	Commonly billed for incorrect day supply. One vaginal system can be used for 13 (28-day) cycles.
Diazepam Rectal Gel	Per box (each box contains 2 rectal delivery systems)	Varies	Varies	Commonly billed for incorrect quantity and day supply (e.g., delivery systems vs box).
Estrace® Cream	Per gram (one tube = 42.5 gm)	Titration therapy with maintenance of 1 application weekly	One 42.5-gram tube = 30-day supply	Commonly incorrectly billed for greater than one tube per month (confirm dosage for therapy, include titration if needed, and document).
Estring®	Per ring	One ring every 84 days	One ring = 84-day supply	Commonly incorrectly refilled too early (i.e., every 30 days instead of every 90 days)Always attempt to bill for correct days supply before reduction to max day supply allowed by Plan.

2022 CVS Caremark Provider Manual - Effective 01/01/2022

CONFIDENTIAL AND PROPRIETARY

CVS_HJC_00001040

CONFIDENTIAL TREATMENT REQUESTED

2022 CVS Caremark Provider Manual - Effective 01/01/2022

PROPER BILLING FOR COMMON MEDICATIONS

DRUG NAME	BILLING UNIT	COMMON DIRECTIONS	COMMON DAY SUPPLY	COMMENTS
Metronidazole gel 0.75%	Per gram	One applicatorful (approximately 5 gm) once or twice a day for 5 days	One 70-gm tube = 5-day supply	Commonly billed for incorrect quantity and day supply (e.g., applicators are reusable).
NuvaRing®	Per ring	Use one ring for 3 weeks, remove for 1 week	One ring = 28-day supply	Box of 3 can be split. Commonly incorrectly billed as 3 for 28 days.
Premarin® Cream	Per gram	0.5 – 2 gm per day depending on therapy	One 30 gram tube = 30-day supply	Commonly incorrectly billed for greater than one tube per month (confirm dosage for therapy, include titration if needed, and document).
Vagifem®	Per tablet	10 mcg tablets, one tablet daily for 2 weeks then taper to maintenance dose of one tablet twice weekly	14 tablets = 14-day supply for starter dose 8 tablets = 28-day supply for maintenance	Commonly billed for incorrect quantity and day supply (e.g., refill contains starter dose quantity).
Medical Devices/Testing Supplies				
Dexcom Transmitter	Per transmitter	Varies	One transmitter = 90-day supply	Commonly incorrectly billed for more than one transmitter. One transmitter is good for 90 days.
Dexcom Reader	Per reader	Varies	One reader = 364 days or Plan Max	Commonly incorrectly billed for more than one reader. One reader is good for 1 year.
Dexcom Sensor	Per sensor	Varies	Varies	Commonly billed for incorrect quantity and day supply (e.g., billed for more than 1 sensor every 10 days).
Freestyle Libre 14 Day Reader	Per reader	Varies	Varies	Commonly incorrectly billed for more than one reader. One reader is good for up to 3 years per manufacturer.
Glucometers (all manufacturers)	Per meter	Varies	Varies	Commonly incorrectly billed for more than one meter.
InPen	Per pen	Varies	One pen = 364-day supply or plan max	Commonly billed for incorrect quantity and day supply (e.g., billed for more than one pen without supporting documentation). One pen is good for 1 year.
Pen Needles and Syringes (all manufacturers)	Per needle/syringe	Varies	Varies	Commonly billed for incorrect quantity (e.g., billed for more than one box without documented utilization).
Topical Preparations				
Acanya® (Clindamycin/Benzoyl), Carac® (Fluorouracil), Differin® (Adapalene) Cream, Epiduo®, Mirvaso®	Per gram	Apply once daily	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization). Also, incorrect package size billed.
Aczone®, Azelex®, Finacea®, Temovate® (Clobetasol) cream/oint.	Per gram	Apply twice daily	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization).
Aldara® (Imiquimod)	Per packet	Apply up to 2 packets each night for 2 weeks, followed by 2 weeks off	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one box without documented utilization).
Denavir®	Per gram	Apply every 2 hours while awake for 4 days within 1 hour of onset of symptoms	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization).

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

CVS_HJC_00001041

CONFIDENTIAL TREATMENT REQUESTED

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

PROPER BILLING FOR COMMON MEDICATIONS

DRUG NAME	BILLING UNIT	COMMON DIRECTIONS	COMMON DAY SUPPLY	COMMENTS
Jublia®	Per mL	Apply once daily to affected toenail(s)	Varies based on application area(s)	Commonly incorrectly billed for more than one bottle without the affected toenail(s) documented.
Picato®	Per tube (One box contains 2 tubes of 0.05% gel OR 3 tubes of 0.015% gel)	Apply one tube daily Use 0.05% gel for 2 consecutive days on trunk/extremities Use 0.015% gel for 3 consecutive days on face/scalp	2 (0.05% gel) = 2-day supply 3 (0.015% gel) = 3-day supply	Commonly billed incorrectly for more than 2- or 3-day supply or for multiple boxes. Also, incorrect strength is selected for area of application indicated by physician.
Zovirax® (Acyclovir) cream/oint.	Per gram	Apply every 3 hours, 6 times a day to adequately cover all lesions of affected area(s) for 7 days	Varies based on application area(s)	Commonly billed for incorrect quantity and day supply (e.g., billed for more than one tube without documented utilization).
Transdermal Systems				
Vivelle-Dot® (Estradiol)	Per patch	One patch twice weekly	8 patches = 28-day supply	Commonly billed for incorrect quantity and day supply (e.g., greater than 2 patches per week).
Xulane®	Per patch (each box contains 3 patches)	One patch once per week for three weeks, remove for one week	3 patches = 28-day supply	Commonly billed for incorrect quantity and day supply (e.g., greater than one box per month).
Injectables				
Avonex® pen kit (verify NDC)	Per kit (each kit contains 4 syringes)	Inject 30 mcg once a week	1 kit (4 syringes) = 28-day supply	Commonly billed for incorrect billing unit (e.g., number of syringes instead of per kit).
Avonex® single-use syringe (verify NDC)	Per syringe	Inject 30 mcg once a week	4 syringes = 28-day supply	Commonly billed for incorrect billing unit (e.g., mL instead of number of syringes) and/or billed for incorrect NDC.
Basaglar®	Per mL	Varies	Varies based on units per day	Commonly billed for incorrect day supply (e.g., one day supply).
Enbrel® multiple-use vial (verify NDC)	Per tray (each carton contains 4 trays)	One injection twice weekly	8 dose trays = 28-day supply	Commonly billed for incorrect NDC (e.g., Enbrel® single-use syringe instead of Enbrel® multiple-use vial).
Enbrel® single-use prefilled syringe	Per mL	One injection twice weekly	4.08 mL (box of four, 25 mg syringes) = 28-day supply 3.92 mL (box of four, 50 mg syringes) = 28-day supply	Commonly billed for incorrect billing unit (e.g., as number of syringes instead of mL) and/or billed for incorrect NDC (Enbrel® multiple-use vial instead of Enbrel® single-use syringe).
Gvoke HypoPen® (verify NDC)	Per mL	Varies	Varies	Commonly billed incorrectly by syringe rather than mL.
Humira® Pen	Per tray	Starter dose varies depending on indication One injection every other week (maintenance)	Varies depending on indication 2 (dose trays) = 28-day supply	Commonly billed for incorrect day supply (e.g., refill contains starter dose quantity).
Imitrex® (Sumatriptan)	Per mL	One injection, may repeat at least 1 hour later, maximum of 2 (6 mg) injections per 24 hours	Varies	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL).
Lovenox® (Enoxaparin)	Per mL	One injection once or twice daily	Varies	Commonly billed for incorrect billing unit (e.g., as number of syringes or total mg dose instead of mL).

2022 CVS Caremark Provider Manual - Effective 01/01/2022

CVS_HJC_00001042

CONFIDENTIAL TREATMENT REQUESTED

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

2022 CVS Caremark Provider Manual - Effective 09/01/2022

PROPER BILLING FOR COMMON MEDICATIONS

DRUG NAME	BILLING UNIT	COMMON DIRECTIONS	COMMON DAY SUPPLY	COMMENTS
Ozempic®	Per mL	Inject 0.25mg once weekly Inject 0.25mg once weekly for 4 weeks then increase to 0.5mg once weekly Inject 0.5mg once weekly Inject 1mg once weekly	1.5 mL = 56-day supply 1.5 mL = 42-day supply 1.5 mL = 28-day supply 3 mL = 28-day supply	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL) and billed with incorrect day supply for quantity dispensed.
Prolia®	Per mL	One injection every 6 months	1 mL = 180-day supply	Commonly billed for incorrect day supply; commonly refilled too early.
Saxenda®	Per mL	Initial dose = 0.6 mg per day for one week, increase dose at weekly intervals until 3 mg Maintenance dose = 3 mg daily	15 mL = 30-day supply	Commonly billed for incorrect quantity for day supply (e.g., 45 mL for a 30-day supply).
Stelara®	Per mL	Initial dose = one injection at week zero, repeat dose at 4 weeks Maintenance dose = one injection, every 12 weeks starting at week 16	1 mL or 2 mL (depending on strength) = 28-day supply 0.5 mL or 1 mL (depending on strength) = 84-day supply	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL) and billed with incorrect day supply for quantity dispensed.
Trenjya®	Per mL	Initial dose = one injection at week zero, repeat dose at 4 weeks Maintenance dose = one injection every 8 weeks starting at week 12	1 mL = 28-day supply 2 mL = 84-day supply 1 mL = 56-day supply	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL) and billed with incorrect day supply for quantity dispensed. Commonly refilled too early.
Trulicity®	Per mL	One injection weekly	2 mL = 28-day supply	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL).
Victoza®	Per mL	0.6 mg per day, 1.2 mg per day, or 1.8 mg per day	6 mL = 30-day supply (for 1.2 mg dose) 9 mL = 30-day supply (for 1.8 mg dose)	Commonly billed for incorrect billing unit (e.g. billed as milligrams instead of milliliters).
Nasal Sprays				
Azelastine	Per mL	One to two sprays per nostril twice daily	30 mL = 30-day supply	Commonly billed for incorrect quantity and day supply.
Dymista®	Per gm	One spray per nostril twice daily	23 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.
Flonase® (Fluticasone)	Per gm	One to two sprays per nostril once daily	16 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.
Miacalcin® (Calcitonin-Salmon)	Per mL	One activation in one nostril once daily	3.7 mL = 30-day supply	Commonly billed for incorrect quantity and day supply.
Nasonex® (Mometasone)	Per gm	Two sprays per nostril once or twice daily	17 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.
Oral Inhalers				
Flovent® HFA 44 mcg Flovent® HFA 110 mcg, 220 mcg	Per gm	Two inhalations twice daily	10.6 gm = 30-day supply 12 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.

CVS_HJC_00001043

PROPER BILLING FOR COMMON MEDICATIONS

DRUG NAME	BILLING UNIT	COMMON DIRECTIONS	COMMON DAY SUPPLY	COMMENTS
Spiriva® Handihaler®	Per capsule	Two inhalations (one capsule) once daily	30 ea = 30-day supply	Commonly billed for incorrect quantity and day supply. Also, incorrect NDC is chosen (e.g., Respimat versus Handihaler).
Spiriva® Respimat®	Per gm	Two inhalations once daily	4 gm = 30-day supply	Commonly billed for incorrect quantity and day supply. Also, incorrect NDC is chosen (e.g., Handihaler versus Respimat).
Tudorza® Pressair®	Per inhaler	One inhalation twice daily	1 ea = 30-day supply	Commonly billed for incorrect quantity and day supply (e.g., number of inhalations).
Kits				
Chantix® Starter Pack Chantix® Continuing Pack	Per tablet (one pack contains 53 tablets) Per tablet (one pack contains 56 tablets)	Initial = 0.5 mg once daily on days one through three, 0.5 mg twice daily on days four through seven, then 1 mg twice daily Maintenance = 1 mg twice daily for twelve weeks	53 tablets (one pack) = 28-day supply 56 tablets (one pack) = 28-day supply	Commonly billed for incorrect quantity and day supply. Also, starter pack is refilled without appropriate documentation. Commonly billed for incorrect quantity and day supply.
Gattex Kit® (verify NDC)	Per kit (one kit contains 1 vial OR one kit contains 30 vials)	Inject 0.05 mg/kg once daily	1 box (one vial)=1-day supply 1 box (30 vials) = 30-day supply	Commonly billed for incorrect quantity (e.g., vial versus box).
Rowasa® (Mesalamine) (verify NDC)	Per box (each box contains 7 bottles)	One enema (4 gm) once daily	1 box (seven bottles) = 7-day supply	Commonly billed for incorrect quantity (e.g., number of bottles or milliliters).

Appendix B - CMS Form No. 10147 (English)

Enrollee's Name (Optional):

Drug and Prescription Number (Optional):

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call **1-800-Medicare** for more information.

PRA Disclosure Statement 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 collection is 0938-0975. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: **1-800-MEDICARE**.

Form CMS-10147 *OMB Approval No. 0938-0975*

Appendix B1 - CMS Form No. 10147 (Spanish)

Nombre del beneficiario (opcional):

Número de receta y de medicamento (opcional):

La cobertura de Medicare de las recetas médicas y sus derechos

Sus derechos si tiene Medicare

Usted **tiene el derecho de solicitar una determinación de cobertura** de su plan Medicare de recetas médicas si está en desacuerdo con la información proporcionada por la farmacia. También tiene **el derecho de solicitar una determinación de cobertura especial conocida como "excepción"** si piensa que:

- Necesita un medicamento que no está en la lista de su plan. A la lista de medicamentos cubiertos se le conoce como "formulario".
- Una regla de cobertura (como la autorización previa o un límite de cantidad) no debe aplicarse debido a su problema médico; o
- Necesita tomar un medicamento no preferido y usted quiere que su plan lo cubra al precio de un medicamento preferido.

Lo qué necesita hacer

Usted o la persona que le ha recetado el medicamento pueden pedirle al plan una determinación de cobertura, llamando al número gratis que aparece en la parte de atrás de la tarjeta del plan, o visitando el sitio web del plan. Usted o su médico puede pedir una determinación acelerada (24 horas) si su salud pudiera estar en peligro si tiene que esperar 72 horas para obtener la respuesta. Usted tendrá que informarle al plan:

1. El nombre del medicamento que no pudo obtener, la dosis y concentración si lo sabe.
2. El nombre de la farmacia donde intentó obtener el medicamento.
3. La fecha en que intentó obtenerlo.
4. Si solicita una excepción, el médico que lo recetó tiene que enviarle a su plan una declaración explicándole el motivo por el cual usted necesita el medicamento que no está en el formulario, el medicamento no preferido o no se debe aplicar una regla de cobertura a usted.

Su plan Medicare de medicamentos recetados le comunicará su decisión por escrito. Si no aprueban la cobertura, la carta del plan le explicará el motivo y cómo apelar la decisión si no está de acuerdo. Si desea más información, consulte los materiales del plan o llame al **1-800-MEDICARE**.

Declaración sobre la Ley para la Reducción de Trámites De acuerdo con la Ley para la Reducción de Trámites de 1995 (PRA en inglés), las personas no están obligadas a responder una recopilación de información a menos que se exhiba un número de control de la oficina de Gerencia y Presupuesto (OMB en inglés) válido. El número de control OMB válido para esta recopilación de información es 0938-0972. El tiempo necesario para responder esta recopilación de información es de aproximadamente 1 minuto por respuesta, incluido el tiempo para revisar instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, llame al **1-800-MEDICARE** o envíe un correo electrónico a: **AltFormat@cms.hhs.gov**.

Formulario de CMS-10147-Spanish **Número de OMB 0938-0975**

Appendix C - Appeals Process Documentation Guidelines

***Plan Sponsor-specific information may apply as communicated by Caremark or Plan Sponsor.**

*****Please Read Thoroughly Prior To Obtaining and Sending Documentation*****

1. Introduction:

   The enclosed report lists discrepancies found as indicated on the Pharmacy Audit Acknowledgement signed by the pharmacy staff on duty at the audit. You have the opportunity to provide documentation to support your pharmacy's claims currently considered discrepant. Ensure you provide the correct documentation for the discrepancy type identified. Your immediate attention is important. All documentation must be **RECEIVED** by Caremark no later than the due date indicated in your cover letter.

2. Documentation Procedures:

   a. Pharmacy Auditing Discrepancy List: The enclosed report lists discrepant claims by prescription number and date of fill. The D1 and D2 columns list the code for the discrepancy type.

   b. Documentation Guidelines: The enclosed guidelines describe the discrepancy types and the documentation required to resolve those discrepancies.

   c. **ALL** documentation is required to include:

      - Pharmacy NABP number;
      - Prescription number of the claim as listed on the Discrepancy List;
      - Date of fill referred to on the Discrepancy List;
      - Patient's full name, address and phone number;
      - Additional information as shown on the Discrepancy List for the specific discrepancy type;
      - Statements from the prescribers must be on prescriber letterhead or prescription pad. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician stamp on the letter).

   Documentation submitted must adhere to the Documentation Guidelines. Documentation such as telephone prescriptions, computer generated labels or documents without all the required information will not be accepted.

3. Mailing Instructions:

   All documentation must be sent by the documentation due date on the cover letter and in one package via **Certified, Express, Express with tracking, or regular USPS mail.** Address your correspondence to:

   Caremark
   Attn: Audit Documentation
   Pharmacy Performance MC 020
   9501 East Shea Boulevard
   Scottsdale, AZ 85260-6719
   Phone: 1-866-488-4709
   Fax: 1-866-310-4135

   Documentation less than fifty (50) pages can be faxed; however, the images must be legible to be considered (e.g., documents on tamper resistant prescription pads may not be legible when faxed).

   Caremark recommends sending documentation with tracking and maintaining a copy of all documentation sent.

   All documentation received will be reviewed, and a Final Audit Discrepancy List will be mailed upon completion of review.

   If you need additional help, please call Caremark Pharmacy Performance at **1-866-488-4709**.

	DISCREPANCY	DEFINITION	Acceptable Documentation
CMP	COMPOUND	Compound claim has been selected for review for verification of pricing, quantity, use, etc.	Send a legible copy of the original compound recipe that was signed by the verifying pharmacist and that includes the names of the all active and inactive ingredients, NDC numbers, quantities, and costs. Billing statements will not be accepted. Also send a copy of the prescription hardcopy and prescription label with directions for use for each date of fill. If written "use as directed", follow SIG documentation guidelines.
CPY	COPAY	Copays are required to be collected by pharmacy, where applicable by law, and cannot be waived, reduced, increased, or discounted	A copy of a patient invoice showing the member copay amount along with evidence the copay was paid in full, such as a signed member statement listing the rx, DOF, and copay paid amount, credit card receipt including auth #, copy of front and back of member's check, other financial documents supporting copay payment.
CQ	CUT QUANTITY	Quantity billed is less than that prescribed and less than that allowed resulting in additional refills and undue dispensing fees	This discrepancy does not require further documentation.
DAW	DISPENSED AS WRITTEN	DAW code submitted was different than the DAW instructions on the prescription	This discrepancy does not require further documentation.
DDB	DIFFERENT DRUG BILLED	Pharmacy billed a different medication and/or NDC than the one dispensed to the patient	This discrepancy does not require further documentation.
DIS	DRUG INVOICE SHORTAGE	Drug wholesaler invoices were not sufficient to support quantities billed	All documentation provided for Drug Invoice Shortage discrepancies must include at a minimum NDC, product name, quantity, invoice number, and dates of purchase. Acceptable documentation includes the following: 1. A summary report of drug purchases and returns directly from the wholesaler; or 2. Send a copy of the original drug wholesaler invoices, if found; or 3. Documentation of drug purchase via other sources. Further verification of these documents may be required such as proof of payment for stock transfers, payment history, copies of checks for drug stock buy-out, bill of sale, payment invoices, etc.
DPC	DUPLICATE PAID CLAIM	Multiple claims for the same prescription fill were submitted	This discrepancy does not require further documentation.
DWC	DATE WRITTEN CORRECTION	The written date submitted by the pharmacy does not match the date written on the prescription hardcopy	This discrepancy does not require further documentation. The claim will be reprocessed for the correct date written.
ETL	EXCEEDS TIME LIMIT	Prescription was filled or refilled for a time period longer than that allowed by the Plan or applicable regulations	This discrepancy does not require further documentation.
GBB	GENERIC vs. BRAND BILLED	A claim was submitted for a brand medication when a generic form of the medication was dispensed	This discrepancy does not require further documentation.
INV	INVALID PRESCRIPTION	Prescription was invalid at the time medication was given to the Eligible Person (state and federal regulations, RMPs, altered Rx, etc.)	This discrepancy does not require further documentation.
MIF	MISFILL	Prescription dispensed was filled with incorrect drug, strength, directions or patient	This discrepancy does not require further documentation.

	DISCREPANCY	DEFINITION	Acceptable Documentation
MP	MISSING PRESCRIPTION	Original hard copy prescription or computer based prescription image cannot be found during the audit	1. Send a copy of the prescriber's original written prescription, if found; or 2. Send a signed statement from the prescriber on prescriber's letterhead or on a written Rx from the prescriber, including medication, quantity, Sig, original fill date and authorized refill dates. The prescriber may fax their documentation to the pharmacy. Prescriber statements must either be on physician letterhead or on a written prescription for the prescriber. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter.) Also include a copy of the dispensing label. If a prescription indicates "Use As Directed", follow SIG documentation guidelines. *COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs WILL NOT BE ACCEPTED.
NPI	INACCURATE PRESCRIBER NUMBER	NPI/DEA number on the prescription did not match the NPI/DEA/prescriber identification number on the claim. The NPI/DEA number is required to be accurate on all controlled substances	This discrepancy does not require further documentation.
NSL	NO SIGNATURE LOG	The signature documenting receipt of the prescription drug cannot be found in the signature logs or the electronic database	1. Send a copy of the signature log with the signature highlighted, if found; or 2. Send a signed statement from the patient verifying receipt of the medication; or 3. Send a signed pharmacy patient profile from the patient including patient's address, phone number, Rx number and date of fill. Each Rx must be initialed by the patient and dated. If delivered to a home or business address, Provider must provide: a. shipping method; b. shipment manifest; c. medication protection method; d. documentation of the prescription number(s) and Covered Item(s) delivered; and e. tracking documentation that the Covered Item was delivered.
OBC	OVER BILLED COMPOUND	Compound claim has been reviewed for pricing, quantity, and use. The allowable amount is listed in the Comments field. The adjusted Discrepant Amount will appear on the final Discrepancy Report	This discrepancy does not require further documentation.
OBQ	OVER BILLED QUANTITY	Quantity billed exceeded the amount authorized by the prescriber, the quantity allowed under the plan, or the quantity dispensed exceeds the days supply submitted	This discrepancy does not require further documentation.
OTH	OTHER	A miscellaneous discrepancy type	Varies with the reason for the discrepancy as listed in the Comments field.
PRD	PRESCRIBER DENIED	Prescription was denied by the prescriber that was on the claim	1. Send a copy of the prescriber's original written prescription, if found; or 2. A signed statement from the prescriber on prescriber letterhead or on a written Rx from the prescriber, including medication, quantity, Sig, original fill date and authorized refill dates. The prescriber may fax their documentation to the pharmacy. Prescriber statements must either be on physician letterhead or on a written prescription for the prescriber. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter). *COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs, WILL NOT BE ACCEPTED.
PTD	PATIENT DENIED	Patient denied requesting and/or receiving the prescription	1. Send a copy of the signature log with the signature highlighted, if found; or 2. Send a signed statement from the patient verifying receipt of the medication; or 3. Send a signed pharmacy patient profile from the patient including patient's address, phone number, Rx number and date of fill. Each Rx must be initialed and dated.

	DISCREPANCY	DEFINITION	Acceptable Documentation
RTS	REFILL TOO SOON	Prescription was refilled sooner than appropriate due to an incorrect days supply on the previous fill date. If Provider dispenses the smallest commercially available package size and enters a day supply based on plan limits, Provider maintains responsibility to adhere to appropriate refill intervals	This discrepancy does not require further documentation.
SIG	INSUFFICIENT DIRECTIONS FOR USE	Hard-copy prescription does not include sufficient information to justify the quantity and days supply billed	Obtain specific dosing instructions from the prescriber. If dosing is prn, specify patient's maximum weekly or monthly usage. Documentation outlining the patient's dose must be obtained from the prescriber on prescriber's letterhead or on a written Rx from the prescriber. The prescriber may fax the documentation to the pharmacy. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter). No notes or verbal conversations with prescriber or office staff will be accepted.
UAR	UNDOCUMENTED AUTHORIZATION OF REFILL	The number of refills billed exceeds the number authorized by the prescriber	Send a signed statement from the prescriber on prescriber letterhead or on a written Rx from the prescriber, authorizing the dispensing. This must include medication, quantity, directions for use, original fill date and authorized refill dates. The prescriber may fax their documentation to the pharmacy. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter). *COMPUTER GENERATED, TELEPHONE PRESCRIPTIONS, TRANSFER RXs, WILL NOT BE ACCEPTED.
VAF	VACCINE ADMININSTRATION FEE	No documentation that a vaccine was administered	1. Send a copy of a vaccine administration log with the signature highlighted, if found; or 2. Send a signed statement from the patient verifying the vaccine was administered.
WP	WRONG PATIENT	Patient identified on a hard copy prescription is not the same patient on the claim	Send a signed statement from the cardholder indicating that the patient whose name is on the prescription is covered by the indicated plan.

Glossary of Terms

Caremark Documents means the Provider Agreement, schedules thereto, addenda, the Provider Manual and all attachments thereto including this Glossary of Terms, Federal Laws and Regulations, State Laws and Regulations, information transmitted by Caremark to Provider through the claims adjudication system, and information transmitted by Caremark to Provider specifically designated by Caremark as a "Caremark Document" which may include educational materials related to products, programs, services, and Plan Sponsor announcements.

Administration Fee means the administration fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a Network Enrollment Form, the claims adjudication system, which may be reduced to the Incentive Amount Submitted (NCPDP field 438-E3) by the Provider.

AWP or Average Wholesale Price means a Price Type including AWP, AAWP and GEAP, published by Medi-Span (with supplements), a Price Type published by MICROMEDEX, or other similar nationally recognized reference which Caremark may select from time to time.

AWP Discount means the AWP percentage discount that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Chargeback means collection by Caremark of amounts paid to a Provider, in whole or in part, that were determined to be owed, including but not limited to, amounts for discrepant claim(s), claim(s) submitted in breach of the Agreement, or identified overpayment(s).

Confidential Caremark Information means any non-public information or data of Caremark and includes but is not limited to, (1) Caremark's products, programs, services, designs, inventions, business practices, policies and procedures, customer list, information related to a Plan Sponsor, trade secrets; (2) MAC lists; (3) reimbursement rates and terms; (4) the Provider Agreement, the Provider Manual, network enrollment forms and other addenda, and all other Caremark Documents; and (5) other information relating to Caremark's business.

Covered Item means any drug, device, or service covered, in whole or in part, in accordance with and subject to the terms of a Plan covering an Eligible Person.

Dispensing Fee means the dispensing fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Dispensing Pharmacy means the pharmacy that is giving or delivering the Covered Item to the Eligible Person.

Dispensing Practitioner means a duly licensed and established practitioner (e.g., MD, DO, RN, NPA, and RPh) operating under a medical license or other appropriate license and that dispenses and sells Covered Items to Eligible Persons through in-person hand delivery at the point of care, solely to the dispensing practitioner's patients in the regular course of the practitioner's practice.

Eligible Person means a person or animal entitled to a Covered Item pursuant to a Plan.

Law means any Federal, State, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, sub-regulatory guidance (including but not limited to, CMS Prescription Drug Benefit Manual, model contracts between the State Medicaid Agency and managed care organizations, and other guidance from State Medicaid Agencies, such as Medicaid Manuals, Bulletins, and other issuances), order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) a condition of granting any applicable permit, license or approval required by Caremark, Provider, or a Plan Sponsor, or other legislative or administrative action of the United States of America, or state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

Licensed Pharmacist means a pharmacist licensed in the United States (including U.S. territories).

MAC or Maximum Allowable Cost means a unit price that has been established as the reimbursement amount to Provider for certain multiple-source drugs without regard to the specific manufacturer whose drug is dispensed.

Medical Foods The term medical food, as defined in section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

Patient Pay Amount means the amount an Eligible Person must pay to Provider at the time a Covered Item is dispensed as indicated by the claims adjudication system, which may include but is not limited to copayments,

coinsurance, deductibles, transaction fees, access fees, and/or taxes.

Pharmacy Services/Provider Services means all services including the provision of prescription drugs usually and customarily rendered by a Provider and Licensed Pharmacist or Dispensing Practitioner licensed to provide pharmacy services in the normal course of business, including services mandated by applicable Law. Pharmacy Services may include, but not be limited to: the maintenance of Eligible Person profiles; the interpretation of prescriptions; the selection of medications and medical devices; the sale of compounding or dispensing of medications and medical devices (also includes Over-the-Counter medications [OTCs] and supplies covered by or used in conjunction with a pharmacy benefit); the counseling of Eligible Persons, which may consist of information about the proper storage, dosing, side effects, potential interactions and use of the medication dispensed; the monitoring of appropriate drug use; and the implementation of drug utilization review programs and other clinical programs and services.

Plan means that portion of a Plan Sponsor's pharmacy benefit plan that relates to Covered Items with respect to a group of Eligible Persons.

Plan Sponsor means the entity that contracts with Caremark or any of Caremark Rx, L.L.C.'s affiliates for pharmacy benefit management services, which entity could be, among other things, an insurance company, self-insured group, health maintenance organization, preferred provider organization, multi-employer trust or third party administrator.

Prescriber means a physician, dentist, physician's assistant, optometrist or other health care professional authorized by law to write prescriptions for prescription drugs within the scope of practice as designated by regulatory agency.

Price Type means a price of a given product for the fill date submitted at the time of claim adjudication as published by a Pricing Source and loaded into the claims adjudication system. Price Type may include, but is not limited to, AWP (Average Wholesale Price), WAC (Wholesale Acquisition Cost), NADAC (National Average Drug Acquisition Cost), ASP (Average Sales Price), FUL (Federal Upper Limit), state-specific AAC (Actual Acquisition Cost), Average AWP (AAWP), Generic Equivalent Average Price (GEAP), etc.

Pricing Source means either a nationally recognized reference that Caremark may reasonably select from time to time or for Plan-specific pricing, a Plan Sponsor, state or other third-party publisher of pricing data supplied to Caremark.

Product Identifier means a series of numerical or alphanumerical digits managed by various organizations and published by Medi-Span, FirstDataBank, MICROMEDEX or other nationally recognized reference which Caremark may reasonably select from time to time, that are used to identify a specific product that, where applicable, is used and formatted according to the NCPDP Product Identifiers Standard. The Food and Drug Administration (FDA) National Drug Code (NDC) as published by Medi-Span and formatted to the 11-digit format defined by NCPDP is an example of a Product Identifier.

Provider means a provider of Pharmacy Services that is the signatory to the Agreement and who must provide all services including the provision of prescription drugs usually and customarily rendered by a provider, Licensed Pharmacist or Dispensing Practitioner licensed to provide such Pharmacy Services in the normal course of business, including services mandated by applicable Law.

Retail Pharmacy means a duly licensed and established community pharmacy or dispensing practitioner that serves walk-in patients and that dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. Participation in Caremark's retail networks is limited to pharmacies (or dispensing practitioners) that are a "Retail Pharmacy". Refer to section **3.04 Standards of Operation** of the Provider Manual.

Third-Party Agreement means an agreement between Caremark and a Caremark client in which Caremark serves as an auditor for that client's participating network pharmacies.

Usual and Customary Price or U&C means the lowest price Provider would charge to a particular customer if such customer were paying cash for an identical prescription on that particular day at that particular location. This price must include any applicable dispensing fee and/or level of effort. This price must include any applicable discounts offered to attract customers.

This page left intentionally blank

This page left intentionally blank

This page left intentionally blank

CONFIDENTIAL TREATMENT REQUESTED

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark. If you are not the intended recipient, you have received this Provider Manual in error and any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
© 2022 CVS Caremark. All rights reserved.

106-55344A 080221

Exhibit 22:
CVS_HJC_00001058 CVS Caremark 2020 Provider Manual

Table of Contents

1. General Information 5

1.01 Proprietary Statement
1.02 Requirement to Adhere to Provider Agreement and Pharmacy Manual Requirements
1.03 Contacting Caremark
1.04 Pharmacy Help Desk
1.05 Contact Information
1.06 Pharmacy Portal
1.06.01 Pharmacy Portal Terms of Use and Confidentiality Statement
1.07 Top Questions Asked by Providers

2. Credentialing and Quality Management 9

2.01 Steps to Become a Provider
2.01.01 Complete the "Pharmacy Pre-Enrollment Questionnaire"
2.01.02 Create a Pharmacy Portal Account to Submit Enrollment Application
2.01.03 Complete and Submit Your Application
2.02 Steps to Become a Complex Compound Provider
2.03 Plan Sponsor Networks
2.04 Credentialing Requirements
2.05 Re-Credentialing
2.06 Notification to Caremark
2.06.01 Notification of Change in Documentation and Other Information
2.06.02 Notification of Closure
2.07 Change in Ownership
2.08 Requests for Documentation
2.09 Reporting of Investigations and Disciplinary Actions
2.10 Criminal Offense Related to Federal Health Care Programs
2.10.01 Pharmacy Criminal Offense
2.10.02 Prescriber Criminal Offense
2.11 Federal Health Care Programs Participation Exclusion: Pharmacy
2.12 Diverse Retail Pharmacy Program

3. Pharmacy Services and Standards 17

3.01 Providing Pharmacy Services to Eligible Persons
3.01.01 Professional Judgment and Conduct
3.01.02 Verification of Eligible Persons
3.01.03 Identification Cards
3.01.04 Nondiscrimination
3.01.05 Eligible Person Solicitation
3.01.06 Eligible Person Complaints
3.01.07 Patient Receipts and Insurance Profiles
3.01.08 Educational Materials and Efforts
3.02 Dispensing Requirements
3.02.01 Hours of Operation
3.02.02 Drug Stock and Inventory
3.02.03 Aberrant Quantities and Volume
3.02.04 Dispensing Covered Items to Eligible Person's Agent
3.02.05 Performance Initiatives
3.02.06 Dispensing Errors
3.03 Patient Pay
3.03.01 Collection of Patient Pay Amounts
3.03.02 Usual and Customary Price
3.03.03 Coupons and Other Programs
3.03.04 Proof of Payment
3.03.05 Documentation
3.03.06 Excess Collections
3.03.07 Limitation on Collection
3.03.08 Violations
3.03.09 Patient Inducements
3.03.10 Waivers
3.03.11 Financial Hardship Program
3.04 Standards of Operation
3.05 Records
3.05.01 Documents and Records Maintenance
3.05.02 Signature Log – Hard Copy or Electronic
3.05.03 Prescription Information
3.06 Referrals
3.06.01 Referral Fees
3.06.02 Referrals to Non-Retail Participating Providers

4. Claims Submission 25

4.01 Payer Sheets and Reject Codes
4.02 General Claim Submission Policies
4.03 Other Claim Submission Requirements
4.04 Dispense as Written Codes
4.05 U&C Validation
4.06 Over-the-Counter Products
4.07 Multi-Ingredient Compound Processing
4.08 Overrides
4.09 Natural Disasters
4.10 Coordination of Benefits
4.10.01 Multiple Transaction Coordination of Benefits
4.10.02 Single Transaction Coordination of Benefits
4.11 Long-Term Care Billing
4.12 Dispensing Pharmacy NPI/NCPDP

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Table of Contents

4.13 Prescriber Identification; Prescriptive Authority
4.14 Transaction Fees
4.15 Transaction Submission Resolution Management Service Fees
4.16 Electronic Submission, Reversal, and Processing Windows
4.16.01 UCF Requirement
4.17 Software Certification
4.18 Schedule of Claims Systems Maintenance
4.18.01 Additional Required Procedures
4.19 Taxes

5. Clinical Programs, Services and Related Messages 36

5.01 Drug Utilization Review
5.02 DUR Conflict Codes and Messaging
5.03 Refill-Too-Soon or Excessive Utilization Reject
5.04 Drug-Drug Interaction Reject Program
5.05 Formularies
5.06 Prior Authorization
5.07 Managed Drug Limitations/Quantity vs. Time
5.08 Dose Optimization
5.09 Step Therapy
5.10 Plan Sponsor Programs
5.11 Federal Regulatory Quality Assurance Programs
5.12 Clinical Studies/Trials

6. Network Participation and Payment 41

6.01 Provider Payment
6.02 Reimbursement
6.03 Changes to AWP
6.04 Maximum Allowable Cost
6.05 Eligible Person Fees and Amounts
6.06 Claims Payment and Other Fees
6.06.01 Remittance Advices
6.06.02 Disputed Claims
6.06.03 Claims Adjustment
6.07 Recoupment and Adjustments
6.08 Workers' Compensation
6.09 Provider Suspension
6.10 Directories

7. Compliance Reviews 46

7.01 Non-Compliance Fees
7.02 Additional Information Regarding Compliance Reviews

8. Professional Audits 48

8.01 Types of Audits
8.01.01 On-site Audits
8.01.02 Investigational Audits
8.01.03 Desktop Audits
8.01.04 Audits by Government Agencies
8.02 Professional Audits Rights
8.03 Documents and Records Production Related to Audits
8.04 Documents and Records Subject to Audit
8.05 Supply of Covered Items; Purchase Invoices
8.05.01 Invoice Documents and Records Maintenance
8.06 Medicare Part D Requirements
8.07 On-Site and Investigational Audit Resolution – Appeals Process
8.07.01 Pharmacy Membership Review Committee
8.08 Corrective Action Plan
8.09 Potentially Fraudulent Activity

9. Medicaid 55

9.01 Compliance with State and Federal Laws
9.02 Enrollment with State Medicaid
9.03 Medicaid Credentialing and Quality Management
9.04 Fraud, Waste and Abuse Compliance Program
9.05 Inspection and Audit of Records and Access to Facilities
9.06 Claims Submission Requirements for Medicaid
9.07 Medicaid Coordination of Benefits
9.08 Prior Authorization
9.09 Denial of Services
9.10 Cultural Competency
9.11 Home Delivery
9.12 Directories

10. Medicare Part D 57

10.01 Medicare Part D Network Standards
10.01.01 Network Participation
10.01.02 Compliance with Laws

CONFIDENTIAL TREATMENT REQUESTED

Table of Contents

10.01.03 Delegated Activity
10.01.04 Offshore Subcontracting
10.01.05 Marketing
10.01.06 Fraud, Waste and Abuse Program
10.01.07 Information on CMS-10147 Pharmacy Notice
10.01.08 Performance Monitoring
10.02 General Information
10.02.01 Part D Reference Information for Pharmacists
10.02.02 Medicare Part D Calls to the Pharmacy Help Desk
10.03 Credentialing
10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies
10.03.02 Federal Health Care Programs Participation Exclusion
10.04 Pharmacy Services and Standards
10.04.01 Plan Identification Cards
10.04.02 General Procedures for Acknowledgement of Enrollment Letters
10.04.03 Best Available Evidence
10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS
10.04.05 Auto-Ship Refill Programs
10.05 Claims Submission
10.05.01 Unique RXBIN/RXPCN Requirement - Medicare Part D
10.05.02 Payment of Clean Claims
10.05.03 Electronic Prescribing
10.05.04 Prescription Origin Code and Fill Number
10.05.05 Improving Drug Utilization Review Controls
10.05.06 Medicare Part D Claims Requiring Overrides
10.05.07 General Medicare Part D Submission Requirements for COB
10.05.08 Formulary Transition Fill Process
10.05.09 Insulin Coverage
10.05.10 Pro-Rated Daily Cost Share
10.05.11 Medicare Part B and Medicare Part D Drug Coverage Determinations
10.05.12 End Stage Renal Disease Claim Processing
10.05.13 Prescriber Identification for Medicare Part D Claims
10.05.14 Claims Submission Window for Medicare Part D
10.05.15 Medicare Part D Claims Adjustment
10.06 Network Participation and Payment
10.06.01 Drug Pricing
10.06.02 Pharmacy Service Type and Patient Residence Requirements
10.07 Special Instructions for Participating LTC Providers
10.07.01 Pharmacies Serving LTC Facilities
10.07.02 LTC Pharmacies Timely Claim Submission
10.07.03 LTC Billing
10.07.04 LTC Days Supply Limitations
10.07.05 LTC Transition Fill
10.07.06 Special Package Indicator
10.07.07 LTC Override Requests
10.07.08 LTC Overrides for Current Part D Enrollees
10.07.09 Medicare Part A and Medicare Part D Drug Coverage Determinations
10.08 Retail Addendum to the Caremark Provider Agreement

11. Medicare Advantage **82**

12. Medicare-Medicaid Plan **84**

12.01 Medicare-Medicaid Networks Standards
12.02 Compliance with State and Federal Laws

13. Qualified Health Plans **85**

14. Intellectual Property, Confidentiality and Proprietary Rights **86**

14.01 Advertising and Trademarks
14.02 Non-Disparagement
14.03 Confidentiality
14.04 Non-Solicitation and Non-Interference
14.05 Proprietary Rights
14.06 Remedies

15. Miscellaneous **88**

15.01 Assignment
15.02 Independent Contractors and Third-Party Beneficiaries
15.03 Court Orders, Subpoenas or Governmental Requests
15.04 Notices

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Table of Contents

15.05 Termination
15.05.01 Termination for Cause
15.05.02 Termination Without Cause
15.05.03 Rights and Remedies in the Event of Termination or Breach
15.06 Survival of Certain Provisions
15.07 Amendments
15.08 Enforceability
15.09 Arbitration
15.10 Force Majeure
15.11 Anti-Kickback Statute, Stark Law, and Caremark Compliance Program
15.12 Rebate Programs
15.13 Eligible Person Communications

16. Federal and State Laws and Regulations 93

16.01 Compliance with Laws

Appendix A - Caremark Payer Specification Sheets 94

Appendix B - Reject Codes 95

Appendix C 96

Appendix D - Drug Submission Requirements 97

Appendix E - Diverse Retail Pharmacy Program 104

Appendix F - New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts 108

Appendix F-1 - Certification Regarding Lobbying 116

Appendix F-2 - Standard Clauses for Managed Care Provider/IPA Contracts for the Fully-Integrated Duals Advantage Program 117

Appendix G - CMS Form No. 10147 (English) 124

Appendix G1 - CMS Form No. 10147 (Spanish) 125

Appendix H - Ohio Medicaid Addendum 126

Appendix I - Appeals Process Documentation Guidelines 133

Appendix J – Dispensing Practitioner 137

Glossary of Terms 140

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

1. General Information

Caremark appreciates the role that network pharmacies (Providers) play in delivering quality care to our Eligible Persons. The 2020 Caremark Provider Manual ("Provider Manual") contains the policies and procedures to which network pharmacies must adhere in order to provide quality care to Caremark Eligible Persons. The Provider Manual and all Payer Specification Sheets are part of the Provider Agreement and are incorporated into the Provider Agreement pursuant to the terms thereof. This Provider Manual supersedes and replaces all previous versions of the Provider Manual. As a network pharmacy, you are responsible for monitoring and complying with all changes to the Provider Manual. Capitalized terms used in the Provider Manual not defined in the Glossary of Terms shall have the same meaning as in the Provider Agreement.

1.01 Proprietary Statement

The Provider Agreement (which includes the Provider Manual) constitutes Confidential Caremark Information and is provided to Provider for business purposes only. Provider must maintain in confidence the Provider Manual, and must not disclose, sell, assign, transfer or give to any third party the Provider Manual or any of its contents without Caremark's prior written consent. Refer to section **14.03 Confidentiality** of the Provider Manual.

1.02 Requirement to Adhere to Provider Agreement and Pharmacy Manual Requirements

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

1.03 Contacting Caremark

Caremark strives to ensure that Providers receive prompt and courteous assistance with questions that may arise. Caremark's Pharmacy Help Desk Representatives are available every day of the year. The Interactive Voice Response (IVR) system is available 24 hours a day, 7 days a week, excluding down time for maintenance and service.

1.04 Pharmacy Help Desk

Following are the phone numbers corresponding with the appropriate Bank Identification Numbers (BINs):

Caremark System	RXBIN	Pharmacy Help Desk Number*
Legacy ADV	004336**	1-800-364-6331
Legacy PCS	610415**	1-800-345-5413
FEP	610239	1-800-345-5413
Legacy CRK	610029**	1-800-421-2342
Caremark	610591	As communicated by plan or refer to ID card
Aetna	610502	1-800-238-6279
IngenioRx	020099	1-833-296-5037

Secondary RXBINs and Plan sponsor-specific RXBINs and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at:

www.caremark.com/pharminfo

*Or as communicated on Eligible Person's Card

**Puerto Rico Providers call toll-free 1-800-842-7331

Pharmacy Help Desk representatives will use reasonable efforts to assist providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with respect to the provision of Pharmacy Services.

Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

Refer to section **10.02 General Information** of the Provider Manual for detail on Medicare Part D Calls to the Pharmacy Help Desk.

CONFIDENTIAL AND PROPRIETARY

1.05 Contact Information

Unless otherwise specified in the Provider Manual, Providers must send inquiries and grievances in writing to:

CVS Caremark
Attn: Network Management, MC 080
9501 East Shea Boulevard
Scottsdale, AZ 85260

1.06 Pharmacy Portal

Caremark provides online access to information via its Pharmacy Portal at **www.rxservices.cvscaremark.com**. Provider may access the Pharmacy Portal to obtain information and other services Caremark may make available. Provider acknowledges that the Pharmacy Portal is an effective medium for communicating Caremark Documents. Provider agrees to check the Pharmacy Portal for updates to ensure awareness of Caremark requirements.

Independent or affiliated-independent providers will be prompted to set a unique username and password as part of the initial login process. Detailed provider-specific account information must be entered as part of the initial login process, including but not limited to, pharmacy NCPDP number (seven digits), pharmacy NPI, state license number, DEA number, etc.

Pharmacy chain and Pharmacy Services Administration Organization ("PSAO") headquarters who have not received login information from Caremark can contact Caremark for assistance through Provider's regular contact.

1.06.01 Pharmacy Portal Terms of Use and Confidentiality Statement

Only pharmacy entities contracted with Caremark as a network provider (and their authorized representatives) may access the Pharmacy Portal, consistent with the Provider Agreement. A user account may only be utilized by the pharmacy Caremark approves as part of the user account registration process. By logging onto the Pharmacy Portal, the user represents it has received approval from Caremark to access the Pharmacy Portal and reimbursement data. Additionally, the user agrees to only access the user account for which it has been approved. Users must not access an account belonging to another user.

The Pharmacy Portal may provide authorized users with various analytical tools (such as MAC Price Lookup, MAC Appeals, MAC Future Pricing, etc.). The Pharmacy Portal, and its content, are the property of Caremark and users are strictly prohibited from using Pharmacy Portal content or information for any purpose other than for the purposes of fulfilling the provider's obligations under the Provider Agreement. Users are strictly prohibited from accessing the Pharmacy Portal using automated means (such as harvesting bots, robots, spiders or scrapers). Caremark reserves the right to remove content from the Pharmacy Portal at its sole and absolute discretion. Improper use or unauthorized access of the Pharmacy Portal may result in termination of Pharmacy Portal use privileges and pursuit of all other remedies available to Caremark.

The information provided in the Pharmacy Portal is Caremark's confidential and proprietary information and considered "Confidential Caremark Information" as this term is defined in the Caremark Provider Manual. Pursuant to the terms of the Caremark Provider Manual, you may not disclose, sell, assign, transfer, or give the information contained therein to any third party.

CONFIDENTIAL TREATMENT REQUESTED

1.07 Top Questions Asked by Providers

1. **What date of birth, sex and/or person code do you have on file for this Eligible Person?**

   Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable attempts/efforts to obtain the necessary information for claim submission. In the event a Plan Sponsor has incorrect eligibility information (e.g., incorrect date of birth), when a Provider submits a claim using the correct eligibility information (e.g., correct date of birth) the claim will reject. In most cases, Caremark will be able to assist the Provider at the point of service with any discrepancies with eligibility information, such as date of birth and sex. However, you should advise your patient that he or she should inform his or her Plan Sponsor of the incorrect eligibility information and that until it is corrected claims will continue to reject.

2. **What is the identification number for this Eligible Person?**

   Provider must request to see the identification card for the Eligible Person to ensure that the prescription is written by the Prescriber for an Eligible Person.

3. **Are person code and patient relationship code required for claim submission?**

   Person code (as printed on the identification card) and patient relationship code data fields are required for submission as outlined in the Caremark Payer Sheets. Many times, person code is printed on the identification card. It is important that this information is submitted accurately to Caremark in order for appropriate Drug Utilization Review (DUR) for that individual to occur.

4. **What Banking Identification Number (RXBIN) do I use for all Caremark Eligible Persons?**

   Provider should submit claims utilizing the corresponding RXBIN which, in most cases, is illustrated on the identification card. A complete list of RXBINs is located on the previous page.

5. **Is a Processor Control Number (RXPCN) required for claim submission?**

   Provider must request to see the identification card for the Eligible Person and examine the identification card to determine if RXPCN information is available. Submit the RXPCN information as it appears on the identification card. If no RXPCN appears on the identification card, submit the default RXPCN according to the RXBIN as outlined in the Caremark Payer Sheets found online at **www.caremark.com/pharminfo.**

6. **What is the Group (RXGRP) number for this Eligible Person?**

   The RXGRP number is located on the Eligible Person's identification card. Refer to section **3.01.03 Identification Cards** of the Provider Manual.

7. **What is the amount this Eligible Person must pay?**

   Provider must submit the claim through the claims system to receive the adjudicated response which will include the amount to collect from the Eligible Person as well as information about eligibility, plan coverage, pricing and applicable clinical programs and services. The representatives at the Pharmacy Help Desk cannot release information about the amount the Eligible Person must pay due to the variables that may impact cost-share.

8. **Is this Eligible Person eligible to receive a vacation supply?**

   Many Plan Sponsors allow for Eligible Persons to secure an early refill for vacation supply. If the Eligible Person states that he or she is eligible for an early refill for vacation supply, Provider must submit the claim as usual. If the claim rejects, Provider should contact the appropriate Pharmacy Help Desk for coverage verification. If the Plan Sponsor does allow for an early refill for vacation supply, the representative from the Pharmacy Help Desk will enter an override.

9. **What is the prior authorization procedure for this Eligible Person?**

   Caremark only administers Prior Authorization programs for some of its Plan Sponsors. Therefore, Provider should note the adjudication response which generally includes the online retransmission instruction or appropriate contact information and telephone numbers.

10. **What are the plan limits for this Eligible Person?**

    Provider must submit the claim through the claims adjudication system to receive the adjudicated response which will include messaging about plan coverage. The representatives at the Pharmacy Help Desk cannot release plan limitation information due to the variables that may impact the coverage for a given drug.

CONFIDENTIAL AND PROPRIETARY

11. **May I waive patient copays?**

    Provider must follow the requirements of the Provider Agreement (including the Provider Manual) for collection of Patient Pay Amounts. Refer to section **3.03 Patient Pay** of the Provider Manual.

12. **How do I know if the Plan allows Coordination of Benefits?**

    Plans may indicate if an Eligible Person's eligibility is supplemental, and Provider may receive a reject indicating that the claim should be submitted to another payer or other COB related message. For Plan Sponsors that allow Coordination of Benefits (COB), refer to section **4.10 Coordination of Benefits** of the Provider Manual for additional information regarding COB claim submission.

13. **Do I need to bill the specific National Drug Code dispensed?**

    Yes. Submitted claims information must be accurate and complete. This includes, but is not limited to, billing the actual National Drug Code (NDC) used for each item within a prescription for compound recipe.

14. **What data field do I use for the <specific data>?**

    Representatives from the Pharmacy Help Desk will reasonably assist Provider where possible to determine which data field should be used for specific data. However, due to the numerous types of software, it is difficult for the representatives to know how each system is set up. Providers should consult with their software vendor or chain headquarters for technical assistance.

15. **I am a new provider owner. Am I responsible for the liabilities and obligations of the previous owner?**

    Yes. Refer to section **2.07 Change in Ownership** of the Provider Manual.

16. **What information is on the Caremark Pharmacy Portal and how do I obtain access?**

    In addition to downloading the Caremark Provider Manual, Providers can also download Provider Manual Amendments, Medicare Part D Plan Sponsor Information, and Vaccine Administration Networks Plan Information from the Pharmacy Portal. Providers can look up Maximum Allowable Cost (MAC) Price using the online mock adjudication and may also submit MAC paid claim appeals via the Pharmacy Portal. Refer to sections **1.06 Pharmacy Portal** and **6.04 Maximum Allowable Cost** of the Provider Manual.

For additional claim processing information, refer to the Caremark Payer Sheets at:

www.caremark.com/pharminfo.

Note: This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Caremark.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

2. Credentialing and Quality Management

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

In order to become a Provider and prior to being allowed to submit claims for payment to Caremark, a pharmacy must accurately complete and submit an application and other documentation required by Caremark, meet Caremark's credentialing requirements, and be able to comply with the requirements of the Provider Agreement, including this Provider Manual. Provider's agreement with Caremark does not guarantee participation in all networks. Caremark, on its own behalf in its sole discretion, or on behalf of a Plan Sponsor, may limit Provider's participation to certain networks. For any Provider with multiple locations, Caremark retains the right to limit participation to one or any number of Provider's pharmacy locations.

Provider must comply with all of Caremark's standards and requirements, credentialing, and quality management initiatives in order to participate in Caremark's network(s), including but not limited to, all applicable federal, state, and local laws as described more fully below.

Caremark has the right to determine, in its sole discretion, whether a provider meets Caremark's credentialing and quality management standards to serve as a Provider for Caremark and its Plan Sponsors. Caremark's determination may include, but is not limited to:

- Denial of enrollment, or
- The right to terminate the Provider Agreement

In making this determination, Caremark may look at all available evidence and may deny enrollment or terminate the Provider Agreement in its sole discretion, including but not limited to, based on:

1. Any noncompliance with the terms of the Provider Agreement, serious and/or significant audit findings, or adverse actions by a governmental regulatory or enforcement entity or agency against:
   a. Provider;
   b Another provider with any common association, ownership or relationship to Provider; or
   c. Any of Provider's respective owners (direct or indirect), officers, directors, employees or affiliated personnel. This also includes Providers that have billed for other entities or that have billed for claims that were previously found to have migrated from other Providers removed from the network.
2. Any conduct that may adversely impact Caremark's relationship with, or Caremark's contractual duties to, a Plan Sponsor;
3. Any conduct that may pose a risk to the health, welfare, safety, or financial well-being of Eligible persons or the general public;
4. Any other conduct that Caremark, in its sole discretion, determines would adversely affect Provider's ability to fulfill the requirements of the Provider Agreement; or
5. If Caremark believes, in its sole discretion, that the Provider may pose an undue risk of potential Fraud, Waste, and/or Abuse.

IMPORTANT:

1. Failure to maintain compliance with any of the credentialing standards set forth below may be used as grounds for termination by Caremark. Caremark also reserves the right to recoup any payments made for claims submitted while Provider is in violation of these standards.
2. Incomplete or inaccurate information provided as part of the application process may result in remedial action by Caremark, including but not limited to, Provider Agreement termination or denial of provider enrollment.
3. Provider shall be responsible for paying the credentialing and recredentialing fee upon the initial application to Caremark and upon full recredentialing, when applicable.

2.01 Steps to Become a Provider

1. Complete the "Pharmacy Pre-Enrollment Questionnaire"
2. Create a Pharmacy Portal account
3. Complete and submit your application, which includes attestation to Provider Agreement

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

2.01.01 Complete the "Pharmacy Pre-Enrollment Questionnaire"

To become a participating provider in a Caremark or Plan Sponsor Network, Provider must accurately complete and submit the "Pharmacy Pre-Enrollment Questionnaire" in order to initiate the enrollment process. This includes disclosing information as set forth in "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E) and "Disclosure of Ownership and Control Information" (42 C.F.R. Part 420, Subpart C).

1. Access the "Pharmacy Pre-Enrollment Questionnaire" at **www.caremark.com/pharminfo** and select "Pharmacy Pre-Enrollment Questionnaire".
2. Supply the required information as outlined in the "Pharmacy Pre-Enrollment Questionnaire". It is important for all Providers to complete the form accurately and in its entirety as Caremark relies on this information in making enrollment determinations.
3. Submit the online questionnaire. Upon successful completion of the "Pharmacy Pre-Enrollment Questionnaire" and approval by Caremark, instructions for creating an online Pharmacy Portal account will be sent to the applicant.

Caremark may require additional pre-enrollment credentialing in its sole discretion. This can include, but is not limited to, pharmacies located in established Health and Human Services-Office of Inspector General (HHS-OIG) designated Health Care Fraud Prevention and Enforcement Action Team (HEAT) areas.

2.01.02 Create a Pharmacy Portal Account to Submit Enrollment Application

Provider must create an online account using the Pharmacy Portal in order to complete and submit an online enrollment application. The online enrollment application must be accompanied by an electronic submission of all required documentation required therein. Failure to submit the online enrollment application within thirty (30) days from the date it was initiated will result in the expiration of the enrollment application thus warranting the applicant to restart the enrollment application process.

At the time of enrollment application submission, the enrollment fee is due and payable.

1. Caremark charges a $1,200 non-refundable fee for each application of enrollment, a $2,000 non-refundable fee for pharmacies located in or near designated HEAT areas, and a $1,500 non-refundable fee for Dispensing Practitioners, regardless of whether Caremark enrolls the Provider. Fees are due at the time of application submission.
2. Caremark charges a $75 fee per pharmacy location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application.
3. Payment must be submitted to Caremark in the form of a cashier's check, made payable to "CVS Health" and mailed to the address below. Failure to submit payment or provide all required enrollment information and documentation within thirty (30) days will result in the denial of the enrollment application. Review of enrollment application will not proceed until payment is received.
   Mail cashier's checks to:

   CVS Health
   Attn: Provider Enrollment, Mail Code 129
   9501 E. Shea Blvd.
   Scottsdale, AZ 85260
4. Submit enrollment questions to Caremark via the "enrollment self-service/pharmacy provider question form" found at **caremark.com/pharmacy**.

2.01.03 Complete and Submit Your Application

Once the applicant submits the online enrollment application, the applicant will be notified via email by Caremark if any required documentation or information is missing or incomplete. The review of an application will not begin until a complete application is received; the enrollment application is not deemed to be complete until all pieces of required documentation, including but not limited to, the attestation to the Provider Agreement, are submitted to Caremark. Enrollment applications are reviewed in the order in which they were received. Enrollment decisions are communicated to applicants via email.

2.02 Steps to Become a Complex Compound Provider

In order to become an approved Provider to dispense and submit non-sterile complex compound claims to Caremark, the provider must first be currently enrolled with Caremark (refer to section **2.01 Steps to Become a Provider** of the Provider Manual) and accurately complete, in its entirety, the Caremark Compound Application.

Providers wishing to submit a Caremark Compound Application may contact Caremark at

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

CompoundApplicationTeam@CVSHealth.com. In the body of the email, include the Provider's name, the corresponding NPI and NCPDP numbers, the contact name, the telephone number, and the request for a Caremark Compound Application.

In order to apply as a non-sterile complex compounder, the Provider must meet the minimum requirements below.

1. Provider must be an established non-sterile complex compound pharmacy able to provide a list of their top ten compounds.
2. Provider must offer a variety of dosage forms.
3. The Provider, pharmacy staff (including the Pharmacist in-charge), and owner(s) are currently in good standing with Caremark.

Steps to become a non-sterile complex compound Provider:

1. Complete the Caremark Compound Application and return with all applicable supporting documents to **CompoundApplicationTeam@CVSHealth.com.**
2. Caremark charges a $500 application fee. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. This application fee is non-refundable and in no way ensures that the pharmacy will be approved to be in Network and able to submit complex compounds.

Mail Cashier's checks to

CVS Health
ATTN: Provider Enrollment, Mail Code 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

IMPORTANT: Incomplete or inaccurate information provided as part of the Complex Compound Provider application process may result in remedial action by Caremark, including but not limited to, Provider Agreement termination or denial of the Provider's Caremark Compound Application.

2.03 Plan Sponsor Networks

Providers wishing to participate in a Plan Sponsor network may send an email to **RxServices@CVSHealth.com** and provide Provider's name, the corresponding National Provider Identifier (NPI) and National Council for Prescription Drug Programs (NCPDP) number, the contact name, the telephone number, and the reason for the email.

2.04 Credentialing Requirements

In order to become and remain a Provider contracted with Caremark, a Provider must comply with Caremark's requirements. These obligations are to be fully met during the enrollment review process and continue on post-enrollment for the duration of Provider's participation in Caremark networks.

All Providers must comply with all applicable Laws and regulations and provide all Pharmacy Services and Covered Items in a professional manner, and in compliance with the highest industry pharmacy practice standards. Failure to comply may result in remedial action by Caremark, including but not limited to, Provider Agreement termination. These requirements include, but are not limited to the following:

1. Provider must maintain in good standing all federal, state, and local licenses, permits and certifications as required by Law.
2. Provider must maintain at all times current and valid pharmacy licensure as issued by the appropriate state agency in which Provider operates to dispense medications or into which it ships medications. Additionally, Provider must meet all standards of operation as described in federal, state, and local laws. Any Pharmacy Services provided where Provider does not possess all required active and valid licenses and/or permits under applicable Law shall be deemed to be invalid and subject to chargeback.
3. All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist and in accordance with Prescriber directions and applicable Law.
4. Provider must require and verify that all personnel employed by or contracted with Provider are licensed and qualified to perform their professional duties and that they act within the scope of their licensure.
5. Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable federal, state, and local laws (including any local laws and regulations) in performing its Pharmacy Services under the

CONFIDENTIAL AND PROPRIETARY

Agreement, including but not limited to, the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395nn); and Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Parts 160, 162, and 164, and the Controlled Substance Act (21 U.S.C. 801-971).

6. Provider must require and verify that Provider and all personnel employed by or contracted with Provider have not been excluded or debarred by any federal or state program. Provider must check the applicable state and federal exclusion lists on a monthly basis to verify that no employees or contractors are on the list. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.
7. Provider must require and verify that any individual for whom there has been a restriction, suspension revocation, probation or any other disciplinary action taken does not provide any service to Caremark or its Eligible Persons. Provider agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.
8. Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions prescribed or claims for items or services furnished by an excluded or debarred Prescriber, and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.
9. Provider must maintain, at its cost and expense, policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1,000,000 per person and $3,000,000 in aggregate, unless otherwise agreed to by Caremark, or such greater amount as required by Law.
    a. Provider must furnish copies of said policies upon enrolling as a Provider with Caremark and as requested by Caremark thereafter. Failure to maintain the minimum coverage may result in immediate termination.
    b. Provider must notify Caremark immediately in writing if its insurance is canceled, lapsed or otherwise terminated. Failure to notify Caremark in writing of any such termination of insurance coverage may result in immediate termination.
    c. Provider must notify Caremark of any changes to the policy, including but not limited to, the location schedule.
10. Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.
11. Provider must support all clinical programs and services and utilize software that will display all messages related to clinical programs and services and that provide for the recording of patient drug and medical information, where utilized by Caremark and as allowed by applicable Law.
12. Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.
13. Provider must dispense prescriptions using standards of operation approved by Caremark and defined in section **4. Claims Submission** of the Provider Manual. Delivering to Eligible Persons by mail or other common carrier as a routine business practice in excess of the percentage allowed by Caremark is unapproved without the express written permission of Caremark. Payment for claims involving unauthorized mail or other remote delivery carrier are subject to chargeback.
14. Providers who utilize an internet site as a routine business practice in the provision of Pharmacy Services (except for refill requests) must maintain Verified Internet Pharmacy Practice Sites (VIPPS) certification through the National Association of Boards of Pharmacy (NABP), but must also otherwise comply with the terms of this subsection.

2.05 Re-Credentialing

Caremark will periodically re-credential Providers. When requested, Provider will be required to submit requested information to Caremark. Failure to supply the documentation in the requested manner and time period may result in suspension, probation, or termination. Caremark reserves the right to increase the transaction fee to a minimum fee of $0.99 per transaction transmitted for failure to provide the requested re-credentialing documentation until such time as the request is complete.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

2.06 Notification to Caremark

2.06.01 Notification of Change in Documentation and Other Information

Unless otherwise specified, Provider must notify Caremark in writing within ten (10) business days of any change in the Provider credentials, documentation and other information provided to Caremark in connection with enrolling as a Provider, including but not limited to, change in credentialing information (e.g., change in "Pharmacy Pre-Enrollment Questionnaire" information, change in enrollment application), name, contact information, services, hours of operation, or 24-hour status.

Notwithstanding the foregoing, Provider must notify Caremark of a change in the Provider's physical location prior to the change. Provider is liable to Caremark for any losses that Caremark incurs (e.g., penalties to a Plan Sponsor) based on Provider's failure to comply with this sub-section. Provider must be reasonably reachable by telephone or facsimile during Provider's hours of operation based on the contact information provided (and as updated) to Caremark as part of enrollment, credentialing or re-credentialing.

Provider must send such notification to Caremark using one of the following options:

- Fax to 480-661-3054
- Mail to:

  CVS Caremark
  Attn: Provider Enrollment, MC 129
  9501 E. Shea Boulevard
  Scottsdale, AZ 85260

- Submit an online "Pharmacy Change Form" located on **Caremark.com/For Pharmacists and Medical Professionals/Pharmacy Enrollment Self-service/Pharmacy Change Form**

2.06.02 Notification of Closure

Provider must notify Caremark in writing of pharmacy closure by no later than ten (10) business days after a closure of its business. Contained within this notification must be the name of the records custodian in the event of future audit-related requests for documentation and information from Caremark or a governmental agency.

Mail to:

CVS Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

2.07 Change in Ownership

A change in ownership or control is defined as (1) any change in who holds, directly or indirectly, the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (2) the right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party.

Provider must notify Caremark of a change in ownership or control, as defined above, in writing within ten (10) business days of the change. Changes in pharmacy provider ownership are subject to Caremark's standard pre-enrollment credentialing review process and fee assessment (refer to section **2.01 Steps to Become a Provider** of the Provider Manual). In order to initiate the change in ownership enrollment proccess, Provider may submit a "Pharmacy Pre-Enrollment Questionnaire" found at **www.caremark.com/pharminfo** and select "Pharmacy Pre-Enrollment Questionnaire", wherein the enroll type of "change of ownership" is selected. Upon successful submission of the Pharmacy Pre-Enrollment Questionnaire, instructions for the creation of an online pharmacy portal account will be sentto applicant via email.

Caremark reserves the right to terminate any Provider Agreement for failure to notify Caremark of a change in ownership or control. To the extent the change of ownership or control interrupts or impacts the terms of existing contracts with Caremark, Caremark reserves the right to cancel such obligations and have no further responsibility or liability for those obligations.

1. Where the Buyer (defined as any successor in interest to an owner or operator) has no existing relationship with Caremark:

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

a. It must execute a new Provider Agreement and meet all of Caremark's credentialing requirements, including completion of the Pharmacy Pre-Enrollment Questionnaire in order to initiate the credentialing process for the acquired pharmacy or pharmacies.
b. Caremark, in its sole discretion may allow assignment of the Provider Agreement for the acquired pharmacy to the Buyer.

2. In the event that the Buyer has an ownership interest or operating rights in an existing Provider, Caremark may elect to:
   a. Apply in whole or in part the terms of the acquired pharmacy's Provider Agreement to the acquired pharmacy or pharmacies;
   b. Apply in whole or in part the terms of the Buyer's Provider Agreement to the acquired pharmacy or pharmacies; or
   c. Require Buyer to complete credentialing and execute a new Provider Agreement for the acquired pharmacies.

The Buyer agrees to assume responsibility for and to guarantee any acquired pharmacy's performance of its obligations under any Caremark Provider Agreement, including any financial obligations, obligations to comply with applicable Law, and the obligation to cooperate with Caremark's audit requirements, whether such obligations arose before or after Buyer's acquisition of an ownership interest in or operating rights with respect to such acquired pharmacy.

Provider shall inform Caremark in writing within ten (10) business days of the sale of any prescription files.

Mail to:

CVS Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

Failure to submit any required documentation related to above within the required timeframe may result in Provider termination. All Change in Ownership notifications are subject to Caremark review, and are not a guarantee of Provider enrollment.

2.08 Requests for Documentation

Caremark may request copies of all documents required for credentialing at any time. Appropriate documents must be provided to Caremark within ten (10) business days.

Provider must respond to Caremark within ten (10) business days of a request for documentation necessary to support claims processing or audits by Plan (or of Plan).

Caremark charges a $75 fee per Provider location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application, and such fee may be offset against other

2.09 Reporting of Investigations and Disciplinary Actions

Provider must notify Caremark in writing within ten (10) business days with detail if:

1. Any of Provider's licenses or permits that are required under applicable Law for Provider to provide Pharmacy Services is, or is in jeopardy of being, suspended or revoked;
2. There are proceedings related to Pharmacy Services that may lead to an adverse action against Provider or affiliate of Provider, or any of their respective officers, directors, current/former employees, or owners (direct or indirect);
3. Any adverse action is taken against (a) Provider; (b) officer, director, current/former employee, owner (direct and indirect) of Provider or affiliate of Provider, including but not limited to, action taken by a Board of Pharmacy, Officer of Inspector General (OIG), System for Award Management (SAM), law enforcement, Drug Enforcement Agency (DEA), or other regulatory body;
4. There is a subpoena of records, issuance of a civil investigative demand letter, plea of no contest, or a filing of a civil lawsuit against a Provider related to Pharmacy Services or Provider's business practices;
5. There is a seizure by law enforcement of Provider's prescription records, computer systems, financial records, accounts, or real property;

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

6. Provider or affiliate of Provider, or any of their respective officers, directors, employees, or owners (direct and indirect) enters into a settlement agreement, Corporate Integrity Agreement, or consent order with a governmental or regulatory agency relating to Pharmacy Services or Provider's business practices, even if there is no admission of liability; or
7. Provider is terminated from a third-party payer's (including a pharmacy benefit manager) network based on cause.

Provider must notify Caremark in writing to:

CVS Caremark
Attn: Provider Enrollment, MC 129
9501 East Shea Boulevard
Scottsdale, AZ 85260

Failure to timely and properly notify Caremark may result in termination of the Provider Agreement or suspension as a participating Provider.

In the event that Caremark receives notice of any of the above investigations and/or disciplinary actions described in this section, Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider in its sole discretion or if required by applicable Law.

2.10 Criminal Offense Related to Federal Health Care Programs

2.10.01 Pharmacy Criminal Offense

Provider must notify Caremark in writing within ten (10) business days if Provider or any of its officers, directors, employees, contractors, agents, or volunteers who provide items or services that will be paid by Medicare, Medicaid, or other Federal or federally-funded health care program or any of its owners has been, within the ambit of 42 U.S.C. § 1320a-7(a) or 1320a-7(b)(1)-(3):

1. Charged with or convicted of any criminal offense (a) related to the delivery of an item or service under any Federal or federally-funded health care program (including Medicare or Medicaid); (b) related to the neglect or abuse of a patient in connection with the delivery of a health care item or service; (c) which is a felony and related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct; (d) which is a felony and related to the unlawful manufacture, distribution, prescription, or dispensing of a Covered Item; or
2. Proposed for exclusion or debarment from participation in Medicare, Medicaid, or other Federal or federally-funded health care program.

For purposes of Provider's notification hereunder, the term "convicted" includes (1) when there has been a finding of guilt against Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner; (2) when Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner has entered and a court has accepted a plea of guilty or nolo contendere (no contest); (3) when Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner has entered into a pre-trial agreement to avoid conviction; and (4) when Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner has entered into participation in a First Offender, deferred adjudication, pardon program, or other arrangement or program where a judgment of conviction has been withheld.

2.10.02 Prescriber Criminal Offense

Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber whom Provider knows has been convicted of any criminal offense as described above within the ambit of 42 U.S.C. § 1320a-7(a). Provider must notify Caremark in writing within ten (10) business days if Provider has knowledge or information of a Prescriber who has been charged with or convicted of any criminal offense as described above within the ambit of 42 U.S.C. § 1320a-7(a). Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

2.11 Federal Health Care Programs Participation Exclusion: Pharmacy

If Provider is excluded or debarred from participation in any Federal health care program (as defined in 42 U.S.C. 1320a-7b(f)), Provider must immediately notify Caremark of any such exclusion or debarment. Provider will be immediately terminated from participation in all Caremark networks. Provider shall not submit any claim to Caremark for a prescription dispensed by Provider if Provider is excluded or debarred from participation in any Federal health care program.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Provider shall not allow any person (whether as an officer, director, employee, contractor, agent, volunteer, owner or otherwise) who is excluded or debarred from participation in any Federal health care programs to directly or indirectly provide any item or service under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services. Provider agrees to implement a policy requiring all new and existing persons engaged by Provider (whether as an officer, director, employee, contractor, agent, volunteer, owner or otherwise) to immediately disclose to Provider any debarment, exclusion, or other event that makes them ineligible to perform work related directly or indirectly to Federal health care programs. Upon such disclosure, Provider must immediately reassign such person to work that does not involve or relate, directly or indirectly, to the provision of items or services under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services.

Provider hereby certifies that:

1. Provider will review the OIG List of Excluded Individuals/Entities (LEIE) and SAM list upon initially hiring or engaging any officer, director, employee, contractor, agent, volunteer, owner, or otherwise, and monthly thereafter and upon any change of ownership in order to ensure that Provider does not allow any person who is excluded or debarred from participation in any Federal health care program to directly or indirectly provide any item or service under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services. Provider agrees to provide such additional information or documentation in this regard as Caremark may reasonably require.
2. Provider will review the Social Security Administration's Death Master File upon initially hiring or engaging any officer, director, employee, contractor, agent, volunteer, owner or otherwise, and monthly thereafter and upon any change of ownership in order to prevent fraudulent use of social security numbers.

Provider agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

Notwithstanding anything to the contrary, if an exclusion is made by an individual state health care program or other government sponsored program, but the exclusion does not extend to all Federal health care programs, Caremark may, in its sole discretion, limit the scope of termination to termination from only certain Caremark networks.

If Provider is excluded or debarred from participation in any Federal health care program:

- Provider will promptly provide to Caremark upon request a list, in such detail as Caremark requires, of all Federal health care program claims submitted on or after the date of such exclusion. All such identified claims are subject to reversal by Caremark as required by Law, Plan Sponsor, or as otherwise deemed necessary or appropriate by Caremark.

If any of Provider's officers, directors, employees, contractors, agents, volunteers or owners are excluded or debarred from participation in any Federal health care program:

- Provider will promptly provide to Caremark upon request a list, in such detail as Caremark requires, of all Federal health care program claims for which the excluded person directly or indirectly provided Pharmacy Services on or after the date of such exclusion. All such identified claims are subject to reversal by Caremark as required by Law, Plan Sponsor, or as otherwise deemed necessary or appropriate by Caremark.

2.12 Diverse Retail Pharmacy Program

The Caremark Supplier Diversity Program targets diverse suppliers of products and services for Caremark's use. The program is designed to complement Caremark's commitment to providing outstanding service to its customers, and it recognizes the critical role diverse suppliers have in its continued success. The Supplier Diversity Program is founded on the principles of sound business practices and social responsibility to the community in which Caremark serves.

One component of the Supplier Diversity Program is the Diverse Retail Pharmacy Program. Under this program Caremark encourages diverse-owned, independent retail pharmacies to become certified business enterprises in order to expand and establish potential business opportunities, sustain and grow their business, take advantage of possible governmental programs, and expand and establish potential new opportunities with other business entities.

Any diverse-owned and operated retail pharmacy contracted with Caremark and certified as a diverse business enterprise by a government or third-party entity can apply for participation in the Diverse Retail Pharmacy Program. Just complete and submit the Caremark Supplier Diversity Profile Form. For more information on this program and the Caremark Supplier Diversity Profile Form, refer to Appendix E of the Provider Manual.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

3. Pharmacy Services and Standards

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Pharmacies are an important part of Caremark's services and our goal to help people on their path to better health. Our Plan Sponsors, which include insurance companies, managed care organizations, third-party administrators, federal and state entities, employers, and union-sponsored benefit plans, entrust us with serving their diverse membership and we are committed to providing them with innovative and quality services and measures to control healthcare spending and improve health outcomes. Through our health services, plans and community pharmacists, we are pioneering a bold new approach to total health, making quality care more affordable, accessible, simple and seamless, to not only help people get well, but help them *stay* well in body, mind and spirit.

3.01 Providing Pharmacy Services to Eligible Persons

3.01.01 Professional Judgment and Conduct

All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist and in accordance with Prescriber directions and applicable Law. Provider must at all times exercise professional judgment in providing Pharmacy Services to an Eligible Person. Provider may refuse to provide Pharmacy Services to an Eligible Person based on professional judgment.

3.01.02 Verification of Eligible Persons

Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Eligible Persons must present an Identification Card to Provider when having a prescription filled. Provider must utilize the information on the Eligible Person's identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable efforts to obtain the necessary information for claim submission. Provider will not be reimbursed for providing Pharmacy Services to an Eligible Person whose eligibility was incorrectly submitted.

3.01.03 Identification Cards

In most cases, the identification card will be produced in the most current NCPDP format and will contain the Eligible Person's identification number, the RXBIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information.

An identification card may show coverage for the Eligible Person only or it may show coverage for the Eligible Person and his or her dependents.

3.01.04 Nondiscrimination

Provider must not discriminate against an Eligible Person on the basis of race, color, national origin, gender, age, religion, disability, medical condition, political convictions, sexual orientation, Eligible Person's enrollment in a Plan, source of payment, marital or family status, or any other basis prohibited by Law. Unless professional judgment dictates otherwise, Provider must deliver Pharmacy Services related to Covered Items to all Eligible Persons.

3.01.05 Eligible Person Solicitation

Provider must not directly or indirectly obtain prescriptions for Eligible Persons via marketing activities, including but not limited to, (1) contacting Eligible Person or Prescriber without a previously existing relationship; (2) obtaining an Eligible Person's primary care provider or billing information through unsolicited methods; and/or (3) contacting or offering to contact a Prescriber on an Eligible Person's behalf without the Eligible Person's express knowledge and authorization for each specific claim. Provider shall not obtain a prescription from a Prescriber not expressly requested by the Eligible Person or by suggesting to an Eligible Person that his or her Prescriber or health plan wants the Eligible Person to receive the medication without the prescriber's express knowledge and authorization. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives, including but not limited to, adherence initiatives, gaps-in-care management, or comprehensive medication reviews with Eligible Persons.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

3.01.06 Eligible Person Complaints

Provider must cooperate with Caremark and Plan Sponsors to resolve Eligible Person complaints. Provider must make a reasonable effort to rectify the situation that leads to the Eligible Person complaint. Provider must maintain written records of events and actions surrounding each complaint.

Provider must participate in and comply with a Plan's applicable appeal, grievance, and external review procedures, including Medicare Part D appeals and expedited appeals procedures, and the resulting decisions of the Plan.

Provider must provide to Caremark timely responses for CMS Complaint Tracking Module (CTM), in accordance with CMS-specified response times, which are typically within 24 hours of receipt of the grievance.

3.01.07 Patient Receipts and Insurance Profiles

Provider may print U&C and Patient Pay Amount on receipts and insurance profiles provided to an Eligible Person. Provider reimbursement pricing information and prices paid to Provider for individual claims under this Provider Agreement are Confidential Caremark Information and may not be disclosed on patient receipts or insurance profiles, subject to applicable Law. Refer to section **14.03 Confidentiality** of the Provider Manual.

Caremark has the right to review and audit documentation to validate Provider's compliance with this section.

3.01.08 Educational Materials and Efforts

Provider must utilize all educational materials to benefit Eligible Persons. All information contained in educational materials related to products, programs, services, and Plan Sponsor announcements constitute Caremark Documents and are Confidential Caremark Information.

Caremark may educate Provider about products, programs and services as well as distribute Plan Sponsor announcements. Educational materials may be distributed through various means, including e-mail, facsimile, mail, or posted on one of the Caremark websites or the Caremark Pharmacy Portal. Refer to section **1.06 Pharmacy Portal** of the Provider Manual.

3.02 Dispensing Requirements

3.02.01 Hours of Operation

Provider must maintain hours of operation that meet the needs of the community, but in all circumstances in accordance with applicable Law. Provider must communicate those hours of operation to Caremark upon enrollment and upon any changes. Provider must be reasonably reachable by telephone or facsimile during Provider's hours of operation (except as described in the "Force Majeure" section of this agreement). In the event that Provider is unreachable after reasonable attempts, Caremark reserves the right to suspend the participation status and other remedies available to Caremark, pending further investigation.

3.02.02 Drug Stock and Inventory

Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

3.02.03 Aberrant Quantities and Volume

Provider must not dispense aberrant quantities of a Covered Item and/or high volume of claims within a therapeutic category (e.g. topicals, dermatologicals), as measured by number of claims, quantity dispensed or dollars, inconsistent with the habits of local Prescribers or Plan Sponsor formularies, at Caremark's sole determination. In the event Provider breaches this provision of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark, including chargeback of applicable claims.

3.02.04 Dispensing Covered Items to Eligible Person's Agent

Provider must obtain the consent of the Eligible Person in order to dispense a Covered Item to a licensed healthcare practitioner in a non-custodial setting, except for deliveries to a family member of the Eligible Person when the Eligible Person is not present at the time of the dispensing of the Covered Item.

3.02.05 Performance Initiatives

Provider must support all Caremark performance initiatives, such as but not limited to, performance network programs (which may include adherence and drug therapy gap alerts), retrospective safety review alerts, formularies, Prior Authorization program, Managed Drug Limitations program, generic incentive programs, Dose Optimization program, Step Therapy program (refer to section **5. Clinical Programs, Services and Related Messages** of the Provider Manual for a further description of these initiatives) and any criteria in such performance initiatives.

CONFIDENTIAL AND PROPRIETARY

As part of the performance initiatives, Provider must inform Eligible Persons when a non-formulary drug has been prescribed and Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider may be paid a fee for services related to such performance initiative efforts.

Provider must not participate in programs that increase the amount billed to Plan Sponsors for Covered Items.

3.02.06 Dispensing Errors

If, as a result of an Eligible Person complaint, claim review, or Prescriber verification, for example, Caremark identifies a potential dispensing error and confirms with Provider the occurrence of such dispensing error, Provider must (1) review the information with the Eligible Person, (2) document the error in accordance with Provider's internal operational procedures, (3) report the error, if required, to any appropriate regulatory agency, including but not limited to, the Institute for Safe Medication Practices (ISMP), and (4) follow all applicable Law. For paid claims that have been determined to have a dispensing error, Caremark reserves the right to charge back the entire claim amount and may request Provider refund the Eligible Person the Patient Pay Amount.

Caremark tracks all dispensing errors identified through Caremark programs and provides notice to Provider of each error. Errors identified are reported internally for clinical review and serious or multiple errors may result in the Provider being notified of a Corrective Action Required (CAR), in which case Provider may be required to provide a Corrective Action Plan (CAP) to detail mechanisms being employed to prevent future errors. Refer to section **8.08 Corrective Action Plan** of the Provider Manual.

3.03 Patient Pay

3.03.01 Collection of Patient Pay Amounts

Patient Pay amounts (e.g. Copayments, Coinsurance, etc.) is an extremely important tool to help align the needs of Plan Participants with those of the Plan Sponsor. The disclosure of the Patient Pay Amount to the Patient is an important step in the adjudication and dispensing process of a prescription as it can assist with ensuring the necessity of a specific medication. The patient, or Eligible Person, may choose to find a more cost effective alternative that is therapeutically equivalent, resulting in cost savings for the Plan Sponsor while maintaining quality patient care. Provider must disclose to each Eligible Person the Patient Pay Amount prior to dispensing the prescription so the Plan Participant has the opportunity to make an informed decision. Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system and in accordance with section **4.05 U&C Validation** of the Provider Manual. Provider must keep evidence of the collection of Patient Pay Amount for review.

Provider has the right to provide an Eligible Person with information about the cost of his or her medication, including lower cost alternatives to assist the Eligible Person in finding affordable, clinically appropriate, alternative medications.

All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.

In the event the first documented effort to collect a Patient Pay Amount is initiated after Provider's receipt of a Caremark audit notice, such collection effort and any thereafter shall not qualify as reasonable efforts to promptly collect Patient Pay Amounts, regardless of any resulting collection of the Patient Pay Amount. Rather, Provider shall be deemed to have waived the Patient Pay Amount in violation of this **Collection of Patient Pay Amounts** section. The foregoing shall not apply to efforts undertaken by Provider to collect Patient Pay Amounts that are initiated within thirty (30) days of the date of the prescription fill.

3.03.02 Usual and Customary Price

Provider must disclose to each Eligible Person Provider's Usual and Customary (U&C) Price if such U&C Price is less than the applicable Patient Pay Amount. Provider must charge the Eligible Person the U&C Price or the Patient Pay Amount, whichever is lower, unless a Plan otherwise requires, and as determined by Caremark's adjudication logic. Notwithstanding the foregoing, Provider must still submit a claim to Caremark, even if the Eligible Person pays the U&C Price.

3.03.03 Coupons and Other Programs

As used in this section, "Pharmaceutical Manufacturer Coupon" means any item or mechanism, including but not limited to, paper coupons, copay cards, e-vouchers, mail-in rebates, and electronic coupon codes funded by a manufacturer, repackager or supplier of pharmaceutical, chemical or compounding products, that reduces the portion of the Patient Pay Amount that an Eligible Person is required to pay for a Covered Item.

CONFIDENTIAL AND PROPRIETARY

Provider must follow specific requirements to use a Pharmaceutical Manufacturer Coupon program to reduce the Patient Pay Amount.

1. Pharmaceutical Manufacturer Coupons may be accepted by a Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:
   a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program, including but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program;
   b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location;
   c. The Covered Item is not a compounded drug, 510(k) cleared medical device or Medical Food.
2. In addition, only certain Covered Items may have Pharmaceutical Manufacturer Coupons applied to reduce the amount the patient is required to pay. The following categories of Covered Items are the only ones where a coupon may be used.
   a. The Covered Item is approved by the U.S. Food and Drug Administration (FDA) through a New Drug Application (NDA) or Abbreviated New Drug Application (ANDA), and is published in the Approved Drug Products with Therapeutic Equivalence Evaluations (or commonly known as the "Orange Book"); or
   b. The Covered Item has a Biologics License Application (BLA), including drugs classified as biosimilars approved under section 351(k) of the Public Health Service Act, and is published in the Lists of Licensed Biological Products (or commonly referred to as the "Purple Book"); or
   c. The Covered Item is an Over-the-Counter (OTC) Covered Item marketed under an official final OTC monograph; or
   d. The Covered Item is a grandfathered drug marketed pre-1938 or pre-1962, or is otherwise Generally Recognized as Safe and Effective (GRASE) by the FDA.

Provider must be able to provide evidence of appropriate coupon use. Provider should review the multiple resources available in order to determine if a coupon can be used to reduce the Patient Pay Amount in accordance with the above requirements.

FDA approved drugs are searchable on the Orange Book at the following website which might be updated from time to time:

www.accessdata.fda.gov/scripts/cder/ob/index.cfm

Similarly, information related to "Purple Book" status can be found at the following website which might be updated from time to time:

www.fda.gov/drugs/therapeutic-biologics-applications-bla/purple-book-lists-licensed-biological-products-reference-product-exclusivity-and-biosimilarity-or

Covered items that are FDA cleared may not be used in conjunction with a coupon to reduce the Patient Pay Amount. A searchable database to review a listing of these items is available at the following website which might be updated from time to time:

www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm

Pharmaceutical Manufacturer Coupons that are only eligible to be used at specific pharmacies are not allowed. Certain Pharmaceutical Manufacturer Programs are specifically disallowed, including but not limited to, those from Affordable Medication Solutions, RetainRx, RxData Resources PBM, Phoenix PBM and all associated programs, including but not limited to, The Association for Precision Pharmacy Services and Arena Health Foundation.

Provider's application of a Pharmaceutical Manufacturer Coupon to reduce a Patient Pay Amount in violation of this section constitutes a prohibited waiver of the Patient Pay Amount.

3.03.04 Proof of Payment

Provider must maintain proof of payment by Eligible Person of the Patient Pay Amount [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash], which shall be subject to Caremark audit.

If the Patient Pay Amount is reduced due to a coordination of benefits, Provider must provide evidence of the claim adjudication to the secondary payer.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

3.03.05 Documentation

Provider must maintain documents to demonstrate its compliance with terms of section **3.03 Patient Pay** of the Provider Manual, and Provider agrees that such documentation is subject to Caremark audit.

3.03.06 Excess Collections

If Caremark determines that Provider has charged or collected from an Eligible Person in excess of the Patient Pay Amount communicated by the claims adjudication system, Provider must promptly reimburse Eligible Person for the excess amount upon Caremark request; otherwise, Caremark reserves the right to recover the excess amount from Provider (including by offset against other amounts owing to Provider) and return the recovered amounts to the Eligible Person.

3.03.07 Limitation on Collection

Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including non-payment by or bankruptcy of a Plan Sponsor or Caremark or where such amount is disallowed or not permitted by a governmental body. For claims of Plan Sponsors who are Medicare Advantage organizations providing Medicare Part C services, Provider must not hold any Eligible Person liable for payment of any fees that are the legal obligation of such Medicare Advantage organization.

3.03.08 Violations

Any act, omission, or scheme that encourages or allows conduct resulting in a violation of section **3.03 Patient Pay** of the Provider Manual, such as but not limited to, pharmacy-sponsored coupons, advertisements, pamphlets, flyers, and website postings promoting waiver of Patient Pay Amounts, is strictly prohibited and may result in the immediate termination of the Provider Agreement and other remedies available to Caremark. Claims submitted in violation of this section are subject to chargeback. Provider agrees that absent the waiver or reduction of Patient Pay Amount, the prescription would not have been dispensed.

3.03.09 Patient Inducements

Provider may not offer or provide any item of value, including but not limited to, gift cards, coupons, or free goods or services, to an Eligible Person to induce or reward the purchase of Pharmacy Services or Covered Items from Provider, unless such items are nominal in value (meaning a value of $15 or less) and the aggregate value of items given to an Eligible Person does not exceed $75 per year, as documented in Provider's records that are subject to audit. Further, notwithstanding the foregoing, Provider may not offer or provide any inducement to an Eligible Person that is prohibited by any applicable Law. This section does not apply to Pharmaceutical Manufacturer Coupons which are addressed separately in the Provider Manual.

3.03.10 Waivers

Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system unless otherwise authorized in writing by Caremark or except for a non-routine, unadvertised waiver of a Patient Pay Amount that does not violate applicable Law and is either:

- A waiver based on an individualized determination of financial need made under a Financial Hardship Program that meets the Financial Hardship Program requirements set forth below; or
- A waiver made following exhaustion of reasonable collection efforts, such as invoices, billing letters, and collection calls.

Provider must document its reasonable collection efforts, and such documentation must include, at minimum, the date the collection effort was sent or contact made, the Patient Pay Amount owed by Eligible Person, results of each collection effort, and final disposition.

If a payment plan is agreed to by Provider with an Eligible Person for the payment of a Patient Pay Amount, all terms of the payment plan, including the total amounts subject to the payment plan and repayment terms, must be documented and written confirmation of such terms must be sent to the Eligible Person. The payment plan must be reasonable and expected to result in full collection of outstanding Patient Pay Amounts owed and must be readily retrievable upon request from Caremark.

3.03.11 Financial Hardship Program

Waivers based on an individualized determination of financial need under a Financial Hardship Program must meet the following requirements.

CONFIDENTIAL AND PROPRIETARY

1. The terms of the Financial Hardship Program must be set forth in a formal written policy adopted by Provider. The policy must specify the documentation required to establish financial need, the criteria for determining eligibility for financial hardship relief and the level of relief to be provided, the application review and approval process, and recordkeeping requirements.
2. Eligible Persons seeking relief under the Financial Hardship Program must submit an application and provide reasonable and objective documentation of financial need that includes federal tax returns and other appropriate documentation.
3. The criteria for determining eligibility for financial hardship relief and the level of relief to be provided must be reasonable.
4. Written notice of qualification for financial relief under the Financial Hardship Program must be provided in writing to the Eligible Person. This notice must specify the amount or portion of the Patient Pay Amount that is being waived and the period of the waiver.
5. Eligibility for continued financial relief under the Financial Hardship Program must be reviewed on at least an annual basis. This review shall be based on an updated application and updated supporting documentation provided by the Eligible Person.
6. Records must be maintained for each Eligible Person receiving financial hardship relief under the Financial Hardship Program. The records must include, at a minimum, the application and supporting documentation submitted by the Eligible Person and a copy of the notice of qualification sent to the Eligible Person.
7. Provider personnel providing final financial hardship approval must be employed by Provider and shall not be contractors or agents of Provider. The identity of the personnel granting approval must be documented and provided as requested by Caremark.
8. The Financial Hardship Program may not be advertised or promoted.
9. The Financial Hardship Program may not be funded, in whole or in part, by any third party.
10. The Financial Hardship Program must meet all requirements and restrictions of applicable Law.

3.04 Standards of Operation

Participation in Caremark's retail networks is limited to pharmacies or dispensing practitioners that are defined as a "Retail Pharmacy". A **"Retail Pharmacy"** is defined as either (1) a duly licensed and established community pharmacy that serves walk-in patients and dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale; or (2) a duly licensed dispensing practitioner that serves patients with whom the dispensing practitioner has a physician-patient relationship and dispenses and sells specialty or non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. For additional information regarding dispensing practitioners refer to **Appendix J** of the Provider Manual.

Not considered "Retail Pharmacies":

1. For purposes of this definition, any Provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, whose number of claims submitted to Caremark for prescriptions that were delivered to Eligible Persons (including common carriers such as USPS, FedEx, UPS or other delivery service) exceeds twenty percent (20%) of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. In such case, Caremark reserves the right to exclude such Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or apply other unique terms and conditions to such Provider's participation in such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing. Caremark further reserves the right to chargeback any improper or excessive payments made to Provider based upon its representation as a retail pharmacy.
2. For purposes of this definition, any Provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, whose number of claims submitted to Caremark for specialty drugs exceeds twenty percent (20%) of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. If Provider has misrepresented itself as a Retail Pharmacy and/or modifies its operations such that it no longer meets the definition of a Retail Pharmacy, in addition to all other rights and remedies, Caremark reserves the right to exclude such Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or apply other unique terms and conditions to such Provider's participation in such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing.
3. For purposes of this definition, any Provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, who is owned by a 340B covered entity or whose volume of claims filled using 340B Drug Pricing Program acquired or replenished drugs is the basis for any pharmaceutical manufacturer denying pharmaceutical rebates for claims filled by Provider, is not considered a Retail Pharmacy. In such case, Caremark reserves the right to apply unique terms and conditions to such Provider's participation in any retail network(s) in which the Provider is participating or any new retail network(s)

CONFIDENTIAL TREATMENT REQUESTED

established, or such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing. All Providers must maintain their NCPDP online provider ID profile services question on 340B so that it is accurate and up to date.

3.05 Records

3.05.01 Documents and Records Maintenance

Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons and Pharmacy Services in accordance with applicable Law and as required by the Provider Agreement, including section **8. Professional Audits** of the Provider Manual.

Provider must maintain its prescription records, books, other documents, and any other items for six (6) years or longer, as required by applicable Law, and shall make them available for review. Records must be kept in their original format for the time period required by applicable Law, if any. For the remainder of the required retention period, subject to applicable guidance, Provider may then transfer such prescription records to an electronic format that replicates the prescription hard copy for the remainder of the retention period.

Provider agrees to make its books and records available for a period of ten (10) years from the termination date of the Provider Agreement.

Refer to section **10. Medicare Part D** of the Provider Manual and the **Federal and State Laws and Regulations** (available on the Caremark Pharmacy Portal) for other document and records maintenance requirements.

Provider must maintain and secure records in accordance with HIPAA requirements, including disposing of any records containing Protected Health Information (PHI) in a secure manner in accordance with guidelines issued by the Secretary of Health and Human Services for rendering such records unusable, unreadable or indecipherable to unauthorized individuals.

3.05.02 Signature Log – Hard Copy or Electronic

Provider must maintain a third-party signature log – hard copy or electronic. The third-party signature log must be in date order, readily accessible, and retained for ten (10) years from date of signature or such period as required by applicable Law and must meet the following criteria:

1. Contains a signature which can be individualized or directly related to each prescription dispensed (e.g. prescription number)
   a. For each claim adjudicated through the claims adjudication system, Provider must obtain the signature of the Eligible Person (or his or her authorized representative) on a dated third-party signature log to confirm that he or she has received the medication recorded.
   b. Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.
2. Maintains the date of the receipt of medication by the Eligible Person
3. Maintains a disclosure to Eligible Person of insurance billing
4. Retrievable for the purposes of audit

Third-party signature log options for mail-delivered prescriptions dispensed in accordance with the Agreement include:

1. If delivered to a home or business address, Provider must maintain:
   a. Patient Pay Amount collection documents
   b. Shipping method
   c. Date of shipment or delivery
   d. Shipment manifest
   e. Medication protection method
   f. Documentation of each prescription number and Covered Item delivered including delivery date
2. Tracking documentation for each Covered Item that was delivered.

If Eligible Person is sent monthly billing statements, Provider may insert a form listing the dates of fill and prescription numbers; the Eligible Person or authorized representative should be instructed to sign, date and return the form with his or her payment.

3.05.03 Prescription Information

All prescription documentation (including electronic records within Provider system and written, faxed, telephoned, and computer-generated orders) for Covered Items written by the Prescriber and dispensed to the Eligible Person, must fulfill the requirements as set forth within applicable Law and contain additional information necessary for proper submission and adjudication of a claim transaction such as:

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

- Full name of the patient for whom the prescription was written by the Prescriber and the address at which the patient resides
- Full name, address, telephone number, and NPI (or other required identification number) of the Prescriber
- Name, quantity and strength of the medication prescribed
- Specific dosage directions
- Generic substitution instructions (if applicable)
- Notation when patient requests that a multi-source brand medication be dispensed
- If prescription is changed, notation of the changed prescription element, time, date, name of authorizing person, and affiliation with Prescriber
- Refill instructions
- Miscellaneous or other information as required in accordance with applicable Law
- Prescription hard copies or electronic prescription records for insulin and diabetic supplies must contain complete documentation of items, quantities dispensed and directions for use

Documentation for a claim transaction which includes vaccine administration must be maintained on the prescription hard copy or electronic prescription record, or in the form of a vaccination administration record (when the administration was included within the claim transaction). Documentation must include:

- Detail regarding the administration (e.g., lot number, expiration)
- Date of the administration
- Name and NPI of Provider directly responsible for administration of the vaccine; if the Provider does not have an NPI, provide the NPI of the pharmacy
- NPI of the Prescriber of the vaccine, following applicable state and federal Law (this may be the same as the Provider administering the vaccine where applicable Law allows)
- Acknowledgement that confirms the Eligible Person received both the medication and the administration

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy, electronic prescription record or Provider systems where it can be readily retrievable.

During the audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, Caremark recommends that Provider document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the Caremark auditor or help to resolve an audit discrepancy.

3.06 Referrals

3.06.01 Referral Fees

Provider shall not offer or pay to any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referrals of patients or other individuals to Provider for the provision of any pharmacy or other healthcare service.

Provider shall not solicit or receive from any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback or other consideration, whether in the form of money or otherwise, as compensation or inducement for Provider's referral of patients or other individuals for the provision of any pharmacy or other healthcare service.

3.06.02 Referrals to Non-Retail Participating Providers

Provider must refer Eligible Persons to mail order, specialty, and/or other specified pharmacies for certain Pharmacy Services as appropriate for his or her plan benefit design and in compliance with applicable Law.

CONFIDENTIAL AND PROPRIETARY

4. Claims Submission

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Notwithstanding anything to the contrary in the Agreement, by participating in a Caremark network Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Agreement unless professional judgment dictates otherwise. Provider agrees that any violation of this section is subject to audit chargeback, non-compliance fees, and/or possible termination as a Provider.

A paid claim as indicated through the claims adjudication system is not an indication by Caremark of Provider's compliance with the Agreement.

4.01 Payer Sheets and Reject Codes

Provider should carefully review the payer sheet referenced in **Appendix A** and located at **www.caremark.com/pharminfo** since the submission of certain optional data elements in the most current NCPDP version is required by Plan Sponsors or state and federal programs and must be submitted for processing.

Caremark utilizes NCPDP reject codes. Refer to **Appendix B** of the Provider Manual for additional information.

4.02 General Claim Submission Policies

The following are general Provider claim submission policies that are applicable to all claim submissions:

1. Each claim constitutes a representation by Provider to Caremark that the Pharmacy Services were provided to the Eligible Person and that the information transmitted is accurate and complete. Submission of incomplete, false, or fraudulent claims is a willful misrepresentation and intentional misconduct by Provider.
2. Unless required by Law or regulation, Provider must not submit claims to any other administrator when documentation confirms Eligible Person's eligibility with Caremark.
3. Unless otherwise permitted by applicable Law, each claim submitted must be for a prescription for a Covered Item that was written by a Prescriber and for which Pharmacy Services for a Covered Item were provided to the Eligible Person for whom the prescription was written.
4. If Provider knows or reasonably should know, that there is not a legitimate Prescriber/patient relationship, Provider must verify the Prescriber/patient relationship prior to dispensing and maintain a record of such verification.
5. Provider must receive Eligible Person consent prior to each fill to dispense the prescription, but such consent is not necessary when the Eligible Person personally initiates the new prescription request or refill.
6. Provider must submit all claims for a Covered Item for Pharmacy Services via the Caremark adjudication system to ensure that plan design, quality, and professional practice standards are met, and that safety and drug utilization review (DUR) are applied.
7. All claims must be submitted online using current NCPDP HIPAA compliant format and in compliance with the Provider Agreement, the Payer Sheets, the Provider Manual, and all applicable Laws, rules and regulations. Caremark may require additional information to process a claim.
8. Provider must not take any steps to circumvent plan design or claims edits. Provider must not modify any claim data fields (e.g., reduce quantities or increase days supply) in order to bypass plan edits or Provider Agreement requirements; and Provider must not use an SCC value to inappropriately override a reject.
9. Provider must display all NCPDP messaging to the dispensing pharmacist. It is imperative that Provider review the claim response in its entirety including primary and secondary messages. Please note that this may require viewing additional screens.
10. Any changes to a prescription, including but not limited to, the Covered Item being prescribed or directions for use, must be approved by the Prescriber prior to dispensing. Provider must date and document the Prescriber approval on the prescription hard copy or electronic prescription record.
11. In order to protect the health and safety of the Eligible Person, Provider must review and act upon DUR messages received from Caremark. As well as reviewing and acting upon Caremark's DUR messages, Provider

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

must perform an internal DUR on each claim to monitor for safety concerns such as drug-to-drug interactions and drug allergy monitoring. Refer to section **5. Clinical Programs, Services and Related Messages** of the Provider Manual.

12. Providers must inform Eligible Persons about the proper storage, dosing, utilization, side effects, potential interactions, and use of the medication dispensed within professional practice guidelines.
13. Provider must include all eleven (11) digits of the correct National Drug Code (NDC) as dispensed even if the manufacturer of the product only indicates ten (10) digits. The NDC must be provided in a 5-4-2 format. Provider must zero-fill to the left when a number has been excluded from the format. Claim submissions utilizing an NDC other than the NDC of the Covered Item dispensed are subject to audit review and chargeback and are not eligible for reimbursement.
14. All Covered Items, including Over-the-Counter (OTC) Covered Items, dispensed via a prescription that are provided to an Eligible Person as prescribed by a Prescriber must be labeled for the Eligible Person.

4.03 Other Claim Submission Requirements

1. **Quantity Dispensed and Days Supply:** Provider must submit the accurate days' supply and quantity on all claims prior to dispensing.
   a. Provider must submit only the quantity indicated on the prescription. Provider must enter the exact metric decimal quantity dispensed (no rounding) on all claim transactions. Provider must submit the quantity based on product description (e.g., kit, volume of medication in milliliters, weight in grams, eaches, number of capsules/tablets). If the quantity is uncertain, Provider must contact the Prescriber to determine the appropriate amount to dispense and notate on the prescription hard copy or electronic prescription record.
   b. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
   c. Provider must not adjust the quantity dispensed to circumvent adjudication edits, reimbursement structure, prior authorization edits, clinical program or benefit design edits based on day supply.
   d. If the Prescriber indicates ambiguous direction such as "use as directed" or "as needed," (e.g., a drug that may be administered on a sliding scale, such as insulin, or a topically applied drug), the Provider must obtain the dosing schedule, dosing range, area of application, frequency, and any other information necessary or applicable to determine the days supply for the quantity dispensed. For example with topical products, the FTU (fingertip-unit) chart is a common reference used to estimate the amount of topical product required based on the area of coverage.
   e. Directions and/or area of application may be obtained from either the Eligible Person or the Prescriber and must be notated on the prescription hard copy or electronic prescription record.
   f. Provider must not combine Prescriber authorized refills.
   g. Provider must consider product expiration and manufacturer storage recommendations when calculating days supply for claim transmission.
2. **Strength Dispensed:** The strength of the medication identified on the claim must be an accurate reflection of that which was prescribed or documentation of the unavailability of the prescribed strength will be required. Provider must utilize the strength originally prescribed by the Prescriber or use an available higher strength single dose of the same medication as described in section **5.08 Dose Optimization** of the Provider Manual. Provider must not utilize a lesser strength in an increased quantity without documentation of unavailability of the prescribed strength.
3. **Plan Limitations Exceeded:** Claims submitted to Caremark that exceed Plan limits for the days supply or quantity dispensed will reject with the message, "Plan Limitations Exceeded." The reject message includes the actual limits such as, "Maximum Days Supply = 34" or "Quantity Limit = 100". Any claims resubmitted must be entered with the accurate quantity and days supply; however, if the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-day supply), and rejects as stated, it is allowable for Provider to resubmit the claim utilizing that quantity and the maximum days supply as provided in the reject messaging. Provider maintains responsibility to adhere to appropriate refill intervals based on the quantity dispensed and actual days supply (based on the prescribed dosing schedule). For additional information regarding Medicare Part D Claims, refer to section **10. Medicare Part D** of the Provider Manual.
4. **Ingredient Cost and Package Size:** Provider is obligated to submit claims using the lowest ingredient cost dosage form and the lowest cost package size container available that results in the lowest reimbursement.
5. **Ophthalmic Products:** Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. A chart to assist in calculating the appropriate days supply for a claim is provided in **Appendix D** of the Provider Manual.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

6. **Drugs with Unusual Submission Requirements:** Claims for some drug products frequently result in incorrect reimbursement. To avoid audit chargebacks, refer to the examples in **Appendix** of the Provider Manual.
7. **Repackaging:** Claims for repackaged, relabeled NDCs submitted to Caremark that result in higher reimbursement than claims for non-repackaged, relabeled NDCs may be subject to recoupment.
8. **Non-Covered Items:** Claims submitted to Caremark in accordance with a Plan Sponsor program to allow limited dispensing of a non-covered item (e.g., 3-day supply approved for a drug on prior authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable day supply.
9. **Federal Health Care Programs Prescriber Participation Exclusion**: Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other Federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions and claims for items or services furnished by an excluded or debarred Prescriber, and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment.
10. **Auto-Ship Refill Programs:** Claims submitted for auto-refill programs must only be for medications used in a maintenance therapy. Refer to section **10.04.05 Auto-Ship Refill Programs** of the Provider Manual.
11. **Prescription Date:** Each prescription claim transmitted must indicate the actual date of fill; billing of claims must not be pre-dated or post-dated. Date of fill is the date on which the Covered Item is prepared and readied for dispensing to the patient. Provider must not bill claims for prescriptions that are not prepared and available for dispensing. If the actual dispense date exceeds seven (7) days from the date of fill submitted to Caremark, the claim must be reversed and reprocessed with the actual dispense date.
12. **Prescription Not Received; Reversal of Claim:** All prescriptions not received by an Eligible Person must be returned to stock and reversed within fourteen (14) days from original submission through the electronic claims system. Provider must ensure that a reversal response is received from Caremark for any claims representing non-dispensed medications. Refer to section **4.16 Electronic Submission, Reversal, and Processing Windows** of the Provider Manual.
13. **Pre-Printed Prescriptions:** Provider must not use pre-printed prescriptions that result in the dispensing of Covered Items that are not the most cost-effective even if they are different salts, bases, release characteristics, or additional drugs in combination.
14. **Test Claims:** Unless otherwise authorized in writing by Caremark, Provider must not submit test claims when a prescription order does not exist (e.g., to determine reimbursement rates). Provider must also not submit test claims acting as a HUB service provider unless given written consent by Caremark.
15. **Vaccines:** When administering vaccines, submit 'MA' (for Medication Administration) in the Professional Service Code field (440-E5) of the DUR/PPS Segment along with a positive incentive fee amount in the Incentive Amount Submitted field (483-E3) of the Pricing Segment when administering vaccines. Providers must be certified and/or trained to administer vaccines. Provider is responsible for verifying with individual state boards of pharmacy to determine if pharmacists can administer vaccines.
16. **Durable Medical Equipment (DME):** Provider must only submit DME claims that are payable under the Plan Sponsor's pharmacy benefit. Provider must submit a valid NDC for the DME. If no NDC exists for a DME, Provider must not submit a claim.

4.04 Dispense as Written Codes

Provider must dispense a generic drug whenever permitted and in accordance with applicable Law. Provider must use its best efforts to carry out Caremark and Plan Sponsor mandatory generic programs. In doing so, Provider must contact the Prescriber to encourage a change to a generic substitute when the prescription contains a "dispense as written" signature for a multi-source brand medication.

To ensure proper payment to Provider and the correct Patient Pay Amount of Eligible Persons, Provider must submit all claims with the accurate Dispense as Written (DAW) code, unless otherwise specifically directed by Caremark. Provider must select from the following codes:

DAW 0—No Product Selection Indicated

- Use DAW 0 when dispensing a generic; that is, when no party (e.g., neither Prescriber, pharmacist, nor Eligible Person) requests the branded version of a multi-source product.
- Use DAW 0 when dispensing a single-source brand product.
- Generic pricing may be applied to claims for multi-source products submitted with DAW 0.

CONFIDENTIAL AND PROPRIETARY

DAW 1—Physician Requested Product Dispensed As Written

- Use DAW 1 only when the Prescriber specifies the branded version of a multi-source product on the prescription hard copy or in the verbally communicated instructions (must be evidenced on the prescription hard copy – original and updated); this documentation must occur prior to Pharmacy Services being rendered.
- Computer systems that default to DAW 1 may result in discrepancies and chargebacks.
- Prescription must follow state substitution Laws.

DAW 2—Substitution Allowed—Patient Requested Product Dispensed

- Use DAW 2 when the Eligible Person requests the branded version of a multi-source product even though a generic is available and the Prescriber has authorized (or not prohibited) a generic, or when the Eligible Person requests that Provider contact the Prescriber to obtain approval for a branded version when neither the original prescription nor the verbally communicated instructions specified the branded version.

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed

- Use DAW 3 when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed.

DAW 4—Substitution Allowed—Generic Not In Stock

- Use DAW 4 when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy.

DAW 5—Substitution Allowed—Brand Dispensed As Generic, Priced As Generic

- Use DAW 5 when dispensing a branded version of a multi-source product as a generic.

DAW 6—This Value Is Used As Communicated By Caremark

DAW 7—Substitution Not Allowed—Brand Mandated By Law

- Use DAW 7 when Law or regulations prohibit the substitution of a brand product even though generic versions of the product may be available in the marketplace.

DAW 8—Substitution Allowed—Generic Not Available

- Use DAW 8 when generic substitution is permitted and the brand product is dispensed because the generic is not currently manufactured, distributed or is unavailable in the marketplace.

DAW 9—Substitution Allowed By Prescriber but Plan Requests the Brand

- Use DAW 9 when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted, but the Plan Sponsor's formulary requests the brand product.

4.05 U&C Validation

Provider is required to submit accurate U&C Prices for all Caremark claims, including U&C Prices which are part of a standard set price generic program offered by Provider (i.e., program that is open and requires no enrollment). Provider must provide, upon request, a record of the dispensing of a prescription (identical to the prescription being audited) that was dispensed to a cash paying customer on the same date if such dispensing occurred. Provider may redact confidential patient health information from the record in accordance with applicable Law, but the record must contain the patient charge amount. Caremark has the right to review and audit documentation and records as detailed in this section to validate that Provider's submitted U&C is in accordance with the Agreement. Provider must allow the Eligible Person to pay either the U&C or the Patient Pay Amount, whichever is lower, unless a Plan otherwise requires. Notwithstanding the foregoing, Provider must still submit a claim to Caremark, even if the Eligible Person pays the U&C.

Provider must not modify its U&C, "gross amount due" (as defined by current NCPDP standards), or ingredient cost claimed on individual claims in order to bypass plan edits or Provider Agreement requirements.

4.06 Over-the-Counter Products

Caremark requires a prescription for Over-the-Counter (OTC) products submitted for reimbursement, except in OTC programs as stated below, and Provider must label and dispense the OTC product in accordance with the prescription and applicable Law. The requirements in sections **7. Compliance Reviews, 8. Professional Audits** and **4.13 Prescriber Identification; Prescriptive Authority** of the Provider Manual are applicable to all OTC claims.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Some Plan Sponsors elect to offer a program where Covered Items include certain OTC products to be dispensed without a prescription. These programs may incorporate a monthly or quarterly maximum; in which case, in the event Eligible Persons reach the allowed maximum amount covered by the Plan, per time period, Eligible Persons are responsible for any amount over the allowed maximum including cusp claims and claims submitted after the allowed maximum is exhausted for that time period.

Upon notification of approval from Caremark, Provider may submit claims for Plan Sponsor OTC programs that do not require a prescription and do not require labeling of the Covered Item by Provider. Provider, however, must maintain a computer-generated label for the OTC product for Caremark's audit purposes. Unless otherwise specified by Caremark, Provider may submit Provider's NPI as the Prescriber identification for these programs for OTC products not requiring a prescription.

4.07 Multi-Ingredient Compound Processing

The following are submission policies for multi-ingredient compound processing.

1. All compounds must be submitted online in the most current NCPDP version format. Caremark payer sheets can be found online at **www.caremark.com/pharminfo**.
2. Provider must submit the accurate dosage form of the final compounded product dispensed in the compound dosage form description code field in the compound segment (must be a valid NCPDP compound segment dosage form value).
3. Enter the total quantity of the final product dispensed in the quantity dispensed field in the claim segment.
4. Enter the calculated cost of the complete compound as the ingredient cost submitted. This calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the Level of Effort (LOE). Caremark, in its sole discretion, will have final determination of professional allowance attributed to claim above the cost.
5. Calculated cost shall not include cost of drug product associated with waste. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
6. Enter the actual Product/Service ID (e.g., NDC or UPC) of each active and inactive item used in the preparation of the compound in the compound segment, including any consumable item (e.g., capsule). Each applicable Product/Service ID must be entered accurately. Incorrect submission of any single or multiple ingredient(s) may result in chargeback of the entire claim.
7. Provider must submit the actual Product/Service ID (e.g., NDC or UPC) of each Covered/non-Covered Item. For any items in the compound, such items are only reimbursable if Provider provides, upon Caremark's request, evidence that each of the active and inactive items in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to chargeback.
8. For compounds that require a delivery device as a component of the final medication product, the device must be submitted as an item in the compound only when the device has a Product/Service ID (e.g., NDC or UPC) and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.
9. When required, Provider must submit the accurate Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) value for the final compounded product in the route of administration field in the claim segment.
10. Enter the LOE in the DUR/PPS Segment. The LOE must reflect the compound types which are referenced in **Figure 1 – Level of Effort Table**, unless otherwise communicated by Caremark. Provider must not program one code for all compounds.

Figure 1 – Level of Effort Table

DUR/PPS (Field 474-8E) Level of Effort	Compound Type
11	Single ingredient capsule Any combination of commercially available products
12	Two ingredient capsule/suppository Transdermal gel

CONFIDENTIAL AND PROPRIETARY

DUR/PPS (Field 474-8E) Level of Effort	Compound Type
13	Three or less ingredient cream/ointment/gel* Three ingredient capsule/suppository* Two or less ingredient troche* Non-complex suspension Tablet triturate*
14	Topical containing controlled substance Three or more ingredient troche* Four or more ingredient cream/ointment/gel* Four or more ingredient capsule/suppository* Complex suspensions (e.g., pediatric/altering PH/base to salt conversion) Chemotherapy cream/ointment/gel* Hormone therapy (capsules/troches/suppositories)
15	Sterile products - limited to aqueous bronchial and nasal inhalations (does not include nasal sprays or irrigations), injections, irrigations for wounds, and ophthalmic drops and ointments per USP <797>

*Using bulk (powder) APIs

11. Coverage determination is performed on each and every item in the compound.
12. Provider may receive a rejected response for a compound claim when item(s) within the compound are not reimbursable; Caremark accepts Submission Clarification Code (SCC) 08 (Process Compound for Approved Ingredients) which will result in an adjudicated response on all items.
13. Non-Covered Item(s) within a compound are not reimbursable.
14. Compounds may be a Covered Part D Drug for Medicare Part D Enrollees provided the compound contains at least one Covered Part D Drug. The item cost must only include components which satisfy the definition of a Covered Part D Drug as defined in 42 C.F.R. § 423.100. Components that are not Covered Part D Drugs as defined by the Centers for Medicare and Medicaid Services (CMS) may be included in the creation of the product, but may not be included in the calculation of the item cost submitted (e.g., sterile water, compounding bulk powders, vitamins, components not utilized for a diagnosis recognized in the compendia). Provider must, however, include all items used in the creation of the compounded product on the multi-ingredient claim transmission.
15. If compounded claims reject for pricing edits (e.g., exceeds maximum cost for the Plan), Provider must not alter the quantity or identity of the individual components submitted to inappropriately enable reimbursement. Provider must not alter the quantity of, or omit an item dispensed to circumvent Caremark's reimbursement structure, such as providing only 83 days of a 90-day supply prescription or dispensing monthly, but billing weekly.
16. Provider must not manipulate claims pricing or the compound indicator for inappropriate financial gain or cause a claim to inappropriately pay.
17. The Caremark adjudicated claim response indicates the total payment for the compound claim. Provider must not balance bill an Eligible Person if prohibited by applicable Law.
18. When a compounded product is dispensed to an Eligible Person, Provider must bill Caremark a single claim for the final compounded product using multi-ingredient functionality (including all active and inactive items used in the creation of the compounded product) and must not bill separate claims to Caremark for individual items or ingredients used in the creation of the compounded product. In an effort to protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.

CONFIDENTIAL TREATMENT REQUESTED

19. Compounds that have a commercially available product are not reimbursable.
    a. In the event a commercially available product becomes unavailable (e.g., product is on backorder, drug shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
    b. If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount.
20. Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.
21. Compounding must be performed by a qualified person as defined by applicable Law.
22. Outsourcing any portion of Pharmacy Services for compounded medications not approved in advance and in writing by Caremark is prohibited.
23. Refer to section **7.02 Additional Information Regarding Compliance Reviews** of the Provider Manual for documentation requirements.

The following must not be billed as a multi-ingredient compound:

1. A combination of products which are not combined to make one final medication for use (e.g., a kit of individual products designed to be used independently)
2. A combination of Covered Items which do not have a medical purpose in combination other than convenient dosage form
3. Any product that contains an item or substance that is classified as a dietary supplement as defined by the Dietary Supplement Health and Education Act (DSHEA) of 1994
4. A commercially available compound kit or commercially available product which is represented by a unique assigned NDC and contains all the items of the final product as such (e.g., kit containing a base and active items and directives for mixture)
5. Compounds dispensed for human consumption or application which include items that are not approved for human use
6. Medications requiring reconstitution prior to dispensing (e.g., powdered oral antibiotics, topical acne preparations, injectable medications)
7. Flavoring of a commercially available product prior to dispensing (e.g., addition of flavor to powdered oral antibiotics), nor should the item cost submitted include flavoring cost
8. Covered Items that are in a ready-to-use form that are transferred from one container to another for use (e.g., pre-filling insulin syringes, transferring multiple bottles into a single IV bag)
9. Any compound that contains a drug product that has been withdrawn or removed from the market because the drug product or components of the drug product have been found to be unsafe or not effective as defined in section 21 C.F.R. § 216.24 of the Code of Federal Regulations

4.08 Overrides

Caremark has developed general prior authorization numbers for some Plan Sponsors for claims that reject. A Pharmacy Help Desk representative can provide information if the Plan Sponsor allows for an override to allow the claim to adjudicate. In addition, some Medicaid Plan Sponsors provide temporary coverage of non-formulary medications. If this is the case, the claim may reject with a message that includes the temporary days supply that will be covered and the prior authorization number to enter into the NCPDP prior authorization number field in order for the claim to adjudicate. Provider must calculate the appropriate quantity for a Covered Item accordingly to correspond with prescription instructions and temporary days supply. Provider must maintain documentation to substantiate any overrides applied to a claim.

4.09 Natural Disasters

Caremark is dedicated to assisting Providers and Eligible Persons in response to emergencies resulting from natural disasters, severe weather, etc. where medical records are either destroyed or not accessible. In the event of a presidential (or other governmental) emergency declaration, Caremark will allow a specific submission clarification code to override the refill-too-soon edit for Eligible Persons impacted within the disaster area. A value of '13' in the Submission Clarification Code (SCC) field, 420-DK, and the displaced Eligible Person's zip code impacted by the disaster (zip code may not be where Eligible Person resides) in field 325-CP, will allow an override without requiring

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

a call to the Pharmacy Help Desk. On the prescription hard copy or electronic prescription record, document the specific declared disaster (e.g., tornado, flood, wildfire), how the member was impacted (e.g., medication damaged, temporary relocation) and the date the disaster override was utilized. Permission may vary by Plan Sponsor. If you need assistance, call the Pharmacy Help Desk.

Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual for contact information.

Refer to section **10. Medicare Part D** of the Provider Manual for additional information.

4.10 Coordination of Benefits

Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any Coordination of Benefits (COB) requirements, and must engage in appropriate COB activities to the extent required by Caremark or applicable Law.

Claim submissions with incorrect COB values are subject to chargeback.

4.10.01 Multiple Transaction Coordination of Benefits

For the majority of plans, Caremark utilizes a typical multiple transaction COB process. Multiple transaction COB consists of one claim submitted to the primary payer followed by one or more claims submitted to the supplemental payer(s). Specific COB RXBINs exist to differentiate between claims that are supplemental to Medicare Part D and claims that are supplemental to non-Medicare Part D coverage.

For COB claims that are supplemental to Medicare Part D, Provider must submit RXBIN 012114 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of Plan-specific claims processing information.

For COB claims that are NOT supplemental to Medicare Part D, Provider must submit RXBIN 013089 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of Plan-specific claims processing information.

Refer to section **10. Medicare Part D** of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets referenced in **Appendix A** of the Provider Manual.

4.10.02 Single Transaction Coordination of Benefits

Caremark may utilize a Single Transaction Coordination of Benefits (STCOB) process whereby Provider sends one transaction to Caremark and the Claim adjudicates against both primary and secondary plans before returning one final response to Provider. Single Transaction COB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for Eligible Persons. When STCOB is utilized, it is not necessary for Provider to submit a separate COB claim in order to coordinate these benefits.

Refer to section **10. Medicare Part D** of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets referenced in **Appendix A** of the Provider Manual.

4.11 Long-Term Care Billing

For information related to Medicare Part D LTC billing, refer to section **10. Medicare Part D** of the Provider Manual.

For Providers providing home health care or Long-term Care (LTC) Covered Items to Eligible Persons, each NDC of the individual drug dispensed must be billed only once to Caremark during any 30-day period unless allowed by Plan Sponsors. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws. Provider must submit claims to Caremark's claims adjudication system for LTC Pharmacy Services.

Provider must bill Caremark once during any 30-day period for medications dispensed continuously over the course of a month for an Eligible Person. One dispensing fee will be paid based on the monthly quantity dispensed of a single drug of a single strength for an Eligible Person. When the medical needs of the Eligible Person require a change in the medication order or the medication provided has a documented medical necessity for limited dispensing (including but not limited to, expiration of product) requiring an additional dispensing of the same drug, Provider may receive one dispensing fee for each new medication order or dispensed quantity limited by medical

CONFIDENTIAL AND PROPRIETARY

necessity. Provider must include within documentation of medical necessity for limited dispensing the diagnosis/clinical reason for the patient need from the Prescriber on the Prescriber's letterhead or prescription pad/form.

4.12 Dispensing Pharmacy NPI/NCPDP

Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification number or other identifiers to submit a claim (including a test claim) to Caremark.

1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;
2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;
3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;
4. Provider is not allowed to submit claims on behalf of another entity;
5. Provider must only submit claims it intends to dispense; and
6. Provider may not act on behalf of another entity regardless of ownership structure.

4.13 Prescriber Identification; Prescriptive Authority

Accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claims adjudication, clinical services, Plan Sponsor initiatives, and audits. A valid and active individual Prescriber National Provider Identifier (NPI) is required on all claims, and failure to submit a valid and active Prescriber NPI may result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI, DEA number or any other number or identifier (e.g. hospital, clinic, or pharmacy identification number) in the prescriber identification field which does not represent an individual Prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate submission clarification code (SCC) to bypass the reject.

4.14 Transaction Fees

Caremark charges network Providers, and Provider agrees to pay, transaction fees that represent pharmacy network management services Caremark provides to network Providers. For every single transaction Provider transmits to Caremark, Caremark may deduct such amounts for the transaction fee from amounts payable to Provider. A single transaction is defined as each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims adjudication system. Each transaction within a multi-claim transmission will be subject to individual transaction fees.

4.15 Transaction Submission Resolution Management Service Fees

Caremark charges network Providers, and Provider agrees to pay, fees for Caremark's resolution of transactions submitted by Provider, including but not limited to, rejected claim resolution, pharmacy compliance, and claims information quality improvement. The fee charged to Provider will be commensurate to the amount of resolution management services Caremark is required to expend based on Provider's claims submissions, as measured comparatively to all other Providers on a retrospective monthly basis. Caremark will determine how the fee will be measured and assessed, as communicated to network Providers in writing accordingly. The Transaction Submission Resolution Management Service Fee charged will be charged per transaction, and Provider has the opportunity to reduce the amount of fees charged based on the degree of resolution of transactions required by Caremark for Provider as compared to all other Providers. Caremark may deduct the fee amount from amounts payable to Provider. Providers will be charged for either a Transaction Fee (as described in section **4.14 Transaction Fees** of the Provider Manual) or a Transaction Submission Resolution Management Service Fee, but not both for the same transaction.

4.16 Electronic Submission, Reversal, and Processing Windows

Unless otherwise agreed in writing and to the extent consistent with applicable Law, all claims must be submitted electronically. Failure to submit a claim within ninety (90) days from the date of fill may result in non-payment of such claim to the extent consistent with applicable Law.

All prescriptions not received by an Eligible Person must be returned to stock and claim must be reversed within fourteen (14) days from original submission through the electronic claims system using data elements as defined

CONFIDENTIAL AND PROPRIETARY

by Caremark's payer sheets (found online at **www.caremark.com/pharminfo**) or as directed by Caremark.

Reversals and resubmits must occur within ninety (90) days of the claim's original submission date, or such other time period as communicated by Caremark or required by applicable Law. For reversals, Provider can reverse up to ninety (90) days from the date on which the claim was originally submitted, including Plan Sponsor-specific payment cycles. For Medicare Part D processing windows, refer to section **10. Medicare Part D** of the Provider Manual.

Except as otherwise required by applicable Law, or in the event of an urgent need to provide service to an Eligible Person while the claims system is unavailable (refer to section **4.18 Schedule of Claims Systems Maintenance** of the Provider Manual), Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (e.g., cartridge, CD-ROM, tape, batch or paper) unless prior written approval is received from Caremark or Plan Sponsor. Caremark charges a handling fee of $2.50 per claim in those situations in which Caremark or Plan Sponsor agree in writing to non-electronic submission or reversal of claims.

4.16.01 UCF Requirement

Caremark reserves the right to require Provider to submit claims via a UCF, along with all supporting documentation that Caremark may require to support the claim, including but not limited to, medical records and Eligible Person attestations, at Caremark's sole discretion.

4.17 Software Certification

Provider must utilize software certified by Caremark and adhere to the NCPDP standards in compliance with HIPAA. Provider must support NCPDP updates as requested from time to time by Caremark. Provider is responsible for and assumes all risk arising from or related to Provider's selection and use of its software. Provider must indemnify Caremark and its affiliates from and against any claim, cause of action, liability, loss, damage, cost, fines, charges and/or expenses arising from or related to Provider's selection and use of its software.

Caremark may provide reasonable technical support to assist Provider in complying with Caremark requirements and industry standards for submitting claims through the claims system. Provider may be assessed a fee by Caremark if Provider submits claims that are not in accordance with current requirements, industry standards or in compliance with government program requirements.

Provider must submit all claims with the software certification ID in field 110-AK. Provider must not release their software certification ID to be used by any other software or other user/entity. Any violation of this rule may result in a reject of the transaction as well as the assessment of an administration fee. Refer to section **7. Compliance Reviews** of the Provider Manual.

If Provider is not submitting claims in accordance with HIPAA-mandated data and/or standards, Caremark may reject the transaction and/or charge a minimum fee of $0.99 per transaction. In addition, Provider is required to provide Eligible Person(s) a bridge supply of medication(s) until such time occurs when Provider is compliant with HIPAA-mandated data and/or current NCPDP standard, and the claim(s) can be adjudicated.

Refer to the NCPDP standard at **www.ncpdp.org/Members/Standards-Lookup.aspx** Membership to NCPDP is required to view this information online.

4.18 Schedule of Claims Systems Maintenance

Maintenance of the claims systems may be scheduled between 11 p.m. and 6 a.m. Eastern Standard Time (EST) every Friday or Saturday as necessary. During the scheduled maintenance, Providers will receive the message, "HOST UNAVAILABLE." If this message displays, Providers must resubmit claims after maintenance is completed.

If maintenance is not needed, Providers will be able to submit claims as usual during those hours. If any other scheduled maintenance is required outside of the published hours listed above, Caremark may notify Provider in advance.

From time to time, unscheduled system maintenance or other circumstances may occur when the adjudication platform(s) may not be available to adjudicate claims for a limited time. At any time, a Provider may contact the Pharmacy Help Desk for assistance or information regarding any claim processing related question. Pharmacy Help Desk Representatives are available 24 hours a day, 7 days a week. Refer to section **1.04 Pharmacy Help Desk** of the Provider Manual.

Note: Providers are reminded that, pursuant to the Provider Agreement, Providers must render services unless professional judgment dictates otherwise.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

4.18.01 Additional Required Procedures

1. If the claims adjudication system indicates a host processing error or unexpected reject has occurred, Provider should attempt to resubmit within a few minutes. If the status continues to indicate a host processing error (downtime circumstance), Provider should hold the transaction and attempt to process it again within the next two hours.

   If two hours have elapsed and the same host processing error or unexpected reject continues to occur, call the Pharmacy Help Desk for additional information regarding system availability and other assistance that may be available at that time. The Pharmacy Help Desk is equipped to assist in guiding the pharmacy through the claim resubmission process when the system becomes available.

2. To ensure that each Eligible Person receives his or her covered prescription drugs, Provider must make reasonable attempts to obtain information necessary to fill a script.

   Provider is requested to serve the Eligible Person by establishing/confirming eligibility/coverage:

   a. If the Eligible Person is available, ask for the ID card. Call the Customer Care number on the ID card to verify eligibility, drug coverage, formulary status and associated Patient Pay Amount.

   b. If the Eligible Person is not available, call the Pharmacy Help Desk.

3. Provider should provide a bridge supply, typically covering three (3) days, for those Eligible Persons in urgent need of medication so that the Eligible Person is not delayed at the pharmacy counter during a system downtime event, or provide service to the Eligible Person and submit a Universal Claim Form (UCF) within the required timeframe.

4.19 Taxes

For purposes of this Section, the term "Provider Taxes" shall include any provider fees, assessments, sales taxes, transaction privilege taxes, occupation taxes or similar fees/taxes imposed by any federal, state or local governmental authority.

Provider is responsible for submitting requests for reimbursement/payment of Provider Taxes for claims requiring such inclusion at the time of the claims submission. In no event shall Caremark be responsible for any Provider Taxes or other liability that may be imposed on Provider. Provider shall be responsible for timely filing any reports or returns and for timely paying all Provider Taxes with the appropriate governmental authorities. Provider is responsible for submitting accurate and authorized claims for Provider Taxes though adjudication and providing support upon written request. Caremark is not responsible for confirming such Provider Tax amounts through adjudication. Reimbursement of Provider Tax is not confirmation or validation. Provider is responsible for any Caremark or Plan Sponsor losses due to incorrect Provider Taxes submitted for claim adjudication.

To the extent permitted under the terms of its agreement with the Plan Sponsor or as required by Law, Caremark agrees to seek reimbursement/payment from the Plan Sponsor for any timely and accurately submitted claim for Provider Taxes incurred by or imposed on Provider by any governmental authority on account of, or based upon, the provision of Pharmacy Services or Covered Items. Caremark is not responsible for correcting claims for Provider Taxes for which Provider failed to submit Provider Taxes.

An Eligible Person may be liable, in addition to any applicable copayment, coinsurance or deductible, for Provider Taxes, unless specifically prohibited under applicable Law; provided, however, that if the applicable governmental authority otherwise compensates Provider or makes Provider whole for any such Provider Taxes, Eligible Person shall have no obligation to reimburse Provider for the amount of Provider Taxes so compensated.

In no event does this section give Provider any additional rights than those allowed by Law.

CONFIDENTIAL AND PROPRIETARY

5. Clinical Programs, Services and Related Messages

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Provider must support all clinical programs and services and utilize software that will display all messages related to clinical programs and services and that provide for the recording of patient drug and medical information where utilized by Caremark and as allowed by applicable Law.

Subject to applicable Law, Provider must provide Caremark any and all reasonably available information that Caremark needs to perform such clinical programs and services, and conduct drug utilization review accordingly. Provider must act upon all messages related to clinical programs subject to professional judgment.

5.01 Drug Utilization Review

Inappropriate drug therapy can cause patient injury and can lead to additional health care costs. In an effort to reduce the number of situations where an Eligible Person may receive inappropriate drug therapy, Caremark implemented a concurrent Drug Utilization Review (DUR) program that detects a potential therapeutic problem at the point of service.

In order to ensure that Provider receives and acts upon all DUR messages, which appear in the claim response, Provider must adhere to the claims submission requirements outlined in section **4. Claims Submission** of the Provider Manual.

The functions of the DUR program are to:

- Analyze prescriptions submitted through Caremark
- Screen prescriptions for several types of therapeutic drug problems
- Serve as a clinical information service

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional judgment of the Provider or Prescriber. The Provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims system and for performing Pharmacy Services in each jurisdiction consistent with the scope of their respective licenses.

Additional information regarding DUR review controls for Medicare Part D claims may apply as specified by Caremark.

5.02 DUR Conflict Codes and Messaging

All DUR messages appear in the claim response. The Provider must view all screens necessary to receive the message detail and act upon all such messages subject to the professional judgment of Provider.

Provider will receive DUR messaging in a format consistent with its software vendor. Provider may need to consult with the software vendor for help with identifying or accessing DUR messages. Caremark, in accordance with current NCPDP standards, returns up to nine (9) DUR messages that can be received on the same claim and requires Provider to have the capability to accept up to nine (9) DUR messages on the same claim.

Refer to the NCPDP standard at **http://www.ncpdp.org/Members/Standards-Lookup.asp** Membership to NCPDP is required to view this information online.

5.03 Refill-Too-Soon or Excessive Utilization Reject

Provider must call the Pharmacy Help Desk if extenuating circumstances justify payment for a claim that was denied for excessive utilization (Refill-Too-Soon). Provider can enter Submission Clarification Codes (SCC) in field 420-DK to override a refill-too-soon reject for Eligible Persons without requiring a call to the Pharmacy Help Desk. Provider must document on the prescription hard copy or electronic prescription record the details of any situation requiring an override. Permission may vary by Plan Sponsor.

Examples of extenuating circumstances include:

- Lost or stolen prescriptions (SCC 04)
- Damaged prescriptions, dropped or broken prescription bottle containing liquid (SCC 04)

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

- Vacation supplies (SCC 03)
- Increase in dosing/therapy change (SCC 05)
- Circumstances such as natural disasters. Refer to section **4.09 Natural Disasters** of the Provider Manual.
- Extra supply for school or similar circumstances (e.g., rescue inhalers or epinephrine auto-injectors)

If you need assistance, call the Pharmacy Help Desk.

5.04 Drug-Drug Interaction Reject Program

The Drug-Drug Interaction Reject Program is a point-of-sale claim reject for selected high-risk drug combinations. The reject will occur if the current drug being submitted and another drug that was dispensed to the Eligible Person are one of the high-risk drug combinations included in the program.

When a claim is rejected for a high-risk drug-drug interaction, a standard drug-drug interaction warning message will be transmitted with the claim reject response. In addition, a secondary message will be transmitted that provides instructions regarding override options.

Depending on the types of overrides that the Caremark Plan Sponsor has authorized, one of the following override option messages will be transmitted:

1. **PPS Code REQD: <<Rejection Message>>**

   In this case, Provider may resubmit the claim with the indicated PPS code to override the reject, based on the professional judgment of Provider and in consultation with the Prescriber.

2. **PA REQD: <<Rejected Message>>**

   A secondary message will include the PA contact number

   In this case, a PA is required to override the reject. The message will provide further instructions on how to obtain an override.

Provider must contact the Prescriber to discuss the drug-drug interaction that has been identified for the current prescription based on the Eligible Person's other active drug therapy. If the Prescriber determines that the prescribed therapy is warranted despite the drug-drug interaction risk, or if the interacting drug has been discontinued, the Provider must pursue an override according to the instructions provided in the claim response message. Otherwise, Provider should obtain a new prescription for an alternative therapy.

5.05 Formularies

Plan Sponsor formularies determine how drugs are covered (e.g., preferred, non-preferred, excluded) for drug therapy selections. The final choice of specific drug selection for an Eligible Person rests solely with the Prescriber.

Provider must support all formulary initiatives and inform Eligible Persons when a non-formulary drug has been prescribed. Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider agrees that for all Plan Sponsors and Eligible Persons, therapeutic programs and formularies take precedence over any agreements or programs to which Provider is a party. Provider also agrees not to implement any substitution programs for Eligible Persons that are inconsistent with such therapeutic programs and formularies.

When a claim is submitted for a non-formulary drug and the Plan has a closed formulary, it may reject with:

Product Not on Formulary

or a similar message, which may include a customized drug alternative.

When a claim is submitted for a non-formulary drug and the Plan has an open formulary, the response may include the message:

NF! Form <<XXX>>

In many cases, the Patient Pay Amount may be higher for a non-formulary medication.

5.06 Prior Authorization

For some Plans, certain medications will require prior authorization. For prior authorization, the Prescriber is required to supply additional documentation to Caremark or the Plan Sponsor to determine whether certain criteria are met for the drug to be covered under the Plan.

Provider must follow Caremark and Plan Sponsor requirements for the prior authorization process, including but

CONFIDENTIAL AND PROPRIETARY

not limited to, obtaining a Prescriber's signature on a prior authorization form if a Prescriber signature is required. In no event may Provider represent itself as a Prescriber or a member of Prescriber's staff as part of the prior authorization process.

If a medication is designated for prior authorization, the claim may reject with the following or similar message:

PRIOR AUTHORIZATION REQUIRED
MD Call <<XXX-XXX-XXXX>>

In most cases, the claims system response will also provide the correct contact information in the subsequent message.

If in the Prescriber's professional judgment the drug is medically necessary, Prescriber will need to call the number provided in the claim message to initiate coverage.

For Aetna RXBIN 610502 only: If no contact number is provided in the messaging, Provider should contact the Prescriber and ask him or her to contact the Precertification Unit for precertification and medical exception requests. The Precertification Unit contact information for RXBIN 610502 is:

Fax: 1-800-408-2386
Phone: 1-800-414-2386
(Hours: Monday through Friday, 8 a.m. to 7 p.m. CT)

Provider must support all clinical programs and services and inform Eligible Persons when a drug designated for prior authorization has been prescribed. Provider must use its best efforts to contact the Prescriber to inform on prior authorization messaging.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

5.07 Managed Drug Limitations/Quantity vs. Time

Some Plan Sponsors implement managed drug limitations (MDL) or quantity vs. time (QVT) programs. MDL or QVT programs allow an Eligible Person to receive up to a set amount of medication per designated timeframe*.

If an Eligible Person presents a prescription for an amount greater than the set amount or has accumulated an amount greater than the set amount within the designated timeframe, the claim will reject with one of the following or similar messages:

PLAN LIMITS EXCEEDED <<# of quantity left>>*
or
MAX QUANTITY XX PER XX DAYS

If there is a remaining quantity within the designated look-back period and within the Plan parameters, Provider can resubmit the claim after the appropriate amount of time has passed using an amount equal to or less than the amount stated in the message.

*If prescribed quantity exceeds the plan parameters, call the Pharmacy Help Desk to verify if Prior Authorization is available.

5.08 Dose Optimization

Dose Optimization is a point-of-service claim reject for selected drugs where multiple daily doses of the drug are prescribed and where a higher strength single daily dose is available and clinically appropriate (e.g., Lipitor® 10 mg 2 tabs/day could be optimized to Lipitor 20 mg 1 tab/day).

For a drug subject to Dose Optimization, the claim will reject with the following or similar message:

MISSING/INVALID DAYS SUPPLY <<use higher strength one per day>>

In the event there is an override option, the subsequent message will list next steps:

CALL HELP DESK <<or a specific Plan Sponsor telephone number>>

Provider must contact Prescriber for a new prescription of a higher strength at the once-daily dosing regimen, then resubmit the claim with the higher strength. If this cannot or should not be done based on the professional judgment of Provider or the Prescriber is unwilling to change the prescription, review Provider messaging for further instructions.

CONFIDENTIAL AND PROPRIETARY

5.09 Step Therapy

Step Therapy requires that a set quantity of certain medication(s) be in an Eligible Person's drug history within a given timeframe before a claim will adjudicate for another drug in a specified therapeutic category. If Provider submits a claim for a Step Therapy and the conditions are not met, the claim will reject with a message similar to the below:

NDC NOT COVERED SUBOPTIMAL REGIMEN
USE <<XXXX>> 1ST
MD CALL <<XXX-XXX-XXXX>> FOR PRIOR AUTHORIZATION

If Provider receives this message, discuss the alternatives with the Prescriber. If in the Prescriber's professional judgment the originally prescribed drug is medically necessary, Prescriber will need to initiate a request for prior authorization.

A qualification period may also be in place for the targeted drug. Once an Eligible Person satisfies the Step Therapy requirements, he or she may obtain the targeted drug for a specific time period (e.g., 60 days). When the qualification period has been exceeded, the Eligible Person must requalify for the prescribed drug by repeating the Step Therapy requirements.

Some Plan Sponsors may choose to give Eligible Persons additional flexibility in choosing not to follow the recommended Step Therapy. A copayment option may be available for some Eligible Persons which allows them to obtain the originally prescribed drug without requiring the Prescriber to call for an override. The Eligible Person may make the decision and obtain the original drug simply by paying a higher copayment.

If this option is in place, claims not meeting the required conditions will reject with the following or similar message:

NDC NOT COVERED SUBOPTIMAL REGIMEN
COPAY = <<XX.XX>>
TO ACCEPT, SUBMIT PA - 99999999999

If you receive this message, discuss the alternatives with the Eligible Person and advise that the originally prescribed drug can be obtained by paying the copayment indicated in the message. If the Eligible Person accepts the copayment, resubmit the claim to Caremark using PA code 99999999999.

5.10 Plan Sponsor Programs

Provider must participate in Plan Sponsor programs as requested by Caremark and/or Plan Sponsors. Provider must maintain internal procedures for compliance with such programs and furnish an outline of such procedures to Caremark upon request. Providers are encouraged to engage in and support Plan Sponsor electronic prescribing initiatives in accordance with applicable Law.

5.11 Federal Regulatory Quality Assurance Programs

Caremark recommends Provider adhere to Federal Regulatory Quality Assurance Programs such as, but not limited to:

- Medication Errors Reporting Program (MERP) through the Institute for Safe Medication Practices (ISMP); more information can be found on the website **www.ISMP.org**
- MedWatch program through the Food & Drug Administration (FDA); more information can be found by calling **1-800-FDA-1088** or on the web-site **www.FDA.gov**

5.12 Clinical Studies/Trials

To the extent Provider participates, or is involved, in a study, directly and indirectly, for which Provider submits claims to Caremark for adjudication and payment for prescriptions obtained by study participants (e.g., Eligible Persons), Provider must obtain prior written approval from Caremark. If prior Caremark written approval is not obtained, claims submitted to Caremark for study participants are subject to chargeback. Caremark's review of the study will be administrative in nature to determine Provider's compliance with the terms of the Provider Agreement, such as but not limited to, determining whether any compensation paid to study participants has the effect of waiving the participant's Patient Pay Amounts under the Plan (which Provider has an obligation to collect in accordance with the Provider Manual – see section **3.03.01 Collection of Patient Pay Amounts**) or whether study premises result in changes in drug regimens that have the effect of increasing Plan Sponsor costs.

Provider requests for approval must include all of the following details:

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

- Study overview
  - Study duration
  - Number of subjects
  - Study locations
  - Medications involved
  - Costs for participants and Plan Sponsors
- Details of insurance for study
- Credentials of study investigators
- Source of funding for the study
- Consideration paid to all study participants, providers, and prescribers
- Copies of all documentation submitted to ethics committees, review boards, or governmental agencies
- Disclosure of any potential conflicts of interest

Requests for approval can be sent to the following address:

CVS Caremark
ATTN: Pharmacy IRB Study Review
9501 E. Shea Boulevard, MC-020
Scottsdale, AZ 85260

The requirements of this section do not apply to FDA-approved clinical trials.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

6. Network Participation and Payment

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Caremark, on its own behalf, or on behalf of a Plan Sponsor, reserves the right to limit Provider's participation in a network to certain Plan Sponsors based on Plan Sponsor network design or contractual rights to determine network participation, including but not limited to, suspension or termination of the Agreement upon a determination by a Plan Sponsor in their sole discretion that Provider has not performed satisfactorily, unless otherwise precluded by applicable Law.

Caremark will reimburse Providers for Pharmacy Services for Covered Services provided as set forth in the Provider Agreement, including any amendments, Network Enrollment Form, exhibits and this Provider Manual. Even if Provider has not signed a rate schedule, Provider is deemed to have accepted participation and the reimbursement rates in any Caremark or Plan Sponsor network in which Provider submits a claim for an Eligible Person in that network. Notwithstanding anything to the contrary in the Agreement, by participating in a Caremark network, Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Agreement unless professional judgment dictates otherwise; provided that Caremark, or Caremark on behalf of a Plan Sponsor, reserves the right to limit Provider's participation in a network to certain Plan Sponsors based upon Plan Sponsor network design.

Plan Sponsors may make determination about network participation.

Caremark may from time to time enter into an arrangement with a plan sponsor ("Other Entity") pursuant to which Provider's Provider Agreement (including reimbursements terms and schedules) with Caremark will be utilized by such Other Entity and such Other Entity's pharmacy benefit manager ("Other PBM") on the Other PBM's adjudication platform, as communicated by Caremark. Provider agrees to cooperate with Caremark, Other Entity, and Other PBM as needed to support such arrangement.

6.01 Provider Payment

Notwithstanding any other provision in the Provider Agreement, in the event of a conflict between the reimbursement rate indicated through the claims adjudication system and a Network Enrollment Form or addendum or any other agreement, the claims adjudication system reimbursement rate will apply provided there is no error in the claims adjudication system resulting in overpayment to Provider or to Eligible Person.

6.02 Reimbursement

Notwithstanding any other provision in the Provider Agreement, claims (excluding compounded medications) submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network may be reimbursed at the lower of:

- Price Type plus an applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee less the applicable Patient Pay Amount (or if applicable Price Type is unavailable for a given drug, Caremark will pay Provider based upon Average Wholesale Price (AWP) minus the applicable AWP Discount plus the applicable Dispensing Fee minus the applicable Patient Pay Amount);
- Maximum Allowable Cost (MAC) plus the applicable Dispensing Fee less the applicable Patient Pay Amount;
- Ingredient cost submitted by Provider plus the applicable Dispensing Fee less the applicable Patient Pay Amount;
- Provider's U&C price less the applicable Patient Pay Amount; or
- Provider's submitted "gross amount due" (as defined by current NCPDP Industry Standards) less the applicable Patient Pay Amount.

Reimbursement will be set forth in a Network Enrollment Form, network addendum, or transmitted online via the adjudication claims adjudication system.

Compounded medications submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of:

- Ingredient cost submitted minus applicable Patient Pay Amount plus Dispensing Fee plus applicable Level of Effort (if submitted) amount (provided Provider accurately submits the ingredient cost submitted in accordance with the Provider Manual);

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

- Provider's U&C price less the applicable Patient Pay Amount;
- Plan Sponsor-specific reimbursement less the applicable Patient Pay Amount; or
- Provider's submitted "gross amount due" (as defined by current NCPDP Industry Standards) less the applicable Patient Pay Amount.

Unless otherwise required by a Plan, Provider may retain the differential between Eligible Person's Patient Pay Amount and Provider's contracted reimbursement amount with Caremark.

6.03 Changes to AWP

In the event Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) discontinues the reporting of Average Wholesale Price (AWP) or changes the manner in which AWP is calculated, then Caremark reserves the right to modify the pricing terms of the Provider Agreement, notwithstanding any other provision in the Provider Agreement. Such modification may include:

- Modification of the AWP unit price reported by Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) by applying the Wholesale Average Cost (WAC) Mark-Up factor (in use before the effective date of a change in the calculation of AWP) to the WAC unit price reported by Medi-Span ("Pre-Settlement AWP Discount");
- Utilization of a modified AWP Discount ("Post-Settlement AWP Discount"); and/or
- Utilization of alternate Price Type other than AWP.

Nothing herein shall limit Caremark's rights and abilities to establish additional networks at reimbursement terms as determined by Caremark.

6.04 Maximum Allowable Cost

Maximum Allowable Cost is a commonly used tool to control drug costs by establishing a fair but competitive unit price generally at a product level, regardless of supplier. MAC pricing incentivizes pharmacies to buy generic products as cheaply as possible, including volume discounts, in order to keep overall prices down for patients and health plans. Caremark does not have visibility to individual pharmacy arrangement with wholesalers; however, it is generally known in the industry that pharmacies do receive purchase discounts and rebates. It is not possible for Caremark to know what every pharmacy pays for every drug; however, Caremark may utilize aggregate information from wholesalers and third-party sources in order to establish MAC prices and, because MAC prices are reviewed continuously and updated frequently, our MAC prices reflect our best understanding of the marketplace pricing and product availability.

Caremark determines Maximum Allowable Cost generally at a product level for generic and multi-source brand products. This determination includes a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), MAC lists published by CMS, National Drug Acquisition Cost (NADAC) published by CMS, Predictive Acquisition Cost (PAC) developed by Glass Box Analytics, and if available, wholesalers and retail pharmacies. Caremark may update its MAC pricing methodology and/or use alternative pricing sources, at its discretion. MAC prices are subject to change, which can occur at least on a weekly basis and are based on marketplace trends and dynamics, and price fluctuations. MAC price lists are Caremark confidential and proprietary information.

For MAC paid claim appeals and as in accordance with Law, as applicable, Provider may appeal the MAC price paid by Caremark at a product level. Submission of a paid claim by Provider is required for this process. Provider must notify Caremark within the period required by applicable Law, and provide all of the following information: date of fill, prescription number, Provider name, Pharmacy NCPDP/NABP number, chain/affiliation code, phone number, email address, and RXBIN. Chain and Pharmacy Services Administration Organization (PSAO) pharmacies will submit MAC paid claim appeals through their respective chain or PSAO headquarters, which will then submit appropriate data to Caremark. Independent pharmacies (those which are not affiliated with a PSAO for contracting purposes) will submit MAC paid claim appeals using the Caremark Pharmacy Portal at **www.rxservices.cvscaremark.com**.

Provider may access the Caremark Pharmacy Portal to obtain current MAC prices and upcoming MAC prices based on Caremark's MAC price update schedule, including for Medicare Part D plans. To locate current or upcoming MAC price information, utilize the "MAC Price Look Up" feature of the Pharmacy Portal available through a secure website: **www.rxservices.cvscaremark.com**. Providers can also request a MAC list by clicking on the "Pharmacists & Medical Professionals" link located at **caremark.com** and submitting a Pharmacy MAC List Request form to **MACPRICE@cvscaremark.com**.

CONFIDENTIAL AND PROPRIETARY

6.05 Eligible Person Fees and Amounts

Unless otherwise authorized by Caremark in writing, Provider must collect at the point of service from Eligible Persons any administrative, transaction, access or other types of such fees or amounts, when applicable. The total amount to collect from the Eligible Person for providing Pharmacy Services, including any such fee or amount, will be communicated through the claims adjudication system and may be debited from Provider's claims payment account. Refer to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual.

6.06 Claims Payment and Other Fees

6.06.01 Remittance Advices

Provider will receive a remittance advice for claim transactions within a payment cycle. Remittance reports may be distributed by mail, posted on one of the Caremark websites, or be available by other electronic means. Caremark payments to Provider may reflect adjustments for claims reversals, resubmissions or amounts owed by Provider to a Plan Sponsor under a provider agreement between Provider and a Plan Sponsor.

If Provider or authorized agent of Provider requires additional remittance reports, the following service fees apply:

SERVICE TYPE	MINIMUM SERVICE FEE
Paper remittance reprint	$150/NPI/cycle
Internet, network data mover (NDM), data recreate, etc.	$500/item/NPI/cycle
Research fee associated with no change in reimbursement	$150/hour
Documentation request/research	$150/hour
Check trace/stop payment	$150/check
EFT Bank Account change	$150/NPI
835 Vendor change	$150/NPI
Provider claim adjustment request	$10/claim

If Provider receives remittance reports electronically, Provider must adhere to HIPAA regulations which mandate ASCX12N 835 and updates as required. Providers with questions regarding the testing, creation and receipt of the 835 data file should contact Caremark at the following address:

Caremark
Attn: Finance MC019
9501 East Shea Boulevard
Scottsdale, AZ 85260

All adjudicated claims detailed in a remittance advice are paid to Provider at one hundred percent (100%) of the reimbursement rate as in accordance with the Provider Agreement, pending audit by Caremark. All claims are subject to completion of audit. Prior to reimbursement, Caremark reserves the right to require additional documentation by Provider to validate a claim(s), including but not limited to, submission of medical records and Eligible Persons attestations.

6.06.02 Disputed Claims

Provider is required to review remittance advices received from Caremark to verify their accuracy. Notwithstanding any provision in the Provider Agreement, if Provider disputes a claim due to failure to pay the contractual reimbursement amount, Provider must notify Caremark in writing within one hundred eighty (180) days from date of fill, or within a longer period required by applicable Law, listing details of the disputed claim payment. Provider's notification of a disputed claim must include the date of fill, prescription number, Eligible Person ID number and Provider NPI or NCPDP. Provider should include a copy of the remittance advice, if possible, and must provide the specific reason for the dispute. If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle, except for any overpayments made to Provider. Notifications may be mailed to:

CONFIDENTIAL AND PROPRIETARY

Caremark
Attn: Network Services, MC023
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark may charge a research fee of $150/hour for any request in which Provider was accurately reimbursed. Caremark is not obligated to reimburse Provider for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim.

Refer to section **6.04 Maximum Allowable Cost** of the Provider Manual for information regarding MAC appeals.

6.06.03 Claims Adjustment

Notwithstanding any provision in the Provider Agreement, if Provider requests an adjustment to a claim (e.g., to correct claims information submitted by Provider), Provider must notify Caremark in writing within one hundred eighty (180) days from date of fill, or within a longer period required by applicable Law. If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle.

Claims adjustment requests must list the date of fill, prescription number, Eligible Person ID number, Provider NPI or NCPDP, Refill Code and TCN ID, the specific reason for the claim adjustment requested, and the information necessary to make the requested adjustment. To request a copy of the Claims Adjustment template, or for questions regarding data submission, contact the Pharmacy Help Desk. Claims adjustment requests may be mailed to:

Caremark
Attn: Adjustment Services, Pharmacy Corrections, NBT-4
9501 East Shea Boulevard
Scottsdale, AZ 85260

Providers may be required to submit claim adjustment requests electronically.

6.07 Recoupment and Adjustments

Caremark is not obligated to reimburse Provider for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider. Refer to section **8. Professional Audits** of the Provider Manual for additional information on audits. Provider agrees and acknowledges that Caremark may, to the fullest extent allowed by law, recoup, charge back, offset, withhold or otherwise adjust payments due to Provider or any affiliate of Provider for claims improperly submitted by Provider or paid by Caremark.

6.08 Workers' Compensation

Notwithstanding anything to the contrary, Caremark may utilize non-Medicare Part D networks for workers' compensation claims. To the extent Caremark utilizes a non-Medicare Part D network for workers' compensation claims and Provider participates in such network, the reimbursement for such workers' compensation claim shall be as reflected in the applicable non-Medicare Part D network addendum (to the extent such network addendum does not conflict with the claims adjudication system) and the following additional terms will apply:

- Section 4.3 or Schedule A, whichever is applicable, of the Provider Agreement, is amended to add "(vi) the reimbursement amount prescribed by a state law for workers' compensation (unless otherwise permitted by such state law), if applicable for workers' compensation claims reimbursement."
- Caremark may utilize a third-party vendor for certain portions of Caremark's network services, including but not limited to, claims processing and pharmacy payments for workers' compensation claims.

6.09 Provider Suspension

Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider if required by applicable Law, or if Caremark has reason to believe Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; (4) is a breach of the Provider Agreement; (5) alters the dispensing patterns of the Provider sufficiently to indicate potential

CONFIDENTIAL AND PROPRIETARY

fraud, waste or abuse; or (6) constitutes potential fraud, waste, or abuse. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement.

If Caremark is unable to reach Provider through any method provided during the enrollment or credentialing process (e.g., mail, telephone, fax, etc.), Caremark reserves the right to immediately suspend Provider. Caremark may elect to perform re-credentialing and/or audit, and may leave the suspension in place until such time as these processes are complete.

6.10 Directories

Caremark and Plan Sponsors may list Provider in directories and databases for distribution to, and use by, Eligible Persons, Plan Sponsors and others as Caremark or a Plan Sponsor determines are necessary. Additionally, Caremark may display Provider, if applicable, in preferred provider performance initiatives in paper, web-based directories, or Plan Sponsor reporting. Refer to section **14.01 Advertising and Trademarks** of the Provider Manual.

CVS Caremark has a requirement to maintain accurate directories of Dispensing Pharmacies so that patients can quickly find pharmacies to fill their prescriptions. Therefore, Providers that have no dispensing activity of Covered Items for a period of time may be immediately removed from the network as determined at CVS Caremark's sole discretion.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

7. Compliance Reviews

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

In order to determine Provider's compliance with the terms of the Provider Agreement and applicable Law, Caremark has the right to examine Provider records (and obtain a copy as necessary) and pharmacy practices as Caremark reasonably determines are necessary. Provider must comply with such examination within the timeframe indicated by Caremark on the notice of the examination and without charge to Caremark. Caremark conducts examinations in accordance with the Provider Agreement and applicable Law and Caremark may, in accordance with applicable Law, refer Provider's non-compliance to local/state/federal investigative and law enforcement agencies as appropriate.

Submission of false or misleading records and documentation may result in chargeback for all claims reviewed and any other remedies available to Caremark, including but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies. If clarification of documentation is requested by Caremark, Provider is required to submit unaltered original documentation.

Examples of Compliance Reviews include:

- Concurrent/Daily Review
- Medicare/Medicaid Review
- Telephone or Facsimile Inquiries
- Provider Tax determinations and legal basis for calculation of such Provider Tax

To the extent consistent with applicable Law, non-compliance of the Agreement includes, but is not limited to,

1. Submitting incorrect data in the claims submission;
2. Failure to provide documents requested by Caremark pursuant to the Agreement;
3. Refusing to accept an Identification Card for an Eligible Person;
4. Refusing to service an Eligible Person because of the reimbursement rate;
5. Failing to submit a claim for a Covered Item for an Eligible Person;
6. Disclosing Confidential Caremark Information;
7. Submitting the incorrect applicable DAW code;
8. Submitting an inaccurate U&C;
9. Non-adherence to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual;
10. Not dispensing an emergency supply of a Covered Item to an Eligible Person as required by applicable Law; and
11. Non-adherence to section **4.17 Software Certification** of the Provider Manual.

Provider must not separate cash and third-party prescription business or own, operate, or affiliate with a non-participating Provider to manipulate claims pricing for inappropriate financial gain.

7.01 Non-Compliance Fees

Caremark may find it necessary to perform reviews on claims prior to payment. Provider agrees that Caremark may review submitted claims and charge a reasonable amount to the Provider consistent with the resources required to perform the review. These reviews may be performed on all claims submitted by the Provider and may include, but not be limited to, consulting with the Prescriber or patient; review of copayment collection evidence, original prescription, prior authorization documentation, etc.; and other reviews to confirm compliance with the Provider Manual and Applicable Law.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Caremark may assess against Provider a $375 administration fee for an initial occurrence of non-compliance or for each non-compliant submitted claim, increasing in $375 increments for subsequent non-compliant events (e.g., $375, $750, $1,125). Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for charges for non-compliance pursuant to the Provider Agreement or any Third-Party Agreement, or claims submitted in breach of the Agreement.

Provider is liable for all fees, interest, penalties, damages, withholds, judgments, financial obligations, or other charges imposed upon Caremark as a result in whole or in part from Provider's non-compliance or omissions of any act or responsibility assumed by Provider under the Agreement.

Caremark's rights under this section survive the termination of the Provider Agreement.

7.02 Additional Information Regarding Compliance Reviews

1. Provider must be reachable by Caremark based on the contact information (as updated) that Provider specified to Caremark as part of enrollment or credentialing. It is essential that Provider keep contact information up to date to ensure reminders and other important communications are received. Refer to section **2.06 Notification to Caremark** of the Provider Manual.
2. Documents and records subject to review include, but are not limited to the following:
    a. Prescription hard copies – scanned images must include both the front and back images of the original and the original must be retained and retrieved if requested
    b. Signature logs
    c. Delivery logs with tracking information for mailed or home/business delivered prescriptions
    d. Prescription label and dispensing label
    e. Compound Record and subformulations, which must include at minimum, NDCs of items used, lot numbers, expiration dates, compounding instruction, final compounded dosage form, signature of verifying pharmacist and certificate of analysis. Provider must keep Compound Records for the same time period as required for prescription hard copies. Refer to section **4. Claims Submission** of the Provider Manual
    f. Evidence of copay collection including proof of financial transaction. Refer to section **3. Pharmacy Services and Standards** of the Provider Manual
    g. Methodology used to determine appropriate beyond-use date
3. For claim submission requirements refer to section **4. Claims Submission** of the Provider Manual.
4. For specific drug submission requirements, refer to **Appendix D – Drug Submission Requirements** of the Provider Manual. Audit Tip Communications may be sent to Providers periodically to advise of drug submission requirement updates.
5. For additional claim processing information, refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.
6. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

8. Professional Audits

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

As a service to its Plan Sponsors and Eligible Persons, and to educate Providers in complying with the Provider Agreement, Caremark engages in an on-going audit program. The audit program also serves to protect against fraud, waste, and abuse. As part of this program, Caremark may conduct reviews and audits of claims prior to payment to ensure compliance with the Provider Agreement. Caremark may also audit the claim post-payment. The positive adjudication of any claim does not limit or preclude Caremark's ability to review or otherwise audit or recoup that claim.

8.01 Types of Audits

Audits may be conducted in the form of an on-site audit, investigational audit, or desktop audit. There are other compliance reviews that Caremark may conduct as described in section **7. Compliance Reviews** of the Provider Manual.

8.01.01 On-site Audits

Caremark performs routine on-site audits. Caremark as a routine business practice may notify Provider two (2) weeks prior to a scheduled audit date or as required by applicable Law. For an on-site audit, auditors will generally review specific documents and records related to claims paid to Provider by Caremark during the previous twenty-four (24) months, unless otherwise required by applicable Law.

8.01.02 Investigational Audits

For an investigational audit, Provider is contacted via telephone, facsimile, or through the mail, and asked to provide specific documents and records related to claims paid to Provider or Eligible Person by Caremark during a specified period. Documentation may include, but not be limited to, prescription hard copies, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications.

8.01.03 Desktop Audits

For a desktop audit, Provider is contacted via telephone, facsimile, or through the mail to satisfy records and documentation requirements for limited reviews (e.g., MEDIC requests, CMS audits, Plan Sponsor audit inquiries, and compliance audits). Records and documentation requested must be provided in a timely manner not to exceed ten (10) days or according to applicable Law. Failure to submit all the required documentation by the due date may result in claim reversal, non-compliance fees, submission of a Corrective Action Plan (CAP), or potential termination from the provider network.

8.01.04 Audits by Government Agencies

Provider agrees that state and federal government agencies and their respective duly authorized representatives or designees, including but not limited to, the Department of Health and Human Services and CMS (collectively "Government Auditors") have the right, for the period allowed by Law, to review, audit, examine, and reproduce Provider's books, records, prescription records, and other documentation, to the extent such Government Agency Audit is required by Law or under the asserted authority of the Government Auditor ("Government Agency Audit"), and Provider will cooperate in good faith with such Government Agency Audit. To the extent the Government Auditor requests either of Caremark's or Plan Sponsor's Provider books, records, prescription records, and other documentation as part of the Government Agency Audit, Provider agrees that it will provide such Provider's books, records, prescription records, and other documentation to Caremark within the timeframe as notified by Caremark based upon the Government Agency Audit, and agrees that Caremark has the right to produce to such Provider's books, records, prescription records, and other documentation in Caremark's possession.

8.02 Professional Audits Rights

During the term of the Provider Agreement and for two (2) years following the termination of the Provider Agreement (or such time permitted under applicable Law), Caremark has the right to audit Provider's records and documents, facility and practices as Caremark reasonably determines are necessary to evaluate Provider's compliance with the

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Provider Agreement and applicable Law. Caremark's audit may cover any claim submitted by Provider or Eligible Person to Caremark or Plan Sponsor for adjudication (regardless of the method of submission), claims for Covered Items, and U&C submissions. To the extent allowed by Law, if there is a conflict between the Provider Manual and applicable Law with respect to an audit of Provider, the audit is subject to the stricter provision.

Nothing in this **Professional Audits** section prohibits Caremark from conducting an audit of Provider that does not follow the established audit procedures set forth in this **Professional Audits** section to determine Provider's compliance with the terms of the Agreement, but in all cases compliant with applicable Law. Refer to section **7. Compliance Reviews** of the Provider Manual for other rights.

Unless unusual circumstances exist, Caremark will schedule an audit in advance and work with Provider to accommodate reasonable schedule change requests made prior to the audit date to a mutually agreeable time. Notice of an audit may be communicated to Provider via facsimile, telephone, or mail.

Throughout the audit process:

- Provider is expected to be an active participant to ensure audit findings are accurate. Provider may designate an employee to facilitate the audit on behalf of Provider.
- Provider must provide the Caremark auditor with a clutter-free work area that does not disrupt the provision of Pharmacy Services, but with ease of access to records and documents required for the audit.
- Provider must maintain proper staffing during the audit to ensure that Provider is reasonably available for questions and the retrieval of records. If possible and requested by Provider, the Caremark auditor will wait a reasonable amount of time (10-15 minutes) while Provider locates any missing records and documents not found during the course of the audit.
- Provider must provide access to a Plan Sponsor (and its representatives or agents) to examine, audit, and copy Provider records and documents pursuant to its authority under contract with Caremark or by applicable Law.

Provider authorizes Caremark to release Provider's information, records, and documents to governmental authorities (and their agents), Plan Sponsors, and wholesalers upon request. Refer to section **8.01.04 Audits by Government Agencies** of the Provider Manual. Caremark reserves its rights under section **14.03 Confidentiality** of the Provider Manual.

If the Caremark auditor is denied access to Provider's records, documents, or facility, Provider is deemed non-compliant. Caremark has the right to recoup one hundred percent (100%) of the amount for the claims in question, with such amount becoming immediately due and owing to Caremark. Caremark has the right to offset the amounts due against any amount due to Provider. Caremark may also exercise all remedies available to it, including but not limited to, payment suspension (in accordance with the terms of the Provider Manual) until the audit is completed or termination of the Agreement. In addition to other remedies, Caremark reserves the right to charge Provider for the costs of travel and expenses associated with the audit and additional resources needed to address audit non-compliance.

Caremark audits do not employ extrapolation unless required under applicable Law.

Provider must notify Caremark in the event of a change in the pharmacy's physical location prior to the change. Refer to section **2.06 Notification to Caremark** of the Provider Manual.

8.03 Documents and Records Production Related to Audits

Provider must provide Caremark with all requested documents and records as Caremark reasonably determines are necessary to evaluate Provider's compliance with the terms of the Provider Agreement and applicable Law, and Provider must fully comply with such requests, including the delivery of all requested documents and records to Caremark by the specified due date and without charge to Caremark; if Provider fails to provide requested documents and records, the entire amount of the paid claim for which documents and records were not provided are due and owing. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date.

Submission of false or misleading records and documentation may result in chargeback for all claims audited and any other remedies available to Caremark, including but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies. If clarification of documentation is requested by Caremark, Provider is required to submit unaltered original documentation.

Documents and records must be readily retrievable at the Dispensing Pharmacy.

Caremark reserves the right to not consider Provider actions (and documentation of such actions) that take place

CONFIDENTIAL AND PROPRIETARY

after Provider is notified of an audit as a demonstration of compliance with the Agreement. Refer also to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual.

Provider's failure to comply with document and records requests as required under the Agreement is a breach of the Agreement and is subject to remedies available to Caremark including termination of the Agreement.

8.04 Documents and Records Subject to Audit

Documents and records subject to audit include, but are not limited to, the following:

- Prescription hard copies - Scanned images must include both the front and back images of the prescription hard copy; and the prescription hard copy must be retained and retrieved if requested. Prescription hard copies or scanned images of prescription hard copies must be legible by Caremark
- Signature logs
- Delivery logs with tracking information for mailed or home/business delivered prescriptions
- Daily prescription logs
- Wholesaler, manufacturer and distributor invoices (with NDC, drug names, quantity, package size, etc.)
- Transaction Statement, Transaction History, and Transaction Information and Documentation as defined in section **8.05 Supply of Covered Items; Purchase Invoices** of the Provider Manual
- Refill information
- Prescriber information
- Patient profiles/Prescriber orders
- Records to validate U&C
- Prescription label and dispensing label
- Provider system report of Pharmacy Services reversed, returned to stock, or not dispensed with confirmation of reversal of the claim submission
- Recorded diagnosis on prescription hard copy or maintained in the computer system for all Medicare Part B Pharmacy Services dispensed under a Medicare Part D plan
- Record of Eligible Person location (e.g., skilled nursing facility, assisted living facility) when claim is dispensed
- Records of transfer/sale between providers of drugs and devices used for Pharmacy Services
- Records of prescription transfers, including evidence of Eligible Person's express permission to Provider to transfer his or her prescription to another pharmacy
- Medication pricing brochures for cash customers (e.g., paper pamphlet, promotional signage, internet listing)
- Patient consent and administration record of vaccine claims (combination vaccine/administration)
- Evidence of copay collection including proof of financial transaction [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash]. If the Patient Pay Amount is reduced due to a coordination of benefits, Provider must provide evidence of the claim adjudication to the secondary payer
- Documents pertaining to individualized determination of financial need or exhaustion of reasonable Patient Pay Amount collection efforts. Refer to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual
- Proof of completion of annual Medicare Part D FWA training and General Compliance Training (GCT)
- Verification that Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **2.11 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual
- Prescription record documentation for Medicare Part D Enrollees with diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD)
- Signed Prescriber or patient attestation legitimizing the dispensing of the prescription if a prescription hard copy, medication order, patient signature log or patient delivery log is not retrievable. Prescriber attestations must be written on the Prescriber's business letterhead or on the Prescriber's prescription. Attestations provided by the Prescriber must clearly indicate the source of the attestation (i.e., clearly visible fax signature that the attestation originated from the Prescriber's office or Prescriber's stamp on the attestation)

CONFIDENTIAL AND PROPRIETARY

- All records acquired in the purchase of a pharmacy or in the purchase of pharmacy files
- Documentation substantiating transmission of submission clarification codes (SCC) or override codes
- Evidence of verification of legitimate Prescriber/patient relationship if Provider knows or reasonably should know that there is not a legitimate Prescriber/patient relationship
- Collaborative practice agreement(s)
- Credit Card Merchant Account Report including evidence of settlement and payment through bank records
- Policies and procedures related to all Provider operations, including but not limited to, collection of Patient Pay Amounts and inventory controls
- Documents to evidence that Provider is compliant with their own policies and procedures and/or corrective action plan
- Any document deemed necessary by Caremark to determine Network Provider's compliance with any terms and conditions set forth within this Provider Manual
- Refer to section **7.02 Additional Information Regarding Compliance Reviews** of the Provider Manual for required Multi-Ingredient Compound Documents

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 C.F.R. 164.502 and 45 C.F.R. 154.501). Provider further acknowledges that in order to receive payment from Caremark, Provider is required to allow Caremark to conduct audits of its prescription and other pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws. Additionally, Provider recognizes that Caremark audit staff may be exposed to or otherwise become aware of certain confidential, protected, and individually identifiable health information of patients who are not Eligible Persons during the course of the audit review, and that such disclosures by Provider to Caremark are incidental to the payment disclosures and are therefore permitted by HIPAA under 45 C.F.R. 164.502(a)(iii) provided that reasonable safeguards are implemented by Provider to limit such incidental disclosures. Caremark will maintain confidentiality of this information and will not disclose, publish or otherwise reveal any of this confidential information except as necessary to conduct its audit pursuant to applicable Law.

8.05 Supply of Covered Items; Purchase Invoices

All Covered Items used by Provider to fill prescriptions or otherwise meet requests of Eligible Persons must be sourced from an Authorized Trading Partner [which includes manufacturers, distributors, wholesalers, and other pharmacies and as defined under the Drug Supply Chain Security Act 21 U.S.C.A § 360eee ("DSCSA")] that is subject to regulatory oversight and duly licensed under all applicable Law, including but not limited to, the Food and Drug Administration, Drug Enforcement Administration and state Boards of Pharmacy. For those Covered Items that are regulated by the DSCSA and any regulations promulgated under the DSCSA, Provider must maintain the Transaction Statement, Transaction History, and Transaction Information that it receives from the Authorized Trading Partner as set forth in this section.

For those Covered Items for which a Transaction Statement, Transaction History and Transaction Information are not required by the DSCSA, Provider must maintain records of the exact quantities purchased, name of the Authorized Trading Partner, Covered Item name(s), NDC, date(s) of purchase, and proof of payment [e.g. copies of credit card receipts, canceled checks (front AND back)] (collectively "Documentation"). Unless permitted by applicable Law, Provider must not use foreign-sourced Covered Items, samples, returned, recalled, expired, or otherwise "suspect", as defined below, Covered Items to dispense to or otherwise provide for Eligible Persons under the Provider Agreement. For diabetic testing supplies, Provider must use diabetic products that have been sourced either from within the manufacturer's authorized distribution channel or purchased directly from the manufacturer.

It is the sole responsibility of Provider to ensure that all wholesalers, manufacturers, distributors, or other pharmacies that Provider utilizes to source Provider's purchases of Covered Items are Authorized Trading Partners, or in the case of diabetic test strips, sourced from within the manufacturer's authorized distribution network. As a means to identify the authorized distribution network, Provider shall search the manufacturer's website and print the listing of authorized distributors from the manufacturer's website and maintain this document in Provider's records to demonstrate compliance. Provider must check the authorized manufacturer's website (no less than annually) to ensure that it is utilizing the most current information in order to protect patient safety.

Provider's receipt of Covered Items when Provider knows, or reasonably should have known, that the Covered Item

CONFIDENTIAL AND PROPRIETARY

is suspect may result in chargeback of claims and other remedies available to Caremark, including but not limited to, termination of the Agreement. For purposes of this section "suspect" means a Covered Item that is potentially counterfeit, diverted or stolen; is potentially intentionally adulterated such that the Covered Item would result in serious adverse health consequences or death to humans; is potentially the subject of a fraudulent transaction; or appears otherwise unfit for distribution such that the Covered Item would result in serious adverse health consequences or death to humans.

Provider must make available to Caremark Transaction Statement, Transaction History, and Transaction Information and Documentation as part of Caremark's audits. Provider must fully cooperate with Caremark in audits or in the course of investigation of suspect or reported violations of this section. Caremark's audit may involve selecting a date range for aggregate purchase invoice review. Provider's purchases occurring within the date range of the aggregate purchase invoice review must be sufficient to support the total quantity dispensed by Provider (or provided to Eligible Persons) as reflected in the claims billed to Caremark during the same date range of the aggregate purchase invoice review. If Provider has not purchased sufficient Covered Items to substantiate the quantity of claims billed, those claims may be subject to chargeback and other remedial action. If Provider fails to timely provide all the requested documentation in accordance with this section, one hundred percent (100%) of the amount for the paid claims audited is subject to chargeback and other remedies available to Caremark, including but not limited to, termination of the Agreement.

8.05.01 Invoice Documents and Records Maintenance

Provider must maintain any Transaction Statement, Transaction History, and Transaction Information provided to Provider pursuant to the DSCSA and any regulations promulgated under the DSCSA for the period required by applicable Law and any Documentation during the term of the Agreement and for two (2) years after the termination of the Agreement.

8.06 Medicare Part D Requirements

Provider must provide documentation to demonstrate compliance with all Medicare Part D requirements (as stated in the Provider Manual, Caremark Medicare Part D Addenda, CMS guidance or under applicable Law) including, but not limited to:

- Long-term Care billing
- Accurate use of Patient Residence and Pharmacy Service Type values
- Compliance with "CMS-10147 Medicare Prescription Drug Coverage and Your Rights" pharmacy notification
- Documentation to establish coverage determinations (e.g., Hospice, Part B vs. Part D, ESRD)
- That Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **2.11 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual to confirm that no Prescriber transmitted on a Medicare Part D claim is on any exclusion list
- Documentation or information requested which relates to a Medicare Part D claim dispensed by Provider but reimbursed directly to other parties, including the Part D Enrollee
- Documentation substantiating any submission clarification codes (SCC) or override codes transmitted on a Medicare Part D claim
- Documentation submitted must comply with guidance set forth by CMS, or any other applicable regulatory body or its designated auditor

If a copy of a prescription or signature log is not retrievable after sufficient effort, Provider must obtain either Prescriber or Eligible Person attestations.

8.07 On-Site and Investigational Audit Resolution – Appeals Process

As part of an audit, Caremark may identify claim discrepancies. If Caremark identifies claim discrepancies, Caremark will send Provider an initial discrepancy report along with Documentation Guidelines (refer to **Appendix I** of the Provider Manual) that show how Provider may address an initial discrepancy and validate the audited claim through a written appeals process.

CONFIDENTIAL TREATMENT REQUESTED

If Provider chooses to appeal the initial discrepancies, Provider must respond to Caremark in writing within thirty (30) days, or other timeframe required by applicable Law, with supporting documentation for the discrepant claim in accordance with the Documentation Guidelines or the Provider Manual. Documentation must be transmitted to Caremark via certified mail, fax, Federal Express, United Parcel Service, or any other certified carrier (with delivery confirmation), and must be received by the due date specified by Caremark. Provider may contact the Pharmacy Performance department at **1-866-488-4709** prior to the documentation due date to request an extension of the documentation due date. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date. Late documentation will not be accepted.

Upon review of Provider's appeal documentation, or at the end of the thirty (30) day appeal period if Provider has not submitted appeal documentation, Caremark will issue a final audit report. Discrepant claims that are not documented and validated in accordance with the Documentation Guidelines or the Provider Manual are detailed in the final discrepancy report and are due and owing to Caremark as of the expiration of the thirty (30) day appeal period, or other timeframe required by applicable Law; however, Caremark has the right to offset, if consistent with applicable Law, against amounts owed to Provider, before the expiration of the thirty (30) day period, or other time period required by Law, for any discrepant claims as allowed for under section **6.09 Provider Suspension** of the Provider Manual. Audit discrepancies are detailed in a final audit discrepancy report.

Any documentation submitted after the documentation due date (i.e., for the initial discrepancy report) or after a final audit discrepancy report is issued may be considered by Caremark as part of Caremark's evaluation of the remedies to be taken by Caremark to address the audit findings, but will not impact the final chargeback amount owed to Caremark.

Refer to section **15.09 Arbitration** of the Provider Manual for the dispute resolution process once the final audit discrepancy report is complete.

If the final audit chargeback exceeds $10,000, Provider must reimburse Caremark twenty percent (20%) of the total final audit chargeback for the cost of the audit, where consistent with applicable Law.

Provider must notify Caremark of Provider's appeal of an initial discrepancy report, in writing to:

Caremark – Audit Manager
Attn: Pharmacy Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for audited discrepant claims, audit-related costs pursuant to the Provider Agreement or any Third-Party Agreement, claims submitted in breach of the Agreement, or any audit conducted by a third-party auditor on behalf of a Plan Sponsor. If the Provider fails to satisfy amounts owed related to an audit finding, certain remedies may apply, including termination of the Provider Agreement and any other available remedies.

When Caremark collects from Provider amounts due as a result of audit discrepancies, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or Plan Sponsor in relation to such adjustment or chargeback.

Once Provider is on notice of an on-site or investigative audit, Provider must not during the audit process adjust or reverse claims that are the subject of the audit as Caremark will perform appropriate adjustments and reversals at the conclusion of the audit process.

Caremark may report its audit findings to Plan Sponsors and local/state/federal investigative and law enforcement agencies (and their agents).

8.07.01 Pharmacy Membership Review Committee

Caremark's Pharmacy Membership Review Committee (PMRC) is a committee responsible for reviewing final audit cases to determine remedial actions that the PMRC determines are appropriate to address the audit findings. The PMRC meets regularly and is comprised of Caremark employees representing multiple departments and industry experiences.

8.08 Corrective Action Plan

A corrective action required (CAR) notice may be sent to Provider requiring Provider to submit a corrective action plan (CAP) concerning issues such as audit findings, dispensing errors, failure to respond to audit requests or as

CONFIDENTIAL AND PROPRIETARY

may be required by applicable Law. Provider must respond to any request for information and action in a CAR notice. Provider's response must be submitted by the date provided on the CAR and must include a CAP. Provider's CAP must include applicable documentation and policies and procedures as specified in the CAR notice to support Provider's CAP. As part of the CAP process, Provider may be assessed a per claim review fee for oversight claim activity during the CAP period. If Provider fails to fully respond to a CAR notice or any other request for information and action as part of the CAR/CAP process, or fails to follow the CAP, Caremark reserves the right to exercise its termination rights under the Provider Agreement, along with other available remedies.

8.09 Potentially Fraudulent Activity

If Provider suspects that potentially fraudulent prescriptions are being presented or that other improprieties regarding claims are occurring, Provider must notify Caremark by telephone at **1-877-841-1851** or by written correspondence at:

Caremark
Attn: Network Performance, MC020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Provide the Eligible Person's name and identification number, the Prescriber name and identification number, a detailed description of the suspected fraudulent activity and any related supporting documentation.

Examples of potentially fraudulent activity that warrant notification to Caremark may include, but not be limited to:

- Eligible Person presenting a forged or altered prescription
- Eligible Person presenting a prescription not written by the Prescriber identified
- Eligible Person calling in his or her own prescription
- Eligible Person presenting a prescription indicating a medication which is not consistent with the practice or specialty of the Prescriber
- Eligible Person presenting a prescription for an ineligible person, or fictitious family member

Provider may also consider notifying the Drug Enforcement Administration (DEA) or other related regulatory agencies.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

9. Medicaid

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

To the extent Provider provides Pharmacy Services to a Medicaid Eligible Person and without limiting any other provision in the Agreement (including the Provider Manual), Provider must, at minimum, comply with the following terms:

9.01 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicaid Eligible Person is made, in whole or in part, from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable state laws including minimum standards of pharmacy practice. Refer to the Federal and State Laws and Regulations section of the Provider Manual (located in the Pharmacy Portal, login required, at **www.rxservices.cvscaremark.com**), including state-specific addenda. Provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. [42 C.F.R. 438.230(c)(2)]. Provider acknowledges that Provider's ability to provide Pharmacy Services under the Agreement for Medicaid Eligible Persons may be revoked if it is determined that Provider has not performed satisfactorily [42 C.F.R. 438.230(c)(1)(iii)].

9.02 Enrollment with State Medicaid

Pursuant to 42 C.F.R. 438.602(b), Provider shall ensure that it is enrolled with each state Medicaid for which Provider provides Pharmacy Services under the Agreement. Provider agrees that if it is not enrolled with the applicable state Medicaid program, it may not provide Pharmacy Services under the Agreement for that state Medicaid program's enrollees.

9.03 Medicaid Credentialing and Quality Management

Provider shall comply with Caremark's credentialing and quality management requirements. Provider must provide Caremark with documentation and other information that is required to comply with "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E); otherwise, Provider may be subject to termination or other available remedies. Refer to section **2. Credentialing and Quality Management** of the Provider Manual for additional information.

Provider must allow CMS, its agents, its designated contractors (e.g., recovery audit contractors), or the applicable state Medicaid agency to conduct unannounced on-site inspections of Provider's location(s). 42 C.F.R. § 455.432.

9.04 Fraud, Waste and Abuse Compliance Program

Provider shall maintain a compliance program in accordance with 42 C.F.R. 438.608 to detect fraud, waste, and abuse.

9.05 Inspection and Audit of Records and Access to Facilities

Pursuant to 42 C.F.R. 438.3(h), Provider shall allow a state Medicaid program, CMS, the DHSS Office of the Inspector General, the Comptroller General, and their designees, to, at any time, inspect and audit any records or documents of Provider, and inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for ten (10) years from the final date of the Agreement or from the date of completion of any audit, whichever is later. See also 42 C.F.R. 438.230(c)(3).

9.06 Claims Submission Requirements for Medicaid

Additional Plan Sponsor-specific information, such as claims submission requirements for 340B drugs, may apply as specified in notices to Provider or in the Caremark Payer Sheets. Refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo.**

9.07 Medicaid Coordination of Benefits

Medicaid is typically the payer of last resort, which pays after any other applicable primary programs have

CONFIDENTIAL AND PROPRIETARY

been billed. Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any COB requirements, and must engage in appropriate COB activities to the extent required by Caremark, or applicable by Law.

Refer to section **4.10 Coordination of Benefits** of the Provider Manual. For complete technical information on COB, refer to the Payer Specification Sheets located at **www.caremark.com/pharminfo**.

9.08 Prior Authorization

Where permitted by applicable state Law and the Plan Sponsor, Provider is authorized to dispense a limited number of days supply of medically necessary Covered Items if the Prescriber is unavailable to process a prior authorization request within a reasonable time period. Plan Sponsor-specific processes and contact information may apply as indicated in Caremark Documents.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

9.09 Denial of Services

Provider must not deny services to an Eligible Person on account of such individual's inability to pay the Patient Pay Amount to the extent consistent with applicable Law.

9.10 Cultural Competency

Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. § 438.206(c)(2).

9.11 Home Delivery

A Medicaid beneficiary may not be charged for the expense or any portion of an expense as the result of a prescription medication being mailed, shipped or delivered, etc.

9.12 Directories

Provider shall provide Caremark with all information that may be needed in connection with Caremark's initiatives to comply with 42 C.F.R. 438.10 concerning pharmacy directories.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

10. Medicare Part D

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

10.01 Medicare Part D Network Standards

To the extent Provider provides Pharmacy Services to a Part D Enrollee, Provider must comply with the following terms contained in this **Medicare Part D Network Standards** section of the Provider Manual. Unless specifically indicated otherwise, these terms apply to all Providers who provide Pharmacy Services to a Part D Enrollee (including retail, home infusion, long-term care, and Indian Health Services/Tribal/Urban Providers). Provider acknowledges that CVS Caremark Part D Services, L.L.C. together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this section) are responsible for providing Part D services on behalf of Part D Plan Sponsors. All capitalized terms used in this **Medicare Part D Network Standards** section will have the same meaning as in the applicable **Addendum to the Caremark Provider Agreement: Terms of Participation in Medicare Part D**, or the **Glossary of Terms** in the Provider Manual

10.01.01 Network Participation

For any Part D plan year, and to ensure adequate access to network pharmacies for Part D Enrollees, Provider must provide Caremark with written notice by no later than March 31 of the prior calendar year if Provider will not be participating in a Medicare Part D network, including but not limited to, the retail, long-term care, and home infusion networks, for that plan year. For example, if Provider will not be participating in the Medicare Part D retail pharmacy network for the 2020 plan year, it must notify Caremark in writing by no later than March 31, 2019. If such timely written notice is not given, Provider must participate in such Medicare Part D network for the entire Part D plan year unless Provider terminates with cause its participation in accordance with the Provider Agreement.

The terms of this **Network Participation** section supersede and amend any inconsistent or contrary provision in the Provider Agreement, including section **15.05.02 Termination Without Cause** of the Provider Manual, but will only apply to the extent that this section is consistent with a Part D Plan Sponsor requirement.

The deadlines set forth in section **6. Network Participation** and Paymentof the Provider Manual do not apply to Medicare Part D network solicitations to participate in a new Medicare Part D network for which the deadline for participation will be as stated in such Caremark written solicitation

10.01.02 Compliance with Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Part D Enrollee is made, in whole or in part, from federal funds, and subjects Provider to laws, such as but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with minimum standards of pharmacy practice under applicable state Law. Refer to section **16. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Caremark Pharmacy Portal, refer to section **1.06 Pharmacy Portal** of the Provider Manual.

10.01.03 Delegated Activity

Provider must obtain prior written approval from Caremark if Provider wishes to delegate any activity or responsibility related to its Pharmacy Services to a subcontractor. Upon Caremark's written approval of such delegation, Provider must obtain written agreement from such subcontractor that the subcontractor will comply with all of the terms and conditions of the Provider Agreement (which includes the Provider Manual) applicable to Provider, including but not limited to, the requirement to comply with the contractual obligations specified for downstream entities in 42 C.F.R. 423.505(i)(2) and (i)(3) that relate to, among other things, retention of books and records, including prescription records, for at least ten (10) years or longer as specified in 42 C.F.R. 505(i)(2); and sections **2.11 Federal Health Care Programs Participation Exclusion: Pharmacy; 4. Claims Submission,** and **8. Professional Audits** of the Provider Manual. Provider'swritten agreement with subcontractor must provide that the agreement and/or delegated activities may be revoked (or specify other remedies) in instances when CMS, Part D Plan Sponsor, or Caremark or any of Caremark's subsidiaries or affiliates determines that the subcontractor has not performed satisfactorily. In the event that any subcontractor is terminated by CMS or Part D Plan Sponsor, Provider must immediately notify Caremark of such termination.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

10.01.04 Offshore Subcontracting

If Provider or any of Provider's subcontractors (or downstream subcontractors) receive, process, transfer, handle, store, or access Protected Health Information (PHI) of Part D Enrollees outside the United States or one of the United States Territories, Provider agrees to notify Caremark and to comply (and to require any downstream subcontractors to comply, as applicable) with the requirements specified in CMS memorandum of July 23, 2007, entitled "Sponsor Activities Performed Outside of the United States (Offshore Subcontracting)." Further, Provider agrees to submit to Caremark information to enable Caremark or Caremark's Part D Plan Sponsors to provide the "Attestation Concerning the Use of Offshore Contractors" form contained in the July 23, 2007, CMS memorandum, which includes, but is not limited to, providing to Caremark information of Provider's own or Provider's offshore subcontractor operations, safeguards to protect PHI, and auditing to ensure protection of PHI.

10.01.05 Marketing

Provider must conduct marketing activity in a manner consistent with the Medicare regulation and guidelines, including the Medicare Communications and Marketing Guidelines. Provider must remain neutral when assisting Part D Enrollees with enrollment decisions in an objective assessment of his or her needs and potential options to meet those needs.

10.01.06 Fraud, Waste and Abuse Program

Provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Compliance Program Guidelines to prevent, detect and correct Fraud, Waste and Abuse (FWA). Provider also agrees to comply with Part D Plan Sponsor's policies and procedures, and any corrective action plans imposed by Part D Plan Sponsors or Caremark related to the Part D Program. Provider must submit copies of Provider's policies and procedures, and corrective actions related to Part D activities as requested by Caremark. Provider must cooperate fully with a Part D Plan Sponsor's FWA investigative activities including providing copies of prescriptions, signature logs, and other requested documentation to support FWA investigations.

10.01.07 Information on CMS-10147 Pharmacy Notice

CMS-10147 - Medicare Prescription Drug Coverage and Your Rights

1. CMS requires that Caremark distribute the "Medicare Prescription Drug Coverage and Your Rights" form (Pharmacy Notice – CMS 10147) to Providers on an annual basis. This form is used to instruct Part D Enrollees to contact their Part D Plan to obtain a coverage determination (prior authorization) or ask for a formulary or tiering exception if the Part D Enrollee disagrees with Plan claim response information provided to the Pharmacy.
2. Pharmacies must provide the Part D Notice of Appeal Rights directly to Part D Enrollees any time the following reject(s) and related messaging occurs on a claim:

   Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

3. This notice is provided in **Appendix G** of the Provider Manual in English and Spanish. This is a standard notice and Provider may not deviate from the content of the notice. Note that the OMB control number [APPROVED OMB #0938-0975] must be displayed in the upper right corner of the notice.
4. This document is distributed to Pharmacy annually by Caremark and is also posted at: **www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html**
5. Distributing this notice fulfills the requirements at 42 C.F.R. § 423.562(a)(3).

10.01.08 Performance Monitoring

Provider understands that Caremark and Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis. Provider must cooperate with Caremark and Part D Plan Sponsor as necessary to support Caremark and Part D Plan Sponsor monitoring strategies, including but not limited to, allowing Caremark and Part D Plan Sponsor to inspect, evaluate and audit Provider's operations, documents and records.

CONFIDENTIAL AND PROPRIETARY

10.02 General Information

10.02.01 Part D Reference Information for Pharmacists

Refer to the following website: **www.cms.gov/Medicare/Medicare.html** which contains helpful information on a variety of Medicare Part D topics for providers. CMS frequently updates this website, so check periodically for the latest information.

10.02.02 Medicare Part D Calls to the Pharmacy Help Desk

The Pharmacy Help Desk interactive voice response (IVR) system immediately routes Medicare Part D inquiries to appropriate information/pharmacy service representatives through an initial request/prompt to discover if Provider is calling on behalf of a Part D Enrollee or about a Medicare Part D Claim.

Provider will be routed to a specialized team prepared to handle and resolve Medicare Part D inquiries. If the Part D Enrollee does not have an ID card available, ask for an acknowledgement letter. If an acknowledgement letter is not available, call **1-800-MEDICARE (1-800-633-4227).** Only if needed, Provider can submit an enhanced E1 transaction to determine the processing information.

The Pharmacy Help Desk numbers are provided below:

Caremark System	RXBIN	Pharmacy Help Desk Number	Point-of-Service Assistance B vs D
Legacy ADV	004336*	1-866-693-4620	
Legacy PCS	610415*	1-800-345-5413	
FEP	610239*	1-800-345-5413	
Legacy CRK	610029*	1-800-421-2342	
Caremark	610591	As communicated by plan or refer to ID card	
SilverScript	004336*	1-866-693-4620	1-855-503-6054
Non-SilverScript	004336*	As communicated by plan or refer to ID card	1-855-238-9379
NEJE (New England Joint Enterprise)	004336*	1-866-693-4620	1-844-635-3407
Aetna	610502	1-800-238-6279	

Secondary RXBINS and Plan sponsor-specific RXBINs and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at **www.caremark.com/pharminfo**.

*Puerto Rico Providers call toll-free 1-800-842-7331.

Pharmacy Help Desk representatives will use reasonable efforts to assist Providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with the respect to the provision of Pharmacy Services. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

10.03 Credentialing

10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies

Provider agrees to comply with the following provisions:

1. Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **10.03.02 Federal Health Care Programs Participation Exclusion** of the Provider Manual.
2. Provider has a record retention policy in place that complies with CMS's minimum of 10-year record retention requirement and with other applicable state Law.
3. Provider has in place and provides FWA training to all employees and managers (who are directly or indirectly involved with the administration of delivery of Part D benefits) within thirty (30) days of their date of hire and annually thereafter.

4. Provider tracks employee and manager attendance for any training conducted.
5. Provider must provide a copy of the training materials upon request.
6. Provider attests that if any services that support the Provider Agreement or if any of its subsidiaries or affiliates are delegated, the performance of those services is monitored by Provider to ensure compliance with the applicable Medicare Part D requirements.
7. Provider has entered into written arrangements with its subcontractors which provide for revocation of the delegation activities or specify other remedies in instances when CMS or Caremark or any of its subsidiaries or affiliates has determined that the parties have not performed satisfactorily.
8. Provider certifies that it is free of any conflicts of interest (within the meaning of the CMS Prescription Drug Benefit Manual, Chapter 9) in administering or delivering its Pharmacy Services, and will require its managers, officers and directors responsible for the administration or delivery of Pharmacy Services for Part D Enrollees to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any such conflict of interest.

10.03.02 Federal Health Care Programs Participation Exclusion

A. Prescriber

In accordance with CMS requirements, Part D Plan Sponsors must have policies and procedures in place to implement a comprehensive program to detect, prevent and control fraud, waste and abuse, including a process to identify any claims that were submitted for drugs that were prescribed by an excluded Prescriber, and a process to report and properly repay any overpayments resulting from inaccurate payments in accordance with CMS policy. The guidance also states that Part D Plan Sponsors must not pay for drugs prescribed by a Prescriber excluded by either the Health and Human Services-Office of Inspector General (HHS-OIG) or System for Award Management (SAM).

Caremark implemented an automated point-of-sale process to deny Part D Claims for drugs prescribed by excluded Prescribers. Provider may receive the following reject:

Reject A1 <<Prescriber is Federally Excluded>>

If Provider receives this electronic message, do not resubmit the claim for processing unless, in Provider's professional judgment, it is an emergency situation. If it is an emergency situation, call the appropriate Pharmacy Help Desk contact number referenced in this section.

The Caremark point-of-sale reject is intended to assist Provider in the identification of excluded Prescribers, but does not serve as a substitute for the Provider's own comprehensive program to identify claims for drugs prescribed by excluded Prescribers. Provider must maintain a comprehensive program to identify claims for drugs prescribed by an excluded Prescriber in the event that a point-of-sale reject does not occur.

B. Precluded Prescriber

In accordance with CMS guidance, claims prescribed by an individual on the Preclusion List will reject with the following or similar reject:

Reject 929 <<Prescriber ID is precluded>>

The Preclusion List includes prescribers who meet one of the following conditions:

- Prescribers that are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Prescribers that have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but is not limited to, felony convictions and Office of Inspector General (OIG) exclusions.

There is no override for this reject. Impacted Part D Enrollees that have concerns or need assistance finding a new Prescriber should contact Medicare's toll-free customer care operations at **1-800-MEDICARE (1-800-633-4227)**.

C. Pharmacy Provider

Pharmacy Provider must review the OIG LEIE and the SAM Excluded Prescriber lists. Provider must not submit any claim to Caremark for a prescription written by an excluded Prescriber, nor should a Pharmacy Provider submit

CONFIDENTIAL AND PROPRIETARY

claims if Provider is excluded or debarred from participation in any Federal health care program. Provider agrees that any claim submitted in violation of this section is subject to chargeback. Refer to section **4.03 Other Claim Submission Requirements**, (bullet 9. **Federal Health Care Programs Prescriber Participation Exclusion**) of the Provider Manual.

10.04 Pharmacy Services and Standards

10.04.01 Plan Identification Cards

Provider must submit claims to the claims adjudication system whenever the Part D Enrollee's plan identification card is presented to or on file with Provider, unless the Part D Enrollee expressly requests that a particular claim not be submitted.

10.04.02 General Procedures for Acknowledgement of Enrollment Letters

In order to comply with CMS requirements, Providers should honor Part D Enrollee acknowledgement of enrollment letters if presented to Provider in place of identification cards.

An acknowledgement letter is a letter that qualified Part D Enrollees receive from their Part D Plan in advance of the distribution of Part D Plan identification cards. The letter should contain sufficient information in order to verify a Part D Enrollee's eligibility and to submit claims to the appropriate location in order for adjudication to occur. Note, letters confirming initial information was received but has yet to be confirmed or processed may not constitute a Part D acknowledgement letter.

If there is insufficient/inaccurate information on the letter or if the claim rejects, the following steps may be useful whether the information was obtained from an acknowledgement letter, an identification card or from the Part D Enrollee directly:

1. If a Part D Enrollee's eligibility cannot be verified, send an enhanced E1 transaction to the Transaction Facilitator (RelayHealth) to verify the Part D Enrollee eligibility and to obtain information necessary to process claims. It is Provider's responsibility to verify Part D Enrollee is the Part D Enrollee identified in the response.
2. If a Part D Enrollee's eligibility cannot be verified in Step 1 but Caremark is the processor, contact the appropriate Pharmacy Help Desk phone number. Refer to sections **1.04 Pharmacy Help Desk** and **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual.
3. If a Part D Enrollee's eligibility cannot be verified in Step 2, call **1-800-MEDICARE** to verify the Part D Plan under which the Part D Enrollee is enrolled, and if possible, verify the Part D Enrollee's eligibility information.

10.04.03 Best Available Evidence

CMS created the Best Available Evidence (BAE) policy requiring Part D Plans to establish the appropriate cost-sharing for low-income Part D Enrollees when presented with evidence that the Part D Enrollee's information was not accurate. As a result, a CMS best practice is for Providers and Part D Plans to work to resolve these issues at the point of sale when Part D Enrollees present appropriate evidence of correct low-income status.

1. Provider should initiate the BAE process in order for a change to a Part D Enrollee's low-income status to occur if Provider is presented with one or more of the following acceptable forms of evidence from Part D Enrollees:
   a. A copy of the Part D Enrollee's Medicaid card which includes the Part D Enrollee's name and an eligibility date during the discrepant period;
   b. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the State staff person who verified the Medicaid status during the discrepant period;
   c. A copy of a State document that confirms active Medicaid status during the discrepant period;
   d. A printout from the State electronic enrollment file showing Medicaid status during the discrepant period;
   e. A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
   f. Other documentation provided by the State showing Medicaid status during the discrepant period.
2. In addition, any one of the following forms of evidence from Part D Enrollees may establish that they are institutionalized and qualify for zero cost-sharing:
   a. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;

CONFIDENTIAL TREATMENT REQUESTED

b. A copy of a State document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or

c. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

3. Acceptable documents that may be used as BAE for demonstrating receipt of Home and Community-Based Services (HCBS) include:
   a. A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the Part D Enrollee's name and HCBS eligibility date during a month after June of the previous calendar year;
   b. A copy of a State-approved HCBS Service Plan that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year;
   c. A copy of a State-issued prior authorization approval letter for HCBS that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year; or
   d. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year.
4. Once Provider has the required acceptable form(s) of evidence, Provider should either:
   a. Contact the Pharmacy Help Desk for appropriate Plan Sponsor contact information; or
   b. Consult the annual Caremark Medicare Part D Plan Sponsor chart distributed to Providers annually.

If urgent, Caremark will work with Provider and Plan Sponsor to update eligibility and resolve the situation; otherwise, Provider should work directly with the Plan Sponsor to submit the acceptable BAE in order for a change to a Part D Enrollee's low-income status to occur through standard protocol.

10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS

In order to avoid any interruptions to receiving drug therapy for Part D Low-Income Subsidy (LICS/LIS) eligible Part D Enrollees who have received a notification from CMS indicating a status change, the Part D Enrollee must apply/re-apply through the Social Security Administration, or he or she may have adjusted copayment and premium liabilities in the future. Providers are encouraged to assist these Part D Enrollees by:

- Helping the Part D Enrollee submit LICS/LIS applications
- Referring the Part D Enrollee to the Social Security Administration at:

  1-800-772-1213
  www.ssa.gov/medicareoutreach2/index.htm

10.04.05 Auto-Ship Refill Programs

Providers may offer Part D Enrollees the option of enrolling in automatic refill programs. Providers must offer such programs in compliance with CMS requirements, including (a) permitting Part D Enrollees to opt-out of auto-ship refill program at any time; (b) providing Part D Enrollees with two (2) shipping reminders prior to shipping; and (c) granting Part D Enrollees a refund for any unwanted fill.

Provider must provide the Part D Enrollee with two (2) shipping reminders before each auto-ship refill order to give the Part D Enrollee sufficient time to cancel or make changes to an order. Shipping reminders must include an approximate shipping date range, information on how to obtain the cost-share for an upcoming auto-ship refill order, and instructions on how to cancel an order. CMS allows Provider to send the shipping reminder based on the Part D Enrollee's preferred method of communication that includes phone, email, text, direct mailing, or other comparable means of communication.

10.05 Claims Submission

10.05.01 Unique RXBIN/RXPCN Requirement - Medicare Part D

Provider must include RXBIN, RXPCN, and RXGRP values on submitted claims. Part D Enrollee profiles must be updated accordingly. Caremark will continue to communicate unique RXBIN/RXPCN/RXGRP combinations of Plan Sponsors. Refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.

10.05.02 Payment of Clean Claims

In accordance with 42 C.F.R. § 423.520, payment for clean claims (that have been determined to be eligible for

CONFIDENTIAL TREATMENT REQUESTED

payment) will be made to Provider within fourteen (14) days (for electronically submitted claims), or thirty (30) days (for non-electronically submitted claims) from the date the claim is received. A clean claim is defined as a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. Claims from a Provider whose participation status has been suspended, in accordance with section **6.09 Provider Suspension** of the Provider Manual, are not eligible for payment unless and until such time as Provider's suspension has been lifted and any offset against amounts owed to Caremark has been processed.

10.05.03 Electronic Prescribing

Providers engaged in e-prescribing must do so in accordance with all CMS and Part D E-Prescribing standards and requirements. Refer to the following web address for specific e-prescribing requirements and their applicable compliance dates: **www.cms.hhs.gov/EPrescribing/**. Additional information is also available in Section 50 of Chapter 7 of the Medicare Part D Prescription Drug Manual, **www.cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/Downloads/Chapter7.pdf.**

10.05.04 Prescription Origin Code and Fill Number

Provider must use the Prescription Origin Code when submitting all Medicare Part D claims. Original fill claims submitted without one of the values below will reject.

The Prescription Origin Code should be placed in the 419-DJ field, and the following values should be used:

1 = Written

2 = Telephone

3 = Electronic

4 = Facsimile

5 = Pharmacy

The Fill Number should be placed in the 403-D3 field, and the following values should be used:

ØØ= Original dispensing

Ø1 to 99 = Refill number

10.05.05 Improving Drug Utilization Review Controls

CMS discusses the need for Medicare Part D Plan Sponsors to employ more effective concurrent and retrospective DUR programs to address overutilization of medications in order to protect Part D Enrollees and to comply with drug utilization management requirements at 42 C.F.R. § 423.153, et seq.

Claims adjudication system edits have been implemented to improve control at the point of sale and ensure that DUR processes comply with CMS requirements for all classes of drugs.

The chart below describes the DUR reject edits and associated Professional Service (PPS) Codes that may be used to override the reject when applicable. Enhanced reject messaging will return to help clarify the reason for the reject. Be sure to review the entire DUR message for instructions which may require viewing additional screens in your software. Since a single claim may trigger more than one concurrent DUR reject, Providers will need to enter the corresponding PPS codes documenting the action for each reject.

The chart below may be used to assist with entering the appropriate PPS Codes.

Edit Name and Description	Reject Message	Reason for Service Code	PPS Professional Service Code	Result of Service Code
Buprenorphine/Opioid: Identifies opioid use after treatment with a buprenorphine product.	Reject 88- PPS CODE REQD: HX BUPENORP; EXCL OPIOID	"DM"	**MØ -** Prescriber consulted **PØ -** Patient consulted **PM -** Patient monitoring	1B - RHP deterrmines alert is not relevant for the Rx and member 1C - Filled with a different dose
Cumulative APAP Check: Checks for excessive cumulative acetaminophen (cAPAP) utilization across multiple prescriptions.	Reject 88– PPS CODE REQD: APAP EXCEEDS 4GM/DAY	"AT"		

Edit Name and Description	Reject Message	Reason for Service Code	PPS Professional Service Code	Result of Service Code
Cumulative Morphine Milligram Equivalent (cMME): Checks for excessive opioid utilization via cumulative morphine equivalent dose (cMED) across multiple drugs and prescriptions.	Soft Reject 922/88- EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD. Hard Reject 922/G4/88 – EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD. PRESCRIBER MUST CALL XXX-XXX-XXXX WHEN CLINICAL EXCEPTION APPLIES	"HC"	**RØ -** Pharmacist consulted other source	1D - Filled with different directions 1F - Filled with a different quantity 1G - Filled with a Prescriber approval 2A - RPH determines Rx should not be filled as written 4B - Dispensed, Palliative Care 4C - Dispensed, Hospice 4D - Dispensed, Cancer Treatment
Excessive Controlled Substance Enhancement: Intended to capture multiple controlled substance (CS) claims (for the same drug or different controlled substances) within the past thirty (30) days.	Reject 88– PPS CODE REQD: MULT CII-V IN LAST 30 DAYS	"DM"		
Dose Check - Max Dose Multiplier: Intended to identify claims with excessively high doses. Applies to all drugs.	Reject 88– PPS CODE REQD: MAX DOSE EXCEEDED – 5X MAX	"HD"		
Multiple Pharmacies: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class at four or more pharmacies. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PHARMACIES/ SAME DRUG CLASS	"DM"		
Multiple Prescribers: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class prescribed by four or more prescribers. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PRESCRIBERS/ SAME DRUG CLASS	"DM"		
Multiple Long Acting Opioids: Designed to identify Part D Enrollees on two or more long acting opioids.	Reject 88 – PPS CODE REQD: 2 OR MORE LA OPIOIDS	"TD"		
Opioid/Benzodiazepine Drug Interaction: Designed to identify Part D Enrollees receiving a medication from both classes of drugs.	Reject 88 – PPS CODE REQD: DRUG INT OPIOIDS AND BENZO	"DD"		
7 Day Opioid Naïve Edit: Designed to identify Part D Enrollees with no history of an opioid in the past 108 days and limit their initial supply to 7 days or less.	Reject 925: IF OPIOID/CANCER HISTORY, RPH USE SCC 10 OR SUBMIT 7 DS OR CALL XXX-XXX-XXXX	Submit SCC "10"	N/A	N/A

CONFIDENTIAL AND PROPRIETARY

Do not save PPS and Result of Service Codes on any prescriptions that have previously rejected for DUR. For an initial fill or any refills, Provider cannot pre-empt the reject by entering PPS Codes prior to the first submission of the claim. Allow the reject to occur and then enter the appropriate PPS Codes on resubmission. Entering PPS Codes prior to allowing the claim to reject will cause the claim to continue to reject.

10.05.06 Medicare Part D Claims Requiring Overrides

A. Natural Disasters

Caremark is dedicated to assisting Providers and Part D Enrollees in response to emergencies resulting from natural disasters, severe weather, etc., where medical records are either destroyed or not accessible. Refer to section **4.09 Natural Disasters** of the Provider Manual. Refer to section **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual for contact information.

B. Network Access

Some Part D Enrollees are allowed by their Part D Plan to obtain prescriptions at out-of-network pharmacies. However, Part D Enrollees may be required to submit paper claims for reimbursement for eligible out-of-network expenses and provide documentation as to why the claims were filled at an out-of-network pharmacy. There are no changes to this process for Part D Enrollees residing in the emergency area.

C. Refill-Too-Soon and Excessive Utilization Rejects

CMS will ensure that rules preventing early refills are waived. This will assist those Part D Enrollees who left or lost their prescription during emergencies.

10.05.07 General Medicare Part D Submission Requirements for COB

Provider must not hold an Eligible Person who is dually eligible for both Medicare and Medicaid liable for Medicare Part A and B Patient Pay Amounts when Medicaid is responsible for paying such amounts for Qualified Medicare Beneficiaries; Provider must accept Caremark's payment as payment in full or bill the appropriate state Medicaid.

For Medicare Secondary Payer (MSP) claims, the primary Medicare Part D RXBIN/RXPCN/RXGRP combinations should be submitted on the COB claim (refer to the Caremark Plan Sponsor grid within the Pharmacy Portal, login required, at **www.rxservices.cvscaremark.com**.)

For COB claims that are supplemental to Medicare Part D, Provider must submit the corresponding RXBIN (refer to section **1. General Information** of the Provider Manual) unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs or RXGRPs as communicated or printed on ID cards. Providers may receive notice of plan-specific claims processing information.

For primary Part D Plan Sponsors who have implemented STCOB, the claim adjudicates against both primary and secondary plans before returning one final response to Provider. Caremark may return a message in the pharmacy response indicating STCOB was used. STCOB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for eligible Part D Enrollees.

Refer to the Caremark Payer Sheets referenced in **Appendix A** or additional details on how to submit Medicare Part D COB claims.

10.05.08 Formulary Transition Fill Process

All Part D Plans are required by CMS to provide a formulary transition plan for Part D Enrollees who are eligible for a transition supply. The intent of the transition plan is to ensure immediate short-term coverage for Part D Enrollees who are either new to a Part D Plan or who otherwise qualify for a Transition Fill (TF). Providers are required to submit TF-eligible claims for eligible Part D Enrollees to ensure these Enrollees are able to receive the TF's to which they are entitled. This will allow Part D Enrollees to continue ongoing therapies while either transitioning to an equivalent formulary drug, or pursuing prior authorizations or formulary exceptions. Drugs excluded under Part D are not eligible for TF.

Caremark provides TF coverage to eligible Part D Enrollees under the circumstances indicated in the "Transition Fill Plan" below when Part D drugs:

- are non-formulary; or
- are formulary and require prior authorization or step therapy under a plan's utilization management rules; or
- have quantity limits or daily dose limits that are not safety related.

CONFIDENTIAL AND PROPRIETARY

TF-eligible claims will process and pay upon initial submission and messages will indicate when claims have paid under TF rules. Providers do not need to resubmit a TF Prior Authorization code for TF-eligible claims to adjudicate upon initial submission. The messages listed below will return with paid TF claims so Providers can remind Part D Enrollees of actions that should be taken to ensure access to prescription drugs in accordance with Part D formularies and benefits. Provider will receive one of the following messages with the paid claim under TF rules:

<<Paid under Transition Fill - Non-formulary>>

<<Paid under Transition Fill - PA required>>

<<Paid under Transition Fill - Other Reject>> (Note: other rejects represented by this message include Step Therapy, Quantity Limits, Daily Dose, etc.)

The following drugs are not TF eligible:

- Drugs not covered under Part D.
- Drugs that are dispensed for reasons other than medically accepted indications.
- Drugs that are dispensed outside of safe utilization recommendations.

For submitted claims not eligible for TF,

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

is intended to remind Provider to provide the required Part D Notice of Appeal Rights directly to Part D Enrollees should he or she want to appeal rejected claims with Part D Plans. Notice must be given directly to Part D Enrollees any time this reject occurs on a claim.

The Transition Supply is an approved month's supply for both the outpatient and the long-term care patient. No changes were made to the long-term care Emergency Supply, which remains a 31-day supply.

Outpatient Transition Fill

Transition Fill Condition	Description	Allowed TF Supply for the Retail Setting
Part D Enrollee who is newly enrolled in Plan	• Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one plan to another after start of contract year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage in the new Plan
Some renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within the look-back period (established by the plan) from date of claim and previous claim not TF for the same reason • If Part D Enrollee has not transitioned before beginning of new Plan benefit year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage effective at the beginning of the new contract year
Part D Enrollee requesting exception and decision still pending	Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted	Contact the Pharmacy Help Desk for Transition Extension Overrides under this Condition

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

For questions, concerns or issues related to Transition Fill claim processing, refer to section **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual for the appropriate telephone number to call.

10.05.09 Insulin Coverage

Medicare Part D Plans cover injectable insulin not used with an insulin infusion pump. Medicare Part B covers external insulin pumps and the insulin that the device uses under durable medical equipment.

10.05.10 Pro-Rated Daily Cost Share

For applicable plans with a copayment benefit, Part D Plan Sponsors must establish and apply a daily cost-sharing rate whenever certain prescriptions (depending on the drug) are dispensed by Provider for less than the Part D Plan Sponsor's defined one-month supply in accordance with 42 C.F.R. § 423.153(b)(4)(i).

Caremark will apply a daily cost-sharing rate for a Covered Part D Drug that is dispensed for less than the plan-defined one-month supply. If a claim applies a daily cost-sharing rate Provider may receive the following message:

> **<<Ø23 – Prorated copayment applied based on days supply. Plan has prorated the copayment based on days supply>>**

The daily cost-sharing rate applies if the drug (brand or generic) is in the form of a solid oral dose and is dispensed for a days supply less than the plan-defined one-month supply under applicable Law, except for the following types of drugs:

- Solid oral doses of antibiotics
- Solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance
- Non-Part D drugs, unless the Part D Plan has specified that copay proration extends to covered drugs that are treated as non-Part D under their benefit plans
- Drugs dispensed by out-of-network providers

10.05.11 Medicare Part B and Medicare Part D Drug Coverage Determinations

For specific rejects addressing (1) drugs excluded from Part D coverage as mandated by the Medicare Modernization Act; and (2) drugs that are covered under Medicare Part B for the designated Part D Enrollee, refer to the NCPDP Payer Sheets at **www.caremark.com/pharminfo**.

Provider must enter an appropriate Patient Residence Code for all Part B vs. Part D claims. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

Caremark uses the following reject codes for drugs that may be covered under Medicare Part B for the designated

Medicare beneficiary:

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A6	This Product/Service May Be Covered Under Part B

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Secondary messaging may also be returned. The secondary message is as follows:

<<B vs D Inquiry RPH Call XXX-XXX-XXXX>>

When Provider receives a reject with secondary messaging and calls the number included in the reject, the Pharmacy Help Desk representative, who is specifically trained to handle Part B vs. Part D determinations, will present a series of criteria to Provider. Based on the information obtained from the pharmacist, the Pharmacy Help Desk representative will be able to promptly assist Provider with processing the Part D claim, if appropriate.This process only applies to certain drug categories and select Part D Plans. For drugs not handled by the Pharmacy Help Desk, the reject message will indicate that a Prior Authorization is required and include the number for initiating a coverage determination.

10.05.12 End Stage Renal Disease Claim Processing

ESRD "Always" Drugs

CMS guidance requiring Part D Plans to impose a prior authorization edit for the four categories of drugs that are "always" used to treat End Stage Renal Disease (ESRD) remains in effect. CMS states that if the "always" drug was used to treat ESRD, it is payable under the Medicare Part B Bundled Payment to the dialysis center, regardless of whether or not dialysis treatment was received on the date the drug was prescribed or dispensed. Provider must maintain prescription record documentation for Part D Enrollees which contains the diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD).

For the ESRD "Always" Drugs, Caremark uses the following reject codes for drugs that may be covered under Medicare Part B Bundled Payment for ESRD:

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A4	This Product May Be Covered Under the Medicare B Bundled Payment to an ESRD Dialysis Facility

In addition to these rejects, **secondarymessaging** will be returned. The secondary message is as follows:

<<Part B vs D: To Resolve RPh Call XXX-XXX-XXXX>>

10.05.13 Prescriber Identification for Medicare Part D Claims

For all Medicare Part D claims, accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claims adjudication, clinical services, Plan Sponsor initiatives, and audits. In addition, CMS requires a valid and active individual Prescriber National Provider Identifier (NPI) on all claims. Failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI, DEA number or any other number or identifier (e.g., hospital, clinic, or pharmacy identification number) in the prescriber identification field which does not represent an individual Prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate submission clarification code (SCC) to bypass the reject. Per CMS, Part D Plan Sponsors are required to only report Type 1 (Individual) NPIs on PDE records. Type 2 (group/organizational identifier) NPIs are not accepted for Prescribers.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Providers must obtain an individual NPI. Any claim submitted with an invalid NPI will reject with the following or similar reject message:

Reject Code	Reject Message
A2	Plan's Prescriber database indicates Prescriber ID submitted is associated with a deceased Prescriber and the Date of Fill/Service of the claim is one year after the deceased date for a non-controlled substance or the Date of Fill/Service of the claim is 180 days after the deceased date for controlled substance
42	Plan's Prescriber database indicates the Prescriber ID submitted is inactive or expired
43	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID is inactive
44	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID is not found
46	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID does not allow this drug DEA class
56	Plan's Prescriber database indicates the Prescriber ID submitted is not found
619	Plan's Prescriber database indicates the Prescriber qualifier is not equal to 01

Below are the various SCC values that may be submitted for the invalid Prescriber ID rejects once Provider has confirmed the ID submitted is valid and the reject for invalid Prescriber ID is not appropriate (the claim is still subject to audit review and chargeback):

Reject Code	SCC Value
A2	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
42	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
43	43 - Prescriber's DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule
44	43 - Prescriber's DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule
46	46 - Prescriber's DEA has prescriptive authority for this drug DEA Schedule
56	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
619	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated

For additional information on identification of a foreign Prescriber, refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo.**

10.05.14 Claims Submission Window for Medicare Part D

Providers have ninety (90) days from original date of fill to receive paid transactions including submissions, reversals and resubmissions of Medicare Part D Claims. Provider Universal Claim Forms (UCFs) will be accepted and processed up to March 31st after the close of the previous plan year in which the date of fill occurred when accompanied by a reasonable explanation why the Medicare Part D Claim could not be submitted and processed online. This timely filing window aligns with the CMS processing windows. Provider UCFs should be clearly identified as "Medicare Part D" claims and should be mailed to the following address:

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

RXBINs 004336, 610591, 610415:

Medicare Part D
PO Box 52066
Phoenix, AZ 85072-2066

Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:

Aetna Medicare Part D
PO Box 52446
Phoenix, AZ 85072-2446

Aetna Medicare Part D LTC
PO Box 14023
Lexington, KY 40512-4023

Refer to section **10.07.02 LTC Pharmacies Timely Claim Submission** of the Provider Manual regarding timely submission of Medicare Part D LTC claims.

10.05.15 Medicare Part D Claims Adjustment

Caremark may adjust paid claims to correct errors or reflect changes in eligibility of Part D Enrollee, to the extent consistent with applicable Law. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider.

Provider must charge Part D Enrollees the correct cost-sharing amount in accordance with the Part D Plan benefit and as required by CMS. For all LTC claims submitted by Providers for Part D Enrollees, and therefore, for whom Caremark has assessed cost-sharing that has been borne by Provider, Caremark will reimburse Provider for such amounts. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

1. Provider agrees that by accepting payment from Caremark for these amounts assessed against Part D Enrollees, Provider is certifying that:
   a. Provider has not collected or otherwise waived such amounts from such Part D Enrollees or their representatives;
   b. Provider is in fact carrying a debt for the amounts charged to such Part D Enrollee; and
   c. The amounts reimbursed by Caremark are appropriate, owed, and payable.
2. In cases where Part D Enrollees claims are retroactively identified as inappropriate overpayments to Provider, Caremark will adjust Provider for such amounts. Provider is responsible for:
   a. Collecting outstanding Patient Pay Amount balances from Part D Enrollees; and
   b. Accurately debiting and/or crediting Part D Enrollees to help maintain accurate True Out-of-Pocket (TrOOP) balances for these retroactively identified claims.

10.06 Network Participation and Payment

10.06.01 Drug Pricing

Notwithstanding anything to the contrary, Caremark utilizes Medi-Span as reference for drug prices. Drug price files are updated every business day. An initial update to the drug price file occurs on January 1, or the following business day each year. Point-of-service claims are adjudicated, and Provider is reimbursed in accordance with these updates.

Provider may access the Caremark Pharmacy Portal at **www.rxservices.cvscaremark.com** to receive advance notice of changes to MAC for Medicare Part D Claims.

10.06.02 Pharmacy Service Type and Patient Residence Requirements

To ensure appropriate adjudication and reimbursement, Providers must submit valid Pharmacy Service Type and Patient Residence values on all claims. Approved Part D Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) values must be submitted accurately to identify claim type. Refer to the NCPDP Payer Sheets at **www.caremark.com/pharminfo**.

CMS Acceptable Code Values	
Pharmacy Service Type – Field 147-U7	01-08 and 99
Patient Residence – Field 384-4X	00, 01, 03, 04, 06, 09, 11

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply.

The only valid claim submission values for Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) are the supported values listed in the NCPDP External Code List (ECL). Submitted values not supported in the ECL will cause the claim to reject with:

Reject U7: <<M/I Pharmacy Service Type>> or

Reject 4X: <<M/I Patient Residence>> respectively.

A blank value will not be allowed in either field for Medicare Part D claims.

As recommended by NCPDP, Caremark accepts the below values to ensure appropriate adjudication and reimbursement. Provider must be in the specific Medicare Part D network in order to submit these codes and receive appropriate payment. Home infusion and Long-term Care Claims must meet the CMS qualifications (e.g., skilled nursing unit) in order to submit these codes and receive appropriate payment.

Pharmacy Type	Claim/Service Type	Pharmacy Service Type (Field 147-U7)	Patient Residence (Field 384-4X)
Retail	Retail	01	01
Home Infusion	HIF	03	01
Home Infusion	ALF	03	04
Long-term Care	LTC	05	03
Long-term Care	ICF/IID	05	09
Assisted Living Facility	ALF	05	04

For Claims submitted for LTC Part D Enrollees with a Patient Residence of 03, an SCC value in field 420-DK is required for brand oral solids. The above table does not include all Patient Residence and Pharmacy Service Type combinations.

10.07 Special Instructions for Participating LTC Providers

The following information is applicable to Providers participating in the Caremark and Part D Plan-specific LTC Medicare Part D networks, unless specified otherwise.

10.07.01 Pharmacies Serving LTC Facilities

Prescription Drug Benefit Manual – Section 40.3.1

Given the unique circumstances of the LTC setting, Part D Enrollees will generally not present the prescription to Provider. In most instances, either the treating Prescriber or his or her authorized agent sends the prescription to Provider. If there is an issue with a requested prescription, Provider is required to contact the treating Prescriber or his or her authorized agent and the Prescriber determines what course of action is appropriate (e.g., the Prescriber may prescribe a different medication or request an exception).

If Provider is off-site, Provider must send (fax or deliver) the CMS-10147 Pharmacy Notice to the location in the LTC facility designatedto accept such notices.

If Provider is on-site, Provider must deliver the notice to the location in the LTC facility designated to accept such notices. The LTC facility staff is responsible for providing the Part D Enrollee (or the Part D Enrollee's appointed representative) and the Part D Enrollee's treating Prescriber with the notice. A copy of the notice should be placed in the Part D Enrollee's file at the LTC facility (refer to **Appendix G** for a copy of the notice in English and Spanish).

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

10.07.02 LTC Pharmacies Timely Claim Submission

Participating LTC Providers will have no less than thirty (30) days, and no more than ninety (90) days to submit claims (42 C.F.R. 423.505(b)(20)) from the original date of fill. This includes electronically submitted claims and non-electronically submitted claims from original date of fill. Non-participating LTC Providers have three (3) years from the original date of fill to file claims.

The requirement above does not eliminate the requirement specified in CMS policy memo dated May 25, 2007, for Part D Plan Sponsors to provide new timely claims filing period for claims incurred by dual-eligible Part D Enrollees during a period of retroactive Part D enrollment.

Provider UCFs should be clearly identified as "Medicare Part D LTC" claims, include the appropriate Pharmacy Service Type and Patient Residence values and should be mailed to the following address:

RXBINs 004336, 610591, 610415:

Long-term Care (LTC) Claims:
Attn: Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:

Aetna Long-term Care (LTC) Claims
Attn: Aetna Medicare Part D LTC
PO Box 14023
Lexington, KY 40512-4023

10.07.03 LTC Billing

Provider must dispense certain brand oral solid Covered Part D Drugs in quantities of fourteen (14) days or less, unless an exemption applies. Caremark has implemented a dispensing fee incentive for those LTC Part D brand and generic drugs in accordance with CMS regulations. Provider agrees to submit claims to Caremark's claim adjudication system for LTC Pharmacy Services. Provider must bill Caremark immediately after dispensing or within thirty (30) days after the dispensing event. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws.

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply. "Brand oral solids" are limited to brand products with the following exceptions to the appropriate days supply (ADS) dispensing rule:

- Generic drugs (ANDA/non-specified)
- Solid oral doses of antibiotics
- Solid oral doses in packaging that cannot be broken (e.g., oral contraceptives)

Other exceptions—Providers, Part D Enrollees and coverage situations—include:

- Assisted Living Facilities (ALF)
- Medicare as a Secondary Payer (MSP)
- Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) and Institutes for Mental Disease (IMD)
- Indian Health Service, Tribal 638, and Urban Indian Health (I/T/U)

Four fields have been utilized to accommodate ADS dispensing requirements: Patient Residence Code, Pharmacy Service Type, Submission Clarification Codes (SCC) and Special Package Indicator (SPI). Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

Submission Clarification Codes:

NCPDP Field 420-DK	
Code	**Description**
21	LTC dispensing: 14 days or less not applicable (N/A) – 14 days or less dispensing is N/A due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e., vacation supply, leave of absence, e-kit, spitter dose). Medication quantities are dispensed as billed
22	LTC dispensing: 7 days – Pharmacy dispenses medication in 7-day supplies

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

NCPDP Field 420-DK	
Code	**Description**
23	LTC dispensing: 4 days – Pharmacy dispenses medication in 4-day supplies
24	LTC dispensing: 3 days – Pharmacy dispenses medication in 3-day supplies
25	LTC dispensing: 2 days – Pharmacy dispenses medication in 2-day supplies
26	LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1-day supplies
27	LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4-day, then 3-day supplies
28	LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2-day, then 2-day, then 3-day supplies
29	LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekends
30	LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes)
31	LTC dispensing: Per med pass dispensing – Remote dispensing per med pass
32	LTC dispensing: PRN on demand – Remote dispensing on demand as needed
33	LTC dispensing: 7 days or less cycle not otherwise represented
34	LTC dispensing: 14 days – Pharmacy dispenses medication in 14-day supplies
35	LTC dispensing: 8-14 day dispensing not listed above – 8-14-day dispensing cycle not otherwise represented
36	LTC dispensing: dispensed outside of short cycle. Medicare Part D coverage was determined post dispensing

Refer to the NCPDP standard at **www.ncpdp.org/Members/Standards-Lookup.aspx.** Membership to NCPDP is required to view this information online.

10.07.04 LTC Days Supply Limitations

As per CMS guidance, LTC Providers in the LTC Medicare Part D networks are only allowed to dispense up to a 31-day supply of medication for Part D Enrollees. In the event that a medication being provided is the smallest commercially available package size and exceeds the allowable 31-day supply, the quantity may be submitted utilizing the quantity of the single package with the corresponding day supply. Refer to section **10.07.03 LTC Billing** of the Provider Manual.

10.07.05 LTC Transition Fill

(NOTE: Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills must be submitted with the appropriate LTC Pharmacy Service Type and Patient Residence Codes. See additional information in the table below).

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Transition Fill Condition	Description	Allowed TF Supply
Part D Enrollee who is newly enrolled in Plan	• Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one plan to another after start of contract year	• Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage in the new Plan.
Renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within 180 days from date of claim and previous claim not TF • If Part D Enrollee has not transitioned before beginning of new Plan benefit year	• Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage effective at the beginning of the new contract year.
*Part D Enrollee residing in LTC facility (New Patient Admission)	LTC New Patient Admission/Level of Care Change within past 30 days	• Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. Multiple fills are allowed within 31 days of admission or change of care. • Submit SCC 420-DK Value "18". • Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes. • If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Transition Fill Condition	Description	Allowed TF Supply
*Part D Enrollee residing in LTC facility (Emergency Supply)	LTC Emergency Supply	• Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense drugs with a first fill of a maximum of 31-day supply, or less if the prescription is written for fewer days. • Submit SCC 420-DK Value "7". • Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes. If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance.
Part D Enrollee requesting exception and decision still pending	Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted	Contact the Pharmacy Help Desk for overrides under this condition.

*Refer to section **10.07.03 LTC Billing** of the Provider Manual for exceptions.

10.07.06 Special Package Indicator

NCPDP has created an additional field for Special Package Indicator (SPI). Caremark does not require SPI Codes at this time, but will accept the values shown below if submitted. At such time Caremark requires SPI Codes, Caremark will provide Provider with written notice.

NCPDP Field 429-DT	
Code	**Description**
0	Not specified
1	Not Unit Dose - product is not being dispensed in special unit dose packaging
2	Manufacturer Unit Dose - a distinct dose as determined by the manufacturer
3	Pharmacy Unit Dose - when the pharmacy has dispensed the drug in a unit-of-use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose
4	Pharmacy Unit Dose Patient Compliance Packaging - Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly
5	Pharmacy Multi-drug Patient Compliance Packaging - Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration
6	Remote Device Unit Dose - Drug is dispensed at the facility, via a remote device, in a unit-of-use package
7	Remote Device Multi-drug Compliance - Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration
8	Manufacturer Unit-of-Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in LTC claims only (as defined in Telecommunication Editorial Document)

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

10.07.07 LTC Override Requests

Emergency Supply:

Note the following text from Chapter 6 of the Medicare Part D manual. The requirement states to allow a one-time emergency fill while an exception or prior authorization is being processed (after the 90-day transition period has expired) for up to 31 days of medication, unless the prescription is written for less than 31 days.

If the prescription in question was written for less than 31 days, it is within CMS guidelines to restrict to one fill. According to CMS regulations, standard prior authorization requests must be decisioned within 72 hours. Standard exception requests must be decisioned within 72 hours of receiving the Prescriber's supporting statement.

Provider shall not apply Emergency Supply overrides to situations outside the defined scenario(s) that CMS describes in the Prescription Drug Benefit Manual below.

Chapter 6 of CMS Prescription Drug Benefit Manual states the following:

Section 30.4.6 - Emergency Supply for Current Enrollees in the LTC Setting
(Rev. 18, Issued: 01-15-16, Effective: 01-15-16; Implementation: 01-15-16)

Since, as a matter of general practice, LTC facility residents must receive their medications as ordered without delay, Part D sponsors must also cover emergency supplies of non-formulary Part D drugs for LTC facility residents after the transition period.

During the first ninety (90) days after enrollment, the Part D Enrollee will receive a transition supply as described in section 30.4. However, to the extent that a Part D Enrollee in an LTC setting is outside his or her 90-day transition period, the Plan Sponsor must still provide an emergency supply of non-formulary Part D drugs while an exception or prior authorization request is being processed. These emergency supplies of non-formulary Part D drugs must be for at least 31 days of medication, regardless of dispensing increments, unless the prescription is written by a Prescriber for less than 31 days. In cases where the smallest available marketed package size is not available for less than a 31-day supply, the Plan Sponsor must still provide an emergency supply when required. Part D Sponsors and their processors must determine how best to process claims in such cases. Multiple 14-day or less supplies can be supplied for brand name drugs to meet a minimum of a 31-day emergency supply requirement. A Plan Sponsor is not expected to provide more than a one-time 31-day emergency fill of a particular drug per LTC stay.

Section 30.4.7 - Level of Care Changes (excerpt)
(Rev. 10, Issued: 02-19-10, Effective/Implementation Date: 03-01-10)

In addition to circumstances impacting new Part D Enrollees who may enter a plan with a medication list that contains non-formulary Part D drugs, other circumstances exist in which unplanned transitions for current Part D Enrollees could arise and in which prescribed drug regimens may not be on sponsor formularies. These circumstances usually involve level of care changes in which a Part D Enrollee is changing from one treatment setting to another. For example, Part D Enrollees who enter LTC facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary with very short term planning taken into account (often under eight hours). Similar situations may exist, for example, for Part D Enrollees who are discharged from a hospital to a home; for Part D Enrollees who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; for Part D Enrollees who give up hospice status to revert to standard Medicare Part A and B benefits; for Part D Enrollees who end an LTC facility stay and return to the community; and for Part D Enrollees who are discharged from psychiatric hospitals with drug regimens that are highly individualized.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Below are Part D Plan Sponsor's utilization management rules to LTC Part D Enrollees for LTC emergency supplies and LTC admissions/level of care changes.

1. An emergency supply must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days.
2. Transition supplies of non-formulary Part D drugs for LTC admission/level of care changes must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days.
3. Provider must maintain documentation substantiating any SCC values or override codes transmitted on a Medicare Part D claim.

Emergency Supply Situations:

- **Emergency Kit Dispensing:** Emergency Kit/Box (E-Box) medications for emergency treatment until standard supply can be dispensed
- **First Fill Following Emergency Kit Dose:** Follow-up fill after emergency dose has been dispensed. This prescription should be filled for the fully prescribed amount minus the emergency dosing
- **LOA (Leave of Absence) Medications:** Separate dispensing of small quantities of medications for take-home use allowing Part D Enrollees to leave facility for weekend visits, holidays, etc.
- **Medication Spit Out:** Medication has been "spit out"
- **Emergency Supply:** Emergency supply of non-formulary drugs and formulary with PA or Step Therapy Requirements
- **LTC Admission/Level of Care Change:** Newly admitted due to clinical status change

  1. Medications may have:
     a. Been filled at retail pharmacy prior to admit;
     b. Been filled prior to transfer and discontinued;
     c. Not followed Part D Enrollee to new facility due to regulatory and compliance issues and same medications reordered upon re-admit
  2. New Admission/Level of Care Change:
     a. Valid within 31 days of New Admission/Level of Care change
     b. Up to 34-day supply with multiple fills
     c. Day Supply of 34 includes those claims where SCC 18 is not used

Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills are submitted with the Pharmacy Service Type (PST) and Patient Residence (PR) that designate LTC (for RXBINs 004336, 012320 and 610591 only).

- For LTC Emergency Supply: Use SCC [NCPDP Field # 420-DK] Value "07"
- For LTC New Patient Admission/Level of Care Change: Use SCC NCPDP [Field # 420-DK] Value "18"

10.07.08 LTC Overrides for Current Part D Enrollees

D.Ø NCPDP FIELD	D.Ø VALUE/CODE	SITUATION	ALLOWANCES
SCC 420-DK	16	Emergency Kit (Emergency Dose)	5-day supply
SCC 420-DK	17	First Fill Following Emergency Kit Dose	Written Rx Less E.R. Kit Dose given
SCC 420-DK	14 (use value 3 for ALF)	Leave of Absence Vacation supply	5-day supply
SCC 420-DK	15	Patient "Spit Out"	Not applicable

CONFIDENTIAL AND PROPRIETARY

D.Ø NCPDP FIELD	D.Ø VALUE/CODE	SITUATION	ALLOWANCES
SCC 420-DK	07	Emergency Supply (only as defined in this section)	31-day supply
SCC 420-DK	18	LTC Admission/ Level of Care Change	Up to 34-day supply with multiple fills within 31 days of admission or change of care, day supply includes claims where no SCC 18 is used after New Admission/Level of Care Change
SCC 420-DK	19	Partial Payment under Medicare Part A	Not applicable

Refer to the NCPDP Payer Sheets at **www.caremark.com/pharminfo**.

10.07.09 Medicare Part A and Medicare Part D Drug Coverage Determinations

LTC Providers should consult their Caremark LTC Addendum regarding clarification on Medicare Part A and Medicare Part D drug coverage determinations.

Hospice care is a Medicare Part A benefit and, therefore, drugs provided by hospice and covered under the Medicare Part A payment to the hospice program are not covered under Part D. Only drugs which are used primarily for relief of pain and symptom control related to an individual's terminal illness are covered by the hospice program. When a Medicare Part D claim rejects due to hospice validation, the claim will also reject with:

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

Reject 75 <<Prior Authorization Required>>

Reject A3 <<This Product May Be Covered Under Hospice – Medicare A>>

In addition to the above rejects, secondary messagingis returned. The secondary message is as follows:

<<Hospice drugs not covered under Part D. If unrelated to terminal diagnosis, call XXX-XXX-XXXX>>.

The reject message will direct the pharmacy to the Pharmacy Help Desk. The Pharmacy Help Desk representative will verify if the Part D Enrollee is in hospice and inform Provider that written termination documentation from hospice or Part D Enrollee is required before an override can be placed.

IMPORTANT:

1. As specified in the Social Security Act, Section 1861(dd), and Federal Regulations (42 C.F.R. Section 418 *et seq.*), hospice programs must provide individuals under hospice care with drugs and biologicals related to the palliation and management of the terminal illness as defined in the hospice plan of care.
2. Stand-alone prescription drug Plan Sponsors cannot easily identify and prevent Part D payment for hospice drugs. Provider should work with LTC facilities in which their patients reside or hospice providers to identify any Part D Enrollees who have elected hospice care and ensure hospice drugs are not billed to Part D.
3. For those Plan Sponsors utilizing Caremark coverage determination services, if the treatment is unrelated to the terminal condition, the Pharmacy Help Desk will direct the Provider to ask the hospice provider to fax the form to the Coverage Determinations and Appeal Department and provide the written documentation for the Part D exception. Provider must provide the Pharmacy Help Desk with the hospice provider's contact information to help expedite the process. Caremark's Prior Authorization department will handle the documentation requests and inform Provider if an approval will be made.
4. For Part D Plan Sponsors not utilizing Caremark for coverage determinations, the telephone number in the message will direct Provider to the Part D Plan Sponsor's coverage determination department to initiate the process.
5. Per CMS guidance, for Part D Enrollees and/or caregivers who state they are no longer in hospice, Caremark requires written documentation prior to overriding the hospice reject. The four acceptable forms are outlined

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00001135

as the Best Available Evidence below. The documentation can be faxed to Caremark at **1-844-242-0904**. Caremark requires a retail and LTC pharmacy to provide the hospice contact information to the Pharmacy Help Desk. Part D Enrollees and/or caregivers may ask Providers to fax the documentation to Caremark.

The following valid documents can be provided as Best Available Evidence of hospice disenrollment or discharge:

1. Written statement from Part D Enrollee to hospice indicating date revocation is to be effective: Applies when Part D Enrollee has chosen to no longer continue with hospice benefits.
2. Notice of Medicare Non-Coverage (NOMNC): Hospice initiates discharge because Part D Enrollee is no longer considered terminally ill.
3. Discharge summary (provided by hospice to a facility or physician): Hospice discharged Part D Enrollee for cause, or because Part D Enrollee is no longer within the hospice service area.
4. NCPDP form: Submitted by hospice or physician indicating date of discharge.

10.08 Retail Addendum to the Caremark Provider Agreement

Terms of Participation in Medicare Part D

By entering into the Provider Agreement, Provider agrees to comply with the following terms (as noted in this Retail Addendum to the Caremark Provider Agreement) to the extent Provider provides Pharmacy Services to a Part D Enrollee and Provider is a Retail Pharmacy as that term is defined in 42 C.F.R. § 423.100. In the event any provision in this Retail Addendum to the Caremark Provider Agreement ("Retail Addendum") conflicts with the terms of the Provider Agreement (including the Provider Manual), the terms of this Retail Addendum shall govern. Provider acknowledges that CVS Caremark Part D Services, L.L.C., together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this Retail Addendum) are responsible for providing Part D services on behalf of Part D Plan Sponsors.

To the extent that Provider shall provide Pharmacy Services to a Part D Enrollee, Provider agrees to comply with any applicable Part D requirements for participation in Part D as a Dispensing Pharmacy.

Without limiting the generality of the foregoing, and notwithstanding anything in the Provider Agreement to the contrary, Provider agrees as follows:

1. Provider agrees to participate as, and perform the functions of, a Part D Retail Dispensing Pharmacy, including any reporting functions required to Part D Plan Sponsors, in accordance with the terms and conditions set forth in this Retail Addendum.
2. Provider agrees to perform its services under this Retail Addendum in a manner that is consistent with, and encompasses the services required to support Part D and in compliance with the contractual obligations of a Part D Plan Sponsor to CMS.
3. Provider agrees not to hold any Part D Enrollee liable for payment of any fees that are the responsibility of Caremark or a Part D Plan Sponsor.
4. Provider and Caremark agree that Provider is not required to accept Insurance Risk as a condition of participation as a Dispensing Pharmacy for Part D, and in the Medicare Part D Retail Network.
5. Provider agrees to comply with all applicable federal and state laws and regulations, CMS guidance or instructions relating to Part D, and any minimum standards for Provider practice established by the States in which Provider is licensed. Provider agrees to comply with all applicable state and federal privacy and security requirements, including the confidentiality and security requirements set forth in 42 C.F.R. § 423.136, the Privacy Rule, Security Rule, and Transactions Standards.
6. Provider agrees to make its books and records available in accordance with, and for the period required by 42 C.F.R. § 423.505(i)(2), which gives HHS, the Comptroller General, or their designees (collectively, "Government Parties"), the right to audit, evaluate, collect, and inspect any books, contracts, records, computers, or other electronic systems, including medical records, and documentation of Provider involving transactions related to CMS' contract with a Part D Plan Sponsor (collectively, "Records"), and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor's contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the ten (10) year retention period. In the case of a request by a Government Party for the direct disclosure by Provider to the Government Party of Records,

CONFIDENTIAL AND PROPRIETARY

Provider shall (a) provide Caremark with prompt written notice of the Government Party's request so that Caremark can object or intervene as it deems proper; (b) take all appropriate steps to protect the confidentiality of the Records, including labeling it "CONFIDENTIAL AND PROPRIETARY – FOIA EXEMPT" and attaching a statement provided by Caremark explaining the application to the Records of any Freedom of Information Act or other exemptions to disclosure; and (c) provide Caremark with the opportunity to review the Records that is subject to disclosure to the Government Party prior to Provider's release of same to the Government Party. Provider also agrees to maintain records and provide access in accordance with 42 C.F.R. § 423.505(b)(10).

7. Provider agrees that, upon a Part D Plan Sponsor delegating any activity or responsibility to Caremark and Caremark in turn delegating that activity or responsibility to Provider pursuant to this Retail Addendum, that activity or responsibility may be revoked if CMS, the Part D Plan Sponsor, or Caremark determines that Provider has not performed satisfactorily. CMS, the Part D Plan Sponsor, or Caremark may also exercise anyremedies available at Law or under the Provider Agreement in lieu of revocation. Further, Provider agrees that such activity or responsibility shall be in accordance with 42 C.F.R. § 423.505(i)(3).
8. Provider agrees that Caremark and any Part D Plan Sponsor (with respect to its Part D Enrollees only) each has the right to approve, suspend, or terminate the Agreement in their sole discretion at any time.
9. Provider agrees that Caremark and the Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis.
10. Provider agrees to provide Part D Enrollees with access to Negotiated Prices for Covered Part D Drugs as required by and in accordance with 42 C.F.R. § 423.104(g).
11. Provider agrees to submit Claims to Caremark's real-time claims adjudication system.
12. Provider agrees that when it dispenses a Covered Part D Drug to a Part D Enrollee, it will inform such Part D Enrollee at the point of sale of the lowest-priced, generically-equivalent version of that Covered Part D Drug, if one exists for the Part D Enrollee's prescription, as well as any associated differential in price in accordance with 42 C.F.R. § 423.132.
13. Provider agrees to implement a method for maintaining up-to-date Part D Enrollee information such as, but not limited to, demographic and allergy (drug) information, and such other information as CMS may require.
14. Provider agrees to implement such utilization management and quality assurance programs, including concurrent drug utilization review, generic substitution and/or therapeutic interchange programs, as Caremark may require, and as consistent with and in compliance with 42 C.F.R. § 423.153(b), (c) and (d). Provider agrees to offer patient counseling to Part D Enrollees, where appropriate and/or required by Law.
15. Provider agrees to fill a prescription for a 90-day supply of Covered Part D drugs for Part D Enrollees at the appropriate cost-sharing and Negotiated Price as communicated by Caremark to Provider through the real-time claims adjudication process, including that which applies to individuals qualifying for the low-income subsidy.
16. Provider agrees to charge/apply the correct cost-sharing amount, including that which applies to individuals qualifying for the low-income subsidy.
17. Part D Claims may be priced using the Provider Agreement, the Caremark Medicare Part D Retail Network, or other Caremark or Plan Sponsor specific network.
18. INTENTIONALLY BLANK
19. Provider acknowledges that it is not a mail order pharmacy and it is a "retail pharmacy" as defined in 42 C.F.R. § 423.100.
20. Entire Agreement. This Retail Addendum, the Provider Agreement, the Provider Manual, and the Medicare Network Enrollment form, and all other applicable enrollment forms, constitute the entire agreement between Provider and Caremark for the purposes of Provider's participation as a Medicare Part D Network Provider, all of which are incorporated by this reference as if fully set forth herein and referred to collectively as the "Provider Agreement" or "Agreement". Any prior agreements, promises, negotiations, or representations related to the terms of this Retail Addendum are terminated and of no force and effect. Provider's non-compliance with any of the provisions of this Retail Addendum will be a breach of the Provider Agreement. All pricing terms are considered to be Caremark's confidential and proprietary information and may not be shared with any third party without express written consent from Caremark.
21. The following terms and phrases, when capitalized and when used in this Retail Addendum, have the meanings

set forth below. All other capitalized terms and conditions shall have the meaning set forth in the Provider Agreement.

a. "Claims" means those claims processed through the Caremark online, real-time claims adjudication system.

b. "CMS" means the Centers for Medicare and Medicaid Services under the Department of Health and Human Services.

c. "Covered Part D Drug(s)" has the same meaning as that term as defined in 42 C.F.R. § 423.100.ß.

d. "Dispensing Fee" has the same meaning as such term is defined in 42 C.F.R. § 423.100 which states that dispensing fee means costs that are incurred at the point of sale and pay for costs in excess of the ingredient cost of a Covered Part D Drug each time a Covered Part D Drug is dispensed, and includes only pharmacy costs associated with ensuring the possession of the appropriate Covered Part D Drug is transferred to a Part D Enrollee.

e. "HHS" means the Department of Health and Human Services.

f. "Insurance Risk" has the same meaning as such term as defined in 42 C.F.R. § 423.4.

g. "Medicare Part D Retail Network" means Claims priced for a Part D Enrollee pursuant to the Retail Addendum to the Caremark Provider Agreement entitled "Caremark Medicare Part D Retail Pharmacy Network."

h. "Negotiated Prices" has the same meaning as such terms as defined 42 C.F.R. § 423.100.

i. "Part D" means Part D of Title XVIII of the Social Security Act, which establishes the Voluntary Prescription Drug Benefit Program under Medicare.

j. "Part D Enrollee" means an individual covered by a Part D Plan.

k. "Part D Plan" has the same meaning as such term as defined in § 423.4, but limited to those Part D Plans that have contracted with SilverScript, L.L.C. to use pharmacy providers that have contracted with Caremark to provide Pharmacy Services to Part D Enrollees.

l. "Part D Plan Sponsor" has the same meaning as such term as defined in 42 C.F.R. § 423.4, but limited to those Part D Plan Sponsors that offer Part D Plans.

m. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

n. "Security Rule" shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. parts 160, 162 and 164, subpart C. Notwithstanding anything to the contrary in the Agreement, any requirements related to the Security Rule shall be effective no earlier than the applicable Compliance Date for the Security Rule.

o. "Transactions Standard" means the Standards for Electronic Transactions under 45 C.F.R. parts 160 and 162, subparts I et.seq.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

11. Medicare Advantage

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

To the extent Provider provides Pharmacy Services for an Eligible Person for a claim covered by a Plan Sponsor that is a Medicare Advantage plan, Provider must comply with the following terms, if applicable:

1. The Department of Health and Human Services, the Comptroller General or their designees have the right to audit, evaluate, collect, and inspect any pertinent information including books, contracts, computer or other electronic systems, including medical records, and documentation related to CMS' contract with Plan Sponsor for a period of ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. 42 C.F.R. 422.504(i) (2)(i)-(ii) and (iv).
2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (a) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (b) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (c) maintaining the records and information in an accurate and timely manner, and (d) ensuring timely access by enrollees to the records and information that pertain to them, including 42 C.F.R. 422.118; 42 C.F.R. 422.504(a)(13).
3. Provider may not hold an Eligible Person liable for payment of fees that are the legal obligation of the Plan Sponsor to fulfill. Such provision will apply, but will not be limited to, insolvency of Caremark or Plan Sponsor, contract breach, and Provider billing. 42 C.F.R. 422.504(g)(1)(i); 422.504(i)(3)(i); MMA Manual Chapter 11, Section 100.
4. Any services performed in accordance with a contract are consistent and comply with the Plan Sponsor's contractual obligations to CMS. 42 C.F.R. 422.504(i)(3)(iii).
5. Provider will be paid in compliance with the requirements of 42 C.F.R. 422.520(b).
6. Caremark and Plan Sponsor may approve, suspend, or terminate the Agreement with respect to Provider's provision of Pharmacy Services for a Medicare Advantage Plan Sponsor. 42 C.F.R. 422.504(i)(5).
7. Caremark and Plan Sponsor have the right to revoke the Provider Agreement with respect to delegated activities performed or to seek other remedies in lieu of termination as provided in the Provider Agreement if Caremark, CMS or the Plan Sponsor determines that Provider has not performed its obligations satisfactorily. Caremark and Plan Sponsor will monitor Provider's performance hereunder on an ongoing basis. 42 C.F.R. 422.504(i)(4)(ii) and (iii).
8. Caremark and Plan Sponsor will review the credentials of medical professionals affiliated with Provider. Caremark and Plan Sponsor will also review and approve the credentialing process, including audits of the credentialing process on an ongoing basis. 42 C.F.R. 422.504(i)(4)(iv).
9. Provider must comply with applicable Medicare laws and regulations and CMS instructions, and to allow audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of ten (10) years. 42 C.F.R. 422.504(i)(4)(v) and MMA Manual, Chapter 11, Section 100.4.
10. Provider agrees that Caremark and Plan Sponsor oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations. MMA Manual, Chapter 11, Section 100.4.
11. Provider must not discriminate in the furnishing of benefits on the basis of any factor that is related to health status, including but not limited to: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (g) disability. 42 C.F.R. 422.110(a).
12. Provider must comply with the Plan Sponsor's policies and procedures and written standards, which in accordance with 42 C.F.R. 422.112(a)(6) require:
    a. Timely access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services are continuously monitored to ensure compliance and that Caremark and Plan Sponsor will take corrective action as necessary;

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

b. Compliance with the Plan Sponsor's coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations; and

c. Provider consideration of beneficiary input into Provider's proposed treatment plan.

13. Provider must ensure that its Pharmacy Services are available 24 hours a day, 7 days a week, when medically necessary. 42 C.F.R. 422.112(a)(7)(ii).

14. Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. 422.112(a)(8).

15. Provider must provide effective and continuous patient care and quality review, and maintain health records in accordance with standards established by the Plan Sponsor, taking into account professional standards and that there is appropriate and confidential exchange of information with other network providers. 42 C.F.R. 422.112(b)(4)(ii)-(iii).

16. Provider must establish procedures to ensure that Eligible Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and systems to address barriers to Eligible Person compliance. 42 C.F.R. 422.112(b)(5) and (6).

17. Nothing in the Agreement shall be construed as requiring Provider to indemnify Caremark or Plan Sponsor against any civil liability for damage caused to an Eligible Person as a result of a Plan Sponsor's denial of medically necessary care to such Eligible Person. 42 C.F.R. 422.212.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

12. Medicare-Medicaid Plan

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

A Medicare-Medicaid Plan (MMP), or dual demonstration plan, is a program administered by CMS and a particular state Medicaid agency that integrates the services provided by both the Medicare and Medicaid programs into one plan provided to eligible Medicare-Medicaid Eligible Persons.

12.01 Medicare-Medicaid Networks Standards

To the extent Provider provides Pharmacy Services to a Medicare-Medicaid Eligible Person, and without limiting any other provision in the Agreement, Provider must comply with CMS Medicare Part D requirements, including the components of the Three-Way contract between CMS, an individual state Medicaid agency, and a specific Plan Sponsor.

12.02 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicare-Medicaid Plan Eligible Person is made, in whole or in part,from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable state laws including minimum standards of pharmacy practice. Refer to section **16. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Caremark Pharmacy Portal, refer to section **1.06 Pharmacy Portal** of the Provider Manual.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

13. Qualified Health Plans

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

For Qualified Health Plan ("QHP") Eligible Persons eligible for health benefits under a QHP ("Eligible Person") offered by a QHP Issuer (as defined in 45 C.F.R. 155.20), or "Plan Sponsor", on the Federally-facilitated Exchange or a State Partnership Exchange, Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and the Department of Health and Human Services ("HHS") guidance, including but not limited to, 45 C.F.R. 156.340(a), to the extent relevant to the Pharmacy Services provided.
2. To permit access by HHS and the Office of Inspector General ("OIG"), or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations in accordance with 45 C.F.R. 156.340(a), until ten (10) years after the final date of the Provider Agreement period.
3. For purposes of clarity, delegated activities and reporting responsibilities as described in 45 C.F.R. 156.340(b), if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.
4. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.
5. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer or Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.
6. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

For QHP Eligible Persons eligible for health benefits under a QHP offered by a QHP Issuer on a State-based Exchange, including but not limited to, **Arkansas, California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington,** Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and guidance issued by HHS, a State-based Exchange or other applicable regulatory body, to the extent relevant to the Pharmacy Services provided.
2. To perform Pharmacy Services in a manner consistent with and in compliance with the QHP Issuer's contractual obligations to the State-based Exchange or other applicable regulatory body.
3. To permit access by HHS, the OIG, the State-based Exchange or other applicable regulatory body, or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations until ten (10) years after the final date of the Provider Agreement period.
4. For purposes of clarity, delegated activities and reporting responsibilities, if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.
5. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.
6. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer, State-based Exchange, applicable regulatory body, Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.
7. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

14. Intellectual Property, Confidentiality and Proprietary Rights

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

14.01 Advertising and Trademarks

Caremark, or its affiliates, retains exclusive rights to, and in, the names "CVS/caremark™" and "Caremark®" together with other distinctive trademarks or service marks that have been used by Caremark or may be adopted or used by Caremark in the future.

Provider must not advertise or use any name, symbol, trademark or service mark of Caremark or Plan Sponsor in advertising or any other promotional information other than as specifically permitted by the Provider Agreement without prior written consent of Caremark or Plan Sponsor respectively.

Caremark or Plan Sponsors may: (1) use the name, logos, address(es) of Provider in directories, informational brochures or other publications provided to Plan Sponsors or Eligible Persons; (2) use the information regarding Provider's services that is provided to Caremark by Provider in publications provided to Plan Sponsors or Eligible Persons; and (3) provide Plan Sponsors or Eligible Persons with credentialing information.

Upon termination for any reason, Provider must immediately discontinue the use of any name, symbol, trademark or service mark of Caremark in advertising or any other promotional information.

14.02 Non-Disparagement

Provider may not place in a false light, disparage, defame, nor make any damaging, derogatory, or unfavorable public statements regarding Caremark, Caremark's products, programs, services, employees, personnel, and brands. Provider will provide appropriate and adequate training to ensure compliance with these requirements. Provider's obligations hereunder shall survive termination of the Agreement.

14.03 Confidentiality

"Confidential Caremark Information" is defined as any non-public information or data of Caremark and includes but is not limited to, (1) Caremark's products, programs, services, designs, inventions, business practices, policies and procedures, customer list, information related to a Plan Sponsor, trade secrets; (2) MAC lists; (3) reimbursement rates and terms; (4) the Provider Agreement, the Provider Manual, network enrollment forms and other addenda, and other Caremark Documents; and (5) other information relating to Caremark's business.

Provider must maintain in confidence and may not disclose, sell, assign, transfer, or give to any third party, including a Plan Sponsor or Eligible Person, Confidential Caremark Information without Caremark's prior written consent. Provider may use Confidential Caremark Information only for the purpose of carrying out its obligations under the Provider Agreement. Provider may disclose Confidential Caremark Information to its employees, agents, consultants, or authorized representatives who have a need to know the Confidential Caremark Information in order to carry out Provider's obligations under the Provider Agreement and who (1) have been informed of the confidential and proprietary nature of the Confidential Caremark Information, and (2) have agreedin writing not to disclose the Confidential Caremark Information to others and to treat the Confidential Caremark Information in accordance with the requirements of this section.

Provider agrees to protect the security of Confidential Caremark Information and to ensure that it is used and disclosed only as permitted herein. Provider must promptly notify Caremark if it becomes aware of any unauthorized use of Confidential Caremark Information. Provider is responsible to Caremark for any breach of this section by its employees, agents, consultants, or authorized representatives.

No Confidential Caremark Information may be quoted or attributed to Provider or Caremark without the prior written consent of Caremark.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00001143

Provider agrees to protect the confidentiality and security of an Eligible Person's personal information (which includes any information that identifies or can be used to identify an Eligible Person), as required by applicable Law, and to use and disclose such information only as permitted by and in accordance with applicable Law.

This **Confidentiality** section applies to the extent consistent with applicable Law.

14.04 Non-Solicitation and Non-Interference

Provider must not (directly or indirectly): (1) communicate with any current Plan Sponsor about terminating its agreement with Caremark; (2) interfere with the relationship or potential relationship between Caremark and a Plan Sponsor or Eligible Person; (3) use or disclose Confidential Caremark Information for the purpose of soliciting a Plan Sponsor or Eligible Person, or for any other purpose not in furtherance of the Agreement; (4) communicate with a Plan Sponsor regarding Provider network participation status or network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor; (5) provide inaccurate plan benefit design information to an Eligible Person; or (6) communicate with any Plan Sponsor or potential Plan Sponsor about entering into an agreement for pharmacy benefit management services with any person other than Caremark.

Provider must not (directly or indirectly): (1) communicate with any Eligible Person or a Plan Sponsor's group(s) about person or group terminating its agreement with the Plan Sponsor; (2) interfere with negotiations that a Plan Sponsor is conducting for the provision of health benefits, including pharmacy benefits, to Eligible Persons or groups; (3) use or disclose to any third party, Eligible Person or Plan Sponsor group information acquired during the term of the Agreement for the purpose of soliciting Eligible Persons or Plan Sponsor groups, or for any other purpose not in furtherance of the Agreement; or (4) communicate with a Plan Sponsor's group regarding Provider's network participation status or the network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor or group.

Nothing contained herein shall prevent Provider from disclosing any information required by Law to be disclosed or otherwise required to be disclosed to an Eligible Person in the fulfillment of the Provider's professional responsibilities for an Eligible Person.

14.05 Proprietary Rights

Provider has no right to use, reproduce or adapt any information, data, work, compilation, computer program, manual, process or invention obtained from, provided by, or owned by Caremark or Plan Sponsor (including but not limited to, products, programs, services, business practices, procedures), without Caremark's prior written consent.

Provider agrees that the information contained in the claims adjudication system that was obtained by and through the administration and adjudication of a claim by Provider is the property of Caremark, and Provider agrees not to claim any right, title, or interest in said information.

Caremark, and its affiliates, have the right to use, reproduce, and adapt any information or data obtained from Provider in any manner deemed appropriate, even if such use is outside the scope of the Provider Agreement, provided such use is in accordance with applicable Law.

14.06 Remedies

Provider acknowledges that any unauthorized disclosure or use of information or data obtained from or provided by Caremark would cause Caremark immediate and irreparable injury or loss that cannot be fully remedied by monetary damages.

Accordingly, if Provider should fail to abide by the provision and terms set forth in these sections of the Provider Manual (**Intellectual Property, Confidentiality, and Proprietary Rights**), Caremark will be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and judgment for damages (including reasonable attorneys' fees and costs) caused by the breach, and all other remedies provided by the Provider Agreement and applicable Law.

CONFIDENTIAL TREATMENT REQUESTED

15. Miscellaneous

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

15.01 Assignment

Neither party may assign the Agreement without the prior written consent of the other party; provided, however, that Caremark may, without consent, assign the Agreement to any direct or indirect parent, subsidiary, or affiliated company or to a successor company.

Any permitted assignee shall assume all obligations of its assignor under the Agreement. The Agreement shall inure to the benefit of and be binding upon each party, its respective successors and permitted assignees.

If Provider's proposed assignment is approved by Caremark, Provider covenants that Provider shall enter into an agreement with such permitted successor or permitted assignee assigning Provider's rights and obligations under the Agreement in form and substance acceptable to Caremark, including naming Caremark as an express third-party beneficiary thereof. Notwithstanding an approved assignment and a permitted successor's or permitted assignee's assumption of Provider's liabilities and obligations under the Agreement, Provider will remain jointly liable for any liabilities and obligations under the Agreement until such permitted successor or permitted assignee satisfies such liabilities and obligations in full.

The terms of this **Assignment** section apply notwithstanding any other provision in the Agreement.

15.02 Independent Contractors and Third-Party Beneficiaries

Caremark and Provider are considered independent contractors, and shall have no other legal relationship under or in connection with the Provider Agreement. Neither party will act as or be deemed a representative of the other party for any reason whatsoever.

Except as otherwise provided for in the Provider Agreement, including but not limited to, the Indemnification section of the Provider Agreement and section **15.09 Arbitration** of the Provider Manual, no term or provision in the Provider Agreement is for the benefit of any person who is not a party to the Provider Agreement, and no such party shall have any right or cause of action under the Provider Agreement.

15.03 Court Orders, Subpoenas or Governmental Requests

If Caremark receives a court order, subpoena or governmental request relating solely to Provider, Caremark may comply with such order, subpoena or request, and Provider must indemnify and hold harmless Caremark for, from, and against any and all costs (including reasonable attorneys' fees and costs), losses, damages, or other expenses Caremark may suffer or incur in connection with the responding to such order, subpoena or request.

If Provider is requested or required to disclose any Confidential Caremark Information, whether by oral questions, interrogatories, requests for information or documents, subpoenas, or other processes, Provider must promptly provide Caremark with written notice of any such request or requirement so that Caremark may seek an appropriate protective order or other appropriate remedy. If such protective order or other remedy is not obtained, Provider will disclose only that portion of the Confidential Caremark Information as to which it has been advised by legal counsel that disclosure is required by Law; and Provider must exercise its best efforts to obtain reliable assurances that confidential treatment will be accorded to the Confidential Caremark Information that is disclosed in response to such requests or requirements.

15.04 Notices

A notice pursuant to the Provider Agreement to Caremark must be in writing, be delivered in person by certified mail, courier, or first class mail, and be addressed to Network Management at Caremark at the address below:

Caremark
Attn: Network Management, MC080
9501 East Shea Boulevard
Scottsdale, AZ 85260

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Any notice to Caremark must also be addressed and delivered to:

Caremark
Attn: General Counsel, MC035
9501 East Shea Boulevard
Scottsdale, AZ 85260

A notice pursuant to the Provider Agreement to Provider must be in writing, delivered in person by certified mail, courier, or first class mail, at the street, mailing, or check mailing address set forth in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark. Notwithstanding the foregoing, Caremark may give notice to Provider (1) via the claims adjudication system; (2) by facsimile via the Provider's facsimile number, or by e-mail via the e-mail address provided by Provider in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark; or (3) via Caremark's Pharmacy Portal.

Notices are deemed received on the date of delivery to the other party when delivered in person, by courier, by e-mail, by facsimile, by secure electronic message, by certified mail, or when posted via Caremark's Pharmacy Portal. If notice is sent by first class mail, the notice is deemed received on the third business day after the date such notice was mailed.

By participating as a provider in Caremark's networks, Provider acknowledges that it has a prior express business relationship with Caremark and consents to receive facsimile communications as well as automated messages from Caremark.

The terms of this **Notices** section apply notwithstanding any other provision in the Provider Agreement.

15.05 Termination

15.05.01 Termination for Cause

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in any Caremark network or Plan Sponsor network) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity. Refer to section **7. Compliance Reviews** of the Provider Manual.

Caremark may immediately terminate the Provider Agreement if:

1. To the extent consistent with applicable Law, Provider makes an assignment for the benefit of creditors, files a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property or a proceeding is commenced against it which will substantially impair its ability to perform the Provider Agreement;
2. Any court, governmental, or regulatory agency issues to Provider an order to cease and desist from providing Pharmacy Services;
3. (a) There is any change in who holds (directly or indirectly) the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (b) The right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party;
4. A levy, writ of garnishment, attachment, execution or similar item is served upon Provider and not removed within ten (10) days from the date of service;
5. Caremark reasonably determines that Provider is no longer active;
6. If the Provider fails to satisfy amounts or other obligations owed to Caremark, certain remedies may apply, including termination of the Provider Agreement and any other available remedies;
7. Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which:
    a. Appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or general public;
    b. Implies a failure to maintain proper licensure and related requirements for licensure;
    c. Otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement;
    d. Is a breach of the Agreement. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement, including termination of pharmacies found to have a direct or indirect relationship with Provider or its affiliates based upon common officers, directors, current/former employees, owners (direct or indirect); or

CONFIDENTIAL AND PROPRIETARY

e. Constitutes fraud, waste or abuse

The termination rights set forth in this section are in addition to any and all other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity. The effective date of a termination shall be determined by Caremark and as in accordance with applicable Law.

For any Provider with multiple locations, Caremark retains the right to terminate one or any number of Provider's pharmacy locations without terminating the Provider Agreement.

15.05.02 Termination Without Cause

Unless precluded by applicable Law, Caremark may at any time terminate the Provider Agreement without cause or terminate Provider from providing Pharmacy Services to specific Plans without cause upon a notice to Provider, regardless of the network(s) in which Provider participates.

Unless precluded by applicable Law, Provider may terminate the Provider Agreement without cause upon one hundred fifty (150) days' prior written notice to Caremark provided, however, that if applicable Law or a Caremark network or a Plan Sponsor network requires a longer notice period, the Provider Agreement shall not terminate until the expiration of such longer period.

Unless precluded by applicable Law, Provider may terminate participation in any Caremark network or a Plan Sponsor network upon one hundred fifty (150) days' prior written notice to Caremark, specifying the date of termination and the names of the Caremark network(s) or Plan Sponsor network(s) in which Provider will no longer participate, provided, however, that if applicable Law or a Caremark network or Plan Sponsor network requires a longer notice period, the termination will not take effect until the expiration of such longer period. Absent the prior written consent of Caremark, Provider may not elect to participate in a Caremark network or a Plan Sponsor network, for thirty (30) days or until the next solicitation period for that Caremark network or Plan Sponsor network, whichever is longer, to the extent consistent with applicable Law.

The terms of this **Termination Without Cause** section apply notwithstanding any other provision in the Provider Agreement. For termination without cause by Provider from a Medicare Part D network, refer to section **10.01.01 Network Participation** of the Provider Manual.

15.05.03 Rights and Remedies in the Event of Termination or Breach

In the event of a termination of the Provider Agreement for any reason, Provider must (upon Caremark's request) surrender the Provider Agreement, Provider Manual, other Caremark Documents, other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control.

In the event Provider breaches any provision of the Provider Agreement, in addition to all other termination rights, Caremark shall have the right, to the extent not contrary to Law, to (1) suspend any and all obligations of Caremark, including payment to Provider, under and in connection with the Provider Agreement, (2) impose reasonable handling, investigation and/or improper use fees, and/or (3) in whole or in part, offset against any amounts owed to Provider under the Provider Agreement or under any other agreement between Caremark and Provider, any amounts required to be paid by Provider to Caremark. These rights and remedies are not exclusive and are in addition to any other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

15.06 Survival of Certain Provisions

Termination of the Provider Agreement or Caremark or Plan Sponsor network will have no effect upon the rights and obligations of the parties accruing prior to the effective date of termination.

15.07 Amendments

From time to time, and notwithstanding any other provision in the Provider Agreement (which includes the Provider Manual), Caremark may amend the Provider Agreement, including the Provider Manual or other Caremark Documents, by giving notice to Provider of the terms of the amendment and specifying the date the amendment becomes effective. If Provider submits claims to Caremark after the effective date of any notice or amendment, the terms of the notice or amendment is accepted by Provider and is considered part of the Provider Agreement.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

15.08 Enforceability

In the event that any provision or term set forth in the Provider Agreement is determined invalid or unenforceable, such invalidity and unenforceability will not affect the validity or enforceability of any other provision or term set forth in the Provider Agreement.

15.09 Arbitration

Any and all disputes between Provider and Caremark [including Caremark's current, future, or former employees, parents, subsidiaries, affiliates, agents and assigns (collectively referred to in this Arbitration section as "Caremark")], including but not limited to, disputes in connection with, arising out of, or relating in any way to, the Provider Agreement or to Provider's participation in one or more Caremark networks or exclusion from any Caremark networks, will be exclusively settled by arbitration. This arbitration provision applies to any dispute arising from events that occurred before, on or after the effective date of this Provider Manual. Any dispute otherwise arbitrable hereunder shall be deemed waived, and no such dispute shall be made or raised, unless a Dispute Notice has been given to Caremark, or arbitration filed, as provided below. Unless otherwise agreed to in writing by the parties, the arbitration shall be administered by the American Arbitration Association ("AAA") pursuant to the then applicable AAA Commercial Arbitration Rules and Mediation Procedures including the rule governing Emergency Measures of Protection (available from the AAA). In no event may the arbitrator(s) award indirect, consequential, or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, injury to reputation, or loss of customers or business, except as required by Law.

The arbitrator(s) shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of the agreement to arbitrate, including but not limited to, any claim that all or part of the agreement to arbitrate is void or voidable for any reason. In the event the arbitrator(s) determine that any provision of this agreement to arbitrate is invalid for any reason, such provision shall be stricken and all remaining provisions will remain in full force and effect. The arbitrator(s) must follow the rule of Law, and the award of the arbitrator(s) will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. Any such arbitration must be conducted in Scottsdale, Arizona and Provider agrees to such jurisdiction, unless otherwise agreed to by the parties in writing.

Discovery shall be limited to documents and information for which there is a direct, substantial, and demonstrable need and where such documents and information can be located and produced at a cost that is reasonable in the context of all surrounding facts and circumstances. Further, when the cost and burden of e-discovery are disproportionate to the likely importance of the requested materials, the arbitrator may deny the requests or require that the requesting party advance the reasonable cost of production to the other side. Absent a showing of exceptional circumstances, as determined by the arbitrator(s), the parties shall be limited to one corporate representative deposition per party with each deposition subject to a four-hour time limit. The expenses of arbitration, including reasonable attorney's fees, will be paid for by the party against whom the final award of the arbitrator(s) is rendered, except as otherwise required by Law.

Arbitration with respect to a dispute is binding and neither Provider nor Caremark will have the right to litigate that dispute through a court. In arbitration, Provider and Caremark will not have the rights that are provided in court, including the right to a trial by judge or jury. In addition, the right to discovery and the right to appeal are limited or eliminated by arbitration. All of these rights are waived and disputes must be resolved through arbitration.

No dispute between Provider and Caremark may be pursued or resolved as part of a class action, private attorney general or other representative action or proceeding (hereafter all included in the term "Class Action"). All disputes are subject to arbitration on an individual basis, not on a class or representative basis, or through any form of consolidated proceedings, and the arbitrator(s) will not resolve Class Action disputes and will not consolidate arbitration proceedings without the express written permission of all parties to the Provider Agreement. Provider and Caremark agree that each may pursue or resolve a dispute against the other only in its individual capacity, and not as a plaintiff or class member in any purported Class Action.

Except as may be required by Law, a party, its employees, agents, consultants, authorized representatives, counsel, or arbitrator(s) shall not disclose the existence, content or results of any dispute or arbitration hereunder without the prior written consent of both parties. In the event a Provider is required by law to make such a disclosure, Provider shall notify Caremark five (5) business days in advance of such disclosure. Provider acknowledges and agrees that any breach of this provision would cause Caremark immediate and irreparable injury or loss that cannot be fully remediated by monetary damages. Accordingly, if Provider, its agents, counsel or arbitrator fail to abide by the terms and conditions set forth in this Section 15.09 of the Provider Manual, Caremark shall be entitled to (i) specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and to judgement for damages (including reasonable attorneys' fees and costs) caused by the breach, (ii) an option to void the dispute resolution or arbitration award; and (iii) to all other legal and equitable remedies available to Caremark.

CONFIDENTIAL TREATMENT REQUESTED

Prior to a party initiating an arbitration, such party shall request in writing to the other party ("Dispute Notice") a meeting of authorized representatives of the parties for the purpose of resolving the dispute. Disputes must be filed within the following timeframes: (i) for audit related disputes, within six (6) months from the date of the final audit findings; (ii) for termination related disputes, within six (6) months from the date of the notification of termination; and (iii) for all other disputes, within six (6) months from the date on which the facts giving rise to the dispute first arose. The parties agree that, within fourteen (14) business days after issuance of the Dispute Notice, each party shall designate a representative to participate in dispute resolution discussions which will be held at a mutually acceptable time and place (or bytelephone) for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner. If despite the good faith efforts of the parties, the authorized representatives of the parties are unable to resolve the dispute within forty-five (45) business days after the issuance of the Dispute Notice, or if the parties fail to meet within such forty-five (45) business days, either party may, by written notice to the other party, submit the dispute to binding arbitration provided however that any demand for arbitration must be filed within six (6) months from the date of the issuance of the Dispute Notice. The above notwithstanding, nothing in this provision shall prevent either party from utilizing the AAA's procedures for emergency relief to seek preliminary injunctive relief to halt or prevent a breach of this Provider Agreement.

Any party initiating an arbitration pursuant to this arbitration section shall place in escrow for the benefit of the opposing party an amount to be determined by the arbitrator(s) as sufficient to cover the estimated attorney's fees and other expenses of arbitration that will be incurred in defense of the arbitration action, which shall in no event be less than $50,000. Such funds will be released upon the entry of a final award of the arbitrator(s), with any excess reimbursed to the initiating party. Failure to place such funds in escrow will constitute a material breach of this arbitration section.

The terms of this arbitration section apply notwithstanding any other or contrary provision in the Provider Agreement, including but not limited to, any contrary language in any **Third Party Beneficiary** provision. This Arbitration section survives the termination of the Provider Agreement and the completion of the business relationship between Provider and Caremark. This arbitration agreement is made pursuant to a transaction involving interstate commerce, and shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

15.10 Force Majeure

Caremark and Provider are excused from performance under the Provider Agreement to the extent that either Caremark or Provider is prevented from performing all or any part of the Provider Agreement as a result of causes that are beyond the affected party's reasonable control, including but not limited to, fire, flood, earthquakes, tornadoes, other acts of God, war, work strikes, civil disturbances, power or communications failure, court order, government intervention, a change in Law, a significant change in the industry, or third-party nonperformance.

15.11 Anti-Kickback Statute, Stark Law, and Caremark Compliance Program

Each party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C § 1320a-7b(b) ("Anti-Kickback Statute"), or the federal "Stark Law," set forth at 42 U.S.C § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Provider Agreement. In addition, Caremark's Code of Conduct and policies and procedures on the Anti-Kickback Statute and Stark Law may be accessed at **www.caremark.com/pharminfo.**

15.12 Rebate Programs

Caremark has the right to submit all prescriptions relating to the Provider Agreement to pharmaceutical companies in connection with Caremark's rebate programs and any similar programs. Provider must not submit any of the prescriptions relating to the Provider Agreement to any pharmaceutical company for the purpose of receiving any rebate, discount or the like, except as authorized by Caremark in writing.

15.13 Eligible Person Communications

Provider understands and acknowledges that Caremark may communicate with Eligible Persons as required by Plan Sponsor, applicable Law, or as Caremark determines is necessary regarding matters such as plan benefits, network design and composition, formulary and clinical issues, and manufacturer recalls.

CONFIDENTIAL TREATMENT REQUESTED

16. Federal and State Laws and Regulations

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

16.01 Compliance with Laws

Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable Laws (including any implementing regulations) in performing its Pharmacy Services under the Agreement, included but not limited to: the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395 nn); Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (45 C.F.R. Parts 160, 162, and 164), and the Controlled Substance Act (21 U.S.. 801-971); and Caremark must comply with all applicable Laws (including any implementing regulations) in performing its duties under the Agreement, provided however that in the event that Provider alleges that Caremark has not complied with an applicable Law, Provider shall not be entitled to a private right of action unless expressly permitted under the underlying applicable Law, and Provider shall not be entitled to any contract damages or other contract remedies against Caremark other than as specified by such underlying applicable Law.

Federal and state specific addenda, as updated from time to time to reflect regulatory changes, are set forth in the Caremark Pharmacy Portal at **www.rxservices.cvscaremark.com** and are incorporated herein by reference. Refer to section **1.06 Pharmacy Portal** of the Provider Manual.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix A - Caremark Payer Specification Sheets

The Caremark Payer Specification Sheets and NCPDP Version D.Ø Payer Sheets can be found at **www.caremark.com/pharminfo**. Please carefully review the appropriate Payer Sheet(s) since the submission of certain optional data elements in the current NCPDP Version may be required by Plan Sponsors and must be submitted for processing.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix B - Reject Codes

A list of reject codes can be found at **www.caremark.com/pharminfo.**

Providers can also refer to the NCPDP standard at **www.ncpdp.org/Members/Standards-Lookup.aspx**. Membership to NCPDP is required to view this information online.

In addition, Providers can contact their software vendor to learn more about submission reject codes.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix C

This page is intentionally left blank.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix D - Drug Submission Requirements

Note: This section contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Caremark.

OPHTHALMIC PRODUCTS

Ophthalmic Drops (solutions and suspensions)

Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. Acute therapy may be submitted for Prescriber-specified days (e.g., ciprofloxacin eye drops for 5 days – enter 5 days supply). Information in the chart below is based on total drops per day being utilized in the prescribed directions and the bottle size being dispensed.

15 gtt/mL Total Drops Per Day	2.5 mL	5 mL	10 mL	15 mL	20 mL	30 mL	40 mL	45mL
One	37 (30/34 acceptable)	75	150	225	300			
Two	18	37 (30/34 acceptable)	75	112 (90/100 acceptable)	150	225	300	337
Three	12	25	50	75	100 (90 acceptable)	150	200	225
Four	9	18	37 (30/34 acceptable)	56	75	112 (90/100 acceptable)	150	168
Six	6	12	25	37 (30/34 acceptable)	50	75	100 (90 acceptable)	112 (90/100 acceptable)
Eight	4	9	18	28	37 (30/34 acceptable)	56	75	84

Ophthalmic Ointments

Eye ointments are typically dispensed as one package per prescription. It is rare for Prescribers to write for more than one tube per prescription. Should a prescription be presented for multiple packages or for quantity unavailable, the pharmacy staff should clarify the prescribed quantity and directions for use to support the prescription and day supply entered on the claim.

Ophthalmic Single-Use Vials

Single-Use vial ophthalmics should be calculated based on directions for use and the dosage units available within the single dose vial and packaging. Note: Single dose vials are commonly used in both eyes during a single dosage application.

	NDC	How Supplied	Common Dosage	Common Day Supply	Common Errors
Restasis®	00023-9163-30	30 single-use vials/package	1 drop 2 times daily in each eye	60 for a 30-day supply	Commonly misbilled as 120 for 30 days. Single-use vial can be utilized for both eyes.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

PROPER BILLING FOR ORAL INHALERS

Refer to section **4. Claims Submission** of the Provider Manual for a list of claim submission requirements.

ORAL INHALER CHART

Inhaler Name	Billing Pkg Size	Total Inhalations Per Box	Manufacturer Recommended Adult Max Daily Dose	Product Expiration Once Opened	TOTAL # of Inhalations Used Per Day					
					1	2	4	6	8	10
					Day Supply ( ) Indicates Acceptable Day Supply					
Advair® Diskus 100/50 mcg, 250/50 mcg, 500/50 mcg	60 ea	60	2	1 month	60	30	-	-	-	-
Advair® HFA 45/21 mcg, 115/21 mcg, 230/21 mcg	12 gm	120	4	N/A	120	60	30	-	-	-
Alvesco® 80 mcg	6.1 gm	60	8	N/A	60	30	15	10	7	-
Alvesco® 160 mcg	6.1 gm	60	4	N/A	60	30	15	-	-	-
Arnuity® Ellipta® 100 mcg	30 ea	30	2	6 weeks	30	15	-	-	-	-
Arnuity® Ellipta® 200 mcg	30 ea	30	1	6 weeks	30	-	-	-	-	-
Asmanex® Twisthaler 220 mcg	1 ea	30	4	45 days	30	15	7	-	-	-
Asmanex® Twisthaler 220 mcg	1 ea	60	4	45 days	60	30	15	-	-	-
Asmanex® Twisthaler 220 mcg	1 ea	120	4	45 days	120	60	30	-	-	-
Asmanex® HFA 110 mcg, 200 mcg	13 gm	120	4	N/A	120	60	30	-	-	-
Atrovent® HFA 17 mcg	12.9 gm	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Bevespi Aerosphere® 9 mcg/4.8 mcg	10.7 gm	120	4	3 months	120	60	30	-	-	-
Breo® Ellipta® 100/25 mcg, 200/25 mcg	60 ea	30	1	6 weeks	30	-	-	-	-	-
Combivent® Respimat® 20/100 mcg	4 gm	120	6	3 months	120	60	30	20	-	-
Dulera® 100/5 mcg, 200/5 mcg	13 gm	120	4	N/A	120	60	30	-	-	-
Flovent® Diskus 100 mcg	60 ea	60	20	2 months	60	30	15	10	7	6
Flovent® Diskus 250 mcg	60 ea	60	8	2 months	60	30	15	10	7	-
Flovent® HFA 44 mcg	10.6 gm	120	20	N/A	120	60	30	20	15	12
Flovent® HFA 110 mcg, 220 mcg	12 gm	120	8	N/A	120	60	30	20	15	-
ProAir® HFA 90 mcg	8.5 gm	200	12	N/A	200	100 (90)	50	33 (30)	25	20
ProAir® RespiClick 90 mcg	1 ea	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Proventil® HFA 90 mcg	6.7 gm	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Pulmicort Flexhaler® 90 mcg	1 ea	60	16	N/A	60	30	15	10	7	6
Pulmicort Flexhaler® 180 mcg	1 ea	120	8	N/A	120	60	30	20	15	-
QVAR RediHaler™ 40 mcg	10.6 gm	120	16	N/A	120	60	30	20	15	12
QVAR RediHaler™ 80 mcg	10.6 gm	120	8	N/A	120	60	30	20	15	-
Seebri™ Neohaler® 15.6 mcg	60 ea	60	2	N/A	60	30	-	-	-	-
Serevent® Diskus® 50 mcg	60 ea	60	2	6 weeks	60	30	-	-	-	-
Spiriva® HandiHaler® 18 mcg	30 ea	30	1	Once Opened	30	-	-	-	-	-
Spiriva® Respimat® 1.25 mcg, 2.5 mcg	4 gm	60	2	3 months	60	30	-	-	-	-
Wixela™ Inhub™ 100/50 mcg, 250/50 mcg, 500/50 mcg	60 ea	60	2	1 month	60	30	-	-	-	-

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

PROPER BILLING FOR NASAL SPRAYS

Refer to section **4. Claims Submission** of the Provider Manual for a list of claim submission requirements.

NASAL SPRAY CHART

Drug Name	Billing Package Size	Total Sprays per Box	Manufacturer Recommended Adult Max Daily Dose	Product Expiration Once Opened	TOTAL # of Sprays Used Per Day					
					1	2	4	6	8	10
					Days' Supply ( ) Indicates Acceptable Days' Supply					
Astepro® (azelastine) 0.15%	30 mL	200	8	N/A	200	100 (90)	50	33 (30)	25	-
azelastine 0.1%	30 mL	200	8	N/A	200	100 (90)	50	33 (30)	25	-
Beconase® AQ 42 mcg	25 gm	180	8	N/A	180	90	45	30	22	-
DDAVP™ (desmopressin) 0.01%	5 mL	50	4	N/A	50	25	12	-	-	-
Dymista™ 137 mcg/50 mcg	23 gm	120	4	N/A	120	60	30	-	-	-
Flonase® (fluticasone) 50 mcg	16 gm	120	4	N/A	120	60	30	-	-	-
Flonase® Sensimist 27.5 mcg	15.8 mL	120	4	N/A	120	60	30	-	-	-
flunisolide 0.025%	25 mL	200	16	N/A	200	100 (90)	50	33 (30)	25	20
ipratropium bromide 0.03%	30 mL	345	12	N/A	345	172	86	57	43	34 (30)
ipratropium bromide 0.06%	15 mL	165	16	N/A	165	82	41	27	20	16
Lazanda® 100 mcg, 300 mcg, 400 mcg	1 ea	8	4	60 days	8	4	2	-	-	-
Miacalcin® (calcitonin/salmon) 200 unit	3.7 mL	30	1	35 days	30	-	-	-	-	-
Narcan® 4 mg/0.1 mL	2 ea	2	N/A	N/A	2	1	-	-	-	-
Nasacort® Allergy 24HR (triamcinolone) 55 mcg	16.9 mL	120	4	N/A	120	60	30	-	-	-
Nasalcrom® (cromolyn) 5.2 mg	26 mL	200	12	N/A	200	100 (90)	50	33 (30)	25	20
Nasonex™ (mometasone) 50 mcg	17 gm	120	4	N/A	120	60	30	-	-	-
Omnaris™ 50 mcg	12.5 gm	120	4	4 months	120	60	30	-	-	-
Qnasl™ 80 mcg	8.7 gm	120	4	N/A	120	60	30	-	-	-
Patanase® (olopatadine) 665 mcg	30.5 gm	240	8	N/A	240	120	60	40	30	-
Rhinocort Aqua™ (budesonide) 32 mcg	8.6 gm	120	8	N/A	120	60	30	20	15	-
Sprix® 15.75 mg/act.	5 ea	40	4	24 hours	5	5	5	5	5	-
Stimate™ (desmopressin) 1.5 mg/mL	2.5 mL	25	2	6 months	25	12	-	-	-	-
Zetonna™ 37 mcg	6.1 gm	60	2	N/A	60	30	-	-	-	-

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

CONFIDENTIAL TREATMENT REQUESTED

PROPER BILLING FOR COMMON MEDICATIONS				
DRUG NAME	**TRANSMIT QUANTITY**	**COMMON DIRECTIONS**	**COMMON DAY SUPPLY**	**COMMENTS**
Oral Tablets/Capsules				
Benicar®, Crestor® (Rosuvastatin), Dexilant, Januvia®, Lipitor® (Atorvastatin), Pravachol® (Pravastatin), Singulair® (Montelukast), Synthroid® (Levothyroxine), Tirosint®, Tricor® (Fenofibrate), Zetia®	Bill as 1 = one tablet/capsule	One tablet/capsule daily	30 tablets/capsules = 30-day supply	Commonly billed for incorrect day supply (e.g., 1 tablet daily billed for 90 tablets for a 30-day supply).
Boniva® (Ibandronate)	Bill as 1 = one tablet	One tablet every month	One tablet = 28-day supply	Commonly billed for incorrect quantity and day supply (e.g. more than one tablet in 28 days).
Cialis® 2.5 mg and 5 mg	Bill as 1 = one tablet	One tablet every day	30 tablets = 30-day supply	Commonly billed for incorrect strength (e.g. as needed versus for daily use).
Contraceptives (various) 28-day	Bill as 28 = one pack	One active tablet daily for twenty one days followed by seven days of inactive tablets	28 tablets = 28-day supply	Commonly billed for incorrect quantity (e.g. 84 for a 28-day supply instead of 28 for a 28-day supply).
Methotrexate	Bill as 1 = one tablet	2.5 mg tablets, various quantities, typically dosed weekly	Varies	Commonly misfilled for incorrect directions.
Oral Suspensions/Solutions				
MiraLax™ Packets (Polyethylene Glycol 3350)	Bill as 1 = one packet	One packet (17 gm) per day	30 packets = 30-day supply	Commonly billed for incorrect billing unit (e.g., grams instead of number of packets).
MoviPrep® Powder for Solution	Bill as 1 = one box	Mix with water and drink as directed prior to procedure	One box = 1 or 2-day supply	Commonly billed for incorrect billing unit (e.g. milliliters instead of per box).
Rectal/Vaginal				
Estrace® Cream	Bill as 42.5 grams = one tube	Titration therapy with maintenance of 1 application weekly	One 42.5 gram tube = 30-day supply	Commonly incorrectly billed for greater than one tube per month (confirm dosage for therapy, include titration if needed, and document).
Estring®	Bill as 1 = one ring	One ring every 84 days	One ring = 84-day supply	Commonly incorrectly billed as more than one ring. Attempt to bill for correct day supply before reduction to max day supply allowed by Plan.
Metronidazole gel 0.75%	Bill per gm	One applicatorful (approximately 5 gm) once or twice a day for five days	70 gm = 7-day supply	Commonly billed for incorrect quantity and day supply (e.g. applicators are reusable)
NuvaRing®	Bill as 1 = one ring	Use one ring for 3 weeks, remove for 1 week	One ring = 28-day supply	Box of 3 can be split. Commonly incorrectly billed as 3 for 28 days
Premarin® Cream	Bill per gm	0.5 – 2 gm per day depending on therapy	One 30 gram tube = 30-day supply	Commonly incorrectly billed for greater than one tube per month (confirm dosage for therapy, include titration if needed, and document).
Vagifem®	Bill as 1 = one tablet	10 mcg tablets, one tablet daily for 2 weeks then taper to maintenance dose of one tablet twice weekly	14 tablets = 14-day supply for starter dose 8 tablets = 28-day supply for maintenance	Commonly billed for incorrect quantity and day supply (e.g., refill contains starter dose quantity).

CVS_HJC_00001157

CONFIDENTIAL TREATMENT REQUESTED

PROPER BILLING FOR COMMON MEDICATIONS				
DRUG NAME	**TRANSMIT QUANTITY**	**COMMON DIRECTIONS**	**COMMON DAY SUPPLY**	**COMMENTS**
Medical Devices/Testing Supplies				
Freestyle Libre 14 Day Reader	Bill as 1 = one reader	Varies	Varies	Commonly incorrectly billed for more than one reader. One reader is good for up to 3 years per manufacturer.
Glucometers (all manufacturers)	Bill as 1 = one meter	Varies	Varies	Commonly incorrectly billed for more than one meter.
Pen Needles and Syringes (all manufacturers)	Bill as 1 = one needle/syringe	Varies	Varies	Commonly billed for incorrect quantity (e.g. billed for more than one box without documented utilization).
Topical Preparations				
Acanya® (Clindamycin/Benzoyl), Carac® (Fluorouracil), Differin® (Adapalene) Cream, Epiduo®, Mirvaso®	Bill per gm	Apply once daily	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization). Also, incorrect package size billed.
Aczone®, Azelex®, Finacea®, Temovate® (Clobetasol) cream/oint.	Bill per gm	Apply twice daily	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization).
Aldara® (Imiquimod)	Bill per packet	Apply up to 2 packets each night for 2 weeks, followed by 2 weeks off	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one box without documented utilization).
Denavir®	Bill per gm	Apply every 2 hours while awake for 4 days within 1 hour of onset of symptoms	Varies based on application area(s)	Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization).
Jublia®	Bill per mL	Apply once daily to affected toenail(s)	Varies based on application area(s)	Commonly incorrectly billed for more than one bottle without the affected toenail(s) documented.
Picato®	Bill as 2 = one box (2 tubes of 0.05% gel) Or Bill as 3 = one box (3 tubes of 0.015% gel)	Apply one tube daily. Use 0.05% gel for 2 consecutive days on trunk/extremities Use 0.015% gel for 3 consecutive days on face/scalp	2 (0.05% gel) = 2-day supply 3 (0.015% gel) = 3-day supp	Commonly billed incorrectly for more than 2- or 3-day supply or for multiple boxes. Also, incorrect strength is selected for area of application indicated by physician.
Zovirax® (Acyclovir) cream/oint.	Bill per gm	Apply every 3 hours, 6 times a day to adequately cover all lesions of affected area(s) for 7 days	Varies based on application area(s)	Commonly billed for incorrect quantity and day supply (e.g. billed for more than one tube without documented utilization).
Transdermal Systems				
Vivelle-Dot® (Estradiol)	Bill as 1 = one patch	One patch twice weekly	8 patches = 28-day supply	Commonly billed for incorrect quantity and day supply (e.g. greater than 2 patches per week).
Xulane®	Bill as 3 = one box (three patches)	One patch once per week for three weeks, remove for one week	3 patches = 28-day supply	Commonly billed for incorrect quantity and day supply (e.g. greater than one box per month).
Injectables				
Avonex® pen kit	Based on NDC Bill as 1 = one kit (4syringes) Or Bill as 1 = one syringe	Inject 30 mcg once a week	Based on NDC 1 kit (4 syringes) = 28-day supply Or 4 syringes = 28-day supply	Commonly billed for incorrect billing unit (e.g. number of syringes instead of per kit).

CVS_HJC_00001158

CONFIDENTIAL TREATMENT REQUESTED

PROPER BILLING FOR COMMON MEDICATIONS

DRUG NAME	TRANSMIT QUANTITY	COMMON DIRECTIONS	COMMON DAY SUPPLY	COMMENTS
Enbrel® multiple-use vial (verify NDC)	Bill as 4 = four dose trays	One injection twice weekly	8 dose trays = 28-day supply	Commonly billed for incorrect NDC (e.g., Enbrel® single-use syringe instead of Enbrel® multiple-use vial).
Enbrel® single-use prefilled syringe	Bill per mL	One injection twice weekly	4.08 mL (box of four, 25 mg syringes) = 28-day supply 3.92 mL (box of four, 50 mg syringes) = 28-day supply	Commonly billed for incorrect billing unit (e.g., as number of syringes instead of mL) and/or billed for incorrect NDC (Enbrel® multiple-use vial instead of Enbrel® single-use syringe.)
Humira® Pen	Bill as 1 = one dose tray	Starter dose varies depending on indication One injection every other week (maintenance)	Varies depending on indication 2 (dose trays) = 28-day supply	Commonly billed for incorrect day supply (e.g., refill contains starter dose quantity).
Imitrex® (Sumatriptan)	Bill per mL	One injection, may repeat at least 1 hour later, maximum of 2 (6 mg) injections per 24 hours	Varies	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL).
Lovenox® (Enoxaparin)	Bill per mL	One injection once or twice daily	Varies	Commonly billed for incorrect billing unit (e.g., as number of syringes or total mg dose instead of mL).
Prolia®	Bill per mL	One injection every 6 months	1 mL = 180-day supply	Commonly billed for incorrect day supply.
Saxenda®	Bill per mL	Initial dose = 0.6 mg per day for one week, increase dose at weekly intervals until 3 mg Maintenance dose = 3 mg daily	15 mL = 30-day supply	Commonly billed for incorrect quantity for day supply (e.g. 45 mL for a 30-day supply).
Stelara®	Bill per mL	Initial dose = one injection at week zero, repeat dose at 4 weeks Maintenance dose = one injection, every 12 weeks starting at week 16	1 mL or 2 mL (depending on strength) = 28-day supply 0.5 mL or 1 mL (depending on strength) = 84-day supply	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL) and billed with incorrect day supply for quantity dispensed.
Trulicity®	Bill per mL	One injection weekly	2 mL = 28-day supply	Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL).
Victoza®	Bill per mL	0.6 mg per day, 1.2 mg per day, or 1.8 mg per day	6 mL = 30-day supply (for 1.2 mg dose) 9 mL = 30-day supply (for 1.8 mg dose)	Commonly billed for incorrect billing unit (e.g. billed as milligrams instead of milliliters).
Nasal Sprays				
Azelastine	Bill per mL	One to two sprays per nostril twice daily	30 mL = 30-day supply	Commonly billed for incorrect quantity and day supply.
Dymista®	Bill per gm	One spray per nostril twice daily	23 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.
Flonase® (Fluticasone)	Bill per gm	One to two sprays per nostril once daily	16 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.
Miacalcin® (Calcitonin- Salmon)	Bill per mL	One activation in one nostril once daily	3.7 mL = 30-day supply	Commonly billed for incorrect quantity and day supply.
Nasonex® (Mometasone)	Bill per gm	Two sprays per nostril once or twice daily	17 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.

CVS_HJC_00001159

CONFIDENTIAL TREATMENT REQUESTED

PROPER BILLING FOR COMMON MEDICATIONS				
DRUG NAME	**TRANSMIT QUANTITY**	**COMMON DIRECTIONS**	**COMMON DAY SUPPLY**	**COMMENTS**
Oral Inhalers				
Flovent® HFA 44 mcg Flovent® HFA 110 mcg, 220 mcg	Bill per gm	Two inhalations twice daily	10.6 gm = 30-day supply 12 gm = 30-day supply	Commonly billed for incorrect quantity and day supply.
Spiriva® Handihaler®	Bill per capsule	Two inhalations (one capsule) once daily	30 ea = 30-day supply	Commonly billed for incorrect quantity and day supply. Also, incorrect NDC is chosen (e.g. Respimat versus Handihaler).
Spiriva® Respimat®	Bill per gm	Two inhalations once daily	4 gm = 30-day supply	Commonly billed for incorrect quantity and day supply. Also, incorrect NDC is chosen (e.g. Handihaler versus Respimat).
Tudorza® Pressair®	Bill as 1 = one inhaler	One inhalation twice daily	1 ea = 30-day supply	Commonly billed for incorrect quantity and day supply (e.g. number of inhalations).
Kits				
Chantix® Starter Pack Chantix® Continuing Pack	Bill as 53 = one pack Bill as 56 = one pack	Initial = 0.5 mg once daily on days one through three, 0.5 mg twice daily on days four through seven, then 1 mg twice daily Maintenance = 1 mg twice daily for twelve weeks	53 tablets (one pack) = 28-day supply 56 tablets (one pack) = 28-day supply	Commonly billed for incorrect quantity and day supply. Also, starter pack is refilled without appropriate documentation.
Gattex Kit® (verify NDC)	Bill as 1 = one box (one vial) Bill as 1 = one box (30 vials)	Inject 0.05 mg/kg once daily	1 box (one vial)=1-day supply 1 box (30 vials) = 30-day supply	Commonly billed for incorrect quantity (e.g. vial versus box).
Rowasa® (Mesalamine) (verify NDC)	Bill as 1 = one box	One enema (4 gm) once daily	1 box (seven bottles) = 7-day supply	Commonly billed for incorrect quantity (e.g. number of bottles or milliliters).
Eye Drops				
Restasis® single-use vials Xiidra® single-use vials	Bill per vial	One drop in both eyes twice daily	60 vials = 30-day supply	Commonly misbilled as 120 vials for a 30-day supply. Single-use vial can be utilized in both eyes.
Restasis® Multi-dose™	Bill per mL	One drop in both eyes twice daily	5.5 mL = 30-day supply	Commonly misbilled for incorrect quantity and day supply.
Zioptan® single-use vials	Bill per vial	One drop in affected eye(s) once daily	30 vials = 30-day supply	Commonly misbilled as 120 vials for a 30-day supply. Single-use vial can be utilized in both eyes.

CVS_HJC_00001160

CONFIDENTIAL AND PROPRIETARY

Appendix E - Diverse Retail Pharmacy Program

Frequently Asked Questions and Supplier Diversity Profile Form

What is the Caremark Diverse Retail Pharmacy Program?

The Diverse Retail Pharmacy Program is a component of the Caremark Supplier Diversity Initiative. The pharmacy program was formed in 2004 to encourage diverse-owned, independent retail pharmacies to become certified diverse business enterprises in order to expand and establish potential business opportunities with Caremark. Through this program, Caremark actively seeks to establish business relationships with diverse-owned retail pharmacies that want to sustain and grow their businesses.

Why was the Supplier Diversity Initiative developed?

The initiative complements the Caremark commitment to sound business practices and social responsibility to the communities we serve, recognizes the critical role diverse-owned businesses play in our continued success, and provides outstanding service and solutions to our customers and clients. Caremark corporate culture encourages support of the program to help ensure that all diverse businesses are given a fair opportunity to do business with us.

How can my pharmacy become part of the Caremark Diverse Retail Pharmacy Program?

You must:

- Be contracted with Caremark as an independent retail pharmacy;
- Be certified as a diverse business enterprise by a government or third-party entity; and
- Apply for the program by completing and submitting a Caremark supplier profile form.

What are the potential benefits of being certified, contracted and part of the program?

As a certified diverse business enterprise enrolled in the Diverse Retail Pharmacy Program, your business will receive:

- Recognition as a diverse business enterprise
- Access to targeted, set-aside federal government programs that ensure that a percentage of business is specifically directed to diverse business enterprises
- Expanded opportunities to sustain and grow your business
- Consideration for participation in Caremark contracts with clients
- Access to capital financing for business development and growth through governmental programs
- Opportunities to secure business with other organizations and other prescription benefit management (PBM) organizations seeking to do business with diverse suppliers
- Access to diverse supplier organizations and networks across the United States

What does it mean to be a certified diverse business enterprise?

It means that your pharmacy will be identified as a diverse owned and operated business entity according to federal classifications. This certification will give your pharmacy access to specially designated government or private programs that can provide you with financial assistance to help sustain, grow and develop your pharmacy business.

What if my pharmacy is not a certified diverse business enterprise? Will it affect my current relationship with Caremark?

If you are currently a contracted Caremark retail pharmacy but are not certified, it will not change your existing relationship with Caremark. However, if you would like to participate in the Caremark Diverse Retail Pharmacy Program your pharmacy will need to become certified.

What if my pharmacy is not contracted with Caremark?

If you would like to participate in the Caremark Diverse Retail Pharmacy Program, your pharmacy will need to become contracted with Caremark as an independently owned pharmacy.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Is it difficult to become certified or contracted, or apply for the program?

No. It is not difficult to become certified and contracted, or apply for the Caremark program, and Caremark can help.

How long does the contracting process take?

The process to become a contracted pharmacy with Caremark can be completed within six (6) to eight (8) weeks.

How long does the certification process take?

Typically the certification process requires sixty (60) to ninety (90) days for completion.

How long does the diverse retail pharmacy application process take?

The process takes approximately two (2) weeks. Caremark needs to verify and confirm the information that is provided and enter your pharmacy into our database. Once that has been completed, your pharmacy will be evaluated for immediate inclusion in contracts with our clients.

Are there any costs or fees involved in the certification process?

Yes. Certification by a third-party entity cost is based on your company revenue, along with an annual renewal fee. Certification by a government entity may involve a small fee and in some cases at no cost.

Are there any fees involved in contracting with Caremark as an independent retail pharmacy?

Yes. There is a one-time application fee. Please contact the Retail Pharmacy Department of Caremark for more information at **www.caremark.com/pharminfo** - "Pharmacy Enrollment Self Service".

Are there any fees involved in applying for the program?

There are no membership fees, dues or other costs associated with applying for and becoming part of the Diverse Retail Pharmacy Program.

How do I know which certification is right for my pharmacy?

Determining which certification to seek depends on your business needs and requirements, where you are located, and where and how you want to grow your business. We suggest that you carefully review the benefits provided by the respective certifying entities.

- Certification with a third-party entity:
  - A certification fee and a yearly renewal fee
  - Inclusion in a national network of diverse-owned businesses
  - Access to grants, private small business administration loans and financial assistance nationwide
  - Opportunities for inclusion in Caremark contracts that utilize diverse suppliers
  - Access to targeted state/local government business opportunities
  - Recognition by government agencies
- Certification with a government entity:
  - Minimal or no fees
  - Access to state/local governmental business opportunities
  - Recognition by government agencies
  - Access to grants, private business administration loans and financial assistance nationwide
  - Opportunities for inclusion in Caremark contracts that use diverse suppliers

What type of certification does my pharmacy need to be eligible for the program?

Pharmacies can be certified with one or more entities, depending on your business needs and qualifications. Caremark recognizes, encourages and affords opportunities to the following types of certified diverse business enterprises:

- 8(a) Business Enterprises (8(a))

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

- Disabled Business Enterprises (DBEs)
- Disabled Veteran Business Enterprises (DVBEs)
- Disadvantaged Business Enterprises (DBEs)
- Historically Underutilized Business Zones (HUBZs)
- Lesbian, Gay, Bisexual and/or Transgender owned Business Enterprises (LGBTBEs)
- Minority Business Enterprises (MBEs)
- Women Business Enterprises (WBEs)
- Veteran Business Enterprises (VBEs)
- Disability Owned Business Enterprises (DOBE)

Who are the recognized Certifying organizations?

- Women Business Enterprises National Council (WBENC)
- National Minority Supplier Development Council (NMSDC)
- National Gay and Lesbian Chamber of Commerce (NGLCC)
- National Veteran Business Development Council (NVBDC)
- National Association of Veteran Owned Businesses (NaVOBA)
- U.S. Pan Asian American Chamber of Commerce (USPAACC)
- U.S. Hispanic Chamber of Commerce (USHCC)
- U.S. Business Leadership Network (USBLN)
- Small Business Association (SBA)
- Various State and Government Agencies

If my pharmacies are located throughout the United States, what kind of certification should I obtain?

You should consider obtaining national certification through a third-party entity for your pharmacies. You could also obtain government certification by the resident state or city of each pharmacy.

Where can I obtain the diverse business enterprise certification form?

You can obtain the form by directly contacting the certifying entity.

Where can I obtain the Caremark contracting and program application forms?

Refer to section **2. Credentialing and Quality Management** of the Provider Manual for information regarding enrollment. You can obtain a program application form by contacting the Caremark Supplier Diversity Department at **1-855-287-2694**

Does Caremark offer assistance with completing and submitting certification, contracting and application forms?

Because certification requirements vary for each certifying entity, Caremark is not able to assist you with that process. We recommend that you contact the entity directly so their staff can assist you with your specific business needs and requirements. However, Caremark can assist you with completing and submitting the Caremark contracting forms (to become an independent retail pharmacy) and supplier profile form.

How will I know when my pharmacy becomes certified?

You will receive notice of certification directly from the government or third-party entity to which you applied.

How will I know when my pharmacy contract is approved with Caremark?

You will be directly contacted and notified by the Caremark Retail Pharmacy Department.

As part of the program is my pharmacy guaranteed business opportunities with Caremark?

Caremark strives to provide opportunities to all qualified suppliers. Participation in the program does not entitle or guarantee business opportunities with Caremark. This process was designed to create and promote fair and equal opportunities for all.

CONFIDENTIAL AND PROPRIETARY

As part of the program will I need to renew my pharmacy's status or reapply to remain a Caremark supplier?

Once contracted and part of the program, your pharmacy will not need to reapply with Caremark. You will, however, need to reapply yearly for certification with the government or third-party entity to which you originally applied.

Once I receive certification as a diverse business enterprise and become contracted as an independent retail pharmacy with Caremark, where do I submit the supplier profile form?

Your completed supplier profile form should be accompanied by a copy of your:

- Current certificates/letters of certification
- Sales catalog or company brochure
- Product profile
- Capability statement

Please e-mail these documents to: **supplierdiversity@cvshealth.com** or create your profile online at **cvshealth.myconnxion.com/user/login.**

How many diverse-owned retail pharmacies is part of the Caremark network?

There are more than 130 certified, diverse-owned independent retail pharmacies in the Caremark network throughout the United States.

How much money does Caremark spend with diverse-owned pharmacies?

Caremark spent approximately $225 million with diverse-owned independent retail pharmacies. By becoming a certified diverse business enterprise and filling out the supplier profile form, your pharmacy can become one of them.

What is unique about the Caremark Diverse Retail Pharmacy Program?

Caremark was one of the first companies in the PBM industry to develop a diverse retail pharmacy program and has a staff dedicated to supporting this important initiative. Our Supplier Diversity Initiative has shown nearly a 20% increase in spend with diverse suppliers yearly and works diligently to develop opportunities for diverse suppliers seeking to provide services that Caremark needs.

What else should I know about Caremark?

Caremark is the largest provider of prescriptions and related health services in the nation. We fill or manage more than one billion prescriptions annually. Through our unmatched breadth of service offerings, Caremark is helping to transform the delivery of health care services in the United States. We are uniquely positioned to effectively help manage costs and improve health care outcomes. To learn more, visit **www.cvshealth.com**.

Supplier Profile Form

Visit our website at **cvshealthsupplierdiversity.com**

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix F - New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts

(Revised April 1, 2017)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the Article 44 plans and Providers that contract with such plans, and who are a party agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO contracts with Providers, and Providers must agree to such clauses.

A. Definitions for Purposes of this Appendix

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer a comprehensive health services plan, or a health and long-term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment. Under these arrangements, such health care Providers and suppliers will provide their service in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of Health Care Services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms and Conditions

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH, effective sixty (60) days subsequent to notice, subject to Public Health Law § 4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH, as may be required by the Medicaid Managed Care contract between the MCO and DOH
3. Assignment of an agreement between an MCO and (a) an IPA/ACO, (b) an institutional network Provider, or (c) a medical group Provider that serves five percent (5%) or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (a) an institutional Provider or (b) a medical group Provider that serves five percent (5%) or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO's Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish

CONFIDENTIAL TREATMENT REQUESTED

to meet general or specific obligations placed on the MCO by statute, regulation, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:

a. quality improvement/management;

b. utilization management, including but not limited to, precertification procedures, referral process or protocols, and reporting of clinical encounter data;

c. member grievances; and

d. Provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees, and shall require its Providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide twenty–four (24) hour coverage and back–up coverage when the Provider is unavailable. The Provider may use a twenty–four (24) hour back–up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA/ACO that is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA/ACO's own acts or omissions, by indemnification or otherwise, to a Provider.

8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of 2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:

   a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid Managed Care contract.

   b. The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.

   c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.

   d. The MCO and the Provider or IPA/ACO agree that a woman's enrollment in the MCO's Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid Managed Care or the MCO does not offer a Medicaid Managed Care product in the mother's county of fiscal responsibility.

   e. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

CONFIDENTIAL AND PROPRIETARY

f. The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of any Member of Congress in connection with the award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying," Appendix attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA/ACO shall complete and submit Standard Form–LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

h. The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).

i. The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).

j. The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information.

k. The Provider or IPA/ACO agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than $25,000 during the 12–month period ending on the date of the request made by DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within thirty-five (35) days of such request.

l. The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG's website, within five (5) days of executing this agreement, stating that:

   i. The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

   ii. All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.

   iii. Payment requests are submitted in accordance with applicable law.

CONFIDENTIAL TREATMENT REQUESTED

m. The Provider or IPA/ACO agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG's website, before the subcontractor requests payment under the subcontract, acknowledging that:

i. The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

ii. All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.

iii. Payment requests are submitted in accordance with applicable law.

10. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA's Providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27–F of the Public Health Law, and Mental Hygiene Law § 33.13.

12. Compliance Program. The Provider agrees that if it claims, orders, or is paid $500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363–d(2) and 18 NYCRR § 521.3.

13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within thirty (30) days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363–d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG's website.

C. Payment and Risk Arrangements

1. Enrollee Non–liability. Provider agrees that in no event, including but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a Managed Long-Term Care plan designated as a Program of All–Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee–for–service basis to a covered person, provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable

CONFIDENTIAL AND PROPRIETARY

efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third-party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA/ACO must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406–c(5–c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology, or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (Provider, IPA/ACO, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided within the required timeframes and under the circumstances described in Public Health Law §4903.

6. The parties agree to follow Section 3224–a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.

7. The parties agree to follow Section 3224–b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS).

8. The parties agree to follow Section 3224–b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a health care Provider, except where: (a) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (b) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six (6) years from date payment was received by the health care Provider with written notice thirty (30) days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

9. The parties agree to follow Section 3224–c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.

10. The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization was required and received from the appropriate person or entity prior to the rendering of the service.

11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:

    a. Provide for the MCO's ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and

    b. Include a provision to address circumstance where the Provider's financial condition indicates an inability to continue accepting such risk; and

    c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and

    d. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.

12. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:

    a. The parties expressly agree to amend or terminate the contract at the direction of DOH (applies to Tier 1, Tier 2, and Tier 3);

    b. The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO☒s progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and

    c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and

    d. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement (applies to Tier 2 and Tier 3).

D. Records and Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government–sponsored programs) available to the MCO (and IPA/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to, newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee's medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable)

CONFIDENTIAL AND PROPRIETARY

expressly acknowledges that the Provider shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid reimbursable services, the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non–renewal of an agreement between an MCO and an IPA/ACO, institutional network Provider, or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, or the termination or non–renewal of an agreement between an IPA/ACO and an institutional Provider or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than forty-five (45) days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than forty-five (45) days' notice provided the MCO demonstrates to the satisfaction of DOH, prior to termination, that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non–renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional sixty (60) days' notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO's Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACO☒s Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA/ACO insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "Provider" shall include the IPA/ACO and**

CONFIDENTIAL TREATMENT REQUESTED

the IPA/ACO's contracted Providers if this Agreement is between the MCO and an IPA/ACO. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation and copies of all decisions.

G. IPA/ACO-Specific Provisions

1. Any reference to IPA/ACO Quality Assurance (QA) activities within this Agreement is limited to the IPA/ACO's analysis of utilization patterns and quality of care on its own behalf and as a service to its contractual Providers.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix F-1 - Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of this Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

TITLE: _____

PHARMACY; ORGANIZATION: _____

PHARMACY NCPDP/NPI: _____

NAME: (PLEASE PRINT) _____

SIGNATURE: _____

*** Please FAX the completed Appendix F-1 page back to Caremark Network Services at 1-866-316-4336. ***

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix F-2 - Standard Clauses for Managed Care Provider/IPA Contracts for the Fully-Integrated Duals Advantage Program

January 1, 2015

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions for Purposes of This Appendix

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms and Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent (5%) or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent (5%) or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:

   - quality improvement/management;
   - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
   - member grievances; and
   - provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.

8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

   a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

   b. The Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and

   c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.

   d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

managed care product in the mother's county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the "Certification Regarding Lobbying," Appendix F-1 attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs).

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

l. The Provider agrees to have an officer, director or partner of the Provider execute and deliver to SDOH a certification, using a form provided by SDOH through OMIG's website, within 5 days of executing this agreement, stating that:

   i. the Provider is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of SDOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO;

   ii. that all claims for care, services or medical supplies for which the provider submits for payment have been provided; and

   iii. that payment requests are submitted in accordance with applicable law.

CONFIDENTIAL AND PROPRIETARY

m. The Provider agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by SDOH through OMIG's website, before the subcontractor requests payment under the subcontract, acknowledging that:

i. the subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of SDOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO;

ii. that all claims for care, services or medical supplies for which the subcontractor submits for payment have been provided; and

iii. that payment requests are submitted in accordance with applicable law.

10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law § 33.13.

12. Compliance Program. The Provider agrees that if it claims, orders, or is paid $500,000.00 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.

13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, that it shall certify to the SDOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR § 521.3 and Social Services Law § 363-d(2) is in place, and shall recertify during the month of December each year thereafter using a form provided by OMIG on its website.

C. Payment/Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, non-payment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-

CONFIDENTIAL TREATMENT REQUESTED

service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law § 4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law § 4903.

D. Records Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

CONFIDENTIAL AND PROPRIETARY

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than nonrenewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period**. For purposes of this clause, the term "provider" shall include the IPA and the IPA's contracted providers if this Agreement is between the MCO and an IPA.** This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services

CONFIDENTIAL TREATMENT REQUESTED

to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix G - CMS Form No. 10147 (English)

OMB Approval No. 0938-0975

Enrollee's Name (Optional):

Drug and Prescription Number (Optional):

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

Your Medicare rights

You have the right to request a coverage determination from your Medicare drug plan if you disagree with information provided by the pharmacy. You also have the right to request a special type of coverage determination called an "exception" if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-MEDICARE for more information.

Form CMS-10147

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix G1 - CMS Form No. 10147 (Spanish)

Número de OMB 0938-0975

Nombre del beneficiario (opcional):

Número de receta y de medicamento (opcional):

LA COBERTURA DE MEDICARE DE LAS RECETAS MÉDICAS Y SUS DERECHOS

Sus derechos si tiene Medicare

Usted tiene el derecho de solicitar una determinación de cobertura de su plan Medicare de recetas médicas si está en desacuerdo con la información proporcionada por la farmacia. También tiene el derecho de solicitar una determinación de cobertura especial conocida como "excepción" si piensa que:

- Necesita un medicamento que no está en la lista de su plan. A la lista de medicamentos cubiertos se le conoce como "formulario;"
- Una regla de cobertura (como la autorización previa o un límite de cantidad) no debe aplicarse debido a su problema médico; o
- Necesita tomar un medicamento no preferido y usted quiere que su plan lo cubra al precio de un medicamento preferido (un copago más bajo).

Lo qué necesita hacer

Usted o la persona que le ha recetado el medicamento pueden pedirle al plan una determinación de cobertura, llamando al número gratis que aparece en la parte de atrás de la tarjeta del plan, o visitando el sitio web del plan. Usted o su médico puede pedir una determinación acelerada (24 horas) si su salud pudiera estar en peligro si tiene que esperar 72 horas para obtener la respuesta. Usted tendrá que informarle al plan:

1. El nombre del medicamento que no pudo obtener, la dosis y concentración si lo sabe.
2. El nombre de la farmacia donde intentó obtener el medicamento.
3. La fecha en que intentó obtenerlo.
4. Si solicita una excepción, el médico que lo recetó tiene que enviarle a su plan una declaración explicándole el motivo por el cual usted necesita el medicamento que no está en el formulario, el medicamento no preferido o no se debe aplicar una regla de cobertura a usted.

Su plan Medicare de medicamentos recetados le comunicará su decisión por escrito. Si no aprueban la cobertura, la carta del plan le explicará el motivo y cómo apelar la decisión si no está de acuerdo.

Si desea más información, consulte los materiales del plan o llame al 1-800-MEDICARE.

Formulario de CMS-10147-Spanish

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix H - Ohio Medicaid Addendum

Medicaid Addendum

This Addendum will supplement the Provider Agreement between Caremark and Provider effective upon Provider's provision of Pharmacy Services to Eligible Persons enrolled in a managed care plan contracting with the Ohio Department of Medicaid's managed Medicaid program and runs concurrently with the terms of the Provider Agreement. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

ADDENDUM DEFINITIONS

Agreement/Base Contract	The contract between the MCP and the subcontractor (delegated entity)
Managed Care Plan (MCP)	A Medicaid managed care plan that enters into a provider agreement with ODM to serve Medicaid consumers, which may include dually-eligible consumers who are enrolled in the MyCare Ohio program (aka Integrated Care Delivery System or ICDS) Plans
Medicaid	Medical assistance provided under a state plan approved under Title XIX of the Social Security Act
Member	A Medicaid recipient enrolled under the care management system pursuant to ORC 5167
OAC	Ohio Administrative Code
ODM	Ohio Department of Medicaid
ORC	Ohio Revised Code
Provider	A hospital, health care facility, physician, dentist, pharmacy or otherwise licensed, certified, or other appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCP's Member

Addendum Provisions

The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

Participating providers providing health care services to MCP's Medicaid Members agree to abide by all of the following specific terms:

1. Provider agrees that with the exception of any Member copayments the MCP has elected to implement in accordance with OAC rule 5160-26-12, the MCP's payment constitutes payment in full for any covered service and will not charge the Member or ODM any copayment, cost sharing, down-payment, or similar charge, refundable or otherwise. This Base Contract does not prohibit Nursing Facilities (NFs) or waiver entities from collecting patient liability payments from Members as specified in OAC rule 5160:1-6-05.1 and 5160:1-6-05.2 or Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODM as specified in OAC rule 5160-28.

   a. MCP shall notify the provider whether MCP has elected to implement any Member copayments and, if applicable, under what circumstances Member copayments are imposed in accordance with OAC rule 5160-26-12.

   b. Provider agrees that Member notification regarding any applicable copayment amounts must be carried out in accordance with OAC rule 5160-26-12.

2. Provider agrees not to hold liable ODM and the Member in the event that the MCP cannot or will not pay for

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

covered services performed by the provider pursuant to the Base Contract with the exception that:

a. FQHCs and RHCs may be reimbursed by ODM in the event of MCP insolvency pursuant to Section 1902(bb) of the Social Security Act.

b. The provider may bill the Member when the MCP has denied prior authorization or referral for the services and the following conditions are met:

i. The Member was notified by the provider of the financial liability in advance of service delivery;

ii. The notification by the provider was in writing, specific to the service being rendered, and clearly states that the Member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and

iii. The notification is dated and signed by the Member.

3. Provider agrees to cooperate with the MCP's quality assessment and performance improvement (QAPI) program in all the MCP's provider subcontracts and employment agreements for physician and nonphysician providers.

4. The MCP shall disseminate written policies that include detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68) and section 5162.15 of the Revised Code, any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCP's policies and procedures for detecting and preventing fraud, waste and abuse; and the provider agrees to abide by the MCP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

5. Provider agrees to abide by the MCP's written policies related to the requirements of 42 U.S.C. Section 1396a(a)(68) and section 5162.15 of the Revised Code, including the MCP's policies for detecting and preventing fraud, waste, and abuse.

6. Provider agrees to cooperate with the ODM external quality review as required by 42 CFR 438.358 and described in OAC Chapter 5160 and on-site audits as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel, and other information.

7. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination apply to this Addendum.

8. Notwithstanding item 7 of this Addendum, the MCP must give the provider at least sixty (60) days prior notice for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the Base Contract be terminated sooner or when the contract is temporary in accordance with 42 CFR 438.602 and the provider fails to enroll as an ODM provider within one hundred twenty (120) days.

9. Notwithstanding item 7 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

a. The provider gives the MCP at least sixty (60) days' prior notice for the nonrenewal or termination of the Base Contract. The effective date for the non-renewal or termination must be the last day of the month; or

b. ODM has proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10(G), regardless of whether the action is appealed. The provider's nonrenewal or termination notice must be received by the MCP within fifteen (15) working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, Provider must extend the nonrenewal or termination date to the last day of the subsequent month.

CONFIDENTIAL AND PROPRIETARY

10. The procedures to be employed upon the ending, nonrenewal, or termination specified in the Base Contract, apply to this Addendum. Provider agrees to promptly supply all records necessary for the settlement of outstanding claims.

11. Notwithstanding items 8 and 9 of this Addendum, in the event of a hospital provider's proposed nonrenewal or termination of the Base Contract, the hospital provider agrees to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the Base Contract and the last date the hospital will provide services to Members under the Base Contract. This notice must be sent at least forty-five (45) calendar days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues less than forty-five (45) calendar days prior notice to the MCP, the notice to Providers who have admitting privileges at the hospital must be sent within one working day of the hospital provider issuing notice of nonrenewal or termination of the Base Contract.

12. Provider agrees to release to the MCP any information necessary for the MCP to perform any of its obligations under the ODM provider agreement, including but not limited to compliance with reporting and quality assurance requirements. Provider agrees the released information will be shared with ODM or ODM designee upon request to the MCP.

13. Provider must supply, upon request, the business transaction information required under 42 C.F.R. 455.105.

14. Provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract and provider and all employees of the provider are not excluded from participating in federally funded health care programs.

15. If the provider is a Medicaid provider, provider must meet the qualifications specified in OAC Chapter 5160, including rule 5160-26-05(C).

16. All laboratory testing sites providing services to Members must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

17. Home health providers must meet the eligible provider requirements specified in OAC Chapter 5160-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.

18. Provider shall be compensated pursuant to the method and in the amounts specified in the corresponding network enrollment forms of the Base Contract.

19. Provider agrees to provide services to all eligible Medicaid consumer populations as specified in the Ohio Department of Medicaid Provider Agreement. Indicate one or both:

    ☒ Medicaid non-dual populations ☒ MyCare Ohio Medicare/Medicaid populations

    Provider may contact Caremark to change the above indication.

20. Provider agrees to provide services to MyCare Ohio consumers within the designated service area.

21. If the provider is a third party administrator (TPA), the provider agrees to include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontractors will forward information to ODM as requested.

22. Provider agrees to provide services as enumerated in **Attachment D** of this Addendum (within the provider's scope of practice).

23. Provider agrees to serve Members through the last day the Base Contract is in effect.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

24. Any amendment to the **Attachment D** and the network enrollment forms specified in item 18 and item 22 must be agreed to in writing by both parties.

25. If Provider is a primary care provider (PCP), Provider agrees to participate in the care coordination requirements outlined in OAC Chapter 5160, including rule 5160-26-03.1.

26. If Provider is a hospital or hospital system, the Addendum must include the completed ODM Hospital Services Form, **Attachment C** of this addendum, which specifies which services of the hospital are included in the Base Contract.

27. MCP agrees not to prohibit, or otherwise restrict a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the following:

    a. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered

    b. Any information the Member needs in order to decide among all relevant treatment options

    c. The risks, benefits, and consequences of treatment versus non-treatment

    d. The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

28. Provider agrees in providing health care services to Members to identify and where indicated arrange, pursuant to the mutually agreed upon procedures between the MCP and Provider for the following at no cost to the Member:

    a. Sign language services.

    b. Oral interpretation and oral translation services.

29. MCP agrees to fulfill the Provider's responsibility to mail or personally deliver notice of the Member's right to request a state hearing whenever the Provider bills a Member due to the MCP's denial of payment of a Medicaid service, as specified in OAC Chapter 5160 including rule 5160-26-08.4, utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.

30. Provider agrees to contact the MCP's designated 24-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC Chapter 5160, including rule 5160-26-03(G).

31. Provider agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting Members by mail.

32. Provider agrees not to bill Members for missed appointments.

33. Provider shall not discriminate in the delivery of services based on the Member's race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

34. Provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

35. Provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

the performance of services under the subcontract on account of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, health status, or ancestry.

36. Provider shall be bound by the same standards of confidentiality which apply to ODM and the state of Ohio as described in OAC rule 5160-1-32 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

37. Provider agrees that their applicable facilities and records will be open to inspection by the MCP, ODM or its designee, or other entities as specified in OAC rule 5160-26-06.

38. Provider agrees that the Base Contract and Addendum are governed by and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP.

    a. ODM will notify the MCP and the MCP shall notify the Provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP.

    b. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.

    c. The MCP shall notify the Provider of all applicable contractual obligations.

39. Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

40. Provider must retain and agrees to allow the MCP access to all Member medical records for a period of not fewer than eight (8) years from the date of service or until any audit initiated within the 8-year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in OAC rule 5160-26-06.

41. Provider agrees to make patient medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the patient.

42. Provider agrees that if the base contract, with the MCP, provides for assignment to another entity, no assignment, in whole or in part, shall take effect without sixty (60) days prior notice to the MCP.

43. Provider agrees to immediately forward any information regarding a member appeal or grievance, as defined in OAC 5160-26-08.4 or 5160-58-08.4, for processing.

44. If Provider is a primary care provider (PCP), a specification, appearing above the signature(s) on the signature page in all PCP subcontract, stating the maximum number of MCP members that each PCP can serve at each practice site for that MCP.

The Ohio Department of Medicaid permit changes to Attachments A, B, C and/or D by mutual written agreement of both parties and without renegotiation of the Base Contract or this Addendum.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Attachment A (Primary Care Provider Attestation)

Attachment B (Non-Primary Care Providers)

Attachment C (Hospital Services Form)

[Not applicable]

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Attachment D: Services Provided

Provider agrees to provide services as enumerated below (specify below):

☐ Ambulance transportation	☐ Mental health and/or substance abuse services
☐ Ambulette transportation	☐ Nursing facility services
☐ Ambulatory Surgery Center	☐ Obstetrical and/or gynecological services
☐ Advanced practice nurse services specify:	☐ Ophthalmology services
☐ Chiropractic services	☐ Outpatient hospital services
☐ Dental services	☐ Physical and occupational therapy
☐ Durable medical equipment (DME)	☐ Podiatry services
☐ Emergency Services	☒ **Pharmacy**
☐ Family planning services and supplies	☐ Physician services
☐ Federally Qualified Health Center services	☐ Primary care provider services
☐ Home health services/Private Duty Nursing	☐ Renal dialysis
☐ Hospice care	☐ Rural Health Clinic services
☐ Medical Imaging	☐ Specialty physician services, Specify (e.g., cardiology, allergy, etc):
☐ Inpatient hospital services	☐ Speech and hearing services
☐ Laboratory services	☐ Vision (optical) services, including eyeglasses
☐ Other Click here to enter text.	

Community Behavioral Health Services (included only in the MyCare Ohio benefit package)

☐ Pharmacological Management	☐ Ambulatory Detox
☐ Behavioral Health Assessment	☐ Targeted Case Management for AOD
☐ Behavioral Health Counseling and Therapy	☐ Intensive Outpatient
☐ Crisis Intervention	☐ Laboratory urinalysis
☐ Partial Hospitalization	☐ Med –Somatic
☐ Community Psychiatric Support Treatment	☐ Methadone Administration

Home and Community Based Services (included only in the MyCare Ohio benefit package)

*indicates service provider types which may be counted in more than 1 county or region. All others may only count in the county where the provider is physically located.

☐ Out of Home Respite Services	☐ Waiver Nursing Services
☐ Adult Day Health Services	☐ Home Delivered Meals*
☐ Waiver Transportation*	☐ Assisted Living Services
☐ Chore Services*	☐ Home Care Attendant
☐ Social Work Counseling	☐ Choices Home Care Attendant
☐ Emergency Response Services*	☐ Enhanced Community Living Services
☐ Home Modification Maintenance and Repair*	☐ Nutritional Consultation
☐ Personal Care Services	☐ Independent Living Assistance
☐ Homemaker Services	☐ Community Transition Services
☐ Pest Control*	☐ Alternative Meals Service
☐ Home Medical Equipment and Supplemental Adaptive and Assistive Device Services*	

CONFIDENTIAL AND PROPRIETARY

Appendix I - Appeals Process Documentation Guidelines

***Plan Sponsor-specific information may apply as communicated by Caremark or Plan Sponsor.**

*****Please Read Thoroughly Prior To Obtaining and Sending Documentation*****

1. Introduction:

   The enclosed report lists discrepancies found as indicated on the Pharmacy Audit Acknowledgement signed by the pharmacy staff on duty at the audit. You have the opportunity to provide documentation to support your pharmacy's claims currently considered discrepant. Ensure you provide the correct documentation for the discrepancy type identified. Your immediate attention is important. All documentation must be **RECEIVED** by Caremark no later than the due date indicated in your cover letter.

2. Documentation Procedures:

   a. Pharmacy Auditing Discrepancy List: The enclosed report lists discrepant claims by prescription number and date of fill. The D1 and D2 columns list the code for the discrepancy type.

   b. Documentation Guidelines: The enclosed guidelines describe the discrepancy types and the documentation required to resolve those discrepancies.

   c. **ALL** documentation is required to include:

      - Pharmacy NABP number;
      - Prescription number of the claim as listed on the Discrepancy List;
      - Date of fill referred to on the Discrepancy List;
      - Patient's full name, address and phone number;
      - Additional information as shown on the Discrepancy List for the specific discrepancy type;
      - Statements from the prescribers must be on prescriber letterhead or prescription pad. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician stamp on the letter).

      Documentation submitted must adhere to the Documentation Guidelines. Documentation such as telephone prescriptions, computer generated labels or documents without all the required information will not be accepted.

3. Mailing Instructions:

   All documentation must be sent by the documentation due date on the cover letter and in one package via **Certified, Express, Express with tracking, or regular USPS mail.** Address your correspondence to:

   Caremark
   Attn: Audit Documentation
   Pharmacy Performance MC 020
   9501 East Shea Boulevard
   Scottsdale, AZ 85260-6719
   Phone: 1-866-488-4709
   Fax: 1-866-310-4135

   Documentation less than fifty (50) pages can be faxed; however, the images must be legible to be considered (e.g., documents on tamper resistant prescription pads may not be legible when faxed).

   Caremark recommends sending documentation with tracking and maintaining a copy of all documentation sent.

   All documentation received will be reviewed, and a Final Audit Discrepancy List will be mailed upon completion of review.

   If you need additional help, please call Caremark Pharmacy Performance at **1-866-488-4709.**

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

	DISCREPANCY	DEFINITION	Acceptable Documentation
CMP	COMPOUND	Compound claim has been selected for review for verification of pricing, quantity, use, etc.	Send a legible copy of the original compound recipe that was signed by the verifying pharmacist and that includes the names of the all active and inactive ingredients, NDC numbers, quantities, and costs. Billing statements will not be accepted. Also send a copy of the prescription hardcopy and prescription label with directions for use for each date of fill. If written "use as directed", follow SIG documentation guidelines.
CPY	COPAY	Copays are required to be collected by pharmacy, where applicable by law, and cannot be waived, reduced, increased, or discounted	A copy of a patient invoice showing the member copay amount along with evidence the copay was paid in full, such as a signed member statement listing the rx, DOF, and copay paid amount, credit card receipt including auth #, copy of front and back of member's check, other financial documents supporting copay payment.
CQ	CUT QUANTITY	Quantity billed is less than that prescribed and less than that allowed resulting in additional refills and undue dispensing fees	This discrepancy does not require further documentation.
DAW	DISPENSED AS WRITTEN	DAW code submitted was different than the DAW instructions on the prescription	This discrepancy does not require further documentation.
DDB	DIFFERENT DRUG BILLED	Pharmacy billed a different medication and/or NDC than the one dispensed to the patient	This discrepancy does not require further documentation.
DIS	DRUG INVOICE SHORTAGE	Drug wholesaler invoices were not sufficient to support quantities billed	All documentation provided for Drug Invoice Shortage discrepancies must include at a minimum NDC, product name, quantity, invoice number, and dates of purchase. Acceptable documentation includes the following: 1. A summary report of drug purchases and returns directly from the wholesaler; or 2. Send a copy of the original drug wholesaler invoices, if found; or 3. Documentation of drug purchase via other sources. Further verification of these documents may be required such as proof of payment for stock transfers, payment history, copies of checks for drug stock buy-out, bill of sale, payment invoices, etc.
DPC	DUPLICATE PAID CLAIM	Multiple claims for the same prescription fill were submitted	This discrepancy does not require further documentation.
DWC	DATE WRITTEN CORRECTION	The written date submitted by the pharmacy does not match the date written on the prescription hardcopy	This discrepancy does not require further documentation. The claim will be reprocessed for the correct date written.
ETL	EXCEEDS TIME LIMIT	Prescription was filled or refilled for a time period longer than that allowed by the Plan or applicable regulations	This discrepancy does not require further documentation.
GBB	GENERIC vs. BRAND BILLED	A claim was submitted for a brand medication when a generic form of the medication was dispensed	This discrepancy does not require further documentation.
INV	INVALID PRESCRIPTION	Prescription was invalid at the time medication was given to the Eligible Person (state and federal regulations, RMPs, altered Rx, etc.)	This discrepancy does not require further documentation.
MIF	MISFILL	Prescription dispensed was filled with incorrect drug, strength, directions or patient	This discrepancy does not require further documentation.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

	DISCREPANCY	DEFINITION	Acceptable Documentation
MP	MISSING PRESCRIPTION	Original hard copy prescription or computer based prescription image cannot be found during the audit	1. Send a copy of the prescriber's original written prescription, if found; or 2. Send a signed statement from the prescriber on prescriber's letterhead or on a written Rx from the prescriber, including medication, quantity, Sig, original fill date and authorized refill dates. The prescriber may fax their documentation to the pharmacy. Prescriber statements must either be on physician letterhead or on a written prescription for the prescriber. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter.) Also include a copy of the dispensing label. If a prescription indicates "Use As Directed", follow SIG documentation guidelines. *COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs WILL NOT BE ACCEPTED.
NPI	INACCURATE PRESCRIBER NUMBER	NPI/DEA number on the prescription did not match the NPI/DEA/prescriber identification number on the claim. The NPI/DEA number is required to be accurate on all controlled substances	This discrepancy does not require further documentation.
NSL	NO SIGNATURE LOG	The signature documenting receipt of the prescription drug cannot be found in the signature logs or the electronic database	1. Send a copy of the signature log with the signature highlighted, if found; or 2. Send a signed statement from the patient verifying receipt of the medication; or 3. Send a signed pharmacy patient profile from the patient including patient's address, phone number, Rx number and date of fill. Each Rx must be initialed by the patient and dated. If delivered to a home or business address, Provider must provide: a. shipping method; b. shipment manifest; c. medication protection method; d. documentation of the prescription number(s) and Covered Item(s) delivered; and e. tracking documentation that the Covered Item was delivered.
OBC	OVER BILLED COMPOUND	Compound claim has been reviewed for pricing, quantity, and use. The allowable amount is listed in the Comments field. The adjusted Discrepant Amount will appear on the final Discrepancy Report	This discrepancy does not require further documentation.
OBQ	OVER BILLED QUANTITY	Quantity billed exceeded the amount authorized by the prescriber, the quantity allowed under the plan, or the quantity dispensed exceeds the days supply submitted	This discrepancy does not require further documentation.
OTH	OTHER	A miscellaneous discrepancy type	Varies with the reason for the discrepancy as listed in the Comments field.
PRD	PRESCRIBER DENIED	Prescription was denied by the prescriber that was on the claim	1. Send a copy of the prescriber's original written prescription, if found; or 2. A signed statement from the prescriber on prescriber letterhead or on a written Rx from the prescriber, including medication, quantity, Sig, original fill date and authorized refill dates. The prescriber may fax their documentation to the pharmacy. Prescriber statements must either be on physician letterhead or on a written prescription for the prescriber. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter). *COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs, WILL NOT BE ACCEPTED.
PTD	PATIENT DENIED	Patient denied requesting and/or receiving the prescription	1. Send a copy of the signature log with the signature highlighted, if found; or 2. Send a signed statement from the patient verifying receipt of the medication; or 3. Send a signed pharmacy patient profile from the patient including patient's address, phone number, Rx number and date of fill. Each Rx must be initialed and dated.

CONFIDENTIAL AND PROPRIETARY

	DISCREPANCY	DEFINITION	Acceptable Documentation
RTS	REFILL TOO SOON	Prescription was refilled sooner than appropriate due to an incorrect days supply on the previous fill date. If Provider dispenses the smallest commercially available package size and enters a day supply based on plan limits, Provider maintains responsibility to adhere to appropriate refill intervals	This discrepancy does not require further documentation.
SIG	INSUFFICIENT DIRECTIONS FOR USE	Hard-copy prescription does not include sufficient information to justify the quantity and days supply billed	Obtain specific dosing instructions from the prescriber. If dosing is prn, specify patient's maximum weekly or monthly usage. Documentation outlining the patient's dose must be obtained from the prescriber on prescriber's letterhead or on a written Rx from the prescriber. The prescriber may fax the documentation to the pharmacy. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter). No notes or verbal conversations with prescriber or office staff will be accepted.
UAR	UNDOCUMENTED AUTHORIZATION OF REFILL	The number of refills billed exceeds the number authorized by the prescriber	Send a signed statement from the prescriber on prescriber letterhead or on a written Rx from the prescriber, authorizing the dispensing. This must include medication, quantity, directions for use, original fill date and authorized refill dates. The prescriber may fax their documentation to the pharmacy. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter). *COMPUTER GENERATED, TELEPHONE PRESCRIPTIONS, TRANSFER RXs, WILL NOT BE ACCEPTED.
VAF	VACCINE ADMININSTRATION FEE	No documentation that a vaccine was administered	1. Send a copy of a vaccine administration log with the signature highlighted, if found; or 2. Send a signed statement from the patient verifying the vaccine was administered.
WP	WRONG PATIENT	Patient identified on a hard copy prescription is not the same patient on the claim	Send a signed statement from the cardholder indicating that the patient whose name is on the prescription is covered by the indicated plan.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Appendix J – Dispensing Practitioner

To the extent Provider is a Dispensing Practitioner, the terms of this **Appendix J** apply to Provider, in addition to other terms of the Agreement, and Provider agrees to the terms of this **Appendix J**. A "Dispensing Practitioner" is defined as a duly licensed and established practitioner (e.g., MD, DO, RN, NPA, and RPh) operating under a medical license or other appropriate license and that dispenses and sells Covered Items to Eligible Persons through in-person hand delivery at the point of care, solely to the dispensing practitioner's patients in the regular course of the practitioner's practice. In the event any provision in this **Appendix J** conflicts with a term of the Provider Agreement (including the Provider Manual and Caremark Documents), the terms of this **Appendix J** shall govern.

1. Caremark reserves the right to limit the participation of Dispensing Practitioner as may be appropriate under applicable Law.

2. **Pre-Enrollment and Post-Enrollment Credentialing**
   Caremark will conduct credentialing of Dispensing Practitioners based on Caremark's credentialing and quality management standards for both new applicants and enrolled Dispensing Practitioners. Dispensing Practitioner agrees that failure to meet Caremark's credentialing and quality management standards may result in denial of enrollment, or with respect to currently enrolled Dispensing Practitioners, termination of the Provider Agreement. An enrollment application must be completed by the Provider or an employee of Provider. Caremark charges a $1500 fee (per NCPDP number) for each enrollment application regardless of whether Caremark enrolls Provider. Payment of the $1500 enrollment fee must be transmitted to Caremark by Provider or the offices of Provider. Caremark charges a $75 fee per dispensing location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application. Caremark may require pre-enrollment on-site or telephone compliance review to assess Provider's operational practices and compliance with the Provider Agreement.

3. **Compliance with Law**
   Provider must follow all applicable Law (e.g., state medical board Law) related to dispensing of Covered Items by a practitioner, including but not limited to, records retention and minimum standards of practice. Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons in accordance with applicable Law. Such documents and records may include, but are not limited to, original prescriptions; signature logs; daily prescription logs; wholesaler, manufacturer and distributor invoices; Prescriber information; and patient profiles as in accordance with the Provider Manual.

   With respect to Part D claims, Provider agrees to make its books and records available in accordance with, and for the period required by 42 CFR §423.505(i)(2), which gives HHS, the Comptroller General, or their designees, the right to audit, evaluate and inspect any books, contracts, records, including medical records, and documentation of Provider involving transactions related to CMS' contract with a Part D Plan Sponsor, and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor's contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the (ten) 10 year retention period. Provider also agrees to maintain records and provide access in accordance with 42 CFR 423.505(b)(10).

4. **Licensure and Reporting of Actions**
   Provider must maintain all required licensure and/or certifications required to be a Dispensing Practitioner in accordance with applicable Law. Provider must notify Caremark in writing within ten (10) business days if Provider's ability to dispense or practice as a licensed practitioner is suspended or revoked, or is in jeopardy of being suspended or revoked or is in any other way limited. Provider's written notice to Caremark must include a detailed description of the issues and allegations.

CONFIDENTIAL AND PROPRIETARY

5. **Standards of Operation**
Provider must meet the standards of the community with regards to dispensing of prescriptions, meeting or exceeding those standards of a reasonable pharmacist.

All Pharmacy Services must be provided by or under direct supervision of Provider. Provider must utilize professional judgment in the dispensing of medication. Provider agrees that Caremark is not responsible for Provider's actions based on Provider's professional judgment.

Prior to dispensing, Provider must provide the patient a written or e-scribe prescription and advise (and document) the patient that the prescription can be filled by a pharmacy of his or her choice.

Provider must physically initial the dispensing record (i.e., refill log, controlled substance log, prescription hardcopy, and prescription label) and the dispensed Covered Item.

Consistent with requirements under state law or standards of care in Provider's state, Provider must maintain a drug use review program to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results.

Provider may only dispense to patients under Provider's medical care.

Provider (through a licensed individual) must counsel the patient on the medication and record that the consultation was performed or declined.

Dispensed prescriptions must affix a prescription label that includes all elements as defined by the applicable state Board of Pharmacy for dispensing by a pharmacist, even in the absence of a requirement by the state Board of Medicine or state Board of Pharmacy for a prescription label for Dispensing Practitioner dispenses.

Provider must not compound or dispense compound kits unless the medication is dispensed for a patient under Provider's direct care and within Provider's specialty (e.g., oncology).

Provider must review state prescription drug monitoring programs (PDMP) prior to prescribing as required by applicable Law, and must report information to PDMPs and review PDMPs as a dispensing practitioner as required by applicable Law.

6. **Drug Inventory**
Provider must manage its drug inventory, order its own inventory, and dispense its own medications. Provider must not outsource its dispensing function.

Provider must meet Drug Quality Security Act (DQSA) standards, including drug recall standards.

Provider must have sufficient drug stock in order to meet the needs of its patients. Drug inventory must be securely stored, and all record keeping requirements must be satisfied.

7. **Claims Submission**
Provider's claims submission must utilize the NPI of the provider where the Covered Item was dispensed to the Eligible Person, unless Caremark expressly authorizes otherwise in writing. Claims submission utilizing an identification number other than the provider who dispensed the Covered Item to the Eligible Person is subject to audit review and chargeback, and is not eligible for reimbursement.

Claims submission to Caremark must be performed by Provider at the dispensing location, and Provider must not use a third party vendor to submit claims; claims submitted in violation of this requirement is subject to chargeback and is not eligible for reimbursement.

Provider must not bill both the Plan's medical and pharmacy benefits for the same claim; otherwise, such claims are subject to chargeback.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

8. **Payment**
   Caremark will only remit payments in the name of Provider, directly to the location where the dispensing activity occurred.

9. **Application Submission**
   All credentialing documents including Standard Operating Procedures should be written and submitted via the Caremark Pharmacy Portal by in-office dispensing physician or in-office staff. Refer to section **1.06 Pharmacy Portal** of the Provider Manual.

   Application submission to Caremark must be performed by Provider at the dispensing location. Provider must not use a third party vendor to submit application. Applications submitted in violation of this requirement are subject to application denial and/or termination of contract. In-office dispensaries with PSAOs that have not received log-in information from Caremark can direct their Caremark Network Account Manager.

   The information provided in the Pharmacy Portal is CVS Caremark's confidential and proprietary information and considered "Confidential Caremark Information" as this term is defined in the Caremark Provider Manual. Pursuant to the terms of the Caremark Provider Manual, you may not disclose, sell, assign, transfer, or give the information contained therein to any third party.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Glossary of Terms

Caremark Documents means the Provider Agreement, schedules thereto, addenda, the Provider Manual and all attachments thereto including this Glossary of Terms, Federal Laws and Regulations, State Laws and Regulations, information transmitted by Caremark to Provider through the claims adjudication system, and information transmitted by Caremark to Provider specifically designated by Caremark as a "Caremark Document" which may include educational materials related to products, programs, services, and Plan Sponsor announcements.

AWP or Average Wholesale Price means the current wholesale cost of a given drug as defined in the latest edition of Medi-Span (with supplements), MICROMEDEX, or any other similar nationally recognized reference which Caremark may reasonably select from time to time.

AWP Discount means the AWP percentage discount that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Chargeback means collection by Caremark of amounts paid to a Provider, in whole or in part, that were determined to be owed, including but not limited to, amounts for discrepant claim(s), claim(s) submitted in breach of the Agreement, or identified overpayment(s).

Confidential Caremark Information means any non-public information or data of Caremark and includes but is not limited to, (1) Caremark's products, programs, services, designs, inventions, business practices, policies and procedures, customer list, information related to a Plan Sponsor, trade secrets; (2) MAC lists; (3) reimbursement rates and terms; (4) the Provider Agreement, the Provider Manual, network enrollment forms and other addenda, and all other Caremark Documents; and (5) other information relating to Caremark's business.

Covered Item means any drug or device covered, in whole or in part, in accordance with and subject to the terms of a Plan covering an Eligible Person.

Dispensing Fee means the dispensing fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Dispensing Pharmacy means the pharmacy that is giving or delivering the Covered Item to the Eligible Person.

Dispensing Practitioner means a duly licensed and established practitioner (e.g., MD, DO, RN, NPA, and RPh) operating under a medical license or other appropriate license and that dispenses and sells Covered Items to Eligible Persons through in-person hand delivery at the point of care, solely to the dispensing practitioner's patients in the regular course of the practitioner's practice.

Eligible Person means a person or animal entitled to a Covered Item pursuant to a Plan.

Law means any Federal, State, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, sub-regulatory guidance (including but not limited to, CMS Prescription Drug Benefit Manual, model contracts between the State Medicaid Agency and managed care organizations, and other guidance from State Medicaid Agencies, such as Medicaid Manuals, Bulletins, and other issuances), order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) a condition of granting any applicable permit, license or approval required by Caremark, Provider, or a Plan Sponsor, or other legislative or administrative action of the United States of America, or state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

Licensed Pharmacist means a pharmacist licensed in the United States (including U.S. territories).

MAC or Maximum Allowable Cost means a unit price that has been established as the reimbursement amount to Provider for certain multiple-source drugs without regard to the specific manufacturer whose drug is dispensed.

Medical Foods: The term medical food, as defined in section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

Patient Pay Amount means the amount an Eligible Person must pay to Provider at the time a Covered Item is dispensed as indicated by the claims adjudication system, which may include but is not limited to copayments, coinsurance, deductibles, transaction fees, access fees, and/or taxes.

Pharmacy Services/Provider Services means all services including the provision of prescription drugs usually

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

and customarily rendered by a Provider and Licensed Pharmacist or Dispensing Practitioner licensed to provide pharmacy services in the normal course of business, including services mandated by applicable Law. Pharmacy Services may include, but not be limited to: the maintenance of Eligible Person profiles; the interpretation of prescriptions; the selection of medications and medical devices; the sale of compounding or dispensing of medications and medical devices (also includes Over-the-Counter medications [OTCs] and supplies covered by or used in conjunction with a pharmacy benefit); the counseling of Eligible Persons, which may consist of information about the proper storage, dosing, side effects, potential interactions and use of the medication dispensed; the monitoring of appropriate drug use; and the implementation of drug utilization review programs and other clinical programs and services.

Plan means that portion of a Plan Sponsor's pharmacy benefit plan that relates to Covered Items with respect to a group of Eligible Persons.

Plan Sponsor means the entity that contracts with Caremark or any of Caremark Rx, L.L.C.'s affiliates for pharmacy benefit management services, which entity could be, among other things, an insurance company, self-insured group, health maintenance organization, preferred provider organization, multi-employer trust or third party administrator.

Prescriber means a physician, dentist, physician's assistant, optometrist or other health care professional authorized by law to write prescriptions for prescription drugs within the scope of practice as designated by regulatory agency.

Price Type means a current price of a given drug as defined by a nationally recognized reference that Caremark may reasonably select from time to time, which may include, but is not limited to: AWP (Average Wholesale Price), WAC (Wholesale Acquisition Cost), AMP (Average Manufacturer Price), ASP (Average Sales Price), DP (Direct Price), or Federal Upper Limit (FUL).

Provider means a provider of Pharmacy Services that is the signatory to the Agreement and who must provide all services including the provision of prescription drugs usually and customarily rendered by a provider, Licensed Pharmacist or Dispensing Practitioner licensed to provide such Pharmacy Services in the normal course of business, including services mandated by applicable Law.

Retail Pharmacy means a duly licensed and established community pharmacy or dispensing practitioner that serves walk-in patients and that dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. Participation in Caremark's retail networks is limited to pharmacies (or dispensing practitioners) that are a "Retail Pharmacy". **Refer to section 3.04 Standards of Operation** of the Provider Manual.

Third-Party Agreement means an agreement between Caremark and a Caremark client in which Caremark serves as an auditor for that client's participating network pharmacies.

Usual and Customary Price or U&C means the lowest price Provider would charge to a particular customer if such customer were paying cash for an identical prescription on that particular day at that particular location. This price must include any applicable dispensing fee and/or level of effort. This price must include any applicable discounts offered to attract customers.

Wholesale Acquisition Cost or WAC means the current wholesale acquisition cost of a given drug as defined in the latest edition of Medi-Span (with supplements), MICROMEDEX, or any other similar nationally recognized reference which Caremark may reasonably select from time to time.

CONFIDENTIAL AND PROPRIETARY

CONFIDENTIAL TREATMENT REQUESTED

Exhibit 23: CVS_HJC_00002411 Letter allowing 986 Specialty Pharmacy 2 to work with Blink Rx

9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719 | 480-391-4359

May 23, 2025

Via facsimile 702-909-4073 and UPS

986 Specialty Pharmacy 2
321 N Buffalo Dr. Ste 120
Las Vegas, NV 89145

NCPDP: 2994817
NPI: 1295251338

Re: Update on Caremark's Policy Regarding Hubs

Dear 986 Specialty Pharmacy 2:

CVS Caremark is committed to providing access to high-quality, cost-effective pharmacy services and recognizes ongoing innovation in our industry to improve the services provided to our clients and their members. We appreciate and value all you do for the patients we jointly serve on behalf of our plan sponsor clients.

We are writing to inform you of a change in policy regarding pharmaceutical hub services ("hubs"). We have learned more about the innovative offerings hubs may provide to help manage prescription drug costs. You may partner with Blink to engage in activities for which Caremark's authorization is required under the Provider Agreement or Provider Manual, (for example, Sections 3.03.01, 3.03(1)(B), 4.03(14), 4.12), provided such activities comply with applicable laws and regulations. As a result, your relationship with a hub will not be the basis for any audit finding or noncompliance with the provider manual.

We understand this guidance is different than what we provided previously. Please follow this direction going forward.

Should you have any questions, please contact Caremark Pharmacy Performance at 1-866-488-4709.

Regards,

CVS Caremark

Exhibit 24: CVS_HJC_00002417 Letter allowing Med Cart Specialty Pharmacy to work with Blink Rx

9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719 | 480-391-4359

CVS caremark™

May 23, 2025

Via facsimile 734-762-6601 and UPS

Med Cart Specialty Pharmacy
32131 Industrial Rd.
Livonia, MI 48150

NCPDP: 2374445
NPI: 1225343221

Re: Update on Caremark's Policy Regarding Hubs

Dear Med Cart Specialty Pharmacy:

CVS Caremark is committed to providing access to high-quality, cost-effective pharmacy services and recognizes ongoing innovation in our industry to improve the services provided to our clients and their members. We appreciate and value all you do for the patients we jointly serve on behalf of our plan sponsor clients.

We are writing to inform you of a change in policy regarding pharmaceutical hub services ("hubs"). We have learned more about the innovative offerings hubs may provide to help manage prescription drug costs. You may partner with Blink to engage in activities for which Caremark's authorization is required under the Provider Agreement or Provider Manual, (for example, Sections 3.03.01, 3.03(1)(B), 4.03(14), 4.12), provided such activities comply with applicable laws and regulations. As a result, your relationship with a hub will not be the basis for any audit finding or noncompliance with the provider manual.

We understand this guidance is different than what we provided previously. Please follow this direction going forward.

Should you have any questions, please contact Caremark Pharmacy Performance at 1-866-488-4709.

Regards,

CVS Caremark

Exhibit 25:
CVS_HJC_00002425 Letter allowing Market 32 Pharmacy to work with Blink Rx

9501 E. Shea Boulevard | Scottsdale, AZ 85260-6719 | 480-391-4359

May 23, 2025

Via facsimile 866-360-9277 and UPS

Market 32 Pharmacy
21 Galaxy Pass
Sutton, MA 01590

NCPDP: 2245024
NPI: 1659754208

Re: Update on Caremark's Policy Regarding Hubs

Dear Market 32 Pharmacy:

CVS Caremark is committed to providing access to high-quality, cost-effective pharmacy services and recognizes ongoing innovation in our industry to improve the services provided to our clients and their members. We appreciate and value all you do for the patients we jointly serve on behalf of our plan sponsor clients.

We are writing to inform you of a change in policy regarding pharmaceutical hub services ("hubs"). We have learned more about the innovative offerings hubs may provide to help manage prescription drug costs. You may partner with Blink to engage in activities for which Caremark's authorization is required under the Provider Agreement or Provider Manual, (for example, Sections 3.03.01, 3.03(1)(B), 4.03(14), 4.12), provided such activities comply with applicable laws and regulations. As a result, your relationship with a hub will not be the basis for any audit finding or noncompliance with the provider manual.

We understand this guidance is different than what we provided previously. Please follow this direction going forward.

Should you have any questions, please contact Caremark Pharmacy Performance at 1-866-488-4709.

Regards,

CVS Caremark

Exhibit 26:
CVS_HJC_00006885 Internal email highlighting changes to the provider manual

From: Mccall, Steven D. [redacted]

Sent: 5/11/2021 8:34:12 PM
To: Correia, Brian J. [redacted]
CC: Smith, AmyL [redacted]
Subject: Test Claims

Hi Brian:

We updated our Provider Manual effective last May with regards to test claims. Specifically the section states the following are prohibited.

Test Claims: Unless otherwise authorized in writing by Caremark, Provider must not submit test claims when a prescription order does not exist (e.g., to determine reimbursement rates). Provider must also not submit test claims acting as a HUB service provider unless given written consent by Caremark.

In essence, the pharmacy is only supposed to bill for claims where there is a script in hand. We had an issue with Amazon (ongoing) where a test claim was submitted and it was noted the claim going to various different Amazon pharmacy locations. The test claims were for a specific drug, lisinopril 2.5mg and diabetic testing supplies, rather than any drug the member may take.

The second as to whether we review for potential test claims, is yes. It is one of the elements to the algorithm for PEAR looking for high reversal rates, and could also trigger our review for low numbers of specific NDC codes.

I will keep you updated on the exchange of information with Amazon relating to the lisinopril issue.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark [redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 27:
CVS_HJC_00008402 Internal email thread investigating hub pharmacy activity

From: Haffner, Heidi H. [redacted]
Sent: 9/10/2019 1:03:51 PM
To: Park, Brian [redacted]; Mccall, Steven D. [redacted]; Dillabough, Michael P [redacted]
CC: Shelby, Mark [redacted]; Smith, Amy L [redacted]
Subject: RE: 5922631 Patient Choice Pharmacy RE: FWA Referral: Suspicious Pharmacy - securemail CFWA 2019-001542

On 9/6/19, Physician Specialty Pharmacy updated their name and address per email, "if new location was occupied by pharmacy.
New address effective in Sunbiz as of 8/19/19.

The new location is 41 miles away from the old.

I also referred to Enrollment for Failure to Warn on 7/22/19.
Jay Medicine Store's pharmacy license is active at the new address.

Old:
Physician Specialty Pharmacy
6258 NORTH W STREET
PENSACOLA FL 32505

New as of 8/19/19:

5721659 NPI: 1922415140
JAY MEDICINE SHOPPE
14088 ALABAMA ST
JAY FL 32565

The pharmacy lists Hydra Medical Ventures as the owner. The address on Sunbiz for Hydra Medical Ventures is **The UPS Store** at:
362 GULF BREEZE PKWY. UNIT 221 GULF BREEZE, FL 32561

19-09-11	EFT	45,621
19-09-04	EFT	170
19-08-28	EFT	886
19-07-24	EFT	42,369
19-07-17	EFT	93,290
19-07-10	EFT	29,966
19-07-03	EFT	53,147
19-06-26	EFT	62,533
19-06-19	EFT	63,671
19-06-12	EFT	47,646
19-06-05	EFT	57,040
19-05-29	EFT	20,212
19-05-22	EFT	248,012
19-05-15	EFT	101,599

Heidi Haffner | Senior Manager, Pharmacy Audit, CVSCaremark
[redacted]
9501 East Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Park, Brian J.
Sent: Monday, August 26, 2019 11:16 AM
To: Mccall, Steven D. [redacted]; Dillabough, Michael P. [redacted]
Cc: Shelby, Mark [redacted]; Haffner, Heidi H. [redacted]; Smith, AmyL [redacted]; Park, Brian J. [redacted]
Subject: 5922631 Patient Choice Pharmacy RE: FWA Referral: Suspicious Pharmacy - securemail CFWA 2019-001542

Steve:

This pharmacy was referred over to Enrollment group due to connection to Cindy Hanson (One Choice Pharmacy 5925079 / Fort Bend 5918353).

Pt Choice Pharmacy appears to be a HUB, but I wasn't able to identify where the claims are migrating to.

When looking at the pharmacy's reject and reversal, there is a high volume of reject/reversals on the products below.
Reject – total 60 unique medications
Reversal – total 36 unique medications

		Values	
CLAIM_STATUS	**DRUG_LBL_NM**	**Count of CLAIM_STATUS**	**Distinct Count of MBR_ID**
Paid		32	10
Reject	DICLOFENAC GEL 3%	2436	1691
	CALCIPOTRIEN CRE 0.005%	2355	1531
	LIDOCAINE OIN 5%	1726	1300
	FENOPROFEN CAP 200MG	1487	1162
	LIDOCAINE CRE TETRACAI	1370	1098
	DOXEPIN HCL CRE 5%	1210	791
	FLUOCINONIDE CRE 0.1%	1164	870
	INFINITY TES BLD GLUC	701	603
	CLOBETASOL OIN 0.05%	673	491
	ONE TCH ULTR TES BLUE 50	627	528
	CALCIPOT/BET OIN .005/.06	487	336
	ACCU-CHEK TES SMRTVIEW	390	304
	FREESTYLE LT LIT STRIPS	359	272
	EASY COMFORT MIS 30G	192	163
	ALCOHOL PAD	161	142
	EASY MINI MIS EJECT	127	107

Reversal	CALCIPOTRIEN CRE 0.005%	808	724
	CLOBETASOL OIN 0.05%	677	635
	LIDOCAINE OIN 5%	673	630
	DICLOFENAC GEL 3%	311	278
	ALCOHOL PAD	214	199
	DOXEPIN HCL CRE 5%	189	180
	ONE TCH ULTR TES BLUE 50	184	178
	CALCIPOT/BET OIN .005/.06	148	142
	FLUOCINONIDE CRE 0.1%	132	124
	ACCU-CHEK TES SMRTVIEW	130	122
	FENOPROFEN CAP 200MG	105	104

When including the date of fills and filtering for the medications listed above, all reject/reversal claims appear to be billed in the month of August, 2019.
The claims however, have not been billed elsewhere after the reversals.

Members are located in 48 different states, with the majority being in Ohio, Texas, Florida, New York and Georgia.

MBR_STATE	Values Sum of PHMCY_TOT_REIM_AMT	Count of CLAIM_STATUS	Distinct Count of MBR_ID
OH	-133294.26	3440	365
MA	-85416.42	650	68
TX	-68502.27	2058	234
FL	-61543.21	1765	201
PA	-56685.56	657	81
IL	-48122.19	674	77
NY	-44287.58	3344	354
MD	-41556.64	709	90
GA	-39501.38	956	106
AZ	-26942.6	272	37

Looking at the clients, there are 499 unique plan sponsors.

LVL1_ACCT_NM	Values Distinct Count of MBR_ID	Sum of PHMCY_TOT_REIM_AMT	Count of CLAIM_STATUS
CARESOURCE OH	175	-54402.13	1732
AETNA-MED-D PDP S5810	147	-51561.23	1249
SERVICE BENE PLAN-BCBSA	74	-58665.85	639
AETNA-MED-D MAPD H5521	71	-44798.93	643
SILVERSCRIPT-INDIV-ENROLL	67	-6821.41	475
HF NY MCR MAPD	55	-4562.28	337
CCN OPTUM REGION 1	38	0	199
CCN OPTUM REGIONS 4,5,6	35	0	219
AETNA-PPO	34	13304.24	342
CNC 223 HIM FL	32	-7033.12	341

Below is the prescribers that prescribed for most unique members for the medications included in reject/reversal tables.

Reject – 2070 unique prescribers

Last Name	First Name	NPI	Claims	Unique Members
(blank)			136	28
GHANEM	FADI	**1093700932**	8	5
LOPEZ	HECTOR	**1346243847**	34	4
TOLEK	CUNEYD	**1174514590**	28	4
GREENE	JOHN	**1275956617**	19	3
LAROQUE	BARBARA	**1255416889**	21	3
MISRA	SAMEER	**1437161262**	28	3
ODURO MANU	GLADYS	**1851588602**	17	3
O'HANLON	ANDREA	**1275826463**	22	3
ONWUKA	CHIKE	**1013065267**	30	3
PISATI	SRILAKSHMI	**1265494447**	15	3
RICHMOND	JOHN	**1649232216**	29	3
SAMPATH	PRAVEEN	**1023348299**	7	3

Reversals – 1501 unique prescribers

Last Name	First Name	NPI	Claims	Unique Members
GHANEM	FADI	**1093700932**	4	3
GREENE	JOHN	**1275956617**	5	3
LOPEZ	HECTOR	**1346243847**	4	3
O'HANLON	ANDREA	**1275826463**	6	3
PISATI	SRILAKSHMI	**1265494447**	6	3
RICHMOND	JOHN	**1649232216**	7	3
TOLEK	CUNEYD	**1174514590**	3	3
ABUL-ELA	MOHAMAD	**1649337411**	3	2
ARIOLA HOPKINS	FRANCISCA	**1821080698**	5	2
ARNOLD	HENDRICK	**1265516017**	2	2

Several prescribers appear on both lists.

WATN data shows the following when filtered for the products that were rejected/reversed.

PHMCY_NM	NCPDP_PRVDR_ID	DRUG_LBL_NM	FILL_DT	Values Count of DRUG_LBL_NM	Sum of CLNT_BILL_AMT
LAKE WORTH PHARMACY	**5707229**	CLOBETASOL OIN 0.05%	8/6/2019	1	135.98
			8/9/2019	1	42.28
		FENOPROFEN CAP 200MG	8/9/2019	1	3181.28
MP PHARMACY	**5725722**	LIDOCAINE OIN 5%	8/6/2019	1	1295.5
PREFERRED PHARMACY	**5900154**	FREESTYLE LT LIT STRIPS	8/8/2019	1	129.58
			8/15/2019	1	129.58
		LIDOCAINE OIN 5%	8/8/2019	1	287.26

		INFINITY TES BLD GLUC	8/19/2019	1	417.88
TOPICAL SOLUTIONS PHARMACY	**0358627**	LIDOCAINE OIN 5%	8/8/2019	1	212.2
		DOXEPIN HCL CRE 5%	8/8/2019	1	433.67
STERLING PHARMACY	**3953406**	LIDOCAINE OIN 5%	8/12/2019	1	84.25
		EASY MINI MIS EJECT	8/15/2019	1	33.22
		CALCIPOTRIEN CRE 0.005%	8/12/2019	1	372.75
		EASY COMFORT MIS 30G	8/15/2019	1	38.38
TEXAS UNICARE PHARMACY	**5911967**	LIDOCAINE CRE TETRACAI	8/7/2019	1	486.94
SUNSET DRUGS	**5710985**	LIDOCAINE CRE TETRACAI	8/12/2019	1	449.12
ACCUSERV PHARMACY	**6004410**	FREESTYLE LT LIT STRIPS	8/12/2019	1	330.77
SPEEDY SCRIPTS 2 PHARMACY	**1014694**	ACCU-CHEK TES SMRTVIEW	8/7/2019	1	315.53
VENUS PHARMACY	**2380335**	CLOBETASOL OIN 0.05%	8/15/2019	1	308.16
AMERICARE RX PHARMACY INC	**5922566**	LIDOCAINE OIN 5%	8/15/2019	1	286.25
GRAND RX	**5926045**	CALCIPOTRIEN CRE 0.005%	8/4/2019	1	199.37
YOUR CHOICE PHARMACY	**4235455**	EASY COMFORT MIS 30G	8/5/2019	1	38.39
		ONE TCH ULTR TES BLUE 50	8/5/2019	1	127.74
		EASY MINI MIS EJECT	8/5/2019	1	33.22
MAYFLOWER PHARMACY	**4551215**	CLOBETASOL OIN 0.05%	8/13/2019	1	193.26
ABO PHCY AND MEDICAL SUPPLIES	**5811826**	FREESTYLE LT LIT STRIPS	8/7/2019	1	138.44
		EASY COMFORT MIS 30G	8/14/2019	1	45.82
MILTON MED & DRUG CO INC	**1016814**	CLOBETASOL OIN 0.05%	8/12/2019	2	164.48
DIRECT PHARMACY SOURCE INC	**5707801**	FREESTYLE LT LIT STRIPS	8/10/2019	1	64.07
		ALCOHOL PAD	8/6/2019	1	97.71
FAITH PHARMACY	**5815002**	FREESTYLE LT LIT STRIPS	8/19/2019	1	144.95
VICTOR PHARMACY	**3313145**	FREESTYLE LT LIT STRIPS	8/17/2019	1	144.95
THE MEDICINE SHOPPE	**3634715**	FREESTYLE LT LIT STRIPS	8/9/2019	1	144.07

COPIAGUE PHARMACY	5816799	FREESTYLE LT LIT STRIPS	8/2/2019	1	140.05
SCHAEPER'S NORTHSIDE PHARMACY	3643904	FREESTYLE LT LIT STRIPS	8/3/2019	1	139.18
EXACT CARE PHARMACY LLC	3678010	FREESTYLE LT LIT STRIPS	8/19/2019	1	139.18
PIONEER PHARMACY	5914975	FREESTYLE LT LIT STRIPS	8/15/2019	1	134.13
SUTTON DRUGS OF LA CENTER	1809536	ONE TCH ULTR TES BLUE 50	8/15/2019	1	127.79
ALBERTSON PHARMACY	5808297	FREESTYLE LT LIT STRIPS	8/9/2019	1	110.66
COASTLINE PHARMACY LLC	5732462	INFINITY TES BLD GLUC	8/7/2019	1	109.52
DELIVERCARERX PHARMACY LLC	1487708	CLOBETASOL OIN 0.05%	8/9/2019	1	83.21
TOMPKINSVILLE PHARMACY INC	3321560	FREESTYLE LT LIT STRIPS	8/2/2019	1	72.88
HARLEM CARE PHARMACY	5808425	FREESTYLE LT LIT STRIPS	8/13/2019	1	72.88
JAMES PHARMACY	3608897	FREESTYLE LT LIT STRIPS	8/1/2019	1	72.21
CAMDEN VILLAGE PHARMACY	3639638	FREESTYLE LT LIT STRIPS	8/6/2019	1	72.21
SULLIVAN DRUGS INC	1427625	ONE TCH ULTR TES BLUE 50	8/1/2019	1	65.23
SEACREST PHARMACY	5711747	EASY COMFORT MIS 30G	8/12/2019	1	43.53
		ALCOHOL PAD	8/12/2019	1	21.42
HEALTHPROMOTE PHARMACY LLC	5717612	ONE TCH ULTR TES BLUE 50	8/6/2019	1	63.2
TRUSTEDMEDRX	5722043	LIDOCAINE OIN 5%	8/19/2019	1	59.72
NOVO PHARMACY	5808893	ALCOHOL PAD	8/9/2019	1	51.15
ROYAL PHARMACY	5916133	EASY COMFORT MIS 30G	8/5/2019	1	47.42
GEORGE PHARMACY CARE CORP	5717092	ALCOHOL PAD	8/12/2019	1	47.35
LORRAINE PHARMACY INC	5826459	ALCOHOL PAD	8/8/2019	1	24.3
FRANKLIN COMMUNITY PHARMACY	1566314	LIDOCAINE OIN 5%	8/19/2019	1	0
Grand Total				**56**	**12204.27**

Brian Park PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted] [redacted]
9501 E Shea Blvd. Mail Code 020. Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Mccall, Steven D.
Sent: Sunday, August 25, 2019 4:50 AM
To: Dillabough, Michael P. [redacted]
Cc: Haffner, Heidi H. [redacted]; Park, Brian J. [redacted]; Smith, AmyL [redacted]
Subject: Fwd: FWA Referral: Suspicious Pharmacy - securemail CFWA 2019-001542

Mike,

Can you review for being a potential hub? What are they submitting and reversing and where are the claims going from reversal to fill. Also, is there a plan in common or home geography?

Thanks, Steve

Sent from my iPhone

Begin forwarded message:

From: "Borowski, Bradley M." [redacted]
Date: August 22, 2019 at 4:21:10 PM EDT
To: "Mccall, Steven D." [redacted], "Borowski, Bradley M." [redacted]
Subject: FW: FWA Referral: Suspicious Pharmacy - securemail CFWA 2019-001542

Help – feedback requested ~

VIVA – FWA Pharmacy Referral

NPI ~ 1841738846 | Patient Choice Pharmacy, Sugarland TX

I did some further analysis upon these activities and believe something is not right…

14,000 Rejects/Reversal upon over 1,400 New patients from across the US n Aug 2019 alone? with their past activities being next to zero..

Bradley Borowski | Advisor - Clinical, Comprehensive Fraud, Waste & Abuse, CVS/Caremark
[redacted]
CVS Health | 9501 E Shea Blvd, MC093 | Scottsdale, AZ 85260

From: Cariddi, Michael C.
Sent: Thursday, August 22, 2019 12:59 PM
To: Borowski, Bradley M. [redacted]
Subject: Re: FWA Referral: Suspicious Pharmacy - securemail CFWA 2019-001542

Hi Brad. I wasn't able to have a side meeting with my Director on this but did you hear anything back from Heidi? I'm out until next Tuesday so a better direction for you to take this is to Pharmacy Audit, specifically Steve McCall. He was very much involved in an almost identical issue a few weeks ago…a lot of "test" claims were being run through. He had a lot of information on it and was very educated on what was likely occurring. My group didn't do much with the issue we got copied on and I don't know how it ended or if it is even still ongoing.

On Aug 22, 2019, at 10:12 AM, Borowski, Bradley M. [redacted] wrote:

Hey Mike ~

Any additional updates to share and you available to discuss further today ?

Brad

[redacted]

From: Cariddi, Michael C.
Sent: Tuesday, August 20, 2019 7:14 PM
To: Borowski, Bradley M. [redacted]
Subject: FWA Referral: Suspicious Pharmacy - securemail CFWA 2019-001542

Hi Brad. We got this issue a few weeks ago and I'll have to find out what we came up with as I wasn't involved very much. From what I recall, the test claims are being die using an app and the doctor's NPI seems to be hard coded and shows up almost all of the test claims. This issue raised a big red flag with Legal and some other groups, but I am pretty sure it got resolved and was not fraud. I'll get some details from my Director as this reached upper levels of Loss Prevention and hey got looped in on the conversations.

I have an all day meeting tomorrow so will send what I can in email and then we can talk on Thursday.

On Aug 20, 2019, at 4:42 PM, Borowski, Bradley M. [redacted] wrote:

Hi Mike,

Lets plan to talk by phone on this one... Tuesday morning

BradBorowski

Bradley Borowski | Advisor - Clinical, Comprehensive Fraud, Waste & Abuse, CVS/Caremark
[redacted] | [redacted]
CVS Health | 9501 E Shea Blvd, MC093 | Scottsdale, AZ 85260

From: Borowski, Bradley M.
Sent: Monday, August 19, 2019 1:51 PM
To: Haffner, Heidi H. <Heidi.Haffner@CVSHealth.com>; Shelby, Mark <Mark.Shelby@CVSHealth.com>
Cc: Borowski, Bradley M. <Bradley.Borowski@CVSHealth.com>
Subject: RE: FWA Referral: Suspicious Pharmacy - securemail

Greetings-

I did some further analysis upon these activities and believe something is not right...

14,000 Rejects/Reversal upon over 1,400 New patients from across the US n Aug 2019 alone? with their past activities being next to zero..

I suspect there may a serious CVSHealth breach occurring, as these ID's appear fresh and not compromised yet... Based upon review of these bene histories, these ID's are from all over the US, with many claims history including only a single

pharmacy use ever. For this list of claims to be assembled and test billing to appear to be occurring, this requires CVSHealth forensic investigations to determine root source of breach.. Do you have any recommendations for such a referral ? I suspect an internal employee may potential be the source..

Is this something your team would further engage upon based upon this *HUGE* volume of REJECT activities & obviously gaming the system for unproven reasons at this time... (but look at the meds and you'll know where this is headed towards – foot baths)

Brad

Bradley Borowski | Advisor - Clinical, Comprehensive Fraud, Waste & Abuse, CVS/Caremark
[redacted]
CVS Health | 9501 E Shea Blvd, MC093 | Scottsdale, AZ 85260
[redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

From: Borowski, Bradley M.
Sent: Thursday, August 15, 2019 11:54 AM
To: Haffner, Heidi H. [redacted]; Shelby, Mark [redacted]
Cc: Borowski, Bradley M. [redacted]; Arellano, Julio [redacted]
Subject: FWA Referral: Suspicious Pharmacy - securemail

VIVA – FWA Pharmacy Referral

NPI ~ 1841738846 | Patient Choice Pharmacy, Sugarland TX

Not a lot of *paid* claims activities (<10), but even within, maybe a couple suspect paid claims..

I ran a pharmacy reject report which shows they are *appearing* to be 'testing' the system with a lot of strange and suspicious looking medication, prescribers, and even beneficiary's over the past week or so– *where are they getting these 'hypothetical' beneficiary ID's or RX Orders from anyway..*

Please advise what actions you may or may not be taking in order for me to provide a follow up response to the original reporter.

Thanks You !

Brad

Bradley Borowski | Advisor - Clinical, Comprehensive Fraud, Waste & Abuse, CVS/Caremark
[redacted]
CVS Health | 9501 E Shea Blvd, MC093 | Scottsdale, AZ 85260

From: Lopes, Bradley A
Sent: Thursday, August 15, 2019 10:14 AM
To: Borowski, Bradley M. [redacted]
Subject: FW: Suspicious Pharmacy

Hey Brad,

Would you be able to look into this pharmacy? They're in Texas and filling some questionable meds.

Thank you,

Brad Lopes | Account Manager, CVS Caremark
[redacted]
9501 E. Shea Blvd, Scottsdale, AZ 85260
<image002.png>
CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Thursday, August 15, 2019 6:33 AM
To: Lopes, Bradley A [redacted]
Subject: [EXTERNAL] Suspicious Pharmacy

Bradley,

This out-of-state pharmacy came up in our review of rejected claims this morning. The pharmacy tried to bill for items such as lidocaine, diclofenac, doxepin, and fenoprofen. Please forward to the FWA team for further review.

<image003.png>

Thanks,
[redacted]

[redacted] | *Supervisor of Pharmacy Operations.* | VIVA HEALTH - *A Member of the UAB Health System* |417 20th Street North, Suite 1100 | Birmingham, Alabama 35203 | ***Telephone:*** [redacted]

Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. You are hereby notified that any review, use, disclosure, duplication or distribution of this transmission by someone other than the intended recipient is strictly prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

VIVA Health does not participate in any discriminatory practices. For more information, visit http://www.vivahealth.com.

Exhibit 28: CVS_HJC_00008671 Internal email thread investigating claims of fraud, waste, and abuse

From: Gustafson, David P. [redacted]
Sent: 3/7/2019 6:51:32 PM
To: Haffner, Heidi H. [redacted]
CC: Correia, Brian J. [redacted]; Mccall, Steven D. [redacted]; Park, Brian J. [redacted]; Wikas, David E. [redacted]; Blagojevic, Milanka [redacted]
Subject: FW: Network Concerns of Hilmar Cheese Co. (Securemail)
Attachments: Latest Email on Hilmar Feb 28th.docx; Steps on Hilmar.msg; Analysis.zip

Hello Heidi,

I wanted to share this latest email below that the TPA sent over yesterday. I'm crafting a response back based on everything I've seen BUT if you have any more feedback based on this latest email let me know asap.

Looks like a Doctor prescribing issue at the heart of this "scam" described but the author is trying to tell a story of how PBM's are complicit in this. Thanks!

3/6/19

Hi Dave,

With further regard to below, here now is a written statement from [redacted]. The statement describes his involvement in the fraudulent scheme impacting the Hilmar Cheese Company Prescription Drug Benefit Plan. The statement essentially embellishes the assessment I gave you in my February 28, 2019 email immediately below.

So here is the scam - - medical records or medical assessments are provided to licensed prescribing physicians, usually those with pain management or anesthesia credentials. These physicians review what is provided and write prescriptions, more than likely to pharmacies they are directed to by the scam perpetrator. In this case, I have listed those pharmacies for you previously. The physicians never see the patient. The records come from identified outside sources such as a chiropractor or a nurse practitioner or who knows what other title may be involved. [redacted] reviewed records from a chiropractor. That's what [redacted] said. [redacted] never established firm chiropractic resources other than in one or two cases. The chiropractic review didn't match the chiropractic treatment the patient related. It really doesn't matter. Whether it is a chiropractor or not, a nurse practitioner or not, the medical info flow is simply a trigger to write a prescription to then use telemedicine technique to write prescriptions attacking health plans. The process is intelligent and relies on health plan information obtained from likely inside sources which could include electronic medical records or pharmacy breach. The other day, Hines told Becky Taylor of this office that they think the pharmacies are victims. I completely disagree. The pharmacies are complicit or at least negligent. Certainly that was the case of Texas Health Rx who CVS threw out of the network but won't tell us why, citing confidentiality. Certainly we need an answer now on Haltom Pharmacy. Certainly, someone at North Houston Pharmacy was blatantly lying or covering up or ignorant when they told [redacted] that [redacted] was a Teladoc physician and that they were filling prescriptions for Teladoc on an auto-fill basis. It is all aimed at health insurance plans as a money grab and, and I am sorry to have to say this, the lack of PBM engagement to thwart these hacks. I am citing this across the PBM spectrum and not singling out CVS. CVS did respond diligently in a clinical fashion with excellent interplay between my office and Milanka Blagojevic. However that response required a full frontal health plan developed control and it lacked product leadership that addresses the electronic delivery process. I am hoping that you and I can develop recommended controls which if not of interest to CVS at a book of business level, would at least be of interest to me for the clients I represent. We can't have another episode where we evolve a response while corporate health plan coffers are being raided. Please help me find someone I can talk to about this. I appreciate all of the assistance I receive from you and Dave Wikas and as I said above, Milanka is an all-star. However, I need the attention of someone who sees a listing ship.

Thanks, Dave.

[redacted]

From: Haffner, Heidi H.
Sent: Monday, March 4, 2019 2:32 PM
To: Gustafson, David P. [redacted]
Cc: Correia, Brian J. [redacted]; Mccall, Steven D. [redacted]; Park, Brian J. [redacted]; Wikas, David E. [redacted]; Blagojevic, Milanka [redacted]
Subject: FW: Network Concerns of Hilmar Cheese Co. (Securemail)

Hi David-

Responses below. We were already aware and audited the 4 pharmacies in question. 1 has been terminated.

From: Gustafson, David P.
Sent: Monday, March 4, 2019 1:58 PM
To: Haffner, Heidi H. [redacted]; Mccall, Steven D. [redacted]; Correia, Brian J. [redacted]
Cc: Park, Brian J. [redacted]; Wikas, David E. [redacted]; Blagojevic, Milanka [redacted]
Subject: RE: Network Concerns of Hilmar Cheese Co. (Securemail)

Networks Team,

The TPA owner just sent over the attached (word file) update on Hilmar Cheese – with more detail that their auditor [redacted] has uncovered. Some doctor and company names included:

*"[redacted] indicated he did not see the patients. He was contacted by a Nurse Practitioner who said the patient needed an Rx written. This was through a company that he was involved with and that he accessed through LinkedIn. The company's name is **Financial Academy**. He also indicated **Indeed.com** is involved.*

It is clear that the pharmacies are instrumental in this fraudulent activity which is why I asked you in my earlier email to document please the controls that CVS has for monitoring their network pharmacies. In my opinion, the old fashion audit after the fact that takes 6 months is obviously a horribly inadequate response in the age of telemedicine."

Next steps:

-Can you updated us on the status of the 4 pharmacy audits you mention?

The 4 pharmacies have been audited.

Texas Health Rx (5916210) terminated Sept 2018

Medstar (4553360) payments suspended to pharmacy Feb 2019. Investigative audit in process.

Haltom (4539295) payments suspended to pharmacy Jan 2019. Audit in post audit appeals process, as allowed by TX law.

North Houston (4510120) audit in post audit appeals process, as allowed by TX law.

-Can networks do anything on this claims around Financial Academy and Indeed.com?

We are not familiar with these entities as they are not contracted.

It appears the prescriber did not deny these rxs as he was working for a telemedicine company. Pharmacies can claim they bill rxs in good faith for rxs authorized by prescribers.

I searched LinkedIn and Indeed.com and don't find listings for "Financial Academy" that appear to recruit teledoctors.

-Can you give us any specifics to answer their main premise of: *what controls that CVS has for monitoring their network pharmacies? + Control & Evaluation of network participants? + How can we id abusers early/proactively?*

Controls-pharmacies agree to a contract. Pharmacy audits are conducted for compliance with the pharmacy's contract.

Monitoring- we conduct pharmacy audits for contractual compliance, conducting more than 4,000 onsite and investigative audits annually and more than 100,000 desk audits.

ID abusers early/proactively-

BEST- aggressive plan edits to control drug spend.

Auditing pharmacies has minimal impact on overall drug spend as these types of claims migrate from pharmacy to pharmacy, as long as they are high reimbursing.

-Don't we have some basic network bullets on things we do there beyond desktop and field audits?

Enrollment and Credentialing require pharmacies to be in compliance with their contract, maintain proper licensure, notify of changes of ownership, notify of any investigations where pharmacy's license may be at risk, etc. NCRC is a credentialing committee in existence ~ 2+ years that reviews pharmacies where their licenses are at risk or related to pharmacies terminated from the network due to findings.

- We've already done some NDC lockouts and UM edits for hyperinflationary drugs/medical devices.

Perfect. Clinical will need to continually monitor new trends as new drugs are added to the NDC file and subject to suspect FWA billing.

Hillmar may also opt for their own pharmacy network, but would assume the legal risk if pharmacy wanted to dispute their exclusion.

I would like to propose a call on this later this week so we can all get on same page and I can confirm what to say in a final response to save this client. I'll send an invite out.

Thanks!

David Gustafson, MBA | Strategic Account Executive
[redacted]
CVS Health | 9501 East Shea Blvd, Scottsdale AZ, 85260

From: Blagojevic, Milanka
Sent: Friday, February 22, 2019 10:03 AM
To: Haffner, Heidi H. [redacted]; Mccall, Steven D. [redacted]; Gustafson, David P. [redacted]; Correia, Brian J. [redacted]
Cc: Wikas, David E. [redacted]; Park, Brian J. [redacted]; Blagojevic, Milanka [redacted]
Subject: RE: Network Concerns of Hilmar Cheese Co. (Securemail)

Thanks Heidi!

In regards to the pharmacy migration, please see the following list (and let me know if you need more member information):

1) G.D. → Started at Texas Health Rx and has since moved to Medstar
2) M.F. → Started at Texas Health Rx and has since moved to Haltom
3) J.C. → Started at Texas Health Rx and has since moved to Haltom
4) S.W. → Has only ever filled at Haltom
5) L.A. → Has only ever filled at Haltom
6) K.M. → Has only ever filled at Haltom
7) R.H. → Has only ever filled at North Houston
8) M.M. → Has only ever filled at North Houston
9) N.O.F. → Has only ever filled at Texas Health Rx, no recent utilization at any of the other identified pharmacies
10) A.M. → Has only ever filled at Ideal

Thank you,
Milanka

Milanka Blagojevic, Pharm.D. | Clinical Advisor, Clinical Account Services, CVS/Caremark
[redacted]
CVS Health | [redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Thank You.

From: Haffner, Heidi H.
Sent: Friday, February 22, 2019 11:43 AM
To: Blagojevic, Milanka [redacted]; Mccall, Steven D. [redacted]; Gustafson, David P. [redacted]; Correia, Brian J. [redacted]
Cc: Wikas, David E. [redacted]; Park, Brian J. [redacted]
Subject: RE: Network Concerns of Hilmar Cheese Co. (Securemail)

Great news on the plan edits, Milanka.

Investigative audits have been conducted or in process for all 4 enrolled pharmacies listed.

Regarding claims from Texas Health Rx (5916210/1447633672), did you identify if that drug spend migrated elsewhere?

- Haltom Pharmacy (Milanka requested CVS audit 4 months ago….any status?)
- Ideal Pharmacy
- North Houston Medical Pharmacy
- Med Star Pharmacy
- Texas Health Rx Pharmacy (recently excluded from CVS network)

Regarding claims returned- Pharmacy Audit can audit for claims being dispensed to members. We typically have no way to know if a patient is returning meds to the pharmacy.
If we identified this through an audit, we could chargeback to the pharmacy. Outside of an audit, it may be a Service Warranty issue.

Heidi Haffner | Senior Manager, Pharmacy Audit, CVS Caremark
[redacted]
CVS Health | 9501 East Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

From: Blagojevic, Milanka
Sent: Friday, February 22, 2019 8:11 AM
To: Mccall, Steven D. [redacted]; Gustafson, David P. [redacted]; Correia, Brian J. [redacted]
Cc: Wikas, David E. [redacted]; Park, Brian J. [redacted]; Haffner, Heidi H. [redacted]; Blagojevic, Milanka [redacted]
Subject: RE: Network Concerns of Hilmar Cheese Co. (Securemail)

Hi Steve,

I am the clinical advisor on the account and we have already implemented several different NDC and GPI lockouts. Additionally, we have also implemented several different UM edits available for any of the hyperinflationary drugs/medical devices. The last change that also took place was the blocking of a prescriber from the network who was involved in prescribing these medications after openly confirming that he had never actually seen the members himself.

At this point in time, the client is satisfied with the plan changes that have occurred and is looking for answers to the highlighted questions to share with affected group.

Thank you,
Milanka

Milanka Blagojevic, Pharm.D. | Clinical Advisor, Clinical Account Services, CVS/Caremark
[redacted]
CVS Health | [redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review,

disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Thank You.

From: Mccall, Steven D.
Sent: Thursday, February 21, 2019 9:11 PM
To: Gustafson, David P. [redacted]; Correia, Brian J. [redacted]
Cc: Blagojevic, Milanka [redacted]; Wikas, David E. [redacted]; Park, Brian J. [redacted]; Haffner, Heidi H. [redacted]
Subject: RE: Network Concerns of Hilmar Cheese Co. (Securemail)

Dave:

Don't forget that the most important item is to work on the formulary for the client to prevent these types of issues. If you have questions, you might want to reach out to clinical as we have been advocating for these types of edits to be sold into clients for a number of years. We can only charge back claims that are legally flawed.

We recommend ndc lockout and/or quantity edits on hyperinflated NDCs. At the end of the day, if a pharmacy has a valid prescription and the drug is covered, the claim will pay. Pharmacy Audit cannot prevent claims from paying—only client edits will prevent these NDCs from paying.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Director, Pharmacy Performance, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Gustafson, David P.
Sent: Thursday, February 21, 2019 1:11 PM
To: Correia, Brian J. [redacted]
Cc: Mccall, Steven D. [redacted]; Blagojevic, Milanka [redacted]; Wikas, David E. [redacted]; Park, Brian J. [redacted]; Haffner, Heidi H. [redacted]
Subject: RE: Network Concerns of Hilmar Cheese Co. (Securemail)

Brian,
Thank You!

I'll look forward to hearing back from Brian and Heidi on those points. We probably need at least the general response back by 2/27 to keep the client happy. Any additional relevant audit findings could follow.

Thanks!

David Gustafson, MBA | Strategic Account Executive
[redacted]
CVS Health | 9501 East Shea Blvd, Scottsdale AZ, 85260

From: Correia, Brian J.
Sent: Thursday, February 21, 2019 12:57 PM
To: Gustafson, David P. [redacted]
Cc: Mccall, Steven D. [redacted]; Blagojevic, Milanka [redacted]; Wikas, David E. [redacted]; Park, Brian J. [redacted]; Haffner, Heidi H. [redacted]
Subject: RE: Network Concerns of Hilmar Cheese Co. (Securemail)

Brian P, Heidi,

Please evaluate these pharmacies for audits. Please get together and answer these questions highlighted below and provide a status on any open audit.

David,

We recommend ndc lockout and/or quantity edits on hyperinflated NDCs. At the end of the day, if a pharmacy has a valid prescription and the drug is covered, the claim will pay. Pharmacy Audit cannot prevent claims from paying—only client edits will prevent these NDCs from paying.

Thanks,

Brian J. Correia, CFE | VP, Network Business Services, CVS/caremark
[redacted]
CVS Health | 9501 E Shea Blvd., Mail Code 020, Scottsdale, AZ 85260-6719

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Gustafson, David P.
Sent: Thursday, February 21, 2019 12:36 PM
To: Correia, Brian J. [redacted]
Cc: Mccall, Steven D. [redacted]; Walker, Wendy H. [redacted];
Blagojevic, Milanka [redacted] Wikas, David E. [redacted]
Subject: Network Concerns of Hilmar Cheese Co. (Securemail)
Importance: High

Hi Brian,

I wanted to escalate this TPA client concern to you because a strategic client Hilmar Cheese Co (over 3,500 members CAG: 6572, T024, 0009) is at risk over what they perceive as CVS network issues.

In short they are hyper aware that some smaller rural Texas pharmacies (list below) seem to be dispensing extreme quantities of various products (most recently to 10 members attached on ZIP file). They are concerned that CVS is not doing enough proactively to address abusers that are costing the plan extreme dollars.

In October my clinical manager Milanka Blagojevic worked with Networks to get one suspect pharmacy Texas Health Rx Pharmacy to be excluded from on network. She also worked with Hilmar to implement the attached UM edits to curb this.

However 4 new rural pharmacies are now showing up on the radar with extreme utilization for the 10 members attached. The TPA is fighting to keep Hilmar with CVS Health but we need network's help to:

1. Research the 10 member/4 pharmacy details provided to see if there is any issue we can uncover and offer help on
2. Answer their highlighted questions below

Our team really appreciate your help on this inquiry! I made a few comments in red at bottom of things we may want to also consider.

TPA (Collective Health CEO) Email of
2-20-19, 12:03 PM

Hi Dave,

Nice to talk with you this morning and thank you for arranging the introduction with Jackie.

As I mentioned the apparent fraudulent drug fills involving pain management medicines has expanded now to five pharmacies and they are:

- Haltom Pharmacy (Milanka requested CVS audit 4 months ago….any status?)
- Ideal Pharmacy
- North Houston Medical Pharmacy
- Med Star Pharmacy
- Texas Health Rx Pharmacy (recently excluded from CVS network)

As you know, Texas Health Rx Pharmacy has been removed from the network and Haltom Pharmacy is under audit. With the expansion to three additional pharmacies as listed above, the questions comes to bear as to the performance review process in place at CVS Health allowing for control / evaluation of these pharmacy network participants. As these abuses become more prevalent, how can we rely on CVS Health to manage the network and identify the abusers early on? Your comments will be appreciated.

In the meantime, I have attached up to date relevant information on the 10 impacted Hilmar Cheese Company plan participants and identified the pharmacy associated with each member. I've also attached their history for ready reference as to the extent of the effected drug abuse. It is quite extensive and expensive. The abuse is concentrated at the compound pharmacy level, it would appear. We are waiting for feedback from Hines & Associates to develop more information on these issues and I will share with you then.

The Hilmar Cheese Company Rx Benefit Plan is achieving phenomenal performance improvement this year, the results of which should be catching glowing attention but is hard to find at first glance because of these drug fills that now exceeds $400,000. The total drugs filled at Texas Health Rx alone was over $240,000. Even more embarrassing, when I rank the pharmacies utilized in Texas by dollar spend, you would expect to see United Pharmacy lead the list. Rather, sadly, Texas Health Rx does. This leads me to my last statement and that is if some of these ten claimants are indicating that they have returned the drugs, why are no credits reflected unless the pharmacy is not processing the returns. In which case, isn't the benefit distribution an issue of concern?

Thanks Dave for any help you can provide with a review of this situation.

[redacted]
President
Combined Benefits Administrators
[redacted]

- Dave Gustafson internal comments – things to consider:
- These 10 members are most of the same prior 9 we investigated with Milanka back in Sept/October – and may have just shifted to new pharmacies.
- Can we agree they are abusers? The drugs detailed on the attached 10 members are not C2's and some are not for pain. Nor are they really centered on compounds as Greg's email states. But the utilization does seem extreme on many – and may merit research.
- The Doc's would seem to have no reason to push these drugs (not C2's) for their benefit unless they are in collusion with these small pharmacies sharing in the high cost reimbursement rates to pharmacies.
- On Greg's last point on "refunds" I don't believe a retail pharmacy can take a drug back at any time…?
- Any status on the Haltom Pharmacy audit that started about 4 months ago?
- To save the client we need to research these cases …and give a full answer as to our network processes around proactively identifying abuse / misuse

Thanks!

David Gustafson, MBA | Strategic Account Executive
[redacted]
CVS Health | 9501 East Shea Blvd, Scottsdale AZ, 85260



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments

Exhibit 29:
CVS_HJC_00008885 Internal email thread discussing changes to the provider manual

From: Walker, Wendy H. [redacted]
Sent: 5/1/2019 7:58:33 PM
To: Correia, Brian J. [redacted]
CC: Mccall, Steven D. [redacted]; Shelby, Mark [redacted]
Subject: RE: MIR Pharmacy Weekly Trending Summary

Brian,
I'm going to talk to Marie about this report – I think it is good, but the Where's Waldo report is very telling . . . I believe the trending report needs to be modified and come into play the first 4 weeks AFTER a pharmacy becomes effective with the new rates . . . that's when we can really see and act on the trends, which will be following the patients and terming the inactive pharmacies (that trended to nothing) after 1 months, so they don't start creeping back up (6 months is too long).

Steve/Mark, is there something that we can add to the effect of pharmacies found to be noncompliant with the PM (i.e., hub models, third party marketers, aberrant quantities, etc.) that have claims activity trend to zero, will be termed for this inactivity after one month? I'm not sure I see the Provider Enrollment current guideline of claims inactivity for 6 months before terming – Is this something we can run through PMRC or NCRC, or both? Much like we tag claims inactivity due to payment suspensions from audit collection attempts/PMRC, we want to tag claims inactivity based on MIR effective dates with an MIR tag (in addition to Audit/PMRC, if applicable). I think we need to get these pharmacies out of our network soon after they become dormant because the 3rd party marketing firms may continue to try and shift claims to them with the current 6-month inactivity window we allow.

Let me know your thoughts – maybe we already have the ability to terminate inactive pharmacies in a shorter timeframe – I just am not aware of it other than a one-off exception here and there?

Thanks,
Wendy

From: Correia, Brian J.
Sent: Wednesday, May 01, 2019 11:56 AM
To: Walker, Wendy H. [redacted]
Subject: Fwd: MIR Pharmacy Weekly Trending Summary

Love the report and would pass to Allison but
I still don't understand the Week 1, etc having
more than a week ??

Brian J. Correia, CFE | VP, Network Business Services, CVS/caremark
[redacted]

CVS Health | 9501 E Shea Blvd., Mail Code 020, Scottsdale, AZ 85260-6719
CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Sent from my iPhone

Begin forwarded message:

From: Mail in Retail Network [redacted]
Date: May 1, 2019 at 2:47:57 PM EDT
To: "Correia, Brian J." [redacted], "Mccall, Steven D." [redacted], "Walker, Wendy H." [redacted], "Haffner, Heidi H." [redacted], "Shelby, Mark" [redacted], "Park, Brian J." [redacted], "Kapadia, Amish B." [redacted], "Chapin, Kathryn" [redacted], "Grosso, Lauren A." [redacted]
Cc: "Dillabough, Michael P." [redacted]
Subject: MIR Pharmacy Weekly Trending Summary

Hello,

Here is the weekly summary that includes another week's worth of data. The attached spreadsheet includes more details if you want to take a deeper look. I've included definitions below to help interpret the information.

Marie

OVERALL SUMMARY

MIR - Phase I Trending

Date range of Data Pull	Stopped Trending	Trending Down	Trending Up	Non-Material	Total
Wk 1: Mar 14 - Mar 28	17	16	9	128	170
Wk 2: Mar 7 - Apr 4	17	14	8	131	170
Wk 3: Feb 28 - Apr 11	23	6	6	135	170
Wk 4: Feb 21 - Apr 18	25	4	5	136	170
Wk 5: Feb 14 - Apr 25	30	7	7	126	170

Definitions

Timeframe:	To keep comparative data the same as post-solicitation time increases, data is pulled in equal parameters before/after solicitation date. Ex. 14 days pre & post, 21 days pre & post, etc...
Non-Material Trending	no change in before and after claims - **OR** - avg claims per day decreased < 25% or avg claims per day increased the < 25% (left overs)
Stopped Trending	0 Claims subitted after solicitation went out - **OR** - 0 claim in most current week
Trending Down	if the avg claims per day decreased by 25% or more and the prior avg claims per day was >= 15
Trending Up	If the avg claims per day increased by 25% of more and the prior avg claims per day was >= 15

PHARMACIES TRENDING UP **PHARMACIES TRENDING DOWN**

NCPDP	Pharmacy_Name	NCPDP	Pharmacy_Name
2993803	PROCARE RX	5918632	IDEAL PHARMACY LLC
5816030	AMANI PHARMACY	5911993	BIZMART PHARMACY
2644018	GO LIVE WELL PHARMACY	4613508	BYRAM HEALTHCARE CENTERS INC
1168788	PRESTIGE PHARMACY	5913480	DOUGHERTY'S PHARMACY HUMBLE, L
4539295	HALTOM PHARMACY	3685154	CAREPOINT PHARMACY
5703043	TOPCARE PHARMACY LLC	5913858	HELPING HAND PHARMACY #4
		1163574	BETA DISCOUNT PHARMACY

Exhibit 30:
CVS_HJC_00009552 Internal email thread discussing changes to the provider manual

From: Mccall, Steven D. [redacted]
Sent: 3/8/2019 9:20:02 PM
To: Hormann, Sabrina M [redacted]
Subject: RE: PM updates

See below...

Steven McCall, R.Ph., M.B.A. | Director, Pharmacy Performance, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Hormann, Sabrina M
Sent: Friday, March 08, 2019 12:35 PM
To: Mccall, Steven D. [redacted]
Subject: FW: PM updates

Sabrina Hormann, PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted]
CVS Health | 9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Kapadia, Amish B.
Sent: Friday, March 8, 2019 12:07 PM
To: Hormann, Sabrina M [redacted]
Subject: PM updates

Items in Blue were discussed in the meeting. Items in red need follow up.

ITEMS UNDER DISCUSSION:
CHANGE OF ADDRESS/ and CHANGE OF OWNERSHIP PAGE 10
–UNREPORTED, REASON FOR TERMS
-FAILURE TO REORT MAY RESULT IN TERMINATIONS WITH CAREMARK
PROVIDER SUSPENSION SECTION
-IF WE ARE NOT ABLE TO COMMUNICATE EITHER THROUGH XXX AS PROVIDER CONTACT INFORITON WILL RESULT IN ADJUSTED SUSPENSION
-PAGE 8
REPORTING OF INVESTIGATIONS AND DISCIPLANRY RECTIONS

DIRTY HANDS
-ASK STEVE FOR NOTES ON LANGUAGE FROM TAO

COMPOUNDS- ADDED VERBIAGE TO CHARGE BACK INCORRECTLY SUBMISSIONS
-BEEF UP AUDIT VERBIAGE

HUB – Under the claims submission section we forbid pharmacies from using a hub by letting them use their NCPDP number or identifier. We should strengthen the language to also prevent network providers from functioning as HUBs

TERMINTATION – Strengthen language to state that for terminations for cause, that they are also being terminated for no cause. (remove risk of irreparable harm) – Amy good with this

RX TRANSFERS – Require a Provider to get explicit permission from Eligible Person to transfer a prescription. New Section. Comment bubble, that need to make sure cleared past Compliance, Mail, Specialty

ANTI KICKBACK FOR ALL – Define what kickback is in lay language and insert in new section outside of Med D. (Kickback makes claim invalid)

ARBITRATION – Lauren is working – will include a requirement to fill out a form for an official dispute, and foreclose on any issues not brought up after 12 months.

FALSE DOCUMENTTION

-ATTACH EXPLANATION VERSUS ADJUST DOCUMENT/MODify

Submission of false or misleading records and documentation may result in chargeback for all claims audited and any other remedies available to Caremark, including but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies. **If clarification of documentation is needed, Provider is required to submit unaltered original documentation along with the explanation on a separate piece of paper.**

COMOUND

– ONE CLAIM, FAILURE ACROSS ENTIRE CLAIM – I think drafted today

SCC CODES

-INAPPROPIATE USE CAUSE CHARGEBACKS – Get Shelby and Shane. Do we want to give an or else if an SCC code is inappropriately used. I would guess the answer is no.

AUTO REFILL

-ADJUST CALL LETTER – New call letter – Med D group to draft – expect allow auto refill after 4 fills. (boo)

ELIGIBLE PERSON SOLICTATION

Language in CVS Provider Manual – New as of 2018:

Eligible Person Solicitation

Provider must not, directly or indirectly (e.g., through a marketing agent) promote or market prescription drug products to Eligible Persons where there is not an existing pharmacist patient relationship based on prior filling of a legend drug. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives but not limited to adherence initiatives, gaps-in-care management or comprehensive medication reviews with Eligible Persons.

Language in MedImpact's Provider Manual (also relatively new; words highlighted in teal are my additions):

Prohibited Activities

Provider shall not (directly or indirectly through a third-party, including telemarketers/marketing companies) obtain its patients and/or obtain prescriptions for Eligible Persons via: (i) cold-calling; (ii) obtaining an Eligible Person's primary care provider or billing information through unsolicited methods; (iii) contacting or offering to contact a prescriber on an Eligible Person's behalf without the Eligible Person's express knowledge and authorization for each specific claim. Provider shall not engage in misleading or deceptive practices, including initiatives to obtain a prescription from a prescriber not expressly requested by the Eligible Person or by suggesting to an Eligible Person that his/her prescriber or the health plan wants the Eligible Person to receive the medication without the prescriber's express knowledge and authorization.

NEED TO CLEAN IT UP.

Amish Kapadia PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted]
CVS Health | 9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 31:
CVS_HJC_00009576 Internal email thread investigating hub pharmacy activity

From: Lindsey, Lisa K. [redacted]
Sent: 4/17/2019 12:10:41 AM
To: Mccall, Steven D. [redacted]
CC: Pershinsky, Helene M [redacted]; Walker, Wendy H. [redacted]; Park, Brian [redacted]
Subject: RE: Alto - BSC review - **Contains PHI on Files**

Thank you all for this information.
I will share the feedback with Barb C tomorrow.

Lisa Lindsey | VP, Client Network Strategies, CVS/caremark [redacted] **CVS Health** | 9501 E Shea Blvd, MC080, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Mccall, Steven D.
Sent: Tuesday, April 16, 2019 4:54 PM
To: Lindsey, Lisa K. [redacted]
Cc: Cormier, Helene [redacted]; Walker, Wendy H. [redacted]; Park, Brian J. [redacted]
Subject: Alto - BSC review - **Contains PHI on Files**

Hi Lisa:

Looking at the claims for Alto Pharmacy, the dispensing profile does not appear to be a normal retail pharmacy. They are looking more like a Dermatology hub pharmacy with some hormone replacement as well. Here are my notes regarding the individual locations. The files contain both BOB and BSC claims, so please remove file if forwarding outside the company. These pharmacies do not appear to be normal retail locations based on dispensing patterns.

Culver City – 5663744 – 6 month volume $150k BSC
Dispensing medications normally from a dermatology hub including topicals and oral isotretinoins. Usually seen with pharmacies that focus on high dollar products with coupons to offset patient pay amount. Additional claims for hormones in the top products.

Irvine – 5663706 – 6 month volume $47k BSC
Dispensing topicals and hormone products but in a much lower volume. Some PrEP products but also low volume.

San Fancisco – 0552403 – 6 month volume $2 million BSC
Top products appear to be HIV medications. However there is also more of the acne products and podiatry topical antifungals (Kerydan and Jublia). Fairly low volume compared to most network providers.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Director, Pharmacy Performance, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Dillabough, Michael P.
Sent: Tuesday, April 16, 2019 3:29 PM
To: Walker, Wendy H. [redacted]
Cc: Cormier, Helene [redacted]; Mccall, Steven D. [redacted]
Subject: RE: URGENT

Wendy, I have finished the drug summary data pulls for the 3 Alto stores listed in the e-mail below.

I ran 2 time frames which coincide with the MIR data pulls: Jul18 – Dec18 & Oct18 – Mar19.

There is one tab for RxClaim business and one tab for BSC business.

Thanks!

Michael Dillabough | Sr. Advisor, Pharmacy Performance
[redacted]
CVS Health | 9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260

From: Walker, Wendy H.
Sent: Tuesday, April 16, 2019 1:10 PM
To: Dillabough, Michael P. [redacted]
Subject: FW: URGENT

Lisa's IM:

[4/16/2019 12:47 PM] Lindsey, Lisa K.:
wendy, did you have any insight on Alto Pharmacies?
are they flagged in MIR data?
[4/16/2019 12:49 PM] Lindsey, Lisa K.:
5663744, 5663706, 0552403
[4/16/2019 12:54 PM] Walker, Wendy H.:
There is one Alto pharmacy (Irvine, CA) on our large MIR spreadsheet - they did not make phase 1 because their shipping % was in-between 25% and 50%, $ volume was not incredibly high, but they have been referred to investigative audit for FWA - they are dabbling in high dollar topicals - I can have Mike Dillabough check if they are ramping up in 2019, but I would not recommend this pharmacy for a preferred network at this time due to some of the concerns -- they will make round 2 or 3 of MIR if they hold this trend.
[4/16/2019 12:58 PM] Walker, Wendy H.:
I just looked in Q1 2019 and I am not seeing Alto 5663706 on my "exceeds 25%" list - let me inquire with Audit to see if they were audited and trended down?? I'll get right back to you.
[4/16/2019 12:59 PM] Lindsey, Lisa K.:
Thanks
[4/16/2019 1:00 PM] Walker, Wendy H.:
I'm showing 270 claims in Q1 2019 - checking with Heidi on what their trending was - incidentally, their last 12 months claims volume is less than 1,000 claims??
[4/16/2019 1:00 PM] Lindsey, Lisa K.:

this is all up to the Roberts and Hourican level

[4/16/2019 1:00 PM] Walker, Wendy H.:

Got it

Do you need anything else

[4/16/2019 1:01 PM] Lindsey, Lisa K.:

you may not see BSC data in there, not sure

[4/16/2019 1:02 PM] Lindsey, Lisa K.:

I'm not clear I understand the referral to FWA and what we might suggest. I'm going to send that over to Brian for input.

From: Walker, Wendy H.
Sent: Tuesday, April 16, 2019 1:09 PM
To: Dillabough, Michael P. [redacted]
Subject: URGENT

frmRecapSearch_Summary

NCPDP	PhcyName	Address	City	ST	Source	RECAP Group	NCPDP Group
0552403	ALTO PHARMACY	1400 TENNESSEE ST UNIT 2	SAN FRANCISCO	CA	RCP	A044	605
5663706	ALTO PHARMACY	9213 RESEARCH DR	IRVINE	CA	RCP	A044	605
5663744	ALTO PHARMACY	6065 BRISTOL PKWY STE 100	CULVER CITY	CA	RCP	A044	605

Highlighted pharmacy showed up on MIR for end of 2018 data. October 2018 – March 2019, the pharmacy did not show up on MIR.

Exhibit 32:
CVS_HJC_00009579 Internal email thread discussing changes to the provider manual

From: Hormann, Sabrina M [redacted]
Sent: 5/3/2019 11:18:12 PM
To: Haffner, Heidi H. [redacted]; Mccall, Steven D. [redacted]
Subject: RE: PM 2020- possible additions

Thanks, Heidi! I incorporated these into our version.

Sabrina Hormann, PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted]
CVS Health |9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Haffner, Heidi H.
Sent: Wednesday, May 1, 2019 10:51 AM
To: Hormann, Sabrina M [redacted]; Mccall, Steven D. [redacted]
Subject: FW: PM 2020- possible additions

Sabrina-
Thanks for reviewing and coordinating.

Steve-
I didn't see the following, and not sure if these were already addressed:

Excluding/omitting info from Enrollment
When enrolling, if pharmacies omit, exclude, or fail to disclose all information, it may be considered a material breech that may result in changes to reimbursement rates and up to, and including immediate termination from the network.

Test Claims
Pharmacies should not submit test claims to determine reimbursement rates and when a prescription order does not exist. Pharmacies should also not submit test claims acting as a HUB service provider unless given written consent by CVS.

From: Hormann, Sabrina M
Sent: Wednesday, May 1, 2019 9:28 AM
To: Shelby, Mark [redacted]; Mccall, Steven D. [redacted]; Terrel, Jaclyn [redacted]; Fenker, Jason [redacted]; Smith, AmyL [redacted]; Grosso, Lauren A. [redacted]; Canale, Shane D. [redacted]; Klein, Angeles [redacted]; Kapadia, Amish B. [redacted]; Haffner, Heidi H. [redacted]; Park, Brian J.

[redacted]; Hormann, Sabrina M[redacted]
Subject: RE: PM 2020

All,
Attached is the legal draft of the PM with our previous edits incorporated. I highlighted areas where Betsy has questions or comments within the text. For sections that were moved, I tried to notate in the comments where they were moved to.

Let me know if you have any questions or if I missed anything. I'll schedule a meeting for us to review again tomorrow.

Thanks!
Sabrina

<< File: 2020 PM_LEGAL Redlined - AUDIT.docx >>

Sabrina Hormann, PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted]
CVS Health |9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

-----Original Appointment-----
From: Shelby, Mark
Sent: Monday, April 29, 2019 10:05 AM
To: Shelby, Mark; Mccall, Steven D.; Terrel, Jaclyn; Fenker, Jason; Smith, AmyL; Deroy, Lauren; Canale, Shane D.; Klein, Angeles; Kapadia, Amish B.; Hormann, Sabrina M; Haffner, Heidi H.; Park, Brian J.
Subject: PM 2020
When: Tuesday, April 30, 2019 8:30 AM-10:00 AM (UTC-07:00) Arizona.
Where: conf_AZ_Shea_1E414_Network Office_A

Team,

We need to review legal changes of PM

<< File: 2020 PM_General_MASTER Redlined_DRAFT 04 19 2019.docx >> << File: 2020 PM_LEGAL Redlined.docx >>
<< File: 2020 Provider Manual Change Tracker 04 19 2019.xlsx >>

Hi Teams – friendly reminder on the attached LEGAL_Redlined copy and that your review and redlines are due by May 6th.

1.Review new content and edits written by Legal.
2.Ensure that no content was lost. Legal has rearranged a few sections and has reworded other sections so your content may have been moved or may look different. Cross check to ensure your content is not missing. I've attached a copy of the Change Tracker which indicates which sections are assigned to you.
3.If you want to submit edits to the Legal version: accept all changes to the LEGAL_Redlined document, save the file with your team name, and start tracking/redlining your changes. Add your questions/comments.
4.Submit your redlines to Tracy no later than May 6 (moving this date up a few days).

Exhibit 33:
CVS_HJC_00009621 Internal email thread investigating pharmacy dispensing patterns

From: Mccall, Steven D. [redacted]
Sent: 6/10/2019 3:36:30 PM
To: Correia, Brian J. [redacted]
Subject: RE: HMSA - Molokai - Background - Do Not Forward as multiple client data included

Yes.

Steven McCall, R.Ph., M.B.A. | Director, Pharmacy Performance, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Correia, Brian J.
Sent: Friday, June 07, 2019 8:04 PM
To: Mccall, Steven D. [redacted]
Subject: Re: HMSA - Molokai - Background - Do Not Forward as multiple client data included

Is this the only pharmacy on Molokai?

Thanks,

Brian J. Correia, CFE | SVP, Network Business Services, CVS/caremark
[redacted]

CVS Health | 9501 E Shea Blvd., Mail Code 020, Scottsdale, AZ 85260-6719
CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Sent from my iPhone

On Jun 7, 2019, at 7:40 PM, Mccall, Steven D. [redacted] wrote:

Hi Barb:

Nice speaking with you today. As discussed today, Molokai Drugs was selected for audits due to unusual dispensing patterns. As a start, Caremark audited 69 stores in 2018. Of those, 25 belonged to a PSAO, 38 were chain stores, and 6 were true (non-affiliated) independents. Of the 69 stores audited, there were 25 CVS/Longs locations so 36% of all audited stores in Hawaii were CVS retail locations. We do this purposefully so that we are not accused of playing favorites by oversampling CVS locations for audit scrutiny.

According to the auditor, Molokai drugs has been professional during the audit, which makes the process a lot more efficient. Specifically, the auditor saw that the store had some unusual trends as seen on this chart.

<image002.png>

If you look the pharmacy was billing a constant pace until mid-2018, than rapidly increased in dollars, however the number of claims was relatively constant. Looking at the drugs themselves, there are a set of hyper-inflated drugs that are being billed including some non-FDA approved vitamins that include Xyzbac, Genicin tabs, Folik-K and Ortho-DF. These items are under high scrutiny by our team as the vitamins tend to adjudicate for more than $1,000 but because they are not FDA approved, they are prohibited from having coupons used to offset patient copayments, which is why the check copies were requested. I'm attaching a tip that came into our group from a network pharmacy warning Caremark that the parent company for Xyzbac was designing programs to evade our reviews by changing to offering a "rebate" check to make it appear that a coupon was not used. In addition, during our data gathering we were able to get a Solubiomix Price List showing the motivation for pushing these types of products. It shows that a bottle of 30 tablets has an AWP of $984 while only costing $410. In the claims from the pharmacy there are payments for single scripts ranging up to $3,000 with copays of $50 to $100, which are being reviewed to insure collection from the patient.

In addition, the pharmacy has begun to bill Metformin ER in a particular version that is extremely expensive. I am also attaching a tip specific to these dosage forms of Metformin. At the pharmacy, there were 413 claims for Metformin ER 1000 mg for $1,898,769. These scripts are not illegal scripts but there are much more reasonable versions with the same clinical benefits. I would be happy to work with the clinical advisor to recommend some products for edits.

I'm hoping that following this audit, that the pharmacy will decide to return to previous dispensing patterns. They have been in the network for a long time. The only concern I have with full sharing is that the chart above is Book of Business. However, when I look at the plans paying for the items above, HMSA is one of the main payers.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Director, Pharmacy Performance, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

<Report from Richie Ray - Richie's Specialty Pharmacy (RSP) Regarding SOLUBIOMIX and Associated Copay Rebate Plans.pdf>

<Report from Richie Ray - Richie's Specialty Pharmacy (RSP) Regarding Multiple Medications Promoted to Compounding Pharmacies.pdf>

<Solubiomix Price List.pdf>

Exhibit 34:
CVS_HJC_00009754 Internal email thread discussing changes to the provider manual

From: Petersen, Tracy N. [redacted]
Sent: 8/20/2019 4:26:36 PM
To: Grosso, Lauren A. [redacted]
CC: Mccall, Steven D. [redacted]; Telschow, Samantha L. [redacted]
Subject: RE: 4.12 Dispensing Pharmacy NPI/NCPDP

No changes. Got it.

Tracy Petersen | Advisor, Pharmacy Communications, CVS Caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-022 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Grosso, Lauren A.
Sent: Monday, August 19, 2019 11:24 AM
To: Petersen, Tracy N. [redacted]
Cc: Mccall, Steven D. [redacted]; Telschow, Samantha L. [redacted]
Subject: RE: 4.12 Dispensing Pharmacy NPI/NCPDP

Hello Tracy,

I've reviewed again, and we can proceed as is.

Thank you,

Lauren Reinsch-Grosso MBA, CPhT | Manager, Network Perfomance, CVS Caremark
[redacted]
9501 E Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Petersen, Tracy N.
Sent: Thursday, August 15, 2019 12:44 PM
To: Grosso, Lauren A. [redacted]
Cc: Mccall, Steven D. [redacted]; Telschow, Samantha L. [redacted]
Subject: 4.12 Dispensing Pharmacy NPI/NCPDP

Hi Lauren! I have a note to follow up with you regarding new language to address central fill. Send me your changes when you can – thanks!

4.12 Dispensing Pharmacy NPI/NCPDP

Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification number or other identifiers to submit a claim (including a test claim) to Caremark. Unless Caremark expressly authorizes otherwise in writing:

1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;
2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;
3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;
4. Provider is not allowed to submit claims on behalf of another entity;
5. Provider must only submit claims it intends to dispense; and
6. Provider may not act on behalf of another entity regardless of ownership structure.

Tracy Petersen | Advisor, Pharmacy Communications, CVS Caremark
[redacted] | [redacted]
CVS Health | 9501 E. Shea Blvd, MC-022 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 35:
CVS_HJC_00010046 Internal email thread investigating pharmacy dispensing patterns

From: Park, Brian J. [redacted]

Sent: 10/16/2019 5:55:07 PM

To: Frey, Korinne [redacted]

CC: Haffner, Heidi H. [redacted]; Chader, Christopher D [redacted]; Domond, Gary [redacted]; Gandhi, Nevil R [redacted]; JOHNSON, SAMANTHA (Network Audit) [redacted]; Palomo, Bertha J. [redacted]; Schmidt, Shanna [redacted]; Thomas, Jennifer A [redacted]; Smith, Amy L [redacted]; Mccall, Steven D. [redacted]; Kapadia, Amish B. [redacted]; Park, Brian [redacted]

Subject: Re: referral for investigative audit: 2312623 Richmond Pharmacy

Hi Korinne:

Can you take a look at the pharmacy's profile and review the top dispensing, client exposures, members/prescribers data, cert IDs, and prescription numbers? Also if pharmacy altered behavior, when did the change occur?

Also take a look at the ownership information and see if there are any potential dirty hands connection.

Thanks

Sent from my iPhone

On Oct 15, 2019, at 4:48 PM, Frey, Korinne [redacted] wrote:

I have already started an audit on this pharmacy.

Thanks,

Korinne Frey, CPhT | Investigator/Advisor, Pharmacy Performance, CVS Caremark
[redacted]
9501 E Shea Blvd MC-020, Scottsdale, AZ 85260
<image002.png>
CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Haffner, Heidi H.
Sent: Tuesday, October 15, 2019 2:46 PM
To: Chader, Christopher D. [redacted]; Domond, Gary [redacted]; Frey, Korinne [redacted]; Gandhi, Nevil [redacted]; JOHNSON, SAMANTHA (Network Audit) [redacted]; Palomo, Bertha J. [redacted]; Schmidt, Shanna [redacted]; Thomas, Jennifer A. [redacted]
Cc: Park, Brian J. [redacted]; Smith, AmyL [redacted]; Mccall, Steven D. [redacted]; Kapadia, Amish B. [redacted]
Subject: referral for investigative audit: 2312623 Richmond Pharmacy
Importance: High

Referral for investigative audit. Reply to all if you can take this audit. Pharmacy may also fit the pattern for potential adjudication suspension.

Concerns:

- <!--[if !supportLists]--><![endif]-->Spike in billing ~ June 2019
- <!--[if !supportLists]--><![endif]-->Potential change in ownership occurred around the same time as trending spike
- <!--[if !supportLists]--><![endif]-->Billing from 2 different Computer Cert IDs
- <!--[if !supportLists]--><![endif]-->Rxs may be dispensed from an off-site location, sent to the pharmacy to mail out
- <!--[if !supportLists]--><![endif]-->High reverse & reject rate, ~ 60% reverse/reject rate
- <!--[if !supportLists]--><![endif]-->Billing hyper-inflated drug products
- <!--[if !supportLists]--><![endif]-->Members have multiple hyper-inflated drug products but other rxs at their local pharmacy
- <!--[if !supportLists]--><![endif]-->Pharmacy is in a town of 250 people, upper western peninsula of Michigan, billing for multiple UAW/Chrysler/GM members in Detroit metro, 4 hours away

2312623 NPI: 1144212812
RICHMOND DRUG
7717 LAKE ST
BEAR LAKE MI 49614

EFF DATE: 09/13/2017

19-10-16	EFT	156,171
19-10-09	EFT	79,322
19-10-02	EFT	126,925
19-09-25	EFT	58,025
19-09-18	EFT	151,965
19-09-11	EFT	154,624
19-09-04	EFT	97,392
19-08-28	EFT	107,651
19-08-21	EFT	6,494
19-08-14	EFT	93,787
19-08-07	EFT	60,423
19-07-24	EFT	80,804
19-07-17	EFT	106,417
19-07-10	EFT	1,263
19-07-03	EFT	27,103
19-06-26	EFT	158,976
19-06-19	EFT	13,683
19-03-27	EFT	34
19-03-20	EFT	1,593
19-03-13	EFT	1,620
19-03-06	EFT	2,056
19-02-27	EFT	4,935
19-02-20	EFT	4,497
19-02-13	EFT	5,372
19-02-06	EFT	6,244

19-01-30 EFT 2,615
19-01-23 EFT 4,918

From: Kapadia, Amish B.
Sent: Wednesday, June 5, 2019 11:29 AM
To: Haffner, Heidi H. [redacted]
Subject: FW: 2312623 Richmond Pharmacy

Looks like the recently got bought out and just started trending in volume. I going to put in for a 455 but I wasn't confused as to why they are not trending. What is the usual delay in remittance? Is the money going somewhere else?

Amish Kapadia PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted]
9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260
<image003.png>
CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Kapadia, Amish B.
Sent: Tuesday, June 4, 2019 11:58 AM
To: Dillabough, Michael P. [redacted]
Cc: Mccall, Steven D. [redacted]
Subject: 2312623 Richmond Pharmacy

Mike

Can you identify where the money is going? It looks like the recently started to bill these high dollar drugs all from the same md. However there trending is zero. Kayleigh comments below suggest there may be a central hub.

Thanks

Amish Kapadia PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted]
9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260
<image003.png>
CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Thomsen, Kayleigh M
Sent: Tuesday, June 4, 2019 10:44 AM
To: Kapadia, Amish B. [redacted]
Subject: ENTTY Spray doc# 191494544323425 SECUREMAIL

Hello,

I called on doc# 191494544323425 at NCPDP: 2312623

Rph was unable to find this claim and any of the patients info, rph stated they are under a new company and they don't have access to new pt info. I spoke with Gabe, RPH who stated they were bought out 3 months ago. If I understood him correctly, the off-site location that bought them processes Rx's, Gabe checks them and fills them, then mails them to off-site location who then mails to patients. Gabe gave me ph# 747-444-6577 Matthew for any further questions.

Thanks,

Kayleigh Thomsen | Consultant, Pharmacy Performance, CVS Caremark
[redacted]
9501 E Shea Blvd. Mail Code 020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 36:
CVS_HJC_00010635 Internal email thread investigating hub pharmacy activity

From: Thomas, Jennifer A. [redacted]

Sent: 7/21/2021 2:08:24 PM

To: Haffner, Heidi H. [redacted]]; Park, Brian J. [redacted]; Smith, AmyL [redacted]; Grosso, Lauren A. [redacted]; Walker, Wendy H. [redacted]

CC: Markovic, Sandra [redacted]; Brady, Jason [redacted]; Shelby, Mark [redacted]; Mccall, Steven D. [redacted]

Subject: RE: PHILRX- copay collections outsourced

I saw extensive transfers from Phil RX in my audit of Meds in Motion and again recently in my audit of Spring Hill Pharmacy (5739567).

Rx Transfer Information

PhilRx, LLC
5900 Roche Dr Ste 107
Columbus, OH 43229-3232
Phone: [redacted]
Fax: [redacted]
Email: [redacted]
Pharmacist: [redacted]

Transfer to
Spring Hill Pharmacy
10475 County Line Rd, Spring Hill, FL, 34609
Phone: [redacted]
Fax: [redacted]
DEA:FV8192988
Pharmacist: [redacted]
Transferred On: 11/05/2019

Rx Information
Redacted PII
Dispensed Drug: DESONATE 0.05 % GEL
Dispensed Manu: Leo Pharma Inc.
Qty Prescribed: 60
Refills Written: 2
Total Fills: 3
Qty Remaining: 180
Directions: [Apply to affected area twice daily for 2 weeks on and 2 weeks off as directed

Note From MD: Escript Note (11/1/2019): Rx Discount Card: UNA Rx CARD- GROUP: CMNNCRX, BIN: 610280, ID: CMNNCRX2345 RxVoucher#3528

Date Written: 11/01/2019
DAW: 0
Prescribed Drug: DESONATE 0.05 % GEL

Prescribed NDC: 50222050460
Dispensed NDC: 50222050460

Prescriber Information
Name: [redacted]
Address: 2685 Forest Hill Blvd, West Palm Beach, FL, 33406
Phone: [redacted]
Fax: [redacted]
DEA:fm4435651
NPI: 1053532077

Patient Information

Redacted PII

Verified w/ MD Aug 2019

Redacted PII

DESONATE 0.05% GEL
NDC: 50222-0504-60 Mfg:Leo
APPLY TO AFFECTED AREA(S) 2 TIMES A DAY FOR 2 WEEKS ON AND FOR 2 WEEKS OFF AS DIRECTED

[redacted]
2685 FOREST HILL BLVD
WEST PALM BEACH, FL 33406-5930
10535 32077 DEA:FM4435651
0000639 Transfer-In

F 09/02/20
Q 60
R 2
OQ 60
DS 30
RPh VP vp
PPY 520.00
Plan 731.28
GP 146.27
ADV1
OH 0
DAW 0

01/27/2021 9:07PM

Jennifer Thomas, CPhT | Lead Sr. Investigator / Advisor, CVS Caremark
[redacted]
CVS Health | 9501 East Shea, MC 020 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Haffner, Heidi H. [redacted]
Sent: Friday, July 2, 2021 2:49 PM
To: Park, Brian J. [redacted]; Smith, AmyL [redacted]; Thomas, Jennifer A. [redacted]; Grosso, Lauren A. [redacted]; Walker, Wendy H. [redacted]
Cc: Markovic, Sandra [redacted]; Brady, Jason [redacted]; Shelby, Mark [redacted]; Mccall, Steven D. [redacted]
Subject: RE: PHILRX- copay collections outsourced

Brian-
Attached are a sample of PhilRx transfers.

I agree we can chargeback for copays that are outsourced.

I don't see the pattern where test claims are being billed, but the rxs in question are billed at various pharmacies, including out-of-state.
PhilRx also appears to be a licensed pharmacy in OH, but not contracted with PBMs, so transferring from pharmacy to pharmacy is allowable.

I called PhilRx today and spoke with Haley Decoy, Rph. Their VRU says *"the prescription management service"*
She confirmed their NPI 1487163598 PhiRx LLC (Phil Pharmacy Solutions LLC) and they are licensed as an "Independent Community Retail (1-Outlet), Lic#0232000001, effective thru 3/31/23.
PhilRx is not contracted with any PBMs.
Haley was cautious about my questions, questioned where I was calling from and why. A few min after I hung up, she called back to confirm who called.

Jenn-
Western Wellness Solutions is Option #4 in their VRU, and appears to be a **wholesaler of drugs**, cosmetics, and medical devices. Have you seen this wholesaler before?

Rx Transfer Information

PhilRx, LLC
5900 Roche Dr Ste 107
Columbus, OH 43229-3232
Phone: [redacted]
Fax: [redacted]
Email: [redacted]
Pharmacist: [redacted]

Transfer to
Carmel Prescription Shop
1001 W Main St, Carmel, IN, 46032
Phone: [redacted]
Fax: [redacted]
DEA:FC7941897
Pharmacist: [redacted]
Transferred On: 02/17/2020

Rx Information
Redacted PII
Dispensed Drug: SEYSARA 100 MG TABLET
Dispensed Manu: Almirall, Llc
Qty Prescribed: 30
Refills Written: 6
Total Fills: 7
Qty Remaining: 210
Directions: [Take 1 tablet by mouth once daily

Note From MD: Escript Note (2/17/2020): 317-710-3633

Date Written: 02/17/2020
DAW: 0

Prescriber Information
Name: [redacted]
Address: 2505 North Lebanon Street, Suite 200, Lebanon, IN, 46052
Phone: [redacted]
Fax: [redacted]
DEA:
NPI: 1912016809

Patient Information
Redacted PII

From: Park, Brian J. [redacted]
Sent: Friday, July 2, 2021 11:50 AM
To: Haffner, Heidi H. [redacted]; Smith, AmyL [redacted]; Thomas, Jennifer A. [redacted]; Grosso, Lauren A. [redacted] Walker, Wendy H. [redacted]
Cc: Markovic, Sandra [redacted]; Brady, Jason [redacted]; Shelby, Mark [redacted]; Mccall, Steven D. [redacted]
Subject: RE: PHILRX- copay collections outsourced

Heidi:

Do you have copies of the transfer hardcopies you can share?
I want to see if they're triaging out prescriptions vs. assigning their own prescription number and then transferring those out to individual pharmacies.

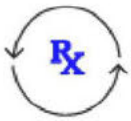
It looks like Phil/PhilRx is engaging in HUB like activities, but also handling all financials including collection of copayments.
So maybe they have their own unique software that communicates adjudication responses back to the dispensing pharmacy as well as Phil?
I don't see how else they would play the patient facing role while closed network of pharmacies fill and ship the medications on Phil's behalf.
Either way, it's a breach of the contract as the copayments are not being collected by the billing/dispensing entities.

https://phil.us/manufacturers



Customizable Adjudication and Fulfillment

Customizable Script Adjudication ensures that your business rules are applied at the point of adjudication with far more flexibility than traditional copay coupons. Drive higher coverage and Customize Prior Authorization process, optimizing for profitability and patient experience, while meeting all payer requirements.



Nationwide Pharmacy Network

Gain access to a nationwide closed pharmacy network that implements all of your business rules with software audit mechanisms in place and real-time data feedback. Consistent, reproducible and predictable patient/prescriber experience across the entire network.

Link to Patient FAQ Below

[redacted]

[redacted]

My Doctor sent my prescription to Phil, what happens next?

Phil
1 year ago · Updated

Once your prescription is received, we will reach out to you via text message to confirm your insurance and shipping information, in addition to creating an account.

When your account is created and we have processed the prescription, you will receive a notification to review and confirm your payment.

Once payment is confirmed, we will send you a link with tracking information once your prescription has shipped.

Why did my Doctor send my prescription to Phil?

Phil
2 years ago · Updated

There are several reasons why Doctors choose to send your prescription to Phil:

-**Pricing**: We are able to get special pricing from the manufacturer on numerous commonly used, brand name medications. In addition to special pricing, we take the time to add any applicable manufacturer's coupons to bring pricing down as much as possible for you.

-**Prior Authorizations**: We work with your Doctor to submit Prior Authorizations should they be required by your insurance for your prescription.

-**Shipping**: Shipping is always free! Your first fill is expedited at no cost to ensure medication can be started ASAP.

-**Automatic Refills**: Removing the hassle of remembering to pick up medications

-**Support**: Our Patient Advocate team is comprised of compassionate and enthusiastic problem-solvers who are here to help. We offer 365 days of support should you have any questions and need assistance!

Is Phil a pharmacy?

Phil
1 year ago · Updated

No, Phil is not a pharmacy. We partner with a network of top-rated and locally-owned specialty pharmacies that fulfill and ship your prescriptions.

Brian Park PharmD | Manager, Pharmacy Performance, CVS Caremark
[redacted]

9501 E Shea Blvd. Mail Code 020. Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Haffner, Heidi H. [redacted]
Sent: Friday, July 2, 2021 9:23 AM
To: Park, Brian J. [redacted]; Smith, AmyL [redacted]; Thomas, Jennifer A. [redacted]; Grosso, Lauren A. [redacted]; Walker, Wendy H. [redacted]
Cc: Markovic, Sandra [redacted]; Brady, Jason [redacted]; Shelby, Mark [redacted]; Mccall, Steven D. [redacted]
Subject: PHILRX- copay collections outsourced

Auditors are reporting seeing transferred rxs from PHILRX for high reimbursing products. PHILRX has not been licensed as a pharmacy since 2019.

Various concerns listed below, but my take is we should chargeback if copay collections are outsourced when copay amts exceed a manufacturer coupon.
Looking for pharmacist input if the transfers from PhilRx to pharmacies are valid.
I'm also not aware of a systematic way to identify these rxs to pull these claims.

PHILRX ws licensed as a "consulting pharmacy" from 2017-2019, but no current pharmacy license found.
Various templates on the internet where prescribers send rxs to PhilRx, and include the patient's cell ph#. PhilRx will apply a manufacturer coupon and ship rx to patients. They will also "handle" Prior Auths thru CoverMyMeds. In one form, they provided 2 ICD-10 codes. Screen shots included in the attached.

Example of pharmacies with rx transfers from PHILRX:

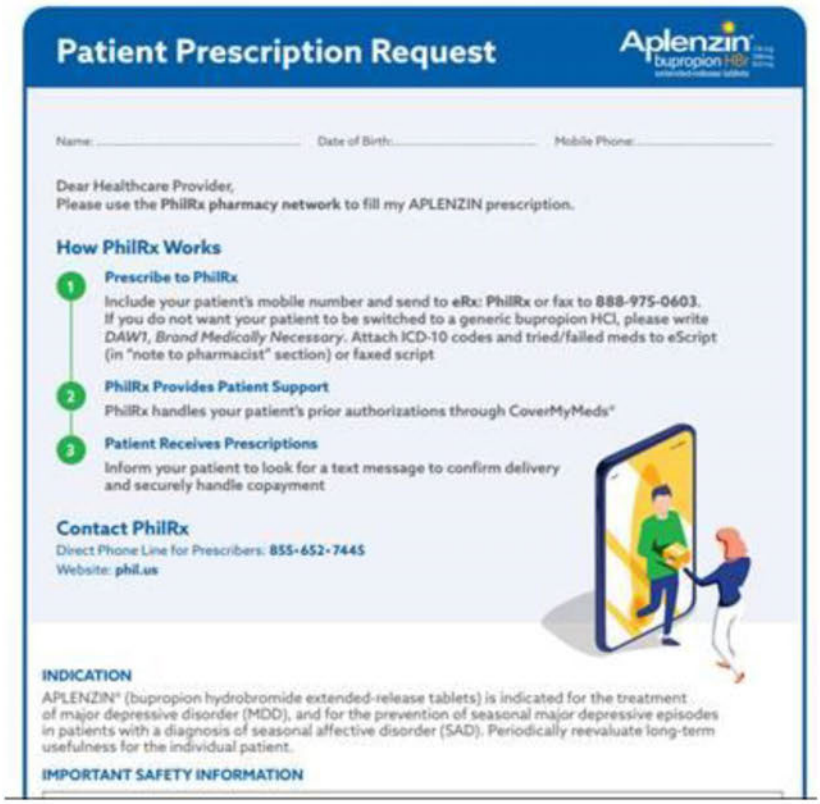
- **1036676 Premier Custom Rx**- on 10/23/20, Tracy Christian at Premier Custom Rx said PhilRx collects the copay on behalf of the pharmacy, minus the processing fee. Rxs can also have manufacturer coupons. Rxs are mailed to patients and patients pay copay thru text platform, and funds are send to pharmacy. Audit finalized $27,755 for 25-CPY, 16-NSL.
- **1569233 Carmel Prescription Shoppe-** multiple transferred rxs from PhilRx. Top paid drug, Aplenzin (Bausch) is top drug paid. Audit in process and auditor verifying of copay collections were outsourced.

Concerns:

- **Copay collections are outsourced to PHILRX which is prohibited by the Provider Manual**
  - PhilRx does apply manufacturer coupons for FDA-approved products when allowable
  - Posts on Yelp show multiplecomplaints about auto-shipping, unwanted meds, and credit card charged for refills that were not authorized
- PhilRx is NOT a licensed pharmacy since 2019, but represents themselves as a pharmacy entity on at least one drug manufacturer website
  - On one website for Addyi, it says "meet Phil, our specialty pharmacy partner"
- **If PHILRX is not a licensed pharmacy, does that invalidate the transferred rxs?**

- **What is the rxs are received and transferred out by a pharmacist, who is not necessarily working at a pharmacy?**
- Prescribers may not be aware that rxs are not being sent to a pharmacy
- Drugs from PhilRx include Aplenzin (buprioprion, AWP $64-$192/tab), Addyi, Epiduo, Forte pump, Fabior Foam, Plexion, Retin-A, Seysara, Riax Aerosol,etc.

Example of template. More in the attachement.



Patient Prescription Request

Aplenzin bupropion HBr

Name: _____ Date of Birth: _____ Mobile Phone: _____

Dear Healthcare Provider,
Please use the **PhilRx pharmacy network** to fill my APLENZIN prescription.

How PhilRx Works

1. **Prescribe to PhilRx**
   Include your patient's mobile number and send to **eRx: PhilRx** or fax to **888-975-0603**. If you do not want your patient to be switched to a generic bupropion HCl, please write *DAW1, Brand Medically Necessary*. Attach ICD-10 codes and tried/failed meds to eScript (in "note to pharmacist" section) or faxed script
2. **PhilRx Provides Patient Support**
   PhilRx handles your patient's prior authorizations through CoverMyMeds®
3. **Patient Receives Prescriptions**
   Inform your patient to look for a text message to confirm delivery and securely handle copayment

Contact PhilRx
Direct Phone Line for Prescribers: **855-652-7445**
Website: **phil.us**

INDICATION
APLENZIN® (bupropion hydrobromide extended-release tablets) is indicated for the treatment of major depressive disorder (MDD), and for the prevention of seasonal major depressive episodes in patients with a diagnosis of seasonal affective disorder (SAD). Periodically reevaluate long-term usefulness for the individual patient.

IMPORTANT SAFETY INFORMATION

Heidi Haffner | Sr. Advisor, Pharmacy Performance
(wfh) 9501 East Shea Blvd, MC-020, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 37:
CVS_HJC_00010909 Internal email thread investigating hub pharmacy activity

From: Terrel, Jaclyn [redacted]

Sent: 12/13/2023 11:49:54 PM

To: Markovic, Sandra [redacted]

CC: Smith, Amy L [redacted]; Terrel, Jaclyn [redacted]; Thomas, Jennifer A [redacted]; Mccall, Steven D. [redacted]; Grosso, Lauren A. [redacted]

Subject: RE: Post Audit Summary for: MED CART SPECIALTY PHARMACY NCPDP# 2374445-87598- Finalized

Hi Sandra,

We have reviewed this audit and need to credit the claims. The pharmacy will submit a CAP. Please reach out if you need to discuss it or we'll be in the office tomorrow 😉

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Markovic, Sandra [redacted]
Sent: Wednesday, December 13, 2023 9:25 AM
To: Terrel, Jaclyn [redacted]; Thomas, Jennifer A [redacted]; Mccall, Steven D. [redacted]; Grosso, Lauren A. [redacted]
Cc: Lindsey, Stormie R [redacted]; Smith, Amy L [redacted]
Subject: RE: Post Audit Summary for: MED CART SPECIALTY PHARMACY NCPDP# 2374445-87598- Finalized

Good morning Jackie,

My team has been informed to hold off on sending the final report until further notice.

Thank you,

Sandra Markovic | Manager, Network Performance, CVS Caremark
[redacted]
9501 E Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Tuesday, December 12, 2023 5:35 PM
To: Thomas, Jennifer A [redacted]; Mccall, Steven D. [redacted]; Grosso, Lauren A. [redacted]; Markovic, Sandra [redacted]
Cc: Lindsey, Stormie R [redacted]; Smith, Amy L [redacted]; Terrel, Jaclyn [redacted]
Subject: RE: Post Audit Summary for: MED CART SPECIALTY PHARMACY NCPDP# 2374445-87598- Finalized
Importance: High

Can we hold off sending the final and CAS to clients?

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Thomas, Jennifer A [redacted]
Sent: Tuesday, December 12, 2023 4:43 PM
To: Mccall, Steven D. [redacted]
Cc: Terrel, Jaclyn [redacted]; Lindsey, Stormie R [redacted]; Smith, Amy L [redacted]
Subject: FW: Post Audit Summary for: MED CART SPECIALTY PHARMACY NCPDP# 2374445-87598- Finalized

Steve

Med Cart Pharmacy is part of CC 2196 (New Albertsons Inc). They are another chain pharmacy using Blink and other HUBs.

The audit just finalized with a $2,794,932.56 final chargeback.

Med Cart signed a C & D in March 2023.

Jennifer Thomas, CPhT | Sr. Manager Pharmacy Audit • Investigations • CVS Caremark
[redacted]
CVS Health | 9501 East Shea, MC 020 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Chavez, Janel E [redacted]
Sent: Tuesday, December 12, 2023 4:35 PM
To: Markovic, Sandra [redacted]; Hoversten, Jeffrey R [redacted]; Pontecorvo, Christine A [redacted] Warner, Robert T [redacted]; Smith, Amy L [redacted] Lindsey, Stormie R [redacted]; Hains, Todd P [redacted]; Alderman, Mary Melissa [redacted] Domond, Gary [redacted]; Thomas, Jennifer A [redacted]
Cc: Terrel, Jaclyn [redacted]; Flores, Elizabeth [redacted]; Grosso, Lauren A. [redacted] Mccall, Steven D. [redacted]; Kapadia, Amish B. [redacted] Urbatchka, Lindsey E [redacted]; Fenker, Jason [redacted]; Palomo, Bertha J. [redacted]; Testa, Elizabeth A [redacted]; Bufalino, Danielle [redacted] Klein, Angeles [redacted]; Cline, Jenifer [redacted]; Curtis, Melissa A [redacted]; Thomsen, Kayleigh M [redacted] Atwood, Jonathan W [redacted]; Jones, Candice [redacted]; Luckinbill, Reagan J. [redacted]; Chavez, Janel E [redacted]; Soza, Rosa [redacted] Lewis, Devona A [redacted]; Rowell, Melissa A [redacted]; Tarlian, Alyssa M [redacted]
Subject: Post Audit Summary for: MED CART SPECIALTY PHARMACY NCPDP# 2374445-87598- Finalized

Post Audit Summary

Pharmacy Information: MED CART SPECIALTY PHARMACY NCPDP# 2374445 / NPI 1225343221

Audit Date: 8/7/2023

Audit Type: Expanded

Audit Time Frame: 3/1/2022-3/31/2023

Payment Suspension: No

Attorney: No

Audit Initiated: An expanded audit was initiated due to an Aetna client call. Pharmacy appeared on reports for dispensing non-FDA products.

Appeals Received: Yes

General Summary:

12 out of 330 CPY discrepancies received credit.
510 out of 1557 DIS discrepancies received credit.

Detailed Summary: The investigative audit for MED CART SPECIALTY PHARMACY was **finalized on 12/12/2023.** The pharmacy submitted additional documentation to be reviewed by Post Audit. This documentation was reviewed and applied to the audit as follows:

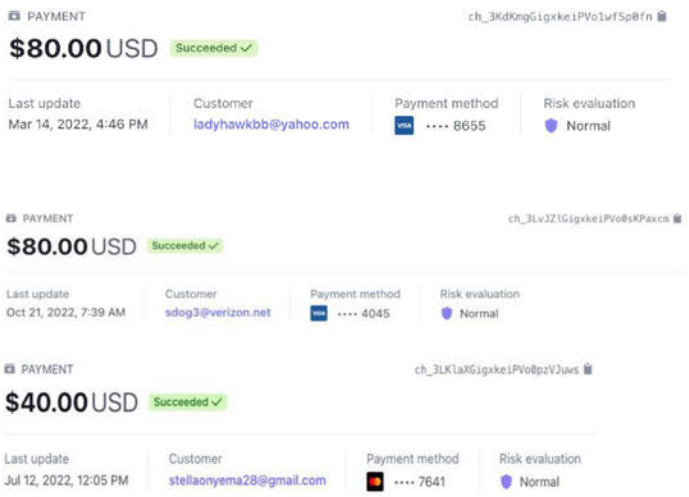
CPY

Auditor comment: "Did not send proof of full copay collection must send receipt & patient attestation confirming entire adjudicated copay has been paid, how copayment was paid and/if CC was used last 4 digits of CC or check copy front & back." (322 CPY- 12 cleared)

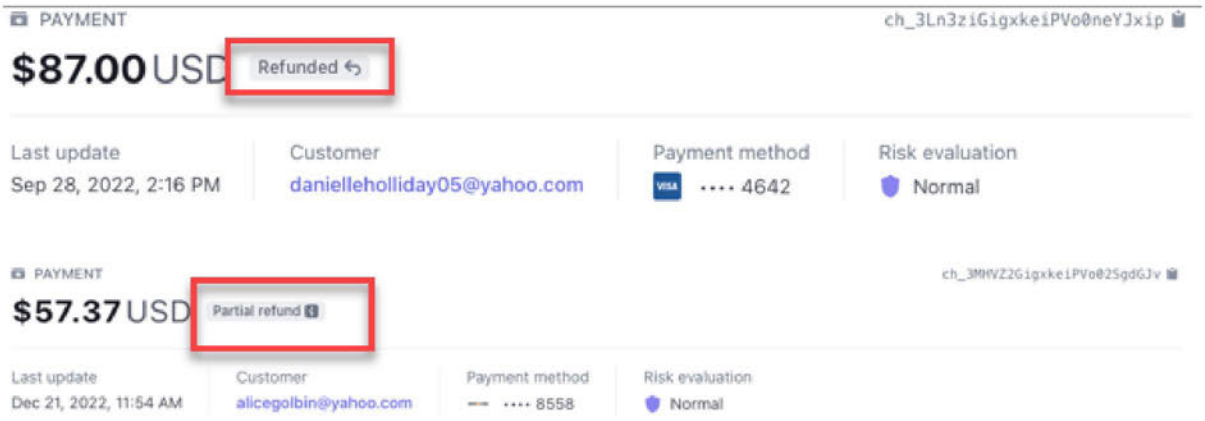
After QC, 12 CPY discrepancies received credit due to the adjudicated copays being $0 through the patient's primary insurance.

The pharmacy submitted an excel spreadsheet showing each claim with the patient pay amounts. For a majority of the CPY claims, the spreadsheet states that "manufacturer assistance" was used to reduce the copays to $0. For the claims that have copays, the spreadsheet has screenshots of payments that only include, the payment amount, date, customer email addresses (see images below), and the payment methods (including last 4 digits of credit cards). There is also no pharmacy or prescription identifying information on the screenshots of payments submitted. **Due to the lack of screenshots that include Bin #, Group #, PCN, and ID #'s showing how copays were reduced, lack of receipts with authorization details, and lack of patient attestations as requested by the auditor, no credit was issued.**

Examples of payment screenshots:



Example of receipt that states "Refunded":



Auditor comment: "Member denied copayment collection, must send receipt & patient attestation confirming entire adjudicated copay has been paid, how copayment was paid and/if CC was used last 4 digits of CC or check copy front & back." (8 CPY- 0 cleared)

The pharmacy submitted an excel spreadsheet showing each claim with the patient pay amounts. For a majority of the CPY claims, the spreadsheet states that secondaries were used to reduce the copays to $0. For the claims that have copays, the spreadsheet has screenshots of payments that only include, the payment amount, date, customer email addresses (see images below), and the payment methods (including last 4 digits of credit cards). There is also no pharmacy or prescription identifying information on the screenshots of payments submitted. The pharmacy also submitted a receipt for rx# 6265364, but no patient attestation. The pharmacy submitted screenshots of the statuses of prescriptions showing sold in their software system for a few claims. **Due to the lack of screenshots that include Bin #, Group #, PCN, and ID #'s showing how copays were reduced, lack of receipts with authorization details, and lack of patient attestations as requested by the auditor, no credit was issued.**

Please note that a majority of the CPY discrepancies that the pharmacy stated "manufacturer assistance" was used, are non- FDA approved medications (Fosteum Plus Cap, Vasculera tab, Rheumate Cap, and Promiseb Cream).

After review, 318 CPY discrepancy remains.

DIS

PRIMUS PHARMACEUTICALS (manufacturer)- The pharmacy submitted a 3PL for RxCrossroads to ship into Michigan for Primus Rx. The pharmacy also submitted proof of payment for purchases from Primus Rx. **Documentation was accepted and the following discrepancies received credit:**

FOSTEUM PLUS CAP- **98 DIS and cleared drug shortage**
PROMISEB CRE- **99 DIS and cleared drug shortage**
RHEUMATE CAP- **130 DIS and cleared drug shortage**
VASCULERA TAB- **183 DIS and cleared drug shortage**

The pharmacy submitted Transaction History Detail Reports for the discrepant medications. Some of the reports show RxCrossroads (3PL), shipped to "Safeway 5918 Stoneridge Mall Rd. Pleasonton, CA 94588. Purchases that were shipped to different locations will not be accepted, and Post Audit did not receive invoice reports Epiceram, Sernivo, and Impoyz Cream. **No credit was issued.**

After review, 1047 DIS discrepancy remains.

The results of the audit are as follows:

Initial Chargeback Amount	$3,577,632.84
Final Chargeback Amount	$2,794,932.56
Audit Fee	$558,986.51

Discrepancy Code	Discrepancy Count
CPY	318
DIS	1047

NABP #:	2374445				
Pharmacy:	MED CART SPECIALTY PHARMACY				
DATE RANGE:	03/01/2022-03/31/2023				
NDC	DRUG LABEL NAME	INVOICE TOTALS	Sum QTY Billed	DIFFERENCE	
68040075217	EPICERAM EMU	0	5580	(5580)	5540 marked
68040075240	EPICERAM EMU PUMP	0	35775	(35775)	29250 marked
69482070099, 68040071338	IMPOYZ CRE 0.025%	0	23500	(23500)	21500 marked
68040071428	SERNIVO SPR 0.05%	0	79800	(79800)	78240 marked

Janel Chavez CPhT | Sr. Analyst, Network Performance, CVS Health
[redacted]
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 38:
CVS_HJC_00010969 Internal CVS Caremark business presentation

CVSHealth.



Caremark Business Review

January 5th, 2020

Agenda

Team and Business overview (Alan) – 15 minutes

Key functional areas & 2021 priorities – 50 minutes:

1. Sales & account management (Tom/Steve) – 20 minutes
2. Member services (Harry) – 10 minutes
3. Network/underwriting (Allison) – 10 minutes
4. Client services (Brian) – 10 minutes

Note: Trade, Specialty & Product will be covered in separate, dedicated 90-minute sessions

Financial overview (Jeff) – 10 minutes

Q&A (All) - 15 min

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVS Health.

CONFIDENTIAL TREATMENT REQUESTED

Overview

- Our **team** has deep expertise coupled with a passion for challenging the way things have always been done
- Our **vision** is to be the most customer-focused, agile, profitable and biggest of the three leading PBMs
- Caremark's 5-year **goal** is to reach $7.4B in Operating Profit by 2024 – representing a bottom-line annual growth of 7.5% compound annual growth over that time horizon
- We are shifting our previous 'win lives / grow share' **strategy** to focus on expanding margins faster than that of the market
- In addition to strong operating profit growth, Caremark will **contribute to the enterprise** through the acceleration of joint medical/pharmacy sales; improvements in Maintenance Choice operations and economics; and as a sales channel for Aetna ancillary products as well as Transformation programs

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.



Additional Backup:

COVID directly addressed upfront in nearly all presentations (Enterprise, Landscape, Transformation, EM, OmniChannel, New business); not in HCB, which was overwhelmingly Enterprise focused
Potential response: Alan may want to hit on COVID and marginal impact on PSS in his opening comments for consistency

Regulatory Risks:
Continued shift from traditional to transparent claims driven by legislative pressure (e.g., prohibition of spread pricing on Medicaid business)
Retail Network Margin: 45% Medicare (transparatent adjudication equal on both sides, no spread); 55% Commercial (58% transparent, 42% tradition) per 3-27 Network Opps EC update
14% of total Caremark adjudicated claims actually create spread per 3-27 Network Opps EC update

Competition:
Optum and ESI are the only competitors that can compete with us when it comes to scale, scope, and delivering COGs
We're continuing to watch potential disruptor activity (partnerships as well), but we're focusing our response on extending out lead against incumbents
Relatedly, we're getting feedback Optum is overweight in rebates and carrying undue risk, and CI/ESI remain distracted on integration having recently lost four major employers to us for the 2022 selling season

Systemic Pressures:
Pricing erosion of ~$2B/year; Historical year-over-year network rate improvements in excess of ~$1B are not sustainable
Locked claims account for ~14% of 2020(B) total network claims (unadjusted, 90s as 1; excludes ZBD claims)
Profit per locked claim is increasing at an unsustainable rate

Culture:
Talent:
Focus on development in mid-senior ranks
Develop and invest in specific talent capabilities (e.g., analytics, finance and general management)
Build multi-level succession plans for critical roles throughout organization; emphasize diversity, enterprise mobility, strategic hiring
Enhance colleague collaboration through new applications (e.g., Microsoft Teams, CRM)
Invest in recruiting, coaching, and mentoring; rotation opportunities for "green box" talent
Development:
Increase diverse representation across the business, specifically mid-level and senior management ranks

Reinforce "How We Work Behaviors"; reinforce a customer-focused culture grounded in continuous learning (Innovation, Caring, Collaboration, Accountability, Integrity)
Engagement survey results: TBD
Caremark Service Excellence (CSX) program:
Build from a culture of continuous learning, driven by data, to improve and empower colleagues and deliver service excellence to customers
Continue positive Welcome Season overall satisfaction trend (10pp increase 2017-2019 [89% in 2019])

---------- ADDITIONAL SUPPORT ----------

NOTABLE COMPETITIVE OVERVIEWS:
PARTNERSHIPS:
Walmart
Created "Walmart Insurance Services LLC" to sell insurance policies (e.g., supplemental Medicare insurance
$4 generic drug program offers members a list of generic prescriptions for significantly discounted prices — often providing Medicare Advantage (MA) patients a more low-cost price than their own insurance would offer
Acquired startup CareZone's medication management platform to help customers keep track of their prescriptions
Opened primary-care clinics: primary care, mental health counseling, diagnostic services, and dental care... compete with our ancillary services we're trying to cross-sell through AET
Partnership with CapitalRx to displace select PBM services around price stability and transparency

Teledoc / Livongo
Telehealth giant Teladoc and digital chronic disease management company Livongo announced an $18.5 billion merger that'll value the combined entity at $37 billion.

WAG / Village
Integrated pharmacy and primary care approach focused on medication adherence, improved patient outcomes, and continuity/improved experience

Amazon
Amazon Care employee health and at home support – employer solutions
PillPack mail drug delivery and medication management
Centene / RxAdvance
Centene made an initial investment in RxAdvance, a full-service cloud-based PBM, and will use its best-in-class technology platform to improve health outcomes and reduce avoidable drug-impacted medical and administrative costs
DISRUPTORS:
Note: Digital health solutions such as mobile apps, patient portals, and care team dashboards are proliferating rapidly. By one estimate, the U.S. investment in such electronic products will reach $410 billion by the end of 2020. Pragmatic digital health solutions improve patient care, make clinical teams more efficient, and reduce costs.

Express Scripts released a digital formulary with the goal of providing 15 digital health programs to its members, starting in January 2020.

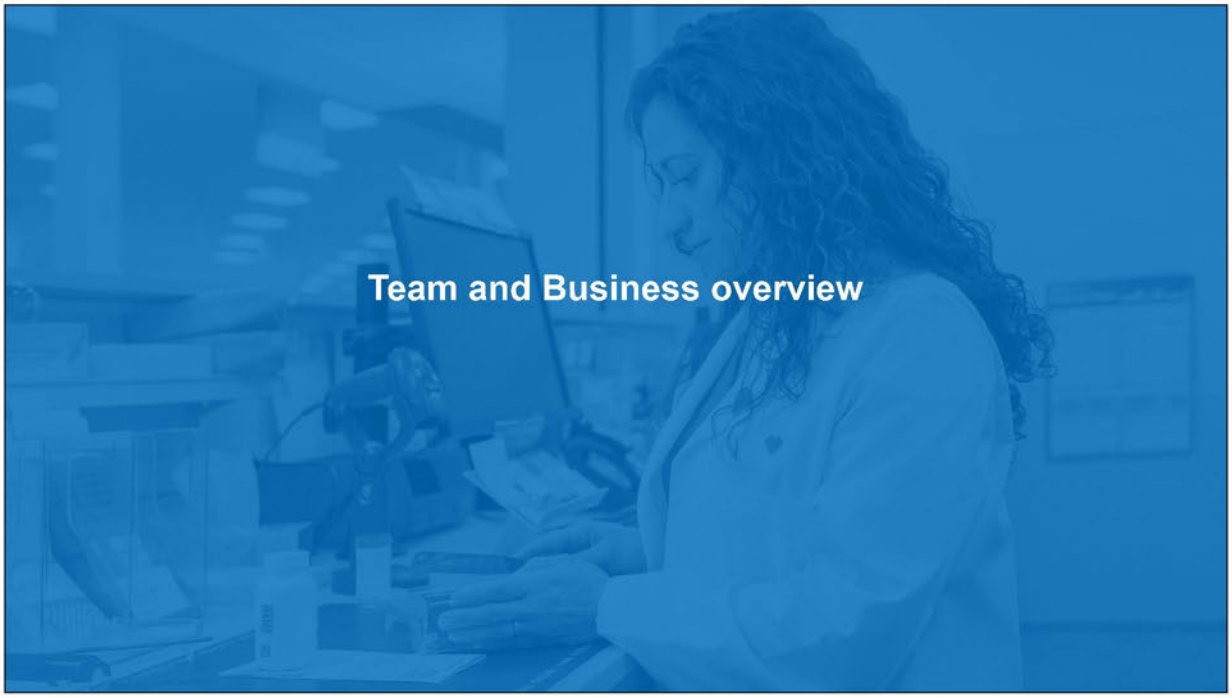
GoodRx
Drug price transparency - prescription drug prices and drug coupons for discounts on medications

Blink Health
E-commerce pharmacy and medication management. Free home delivery on select drugs. Discount prescriptions.

WithMe Health
High-touch, personalized medication management and guidance... services for patients, employers (members) and providers
Digital first and AI enabled engagement; personalized medication guidance

CapitalRx
Clearinghouse model... joining forces with Walmart to bring transparency of unit prices across specialty and mail order prescriptions
Offers employers a guaranteed price for each prescription. We're providing cost certainty on every transaction, not a constantly fluctuating

Archimedes
Carve out focused specialty management solutions for employers, health plans, PBMS...


Team and Business overview

Our team has deep expertise and a passion for challenging the way things have always been done



Alan Lotvin
President of Caremark

Direct Reports



Gary Loeber
Pharmaceutical Contracting / Purchasing



Prem Shah
Specialty



Allison Brown
Network / Underwriting



Brian Leadingham
Client Services



Harry Travis
Member services operations



Steven Schaper
Employer Sales and Acct Mgmt



Tom Gilson
Health plan Sales and Acct Mgmt



Lisa Rometty
Kidney Care



Megan Hall
Sales acceleration / Strategic Advisor



Tammy Lewis
Chief Marketing Officer

Non-direct reports



Ajoy Kodali
IT



Carolyn Wiesenhahn
HR



Sree Chaguturu
Chief Medical Officer



Jeff Goddard
CFO



Melissa Schulman
Government & Public Affairs



Bob Darin
Chief Analytics Officer



Sara Hankins
Assistant General Counsel



Ali Keshavarz
Chief Analytics Officer



Pat Walsh
Digital



Tracy Ogden
Corp. Comms.



Eric Rautiola
Enterprise Strategy

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVS Health.

Check with Jeff/Brett on lives / clients

Caremark Business Key Stats

Our Organization

- P&L includes Mail, Network, Specialty, Rebates & Other Manufacturer Considerations, and Other
- Other assets include Coram, Accordant, Novologix
- ~31K colleagues, including clinicians

Our Clients

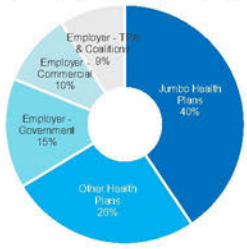
- 74 health plan clients (including Aetna) that use our PBM services, plus 180+ non-PBM health plans (e.g., use Specialty Rx)
- ~2,000 employer clients

Our Feedback

2019 Overall Member Satisfaction[1] = 95%
2019 Overall Client Satisfaction[2] = 98%

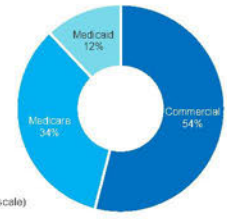
Pharmacy Services Client Profile

Client Type (2019 Revenue)

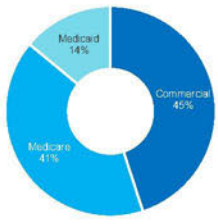


Jumbo Health Plans:
Aetna, Anthem, Centene

2019 Revenue by LoB

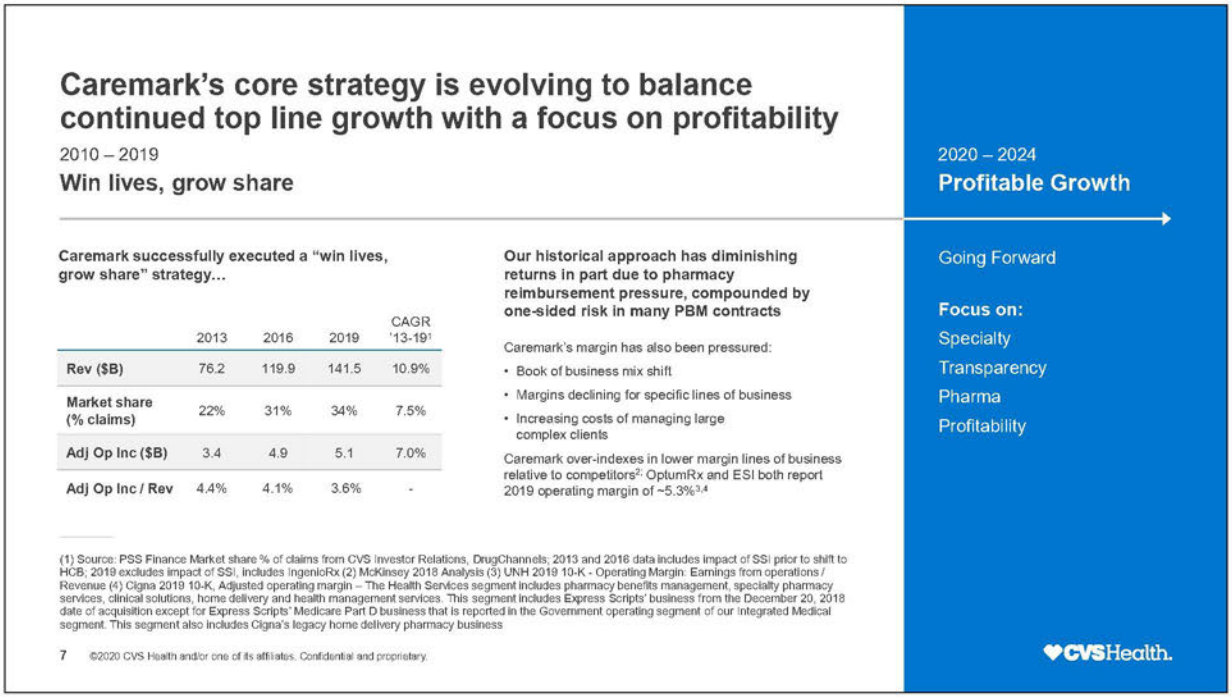


2019 Script Volume by LoB



Note: figures are 2019, 3Q2020 SOS Fact Sheet
1. With Prescription Benefit Services for total book of business - Top-Three Box (Percent Satisfied or better on a five point scale)
2. Full year, for total book of CVS Caremark business - Top-Three Box (Percent Satisfied or better on a five point scale)

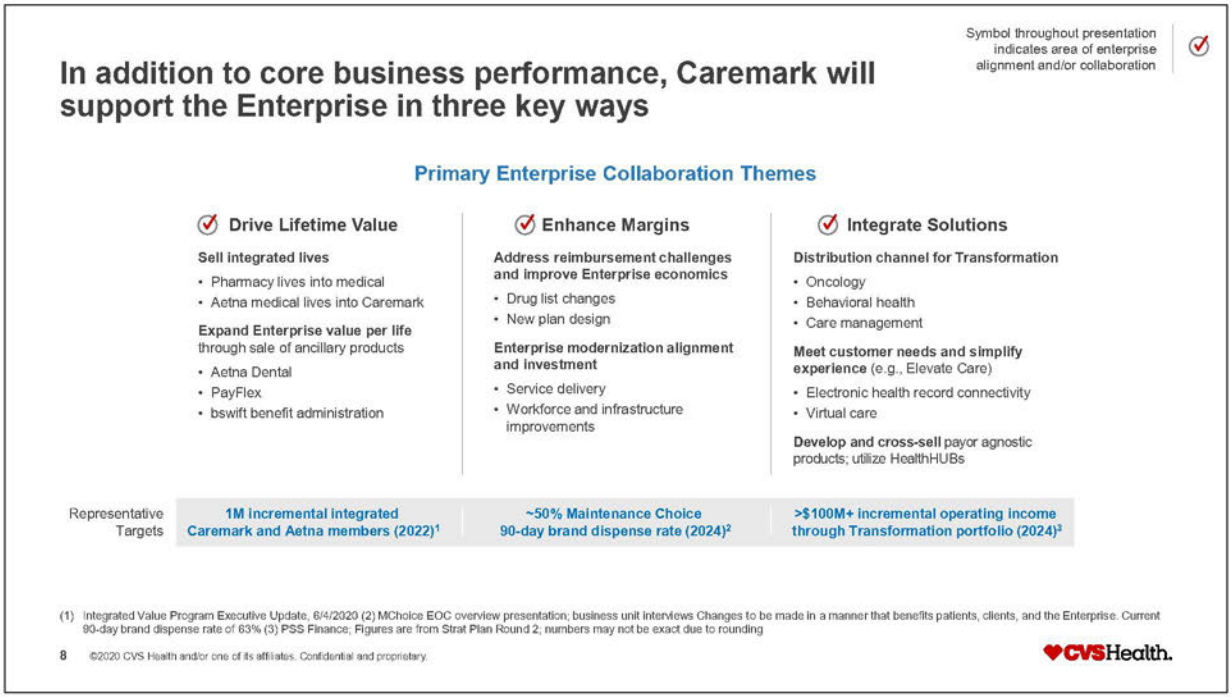
CONFIDENTIAL TREATMENT REQUESTED



Talking Points:
Very different plan than the last review; here we lay out why/what's informing the change and different view of the business

Additional Backup:
PSS Finance:
Using EBIT ex Amort, which is what we typically use for EBIT requests, Wellpartner value is $103.9M
Combining this with the 340B value yields a total of $417.5M

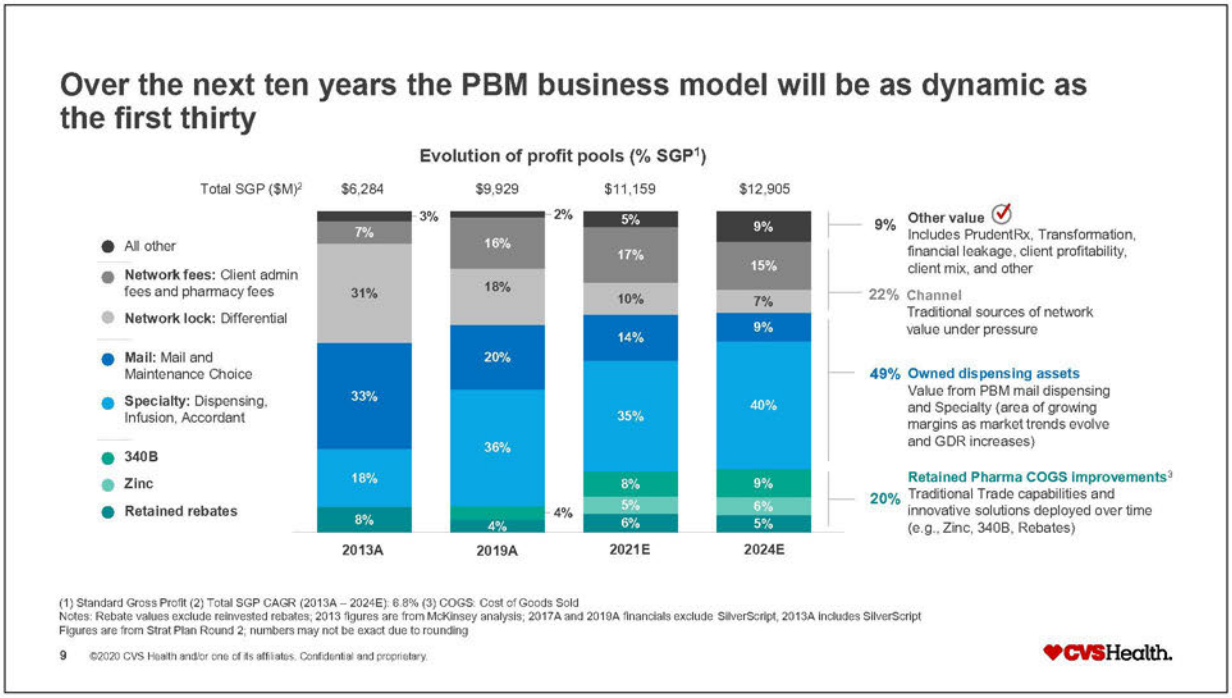
OptumRx: https://www.annualreports.com/HostedData/AnnualReports/PDF/NYSE_UNH_2019.pdf (pg 38)
CI: https://www.annualreports.com/HostedData/AnnualReports/PDF/NYSE_CI_2019.pdf (pg 98)



Enabling Capabilities
Talent: Invest in capabilities (analytics, finance and general management) and development; facilitate customer-focused culture and colleague collaboration through key investments (e.g., Microsoft Teams, CRM)
Clinical excellence: Develop evidence-based strategies to improve patient care and adherence, minimize costs, and increase satisfaction (e.g., Accordant, Novologix)
Technology: Reduce 40+ pharmacy systems by migrating to the cloud and utilizing enterprise platforms
Operating Model: We'll use learnings of the past few months to better execute on service delivery, process, and infrastructure improvements, while aligning with enterprise modernization investments already underway

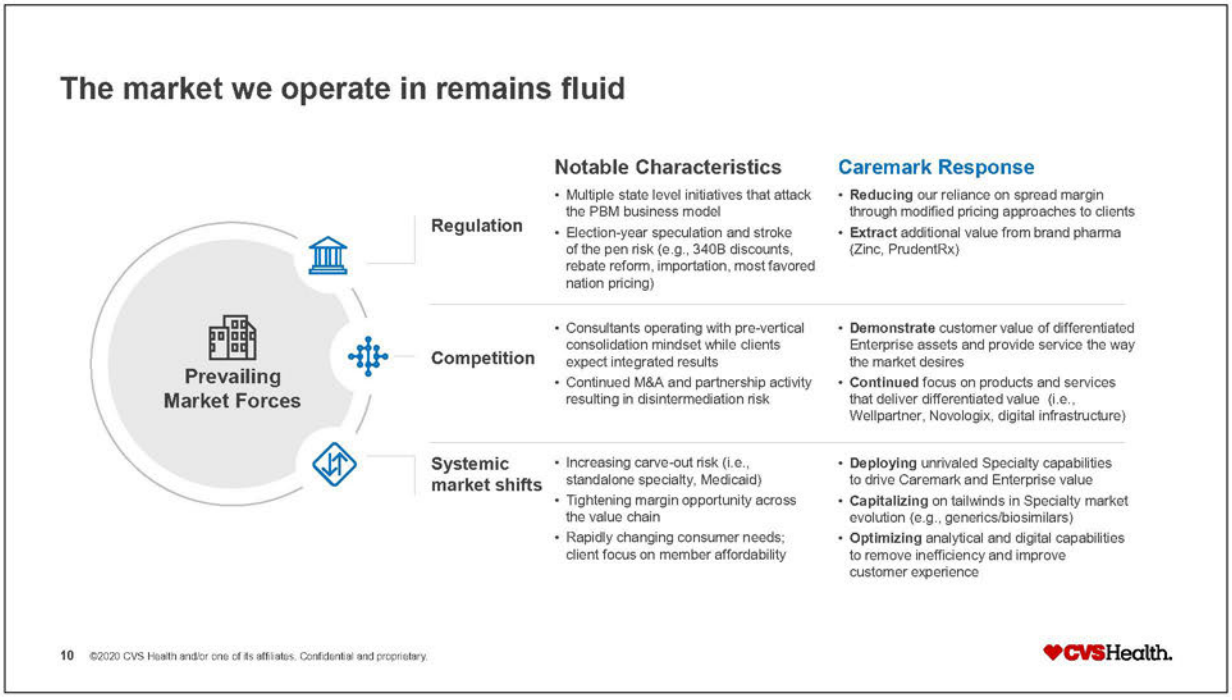
Capital: Align investments and targeted acquisitions with long-term strategy / capability development to inform decision making and trade-offs

_____
PBM to Medical: Caremark pharmacy into existing Aetna medical customer base
550k membership growth by 2022
Medical to PBM: Aetna medical into existing Caremark pharmacy employer customer base
400k membership growth by 2022
Aetna Specialty to PBM: Dental, Vision, Voluntary, EAP, PayFlex, and bswift into CMK pharmacy customer base
935k membership growth by 2025
Caremark Reseller Strategy: Targeted Commercial, Medicare, Medicaid, and Exchange growth
100k annual growth in commercial membership



Rebate Executive Order – Perspective received from GA 9/20/20
July 24, 2020 – The EOs specifically order the administration to develop regulations around the use of pharmaceutical rebates in Medicare, setting Medicare reimbursement rates at international prices in Medicare Part B, the importation of prescription drugs from Canada, and providing uninsured patients with low-cost insulin through the 340B program. While none of the orders will immediately change agency policies or operations, they are directives to the various arms of the administration to begin formal rulemaking processes to enact the new policies

Received from Government Affairs – Perspective received from GA 9/20/20
Network Regulatory talking points: When States Return to Session in 2021 we expect anti-PBM activity to pick up
Attacks on Network Structure/Affiliate Pharmacies*: These proposals restrict the ability to create preferred networks or inclusion of affiliates in determining network adequacy, prohibit differential cost sharing in networks, eliminate exclusive specialty programs, require parity reimbursement between non-affiliates vs. affiliates, etc
Prohibition of Spread Pricing: Legislation has been proposed to prohibit spread pricing in commercial market



Talking Point (Govt Affairs Draft Insight)

340B Policy Changes Present a Variety of Business Risks Going Forward: The Trump Administration, select states and manufacturers have proposed a number of changes to the 340B program. Manufacturers have taken unprecedented actions to reduce the scope of the program and shift the financial burden of discounts. These actions are already the subject of Congressional scrutiny and likely legal action.

State restrictions: States have passed and continue to consider legislation that CEs be guaranteed network entry and reimbursement at retail rates. Caremark clients continue to ask for reduced rates for 340B claims that get rejected by manufacturers, which leads to additional anti-PBM sentiment

Manufacturers: Multiple manufacturers have established new policies requiring CEs to provide contract pharmacy claims data. This could allow manufacturers to identify claims they believe to be improper for commercial rebates, which could lead to increased disputed claims. We are considering options to provide these services to manufacturers.

Executive Order: The White House has released an EO requiring insulin and EpiPens be dispensed to patients at FQHCs at no more than the 340B acquisition cost. For Caremark, if the final rule includes EOs there could be logistical issues in claim identification. Aetna also includes FQHCs in network and would have to shift OOPs

Contract Pharmacies: Multiple manufacturers have established new policies refusing to supply certain drugs to 340B contract pharmacies. Eliminating the ability to use contract pharmacies would affect both retail revenue from 340B and limit services provided by Wellpartner.

Continued evolution of the PBM industry creates opportunities for strategic differentiation and innovation

Strategic Consideration	Industry Dynamic
Customers' evolving needs	• Specialty dispensing and initiatives remain integral to PBM strategy • Client requirements for increased "transparency" and clarity of incentives, due to distrust of PBMs
Shifting sources of profit to support client pricing	• Network lock under commercial and regulatory pressure • New approaches to pharma required to continue to lower COGS[1]
Increasing perceived level of differentiation	• Commoditized marketplace hampers ability to receive credit for solutions outside of unit price • Community-based assets and focus on specialty risk products can set players apart • Service can be differentiating, achieved through transparency and operational excellence
Legislation/policies limit PBM ability to lower drug costs	• Broad limits on pricing in retail networks, stable on therapy rules, anti-biosimilar approaches • Potential new administration on the horizon and broader drug pricing policies

Our strategic agenda prioritizes a customer-facing approach to developing solutions to increase growth within the PBM, with a focus on Specialty, as well as driving value across other areas of the Enterprise (e.g., Retail margin, Aetna cross-sell)

(1) COGS: Cost of Goods Sold

 ©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

Talking Point: Enterprise may lose PBM value, but maintain retail and specialty value and have solutions for both (e.g., nimble)

Proxies for sense of magnitude:
Customer needs: Experience ~$2B in annual price erosion
Shifting sources of profit: Network rate improvement of ~$1B per year unsustainable; locked claims account for 14% of total network claims (2020B) versus 28% in 2018
Differentiation: Focused on extending our lead in purchasing/COGs which is the beginning of the flywheel
Legislation: Continued risk, specifically by way of executive order related to rebates, spread, 340B and importation. Even if not realistic/durable, continued to add uncertainty and distrust

Six key areas differentiate our approach in the market and drive substantial operating income growth

Focus areas today

Focus Area	Key 2021 Priorities
1. Sales & retention strategy	• Frame our value externally to highlight differentiation and deliver on 2022/23 selling season • Optimize results — win, retain, and grow profitable business to re-index business mix • Drive Enterprise value - win through Aetna (ASO/FI)[1] and other resellers; Enterprise "value per life"
2. Meet clients' needs	• Client alignment — meet/anticipate objectives and solve transparency needs • Build a more proactive, personalized, and consistent member experience through digital enablement and responsiveness
3. Spend management	• Specialty focus — utilization management, COGS[1], medical benefit management
4. Continue to evolve PBM business model	• Extract incremental value from pharma (340B, Zinc, PrudentRx) • Grow specialty dispensing • Enterprise opportunities to co-develop and sell additional medical management solutions
5. Enhanced client-level profitability	• Eliminate financial leakage • Establish path to profit expansion as part of underwriting process • Utilize client-level P&L management as regular part of account management process to expand account profit
6. Operating model optimization	• Deliver service excellence to our customers and create a culture of continuous learning, driven by data • Process improvements, select technology enhancements and Enterprise Modernization; reduce cost of service and selling, general, & administrative

Trade, Specialty & Product will be covered in separate, dedicated 90-minute sessions

(1) ASO: Administrative services organization; FI: Fully insured; COGS: Cost of Goods Sold (2) Operating income; source: PSS Finance; values are preliminary

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVS Health.

CONFIDENTIAL TREATMENT REQUESTED

Caremark 2021 Goals (1 of 2)

Alan Lotvin EVP, President of Caremark

Corresponding strategic imperative to be added	Status Q1	Q2	Q3	Q4
1. Achieve key 2021 financial and performance goals				
Achieve revenue and operating income targets				
• PBM revenue target of $144,251M or 2.8% growth (JG)	o	o	o	o
• PBM overall op income target of $5,873M (JG)	o	o	o	o
• Specialty op income target of $3,240M (PS)	o	o	o	o
Grow our specialty business				
• 19% revenue growth from standalone and open market (PS)	o	o	o	o
Manage rebate guarantees effectively				
• Actual rebate guarantee performance will meet forecasted guarantee targets (AB/GL)	o	o	o	o
• Achieve $75M in rebate guarantee cost avoidance through Financial Change Order process (AB)	o	o	o	o
Manage expenses effectively				
• 47.4% operating expenses as % of SGP (JG)	o	o	o	o
• $128M incremental gross ($229M cumulative that includes 2020) savings from Enterprise Modernization (BL)	o	o	o	o
Achieve other key financial targets				
• Achieve $56M in rebate Mitigation/Contract Optimization (AB)	o	o	o	o
• Achieve $420M in 2021 projected new Zinc value (GL)	o	o	o	o
• Achieve 2021 340B op income target (GL/PS)	o	o	o	o
• Achieve 2021 EBIT target in retained rebates* (JG)	o	o	o	o
• Achieve $1,693M EBIT from network lock (AB)	o	o	o	o
2. Be the best manager of spend				
Maintain overall drug trend				
• 2021 overall and specialty drug trend will be same or better than their respective 3-year rolling average (2018-2020) (PS/GL/SC)	o	o	o	o
Drive to lowest net cost strategy in each therapeutic category by formulary				
• Financial evaluation of each therapeutic category / formulary has been completed and lowest net cost strategy confirmed (GL)	o	o	o	o
Manage utilization effectively				
• TBD specialty utilization management metric* (PS/SC)	o	o	o	o
• Drive client medical benefits savings of $400M through Novologix and Medical Rebates (PS)	o	o	o	o
Drive appropriate therapies				
• Blended GSR rate of 79% (PS/SC)	o	o	o	o

*Metric to be finalized by end of Q12021 or earlier

	Status Q1	Q2	Q3	Q4
3. Outperform in key products and other value initiatives				
Ensure delivery of products and services to win new business				
• Deliver 2021 P&L Oncology target of $16.9M (PS)	o	o	o	o
• Achieve $100M client savings through PrudentRx (PS)	o	o	o	o
• Capture 2.8M claims through CVS Caremark Drug Discount Program (PS)	o	o	o	o
• Achieve 2021 composite safety, clinical effectiveness and patient experience targets for Mail, Specialty Mail, Specialty Retail and Coram (SC)	o	o	o	o
4. Meet client needs and achieve key strategic sales goals				
Build more trust via transparency approach				
• Achieve 2021 CRLS targets on operating in open and honest manner for health plans and employers* (TG/SS)	o	o	o	o
Improve overall client satisfaction				
• Achieve 2021 client satisfaction survey results for health plans and employers* (TG/SS)	o	o	o	o
Achieve key strategic sales goals				
• Win 2-3 marquee employers to demonstrate integrated value (TG/SS)	o	o	o	o
• Win 1-2 major health plans to validate open platform strategy (SS/TG)	o	o	o	o
• Deliver on reprioritized sales strategy aligned to profitability (TG/SS)	o	o	o	o
Deliver strong 2022/23 selling season				
• 22' Client retention target* (TG/SS)	o	o	o	o
• 22' Net Revenue of $2.9B (TG/SS)	o	o	o	o
5. Optimize and enhance the business and improve how we serve our clients				
Execute seamless welcome season and accomplish Caremark service excellence program goals				
• Achieve 2021 target on 50% yoy reduction of welcome season client issues (BL)	o	o	o	o
• Achieve 2021 target on 30% yoy reduction of client issues (BL)	o	o	o	o
Achieve client service performance guarantees and service warranties targets				
• Achieve 2021 performance guarantees/service warranties targets* (BL)	o	o	o	o
Implement key infrastructure and process improvements				
• Create system to manage and improve formulary/UM across the enterprise including data driven insights to drive value (AB/JG/AJK/GL/SC)	o	o	o	o
• Complete Epic implementation in Coram (PS)	o	o	o	o
• Finalize the migration to SPRx 2.0 (AJK/PS)	o	o	o	o
• Achieve 2021 client savings targets from benefit automation 2.0* (AJK/BL/SS/TG)	o	o	o	o
Enhance contract administration processes and improve modeling/forecasting				
• 45% of employer client volume processed through new ecosystem post MVP launch (AB)	o	o	o	o

Caremark 2021 Goals (2 of 2)

Alan Lotvin EVP, President of Caremark

Corresponding strategic imperative to be added	Status Q1	Q2	Q3	Q4
5. Optimize and enhance the business and improve how we serve our clients (cont'd)				
Adopt Agile / DevSecOps practices to improve time to value for the business by accelerating cloud adoption				
• Increase Speed to Market by 20% via XP/ DevSec Ops practices across all projects (AJK)	O	O	O	O
Enhance client fee recovery process				
• Improve process to capture fees that client have agreed to pay for that we are currently not capturing at this time (JG/SS/TG)	O	O	O	O
6. Enhance and simplify the member experience				
Improve customer satisfaction				
• Flat to the 2020 baseline MIP result (HT/TL)	O	O	O	O
Grow the digitally engaged user base where it matters				
• Achieve growth in digital monthly active users for Caremark website, app and messaging* from Q1 to Q4 (PW)	O	O	O	O
• Achieve growth target on digital monthly active users for Specialty website, app and messaging* from Q1 to Q4 (PW)	O	O	O	O
Reduce cost of service through digital enablement				
• Achieve reduction in calls per 1k claims *where it matters* to eliminate dissatisfiers from Q1 to Q4* (HT/PW/TL)	O	O	O	O
• Achieve target % of refills initiated in digital* (HT/TL/PW)	O	O	O	O
• Patient reported CSAT for order status checks initiated in digital (HT/TL/PW)	O	O	O	O
7. Improve our positioning in the marketplace				
Improve our positioning through marketing/communications				
• Enhance brand through development and consistent communication of Caremark narrative (i.e., best manager of drug spend, transparency/service excellence, innovation on pharmacy costs/health outcomes) (TL)	O	O	O	O
• Thought leadership for clients/influencers on clinical content including COVID-19 (TL/SC/TG/SS/MS)	O	O	O	O
• Enhance reputation of CVS Caremark across multiple stakeholders compared to competitors (TO)	O	O	O	O
Influence marketplace via government affairs approach				
• Influence at the federal and state levels on public policies that promote and protect business growth (MS)	O	O	O	O
Enhance relationships with benefit consultants and deliver strong 2022 selling season				
• YoY win and retention rate improvement via Aon, Mercer, SBG/Gallagher, Willis Towers (TG/SS)	O	O	O	O

	Status Q1	Q2	Q3	Q4
8. Deliver enterprise value				
Successful delivery of products and services to win new business				
• Achieve 2021 target of $27 M (SS/TG)	O	O	O	O
• Achieve 2022 target on selling transformation products via Caremark (SS/TG)	O	O	O	O
• 2021 bold growth goal of 100k medical to Rx lives + 275 Rx to medical lives and 2022 bold growth goal of 300k medical to Rx lives + 325 Rx to medical lives (SS/DF)	O	O	O	O
Improve enterprise economics				
• Reduce MChoice 90-day brand dispense rate to 58%; 2024 target of ~50% (PS)	O	O	O	O
9. Successfully execute Kidney Care strategy				
Operationalize Home Channels				
• Pilot new Dialysis Services channels for RSAO (2Q-4Q) to be fully operational for scale in 2022 (LR)	O	O	O	O
Complete ecosystem pilots				
• Complete ecosystem pilots by 4Q21 within JV including capabilities utilizing Health hubs, Virtual care, health cloud key for maximum patient capture, EBIT creation (LR)	O	O	O	O
Complete HemoCare commercialization plan				
• Complete HemoCare Commercialization plan in 1Q21 including path to resolving reliability and service model costs by 2Q21 (LR)	O	O	O	O
Achieve clinical trials milestones				
• Meet all Clinical Trial milestones and complete Clinical trial in 3Q21 (LR)	O	O	O	O
10. Achieve strategic talent development goals				
Increase diverse representation and inclusion				
• Contribute to enterprise goals regarding representation* (CW)	O	O	O	O
Ensure strong succession slates for critical roles, emphasizing enterprise mobility, strategic hiring, and development				
• 1-2 Ready Now or within 1-year successors for each EC role and critical roles or plan to identify successors (internal or external) of critical roles (CW)	O	O	O	O
• Purposeful mobility plans for high potential talent (CW)	O	O	O	O
• Maintain or increase % of high performing talent in critical roles (CW)	O	O	O	O
Continue to build and improve leadership team dynamics and drive adoption of "How We Work" behaviors				
• YOY increase on engagement survey results on alignment (CW)	O	O	O	O
Successfully execute COVID Worksite Recovery				
• Enable colleagues to return to worksites safely while enabling positive changes in how and where we work (CW)	O	O	O	O

*Metric to be finalized by end of Q12021 or earlier


Key functional areas & 2021 priorities

Strategic focus #1: Sales & retention strategy; Strategic focus #2: Meet clients' needs

Sales & Account Management Overview

Context

- Caremark won the '20/'21 sales season, with Optum right behind us – ESI lost significant share to both of us and is still vulnerable in the short term
- Notable keys to success in '20 included a significant investment in consultant relations, an increase in executive engagement with clients, a willingness to provide more transparency and an increased emphasis on being the best managers of our client's pharmacy spend to ground our sales story
- We need to continue to build upon the momentum from '20/'21 sales season make an early impact on the '22/23 selling season with at-risk renewals and high-priority prospects

Key Organizational Stats

Health Plan

Leader: Tom Gilson, SVP PBM Health Plans
Org Size: ~400
Scope: Regional Teams: Central, West, East; Specialty, Client Ops

Employers

Leader: Steve Schaper, SVP PBM Employer Groups
Org Size: ~1.2k
Scope: Government, Nat'l Accounts, Coalitions, Key Accounts, Account Mgmt., Clinical Advisors

Key 2021 Priorities

Frame our value externally to highlight differentiation and deliver on 2022/23 selling season

- Best manager of client's Rx spend (focus on Specialty)
- Transparent in our execution and financial dealings w/ clients
- Innovative solutions

Increase client trust and transparency

- Demonstrate alignment of incentives
- Provide clear proof points to show client benefit

Win, retain, and grow profitable business to re-index business mix

- Ensure each prospect/renewal has a profitability expansion plan as part of underwriting process

Focus on delivering Enterprise value

- Win through Aetna (ASO/FI) and other resellers; drive Enterprise "value per life" through company store cross-sell
- Partner with Transformation to co-develop and sell through additional pharmacy and medical management solutions for clients

CVSHealth.

Strategic focus #1: Sales & retention strategy

We are focused on communicating our value to clients in a way that resonates with their priorities

Accelerating our position of strength

Focus Areas

Best manager of client's Rx spend (focus on Specialty)

- Focus on products and solutions that lower our client's Rx spend – with proof points, guarantees, and risk offerings to differentiate Caremark
- Aggressive Specialty cost management continues to be focus for clients

Trust and Transparency

- Dispel the notion of 'the fox guarding the hen house' through client level reporting, analytics, and alignment of formulary and utilization management to deliver best-in-class results
- Clearly demonstrate low net cost strategy and pricing change impacts to clients
- Changing public perception of PBMs
- Continued investment in financial acumen training for staff

Innovative Solutions

- Specialty innovation (Transform Oncology Care, oncology risk carve-out, HIV prevention, Specialty Expedite)
- Leverage the value of the integrated model
- Establish clear link between Transformation/HealthHUB solutions and lowering Rx costs
- Advanced data & analytics
- Improving the member experience through digital assets

Being the best manager of specialty trend and addressing market concerns will enable differentiation and profitable growth for CVS Health

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

CONFIDENTIAL TREATMENT REQUESTED

Strategic focus #2: Meet clients' needs

Creating greater transparency with clients is a critical differentiator for us

Guiding Principles

Provide detailed data to enable clients to understand Caremark actions

"Transparent enough" means Caremark provides sufficient information to make rationale clear and avoid mistrust

Reservation of Rights Case Study

MERCER

Problem: Inconsistent methodologies to define brand versus generic drug class

Solution: Proactively worked with Mercer (~$2.5B account) to develop a new approach to:

- Standardize reservation of rights in contracts
- Establish appropriate reporting transparency
- Develop mutually agreed-upon algorithm (certified by auditor) to report drug level impacts

Results:

- **Guarantee adjustments treated as contract administration, not contentious negotiation**
- Template / case study to support streamlining management of definitions
- Contributes to selling season success in growing business (e.g., Halliburton $35M) and retaining existing clients (e.g., Bristol-Myers Squibb $93M)

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

CONFIDENTIAL TREATMENT REQUESTED

Strategic focus #2: Meet clients' needs

Member Services Functional Overview

Organization
Leader: Harry Travis, SVP Member Services Operations
Org Size: ~19K

Customer Care

- 5-10K FTEs
- 36 million calls per year or >100K calls per day covering all 100+ million members

Pharmacy Operations

Mail
- Dispensing ~ 1+ million Rx per week

Specialty
- Dispensing ~12 million Specialty Rx annually[1]
- Largest Specialty Pharmacy in the country
- 30+ Clinical Centers of Excellence

Other Functions

Government Services (Coverage, Determinations and Appeals for Med D plans)
- 16.4M beneficiaries across 54 MAPD and PDP clients[2]
- Our clients grow 3x faster than industry

Commercial Clinical Operations (Prior Auth and MTM services for all plans)
- MTM savings up to 4% of specialty spend
- Proactive Refill Requests simplify refills for members and improves adherence, had ~64 million Rx enrollments in 2019

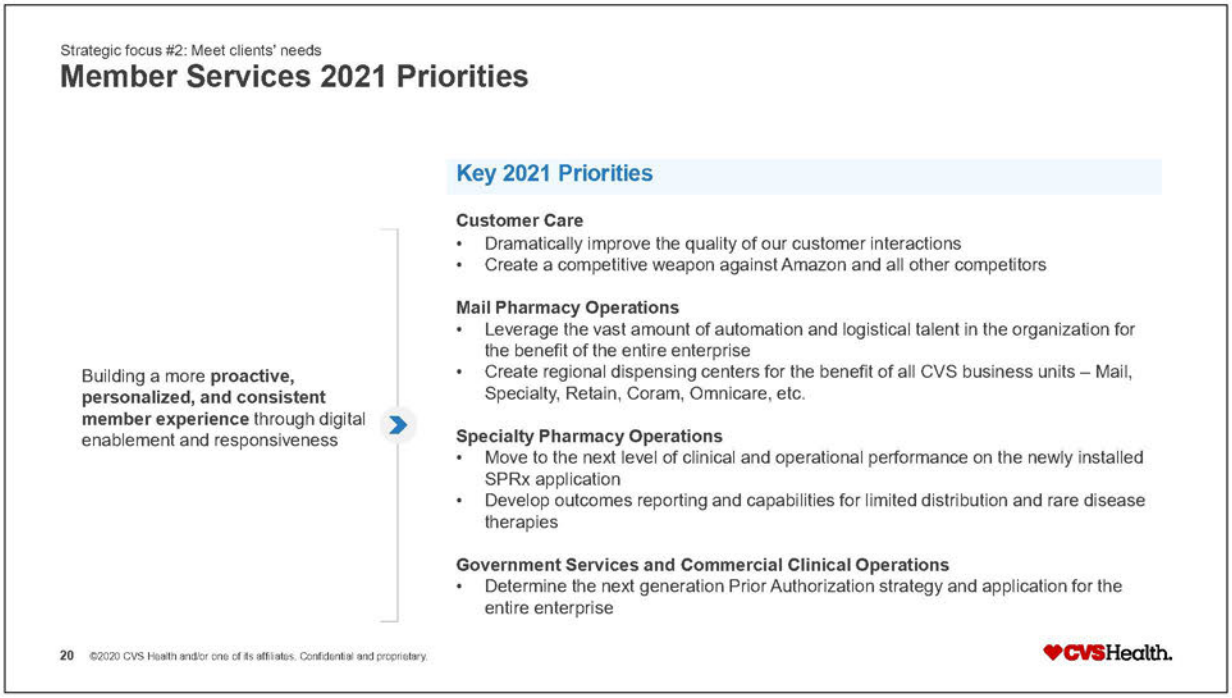
Strategy and Process Innovation Team

Government and Reg Affairs (PBM services)

Source: 3Q 2020 SOS Fact sheet from investor relations; MyStats CVS metrics database
1. 2019 - includes Mail, Retail, and Coram
2. 2019

CVSHealth.

26.2 million lives in exclusive specialty
In 2019, CVS Health delivered $2.8 billion in Specialty UM* savings



Our goal is to give our members the tools they need to easily interact with us according to their preferences and continuously improve and simplify the member experience.

Strategic focus #5: Enhanced profitability

Network / Underwriting Overview

Checking with Sean C on underwriting $ and Network Margin

Context

Caremark underwriting processes $120B+ of revenue annually; this volume creates a tremendous opportunity to utilize advanced analytics and forecasting to eliminate financial leakage. **Automation and modernization of PBM client contracting processes and underwriting model will increase precision and support efficient, profitable growth**

We continue to see network spread margin under pressure, largely driven by legislative action, but also driven by profit per lock increasing at an unsustainable rate and by a shift in the business mix decreasing overall lockable business. **We have implemented and will continue to explore new reimbursement models to allow us to retain our margin where possible**

Key Organizational Stats

Leader: Allison Brown, SVP Client Financial Analysis / Networks
Org Size: ~650
Scope: Underwriting, Proposals, Client-Specific Analytics Consulting, Actuarial, Network Services, Network Strategy and P&L, Government Program P&L

Key 2021 Priorities

Aligning for Profitability

- Drive continuous improvement in underwriting profitability, including rebate modeling
- Goal of 45% of employer client volume processed through new ecosystem post MVP launch

Defining our long-term network strategy

- Independent composition & reimbursement
- Spread vs. pass-through

Achieve key P&L financial targets

- Execute on Network Margin 2021 goals
- Manage rebates effectively
- Establish and enhance the PBM Network, Medicare, and Medicaid P&Ls

CVSHealth.

Strategic focus #5: Enhanced profitability

Operating model improvements will drive overall profitability, resulting in greater price competitiveness in the market

Opportunity	Enhance Contract Administration Processes	More Timely Data Models to Drive Client Profitability
Desired Outcomes	Mitigate rapidly increasing complexity of client contracts	Improve margins and pricing by providing actionable client-level financial insights
Key Initiatives	• **Improve accuracy** through connected and automated data ecosystem (e.g., Aligning for Profitability) • **Re-design processes** to create a service culture of transparency and accountability (e.g. Caremark Service Excellence)	• **Provide increased flexibility and precision**: create models that reflect truer market dynamics • **Establish measurable path** to improve profitability at initial underwriting
Value	**$100-$200M**	**$200-$300M**

 ©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

Contracting Processes example: WellCare: Incorrect specialty brand rate contracted and implemented leaving specialty guarantees at risk (~$180M)
State of TN: Multiple end to end process gaps (e.g., benefit coding to rebate invoicing) resulting in under invoiced rebates

Enhance Client Profitability Example: Google: Client used open formulary as an employee retention tool. Initially priced aggressively to win business but explosive growth and bad mix created rebate guarantee issue and attempt to exercise reservation of rights resulted in client retention risk

Strategic focus #6: Operating model optimization

Client Services Overview

Context

Service delivery to our clients is critical to continuing to **achieve high customer and member satisfaction** and ultimately client retention.

We view service as a differentiator and are developing **a customer-centric culture that provides safe, accurate, timely service to our clients and members** through our Caremark Service Excellence program that reduces client issues and decreases costs.

Key Stats

Leader: Brian Leadingham, SVP Client Services
Org Size: ~1.5k
Functional areas:

- Benefits & clinical operations
- Client Implementations
- Member Communications
- Direct Member Reimbursement
- Client Service Center
- Service excellence
- Enterprise modernization

Key '21 Priorities

Expanded commitment to Customer Service Excellence

- Creating a culture of continuous learning
- Establishing process innovation
- Delivering service excellence

Execute seamless welcome season

- Proactive management of customer needs to drive customer satisfaction

Optimize performance and service

- Manage performance guarantees and service warranties
- Proactive management of customer needs to increase customer satisfaction
- Transform the operating model and drive savings from Enterprise Modernization initiatives

CVSHealth.

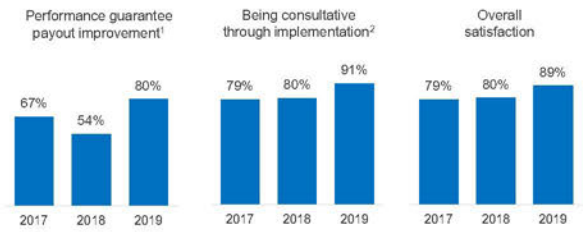
Strategic focus #6: Operating model optimization

We are building on best practices from successful Welcome Seasons with Caremark Service Excellence (CSX)

Welcome Season process has improved significantly due to intentional focus on customer retention and loyalty metrics

CSX will apply these learnings to improve overall client experience

Welcome Season results over time



Goals of cross-functional Center of Excellence

Deliver service excellence to our customers

Create a culture of continuous learning, driven by data

How it works

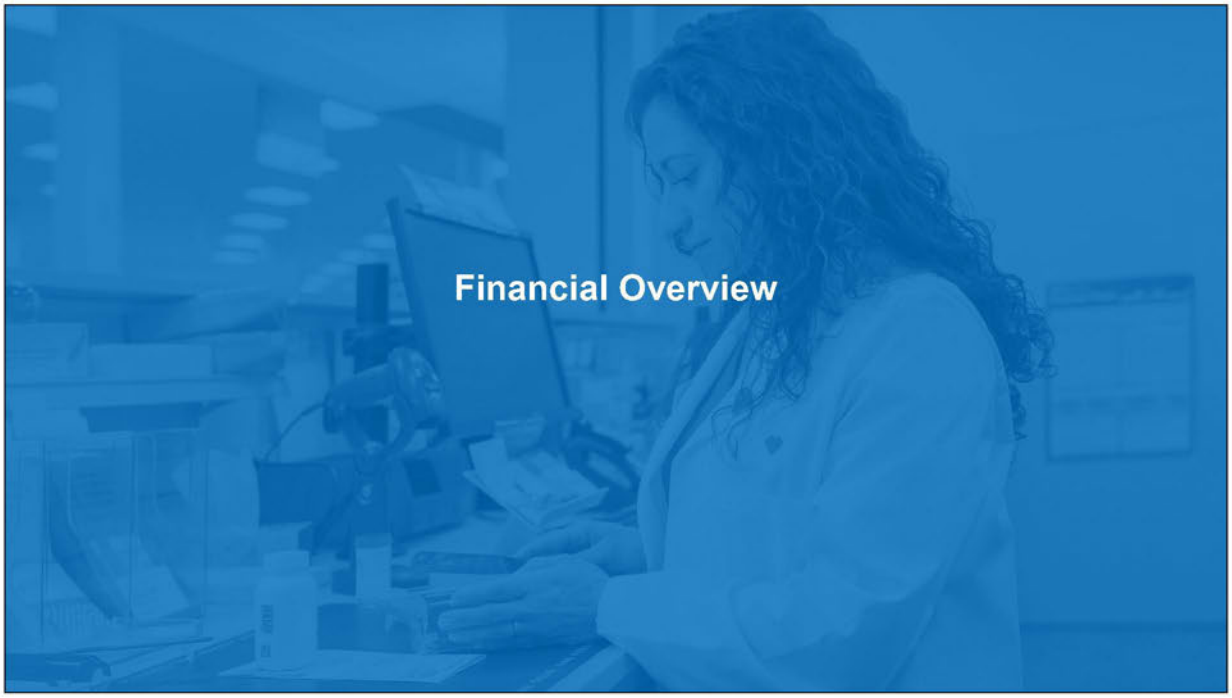
1. Raise **visibility** to issues
2. Resolve issue and determine **root cause**
3. identify opportunities for **issue prevention**
4. Prioritize projects and investments
5. **Measure** and **assess** impact

Note: 2017 results correspond to 2/2017-1/2018; 2018 results correspond to 2/2018-1/2019; 2019 results correspond to 2/2019-1/2020; 1. Top 2 Box– client perspective per client satisfaction question; 2. Top 2 Box
Source: Sabrina Williams

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVS Health.

CONFIDENTIAL TREATMENT REQUESTED


Financial Overview

Finance & Financial Operations

Context

There are 74 PBM health plan clients including Aetna covering 68.1m lives. We serve ~2,000 EG clients (this includes Specialty and Coram stand-alone payors), representing 103.5m lives.

While clients and consultants consistently emphasize **price as the main decision driver,** on any given deal competitors can match or meet pricing through multiple rounds of the bid process.

Caremark will retain (and forestall a renewal RFP) or win business by implementing strategies that emphasize high growth and ensure delivery of innovative products and se

Placeholder

Key Stats

Leader: Jeffrey Goddard
Org Size: ~2k
Functional areas:
Margin management, Cost Management, FP&A, Customer Verticals & Product, Finance Transformation, Controller, Client Audit & Risk Governance, Specialty

Key 2021 Priorities

Deliver 2022/23 selling season

- Win 1-2 major HPs to validate open platform strategy
- Win 2-3 marquee EGs to validate integrated value story

Increase client trust and transparency

- monstrating alignment of incentives
- viding clear proof points to show client benefit

ain, and grow profitable business to re-index business mix

- Ensure each prospect/renewal has a profitability expansion plan as part of underwriting process
- Grow specialty dispensing

Focus on delivering Enterprise value

- Win through Aetna (ASO/FI) and other resellers; drive Enterprise "value per life"
- Partner with Transformation to co-develop and sell through additional medical management solutions for clients

CVSHealth.

Pharmacy Services 2020-2022 Financials

Favorable / (Unfavorable) $ in millions	2020 9+3 FC	2021 BUD V4	2022 BUD V4	2021BV4 vs. 2020FC $	2021BV4 vs. 2020FC %	2022BV4 vs. 2021BV4 $	2022BV4 vs. 2021BV4 %
Revenue							
Mail	$ 15,805	$ 15,737	$ 16,642	$ (68)	(0.4%)	$ 905	5.8%
Network	108,362	$ 112,519	115,471	4,157	3.8%	2,952	2.6%
Specialty	51,613	$ 55,114	58,371	3,501	6.8%	3,257	5.9%
Rebates & Other Manuf Considerations	(35,891)	$ (39,496)	(41,809)	(3,605)	10.0%	(2,313)	5.9%
Other	461	$ 377	325	(84)	(18.3%)	(52)	(13.7%)
Total Revenue	**140,351**	**144,251**	**149,000**	**3,900**	**2.8%**	**4,750**	**3.3%**
Standard Gross Profit (SGP)							
Mail	1,860	1,646	1,476	(214)	(11.5%)	(170)	(10.3%)
Network	2,479	2,564	2,410	85	3.4%	(153)	(6.0%)
Specialty	4,610	4,918	5,659	308	6.7%	741	15.1%
Rebates & Other Manuf Considerations	1,422	1,688	1,870	266	18.7%	181	10.7%
Other	413	340	324	(73)	(17.7%)	(16)	(4.8%)
Total SGP	**10,785**	**11,156**	**11,738**	**371**	**3.4%**	**582**	**5.2%**
% to Revenue / bps	*7.7%*	*7.7%*	*7.9%*		*5*		*(14)*
Total Cost of Service (COS)	**3,934**	**4,036**	**4,130**	**(103)**	**(2.6%)**	**(94)**	**(2.3%)**
% to Revenue / bps	*2.8%*	*2.8%*	*2.8%*		*(0)*		*3*
Total Gross Profit	**6,851**	**7,120**	**7,608**	**269**	**3.9%**	**488**	**6.9%**
% to Revenue / bps	*4.9%*	*4.9%*	*5.1%*		*5*		*(17)*
SG&A	**1,191**	**1,246**	**1,311**	**(55)**	**(5%)**	**(65)**	**(5.2%)**
% to Revenue / bps	*0.8%*	*0.9%*	*0.9%*		*2*		*(2)*
Adjusted Operating Income	**$ 5,660**	**$ 5,873**	**$ 6,297**	**$ 214**	**3.8%**	**424**	**7.2%**
% to Revenue / bps	*4.0%*	*4.1%*	*4.2%*		*4*		*(15)*

Key Takeaways

2021 Budget

- **Adjusted volume** growth of 5.4% driven by net new business, utilization, and lower 2020 network volume due to COVID
- **Revenue** growth driven by inflation, net new business, and Specialty growth offset by higher paid rebates
- **Operating Income** growth driven by network COGS improvements, Zinc, and purchasing partially offset by pricing

2022 Budget

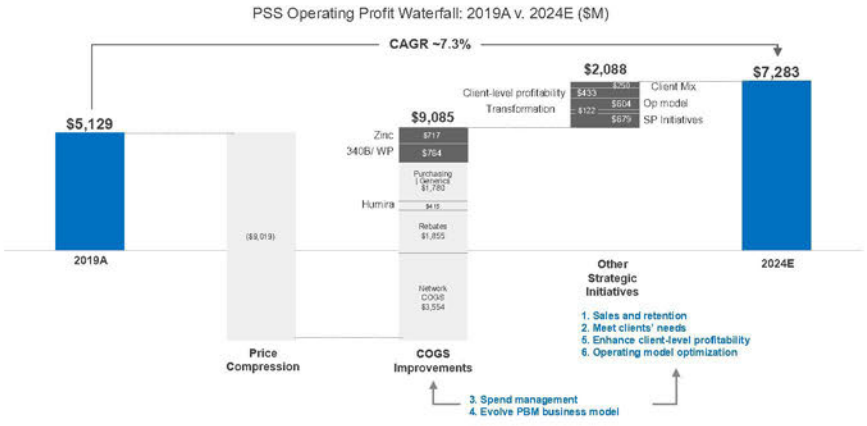
- **Adjusted volume** growth of 3.2%
- **Revenue** growth driven by inflation, net new business, and Specialty growth offset by higher paid rebates
- **Operating Income** implies 7.2% year over year growth. Current 2022 outlook aligned to strategic plan expectations with adjustment for financial improvement initiatives

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

CONFIDENTIAL TREATMENT REQUESTED

Caremark will deliver ~7.3% compound annual growth over the next five years, overcoming ~$9B in price compression

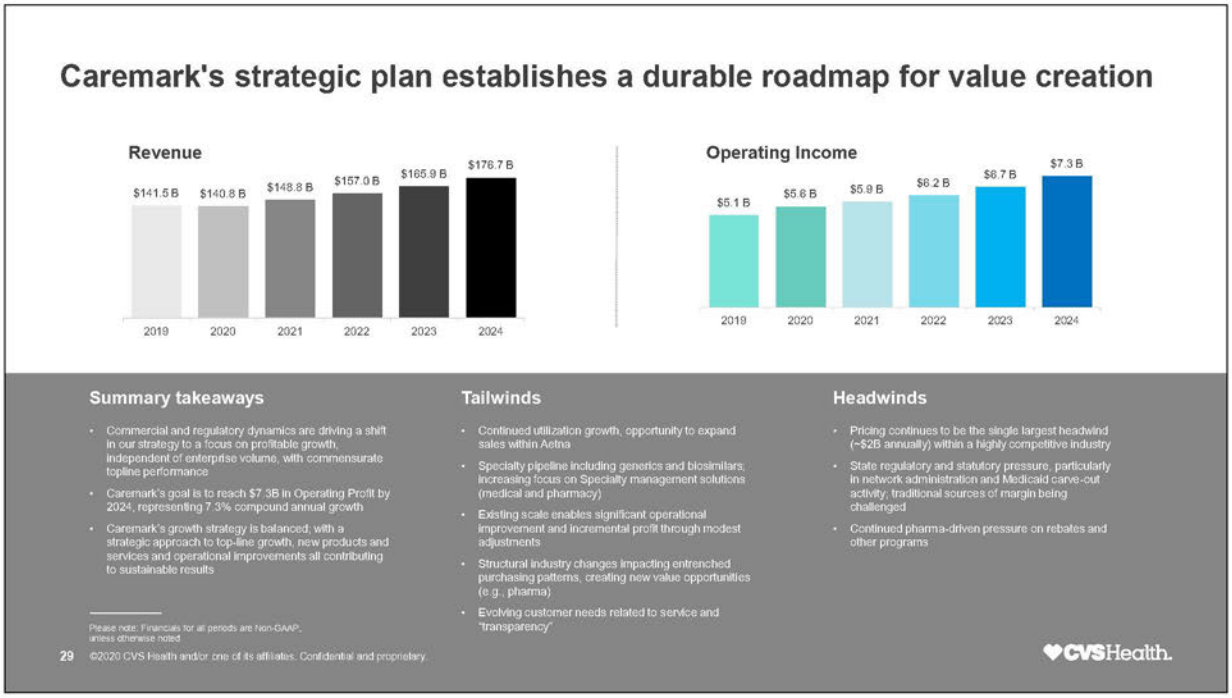


Source: PSS Finance; values are preliminary; SP Initiatives includes PrudentRx; Enterprise modernization value captured in Op Model; 2020 Financial Leakage included in Network COGs

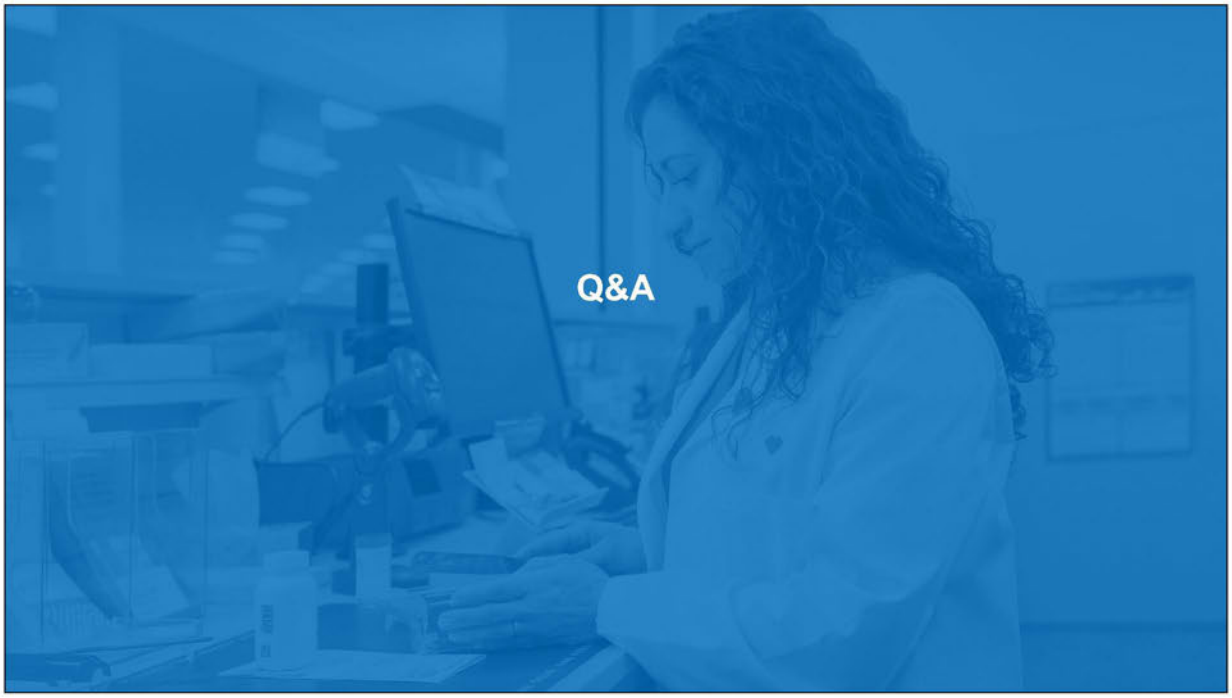
 ©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

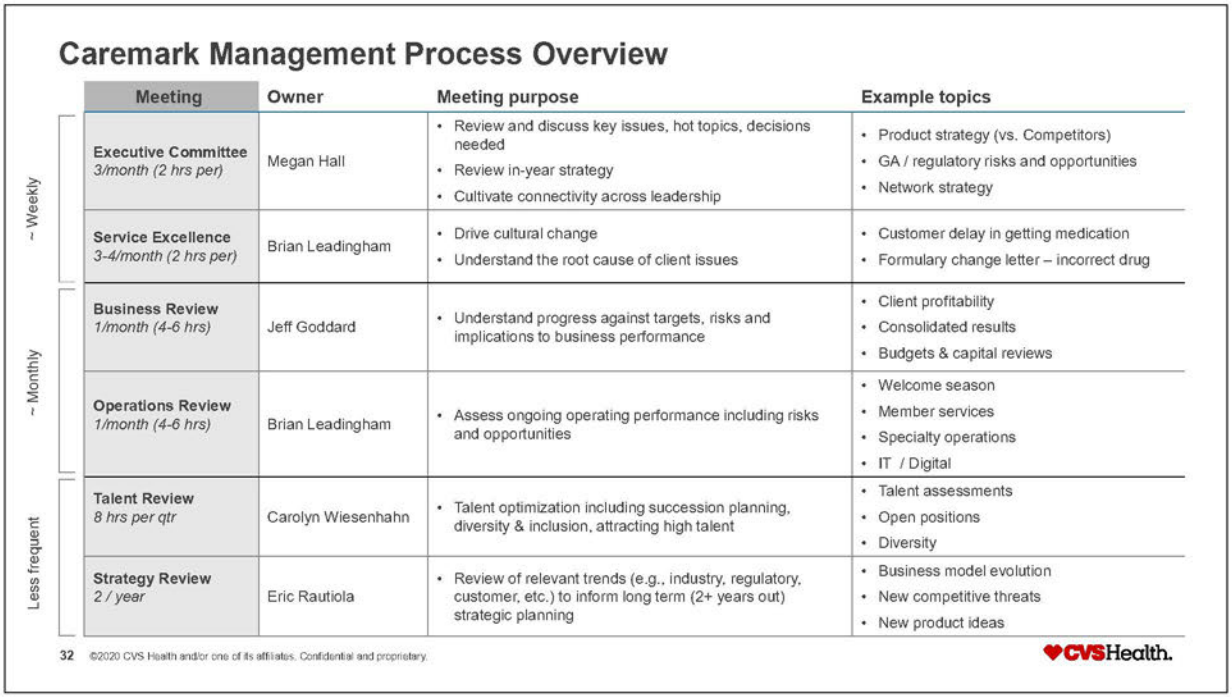
Price compression and COGS improvements are linked. Theoretically, the point(s) at which you stop getting value out of network/pharma is the same point pricing pressure would begin to diminish
Strat plan 2 submission showed ~$216M of financial leakage in 2020; this value is now reduced from Network COGs



Very different plan than the last review; here we lay out why/what's informing the change and different view of the business HCB, Retail, EM, OmniChannel, and new business sections include a formal summary/recap and key next steps. Potential Response: Transition to Kidney, but may want to spend time at the end voicing over the key messages (shift in strategy) and next steps (finance-led focus on our six focus areas)


Q&A

Appendix



Caremark Management Process Overview

	Meeting	Owner	Meeting purpose	Example topics
~ Weekly	**Executive Committee** *3/month (2 hrs per)*	Megan Hall	• Review and discuss key issues, hot topics, decisions needed • Review in-year strategy • Cultivate connectivity across leadership	• Product strategy (vs. Competitors) • GA / regulatory risks and opportunities • Network strategy
~ Weekly	**Service Excellence** *3-4/month (2 hrs per)*	Brian Leadingham	• Drive cultural change • Understand the root cause of client issues	• Customer delay in getting medication • Formulary change letter – incorrect drug
~ Monthly	**Business Review** *1/month (4-6 hrs)*	Jeff Goddard	• Understand progress against targets, risks and implications to business performance	• Client profitability • Consolidated results • Budgets & capital reviews
~ Monthly	**Operations Review** *1/month (4-6 hrs)*	Brian Leadingham	• Assess ongoing operating performance including risks and opportunities	• Welcome season • Member services • Specialty operations • IT / Digital
Less frequent	**Talent Review** *8 hrs per qtr*	Carolyn Wiesenhahn	• Talent optimization including succession planning, diversity & inclusion, attracting high talent	• Talent assessments • Open positions • Diversity
Less frequent	**Strategy Review** *2 / year*	Eric Rautiola	• Review of relevant trends (e.g., industry, regulatory, customer, etc.) to inform long term (2+ years out) strategic planning	• Business model evolution • New competitive threats • New product ideas

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

Add owner

Pharmacy Services P&L – Annotated

$ In millions	2019 Actual	Explanation of Income Statement line item
Revenue		
Mail & Maintenance Choice **	$ 15,427	Revenues from Rxs dispensed at Caremark mail pharmacies and maintenance choice dispenses at Retail pharmacies. Client reimbursement is generally based on discount off of AWP benchmark for drug dispensed
Network	112,320	Revenues from Rxs dispensed at retail pharmacies (incl. CVS). Client reimbursement is generally based on discount off of AWP benchmark for drug dispensed and subject to various pricing guarantees
Specialty	45,556	Revenues from Rxs dispense at Caremark specialty pharmacies as well as infusion and enteral services.Client reimbursement is generally based on discount off of AWP benchmark for drug dispensed and subject to various pricing guarantees
Rebates	(32,259)	Portion of rebates and other consideration from pharmaceutical manufacturers that are payable to clients
Other	448	Clincal program revenue (e.g. Transform Diabetes, Pharmacy Advisor), data fees, other fees
Total Revenue	**141,491**	
Cost of Goods Sold (COGS)		
Mail & Maintenance Choice **	$ 13,437	Cost of inventory for Rx dispensed from Caremark mail pharmacy
Network	109,601	Reimbursements to the retail pharmacy for dispensing the Rx.
Specialty	41,535	Cost of inventory for Rx dispensed from Caremark mail pharmacy
Rebates	(33,047)	Rebates and other consideration earned from pharmaceutical manufacturers for formulary placement
Other	36	Clinical program costs (e.g. glucometers)
Total COGS	**131,562**	
Standard Gross Profit (SGP)	*[= Revenue less COGS]*	
Mail & Maintenance Choice **	1,990	Spread between client reimbursement to Caremark and cost of drug
Network	2,719	For traditional contracts, spread between client reimbursement to Caremark and reimbursement to dispensing pharmacy. For transparent contracts, the client administration fees.
Specialty	4,021	Spread between client reimbursement to Caremark and cost of drug
Rebates	788	Retained rebates before adjusting for reinvested rebates (Caremark gives client better pricing in exchange for retaining more rebates)
Other	412	Net impact of clinical programs, data fees, and other fees
Total SGP	**9,929**	
Cost of Service (COS)	**3,683**	Direct operational expenses- expenses associated with pharmacy / call center / clinical operations, IT adjudication support, client benefit setup, and member communications
SG&A	**1,117**	Overhead costs- support organizations including sales, marketing, analytics, finance, and allocated costs from corporate. Also includes bad debt.
Adjusted Operating Income	**$ 5,129**	Non-GAAP income which excludes intangible amortization
% to Revenue	*3.6%*	

** Maintenance Choice profit is recorded on both the PSS and Retail P&Ls and eliminated in enterprise consolidation. The PSS imputes profit on Maintenance Choice scripts "as if" it were dispensed from a PSS mail pharmacy.

©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

CONFIDENTIAL TREATMENT REQUESTED

Pharmacy Services Budget – Key Channel Financial Drivers (9+3 FC)

	Sales / Volume	Margins	Initiatives for current and future growth
Specialty	**+2.4% revenue increase** • Script increase of 3.5% (90's as 3) • Drug price inflation of 4.3% • Script utilization 1.8%	***8% year over year earnings growth off a base of 19% earnings growth in 2020*** **(3) bps decrease in SGP margin** • Price erosion: ($515) • Cost of goods improvements: $409 • 340B / Wellpartner: $157	• Capitalize on generic / biosimilar launches • Continue innovation (e.g. 340B, PrudentRx & Oncology) • Manage drug spend and trend • Grow standalone and open market
Network	**+2.3% revenue increase** • Script increase of 5.6% (90's as 3) • Drug price inflation of 3.9% • Script utilization 1.9% ex Covid	**(1) bps decrease in SGP margin** • Price erosion: ($953) • Look / fees: $952	• Maintain profitability as market shifts away from traditional pricing • Effectively manage complex guarantees • Drive enterprise share
Mail and Maintenance Choice	**(0.4)% revenue decrease** • Scripts increase of 1.4% (90's as 3) • Drug price inflation 3.5% • Script utilization flat to (9+3) forecast	**(131) bps decrease in SGP margin** • Price erosion: ($142) • Purchasing/ COGS/ Mix ($28)	• Improve member experience • Drive best in industry brand & generic COGS • Solidify enterprise strategy for Maintenance Choice • Effectively manage guarantees
Expenses / Other		• Zinc value of $420M • Operating expense as % of Standard Gross Profit improves each year • Contingency: ~$100M per year	• Partner with enterprise to cross-sell • Optimize & modernize cost structure • Expand newer value pools (e.g. Zinc) • Formulary innovation (value-based contracts, etc.) • Optimize client mix / profitability

 ©2020 CVS Health and/or one of its affiliates. Confidential and proprietary.

CVSHealth.

Enabling Capabilities
Talent: Invest in capabilities (analytics, finance and general management) and development; facilitate customer-focused culture and colleague collaboration through key investments (e.g., Microsoft Teams, CRM)
Clinical excellence: Develop evidence-based strategies to improve patient care and adherence, minimize costs, and increase satisfaction (e.g., Accordant, Novologix)
Technology: Reduce 40+ pharmacy systems by migrating to the cloud and utilizing enterprise platforms
Capital: Align investments and targeted acquisitions with long-term strategy / capability development to inform decision making and trade-offs

PBM to Medical: Caremark pharmacy into existing Aetna medical customer base
550k membership growth by 2022
Medical to PBM: Aetna medical into existing Caremark pharmacy employer customer base
400k membership growth by 2022
Aetna Specialty to PBM: Dental, Vision, Voluntary, EAP, PayFlex, and bswift into CMK pharmacy customer base
935k membership growth by 2025
Caremark Reseller Strategy: Targeted Commercial, Medicare, Medicaid, and Exchange growth
100k annual growth in commercial membership

Exhibit 39:
CVS_HJC_00011011 Internal CVS Caremark business presentation developing the plan to create an in-house hub pharmacy

CVSHealth

Competing and winning in omnichannel pharmacy

July 2019

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

Executive Summary

Context:

- The competitive landscape is shifting to an omnichannel experience and we need to act. Amazon and a preponderance of smaller players are making substantial digital advances with the potential to redefine the 'traditional' pharmacy experience
- Extrapolation of recent analysis from AllianceBernstein suggests 20% of Rxs may be filled online by 2027
  - If CVS is able to win fair share, this represents a 375M Rx growth opportunity
  - However, CVS could also cede 135M to 230M annual Rxs due to this shift and Amazon's entrance
- CVS needs to make long-term digital investments to meet this opportunity/ threat and keep up with rapidly evolving patient expectations. To ensure our digital capabilities are truly omnichannel and on par with those of our competitors we should:
  1. Enhance our customer-facing assets and create a **'branch-less', customer-first Digital Pharmacy**
  2. Develop the **capabilities to connect with third parties** to enable CVS to reach patients in new settings and to serve as a digital **Pharmacy as a Service** driving incremental script growth

Today, we'd like to discuss what is necessary to acquire these capabilities:

- **Build vs. buy vs. partner:** We could gain such capabilities through partnerships or acquisitions of leading players like Capsule and TruePill, or develop them internally through a sustained multiyear investment
- We also believe there is a misconception around what a customer-centric digital pharmacy is and would like to dispel the notion that our current capabilities already represent a "digital pharmacy"
- Our scenarios suggest **that a sustained build approach** will ultimately unlock the most value:
  - **Why not buy?:** Recent comps and funding rounds indicate high price tags exceeding our realistic limit. Furthermore, integrating one of these experiences into our legacy pharmacy systems would still require a substantial investment
  - **Why not partner?:** We don't believe partnership opportunities with Capsule/True Pill to be compelling or of substantial size
  - **We need to invest in and build** an enterprise pharmacy platform primarily focused on a customer-centric digital experience (the greater of the two needs) and enabling integration with a broader "Front Door to Health" solution. This will require incremental sustained investment of **$16-18M annually over a 3+ year horizon**
- To realize this **Digital Pharmacy and Pharmacy as a Service** vision, it is imperative that we **invest more in our digital funding** by 1) reprioritizing funding from elsewhere in Digital or CVS and/or 2) partnering with someone (e.g. Google) to achieve our goals

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

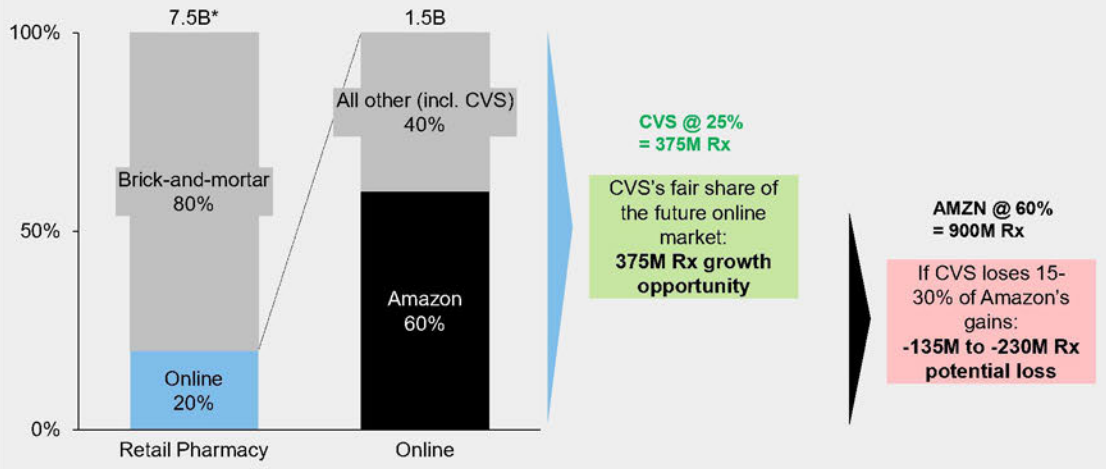
For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

If 20% of scripts are online in 2027, winning fair share could represent 375M in growth; failing to act could result in real losses to Amazon

Retail Pharmacy Market in 2027 (scripts)

(Projects from investment research firm Alliance Bernstein)



* Analysis assumes 4% total market CAGR

Note: According to new PYMNTS research, Amazon's total gross sales in health and personal care products has increased since 2014 at a 43% CAGR. **Amazon will account for a 32.5% share in eCommerce sales of health and personal care sales in 2018**, up from 27.9 percent last year.

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

Pharmacy disruptors have developed two key digital models: 1) Digital Pharmacy and 2) Pharmacy as a Service

1 Digital Pharmacy
(Branch-less, customer first experience)

CAPSULE · alto pharmacy · PillPack an amazon company

- No need to communicate with a physical retail store, patient can create an online profile to receive prescriptions
- Manage and track order in near real-time, schedule delivery online
- 24/7 pharmacy and customer service chat

2 Pharmacy as a Service
(Connect with third parties)

TruePill · Nimble · phil · PillPack * an amazon company

- Third party connectivity via robust set of APIs to offer services (e.g. medication management software, back end fulfillment, delivery, customer service, etc.)
- Services could support other pharmacies (e.g. independents) or other providers (e.g. asynchronous telehealth companies)

CVS needs to invest now to develop both of these digital experiences to not be displaced by digital disruptors

* PillPack has reportedly approached Livongo to serve as a backend fulfillment platform and Lemonaid in some capacity (details not known)

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

CVS should prioritize Digital Pharmacy capabilities due to the larger opportunity size of 375M scripts vs <10M for each service capability

	1 Digital Pharmacy		2 Pharmacy as a Service	
CVS Priority	**FIRST PRIORITY**		**SECOND (CRITICAL) PRIOIRTY**	
Short Term Potential Rx Losses	**1M**	• In 2018, CVS lost over 0.6M potential Rxs to Digital pharmacies[1] • If trend continues, CVS could cede **nearly 1M Rxs** in 2019 with estimated CAGR for Digital pharmacies of 17.5%[2]	**TruePill example** **1M-5.4M**	• TruePill's clients are growing rapidly with high valuations (examples: HIMS, ro) • Headwind to CVS (calculated at "fair share") from asynchronous telemedicine to CVS in 2019 is estimated between **1.1-5.4M Rxs**[4]
Long Term Potential Rx Gains *by 2027*	**375M** **(135-215M)**	• Alliance Bernstein predicts that by 2027 20% of all Rxs, ~1.5B, will be filled online[3] • If CVS is able to win fair share, this represents a **375M Rx growth opportunity** • However, CVS could also easily cede 135M to 230M annual Rxs due to this shift in 2027[3]	**TruePill example** **1.7M-10.8M** **++**	• CVS could be gaining up to **10M RXs** annually by 2022 if it is able to win fair share in the pharmacy as a service market (CAGR of 14.6% applied[4]) *Investing here could be critical to prevent others (e.g., AMZN) from sweeping this market which could represent much of the entire digital Rx space*

Note: Size could increase based on additional service offerings
(i.e. this opportunity size reflects TruePill's back end fulfillment capabilities to asynchronous telehealth companies only)

1 – Quarterly transfer data provided by the MDP team. Projection accounts for lost refills due to patient transfers and assumes 86% adherence;
2 – BusinessWire estimates CAGR for Digital Pharmacy market of 17.5% between 2018-2024; Impact to CVS could be larger in 2019 with Amazon beginning to aggressively market PillPack; 3 – Source: Alliance Bernstein article "How Fast Will drug Stores Get Amazoned?"; 4 – Analysis completed by CVS Telehealth team, CAGR 14.6%

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

We need to develop Digital Pharmacy and Pharmacy as a Service capabilities to maintain fair share in the future omnichannel world

What we already have…	What we lack…	What we need to develop…
		1 A customer-first Digital Pharmacy
• 'Right to win' in pharmacy (established brand)	• The 'right to win' in the digital space	• A revamped digital experience (through sustained investment)
• Large existing patient base	• Omnichannel patient-focused customer service	• An on-demand, branch-less service platform
		2 Pharmacy as a Service capabilities
• B2B relationships (networks, purchasing power)	• The means to connect with B2B digital partners	• External pharmacy API platform and capabilities
• A nationwide footprint & capacity across many stores	• Opportunities to take advantage of capacity	• A model to fill for a new type of B2B 'customer' ("pharmacy for others")

We must deliver both capabilities that provide customers a seamless, 'access from anywhere' digital experience and those that enable us to connect with external platforms

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

1 A customer-first Digital Pharmacy

We do not have a customer-first digital pharmacy; We must fill gaps to achieve our vision of a customer-first, "branchless" digital platform

Customer pain points in current CVS Digital Rx Experience	What patients should experience from a Digital Pharmacy
• Patient cannot create Rx-tied digital account **until after they have filled prescriptions at the retail pharmacy**	• Patient can get started and create full pharmacy profile online **without having to go to the store or call**
• For first fills, **patients do not receive any confirmation** from CVS until the order has been prepped by the store team	• Send an **order received notification** to digitally engaged patients with estimated ready time
• Patient who prefers Rx delivered must request a refill, wait for store to fill order, get Rx ready notification, **then log back in to checkout for delivery**	• **When submitting fill request**, patient can choose to pickup Rx from any store within 2 hours or have it delivered
• **Patient doesn't know the price of an order** until after it has been prepped by the store team	• **Show adjudicated price** (copay) to patient when submitting digital fill order
• Patients must learn about and opt into **each of our pharmacy programs independently**, e.g.: - ReadyFill and ScriptSync presented separately - MDP presented as a completely separate service and enrollment flow	• Ability to set up **recurring pharmacy orders** that include: – Auto refills and renewals – Synchronized Rx – Delivery or pickup optional – MDP optional – Passive checkout
• Customers seeking help or clinical guidance **must go to the store or call**	• 24/7 **pharmacy and customer service chat**

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

After examining options to Build, Buy, and Partner, we recommend a build strategy and believe it will yield the most long-term value

	BUILD	BUY	PARTNER
VISION	**Two-phased approach:** **Phase 1:** Expedite closure of digital Rx customer journey (Q1 2020- Q2 2021) **Phase 2:** Seamless integration of central and local fill nodes and real time adjudication (beyond Q2 2021)	**Two acquisition targets:** **Capsule & TruePill** were identified as solutions to acquire for Digital-First Pharmacy and B2B Pharmacy fulfillment needs	**Two paths for partnership identified:** **1. Digital-First Pharmacy:** Partner with another entity to service customers through a digital-first model where customers can initiate and manage pharmacy services fully via digital channels (e.g., Capsule) **2. B2B Pharmacy Fulfillment:** Partner w/ existing platform to bolster fulfillment capabilities for third parties
CONSIDERATIONS	▪ **Difficult** – Technical capabilities different than existing Rx roadmap. Will require multi-year investment ▪ **Long lead time** – Competitors are established in the market	▪ **Costly** - Likely expensive due to growth potential and historical funding ▪ **Integration challenges** – Would require integration into CVS infrastructure	▪ **Small opportunity size** due to limitation by geographies and low Rx volume ▪ **Low strategic fit** in building competitor's brand (Capsule) ▪ **Complexity in determining joint revenue** sharing on growth ▪ **High integration cost** and low margins
ESTIMATED COSTS	▪ **IT Work -** $5-7M (Phase 1) ▪ **Digital Work –** $11M x 3 years	▪ CVS team standalone valuation $125M – $160M for TruePill & $210M – $255M for Capsule, however market expectations are significantly higher ▪ **Integration Cost** - $20-$40M x 3 years	▪ **Integration Cost** - *more analysis needed to determine integration cost*

Digital

* - Details on the Build, Buy, and Partner analysis are available in the appendix

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

CVSHealth

For internal use only – pending legal review

Investing in building both capabilities will allow us to combat disruption and win share in these fast growing markets

1 Digital Pharmacy

- **Largest threat/ opportunity** with an estimated annual headwind of over 135M – 230M Rx by 2027
- **We recommend to prioritize development of an enterprise digital pharmacy platform** to position CVS to win in the fast growing Digital Pharmacy market

Rationale:

- **Create a unified pharmacy experience across various CVS assets** for our patients
- Integrate patient experiences into an end-to-end health journey to **uniquely differentiate us from Amazon**
- Could leverage platform foundation for other capabilities (e.g. Pharmacy as a Service, APIs, etc.)
- In-house build through a sustained multiyear investment will require less up-front funding than an acquisition and allow us to **launch first competitive features within 18-24 months**

FIRST PRIORITY

2 Pharmacy as a Service

- Opportunity presents lower immediate gains but will help **unlock new revenue streams** and enable CVS to **become a dominant player in this niche**
- Acquiring TruePill would be more expensive than a build approach due to upfront investment and integration costs but **could provide a number of quick synergies***

Rationale:

- Leveraging CVS economies of scale in purchasing
- Owning TruePill's established relationships with fast growing clients in the asynchronous telemedicine space
- Faster speed to market to scale these capabilities to new clients in the provider, payer, or digital health industries

We recommend exploring a deal with TruePill in parallel

SECOND PRIOIRTY

* Would require more due diligence

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

Building a competitive omnichannel experience will require incremental sustained investment of $16M-18M over a multi-year horizon

	Phase 1 (Q1 2020-Q2 2021): *Expedite closure of digital Rx customer journey gaps*	Future Phases (beyond Q2 2021): *Seamless integration of central and local fill nodes and real time adjudication*
Key New Features	• **Get started online** with intuitive onboarding flow • **Status of transfer request visible** to customer • **Order received notification** for first fills • Refill transaction that includes **estimated copay and delivery preference** • User-friendly tools for setting up **synced, recurring delivery** orders • **24/7 pharmacy chat**	• **Create a hub pharmacy** to intake and route fill requests received from B2B2C partners and patients living far from a physical store • **Transfer recurring Rx basket** seamlessly into multi-dose packs • **Show real adjudicated price** during refill transaction • Ability to **schedule delivery window** during refill transaction
Fulfillment Model	• All orders processed by local retail pharmacies (as today) • Minimal impact to current store workflow	• Home delivery of refills and recurring orders processed by low cost, highly automated central fill node
Non-Digital Dependencies (vendors, RxConnect, Rx Ops)	• Access to insurance eligibility check (via RelayHealth) • Ability to write/update insurance info. and communication preferences associated with customer profile • Trigger order received notification for 1st fills • Refactor heavy/slow service calls from Digital to RxC, replace with microservices • Operationalize a team to respond to customer chats	• Ability to call for medication inventory chain wide • Ability to initiate claim adjudication and pass output to system of record (RxConnect) • Bypass delivery confirmation for refills and recurring orders • System to transfer scripts/fills from central hub to local store for same day pickup or delivery, then back to central hub
Approx. Development Cost / Timeline	• **Digital CAPEX: $11M/yr. (1 train, 5 scrum teams)** • **Retail IT CAPEX: $5-7M** • **Timeline:** 12-18 months	• **TBD**

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011020

To self fund, we need to pivot the work of 5 agile scrum teams ($11M) and find $5-7M for Retail IT or dissolve 3 additional digital teams

- Retail Pharmacy:
  - Requires 5 teams / $10-11M to support and maintain existing products used by patients today
  - Evaluated 8 remaining retail focused teams; tradeoff to pivot teams focus is too high to recommend
- PBM requires 6 teams / $12-13M to support and maintain existing products; possible that we could expect to slow progress on key initiatives by pushing maintenance work to BU funded teams, but requires top down leadership support
- Retail IT investment is necessary to meet growth targets; Withdrawal of funding would compromise key growth drivers

2019/2020 flat investment scenario		Candidate teams to pivot to this work	Business Tradeoff	Recommendation
Retail	$24M Digital funding $4M BU funding ~13 scrum teams	2 teams currently building MDP integrated digital experience	Remove support from recently launched growth driver	Not viable
		1 team supporting saving patients money enhancements in the app	Remove support from recently launched growth driver	Not viable
		1 team that supports Clinical team in driving adherence	Slows progress on core initiative	Not viable
		2 teams to extend benefits of Rx personalization to digital	Slows progress on core initiative	Not viable
		2 teams supporting Med Cost Reduction next best action prompting via digital channels	Removes support from core enterprise initiative	Requires cross BU leadership alignment
PBM	$12M Digital Funding $22M BU funding ~16 scrum teams	1 team supporting Elevate Care reduction via digital order status improvements	2020 expense reduction driver is slowed, not stopped	Requires cross BU leadership alignment
		1 team supporting Specialty EHR interoperability to win open market patients	2020 growth driver is slowed not stopped	Requires cross BU leadership alignment
		1 team supporting Specialty patient engagement	2020 growth driver is slowed, not stopped	Requires cross BU leadership alignment

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

Next steps

1. Alignment
- Gain alignment on the need and source for the investment to build the omnichannel pharmacy experience

2. Prioritization and Planning
- Finalize the plan to fund and timeline to deliver the build for these capabilities

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary
For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011022

DRAFT

APPENDIX / COMPETITIVE INTELLIGENCE DEEP DIVE

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

Current CVS Digital Pharmacy customer experience has significant gaps relative to digital-native pharmacies (1/2)

		Capsule	Pill Pack + Amazon	CVS pharmacy	On 2019 roadmap
Get Started / Set Up Account	"Get Started" button	✓	✓		✓
	Create account with username/pw	✓	✓	✓	
	Force tie to in-store profile			✓	
	Validate Shipping Address		✓	**Gap:** Guided onboarding flow that begins before sending an Rx	
	Look up doctor from name and zip		✓		
	Search for eligible insurance		✓		
	Scan insurance card	✓	✓		
	Set contact method preferences	✓	✓		
	Save Credit/Debit and/or HSA/FSA	✓	✓	✓	
	Loyalty program			✓	
	Welcome tutorial video		✓		
"Import" Rx	Request transfer with manual form field for pharmacy and Rx info	✓	✓	✓	
	Scan pill bottle to transfer	✓			✓
	Enter doc info to contact for new Rx	✓	✓	**Gap:** Import Rx from digital account	
	Look up Rx info from insurance		✓		
	Accept electronic Rx and send "Rx received notification"	✓	✓		✓
	E2E messaging about transfer status	✓	✓		

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011024

Current CVS Digital Pharmacy customer experience has significant gaps relative to digital-native pharmacies (2/2)

		Capsule	Pill Pack + Amazon	CVS pharmacy	On 2019 roadmap
Place Order	Request delivery from transfer/ refill		✓		
	Add OTC/Vitamins		✓	✓	✓
	Add health/beauty items		✓	✓	✓
	Set a recurring order schedule		✓	Gap: Make it easy to set up recurring orders	
	Default into auto-refills /renewals	✓	✓		
	Default into synchronized scripts		✓		
	Show copay before order placed				
Fulfill order	Pickup in store or at drive-through		✓ Free	✓ Free	✓
	Delivery in 2 hours	✓ Free	✓ Free if >$35 with Prime		
	Same day delivery	✓ Free	✓ Free if >$35 with Prime	✓ $7.99; Free in NYC	✓
	Scheduled delivery windows	✓ Free	✓ Free if >$35 with Prime	Gap: Fast, free delivery	✓
	1-2 day delivery (from Rx filled)	✓ Free	✓ Free no min. with Prime	✓ $4.99; Free with Carepass	✓
	> 2 day delivery		✓ Free		
Post-order service	Real time order tracking	✓			
	Welcome packet in first order		✓		
	24/7 Pharmacy chat	✓	✓	Gap: Pharmacy Chat	
	Push savings opportunity				
	Dynamic medication reminders		✓		

✓ Likely Prime membership feature with Amazon logistics capabilities

Digital

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

Phase 1 investment estimate detail for "Branchless" Digital Pharmacy build

	Phase 1: Expedite resolution of digital Rx customer journey gaps
Key New Features	• Get started online with intuitive onboarding flow • Status of transfer request visible to customer • Order received notification for first fills • Refill transaction that includes estimated copay and delivery preference • User-friendly tools for setting up synced, recurring delivery orders • 24/7 pharmacy chat
Fulfillment Model	• All orders processed by local retail pharmacies (as today) • Minimal impact to current store workflow
Non-Digital Dependencies (vendors, Rx Ops, and Rx connet)	• Access to insurance eligibility check (via RelayHealth) • Ability to write/update insurance info. and communication preferences associated with customer profile • Trigger order received notification for 1st fills • Refactor RxConnect service calls into microservices • Operationalize a team to respond to customer chats
Approx. Development Cost / Timeline	• **Digital CAPEX**: **$11M/yr. (1 train, 5 scrum teams)** • **Other IT CAPEX**: **$5-7M** • **Timeline:** 12-18 months (Q1 2020 – Q2 2021)

Digital Work

- Charter a "Branchless Pharmacy" release train comprised of 5 agile product teams @ $2.2M/team/year
  1. Get started
  2. 1-step Rx ordering
  3. Recurring Rx orders
  4. Order status & customer notifications
  5. Pharmacy Chat

Non-Digital IT Work

Scope	BUG
Digital E1 transaction	8K
Digital update insurance	8-15K
Set communication preferences (e.g., IVR, TCPA) from digital	9K
Trigger notification to patient when new Rx received	20-25K
Refactor RxC calls into microservices	10K
Contingency for work in ESL, EPH, West, Nuance, etc. layers	+15%
Total Phase 1 Estimate	63-77K hours $4.5-5.5M

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

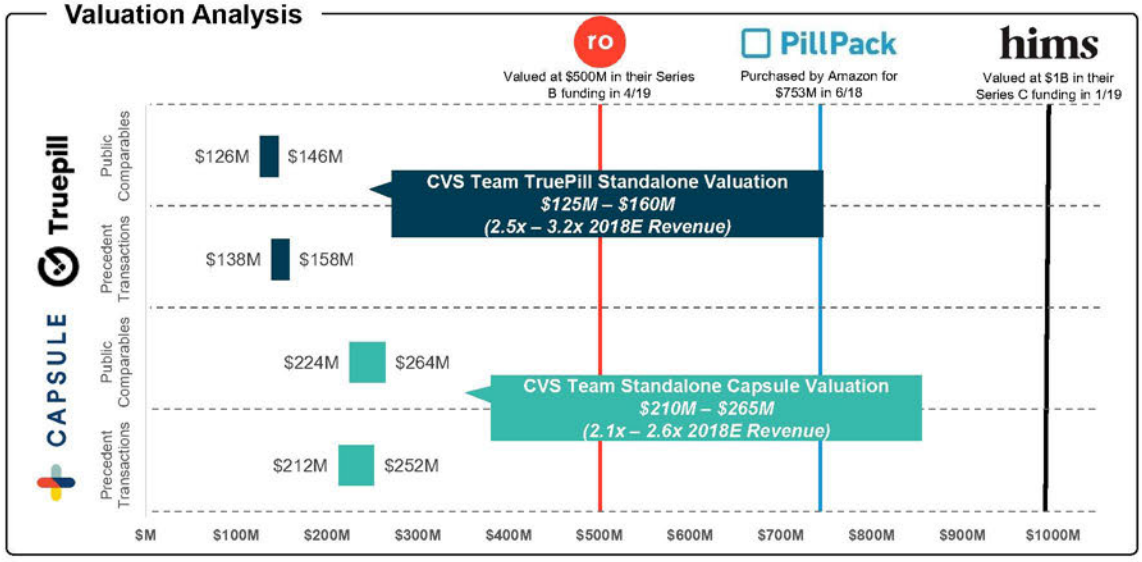
CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011026

For internal use only – pending legal review

Buy Analysis

- TruePill & Capsule were identified as acquisition targets to support portions of the digital pharmacy strategy
- The CVS Team assessed the value of TruePill to be $125–160M and Capsule to be $210-265M. However, the market is has set higher expectations for valuation with the following key examples:
  - PillPack was purchased for $735M at 7.35x 2017E Revenue
  - Roman and Hims which are Capsule's clients are currently valued by VC investments at $500M and $1B respectively
- Additionally, note that the acquisition would require IT integration of around $20-$40M x 3 years

Valuation Analysis



©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

Build | Buy | Partner

Partnership Analysis

For internal use only – pending legal review

- The EG&D, Digital, and Retail Pharmacy teams scoped two potential paths for partnership:
  - **Digital-First Pharmacy:** Partner with another entity to service customers through a digital-first pharmacy model where customers can initiate and manage pharmacy services fully via digital services
  - **B2B Pharmacy Fulfillment:** Partner with existing platform to bolster fulfillment capabilities for third parties
- In order to evaluate these opportunities, the EG&D team refreshed conversations and our perspective with leading players in these segments: TruePill and Capsule

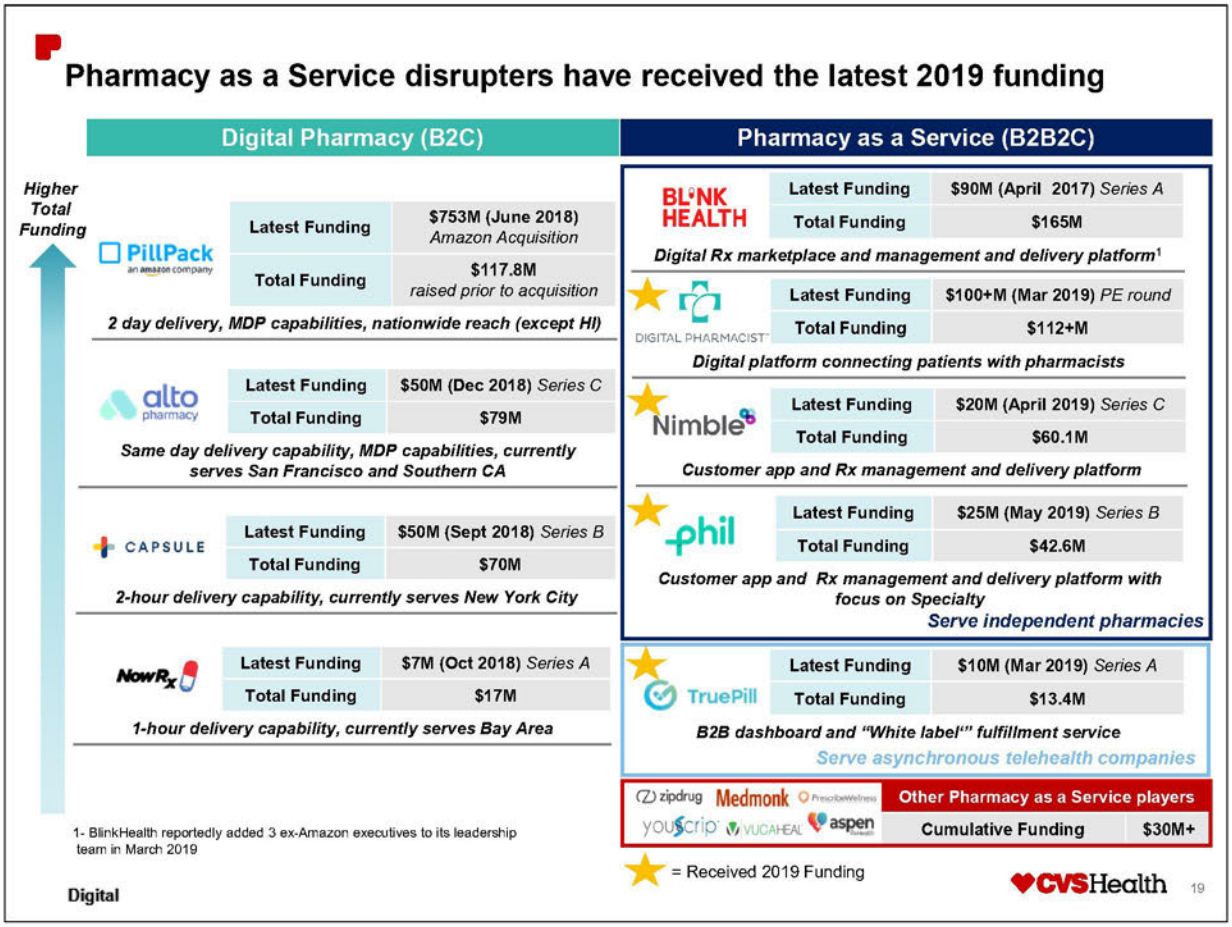
	CAPSULE ***Leading digital-first pharmacy in NYC***	Truepill ***B2B pharmacy fulfillment service***
OPPORTUNITY	▪ Leverage Capsule's digital-first pharmacy experience in CVS markets with low market share or geographic presence ▪ Capsule would acquire patients and provide front-end experience while CVS provides fulfillment services through delivery or in-store pickup in order to jointly serve the customer	▪ TruePill is unable to offer its clients the ability to fill certain scripts (mostly same day and cold chain) ▪ CVS could leverage its existing fulfillment channels to offer these services ▪ TruePill also sees opportunity to partner with CVS specialty
CONSIDERATIONS	▪ Small opportunity size due to current limitation by geographies and product fit in other geographies ○ Capsule is currently only in NYC ○ Uses bikes to deliver ▪ Complexity in determining joint revenue sharing on growth ▪ Low strategic fit: ○ We would be helping a competitor to build brand in new geographies	▪ Small opportunity size due to low volume of eligible scripts (~170K Rxs annually translating into $2.8M profit[1]) ▪ Integration could be costly at present due to a lack of CVS API capability; lower margin implications with manual script transfers and call center / tech labor costs ▪ TruePill delivery model offers free delivery for non-same day scripts --- asked if CVS could absorb delivery cost which has financial implications; In-store pharmacy pick up would be okay for other Rxs (e.g. cold chain, acute)
	Partnership doesn't seem strategically compelling	***Partnership is limited in value for LOE. More appealing with robust APIs built. Acquisition would yield the most compelling synergies***

1 - Opportunity size excludes Specialty Rxs and does not account for delivery cost, which per Truepill model CVS will absorb if applicable

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

Pharmacy as a Service disrupters have received the latest 2019 funding



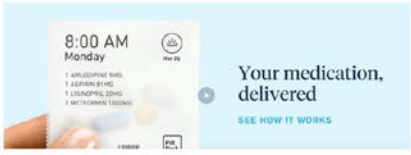
1 PillPack an amazon company

Digital Pharmacy | Pharmacy as a Service

Amazon is putting significant resources to integrate and expand PillPack; Working to diversify offerings in the long term

Recent PillPack updates

Marketing	• PillPack **started marketing to Prime members** (Apr '19) • Separately, Amazon has launched targeted **Prime campaigns to expand its reach in older and underserved populations** – e.g., **Medicaid**
Capabilities	• **Platform for prescription management (pharmacyOS)** shares similarities with Fulfillment by Amazon (FBA) • **Pharmacy API** for payers, manufacturers and other new companies (Capabilities above enable Amazon to fill medication for others*)
Expanded capacity	• Currently **5 physical pharmacies** (NH, NY, TX, FL, AZ) • Amazon is **building out a 175,000-sq.ft. pharmacy operation in Phoenix** (size of a Walmart Supercenter) to serve as a retail pharmacy and distribution center for



Customer Demographics

$5K annual spend
(including insurance payments & copays)

Age: 50s / 60s

Company Financials (Pre-Acquisition Base)

SOURCE: PillPack Pitch Deck

	2018E	2019E	2020E
Revenue	$299M	$635M	$1.2B
YoY Growth		*212%*	*189%*

Long Term Strategy

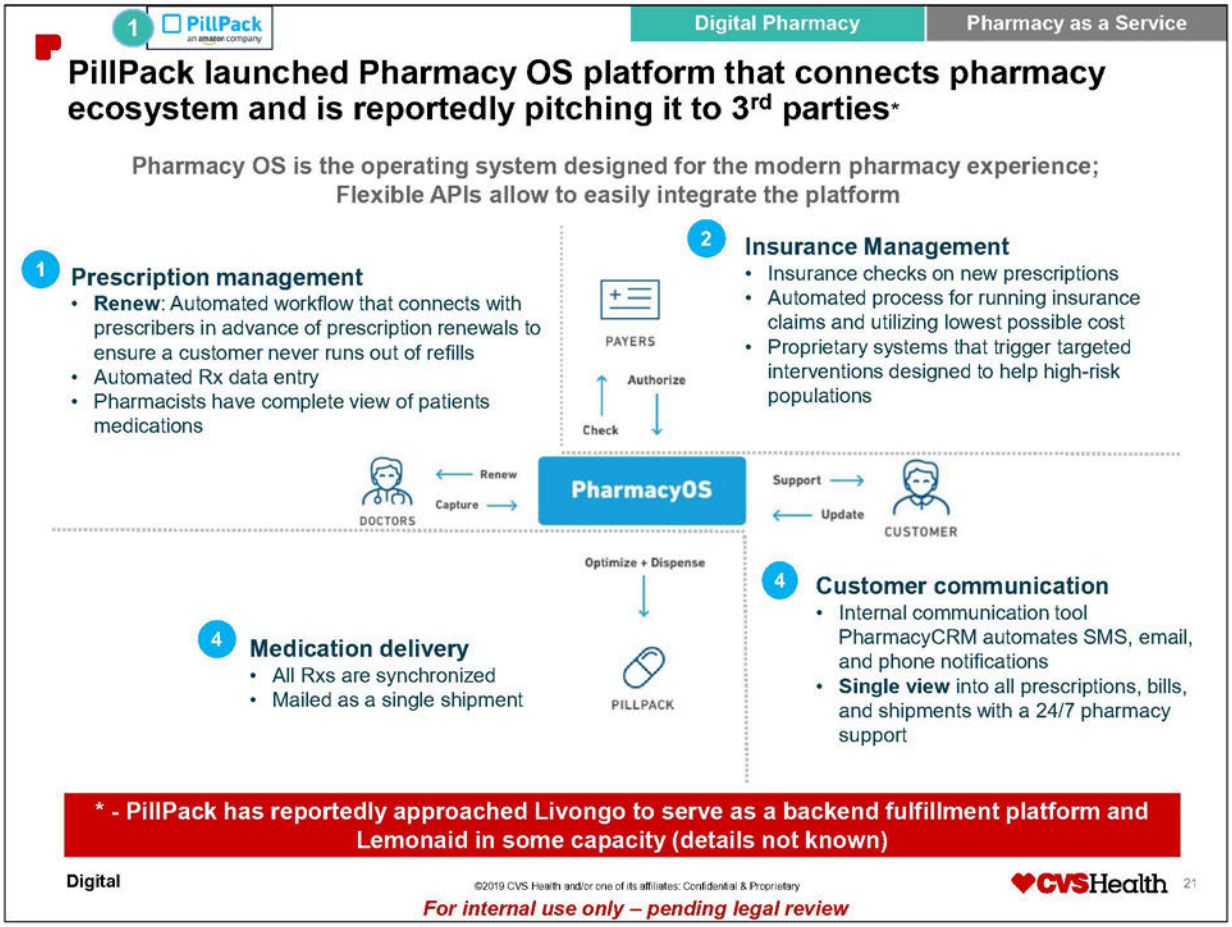
Amazon operating alignment	• **Free one-day delivery to Prime members nationwide** could be extended to PillPack • **Lower operating cost: a 6-month exemption granted in AZ to allow technicians to transfer medications from other pharmacies** (task currently performed by pharmacists in all but 13 states)
Expanded scope of operations / services	• **BCBS and PillPack launched partnership** to provide home delivery, discounts on OTC drugs, and other benefits to eligible members (primarily Medicare Advantage and Part D patients for now) • **Amazon is looking into ways data can be pushed and pulled from EMRs through Alexa enabled devices**. Pilot active with six health care companies and providers to allow customers to access their medical information (from tracking Rx delivery status with Express Scripts to finding and scheduling same day appointment with Swedish Health Connect).

*- PillPack has reportedly approached Livongo to serve as a backend fulfillment platform and Lemonaid in some capacity (details not known)

Digital Sources: CB Insights report "Amazon Strategy – Healthcare", CNBC

CVSHealth 20

For internal use only – pending legal review


1
PillPack
an amazon company
Digital Pharmacy
Pharmacy as a Service
PillPack launched Pharmacy OS platform that connects pharmacy ecosystem and is reportedly pitching it to 3rd parties*
Pharmacy OS is the operating system designed for the modern pharmacy experience; Flexible APIs allow to easily integrate the platform
1
Prescription management
• Renew: Automated workflow that connects with prescribers in advance of prescription renewals to ensure a customer never runs out of refills
• Automated Rx data entry
• Pharmacists have complete view of patients medications
2
Insurance Management
• Insurance checks on new prescriptions
• Automated process for running insurance claims and utilizing lowest possible cost
• Proprietary systems that trigger targeted interventions designed to help high-risk populations
PAYERS
Authorize
Check
DOCTORS
Renew
Capture
PharmacyOS
Support
Update
CUSTOMER
Optimize + Dispense
PILLPACK
4
Medication delivery
• All Rxs are synchronized
• Mailed as a single shipment
4
Customer communication
• Internal communication tool PharmacyCRM automates SMS, email, and phone notifications
• Single view into all prescriptions, bills, and shipments with a 24/7 pharmacy support
* - PillPack has reportedly approached Livongo to serve as a backend fulfillment platform and Lemonaid in some capacity (details not known)
Digital
©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary
CVSHealth
21
For internal use only – pending legal review

Alto Pharmacy has proven the success of its model in the West; it has landed funds to expand nationwide and diversify offerings

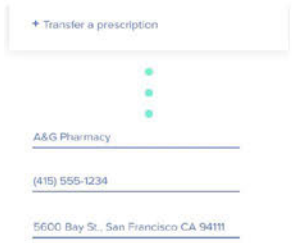
Company Milestones

2015-2017	• Founded as an online pharmacy to serve the Bay Area • Offers free same day delivery • Expands to LA and Orange County in 2016 with $25M in series B funding
2018-2019	• Best in class automation allows each Alto pharmacy to cover the reach of 400 chain pharmacies • Raises $50M in series C to expand nationwide and open mail-order service • Plans to launch new products for chronic and complex therapeutic areas (to-date launched Fertility and HIV offerings)

Key Features

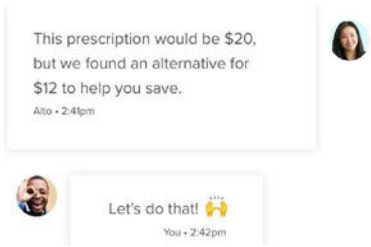
1 Send prescription from anywhere

- Tell the doctor to send e-script to Alto
- Or transfer existing prescription in the Alto app
- Alto does the rest (coordinates with insurance and understands treatment)



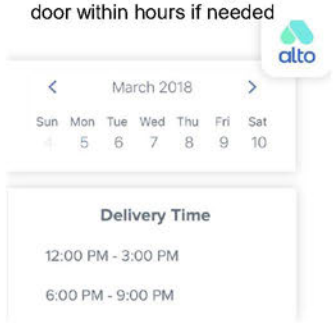
2 Choose best medications

- Finds ways to save on prescriptions



3 Schedule delivery

- Alto couriers arrive at patients door within hours if needed



©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011032

3 CAPSULE

Digital Pharmacy | Pharmacy as a Service

Capsule has developed a "branch-less" pharmacy with frictionless customer experience; it's gaining traction in NYC with plans to expand

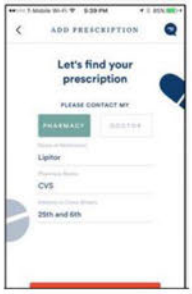
Company Milestones

2018	• Revenue growth of 3.5x, reaching $100M • Tens of thousands of new customers in NYC
2019	• Plans to double employees and expand nationally • Wall Street has identified Capsule as likely acquisition target for large drug chains

Key Features

1 Easy On-Boarding

- New Rxs e-prescribed from doctor
- Transfers coordinated within one day
- Text confirmation
- Insurance card image capture



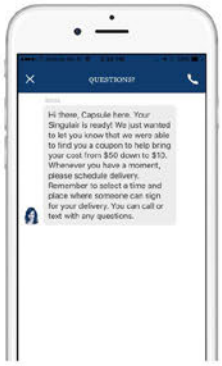
2 Improved Rx Management

- Clean interface for Rx view, including co-pay information
- Easily schedule drop off time, signature required by someone
- 2 hour delivery anywhere in NYC



3 24/7 Customer Service

- Pharmacists available by phone call or SMS for medication questions



Digital

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

CVSHealth

For internal use only – pending legal review

NowRx is an on-demand pharmacy that delivers prescriptions to the customer, either same-day for free or within 1-hour for a $5 service fee

Company Milestones

2015-2017	• Founded in 2015 as an online pharmacy in the Bay Area • 400 Bay Area doctors in the network • Low cost business model due to automation and low fixed overhead cost
2018	• Raises $7M in Series A to expand to new areas in CA • HIPAA compliant healthcare app for voice ordering Rxs through Amazon Alexa (now also HIPAA complaint) and Google Home

Key Features

1 Removed friction

- Platform handles Rx directly from providers
- Patient is notified to confirm copay

2 View order status in real time

- View copay and track order status

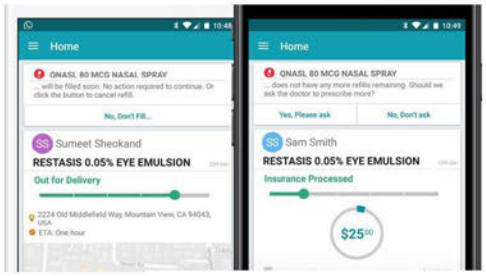
3 "Alexa, open NowRX'

- Video chat with the pharmacist
- Refill or renew a prescription with the voice command

To use NowRx services for any of your pharmacy needs:

Call or Text us on:
844-466-6979

You can also download the NowRx app from your mobile device. We'll take care of the rest.



©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00011034

1 BLINK HEALTH

Digital Pharmacy | Pharmacy as a Service

More players are adjusting their models to serve niche areas of Pharmacy as a Service value chain

Blink Health is a platform that enables users to search for medical prescriptions online and pick them up from partner pharmacies

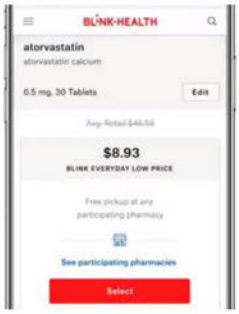
Company Milestones

2014 - 2018	• Launched in NYC as a marketplace to compare Rx prices and fill them at partner pharmacies • $165M total funding raised • Multiple law suites settled due to questionable public claims
2019	• Focus on scaling the platform • Adds three former Amazon leaders in senior executive roles • Expands offerings: Launches online consultations for men's health drugs

How it works

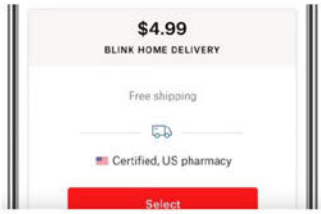
1 Search for medication

- Find medication at a **lowest price**
- **Pay online**



2 Choose delivery option

- **Free pick up at a partner pharmacy** that filled a Rx for BlinkHealth
- **Home delivery** with free shipping (4+ days on average via USPS)



3 Fill Rx at a partner pharmacy

- If in-store pick up is selected, present proof of purchase to the pharmacists and pick up the Rx
- **35,000 partner pharmacies nationwide**



© 2019 CVS Health Confidential & Proprietary

Sources: Bloomberg

CVSHealth

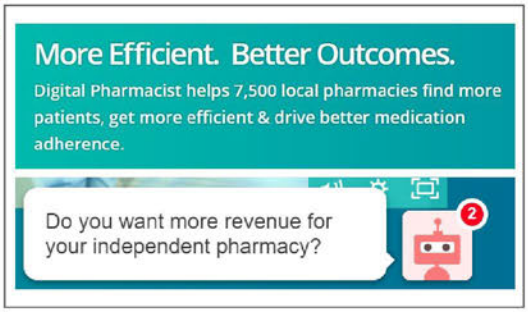
CONFIDENTIAL TREATMENT REQUESTED

Digital Pharmacist company profile

Digital Pharmacist powers digital communication and adherence solutions for over 7,500 pharmacies

Company Milestones

2012 - 2018	• Launched in Austin as a marketplace to compare Rx prices and fill them at partner pharmacies • $12.2M total funding raised • Enables over 1,300 specialty and community pharmacy websites, mobile applications and email newsletters
2019	• Raised over $100M+ in Private Equity round • Focus on scaling the platform to support high demand from independents



How it works

1 Digital services

- Offers branded HIPAA and ADA-compliant websites and mobile apps for medication management
- Provides two-way messaging services between pharmacists and patients

2 Communication (IVR) services

- The only inbound and outbound IVR system for independent pharmacies hosted on Google Cloud
- Compliant with 70 different pharmacy management system
- No set up fees

3 Adherence and Clinical solutions

- Provides integrated refill reminders
- Improves education through high-quality health information and classes

© 2019 CVS Health Confidential & Proprietary

NimbleRx is reinventing its business model to serve independent pharmacies with a competitive delivery and digital pharmacy offering

Original business model (2014 – 2019)

Full service pharmacy

- Accepted doctor eRx orders / patient delivery
- 6 physical pharmacy locations in Bay Area

New business model (January 2019)

On demand drug delivery platform

- **Aims to be the go-to on demand delivery company for the 20K+ independent pharmacies in the US**
- Shut down 6 Bay Area pharmacies and cut ~50% staff
- 600 pharmacies reportedly signed up since Jan 2019

Example Pharmacy Relationship:

BARTELL DRUGS Powered by Nimble

$6.99 delivery & $0.99 service fee charged to customers for Nimble service

New Model: How it works

1. Independent Pharmacy sends NimbleRX patient prescription information



2. NimbleRx contacts patient to schedule delivery and fills a Rx
3. Prescription is delivered to the patient's home or office the same-day (in select locations)



4. Patient can view and manage prescriptions via NimbleRx app



Sources: CNBC, Crunchbase.com

© 2019 CVS Health Confidential & Proprietary

CVSHealth

4 phil

Digital Pharmacy | Pharmacy as a Service

Phil provides end-to-end specialty prescription management and delivery service, connecting all stakeholders in the specialty pharmacy ecosystem

Company Milestones	
2015	• Launched as a Rx management and delivery platform in CA • In 1st year scaled from CA to 18 states to cover 2/3 of US population
2019	• Lands $25M in series B funding (May 2019) • Shifts **focus to Specialty pharmacy** • Connects patients, pharmacies, prescribers, and manufacturers across 50 states • Over 36,000 doctors in Phil network

Value Proposition

Patients

Patient Benefits

- Claims **lowest pricing** on most Specialty Rx
- **Free overnight delivery**
- **Amazon Prime-like experience**: online delivery tracking and refill scheduling
- 24/7 patient support

Pharmacies

Partner With Phil to Grow Your Specialty Business

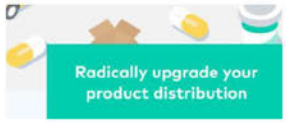
- **Access to thousand of new customers:** platform connects independent pharmacies with patients
- **Zero upfront costs**: pharmacies pay only after customers use Phil software

Prescribers

Prescriber Benefits

- **One stop shop for all Specialty Rx**
- Simplified prior authorizations
- **Real time tracking** of every Rx in single screen
- Claims 56% **improvement in adherence** (compared to retail pharmacies)

Manufacturers



- Improve Rx fulfillment rate
- More **control over patient experience**
- Prevent unauthorized switching
- Comprehensive data access

Sources: Crunchbase.com, Highya

© 2019 CVS Health Confidential & Proprietary

CVSHealth

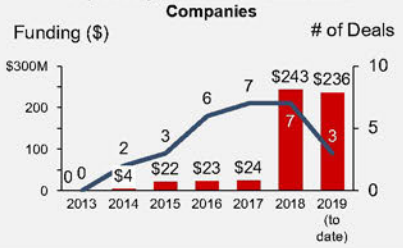
TruePill raises $10M in series B, plans to grow telemedicine market and expand to UK with fresh funding

TruePill is "AWS for pharmacies" - TechCrunch.com

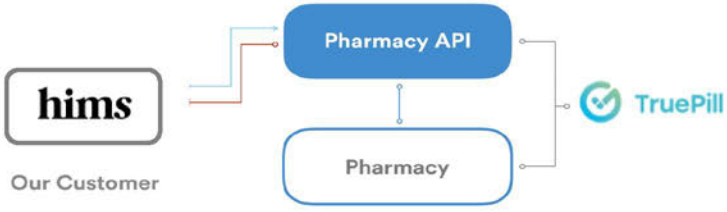
New telemedicine companies are changing the way patients find care and receive prescriptions:

- YoDerm — DERMATOLOGY
- nurx — BIRTH CONTROL
- LEMONAID — MANY CONDITIONS
- hers — FEMALE HEALTH
- hims — MALE HEALTH
- Dear Brightly — PERSONALIZED SKINCARE
- pandia health — BIRTH CONTROL

Top 10 Asynchronous Telemedicine Companies



TruePill has built the "white label" fulfillment platform to become a digital "pharmacy for others" (B2B2C)



- TruePill has reportedly filled over 1M of birth control, erectile dysfunction, and hair loss treatment medications since 2016
- Company plans to build the next generation of the pharmacy infrastructure powering the shift in telemedicine industry

Source: Techcrunch.com

© 2019 CVS Health Confidential & Proprietary

For internal use only – pending legal review

Asynchronous telemedicine start-ups are aiming to redefine convenience with one-stop diagnosis and delivery

Diagnose

A significant 2018 increase in investment $….

Top 10 Asynchronous Telemedicine Companies

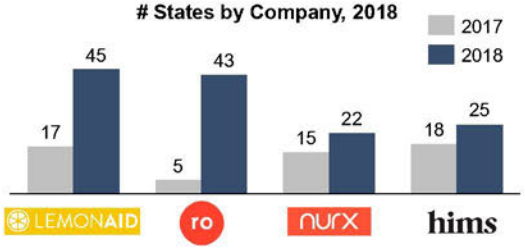


Valuation by Company, 2018

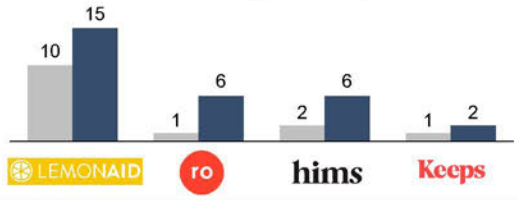
	Company	2018 Funding	Valuation
1	hims	$197M	$1B
2	(Roman)	$91M	$105M*
3	nurx	$41M	$99M
4	Keeps	$23M	N/A
5	(The Pill Club)	$62M	N/A

…has led to rapid asynchronous telemedicine expansion

 # States by Company, 2018



 # Conditions by Company, 2018



Deliver

TruePill

- Operational hurdles of filling Rxs and delivering are left to third parties
- TruePill is the leading example of a company functioning as the "pharmacy for others"

Sources: 1 - CB Insights; 2 - Crunchbase.com, 3 – Marketingsherpa.com, 4 – Healthcare-informatics.com; *Estimated based on estimated revenue and multiplier of 3.5x

Digital

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

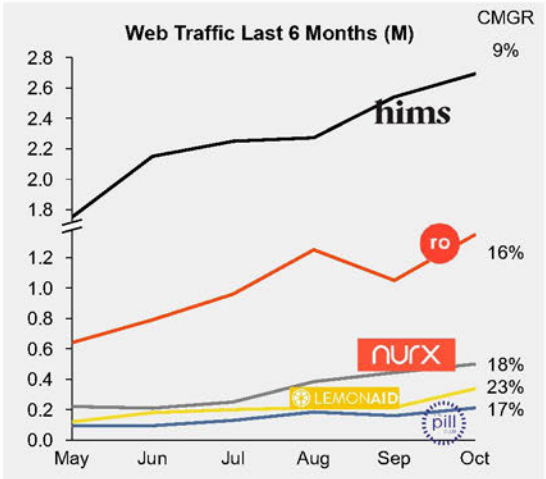
CVSHealth

For internal use only – pending legal review

For internal use only – pending legal review

Asynchronous telemedicine players are creating an opportune window to seriously enter the space

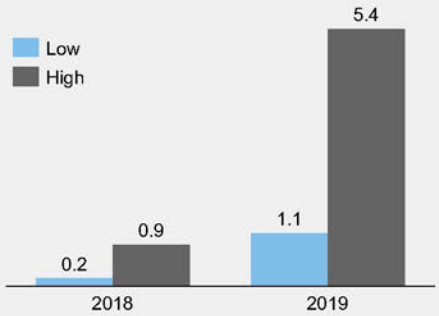
…RESULTING IN INCREASED TRAFFIC AND UNIQUE MONTHLY USERS…



…THAT COULD RISK >5M PRESCRIPTIONS FROM OUR OTHER BUSINESSES

Asynchronous players are growing the market and taking share by prescribing and filling, particularly for conditions with recent generic introductions (e.g., ED and BC)

Headwind Scripts from Asynchronous Players (M)*



Source: Similarweb; CVS Analysis

* Assumes: 1-5% conversion for a monthly active user; top 10 players = to 90% of the market; 14.6% CAGR; 25% CVS fair share

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011041

For internal use only – pending legal review

TruePill's clients are growing rapidly with high valuations

	hims	ro	nurx
Description	E-commerce brands for **men's health** (hair loss, ED, etc.) and **women's health** (birth control, skin care, etc.) products with prescriptions available through telemedicine consults	Script led telemedicine service with three separate services for **men's health, smoking cessation**, and **menopausal/post-menopausal health**	Women's health company with telemedicine consults for **birth control, STI testing, and HIV prevention**
Traction & Growth	▪ Launched Hims in 2017, grew to add Hers in 2018 ▪ Within first 5 months of launch reportedly brought in $10M revenue	▪ Launched in 2017 ▪ Expanded to smoking session in 2018 and menopause in 2019	▪ Launched in 2015 with birth control only ▪ Expanded to STI Testing and HIV prevention in 2018
Funding & Valuation			

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

https://www.gq.com/story/hims-millennial-erectile-dysfunction-200-million

For internal use only – pending legal review

Company Overview: Truepill

TruePill is a back-end pharmacy management and fulfillment service for digital pharmacies

COMPANY BACKGROUND

Background Information

- Founded in 2017 in CA
- Public launch March 2019
- 8 developers, >100 pharmacy/distribution workers
- Founder: Umar Afridi – Former Pharmacist

Funding

- $13.4M raised
- Latest round Series A closed March 2019

Current Status

- Licensed in all 50 states and Washington DC
- Purchasing direct from drug manufacturers with negotiated Net 30
- 50K prescriptions per month with 2.6M Revenue in March 2019 with a reported 25% MoM growth
- 60% cash paying customers (April 2018)
- 7000 sq. ft. facility with capacity to fill 50K orders per day
- Partnerships established with digital pharmacies and "new wave" telemedicine companies

PRODUCT OVERVIEW

Product Components

- APIs for partners to send information and receive real-time tracking, status, etc.
  - API also includes co-pay price checking
- Pharmacy management tool built for working with partners
- Pharmacy fulfillment center with capability to customize packaging for each partner

"Pharmacy as a Service" BUSINESS MODEL

Economic Model

- API is available for free
- Revenue: SaaS subscription, dispensing fee, and fulfillment margin

Value Proposition for Partners

- Full back-end for digital pharmacies including software and drug fulfillment
- Customizable packaging / branding
- License allows roll out to all 50 states from day one

Notable Partnerships

nurx — Fulfilling majority of prescriptions with the exception of out-of-network

hims — All of hair loss medications, OTCs, and ED

pandia health

roman

ZappRx

phil

TowerView Health

LEMONAID

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

For internal use only – pending legal review

Valuation Methodology & Key Assumptions

Methodology

- Evaluated comparable public companies and precedent M&A transactions within three industries: Retail Pharmacy, E-Commerce, and Healthcare IT
- Calculated a unique weighted average of the EV/Revenue multiples for TruePill and Capsule based their business models (see category weighting in the assumptions below)
- The range for high vs. low on each multiple estimation is .2X
- Multiples were applied to the estimated 2018 revenue to calculate the valuation range

Key Assumptions

Truepill

- **Estimated Revenue**
  - $50M in 2018
  - Source: TruePill reported $2.6M revenue in March 2018 and we applied a 10% MoM growth rate
- **Category Weighting**
  - Retail Pharmacy: 50%
  - E-Commerce: 20%
  - Healthcare IT: 30%
- **Funding Information**
  - $13.5M raised in venture capital
  - Most recent round Series A in 3/19

CAPSULE

- **Estimated Revenue**
  - $100M in 2018
  - Source: Capsule reported they are in the "hundreds of millions" after 3.5X revenue growth in 2018 and are similar in size to Pillpack which was reported to have $100M in revenue in 2017
- **Category Weighting**
  - Retail Pharmacy: 50%
  - E-Commerce: 35%
  - Healthcare IT: 15%
- **Funding Information**
  - $70M raised in venture capital
  - Most recent round Series B in 8/18

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011044

For internal use only – pending legal review

DRAFT

Summary of Trading Comparables

($ in Millions)

Company Name	Enterprise Value (EV)	EV/Revenue		EV/EBITA	
		2018	2019	2018	2019
Retail Pharmacy Comparables					
Walmart	342,635.8	0.7x	0.7x	10.4x	10.6x
The Kroger Co.	33,797.0	0.3x	0.3x	6.5x	6.3x
Rite Aid Corporation	3,623.5	0.2x	0.2x	6.6x	6.8x
Walgreens Boots Alliance	68,223.0	0.5x	0.5x	8.9x	7.8x
CVS Health Corporation	137,420.5	0.7x	0.5x	11.1x	8.0x
Retail Pharmacy Averages	117,140.0	0.5x	0.4x	8.7x	7.9x
E-Commerce Comparables					
eBay	$38,917.6	3.6x	3.6x	13.0x	9.7x
Groupon	1,416.4	0.5x	0.6x	9.4x	5.3x
Wayfair	13,387.4	2.0x	1.5x	(33.1x)	(48.7x)
Etsy	7,813.8	12.9x	9.9x	79.9x	39.9x
Overstock.com	474.7	0.3x	0.3x	(2.5x)	(5.7x)
E-Commerce Averages	12,402.0	3.9x	3.2x	13.3x	0.1x
Healthcare IT Comparables					
Medidata	$5,274.2	8.3x	7.1x	61.3x	29.1x
AllScripts	2,225.8	1.3x	1.2x	31.9x	7.3x
Teladoc	3,939.5	9.4x	7.3x	(139.7x)	134.0x
Cerner	20,333.3	3.8x	3.5x	16.8x	12.0x
Healthcare IT Averages	7,943.2	5.7x	4.8x	(7.4x)	45.6x
High		**12.9x**	**9.9x**	**79.9x**	**134.0x**
Median		**1.0x**	**0.9x**	**9.9x**	**7.9x**
Average		**3.2x**	**2.6x**	**5.7x**	**15.9x**
Low		**0.2x**	**0.2x**	**(139.7x)**	**(48.7x)**

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

Summary of Relevant Precedent Transactions

($ in Millions)

Announced Date	Target	Buyer/Investor	Description	Enterprise Value	EV/ LTM Rev	EV/ LTM EBITDA
Retail Pharmacy Transactions						
8/6/14	Alliance Boots GmbH	Walgreens Boots Alliance	Retail Pharmacy	$36,622.7	0.9x	14.4x
12/16/15	Target (Pharmacies)	CVS Health	Retail Pharmacy	$1,900.0	NA	NA
6/13/18	CarePoint Partners, LLC	BioScrip, Inc.	Specialty Pharmacy	$221.1	1.6x	NA
11/17/18	Leehar Distributors, Inc.	Diplomat Pharmacy, Inc.	PBM	$595.6	1.5x	14.5x
E-Commerce Transactions						
11/7/16	Blue Nile	Bain Capital	E-Commerce	$456.2	1.0x	27.8x
5/4/17	Grays eCommerce	Leasing Finance	E-Commerce	$133.6	1.3x	13.4x
4/10/17	RetailMeNot	Harland Clarke	E-Commerce	$455.1	1.5x	14.8x
5/31/17	Chewy	Petsmart	E-Commerce	$3,350.0	3.7x	NA
6/30/17	Bonobos	Walmart	E-Commerce	$310.0	2.5x	NA
Healthcare IT & Digital Health Transactions						
6/26/15	NantHealth	Allscripts	Healthcare IT	$200.0	3.3x	NA
1/20/17	M3	Goldman Sachs	Healthcare IT	$10,807.7	13.1x	39.7x
2/8/18	Patient Access Solutions	Kange Corp	Healthcare IT	$6.2	3.2x	NA
6/6/18	Best Doctors	Teladoc	Healthcare IT	$440.0	4.4x	44.9x
6/28/18	PillPack	Amazon	Retail Pharmacy / HC IT	$753.0	7.5x	NA
High					**13.1x**	**44.9x**
Median					**1.5x**	**14.7x**
Average					**3.1x**	**22.5x**
Low					**0.7x**	**10.8x**

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

For internal use only – pending legal review

CVS Digital Pharmacy API has potential to provide a unique and attractive value proposition for a variety of audiences

Potential Customers

- **Asynchronous Telehealth**: Provide services such as same-day delivery for acute and last min customers
- **Synchronous Telehealth**: Provide services such as same-day delivery for acute and last min customers
- **Adherence & Savings**: Enable additional services such as initiating Rx and delivery to enable full end-to-end experience (e.g. GoodRx) and prevent gaps in therapy (e.g. Medisafe)
- **Health Plans/Employers**: Provide digital pharmacy services to help members access, obtain, and adhere to therapy
- **Independent Pharmacies**: Provide services such as same-day delivery that small players do not have infrastructure to support
- **Specialty Pharmacies**: Provide services such as same-day delivery, highly critical for Specialty patients

Competitors

PillPack — Acquired by Amazon. Will likely be integrated into Prime soon (ultimately, free same-day delivery and eventually in hours). Can combine with OTC offerings.

Truepill — Current dominant player (have processed >1MM prescriptions). Customers include healthcare organizations and recent expansion into D2C digital health (Lemonaid, NuRx, HIMs). Offer customized packaging and branding and online dashboard.

Why We Can Win

- **Price:** Digital pharmacies are charging high premiums for convenience of back-end fulfillment. Bloomberg reported async players charge a 6x mark-up. Mia's paid $180 for Latisse fulfilled by TruePill vs. GoodRx price $60.
- **Same-Day Delivery**: We can offer same-day (Shipt) and 1-2 day delivery nationwide. Truepill's fastest shipping option is 4-6 days.
- **Adherence:** We have unparalleled adherence tools and success metrics.
- **Retail Presence**: We have ~9,800 locations across the US, while others do not have a physical footprint.
- **Access to Pharmacists**: We have a vast network of pharmacists to provide customer support
- **Brand Equity**: The CVS brand name is well-known and reliable in a space that relies on trust

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

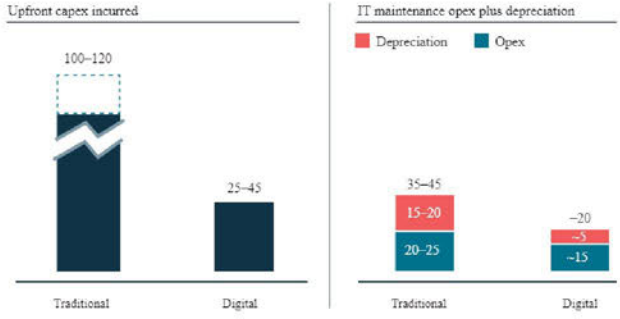
For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED

Financial Services Analog: Traditional banks are launching digital-only brands to attract new audiences

- Traditional banks are launching digital-only brands as a way to attract new, digitally-oriented, customers and defend against increasing competition from fintechs (e.g. Wealthfront)
  - Per Forrester, these digital banks have embraced mobile to create differentiation, using digital touchpoints to offer simple, convenient, and more personalized customer experiences combined with relevant guidance and advice
  - Examples include: Marcus by Goldman Sachs, Finn by JP Morgan Chase, Bo by RBS, Greenhouse by Wells Fargo, Hello Bank by BNP Paribas, DBS Digibank, and HSBC's "Project Iceberg"

- According to McKinsey, digital-only banks require ~1/4th of upfront IT CapEx and ~1/2 the OpEx + Depreciation
  - Lower cost due to absence of physical branches, simplified up-front product offerings, and more streamlined processes that reduce need for expensive legacy systems



"We are trying to do with the brick-and-mortar traditional retail banks what Amazon did to the retail brick-and-mortar industry, or iTunes did to the music industry" - Harit Talwar, Head of Consumer, Goldman Sachs

We were ready to create something from scratch that our customers are looking for." - Omer Ismail, Head of U.S. Consumer Business, Goldman Sachs

"We wanted to deliver the best of both worlds, the best customer experience and the capabilities of a big bank. We continue to use our back end without impacting the front end" – Andy Maguire, COO HSBC

Digit…

Source: McKinsey "Building a Digital Banking Business"

©2019 CV… …/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CVSHealth

CONFIDENTIAL TREATMENT REQUESTED

Financial Services Analog: Disparity in strategies explain why Goldman Sachs' Marcus is thriving, while JPM's Finn was shuttered

	finn by CHASE	Marcus: BY GOLDMAN SACHS
# of Customers	• 47K (June 2019)	• >4MM (June 2019)
Value Proposition	• Low Interest Rate: 0.1-0.4% • New, digital features (e.g. auto-save, which was eventually rolled out in main JPM Chase app) • Free access to Chase ATMs • Digital sign-up	• BIC Interest Rate; 2.25% • Fully customizable loans (no set term, adjustable monthly payment etc) • No fees – ever • $1 min deposit
Executive Commitment	• Team of only 50 employees • Sparingly mentioned on earnings calls • Limited marketing for Finn while rapidly expanding branch footprint • Positioned as testing ground to pilot digital services to bring back to primary user base • *"With Finn, we're able to learn from that audience really well. We work with [the Finn team] and their user research and then work to scale [our app] to the rest of our customers."*	• Team of 700 employees as of February 2018 • Invested $1.1B to build Marcus tech & brand • Declared goal to grow to 30-50MM customers • Acquired Clarity Money for $100MM (uses AI to provide personalized financial suggestions) • CEO, Lloyd Blankfein, makes calls to Marcus customers to ask about their experience (typically only made to large funds & corp.) • Advertised during NFL playoffs – never done before
Differentiation from Parent Brand	• Built on top of existing mobile app infrastructure with little differentiation in features / functionality • Rolled out online-only account open process, similar to Finn's, blurring distinction between the two offerings • Not fully digital - still relied on some manual and paper-based processes	• Distinct brand / site look and feel • Marcus' tagline "You Can Money" is very different from the stodgy GS brand • Marketed to mass / youth vs. elite / older • Chose the name Marcus "felt fresh and had a sense of modernity to it, conveying that this was a digital offering (vs. traditional)"

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011049

Financial Services Analog: Five principles for success with digital-only brands

- **Provide market-leading value proposition to draw consumers from traditional players**
  - Leading digital-only brands address a primary need or "delight" customers by solving a pain point unaddressed by current offerings[1]
    - Consumer research was key in building Marcus by Goldman Sachs. The company talked to >10K consumers, both qualitatively and quantitatively, to help build the product[2]
    - For example, Revolut allows users to send, receive, and split bills in around 25 currencies, with other customers using the geolocation-based "nearby" feature[1]
- **Secure strong executive support and commitment**
  - "Number one [secret to building a new digital bank within a large existing bank] is having full support from the chief executive and the chairman. Unless the CEO is driving the vision, there's no point in starting, and the board needs to be willing to back the CEO." – Mark Bailie, CEO of Bo (RBS)[3]
- **Ensure true differentiation between parent and new digital-only brand**
  - The absence of an overarching strategy that outlines how the digital bank complements the parent core business (e.g., targeting a different segment; offering a distinct set of products) is likely to cause conflict and loss of revenues and customers for both entities[1]
- **Use data and analytics extensively across the value chain**[1]
  - Leading digital banks use data (collected directly from customers and sourced from third parties) and advanced analytics techniques to automate decisions across the end-to-end banking value chain—leading to higher accuracy and efficiency at scale, while delivering a superior customer experience[1]
- **Monetize key assets through B2B2C models**[1]
  - Digital-only companies can generate additional revenues by licensing white-labelled technology solutions to other organizations[1]
  - BankMobile, a US-based digital bank, provides around 800 universities with white-label technology for distributing financial aid refunds to students and Moven offers spend-tracking solutions that can be integrated in other banks' digital apps[1]

Sources: 1) McKinsey "Ten Lessons for Launching a Greenfield Digital Banking Business" , 2) CMO.com, 3) Oliver Wyman interview

©2019 CVS Health and/or one of its affiliates: Confidential & Proprietary

For internal use only – pending legal review

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011050

Exhibit 40:
CVS_HJC_00011061 Industry research about Blink Rx


IMS Health & Quintiles are now
IQVIA™
Discount and Cash Program Assessment on Patient Utilization
Phase II Executive Summary
January 28th, 2019
Copyright © 2017 IQVIA. All rights reserved.

Table of Contents

+ **Executive Summary**
+ Next Steps
+ Selected Supporting Data

CONFIDENTIAL TREATMENT REQUESTED

Key findings to-date in discount card utilization investigation

- In the generic Statins market, discount cards account for about 2% of volume, and cash another 3%
  - These utilization rates are comparable to most other generic markets
  - Top discount card programs by volume include: GoodRx, United Networks, ScriptSave, SingleCare, & Paramount
- In Phase 2, patients that started with an insured fill and then switched to a discount card became the primary patient segment of interest
  - Of the 37 million observed patients filling a generic Statin in 2017, these patients accounted for 2% of the population, with 92% of patients only filling with insurance
  - In tracking patient activity following a discount card switch, patients at CVS pharmacies were more likely to switch back to insurance than patients at other retail pharmacies
- Most (56%) patients that switched from insurance to a discount card did so after a rejection or reversal,
  - 40% are rejected; 10% have a OPC decrease; 11% are reversed with the same/higher OPC; 38% have the same/higher OPC
- CVS patients paid a higher out-of-pocket cost for a discount card than other retail pharmacies
- 90% of patients who switched from insurance to a discount card did so without also switching pharmacies
  - Patients at CVS switched pharmacies for a discount card at an even lower rate of about 5%
  - Those patients that do switch pharmacies are switching to food store-type pharmacies at the highest rate

Source: IQVIA US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

CONFIDENTIAL TREATMENT REQUESTED

Table of Contents

+ Executive Summary
+ **Next Steps**
+ Selected Supporting Data

CONFIDENTIAL TREATMENT REQUESTED

Based on Phase II findings, IQVIA proposes revising the initial analyses planned for Phase III

1. Selected Phase II metrics across markets
   - Prevalence of patient type
   - Avg. OPC for insured vs. discount fills
   - CVS pharmacy switching
     - CVS patients may switch for certain discount cards not available at CVS
     - If CVS patients switch, where do they go and do they fill other Rx at non-CVS stores

2. Patient categorization based on total prescription costs
   - Including comorbidity therapy use and cost

3. Identify outlier therapies, where cash/discount fills despite insurance occur more

Source: US Market Access Strategy Consulting analysis

CONFIDENTIAL TREATMENT REQUESTED

Other potential business questions

- For patients who switch pharmacies:
  - When patients switch to discount cards are they also switching their plans? Are they changing plans within the same payer? What is the distribution of plan/payer switching by month?
  - What are the patient ages – are patients switching from Commercial to Med D? Are most of these patients falling into the category of age 65?
- When patients pay more:
  - What is the distribution of patients paying more and less? How much more?
  - For patients who pay significantly more, were these patients more likely to have changed plans and been in a hole?
  - Were patients in a co-pay/deductible situation?
- Are there differences if we look at patients who use discount cards for a therapeutically equivalent statin?
- Are patients who pay less more likely to stay on discount card? Are patients who pay more, more likely to come back to plan?
- Are there geos/ at risk geos that are more likely to have seen switched to discount care, then moved back to plan?
- After deep dive – would CVS want to conduct Primary Research to validate what is happening with patients?
  - What was their experience? Why did they start using it?

Source: US Market Access Strategy Consulting analysis

CONFIDENTIAL TREATMENT REQUESTED

Table of Contents

+ Executive Summary
+ Next Steps
+ **Selected Supporting Data**

CONFIDENTIAL TREATMENT REQUESTED

Based on various evaluated criteria, the statin market was selected for prototyping phase II analyses

Potential Phase II Market	Cash Discount Volume	Cash Discount Utilization Rate	% Cash Discount by Insured Patients	% Cash / Discount / Coupon Mix	Average Number of Scripts	Average Final Out-of-Pocket Cost (OPC)	Other Considerations
SSRI/SNRI	7.5M	3%	46%	3% Cash / 3% Discount / 1% Coupon	6 Claims	$21 Cash / $14 Discount / $5 Commercial	Skewed towards certain demographics
Hypertension	4.8M	2%	42%	3% Cash / 2% Discount / <1% Coupon	6 Claims	$22 Cash / $12 Discount / $4 Commercial	Representative cross-section of US
Vascular Agents	5.9M	3%	40%	4% Cash / 3% Discount / 1% Coupon	6 Claims	$8 Cash / $8 Discount / $4 Commercial	Lower cost drugs (based on average cash OPC)
Statins	4.1M	2%	44%	3% Cash / 2% Discount / <1% Coupon	5 Claims	$17 Cash / $10 Discount / $4 Commercial	Important for CVS pricing decisions
Blood Factors	2.4M	10%	85%	23% Cash / 10% Discount / 1% Coupon	4 Claims	$5 Cash / $5 Discount / $3 Commercial	OTC competition, lower cost drugs
Obesity	2.1M	28%	76%	36% Cash / 28% Discount / 2% Coupon	3 Claims	$27 Cash / $19 Discount / $14 Commercial	Often not covered by insurers
Vitamins	2.5M	6%	82%	17% Cash / 6% Discount / 1% Coupon	3 Claims	$5 Cash / $4 Discount / $2 Commercial	OTC competition, lower cost drugs
Sleep	2.2M	6%	74%	6% Cash / 6% Discount / <1% Coupon	3 Claims	$36 Cash / $18 Discount / $5 Commercial	OTC competition

Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

High discount volume | High discount utilization rate | Moderate discount utilization rate

Confidential – for CVS internal use only

CONFIDENTIAL TREATMENT REQUESTED

Insured patients with insurance and cash/discount fills for a product are the focus for Phase II (Cohort #2)

Product-Level Patient Cohort Creation Criteria (2017)

Patient Cohort Number	Patient Cohort Description	Insurance Status in 2017	Insurance Fills for Product in 2017	Cash / Discount Fills for Product in 2017
1 (Control)	Insured patients with only insured fills for a product	✓	✓	
2A	Insured patients with insurance and discount fills for a product	✓	✓	✓
2B (Control)	Insured patients with insurance and cash fills for a product	✓	✓	✓
3	Insured patients with only cash/discount fills for a product	✓		✓
4	Patients with no insurance with only cash/discount fills for a product			✓

Cohort 2A Subgroup	Cohort Description
A1	Insured then a single discount program fill
B1	Insured then a single discount fill and subsequent insured fills
C1	Insured then multiple discount fills
D1	Insured then a mix of discount program and insured fills
E1	Discount card fill and then insured fills

Cohort 2B Subgroup	Cohort Description
A2	Insured then a single cash fill
B2	Insured then a single cash fill and subsequent insured fills
C2	Insured then multiple cash fills
D2	Insured then a mix of cash and insured fills
E2	Cash fill and then insured fills

Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx dataset

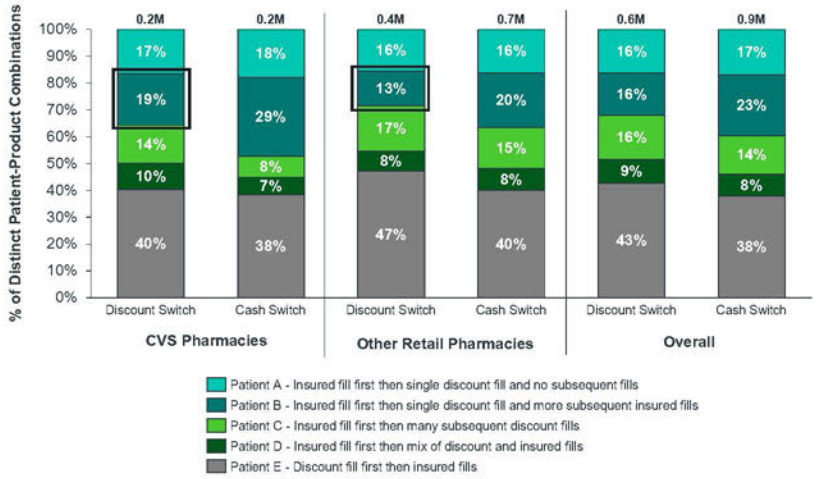
Confidential – for CVS internal use only

IQVIA

CONFIDENTIAL TREATMENT REQUESTED

Compared to the benchmark, CVS pharmacies have a higher proportion of Patient B who revert to filling through insurance after their discount switch

CVS vs. Other Retail Pharmacies Cohort 2* Discount & Cash Switching Behavior



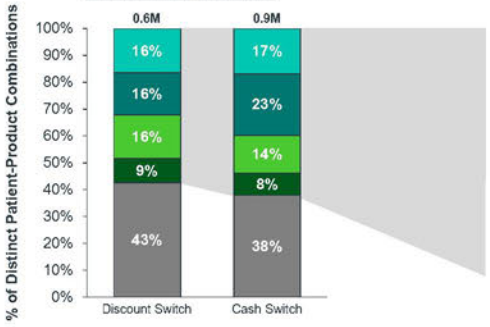
*Patient cohort 2 includes insured patients filling with insurance and cash / discount fills
Note: CVS vs. all other pharmacies assignment is based on the pharmacy associated with the insurance fill prior to the cash / discount switch; mode pharmacy was used for patient E
Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

IQVIA

CONFIDENTIAL TREATMENT REQUESTED

As reviewed previously, patients who switch from insurance to a cash or discount fill pay more for their generic statin on average

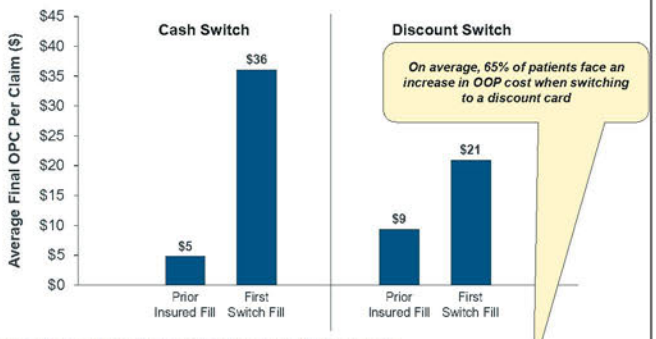
Cohort 2* Cash / Discount Switching Behavior



- Patient A - Insured fill first then single discount fill and no subsequent fills
- Patient B - Insured fill first then single discount fill and more subsequent insured fills
- Patient C - Insured fill first then many subsequent discount fills
- Patient D - Insured fill first then mix of discount and insured fills
- Patient E - Discount fill first then insured fills

Cash / Discount Switch Average Final Out-of-Pocket Cost

(Cohort 2; Top 5 Statin Generics; 2017)



From prior insured fill to first switch fill, percent of patients with:

OPC decrease	7%	20%
Same OPC	18%	15%
OPC increase	75%	65%

*Patient cohort 2 includes insured patients filling with insurance and cash / discount fills
Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

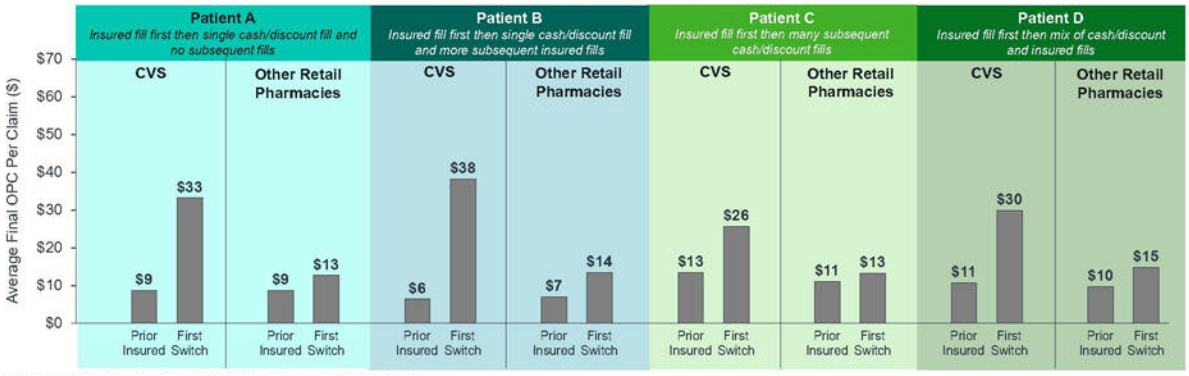
IQVIA

CONFIDENTIAL TREATMENT REQUESTED

Compared to the benchmark, CVS patients have a higher average final OPC when moving to a discount program

CVS vs. Other Retail Pharmacies Discount Switch Average Final Out-of-Pocket Cost by Patient Cohort 2 Subgroups

(Cohort 2; Retail; 2017; Unprojected)



From prior insured fill to first switch fill, percent of patients with:

	Patient A		Patient B		Patient C		Patient D	
	CVS	Other Retail Pharmacies	CVS	Other Retail Pharmacies	CVS	Other Retail Pharmacies	CVS	Other Retail Pharmacies
OPC decrease	15%	26%	8%	22%	25%	27%	18%	20%
Same OPC	3%	17%	3%	26%	5%	14%	3%	20%
OPC increase	83%	57%	88%	52%	70%	59%	79%	60%

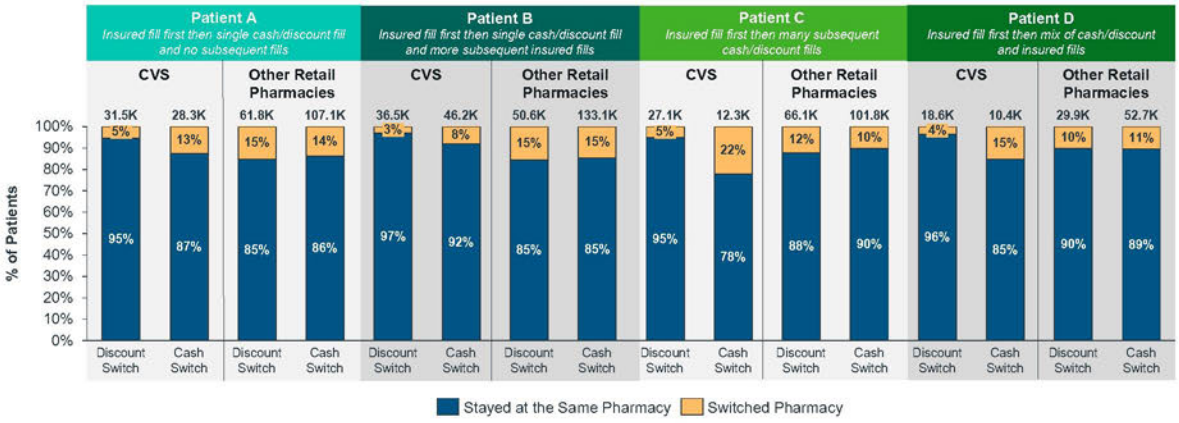
Note: CVS vs. all other pharmacies assignment is based on the pharmacy associated with the insurance fill prior to the cash / discount switch
Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

IQVIA

CONFIDENTIAL TREATMENT REQUESTED

Compared to the benchmark, less CVS patients switch to another pharmacy when switching to a discount card across patient cohorts (~5% CVS vs. ~15% benchmark)

CVS vs. Other Retail Pharmacies Patient Pharmacy Switching at Cash / Discount Switch
(Retail Only, Statins*, 2017)



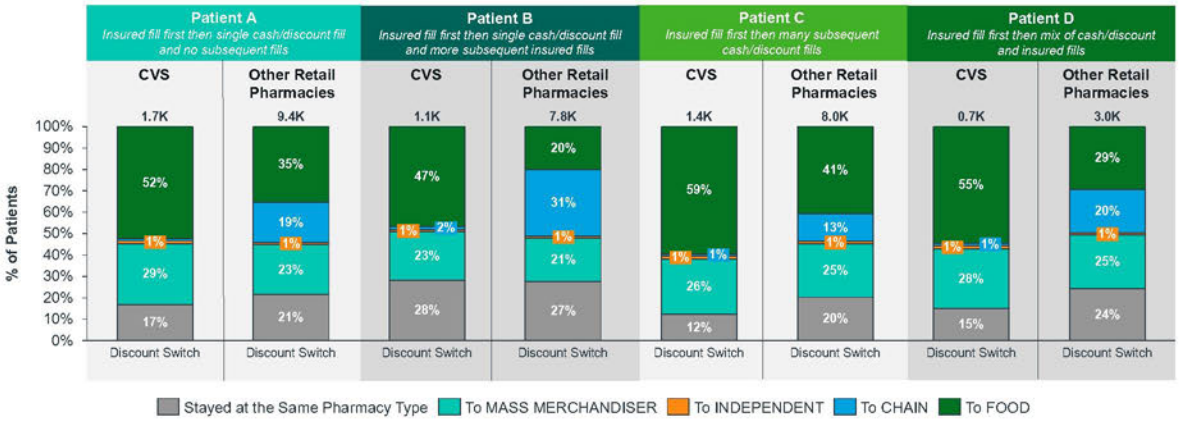
*Products included in the market basket are Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, and Simvastatin
Note: CVS vs. all other pharmacies assignment is based on the pharmacy associated with the insurance fill prior to the cash / discount switch
Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

IQVIA

CONFIDENTIAL TREATMENT REQUESTED

Compared to the benchmark, CVS patients switching to discount cards switch to fill at food store pharmacies at a higher rate

Pharmacy Type CVS vs. Other Retail Pharmacies Patients are Switching to at Discount Switch
(Retail Only, Statins*, 2017)



*Products included in the market basket are Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, and Simvastatin
Note: CVS vs. all other pharmacies assignment is based on the pharmacy associated with the insurance fill prior to the cash / discount switch
Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

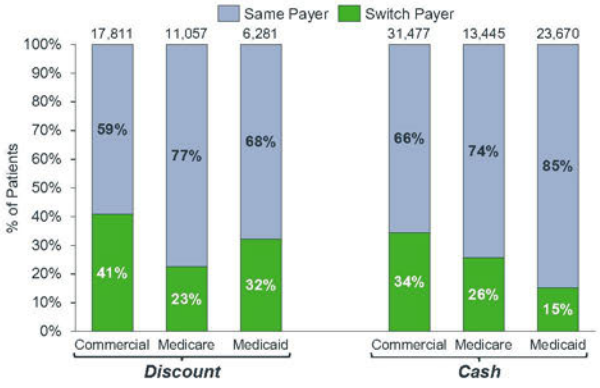
IQVIA

CONFIDENTIAL TREATMENT REQUESTED

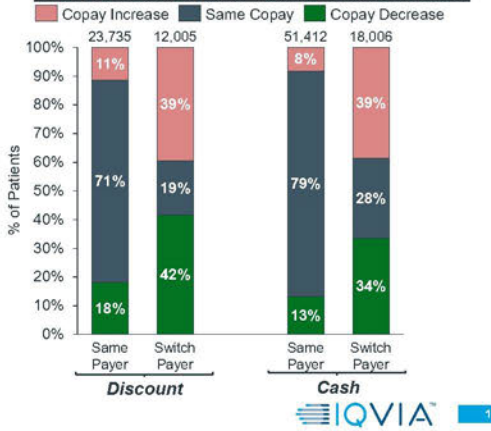
Most patients that switch back to insurance after a cash/discount switch go back to their previous insurer paying the same copay

- Switching from insurance to discount back to insurance does not appear to be driven by switching to a new insurer

Cohort 2, Patient B Payer Switch From Before and After Discount/Cash Switch



Cohort 2, Patient B Payer Switch Copay Change From Before and After Discount/Cash Switch



Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

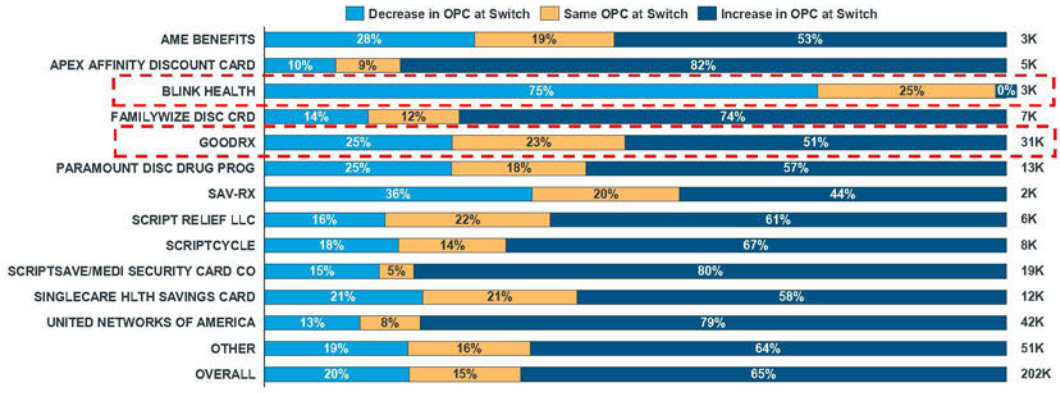
IQVIA

15

Blink Health is the only card that always provides patients with an OPC that is more competitive than the cost of their insured Rx

- Most discount card script costs are higher than what the patient paid on the prior insured claim

Patient OPC Change by Discount Card and Mode Insurance Channel
(Discount Switch, Insured Patients Only, Retail Only, Statins*, 2017)



*Products included in the market basket are Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, and Simvastatin
Source: US Market Access Strategy Consulting analysis; IQVIA Unprojected LRx Dataset

Analysis focused on switching when days supplied is the same to control for differences in units

IQVIA

16

Exhibit 41:
CVS_HJC_00011092 Internal research about Blink Rx

For Internal Use Only

Product Battlecard-Blink Health & BlinkRx

BLINK HEALTH

Overview:

Blink Health partners with prescription medication manufacturers to offer users discounted OOP prices. Services are divided into 2 categories: low-cost generic medications available at 35K+ participating pharmacies, and a digital pharmacy that delivers certain brand-name specialty medications

Key Leaders

- Geoffrey Chaiken (CEO)- founder of Marinus Pharmaceuticals
- Selvam Velmurugan (CTO)- formerly CPO at Aetion with additional experience at AMZN/GOOG
- Michael Nameth (EVP Specialty Pharmacy)- former CEO at Aureus Health Services and EVP at Walgreens
- Variety of other leaders from Groupon and Reddit

Key Services/Solutions

Blink Health: GoodRx-esque offering that provides users with low priced generics through an online discount card service

BlinkRx: Digital pharmacy that lowers prescription drug costs for select specialty medications by analyzing insurance, conducting benefits investigations, and applying manufacturer discounts. Patients fill their script through Blink, receive a text with lowest price, and get free home delivery.

Competitive Differentiation:

- Core mission is to reduce cost of prescription meds via direct negotiations with manufacturers
- Hybrid approach to pharmacy benefits involves not accepting insurance for generics while embracing it for brand-name meds

Key Selling Points

- Offers online consultations for various conditions to those without a current prescription
- Easy user interface with emphasis on medication search/choice of delivery
- Offers a generic price-match guarantee (within 28 days of purchase)

Pitch

"Tell us what medication you need. We'll find the lowest price"

Pricing

- Price match guarantee for generics
- Subscription model for medications prescribed via online consultations (~$10 + cost of medication)

Talking Points:

- Even with direct manufacturer negotiation, Blinks prices are not always lower than other players like GoodRx or InsideRx
- Blink is essentially another drug card with a payment model twist, which could cost members more than a pharmacy's cash price
- Blink has been involved in several lawsuits from MedImpact to former employees/ investors (lawsuits appear to be 2017-2019)
- Online consultation availability varies by condition, age, and location
- Some customers have noted difficulty reaching customer service

Exhibit 42:
CVS_HJC_00011094 Internal email thread between David Joyner and others discussing Blink Rx

From: Kimball, Greggory [redacted]
Sent: 9/27/2024 2:00:53 PM
To: Joyner, David [redacted]
Subject: RE: Blink Health
Attachments: image001.png

Amazing.

Gregg Kimball
[redacted]

From: Joyner, David [redacted]
Sent: Friday, September 27, 2024 9:26 AM
To: Kimball, Greggory [redacted]
Subject: Re: Blink Health

Adding to intel.

Blink's product was a "prepay" cash discount model. They were tapping into "funded" rates for the retail network which are deeper than cash discount networks. That's why the large retailers don't participate.

Likely no one will check this battlecard but an important topic/background for certain congressman being supported by Blink.. Another example of a large PBM not allowing the small guys to compete. What's lost in the headline is fraud.

From: Kimball, Greggory [redacted]
Date: Thursday, September 26, 2024 at 7:47 PM
To: Joyner, David [redacted]
Subject: Fw: Blink Health

Here you go. First I've heard of them.

Gregg Kimball
[redacted]

From: Macias, Charlie [redacted]
Sent: Thursday, September 26, 2024 8:29:50 PM
To: Kimball, Greggory [redacted]
Subject: Blink Health

Hi Gregg,

See attached for an overview of Blink.

There are two offerings…Blink Health is their original offering similar to GoodRx and they have BlinkRx which is a tool that analyzes insurance benefits to help users decide whether to use their insurance for specialty brand-name medications.

I also loaded on Crayon: https://app.crayon.co/act/cvs-health/battlecard/60030/?tileID=472508

Charlie Macias, MHA, CPHQ
Manager, Competitive and Market Insights
CVS Health | [redacted]

Columbus, Ohio



Exhibit 43:
CVS_HJC_00011257 Internal email thread discussing Blink Rx's application to become a certified software vendor

From: Graham, Heather L. [redacted]
Sent: 5/24/2021 2:21:51 PM
To: Mccall, Steven D. [redacted]; Terrel, Jaclyn [redacted]; Haffner, Heidi H. [redacted]
CC: Brady, Eddie [redacted]; Long, Victoria M. [redacted]; Greksa, Edward L. [redacted]; Falcione, Terra [redacted]; Redner, Gina A. [redacted]
Subject: RE: Blink Health

Thanks for all the help everyone.

They are trying to certify with us as a pharmacy software vendor but it doesn't sound like that is what they are.

Upcoming OOO
5/26 PTO
5/31 Holiday
6/1-6/4 PTO

For NCPDP Standard questions, please send an email to NetworkNCPDPInquiries@CVSHealth.com

Heather Graham | Director, Network Standards and Technology, CVS Caremark
CVS Health | [redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

From: Mccall, Steven D. [redacted]
Sent: Friday, May 21, 2021 4:20 PM
To: Terrel, Jaclyn [redacted]; Graham, Heather L. [redacted]; Haffner, Heidi H. [redacted]
Cc: Brady, Eddie [redacted]; Long, Victoria M. [redacted]; Greksa, Edward L. [redacted]; Falcione, Terra [redacted]; Redner, Gina A. [redacted]
Subject: RE: Blink Health

They do digital pricing similar to GoodRx. They would contract direct with pharmacies to advertise their "cash" rates on their apps for a fee for patients that fill.

https://www.mobihealthnews.com/content/early-blink-health-investor-files-30-million-lawsuit-against-company

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Friday, May 21, 2021 12:11 PM
To: Graham, Heather L. [redacted]; Haffner, Heidi H. [redacted]
Mccall, Steven D. [redacted]
Cc: Brady, Eddie [redacted]; Long, Victoria M. [redacted];

Greksa, Edward L. [redacted]; Falcione, Terra [redacted]; Terrel, Jaclyn [redacted] Redner, Gina A. [redacted]
Subject: RE: Blink Health

Hi Heather,

I'm not familiar with them. Just googling it, it appears to be an online, discount vendor that mails. Possibly links a member to a specific pharmacy for the best deal.

+ Heidi and Steve to see if they have any insight.

Thanks,
Jackie

Jackie Terrel, PharmD | Senior Manager, CVS Caremark
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Graham, Heather L. [redacted]
Sent: Friday, May 21, 2021 11:14 AM
To: Redner, Gina A. [redacted]; Terrel, Jaclyn [redacted]
Cc: Brady, Eddie [redacted] Long, Victoria M. [redacted]
Greksa, Edward L. [redacted]
Subject: RE: Blink Health

Gina and Jackie,
We are trying to figure out what this company's business model is. They say they are a pharmacy software company but don't have a user interface for their pharmacy. We can't see how that is possible. Just wondering if you are familiar with them.
Thanks,
Heather

Upcoming OOO
5/26 PTO
5/31 Holiday
6/1-6/4 PTO

For NCPDP Standard questions, please send an email to NetworkNCPDPInquiries@CVSHealth.com

Heather Graham | Director, Network Standards and Technology, CVS Caremark
CVS Health | [redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

From: Long, Victoria M. [redacted]
Sent: Friday, May 21, 2021 1:07 PM
To: Redner, Gina A. [redacted]; Terrel, Jaclyn [redacted]
Cc: Long, Victoria M. [redacted]; Graham, Heather L. [redacted]
Subject: Blink Health

Hi Gina and Jackie,

I am currently working with a vendor Blink Health to testr their pharmacy software certification. Can you research if Blink Health has a contract?

Thanks!

Vicky

Upcoming OOO
5/22 – 5/28 PTO
5/31 Holiday
9/21 – 9/28 PTO

For NCPDP Standard questions, please send an email to NetworkNCPDPInquiries@CVSHealth.com
For ID Card Approval questions, please send an email to NetworkCardApprovals@CVSHealth.com

Vicky Long | SR Consultant, Network Productivity, Standards, and Initiatives, CVS Caremark
CVS Health | [redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Exhibit 44:
CVS_HJC_00011347
BlueCross BlueShield Association audit report

SIU INVESTIGATIVE REPORT

BlueCross BlueShield Association

Investigative Report

Name of Case: Carepoint Pharmacy **Date of Report:** 02/24/2022

Allegation: 1) Questionable Billing - Dispensing High Volume / High-Cost Medications to FEP members throughout the United States. Outlier drugs – Alinia, Xhance, Aplenzin.

2) Acting as a Central Fill Pharmacy for Philrx.

3) Possible Provider Collusion – Outlier physician [redacted]

Potential Violation: 31 U.S.C. § 3729 False Claims Act
18 U.S.C. § 1341 Mail Fraud
18 U.S.C. § 1343 Wire Fraud
18 U.S.C. § 371 Conspiracy
.

Investigator Name: Martha Hughes

Potential FEP Exposure Related to the Allegation: $3,209,866.85

Additional Information

Subjects: Carepoint Pharmacy:
148733 9 Commerce Dr.
Schaumberg, IL 60173
Phone – [redacted]
NCPDP 1487330
NPI - 1598013864
DEA - FC3505534
Tax ID - 460526382
St Lic – 054018043
Web: info@carepointrx.com
[redacted] – President
[redacted] – Corporate Officer
Additional Locations: 1. NPI 1760840664
2. NPI 1144772880
3. NPI 1003345703
4. NPI 1962937193
5. NPI 1487169405

Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.

6. NPI 1083074546

Case Synopsis:

During a review of a high-risk report regarding pharmacies with high dollar billing, Carepoint Pharmacy was identified as/reviewed as an outlier. Several high-cost medications were identified that may have more cost-effective alternatives. The drugs Alinia, Xhance, and Aplenzin were outliers by claims volume compared to all other drugs. It was determined that Carepoint Pharmacy has seven (7) locations all owned by [redacted]. A review of the additional pharmacies showed only high-dollar billing, specifically with dermatological drugs. Letters sent out to members and providers revealed that although Carepoint Pharmacy was billing for the drugs, members were receiving drugs from Philrx. Additional investigation revealed doctors were recommending both Carepoint and Philrx. One outlier physician was [redacted] who used Carepoint Pharmacy for 301 of her 582 prescriptions dispensed or 52%.

Case Narrative:

This pharmacy originally came to the attention of MQA on 9/28/2021, as the result of a cost surveillance review. Carepoint Pharmacy was found to be billing high dollar drugs. A Data run was completed for **8/1/2018 – 9/23/2021**. The results of the 36 months showed:

2296 FEP members
5,908 claims = $1,616,466.62

The top 10 drugs billed accounted for 44% of all claims.

2021 Top 10 Drugs by claims

Row Labels	Count of Drug Name	Sum of Total Paid Amt
ODACTRA	232	40903.49
ADDYI	170	0
SODIUM SULFACETAMIDE/SULF	138	7827.2
DAPSONE	120	10634.62
GRASTEK	118	20238.09
XHANCE	103	40165.32
MINOCYCLINE HYDROCHLORIDE	81	9931.13
DOXYCYCLINE HYCLATE	61	6325.22
ALINIA	58	153413.92
ADAPALENE	49	1597.37

2021 Top 10 Drugs by cost

CONFIDENTIAL TREATMENT REQUESTED

Row Labels	Count of Drug Name	Sum of Total Paid Amt
ALINIA	58	153413.92
APLENZIN	26	42929.46
ODACTRA	232	40903.49
XHANCE	103	40165.32
GRASTEK	118	20238.09
WELLBUTRIN XL	14	15189.7
DAPSONE	120	10634.62
EPIDUO FORTE	40	10021.98
MINOCYCLINE HYDROCHLORIDE	81	9931.13
SODIUM SULFACETAMIDE/SULF	138	7827.2

Research was conducted on Carepoint Pharmacy with the following results:

Carepoint Pharmacy:
148733 9 Commerce Dr.
Schaumberg, IL 60173

Effective 10/05/2012
[redacted] – President
[redacted] – Corporate Officer
Phone – 855-237-9112
Fax – 855-237-9113
Email – info@carepointrx.com
NPI - 1598013864
DEA - FC3505534
Tax ID - 460526382
St Lic – 054018043

Ill Board of Pharmacy lists as Carepoint Healthcare, LLC Active since 9/25/2012. No Disciplinary actions.

A Google search shows the pharmacy to be a warehouse type business with no obvious commercial entry:

CONFIDENTIAL TREATMENT REQUESTED





A Google search of the company's website has a portal for Providers and gives downloadable prescription forms. All forms are for High dollar drugs. No Generics. The forms all have the pharmacy's name printed at the top.

The following are a list of pharmacies owned by Pritesh Patel:

NCPDP: 1167964, NPI 1760840664
80 Horizon Dr.
Suite 504-601A
Suwanee, GA 30024-2936
[redacted]
Effective 1/19/2016

NCPDP: 1492862, NPI 1144772880
33 E. Irving Park Rd.
Roselle, IL 60172-2017
[redacted]

Info@carepointrx.com
Effective 11/19/2016, Term 1/3/2022 (Out of Business)

NCPDP: 1568328, NPI 1003345703
7305 E. 96th St.
Suite 500
Indianapolis, In 46250-4147
[redacted]
Effective 6/7/2017

NCPDP: 3685154, NPI 1962937193
1313 Cameron Ave.
Lewis Center, OH 43035-9662
[redacted]
Effective 4/25/2017

NCPDP: 5736410, NPI 1487169405
10753 Park Blvd.
Seminole, FL 33772-5420
[redacted]
Effective 3/27/2018

NCPDP: 5918391, NPI 1083074546
1801 S. Dairy Ashford Rd.
Suite 127
Houston, Tx 77077-4776
[redacted]
Effective 4/29/2016

In December the pharmacy was reviewed again due to a spike in October sales. Data was run from **8/01/2018 – 11/29/2021** with the following results:

2377 FEP members
6,204 claims = $1,701,457.85
In 2 months, there was an increase by 296 claims and $84,991.23

CONFIDENTIAL TREATMENT REQUESTED

Alinia was a possible outlier. Alinia is an anti-parasititic used to treat diarrhea caused by parasite infection. When looking specifically at Alinia:

- Only 2021 - first claim 05/21/2021 – 11/26/2021
- 76 claims = $220,161.49
- 54 FEP members
- 14 member states (TX #1)
- Member age – 09 – 88 years old

Xhance was the 2nd most expensive drug. Xhance is a nasal spray used to treat nasal polyps. It is the same drug as the over-the-counter drug Flonase but is at a greater strength. When looking specifically at XHance:

- Xhance 2021 claims – (201 claims) first claim 3/1/2021-11/26/2021
- 58 FEP Members
- 59 providers
- No Outlier providers

Top 10 drugs in 2021 by dollars:

Row Labels	Count of Drug Name	Sum of Total Paid Amt
ALINIA	76	220161.49
XHANCE	201	82880.94
APLENZIN	32	56648.97
ODACTRA	305	53907.5
GRASTEK	131	22936.34
WELLBUTRIN XL	14	15189.7
DAPSONE	134	11873.4
EPIDUO FORTE	45	11231.47
MINOCYCLINE HYDROCHLORIDE	87	10668.78
SODIUM SULFACETAMIDE/SULF	159	8958.74

On 12/27/21, letters were sent out to 88 providers and 101 members based on claims from Carepoint Pharmacy. The letters were focused on members receiving Alinia and Xhance as well as Halog and Aplenzin. Halog is a high potency corticosteroid; applied topically for certain skin conditions (eczema, dermatitis). Aplenzin is an antidepressant/smoking cessation drug.

As letters from members and providers were received and reviewed many stated they had gotten the drugs from Blink Pharmacy or **Phil Rx** in addition to Carepoint. Research was conducted on these two pharmacies:

Blink Pharmacy Plus **(Appears to be a digital discount coupon pharmacy)**
NCPDP: 6008925
NPI 1346883881
Effective 10/23/2019
3 Penn Ctr. W.
Suite 320
Pittsburgh, PA 15276

CONFIDENTIAL TREATMENT REQUESTED

[redacted]
DEA FB9121500
Tax ID 301027668
St. Lic PP482929

Google: Lists Blink Pharmacy Plus as Blink Rx – A digital pharmacy. Offers home delivery or pick up at participating stores like Saveway. Address 4696 West Overland Rd. Suite 274 Boise, ID 83705.

Blink is also Registered with Missouri Board of Pharmacy NPI 1063919710 1415 N Outer 40 Rd. Suite 350 Chesterfield Mo. 63017. PA Board of Pharmacy lists Michael Stanley as PIC. Active license since 10/23/2019. No Disciplinary Actions

PhilRx:
NCPDP: 0364668, NPI: 1003404278
6991 E. Camelback
Suite C-340
Scottsdale, AZ 85251

Effective 3/5/21
Corporate Name: Costanoa Health Systems, LLC
[redacted]
DEA – 845060840
St. Lic Y008386

The pharmacy does not have a Website. Sign not visible in office building. Zip recruiter was hiring a pharmacy tech as of 2/17/22. AZ Board of Pharmacy lists it as Costanoa Health Systems, LLC dba PhilRx. Issued 12/3/2020. No Discipline.

A google search of the business shows it to be in a business office building, presumably on the 3rd floor. This is no signage on the exterior advertising it's presence.

CONFIDENTIAL TREATMENT REQUESTED



As of 2/18/2022, 17 providers had responded to the questionnaire. Of those, 3 reported the patient used Philrx. Two reported they had not prescribed Aplenzin but had prescribed Wellbutrin instead. Attempts were made to contact these providers:

On 2/18/22, I interviewed [redacted], Medical Assistant to PA [redacted]. She reported that the sales rep for Alinia had put them in touch with Carepoint Pharmacy and recommended. The doctor's office recommended the pharmacy to the patient as they were supposed to have discounted prices. See the MOI of [redacted], attached herein.

On 2/22/22, I interviewed [redacted], Nurse Assistant for [redacted]n. She reported that a sales rep for Aplenzin and Wellbutrin had recommended Philrx and said they would not have to do a PA. See the MOI of [redacted], attached herein.

On 2/25/2022, I interviewed [redacted], Office Manager for PA [redacted]. She reported that a sales rep for Aplenzin left a sample book and inside were tear-off tabs with the Philrx pharmacy contact information. See the MOI of [redacted], attached herein.

On 2/22/2022, I interviewed Member Redacted - PHI who stated that his doctor had recommended Carepoint Pharmacy for both himself and his wife. See the MOI of Redacted - PHI attached herein.

On 2/22/2022, I received an email from member Redacted - PHI who stated that her doctor had recommended Philrx. She stated that she did not know the relationship between Carepoint Pharmacy and Philrx. The label on the medication came from a couple of different pharmacies, including Carepoint, but now was Philrx.

On 2/22/2022, 36 months of claims data was run for both Philrx and Blink. **No claims for FEP members were found for either pharmacy.**

Based on the above responses, it would appear Carepoint Pharmacy is operating as a central fill pharmacy for Philrx, which is a contract violation.

On 2/23/2022, an additional set of letters was sent out to members and providers, extending to include drugs other than the four previously sent.

On 2/22/2022, 36 months of claims data was run for the six additional Carepoint Pharmacies listed above. Below is a summary of the findings:

Address	NPI	Total Amt	Total Scripts	Top 5 Drugs Billed	Top 5 Drugs Dispensed
9 E. Commerce Dr, Schaumberg, IL	1598013864	$1,701,457	6204	Alinia, Lysodren, Metopirone, Doxycycline, Epiduo Forte	Epiduo Forte, Odactra, Sodium Sulfacetamide/sulf, Doxycycline Hyclate, Aczone
7305 E. 96th St. suite 500 Indianapolis, In	1003345703	$154,304	794	Epiduo Forte, Aczone, Seysara, Halog, Zembrace Symtouch	Epiduo Forte, Doxycycline Hyclate, Aczone, Minocycline Hydro, Sodium Sulfacetamide
1313 Cameron Ave. Lewis Center, OH	1962937193	$217,106	1050	Epiduo Forte, Soolantra, Doxycycline, Aczone, Doxycycline Hyclate	Epiduo Forte, Soolantra, Clobetasol Propionate, Aczone, Doxycycline
33 E. Irving Park Rd. Roselle, IL	1144772880	$1,906	15	Doxycycline, Baxdela, Minocycline Hydrochloride, Epiduo Forte, Sodium Sulfacetamide	Doxycycline, Sodium Sulfacetamide, Spironolactone, Cobetasol Propionate, Baxdela
10753 Park Blvd. Seminole, Fl	1487169405	$166,122	778	Doxycycline, Epiduo Forte, Doxycycline Hyclate, Soolantra, Absorica	Sodium Sulfacetamide, Epiduo Forte, Soolantra, Doxycycline Hyclate, Adapalene
80 Horizon Dr. Suite 504-601A Suwanee, GA	1760840664	$789,953	2999	Doxycycline, Epiduo Forte, Soolantra, Aczone, Seysara	Epiduo Forte, Doxycycline, Soolantra, Aczone, Sodium Sulfacetamide

CONFIDENTIAL TREATMENT REQUESTED

1801 S. Dairy Ashford Rd. #127 Houston, Tx	1083074546	$179,018	884	Doxycycline Hyclate, Epiduo Forte, Cycleobenzaprine Hydro, Odactra, Sodium sulfacetamide	Wellbutrin, Doxycycline Hyclate, Epiduo forte, Doxycycline, Soolantra

In analyzing the claims from the six additional pharmacies, it appears they are focusing only on dermatologic drugs. There are **NO** controls dispensed from these pharmacies or other routine maintenance drugs. Unlike the Schaumberg location however, their claims did not increase at the end of 2021.

A review of providers revealed on outlier physician. [redacted] was responsible for 359 or 6% of all claims for the 36 months. As stated above, in looking at [redacted] prescribing history, 52% of her prescriptions were filled by Carepoint Pharmacy. It should be noted that [redacted] is a Dermatologist.

[redacted]
LNPID: PIZ224A2ER **Active**
DEA: AB9288956 **Active**
NPI: 1457402109 **Active**
UPIN: C89174
CSR Number: 336.024429 **Active**
License: 036.059834 Active
License State: IL
Gender: F
Professional Suffix: MD
Practitioner Type: Physician
Practitioner Specialty: Dermatology
Date of Birth: [redacted]
Address:
AESTHETIC DERMATOLOGY
1009 W FULTON MARKET
CHICAGO, IL 60607-1222
Phone: [redacted]

Carepoint was terminated from Humana in 2015 for the Illinois location and 2018 for the Georgia location. I spoke with Investigator [redacted], Humana SIU, who reported that during the time they had been looking at Carepoint they had determined there was collaboration between prescriber offices and the pharmacy but had not gone further in their investigation regarding that angle.

Investigative Plan / Recommendations:

CONFIDENTIAL TREATMENT REQUESTED

In light of all the preceding, further investigation and/or intervention is necessary, most importantly to determine if there are one or more violations of:

31 U.S.C. § 3729 False Claims Act
18 U.S.C. § 1341 Mail Fraud
18 U.S.C. § 1343 Wire Fraud
18 U.S.C. § 371 Conspiracy

Recommend an RFI requesting financial billing information from the seven Carepoint Pharmacies and PhilRx to determine a financial relationship between them and possibly any physicians.

I submit this preliminary record to the BCBSA FEP-SIU Director's Office for review and determination of appropriate follow-up. At this time, I am producing Member and Provider Questionnaires and will add questionnaire responses as they are received. No further action taken at this time.

CONFIDENTIAL TREATMENT REQUESTED

Exhibit 45:
CVS_HJC_00011370 Internal email thread discussing how Carepoint Pharmacy worked with Blink Rx

From: Kapadia, Amish B. [redacted]
Sent: 3/22/2022 5:39:51 PM
To: Walker, Wendy H. [redacted]; Falzarano, Andrew [redacted]
CC: Smith, AmyL [redacted]; Mccall, Steven D. [redacted]; Kapadia, Amish B. [redacted]
Subject: Central Fill/ Hub billing Carepoint Pharmacy/ Blink Health
Attachments: FW_ Carepoint Audit Outstanding Questions.eml; FW_ Caremark Audit Carepoint Pharmacy 1487330.eml; Carepoint CAP.eml; image003.png; image004.png; image005.png; image006.png; image015.png; image016.jpg; image017.png; image018.png; image019.png

Wendy

On the call yesterday you mentioned Andrew and yourself have started to look at providers that leverage a central fill process. I wanted to forward you some information that Zoe collected on Carepoint pharmacy located in Schaumburg Il. The owners of Carepoint have a group of pharmacies with multiple bad audits and they have also been placed on a CAP by our team (see attached). In this latest instance their chief compliance office admits to violating their agreement to collect copayments. As you can see below (and in the attached emails) David responds to Zoe's questions in writing indicating they work with Blink Health to facilitate copay collections. Blink Health then reimburses the pharmacy with a single-used "credit card" for the value of the copay. Not sure if you can take action but I think this is something that warrants further review for potential action.

Thanks

Hello Zoe,
I have spoken with our team and have the following answers/requests:

1. Explain what does "216 Days Past Due" means? Can you provide Rx#/context so that I may review and confirm?
2. Explain what does "Medisol Direct Purchase//DDAS" means? This likely means we purchase that product from Medisol and/or Dermadash. If you can provide specific Rx#s, I can review and confirm.
3. Who is MD Exam? I am unfamiliar with "MD Exam." Can you provide Rx#/context so that I may review?
4. Who collects the copay for claims with MD Exam? See response to #3.
5. List the programs or drugs (none) where copay are collected by an entity other than Carepoint.
   1. MD2RX (No longer in business)
   2. Phil Rx
   3. Blink Rx
6. Prescriptions filled for Blink Health, who bills the claims? Carepoint bills the claim to PBM. Who collects copay? Blink collects the copay as the patient experience is through Blink. And How is Carepoint reimbursed? Blink creates a single-used "Credit card" for Carepoint for the value of the copay.
7. Explain how the prescription numbers beginning with 99000* were billed. Include who billed and how they remained billed for more than 7 days when they were not dispensed. These scripts were billed with a benefits verification tool that was provided by Change Healthcare, a payment/revenue system Carepoint utilized. Carepoint was under the impression that these were test bill claims, not true adjudications. We have since learned that this is not the case and reversed the claims once we received confirmation. An error in the Change Healthcare system caused the B2 transaction to fail without be noticed by their team. We are no longer using that product, and, in fact, Change Healthcare has discontinued the product altogether.
8. Provide policy and procedure on reversing claims not dispensed. See Attached. Through CPHub, any prescription that is not dispensed is automatically reversed by the system 7 days later and placed on hold until patient calls in to authorize and fill the medication.
9. Provide policy and procedure for copay collections. See Attached

10. Who are pharmacy's wholesalers? ALK-ABELLO, American Pharmaceutical Dist., Amerisource Bergen, Anda Generics, AndMEDRX LLC, Artesa Labs, Bausch Health US, BLUPAX Pharma, Cintex Services, EPI Health, FFF Enterprises, Galderma Labs, JG Pharma, Journey Medical Corp, Marnel Pharmaceuticals, Mayne Pharma, Medimetricks Pharma, Medisol Pharmaceuticals, Phil Inc., Prasco Labs, Real Value Products, Upsher-Smith Labs

Please let me know if you have additional questions.

Thank You,

[redacted]
Chief Compliance Officer

[redacted]

Chicago | Atlanta | Houston
Columbus | Indianapolis | Tampa
www.carepoint.pharmacy

CONFIDENTIALITY NOTICE This electronic mail transmission may contain privileged, confidential and/or protected health information and is intended only for the review of the party to whom it is addressed. Any unauthorized use or disclosure of the information contained herein may be a violation of federal law, including the Health Insurance Portability and Accountability Act (HIPAA). If you have received this transmission in error, please immediately return it to the sender, delete it and destroy it without reading it. Unintended transmission shall not constitute the waiver of the attorney-client or any other privilege.

Amish Kapadia PharmD | Senior Manager, Network Audit, CVS Caremark

[redacted]
9501 E Shea Blvd. Mail Code 053, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 46: CVS_HJC_00011411 Internal email thread discussing changes to the provider manual

From: Grosso, Lauren A. [redacted]
Sent: 8/2/2022 7:53:36 PM
To: Walker, Wendy H [redacted]; Terrel, Jaclyn [redacted]; Mccall, Steven D. [redacted] Falzarano, Andrew [redacted]; Thomas, Jennifer A [redacted]
CC: Kapadia, Amish B. [redacted]]; Mccall, Steven D. [redacted]
Subject: RE: therapeutic cost manipulation framework

Hello,

Reviving this email just in case we want to revisit any of this language based on recent observations in pharmacy activities.

Thanks,
Lauren

Lauren Grosso, MBA | Director, CVS Caremark
p 480-209-8181| **f** 480-314-6099
9501 E Shea Blvd, Mail Code 020, Scottsdale, AZ 85260



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Kapadia, Amish B. [redacted]
Sent: Tuesday, February 15, 2022 2:30 PM
To: Walker, Wendy H. [redacted]
Cc: Falzarano, Andrew [redacted]; Haffner, Heidi H. [redacted]; Grosso, Lauren A. [redacted]; Mccall, Steven D. [redacted]; Kapadia, Amish B. [redacted]
Subject: FW: therapeutic cost manipulation framework

Wendy

After today's legal call I was just thinking about this proposed PM verbiage. I tweaked it slightly as I think we will see more providers acting as local pharmacy providers for third party hubs (ex/ blink rx).

Thanks

Proposed language:

3.02.03 Aberrant Practices and Trends

Caremark has implemented programs to address aberrant Provider practices that focus on a Provider's welfare rather than best practices of providing clinical, cost-effective solutions for eligible person(s). Providers participating in a Caremark network(s) must not engage in practices that negatively impact the health and financial welfare of Eligible Persons and Plan Sponsors. This includes but is not limited to following:

1. Dispensing:

a. Drug products inconsistent with the habits of local Prescribers or Plan Sponsor formularies, at Caremark's sole determination.

i. Aberrant quantities of a Covered Item and/or disparate volume of claims within a therapeutic category (e.g., topicals, dermatologicals), as measured by number of claims, quantity dispensed and/or dollars;

ii. Limited medications and/or therapeutic categories (e.g., topicals products, diabetic test products, skin care products, etc.);

b. Demonstrating purchasing practices (e.g., higher cost drug products) that are not in keeping with habits of local prescribers or plan sponsor formularies

2. Therapeutic cost manipulation:

a. Billing NDC's with elevated average wholesale price (AWP), or a novel strength of an older generic product in which the pricing appears disproportionately high compared to other products within the same Generic Product Identifier (GPI) class.

b. Billing elevated AWP combination products of two or more established low-cost generic OTC products to obtain higher reimbursement.

c. Misusing member data for Provider's own use

i. Submitting test claims with no subsequent paid claims (also known as "negative" claims) to ascertain which products have higher reimbursement.

ii. Submitting claims without prescriber prescription authorization

iii. Soliciting prescribers to authorize multiple medications with higher reimbursement.

1. Pre-printed template prescriptions with multiple known high reimbursement products and/or check-box (e.g, select all) authorization for multiple products.

iv. Circumventing plan design edits to obtain higher reimbursement and/or additional incentives from third parties such as marketers and manufactures.

v. Submitting Prior Authorizations on behalf of prescribers to obtain approval for non-medically necessary products.

vi. Participating in schemes which have been associated with Fraud Waste and Abuse as identified by law enforcement or other regulatory agencies (e.g, Center for Medicare & Medicaid Services, Medicare Drug Integrity Contractor, etc.)

3. Facilitate the operation of a pharmacy billing hub, or alternative pharmacy provider (with or without common ownership):

a. Sharing eligible person's private and confidential identify information with third parties such as marketers or pharmaceutical hubs.

b. Leveraging multiple third party software platforms to obtain drug reimbursement data.

c. Act as a third party billing hub to test and transfer prescriptions to local pharmacy providers.

d. Participate as a fulfillment center (e.g, local pharmacy provider) for a third party billing entity.

i. Dispense medications pursuant to prescriptions obtain from non-prescriber third party entities.

ii. Collecting copayments on behalf of a third party entity.

iii. Obtaining payment from third party entities for dispensing services provided as a local hub provider.

In the event Provider breaches this provision of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark, including chargeback of applicable claims.

Amish Kapadia PharmD | Manager, Network Pharmacy, CVS Caremark
[redacted]
9501 E Shea Blvd. Mail Code 053, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Kapadia, Amish B. [redacted]
Sent: Wednesday, January 12, 2022 2:59 PM
To: Walker, Wendy H. [redacted] Urbatchka, Lindsey E [redacted]; Smith, AmyL [redacted] Falzarano, Andrew [redacted]; Haffner, Heidi H. [redacted]
Cc: Grosso, Lauren A. [redacted]; Terrel, Jaclyn [redacted]; Kapadia, Amish B. [redacted]
Subject: therapeutic cost manipulation framework

Wendy

Sorry for not getting back sooner. This is what I was thinking in terms of adding therapeutic cost manipulation into the provider manual. I've also included data points on how we would be able to identify providers along with potential action we could take. I hope this helps the team and please feel free to amend.

Thanks

Proposed language:

3.02.03 Aberrant Practices and Trends

Caremark has implemented programs to address aberrant Provider practices that focus on a Provider's welfare rather than best practices of providing clinical, cost-effective solutions for eligible person(s). Providers participating in a Caremark network(s) must not engage in practices that negatively impact the health and financial welfare of Eligible Persons and Plan Sponsors. This includes but is not limited to following:

1. Dispensing:

a. Drug products inconsistent with the habits of local Prescribers or Plan Sponsor formularies, at Caremark's sole determination.

i. Aberrant quantities of a Covered Item and/or disparate volume of claims within a therapeutic category (e.g., topicals, dermatologicals), as measured by number of claims, quantity dispensed and/or dollars;

ii. Limited medications and/or therapeutic categories (e.g., topicals products, diabetic test products, skin care products, etc.);

b. Demonstrating purchasing practices (e.g., higher cost drug products) that are not in keeping with habits of local prescribers or plan sponsor formularies

2. Therapeutic cost manipulation:

a. Billing NDC's with elevated average wholesale price (AWP), or a novel strength of an older generic product in which the pricing appears disproportionately high compared to other products within the same Generic Product Identifier (GPI) class.

b. Billing elevated AWP combination products of two or more established low-cost generic OTC products to obtain higher reimbursement.

c. Misusing member data for Provider's own use

i. Submitting test claims with no subsequent paid claims (also known as "negative" claims) to ascertain which products have higher reimbursement.

ii. Submitting claims without prescriber prescription authorization

iii. Acting as a billing hub to verify patient benefits for other providers.
iv. Sharing eligible person's private and confidential identify information with other third parties such as marketers and alternate pharmacies (with or without common ownership).

d. Soliciting prescribers to authorize multiple medications with higher reimbursement.

i. Pre-printed template prescriptions with multiple known high reimbursement products and/or check-box (e.g, select all) authorization for multiple products.

e. Circumventing plan design edits to obtain higher reimbursement and/or additional incentives from third parties such as marketers and manufactures.

f. Submitting Prior Authorizations on behalf of prescribers to obtain approval for non-medically necessary products.

g. Participating in schemes which have been associated with Fraud Waste and Abuse as identified by law enforcement or other regulatory agencies (e.g, Center for Medicare & Medicaid Services, Medicare Drug Integrity Contractor, etc.)

In the event Provider breaches this provision of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark, including chargeback of applicable claims.

Tools we can use to monitor and take action:

1. NOPP report, as I understand we have only taken action on OPP drugs.
2. Heidi's Hub billing report
3. Hard copy requests from the provider (assuming resources but we could leverage daily review referrals based on what they see)
4. Audit files and or comments from auditors
5. HMPS Risk Assessment Data (mikes/amy's report for client rollup summary)
6. Additional analytics similar to MIR data pulls we have done in the past

Potential Actions:

1. Cease and Desist Letters
2. Soliciting into an MIR like rate (non retail provider in retail networks)
3. CAPs
4. Placing provider in a monitor network and charge a fee to review billings
5. Term from network

Amish Kapadia PharmD | Manager, Network Pharmacy, CVS Caremark
[redacted]
9501 E Shea Blvd. Mail Code 053, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 47: CVS_HJC_00011857 Cease-and-desist letter sent to White Drug

CVS/caremark 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

Thursday, March 14, 2023

VIA UPS AND FACSIMILE 701-893-9053
CC: Thrifty White Stores

Thrifty White Stores DBA White Drug
706 38TH ST N STE A
FARGO, ND 58102

Re: Cease and Desist – Pharmaceutical Hub Practices
NCPDP 3504138 NPI 1003906942

Dear Pharmacy Owner(s),

CVS Caremark ("Caremark") has recently become aware of practices between Thrifty White Stores and White Drug and Blink RX, philRx, Carepoint Pharmacy and/or other hub pharmacies for prescription claims that are in violation of your Provider Agreement with Caremark.

The Caremark Provider Manual states in **4.12 Dispensing Pharmacy NPI/NCPDP**:

> *Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark.*
> *1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;*
> *2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;*
> *3. Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers;*
> *4. Provider is not allowed to submit claims on behalf of another entity;*
> *5. Provider must only submit claims it intends to dispense; and*
> *6. Provider may not act on behalf of another entity regardless of ownership structure.*

The Caremark Provider Manual states in **3.03.01 Collection of Patient Pay Amounts**:

> *All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.*

Caremark has reviewed prescriptions for our Plan Sponsors and determined Thrifty White Stores and White Drug is not in compliance with the above listed provisions of the Caremark Provider Manual. Caremark demands Thrifty White Stores and White Drug

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011857

immediately remedy their noncompliance as indicated in the **Required Actions** section of this letter.

REQUIRED ACTIONS

Caremark requires that Thrifty White Stores and White Drug:

1. Immediately cease allowing an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification ID, or other identifier to submit a claim (including a test claim) to Caremark; and
2. Immediately cease allowing all pharmaceutical hubs including those using the following CERT ID's to submit test claims using your NPI number and NCPDP number.

DayTech LLC	D012000017
Digital Simplistics	D012000047
CarePoint	D012000149
	D012500011
	D012500020

3. Immediately cease outsourcing the collection of Patient Pay amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity

Thrifty White Stores and White Drug's signed acknowledgement must be received by Caremark via facsimile **at (480) 661-2787 within two weeks of receipt of this letter (on or before March 28, 2023).** Thrifty White Stores and White Drug's failure to comply with the terms of this letter may result in Caremark immediately exercising all remedies available to Caremark, including and up to termination of the Provider Agreement. This does not waive any rights Caremark may exert under contract or applicable Law.

Caremark is also notifying you that future communications with Thrifty White Stores and White Drug's regarding audits and/or reviews conducted by Caremark may be forthcoming.

Regards,

CVS Caremark
Pharmacy Performance

_____ _____ _____

Signature of Pharmacy Owner | Print Name and Title | Date

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00011858

Exhibit 48:
CVS_HJC_00011886 Internal email thread discussing White Drug's compliance with the cease-and-desist letter

From: Thomas, Jennifer A [redacted]
Sent: 6/22/2023 9:43:18 PM
To: Mccall, Steven D. [redacted]; Harris, Stephanie [redacted]
CC: Terrel, Jaclyn [redacted]
Subject: FW: White Drug 3504138

Please see below.

I will schedule a call when Steve returns to discuss next steps as it appears White Drug is in violation of the C&D they signed in March.

Jenn

Jennifer Thomas, CPhT | Sr. Manager Pharmacy Audit • Investigations • CVS Caremark
[redacted]
CVS Health | 9501 East Shea, MC 020 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Bufalino, Danielle [redacted]
Sent: Thursday, June 22, 2023 2:39 PM
To: Terrel, Jaclyn [redacted] Thomas, Jennifer A [redacted]
Cc: Bufalino, Danielle [redacted]
Subject: White Drug 3504138

Hello,

Seth was just reviewing this claim and was informed by White Drug that Blink Health is billing prescriptions for them. They transferred him to Blink during the call but I advised him to hang up and put into a holding queue. It appears we have an audit in process for this pharmacy. How would you like me to have Seth proceed with this claim?

Thank you,

Danielle Bufalino, PharmD | Manager, Pharmacy Performance, CVS/Caremark
[redacted] *(Please note I am working remotely due to COVID-19 – please contact me by email.)*
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

Upcoming PTO:
6/1-6/9

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Cook, Seth J [redacted]
Sent: Thursday, June 22, 2023 2:07 PM

To: Bufalino, Danielle [redacted]
Subject: Securemail

DOC: 231645834922054 999 NCPDP: 3504138

Vascepa Cap 1GM 120/20 Should Be 120/30

Take 2 Capsules PO BID Per [redacted], Technician in Training, Asked To Reprocess 120/30, Informed That They Cannot Edit Claim Because White Drug Is Only The "Fulfillment Pharmacy" On Behalf Of Blink Health, Who Does All Patient And Prescriber Contact, The Billing And Prints The Label, Asked To Speak To Pharmacist, Pharmacy Declined

Was transferred to Blink Health [redacted] until instructed by Management to not speak with them.

Seth Cook, CPhT (He.Him.His.) | Analyst, Network Management

[redacted]
9501 E. Shea Blvd., Scottsdale, AZ 85260



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 49:
CVS_HJC_00011904 Internal email thread discussing hub pharmacy activities

From: Mccall, Steven D. [redacted]
Sent: 7/10/2023 4:39:47 PM
To: Safranyos, Michael R. [redacted]
Subject: RE: XHance - Hub Concerns

Similar. We see Phil, Blink and others that are moving into this role in the ecosystem.

Word on the street is that it will increase with small, hyper-inflated players. We are seeing if we can block folks from using other's NCPDP. We haven't made it above the line on this project.

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Safranyos, Michael R. [redacted]
Sent: Monday, July 10, 2023 9:28 AM
To: Mccall, Steven D. [redacted]
Subject: RE: XHance - Hub Concerns

Is this connected to our previous exchange regarding this Phil group? This came up for drugs like Truhdesa and Wellbutrin XL in the past.

Mike

Mike Safranyos, PharmD | Sr. Clinical Advisor, CVS Caremark
[redacted]
Pittsburgh, PA

From: Mccall, Steven D. [redacted]
Sent: Monday, July 10, 2023 12:13 PM
To: Fredell, Joshua W [redacted]; Safranyos, Michael R. [redacted]; Turkovich, Barb [redacted]
Cc: Robinson, Christopher S. [redacted]; Terrel, Jaclyn [redacted]; Fenker, Jason [redacted]; Mccann, Herbert [redacted]; Maschak, Andrea [redacted]; Habtom, Saba [redacted] Masiello, Marisa [redacted] Turkovich, Barb [redacted] Mone, Michael A [redacted] Correia, Brian J. [redacted]; Murphy, Michael S. [redacted]
Subject: RE: XHance - Hub Concerns

This has been one that Jason and Jackie have been chasing. They initially started through sending test claims from their own location with the NCPDP of a retail in-network pharmacy to do a coverage determination. I would read this to be that a non-contracted entity accessed PHI through our system by using false identifiers. Jason sent out a slew of Cease and Desist letters and we had that crowd end their contracts. Xhance, and their hub are just going to new pharmacies to do the exact same thing including a chain location. We audited the location and last week we saw the business pop over to Amber pharmacy, which is a large specialty owned by Hy-Vee.

Hub Activities:

- Receives script sent to the hub from the doctor

- Sends test claim using the NCPDP for a contracted retail pharmacy – Reverses the claim
- Collects via App the copay from member, although it is believed that mostly they coupon the copay off to avoid patient abandonment
- Transfers the prescription to in-network pharmacy to slap a label on and send to patient

In effect, the hub is recreating the business model for Philidor that caused such an issue. The other challenge that is leading to the expenses is that because the member is isolated from the copayment and the retail pharmacist is the expected behavior with a high copayment would be for the pharmacy to advise the patient OTC fluticasone is readily available for a very nominal amount. There is also a large concern with a non-contracted entity accessing PHI from the system and the engine looks to the NCPDP for the validation.

We are happy to get together with you and Medical Affairs to re-discuss. I see Xhance to be a gateway drug to get pharmacies bringing on hyper inflated products.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Fredell, Joshua W [redacted]
Sent: Monday, July 10, 2023 6:56 AM
To: Safranyos, Michael R. [redacted]; Mccall, Steven D. [redacted] Turkovich, Barb [redacted]
Cc: Robinson, Christopher S. [redacted] Terrel, Jaclyn [redacted] Fenker, Jason [redacted]; Mccann, Herbert [redacted] Maschak, Andrea [redacted] Habtom, Saba [redacted]; Masiello, Marisa [redacted]; Turkovich, Barb [redacted]
Subject: RE: XHance - Hub Concerns

I will ask my team to engage with our formulary partners to determine if formulary removal from our commercial templates is an appropriate step we can take.

Josh

From: Safranyos, Michael R. [redacted]
Sent: Monday, July 10, 2023 7:26 AM
To: Mccall, Steven D. [redacted]; Turkovich, Barb [redacted]
Cc: Robinson, Christopher S. [redacted]; Terrel, Jaclyn [redacted]; Fenker, Jason [redacted]; Fredell, Joshua W [redacted]; Mccann, Herbert [redacted]; Maschak, Andrea [redacted]; Habtom, Saba [redacted]; Masiello, Marisa [redacted] Turkovich, Barb [redacted]
Subject: RE: XHance - Hub Concerns

Good morning Steve,

Thanks for the heads up. This one actually hit our radar when it first launched. We reviewed it for our Drug Exclusion Plan Design strategy which would give clients an option to exclude it with no pathway to coverage. However if I recall correctly, our Medical Affairs team wasn't comfortable with not having an exception pathway. The product is currently covered on our Standard Formulary as a non-preferred agent. We've seen a few clients where the product has started to slowly uptick in utilization but it hasn't been

significant yet. For now, we've been trying to promote our standard prior authorization which requires trial/failure of an alternative intranasal corticosteroid.

By chance, do you know which central hub practices are involved? We recently came across some interesting trends with Vyleesi where the website links patients to a virtual practice known as Beyond MD. The majority of rxs across our book of business are being filled at KnippeRx pharmacy (https://www.knipperx.com/) and coming from 2 primary prescribers. We looked at some clinical exception approvals and the doctors seem to be submitting similar information. Just curious if this is another product linked to that scenario.

Mike

Mike Safranyos, PharmD | Sr. Clinical Advisor, CVS Caremark
[redacted]
Pittsburgh, PA

From: Mccall, Steven D. [redacted]
Sent: Friday, July 7, 2023 6:56 PM
To: Safranyos, Michael R. [redacted]; Turkovich, Barb [redacted]
Cc: Robinson, Christopher S. [redacted]; Terrel, Jaclyn [redacted]; Fenker, Jason [redacted]; Fredell, Joshua W [redacted]; Mccann, Herbert [redacted] Maschak, Andrea [redacted]
Subject: XHance - Hub Concerns

Hey Mike:

Have you looked at using an NDC block for XHance? We are seeing chains starting to have central hub practices with this product. Basically a fluticasone at a crazy price versus the current 6 for $30 that you would find at Costco. Main difference is an indication for nasal polyps and a different plastic piece. Let me know if you want to chat.

https://www.xhance.com/

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 50:
CVS_HJC_00012275 Internal email thread discussing White Drug's compliance with the cease-and-desist letter

From: Thomas, Jennifer A [redacted]
Sent: 10/14/2023 6:34:04 PM
To: Terrel, Jaclyn [redacted]; Mccall, Steven D. [redacted]
CC: Bufalino, Danielle [redacted]
Subject: RE: White Drug - 3976872 - Miebo
Attachments: SKM_C550i23032813080.pdf; image001.png; image002.jpg; image003.jpg; image004.jpg

I also had Stormie put it in DSA a few months ago.

Jennifer Thomas, CPhT | Sr. Manager Pharmacy Audit • Investigations • CVS Caremark
[redacted]
CVS Health | 9501 East Shea, MC 020 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Saturday, October 14, 2023 11:13 AM
To: Thomas, Jennifer A [redacted]; Mccall, Steven D. [redacted]
Cc: Bufalino, Danielle [redacted]; Terrel, Jaclyn [redacted]
Subject: RE: White Drug - 3976872 - Miebo

Can you provide me the signed C&D?

Thanks for the intel sharing Bufalino!

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Thomas, Jennifer A [redacted]
Sent: Thursday, October 12, 2023 8:19 AM
To: Mccall, Steven D. [redacted]
Cc: Bufalino, Danielle [redacted]; Terrel, Jaclyn [redacted]
Subject: White Drug - 3976872 - Miebo

Steve

Danielle's team came across a new drug for dry eye yesterday, Miebo. It became effective June 2023 and is ~$923.00 / 3 ml bottle.

During their review they found multiple claims from White Drug, a majority were out of state members.

After reviewing the Miebo website further it directs members to Blink to obtain the item.

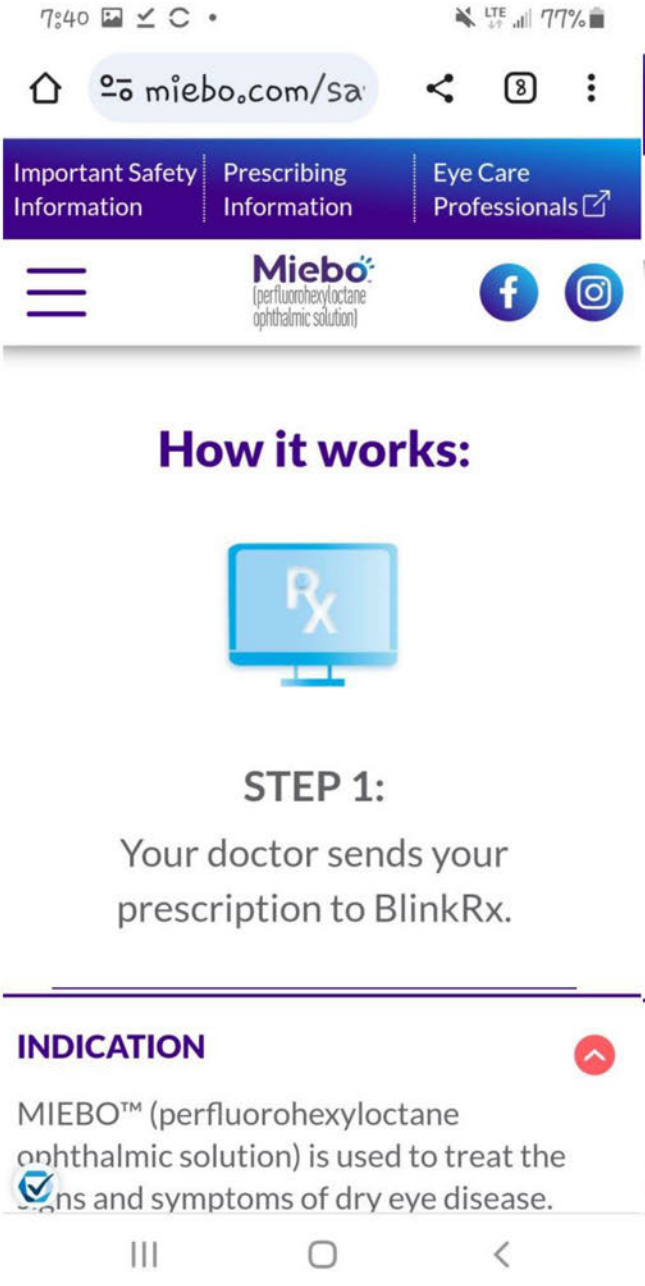
I had Mike run a query, the first claim for this item was not billed until 8/28/2023, and really ramped up after 9/11/2023.

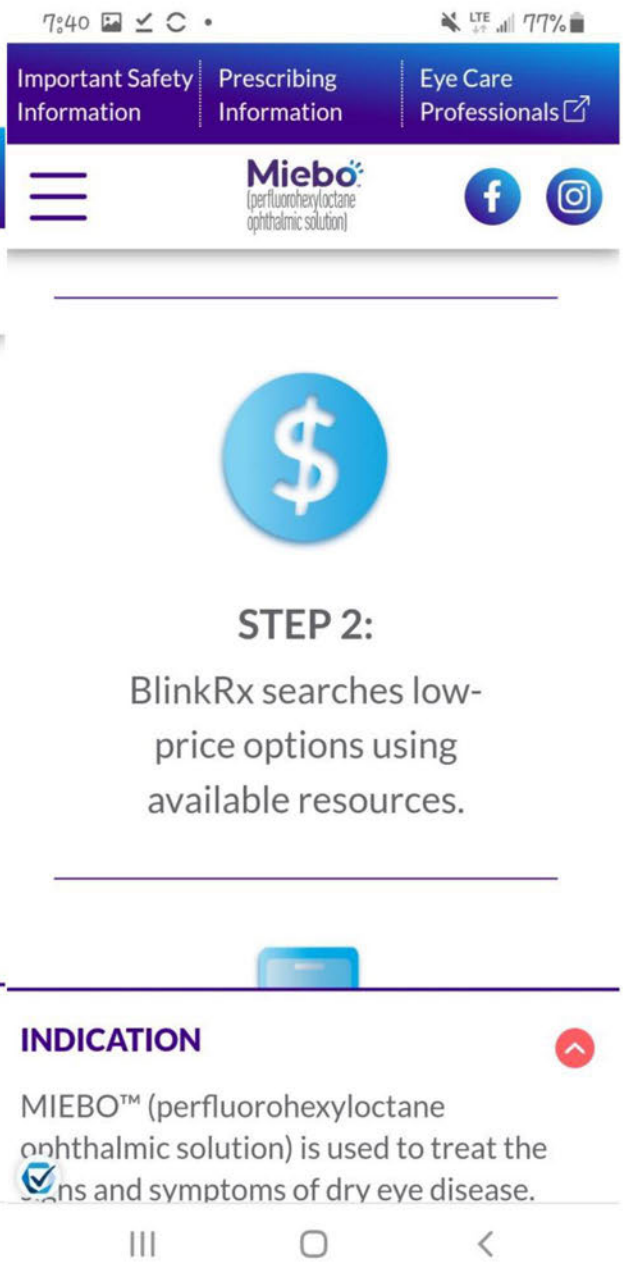
The top billing pharmacy for this item is White Drug, followed by Carepoint and Postmeds. It significantly drops from there (1 or two claims at random pharmacies).

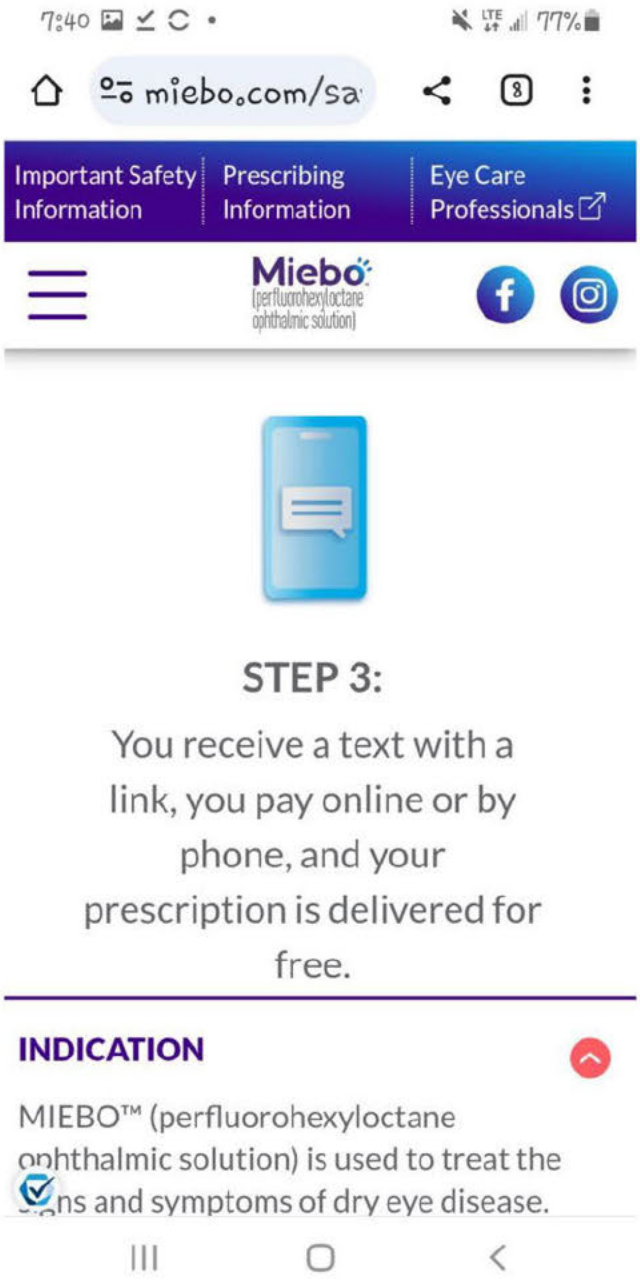
NCPDP	PNAME	TOT_CLMS	GT_50_MILES	AVG_DISTANCE	TOT_AMTPD
3504138	WHITE DRUG	488	488	1195	$ 269,504.18
1487330	CAREPOINT PHARMACY	349	331	869	$ 206,959.89
5660091	POSTMEDS INC	230	217	1622	$ 145,343.45

This is just further evidence that White Drug has not abided by the Cease and Desist that was previously sent.

Our internal firewall blocks the website, but I was able to pull this from my cell phone.


7:40
77%
miebo.com/sa
Important Safety Information
Prescribing Information
Eye Care Professionals
Miebo
(perfluorohexyloctane ophthalmic solution)
How it works:
STEP 1:
Your doctor sends your prescription to BlinkRx.
INDICATION
MIEBO™ (perfluorohexyloctane ophthalmic solution) is used to treat the


7:40
77%
Important Safety Information
Prescribing Information
Eye Care Professionals
Miebo
(perfluorohexyloctane ophthalmic solution)
STEP 2:
BlinkRx searches low-price options using available resources.
INDICATION
MIEBO™ (perfluorohexyloctane ophthalmic solution) is used to treat the



Jennifer Thomas, CPhT | Sr. Manager Pharmacy Audit • Investigations • CVS Caremark
[redacted]
CVS Health | 9501 East Shea, MC 020 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 51:
CVS_HJC_00012313 Internal email thread discussing White Drug's compliance with the cease-and-desist letter

From: Terrel, Jaclyn [redacted]
Sent: 1/29/2024 10:45:35 PM
To: Bufalino, Danielle [redacted]; Thomas, Jennifer A [redacted]; Mccall, Steven D. [redacted]
CC: Terrel, Jaclyn [redacted]
Subject: RE: White Drug 3504138 and Blink Rx
Attachments: SKM_C550i23032813080.pdf

Thanks Bufalino! Nice work!

They signed the C&D 3/28/23. I'm going to think about next steps and touch base with the group when I have the options of how to proceed.

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Bufalino, Danielle [redacted]
Sent: Monday, January 29, 2024 2:40 PM
To: Thomas, Jennifer A [redacted]; Mccall, Steven D. [redacted]; Terrel, Jaclyn [redacted]
Cc: Bufalino, Danielle [redacted]
Subject: White Drug 3504138 and Blink Rx

Hello,

During my DR sweep I came across a Miebo claim billed at White Drug 3504138. I noticed the patient was in a different state than the pharmacy. I ran a query for this GPI and NCPDP and from 10/1/23-1/29/24 White Drug had over 10,000 paid claims for this medication. Almost all the patients, besides 2, appear to be living in a different state than the pharmacy. I also checked other claims in multiple patient's profiles to verify that they were in fact in a different state and it wasn't just the case of them not having an updated address. Besides Meibo, these members had other paid claims at a pharmacy in the same state as their address. I ran a second query to look at all claims being submitted for this GPI at this NCPDP. In that same time frame, there were over 21,000 rejections and reversals. It seems they may be doing test claiming as well.

The Miebo website specifically calls out BlinkRx as a means of obtaining the prescription. Based on the data, it appears White Drug is still participating in hub practices.

https://www.miebo.com/savings-and-support/



Thank you

Danielle Bufalino, PharmD | Manager, Pharmacy Performance, CVS/Caremark
[redacted] *(Please note I am working remotely due to COVID-19 – please contact me by email.)*
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

Upcoming PTO:
2/16-2/21

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 52:
CVS_HJC_00012329 Internal email thread discussing a CVS audit of an independent pharmacy

From: Chavez, Janel E [redacted]

Sent: 5/1/2024 11:08:37 PM

To: Markovic, Sandra [redacted]; Hoversten, Jeffrey R [redacted] Pontecorvo, Christine A [redacted]; Warner, Robert T [redacted]; Smith, Amy L [redacted]; Lindsey, Stormie R [redacted]; Hains, Todd P [redacted]; Alderman, Mary Melissa [redacted]; Domond, Gary [redacted]; Thomas, Jennifer A [redacted]

CC: Terrel, Jaclyn [redacted]; Flores, Elizabeth [redacted]; Grosso, Lauren A. [redacted]; Mccall, Steven D. [redacted]; Kapadia, Amish B. [redacted]; Urbatchka, Lindsey E [redacted]; Fenker, Jason [redacted]; Palomo, Bertha J. [redacted]; Testa, Elizabeth A [redacted]; Bufalino, Danielle [redacted]; Klein, Angeles [redacted]; Cline, Jenifer [redacted]; Curtis, Melissa A [redacted]; Thomsen, Kayleigh M [redacted]; Atwood, Jonathan W [redacted]; Jones, Candice [redacted]; Luckinbill, Reagan J [redacted]; Chavez, Janel E [redacted]; Soza, Rosa [redacted]; Lewis, Devona A [redacted]; Rowell, Melissa A [redacted]; Tarlian, Alyssa M [redacted]

Subject: Post Audit Summary for: FOOT AND ANKLE SPECIALISTS OF AZ NCPDP# 0366016-92936- Finalized

Post Audit Summary

Pharmacy Information: FOOT AND ANKLE SPECIALISTS OF AZ NCPDP# 0366016 / NPI 1003436635

Audit Date: 3/8/2024

Audit Type: Expanded

Audit Time Frame: 12/1/2022-12/31/2023

Payment Suspension: No

Attorney: No

Audit Initiated: An expanded audit was initiated due to the pharmacy appearing on Aetna FWA report for trending, billing hyper inflated drugs, no audit history, and for conducting test claims.

Appeals Received: Yes

General Summary:

0 out of 2 INV discrepancies received credit.

Detailed Summary: The investigative audit for FOOT AND ANKLE SPECIALISTS OF AZ was **finalized on 5/1/2024**. The pharmacy submitted additional documentation to be reviewed by Post Audit. This documentation was reviewed and applied to the audit as follows:

INV

Auditor comment: "Pharmacy used invalid secondary payor (Alpha Script)." (2 INV- 0 cleared)

The pharmacy submitted an email stating that the auditors' comments on the discrepancy report state that "Alpha ScripT" was used, but the pharmacy used Alpha Scrip. See image below:

Post Audit

From: [redacted]
Sent: Friday, April 19, 2024 3:22 PM
To: Post Audit
Cc: [redacted]
Subject: [EXTERNAL] Ref 0366016/92936 F&A Specialist of AZ-Sun City West

****** External Email - Use Caution ******

CVS Caremark
Attn: Audit Documentation-Jackie Terrel, PharmD
Pharmacy Performance MC020
9501 East Shea Blvd
Scottsdale, AZ 85260-6719
Phone: [redacted]
Fax: [redacted]
Email: Post.Audit@CvsCaremark.com

Good Afternoon,

Regarding 0336016/92936, Audit discrepancy indicates AlphaScript, a Savings Card. Alphascrip is a Copay Card. We reached out to Alphascrip to confirm that this is a Copay Card and confirmed that there shouldn't be any problems being that CVS/Caremark pharmacies are redeeming Alphascrip Copay Cards reguarly.

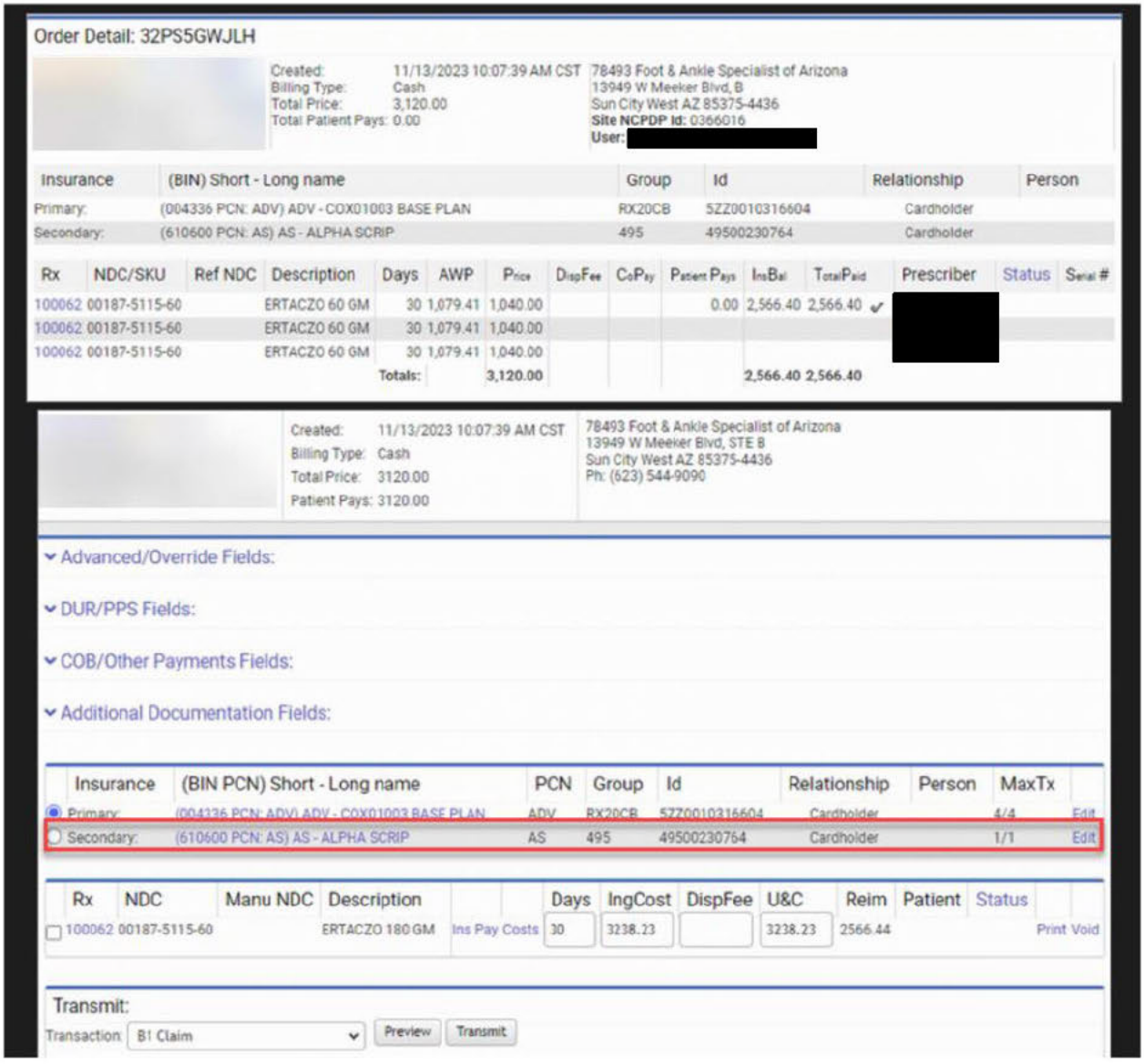
Please take special note of the name difference of these two entities: one is AlphaScript, whereas the other is AlphaScrip. Alphascript is indicated in the discrepancy letter, whereas, facility dispensed/adjudicated using Alphascrip.

[redacted]
Foot & Ankle Specialist of Arizona

Rx# 1000062- Please see the adjudication screenshot submitted to the auditor showing that a coupon was used:

Coupon info on screenshot:

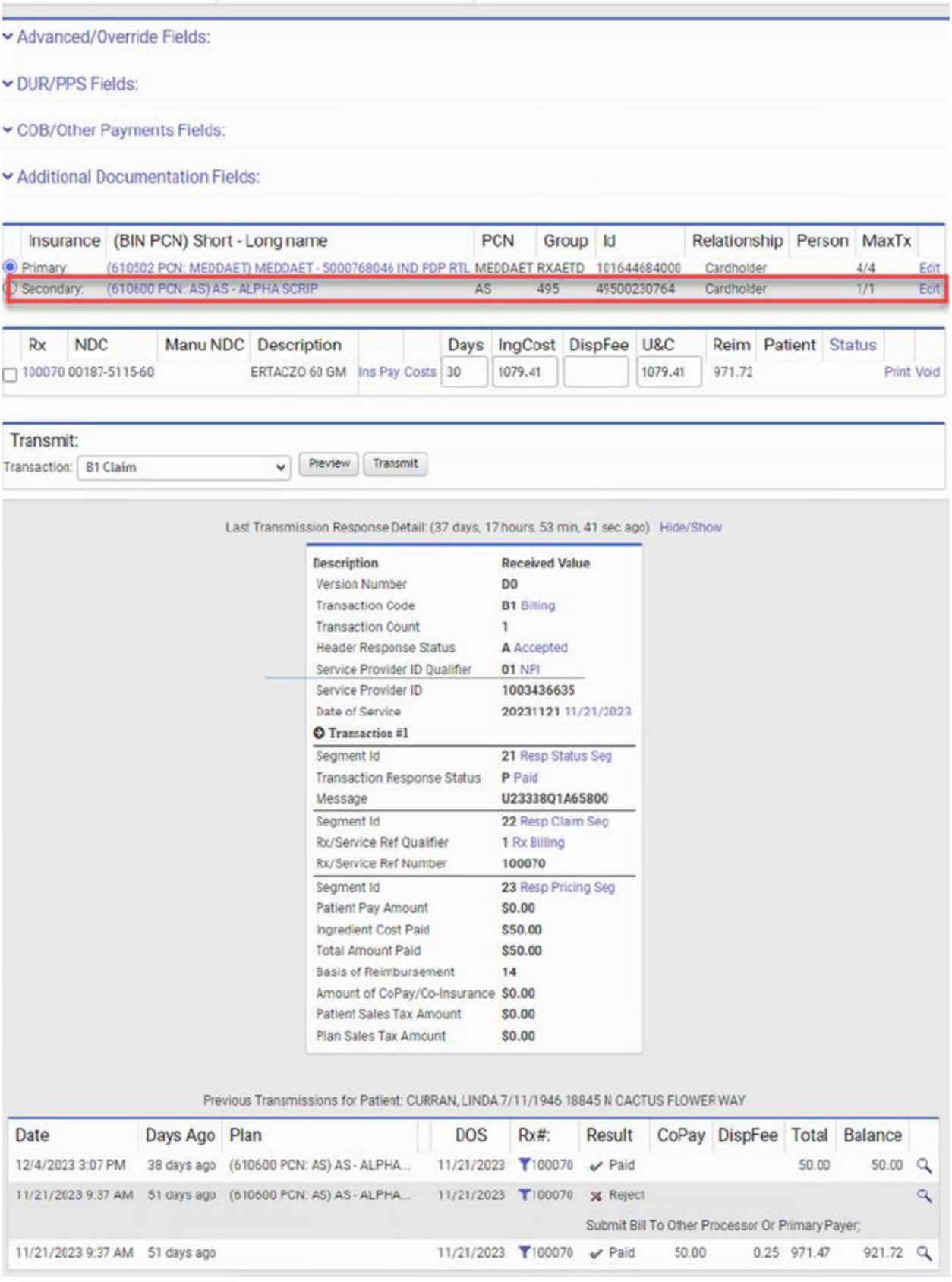
BIN: 610600
Group #: 495
PCN: AS
ID #: 49500230764



Rx# 100070- Please see the adjudication screenshot submitted to the auditor showing that a coupon was used:

Coupon info on screenshot:

BIN: 610600
Group #: 495
PCN: AS
ID #: 49500230764 (same ID # as patient [redacted])



Due to the pharmacy using Alpha Scrip copay cards, which is a violation of Section 3.03.01 of the Caremark Provider Manual that states, "Pharmaceutical Manufacturer Coupons that are only eligible to be used at specific pharmacies are not allowed. Certain Pharmaceutical Manufacturer Programs are specifically disallowed including, but not limited to, those from Alpha Scrip, SimpleSaveRx, Affordable Medication Solutions, RetainRx, RxData Resources PBM, Phoenix PBM and all associated programs, including, but not

limited to, The Association for Precision Pharmacy Services and Arena Health Foundation," no credit was issued.

DC1	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
INV	0100062	11/13/2023	ERTACZO CRE 2%	$85.00	180	Email explaining they used Alpha Scrip, not Alpha ScripT; **Violates Section 3.03.03 of the Caremark Provider Manual**	No Credit
INV	0100070	11/21/2023	ERTACZO CRE 2%	$50.00	60	Email explaining they used Alpha Scrip, not Alpha ScripT; **Violates Section 3.03.03 of the Caremark Provider Manual**	No Credit

After review, 2 INV discrepancies remain.

The results of the audit are as follows:

Initial Chargeback Amount	$3,402.77
Final Chargeback Amount	$3,402.77
Audit Fee	$0.00

Discrepancy Code	Discrepancy Count
INV	2

Janel Chavez CPhT | Sr. Analyst, Network Performance, CVS Health
[redacted]
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 53:
CVS_HJC_00012411 Internal email thread discussing a CVS audit of an independent pharmacy

From: Chavez, Janel E [redacted]

Sent: 7/22/2024 9:33:17 PM

To: Markovic, Sandra [redacted]; Hoversten, Jeffrey R [redacted]; Pontecorvo, Christine A [redacted]; Warner, Robert T [redacted]; Smith, Amy L [redacted]; Lindsey, Stormie R [redacted]; Hains, Todd P [redacted]; Alderman, Mary Melissa [redacted]; Thomas, Jennifer A [redacted]; Tourani, Zohreh [redacted]

CC: Terrel, Jaclyn [redacted]; Flores, Elizabeth [redacted]; Grosso, Lauren A. [redacted]; Mccall, Steven D. [redacted]; Kapadia, Amish B. [redacted]; Urbatchka, Lindsey E [redacted]; Fenker, Jason [redacted]; Palomo, Bertha J. [redacted]; Testa, Elizabeth A [redacted]; Bufalino, Danielle [redacted]; Klein, Angeles [redacted]; Cline, Jenifer [redacted]; Curtis, Melissa A [redacted]; Thomsen, Kayleigh M [redacted]; Atwood, Jonathan W [redacted]; Jones, Candice [redacted]; Luckinbill, Reagan J [redacted]; Chavez, Janel E [redacted]; Soza, Rosa [redacted]; Lewis, Devona A [redacted]; Rowell, Melissa A [redacted]; Tarlian, Alyssa M [redacted]

Subject: Post Audit Summary for: HEMMANUEL PHARMACY NCPDP# 5934597-93579- Finalized

Post Audit Summary

Pharmacy Information: HEMMANUEL PHARMACY NCPDP# 5934597 / NPI 1366014300

Audit Date: 5/13/2024

Audit Type: Expanded

Audit Time Frame: 3/15/2023-1/15/2024

Payment Suspension: No

Attorney: No

Audit Initiated: An expanded audit was initiated due to management referral. "Pharmacy running test claims through Nobel Telehealth. Member complaint from Aetna member stating they received a shipment they did not request. Per Danielle Bufalino: Hemmanuel Pharmacy partnering with Noble Telehealth. Large amounts of test claims for hyperinflated meds. C&D letter did go out to pharmacy, but Aetna concerned with meds being shipped to patient without their knowledge and patients not even receiving these meds."

Appeals Received: Yes

General Summary:

0 out of 9 CPY discrepancies received credit.
7 out of 26 DIS discrepancies received credit.
2 out of 32 OTH discrepancies received credit.
0 out of 2 PRD discrepancies received credit.

Detailed Summary: The investigative audit for HEMMANUEL PHARMACY was **finalized on 7/22/2024**. The pharmacy submitted additional documentation to be reviewed by Post Audit. This documentation was reviewed and applied to the audit as follows:

After QC of the McKesson invoice report, the following discrepancies received credit:

TRESIBA FLEX PEN 200U/ML- **2 DIS and cleared drug shortage**

After QC of the Amerisource invoice report, the following discrepancies received credit:

SHINGRIX INJ 50/0.5ML- **5 DIS and cleared drug shortage**

CPY

Auditor comment: "Additional info required for copay collection. Original receipt, pt attestation confirming how & when adjudicated copay was paid and bank statement for cash deposit." (1 CPY- 0 cleared)

The pharmacy submitted a patient attestation and proof of delivery. **Due to the lack of bank statements showing cash collected for copays was deposited, as requested by the auditor, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
CPY		0647871	12/9/2023	NOVOLOG F/P PEN 100U/ML	$75.00	15	Patient attestation; Proof of delivery; **No bank statements submitted**	No Credit

Auditor comment: "Additional info required. Original receipt, secondary payor info, pt attestation confirming how & when adjudicated copay was paid, proof of deposited check, last4digits of CC, bank statement for cash deposit." (7 CPY- 0 cleared)

Not addressed in this appeal, discrepancies remain as is.

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH	CPY	0636064	1/2/2024	LOFENA TAB 25MG	$1,741.80	120	No docs	No Credit
OTH	CPY	0643791	1/5/2024	NORGESIC TAB FORTE	$250.00	120	No docs	No Credit
OTH	CPY	0647770	1/8/2024	CROTAN LOT 10%	$75.00	474	No docs	No Credit
OTH	CPY	0644758	1/11/2024	CROTAN LOT 10%	$100.00	474	No docs	No Credit
OTH	CPY	0647770	12/8/2023	CROTAN LOT 10%	$75.00	474	No docs	No Credit
OTH	CPY	0644760	1/11/2024	METHOCARBAMO TAB 1000MG	$495.00	100	No docs	No Credit
OTH	CPY	0636068	1/2/2024	BUTALB/ACETA TAB 50-300MG	$545.47	100	No docs	No Credit

Auditor comment: "Additional information required for copayment collection. Patient attestation confirming entire adjudicated copay has been paid, how & when copay was paid check copy front & back and proof of deposit." (1 CPY- 0 cleared)

RX# 643540 (10/16/23)- The pharmacy submitted a patient attestation dated 10/16/23 (same date as the date of fill), delivery slip, and copy of front and back of the check used. **Due to the patient attestation being dated prior to the audit, the patient attestation not including copay information as requested by the auditor, and**

the image of the back of the check not being legible, and no bank statements submitted, no credit was issued.

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
CPY		0643540	10/16/2023	NAPROXEN SUS 125/5ML	$956.32	1000	Patient attestation dated 10/16/23; Delivery slip; Copy of front/back of check; **Patient attestation dated prior to the audit, patient attestation missing copay info, back of check not legible, and no bank statements submitted**	No Credit

After review, 9 CPY discrepancies remain.

DIS

MCKESSON- The wholesaler submitted an invoice report for a purchase of SHINGRIX INJ 50/0.5ML made 3/1/23-1/15/24 (no date specified for the purchase). **Due to the drug shortage clearing during QC, no additional credit was issued.**

AMERISOURCE- The pharmacy submitted an invoice report for purchases of SHINGRIX INJ 50/0.5ML for the audit timeframe. **Due to the shortage clearing during QC, no additional credit was issued.**

After review, 19 DIS discrepancies remain.

OTH

Auditor comment: "Must send proof of delivery/pickup/mail showing date, original receipt & patient attestation confirming receipt of meds & entire adjudicated copay has been paid, how/when copay was paid if CC was used last 4 digits, CC merchant report or check copy front & back." (2 OTH- 0 cleared)

The pharmacy submitted patient attestations, sig logs for delivery, and copies of front and back of checks used to pay copays. **Due to the patient attestations being dated prior to the audit, the patient attestations not including copay information as requested by the auditor, the images of the back of the checks not being legible, and no bank statements submitted, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH		0643540	11/14/2023	NAPROXEN SUS 125/5ML	$956.32	1000	Patient attestation dated 11/14/23; Sig log for delivery; Copy of front/back of check; **Patient attestation dated prior to the audit and missing copay info, no proof of delivery, just a sig log, and back of check not legible**	No Credit
OTH		0643540	12/6/2023	NAPROXEN SUS 125/5ML	$668.74	1000	Patient attestation dated 12/6/23; Sig log for delivery; Copy of front/back of check; **Patient attestation dated prior to the audit and missing copay info, no proof of delivery, just a sig log, and back of check not legible**	No Credit

Auditor comment: "Must send trackable proof of delivery showing delivery date and patient attestation confirming receipt of meds including date received." (2 OTH- 0 cleared)

The pharmacy submitted patient attestations, and sig logs for delivery. **Due to the lack of proof of delivery (only sent a signature) showing where meds were delivered from and to, and the patient attestations being dated prior to the audit, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH		0645204	11/24/2023	DUPIXENT INJ 300/2ML	$0.00	4	Patient attestation dated 11/24/23; Sig log for delivery; **Patient attestation dated prior to the audit and no proof of delivery, just a sig log**	No Credit
OTH		0645204	12/26/2023	DUPIXENT INJ 300/2ML	$0.00	4	Patient attestation dated 12/26/23; Sig log for delivery; **Patient attestation dated prior to the audit and no proof of delivery, just a sig log**	No Credit

Auditor comment: "Provide evidence MD-PT relationship. Ex: chart notes, H&P exam notes & other medical records. Include validations this item was prescribed, time, place & means of interaction w/ PT by MD." (20 OTH- 2 cleared)

RX# 637882 AND 637881 (1/2/24)- **2 OTH discrepancies were removed due to the claims already being charged back as PRD with the same external comment.**

The Pharamcy submitted chart notes. **Due to the lack of visible sourcing and no mention of the medications that are discrepant in the chart notes, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH	CPY	0636064	1/2/2024	LOFENA TAB 25MG	$1,741.80	120	Chart notes; **No visible sourcing**	No Credit
OTH		0646031	1/9/2024	NAPROXEN SUS 125/5ML	$0.00	1000	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH		0638405	10/10/2023	KETOPROFEN CAP 25MG	$0.00	400	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH		0644164	10/24/2023	NAPROXEN SUS 125/5ML	$0.00	1000	Chart notes; **Chart notes show that Naproxen EC 500mg tabs were prescribed, not the suspension, and no visible sourcing**	No Credit
OTH		0646033	11/16/2023	DIFLORASONE CRE 0.05%	$0.00	60	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH	CPY	0643791	1/5/2024	NORGESIC TAB FORTE	$250.00	120	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH		0633152	10/10/2023	SALICYLIC AC OIN 3%	$0.00	240	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH		0644164	11/14/2023	NAPROXEN SUS 125/5ML	$0.00	1000	Chart notes; **Chart notes show that Naproxen EC 500mg tabs were prescribed, not the suspension, and no visible sourcing**	No Credit
OTH	CPY	0647770	1/8/2024	CROTAN LOT 10%	$75.00	474	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH	CPY	0644758	1/11/2024	CROTAN LOT 10%	$100.00	474	Chart notes; **Chart do not show the discrepant meds were prescribed, and no visible sourcing**	No Credit
OTH		0635114	7/7/2023	SALICYLIC AC OIN 3%	$10.35	240	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit

OTH	CPY	0647770	12/8/2023	CROTAN LOT 10%	$75.00	474	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH		0644164	12/14/2023	NAPROXEN SUS 125/5ML	$0.00	1000	Chart notes; **Chart notes show that Naproxen EC 500mg tabs were prescribed, not the suspension, and no visible sourcing**	No Credit
OTH	CPY	0644760	1/11/2024	METHOCARBAMO TAB 1000MG	$495.00	100	Chart notes; **Chart do not show the discrepant meds were prescribed, and no visible sourcing**	No Credit
OTH		0641927	1/4/2024	LOFENA TAB 25MG	$1.55	120	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH		0632716	6/12/2023	NORGESIC TAB FORTE	$0.00	120	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH		0639912	11/29/2023	DIFLORASONE CRE 0.05%	$4.15	60	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
OTH	CPY	0636068	1/2/2024	BUTALB/ACETA TAB 50-300MG	$545.47	100	Chart notes; **No visible sourcing**	No Credit

Auditor comment: "Provide evidence MD-PT relationship. Ex: chart notes//Must send trackable proof of delivery showing delivery date and patient attestation confirming receipt of meds including date received." (8 OTH- 0 cleared)

The Pharamcy submitted chart notes. **Due to the lack of visible sourcing, no mention of the medications that are discrepant in the chart notes, and lack of patient attestations as requested by the auditor, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH		0639912	1/4/2024	DIFLORASONE CRE 0.05%	$4.50	60	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit
OTH		0646031	11/16/2023	NAPROXEN SUS 125/5ML	$0.00	1000	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit
OTH		0633152	6/15/2023	SALICYLIC AC OIN 3%	$0.00	240	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit
OTH		0639912	9/2/2023	DIFLORASONE CRE 0.05%	$4.15	60	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit
OTH		0639912	10/4/2023	DIFLORASONE CRE 0.05%	$4.15	60	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit
OTH		0646033	12/16/2023	DIFLORASONE CRE 0.05%	$0.00	60	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit
OTH		0646031	12/14/2023	NAPROXEN SUS 125/5ML	$0.00	1000	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit
OTH		0646033	1/9/2024	DIFLORASONE CRE 0.05%	$0.00	60	Chart notes; **No mention of the discrepant meds in the chart notes, no visible sourcing, and no patient attestation submitted**	No Credit

After review, 30 OTH discrepancies remain.

PRD

Auditor comment: "Provide evidence MD-PT relationship. Ex: chart notes, H&P exam notes & other medical records. Include validations this item was prescribed, time, place & means of interaction w/ PT by MD." (2 PRD-0 cleared)

The Pharamcy submitted chart notes. **Due to the lack of visible sourcing and no mention of the medications that are discrepant in the chart notes, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
PRD		0637882	1/2/2024	KETOPROFEN CAP 25MG	$0.00	400	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit
PRD		0637881	1/2/2024	CHLORZOXAZON TAB 250MG	$0.00	120	Chart notes; **No mention of the discrepant meds in the chart notes, and no visible sourcing**	No Credit

After review, 2 PRD discrepancies remain.

****Texas Prompt Pay Verified****

The results of the audit are as follows:

Initial Chargeback Amount	$81,815.04
Final Chargeback Amount	$76,837.90
Audit Fee	$15,367.58

Discrepancy Code	Discrepancy Count
CPY	9
DIS	19
OTH	30
PRD	2

NABP #:	**5934597**				
Pharmacy:	**HEMMANUEL PHARMACY**				
DATE RANGE:	**3/15/2023-1/15/2024**				
NDC	**DRUG LABEL NAME**	**INVOICE TOTALS**	**Sum QTY Billed**	**DIFFERENCE**	
11877001133, 11877001140	BINAXNOW COV KIT HOME TES	520	**14622**	(14102)	0 cb
91237000117	EASY MINI MIS EJECT (LANCING DEVICE)	400	**546**	(146)	38 cb
82607066028, 82607066026, 82607066027	FLOWFLEX KIT TEST	4968	**14506**	(9538)	0 cb

Janel Chavez CPhT | Sr. Analyst, Network Performance, CVS Health
[redacted]
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 54:
CVS_HJC_00012459 Internal email thread discussing sending a cease-and-desist letter to an independent pharmacy

From: Mccall, Steven D. [redacted]
Sent: 8/5/2024 10:34:22 PM
To: Terrel, Jaclyn [redacted] Fenker, Jason [redacted]
CC: Bufalino, Danielle [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Yes, please.

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Monday, August 5, 2024 3:31 PM
To: Mccall, Steven D. [redacted]; Fenker, Jason [redacted]
Cc: Bufalino, Danielle [redacted]; Terrel, Jaclyn [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Thanks. Buff can you finalize and mail on Thursday? Steve did you want to email the contacts directly as well?

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Mccall, Steven D. [redacted]
Sent: Monday, August 5, 2024 3:27 PM
To: Fenker, Jason [redacted]; Terrel, Jaclyn [redacted]
Cc: Bufalino, Danielle [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Added ASPN, since Assembia was listed on two examples.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination,

distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Fenker, Jason [redacted]
Sent: Monday, August 5, 2024 3:17 PM
To: Terrel, Jaclyn [redacted]; Mccall, Steven D. [redacted]
Cc: Bufalino, Danielle [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

I had a minor suggestion.

Thanks,
Jason

Jason Fenker, PharmD | Sr Manager, Network Pharmacy, CVS Caremark
[redacted]
9501 E Shea Blvd, Mail Code 0020, Scottsdale, AZ 85260

Upcoming PTO:

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Monday, August 5, 2024 1:44 PM
To: Fenker, Jason [redacted]; Mccall, Steven D. [redacted]
Cc: Terrel, Jaclyn [redacted] Bufalino, Danielle [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Hey Fenk and Steve-o. Please review and provide additional edits.

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Bufalino, Danielle [redacted]
Sent: Thursday, August 1, 2024 12:02 PM
To: Terrel, Jaclyn [redacted]
Cc: Fenker, Jason [redacted]; Mccall, Steven D. [redacted]; Bufalino,

Danielle [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

I cleaned up the first paragraph and added drugs that call out blink and phil.

Thank you,
Danielle

Danielle Bufalino, PharmD | Manager, Pharmacy Performance, CVS/Caremark
[redacted] *(Please note I am working remotely due to COVID-19 – please contact me by email.)*
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

Upcoming PTO:



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Wednesday, July 31, 2024 3:58 PM
To: Bufalino, Danielle [redacted]
Cc: Fenker, Jason [redacted]; Mccall, Steven D. [redacted]; Terrel, Jaclyn [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Thanks buff. Please see my edits.

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Bufalino, Danielle [redacted]
Sent: Wednesday, July 31, 2024 12:33 PM
To: Terrel, Jaclyn [redacted]
Cc: Fenker, Jason [redacted]; Mccall, Steven D. [redacted]; Bufalino, Danielle [redacted]
Subject: RE: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Hello,

Attached is the draft for Polaris's C&D.

Thank you,
Danielle

Danielle Bufalino, PharmD | Manager, Pharmacy Performance, CVS/Caremark
[redacted] *(Please note I am working remotely due to COVID-19 – please contact me by email.)*
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260

Upcoming PTO:



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Tuesday, July 30, 2024 10:25 AM
To: Bufalino, Danielle [redacted]
Cc: Fenker, Jason [redacted]; Mccall, Steven D. [redacted]; Terrel, Jaclyn [redacted]
Subject: FW: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Hey Buff,

In Jason's absence, can you start a draft C&D for this pharmacy? The C&D will be for HUB practices. We will need to cite the usual PM language and then provide the information or habits of the pharmacy that point towards these practices. Jay had already pulled Trudhesa data below, not sure they are pulling other known HUB drugs.

I also want to add that that we have to be able to reach them so let's add PM language here as well, believe provision 7 covers it, and provide the contact information they have on file. We will also need to add a blurb that if it's incorrect, they need to contact Caremark immediately to update. I can help you put in the change form information if you don't have it already.

Let's aim for this week sometime please.

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Terrel, Jaclyn [redacted]
Sent: Monday, July 29, 2024 3:33 PM
To: Mccall, Steven D. [redacted]; Falzarano, Andrew [redacted]
Cc: Terrel, Jaclyn [redacted]
Subject: FW: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

Jay had pulled this for the call tomorrow. Also, I don't think we ever received an official cap from them.

Thanks,
Jackie

Jackie Terrel, PharmD | Director, Pharmacy Performance
9501 E Shea BLVD, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Fenker, Jason [redacted]
Sent: Tuesday, July 16, 2024 12:41 PM
To: Mccall, Steven D. [redacted]; Terrel, Jaclyn [redacted]
Subject: FW: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services **Contains PHI**

FYI on this Polaris Pharmacy Services call (7/30/24) – I'll be on PTO.

1. The pharmacy had a substantial number of Trudhesa claims. Based on data, not seeing the standard hub behavior. To note, in one year…client spend on Trudhesa from this pharmacy is $7.4M. Also to note, there must have been a recent name change https://premierpharmacyservices.com/

Time frame: 5/28/2023 to 5/28/2024

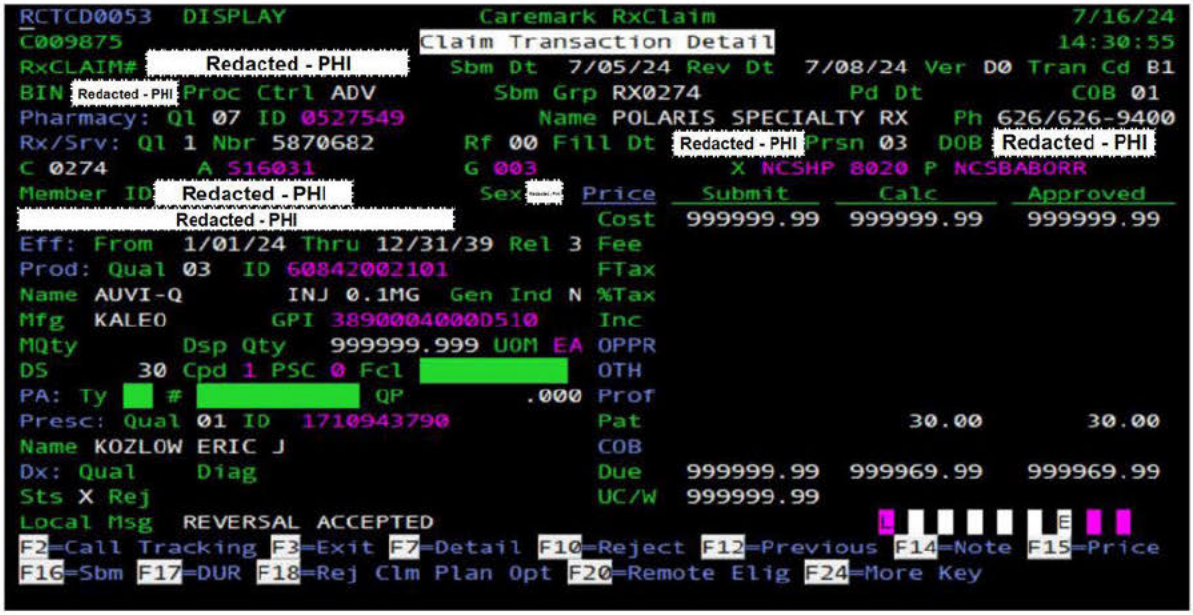
Status	Claims	% Claims
P	3346	70.10%
R	963	20.18%
V	464	9.72%
Grand Total	**4773**	**100.00%**

And, here is a look at the member states

Mbr State	Claims	% Claims
	10	0.21%
AL	33	0.69%
AR	57	1.19%
AZ	201	4.21%
CA	591	12.38%
CO	51	1.07%
CT	148	3.10%
DC	25	0.52%
DE	54	1.13%
FL	236	4.94%
GA	261	5.47%
IA	14	0.29%
ID	14	0.29%
IL	133	2.79%
IN	55	1.15%
KS	32	0.67%
KY	154	3.23%
LA	86	1.80%
MA	73	1.53%
MD	181	3.79%
ME	14	0.29%
MI	36	0.75%
MN	21	0.44%
MO	96	2.01%
MS	50	1.05%
NC	140	2.93%
NE	21	0.44%
NH	1	0.02%
NJ	166	3.48%
NM	27	0.57%
NV	74	1.55%
NY	265	5.55%
OH	104	2.18%
OK	98	2.05%
OR	13	0.27%
PA	378	7.92%
RI	14	0.29%
SC	75	1.57%
SD	2	0.04%
TN	148	3.10%
TX	315	6.60%
UT	49	1.03%
VA	177	3.71%
VT	1	0.02%
WA	37	0.78%
WI	21	0.44%
WV	16	0.34%
WY	5	0.10%
Grand Total	**4773**	**100.00%**

2. We sent several requests for documentation on random Trudhesa claims and Polaris never responded.

3. $1M overbilled quantity claim for Auvi-Q and I was never able to speak to the pharmacy. It was finally reversed, but the pharmacy never returned my voicemails or faxes. Speaking to someone on this Auvi-Q claim was very difficult and not successful as I was transferred several times. Why?



Thanks,
Jason

Jason Fenker, PharmD | Sr Manager, Network Pharmacy, CVS Caremark
[redacted]
9501 E Shea Blvd, Mail Code 0020, Scottsdale, AZ 85260

Upcoming PTO:

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

-----Original Appointment-----
From: Fenker, Jason
Sent: Tuesday, July 16, 2024 12:23 PM
To: Hedges, Marc B
Subject: Declined: [Place Holder] Chain Enrollment Packet - Polaris Pharmacy Services
When: Tuesday, July 30, 2024 12:00 PM-12:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

Hey Marc – I'll be on PTO[redacted]

Exhibit 55: CVS_HJC_00012600 Email thread between White Drug's counsel and CVS discussing White Drug's compliance with the cease-and-desist letter

From: Lyster, Amy [redacted]
Sent: 9/24/2024 8:30:43 PM
To: Mccall, Steven D [redacted]; Smith, Amy L [redacted]; Terrel, Jaclyn [redacted]; Fenker, Jason [redacted]
CC: Lyster, Amy [redacted]
Subject: FW: White Drug

From: [redacted]
Sent: Tuesday, September 24, 2024 3:57 PM
To: Lyster, Amy [redacted]
Cc: Thomas, Robin D [redacted]
Subject: [EXTERNAL] RE: White Drug

****** External Email - Use Caution ******

Amy: Per our September 11, 2024 correspondence, the Pharmacy is unaware of circumstances in which Blink Rx is processing Pharmacy claims. Certainly, Blink Rx has no authority to do so. As referenced previously, should Caremark see any evidence of third-party claim submissions in the future, the Pharmacy requests that it be informed immediately so that they can identify and take appropriate action. The Pharmacy may receive transfers from other pharmacies such as Blink to fill prescriptions.

We appreciate the communication.

[redacted]

[redacted]
Shareholder
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
901 K Street, NW
Suite 900
Washington, DC 20001

Direct: [redacted]
Fax: [redacted]
E-mail: [redacted]
www.bakerdonelson.com

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC represents clients across the U.S. and abroad from offices in Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Washington, D.C.

From: Lyster, Amy [redacted]
Sent: Tuesday, September 24, 2024 1:59 PM
To: [redacted]
Cc: Thomas, Robin D [redacted]; Lyster, Amy [redacted]
Subject: RE: White Drug

[redacted]

I am following up on the below email. Please advise.

Thank you.

From: Lyster, Amy
Sent: Tuesday, September 17, 2024 8:21 AM
To: [redacted]
Cc: Thomas, Robin D [redacted]; Lyster, Amy [redacted]
Subject: RE: White Drug

[redacted]

Your letter hasn't addressed Caremark's main concern – the use of Blink Rx to process claims. On no less than three separate occasions, your client's employees have volunteered in discussions with Caremark that claims are running through Blink. This runs counter to the statements made in your letter. Please advise.

Thank you.

Amy K. Lyster | Senior Counsel, CVS Health
[redacted]

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Wednesday, September 11, 2024 10:32 AM
To: Lyster, Amy [redacted]
Cc: Thomas, Robin D [redacted]
Subject: [EXTERNAL] RE: White Drug

****** External Email - Use Caution ******

Appreciate the recent conversation. Please see attached.

[redacted]

[redacted]
Shareholder
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
901 K Street, NW
Suite 900
Washington, DC 20001

Direct: [redacted]
Fax: [redacted]
E-mail: [redacted]
www.bakerdonelson.com

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC represents clients across the U.S. and abroad from offices in Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Washington, D.C.

From: [redacted]
Sent: Thursday, September 5, 2024 4:31 PM
To: Lyster, Amy [redacted]
Cc: Thomas, Robin D [redacted]
Subject: RE: White Drug

Thanks.

From: Lyster, Amy [redacted]
Sent: Thursday, September 5, 2024 4:24 PM
To: [redacted]
Cc: Thomas, Robin D [redacted]
Subject: RE: White Drug

Confirmed. Thank you.

From: [redacted]
Sent: Thursday, September 5, 2024 3:43 PM
To: Lyster, Amy [redacted]
Cc: Thomas, Robin D [redacted]
Subject: [EXTERNAL] FW: White Drug

****** External Email - Use Caution ******

Amy:

Per our call today, we understand that White Drug #061 has been granted an extension up to next Friday (September 13) to submit the response to your August 22, 2024 letter entitled "Final Notice – Response."

If you could confirm this to be accurate, that would be much appreciated.

Thanks.

[redacted]

[redacted]
Shareholder
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
901 K Street, NW
Suite 900
Washington, DC 20001

Direct: [redacted]
Fax: [redacted]
E-mail: [redacted]
www.bakerdonelson.com

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC represents clients across the U.S. and abroad from offices in Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Washington, D.C.

From: [redacted]
Sent: Tuesday, September 3, 2024 4:21 PM
To: Lyster, Amy [redacted]
Cc: Thomas, Robin D [redacted]
Subject: RE: White Drug

Amy:

Hope you had a good holiday weekend. We received your August 22, 2024 letter. In this letter, there is a reference to two claims that Caremark says was recently submitted utilizing White Drug's NCPDP or NPI number. The fill dates for these two claims are listed by Caremark as 10/20/2024 and 8/16/2032.

Can you please send us more information regarding these two claims to allow the Pharmacy to properly research the matter? We would respectfully request some additional time to submit the response after receiving this information. Please confirm.

[redacted]

[redacted]
Shareholder
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
901 K Street, NW
Suite 900
Washington, DC 20001

Direct: [redacted]
Fax: [redacted]
E-mail: [redacted]
www.bakerdonelson.com

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC represents clients across the U.S. and abroad from offices in Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Washington, D.C.

From: Lyster, Amy [redacted]
Sent: Thursday, August 22, 2024 12:52 PM
To: [redacted]
Cc: Thomas, Robin D [redacted]; Lyster, Amy [redacted]
Subject: RE: White Drug

[redacted]

Please see the attached correspondence from Caremark.

Thank you.

Amy K. Lyster | Senior Counsel, CVS Health
[redacted]

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution

or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Azia, Steve [redacted]
Sent: Friday, August 9, 2024 12:22 PM
To: Lyster, Amy [redacted] Thomas, Robin D [redacted]
Subject: [EXTERNAL] FW: White Drug

****** External Email - Use Caution ******

I wanted to follow-up regarding this matter to ensure we maintain an open dialogue. The Pharmacy is continuing to work diligently with its vendors to put additional blocks in place that make submission of claims by a third party impossible.

As noted in our 7/26/2024 correspondence, should Caremark see any evidence of third-party claim submissions, the Pharmacy asks that they be informed immediately so that they can identify and take action against the perpetrator.

We are available to discuss at your convenience.

Thank you,

[redacted]

[redacted]
Shareholder
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
901 K Street, NW
Suite 900
Washington, DC 20001

Direct: [redacted]
Fax: [redacted]
E-mail: [redacted]
www.bakerdonelson.com

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC represents clients across the U.S. and abroad from offices in Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Washington, D.C.

From: [redacted]
Sent: Friday, July 26, 2024 3:51 PM
To: Thomas, Robin D [redacted] Lyster, Amy [redacted]
Subject: RE: White Drug

Please find White Drug #061's response attached. We have also submitted the attached correspondence to the fax number listed in the notice.

We are available should Caremark have any questions.

Thank you,

[redacted]

[redacted]
Shareholder
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC

901 K Street, NW
Suite 900
Washington, DC 20001

Direct: [redacted]
Fax: [redacted]
E-mail: [redacted]
www.bakerdonelson.com

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC represents clients across the U.S. and abroad from offices in Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Washington, D.C.

From: Thomas, Robin D [redacted]
Sent: Friday, July 19, 2024 10:27 AM
To: [redacted]; Lyster, Amy [redacted]
Subject: RE: White Drug

[redacted] The business team has extended the response deadline to Friday, 7/26/2024, and has provided the following examples:

NCPDP_PRVDR_ID	RX_NBR	FILL_DT	PHMCY_NM	DRUG_LBL_NM
3504138	931801129	7/1/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931801130	7/1/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107732488	7/1/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931806352	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107740364	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931809884	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107679984	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931810192	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107346345	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931810207	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107746498	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931812120	7/2/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931823576	7/5/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107599209	7/5/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107732488	7/5/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931840956	7/9/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107740364	7/9/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931850778	7/10/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107827402	7/10/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107732488	7/10/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931852682	7/10/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107835029	7/10/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	931886951	7/16/2024	WHITE DRUG	GIMOTI SPR 15MG
3504138	107827402	7/16/2024	WHITE DRUG	GIMOTI SPR 15MG

Duplicate prescritpion number with different Date of Fill

Robin Thomas, CP (She.Her.Hers.)
Senior Paralegal
Remote, Arizona

CVSHealth

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Wednesday, July 17, 2024 10:53 AM
To: Lyster, Amy [redacted]
Cc: Thomas, Robin D [redacted]
Subject: [EXTERNAL] White Drug

****** External Email - Use Caution ******

Amy:

We represent White Drug located in Fargo, North Dakota. The Pharmacy received a notice dated July 5, 2024 stating, in part, that White Drug "continues to allow a third party to submit [test] claims to Caremark." The Pharmacy was surprised to receive this information and is researching the matter. Any submission by a third party is against Pharmacy policy.

Can you please provide us the claim information for claims that you believe were submitted by a third party? Upon receiving this information, we respectfully request a few extra days to review the claim information and submit a response addressing the issue.

[redacted]
Shareholder
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
901 K Street, NW
Suite 900
Washington, DC 20001

Direct: [redacted]
Fax: [redacted]
E-mail: [redacted]
www.bakerdonelson.com

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC represents clients across the U.S. and abroad from offices in Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Washington, D.C.

NOTICE: This electronic mail transmission with any attachments may constitute an attorney-client communication, protected health information (PHI) or other confidential information that is in fact confidential, legally protected from disclosure and/or protected by the attorney-client privilege. If you are the intended recipient, please maintain confidentiality and be aware that forwarding this e-mail to others may result in a waiver of these protections and privileges and regardless electronic communications may be at times illegally accessed and viewed. If you are not the intended recipient, this e-mail is not intended for transmission to you, nor to be read, reviewed, used, distributed or even received by you or any other unauthorized persons. If you have received this electronic mail transmission in error, please double delete it from your system immediately without copying, reading or disseminating it, and notify the sender by reply e-mail, so that our address record can be corrected. Thank you very much.

Exhibit 56:
CVS_HJC_00012614 Internal email thread discussing a CVS audit of an independent pharmacy

From: Chavez, Janel E [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=D1752A12FFE5478097F303D874638114-CHAVEZ, JAN]
Sent: 9/30/2024 7:06:32 PM
To: Markovic, Sandra [sandra.markovic@cvshealth.com]; Hoversten, Jeffrey R [jeffrey.hoversten@cvshealth.com]; Pontecorvo, Christine A [christine.pontecorvo@cvshealth.com]; Warner, Robert T [robert.warner@cvshealth.com]; Smith, Amy L [amy.smith@cvshealth.com]; Lindsey, Stormie R [stormie.lindsey@cvshealth.com]; Hains, Todd P [todd.hains@cvshealth.com]; Alderman, Mary Melissa [mary.alderman@cvshealth.com]; Thomas, Jennifer A [jennifer.thomas@cvshealth.com]; Ralhan, Niyati [niyati.ralhan@cvshealth.com]
CC: Terrel, Jaclyn [jaclyn.terrel@cvshealth.com]; Flores, Elizabeth [elizabeth.flores@cvshealth.com]; Grosso, Lauren A. [lauren.grosso@cvshealth.com]; Mccall, Steven D. [steven.mccall@cvshealth.com]; Kapadia, Amish B. [amish.kapadia@cvshealth.com]; Urbatchka, Lindsey E [lindsey.urbatchka@cvshealth.com]; Fenker, Jason [jason.fenker@cvshealth.com]; Palomo, Bertha J. [bertha.palomo@cvshealth.com]; Testa, Elizabeth A [elizabeth.testa@cvshealth.com]; Bufalino, Danielle [danielle.bufalino@cvshealth.com]; Klein, Angeles [angeles.klein@cvshealth.com]; Cline, Jenifer [jenifer.cline@cvshealth.com]; Curtis, Melissa A [melissa.curtis2@cvshealth.com]; Thomsen, Kayleigh M [kayleigh.thomsen@cvshealth.com]; Atwood, Jonathan W [jonathan.atwood@cvshealth.com]; Jones, Candice [candice.jones@cvshealth.com]; Luckinbill, Reagan J [reagan.luckinbill@cvshealth.com]; Chavez, Janel E [janel.chavez@cvshealth.com]; Soza, Rosa [rosa.soza@cvshealth.com]; Lewis, Devona A [devona.lewis@cvshealth.com]; Rowell, Melissa A [melissa.rowell@cvshealth.com]; Tarlian, Alyssa M [alyssa.tarlian@cvshealth.com]
Subject: Post Audit Summary for: POD PHARMACY NCPDP# 3157232-93380- Finalized **ATTORNEY**

Post Audit Summary

Pharmacy Information: POD PHARMACY NCPDP# 3157232 / NPI 1386271989

Audit Date: 4/25/2024

Audit Type: Expanded

Audit Time Frame: 1/1/2023-12/31/2023

Payment Suspension: No

Attorney: Yes

Satish V. Poondi, Esq.
TISS ATTORNEYS AT LAW
290 W. Mt. Pleasant Ave, Suite 2350
Livingston, NJ 07039
P: 973.533.1000
E: spoondi@trenkisabel.law

Audit Initiated: An expanded audit was initiated due to a referral from the onsite auditor. Per onsite auditor, "claims within this audit transferred in from Wappingers Pharmacy in Wappingers Falls, NY over 65 miles North of this location. The owner Sumeet Datwani stated he had no idea why they transferred in from this pharmacy. The pharmacy appears to be filling prescriptions written by prescribers over 50 miles from this pharmacy location with patients also addresses 50 miles plus from this location. The owner was not able to provide a reason for this. Pharmacy appears to be running test claims for hyper inflated products for non-local patients, then transferring out to another pharmacy after reversing."

Appeals Received: Yes

Timeline:

5/8/2024- Initial audit report delivered to the pharmacy
5/15/2024- Documentation received from Kinray
5/16/2024- Documentation received from Kinray
6/26/2024- Original documentation due date
6/26/2024- Pharmacy requested an extension which was approved with new documentation due date of 7/10/2024
6/27/2024- Documentation received from attorney
7/10/2024- New documentation due date
8/29/2024- Email received from attorney regarding C&D Letter
9/12/2024- Email received from attorney regarding C&D Letter
9/30/2024- Audit finalized

General Summary:

1 out of 3 CPY discrepancies received credit.
1 out of 3 DIS discrepancies received credit.
0 out of 1 OBQ discrepancies received credit.
20 out of 25 OTH discrepancies received credit.

Detailed Summary: The investigative audit for POD PHARMACY was **finalized on 9/30/2024**. The pharmacy's attorney submitted additional documentation to be reviewed by Post Audit. This documentation was reviewed and applied to the audit as follows:

Exhibit A: Copy of Initial Discrepancy Report
Exhibit B: Patient attestations and proof of deliveries
Exhibit C: Adjudication screenshots for RX# 143072
Exhibit D: Drug Dispensed Report for KRYSTEXXA INJ 8MG/ML

The attorney submitted a letter on 9/12/2024 acknowledging the receipt of Caremark's Cease & Desist Letter regarding Section 5.06 in the Caremark Provider Manual and stated the pharmacy disputes the assertations but will comply with Section 5.06.

CPY

Auditor comment: "Copayment collection receipt & pick up log not accepted. Must send receipt & patient attestation confirming receipt of meds, copay has been paid, how and when copay was paid." (2 CPY- 0 cleared)

The attorney submitted a patient attestation stating the meds were picked up and adjudication screenshots showing Change Healthcare reduced the copays to $10. **Due to the patient attestation not including any copay information and the lack of receipts as requested by the auditor, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit

CPY	OTH	0143072	11/13/2023	TYRVAYA SPR 0.03MG	$150.00	8	Patient attestation for p/u the meds; Adjudication screenshot showing copay was reduced to $10 by Change Healthcare; **Patient attestation does not have copay info in it and no receipt submitted**	No Credit
CPY	OTH	0143072	12/27/2023	TYRVAYA SPR 0.03MG	$150.00	8	Patient attestation for p/u the meds; Adjudication screenshot showing copay was reduced to $10 by Change Healthcare; **Patient attestation does not have copay info in it and no receipt submitted**	No Credit

Auditor comment: "Proof of CPY collection & proof of delivery not provided. Must send trackable proof of delivery, receipt & patient attestation confirming receipt of meds and entire adjudicated copay has been paid, how copayment was paid and/if CC was used last 4 digits." (1 CPY- 1 cleared)

The attorney stated that the pharmacy has no record of dispensing this prescription on 10/7/23. After further review, the pharmacy reversed the claim on 1/30/24, PRIOR to receiving the audit notice on 2/7/24. **Credit was issued for 1 CPY discrepancy.**

After review, 2 CPY discrepancies remain.

DIS

KINRAY- The wholesaler submitted an invoice report for the audit timeframe. **Due to the purchase being duplicates of what the auditor received, no credit was issued.**

- The wholesaler also submitted an invoice report for 8/15/21-12/31/23. **Purchases outside the audit timeframe were not accepted and no credit was issued.** Purchases from 1 month prior were accepted, and the following discrepancies received credit:

HUMIRA PEN INJ 40MG/0.8- **1 DIS and cleared drug shortage**

KRYSTEXXA INJ 8MG/ML- The attorney submitted a drug dispensed report from 7/9/2022-12/31/2023. **No credit was issued.**

The attorney addressed purchases that occurred prior to the audit timeframe. Please note that purchases from 1 month prior were only received from Kinray and were already accounted for. **No additional credit was issued.**

After review, 2 DIS discrepancies remain.

OBQ

Auditor comment: "Apply to every nail topically at bedtime// 8ml should have been sufficient for a 30days supply." (1 OBQ- 0 cleared)

Not addressed in this appeal, discrepancy remains as is.

DC1	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OBQ	0145589	9/19/2023	JUBLIA SOL 10%	$55.00	12	No docs	No Credit

OTH

Auditor comment: "Copayment collection receipt & pick up log not accepted. Must send receipt & patient attestation confirming receipt of meds, copay has been paid, how and when copay was paid." (2 OTH- 2 cleared)

The attorney submitted patient attestations. **Documentation was accepted and 2 OTH discrepancies received credit.**

Auditor comment: "Member over 50 miles from pharmacy POD not accepted. Must send trackable proof of delivery for this date of service, must include tracking #, delivery date, address item was delivered to, patient attestation confirming how & when item received." (6 OTH- 4 cleared)

The attorney submitted patient attestations signed electronically with signature tracking and delivery tracking. **Documentation was accepted and 4 OTH discrepancies received credit.**

RX# 123245- The attorney submitted a patient attestation signed electronically with signature tracking. **Due to the lack of proof of delivery as requested by the auditor, no credit was issued.**

RX# 120744- The attorney submitted delivery tracking. **Due to the lack of a patient attestation as requested by the auditor, no credit was issued.**

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH		0123245	4/5/2023	AUVELITY TAB 45-105MG	$500.26	60	Patient attestation signed electronically w/ sig tracking; **No proof of delivery submitted**	No Credit
OTH		0120744	3/10/2023	UBRELVY TAB 100MG	$1,101.89	16	Delivery tracking; **No patient attestation submitted**	No Credit

Auditor comment: "No signature log provided - Provide patient attestation confirming how & when RX was delivered." (2 OTH- 2 cleared)

The attorney submitted patient attestations signed electronically with signature tracking. **Documentation was accepted and 2 OTH discrepancies received credit.**

Auditor comment: "Out of state patient. Pharmacy did not provide proof of delivery. Must send trackable proof of delivery for this date of service, must include tracking #, delivery date, address item was delivered to, patient attestation confirming how & when item." (2 OTH- 0 cleared)

Not addressed in this appeal, discrepancies remain as is.

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH		0140891	8/14/2023	XHANCE SPR 93MCG	$455.97	16	No docs	No Credit
OTH		0140891	9/10/2023	XHANCE SPR 93MCG	$455.97	16	No docs	No Credit

Auditor comment: "Pharmacy did not provide a trackable proof of delivery for this date of service. Must send trackable proof of delivery for this date of service, must include tracking #, delivery date, address item was delivered to, pt attestation confirming how & when submitted." (1 OTH- 1 cleared)

The attorney submitted patient attestations signed electronically with signature tracking and delivery tracking. **Documentation was accepted and 1 OTH discrepancy received credit.**

Auditor comment: "Pick up record not accepted. Provide signed patient attestation confirming how & when RX was delivered." (11 OTH- 10 cleared)

The attorney submitted patient attestations signed electronically with signature tracking. **Documentation was accepted and 10 OTH discrepancies received credit.**

RX# 125548- Not addressed in this appeal, discrepancy remains as is.

DC1	DC2	RX #	DOF	Drug	Copay	QTY	Post Audit Documentation	Credit
OTH		0125548	7/6/2023	LOREEV XR CAP 1MG	$114.81	30	No docs	No Credit

Auditor comment: "Proof of CPY collection & proof of delivery not provided. Must send trackable proof of delivery, receipt & patient attestation confirming receipt of meds and entire adjudicated copay has been paid, how copayment was paid and/if CC was used last 4 digits." (1 OTH- 1 cleared)

The attorney stated that the pharmacy has no record of dispensing this prescription on 10/7/23. After further review, the pharmacy reversed the claim on 1/30/24, PRIOR to receiving the audit notice on 2/7/24. **Credit was issued for 1 OTH discrepancy.**

After review, 5 OTH discrepancy remains.

The results of the audit are as follows:

Initial Chargeback Amount	$56,714.93
Final Chargeback Amount	$33,067.81
Audit Fee	$6,613.56

Discrepancy Code	Discrepancy Count
CPY	2
DIS	2
OBQ	1
OTH	5

NABP # : 3157232				
Pharmacy: POD PHARMACY				
DATE RANGE: 1/1/2023-12/31/2023				
NDC	DRUG LABEL NAME	INVOICE TOTALS	Sum QTY Billed	DIFFERENCE
43068011002	FANAPT TAB 10MG	540	570	(30)
75987008010	KRYSTEXXA INJ 8MG/ML	14	15	(1)

Janel Chavez CPhT | Sr. Analyst, Network Performance, CVS Health
p 480-391-4239 | **f** 480-314-6051
9501 E. Shea Blvd, Mail Code 020, Scottsdale, AZ 85260



CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 57:
CVS_HJC_00012693 Email thread between Carepoint Pharmacy and CVS discussing Carepoint's compliance with the cease-and-desist letter

From: Smith, Amy L [redacted]
Sent: 10/11/2024 9:10:49 PM
To: Mccall, Steven D [redacted]
Subject: FW: Carepoint Pharmacy Audit Follow Up Information
Attachments: PHIL_Partner_Pharmacy_Agreement - fully exec 060220 [REDACTED].pdf; Blink Health Hub Agreement - executed101420.pdf; Exhibit_2.6_Carepoint_Hub_Exhibit_New_Products_(Execution_Copy)_signed by Blink - fully exec 030123.pdf; Exhibit 2.7 Carepoint Hub Exhibit (New Products) - CP signed 051923_FE.pdf; Exhibit_2.8_Carepoint_Hub_Exhibit_(New_Products)_(BH_Draft_8.15)_-_CP_signed_081623_FE.pdf; Carepoint Pharmacy Active Vendors.pdf; Arcutis_ZORYVE_Prescription_Form.pdf

Thank you,

Amy Smith | Sr. Manager, Network Management, CVS/caremark [redacted]
CVS Health | 9501 E Shea Blvd., MC 020, Scottsdale, AZ 85260
Engage with us: CVS Health | Twitter | LinkedIn | Facebook | YouTube

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Sutts, Sahra L
Sent: Friday, October 11, 2024 4:26 AM
To: Smith, Amy L
Subject: FW: Carepoint Pharmacy Audit Follow Up Information

Hi Amy,
It would not allow me to attach the email, so I am forwarding the whole thing to you.
Let me know if you need anything else,

Sahra Sutts CPhT | Sr Analyst, Business Auditor, CVS Caremark [redacted]
9501 East Shea Blvd, MC-020, Scottsdale, AZ 8526

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: [redacted]
Sent: Friday, April 5, 2024 5:06 PM
To: Sutts, Sahra L [redacted]
Subject: [EXTERNAL] Carepoint Pharmacy Audit Follow Up Information
Importance: High
****** External Email - Use Caution ******

Good afternoon Sahra,
Thank you again for the valuable information and tips you provided after the audit yesterday. As instructed, here are the follow-up documents you requested. Regarding the Phil and Blink Hub agreements, Phil is one Agreement and Blink is the original Agreement and three exhibits that explicitly state that the pharmacy will collect copay directly from the patient.
If you have any questions or require any other information besides the Hub agreements, vendor list and the Arcutis fax form, please let me know and I will get it to you. Have a nice weekend.

[redacted]
Pharmacy & Compliance Manager

[redacted]

Chicago | Tampa
www.carepoint.pharmacy

Mail Service
Pharmacy
01/01/2025

CONFIDENTIALITY NOTICE This electronic mail transmission may contain privileged, confidential and/or protected health information and is intended only for the review of the party to whom it is addressed. Any unauthorized use or disclosure of the information contained herein may be a violation of federal law, including the Health Insurance Portability and Accountability Act (HIPAA). If you have received this transmission in error, please immediately return it to the sender, delete it and destroy it without reading it. Unintended transmission shall not constitute the waiver of the attorney-client or any other privilege.

Exhibit 58:
CVS_HJC_00012783 Internal email thread discussing Blink Rx

From: Mccall, Steven D [redacted]
Sent: 11/13/2024 9:11:28 PM
To: Smith, Amy L [redacted]
Subject: FW: blink

FYI

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Mccall, Steven D
Sent: Wednesday, November 13, 2024 1:38 PM
To: Schulman, Melissa A. [redacted]; Wellman, William H [redacted]
Cc: Rosenbaum, Amy D [redacted]
Subject: RE: blink

Couple possibles.

White drug has been avoiding question – We started an audit on their claims. I think they are in ND
There is a Fertility pharmacy in Mass – Sent Cease and Desist last week to them

Not much else, although other PBMs may also be taking actions. Central distribution of an expensive non-specialty drug looks like FWA to plan sponsors. For instance our Hawaii client was the one requesting us to audit the ND pharmacy shipping drugs to their state.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Schulman, Melissa A. [redacted]
Sent: Wednesday, November 13, 2024 1:00 PM
To: Wellman, William H [redacted]; Mccall, Steven D [redacted]
Cc: Rosenbaum, Amy D [redacted]
Subject: blink

Has anything happened recently or changed t hat would have fired Blink up?
Thanks,
Melissa

Melissa Schulman | Senior Vice President, Government and Public Affairs
[redacted]

I may send an email outside of regular business hours, but I don't expect you to respond outside of regular business hours.

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 59:
CVS_HJC_00012791 Internal email thread discussing Blink Rx

From: Mccall, Steven D [redacted]
Sent: 11/13/2024 10:32:48 PM
To: Schulman, Melissa A. [redacted]; Wellman, William H [redacted]
CC: Rosenbaum, Amy D [redacted]
Subject: RE: blink

Yes, they both do products for Blink.

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Schulman, Melissa A. [redacted]
Sent: Wednesday, November 13, 2024 3:16 PM
To: Mccall, Steven D [redacted] Wellman, William H [redacted]
Cc: Rosenbaum, Amy D [redacted]
Subject: RE: blink

Are they affiliated with Blink?

From: Mccall, Steven D [redacted]
Sent: Wednesday, November 13, 2024 3:38 PM
To: Schulman, Melissa A. [redacted]; Wellman, William H
[redacted]
Cc: Rosenbaum, Amy D [redacted]
Subject: RE: blink

Couple possibles.

White drug has been avoiding question – We started an audit on their claims. I think they are in ND
There is a Fertility pharmacy in Mass – Sent Cease and Desist last week to them

Not much else, although other PBMs may also be taking actions. Central distribution of an expensive non-specialty drug looks like FWA to plan sponsors. For instance our Hawaii client was the one requesting us to audit the ND pharmacy shipping drugs to their state.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Schulman, Melissa A. [redacted]
Sent: Wednesday, November 13, 2024 1:00 PM
To: Wellman, William H [redacted]; Mccall, Steven D [redacted]

Cc: Rosenbaum, Amy D [redacted]
Subject: blink

Has anything happened recently or changed t hat would have fired Blink up?
Thanks,
Melissa

Melissa Schulman | Senior Vice President, Government and Public Affairs
[redacted]

I may send an email outside of regular business hours, but I don't expect you to respond outside of regular business hours.

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

Exhibit 60:
CVS_HJC_00012799 Internal email thread discussing Blink Rx

From: Wellman, William H [redacted]
Sent: 11/13/2024 11:05:35 PM
To: Courtman, Steve [redacted]; Lynch, Christine [redacted]; Moore, Jim [redacted]; Lynch, John H [redacted]; Mccall, Steven D [redacted]
CC: Blando, Phillip J [redacted]; MAGNINO, LISA [redacted]; Peters, Rachel M (Sr Mgr,Corporate Comms) [redacted] Kissick, Scott B [redacted]
Subject: RE: Time sensitive: Blink question

There were questions being asked by legislators in Sep through Melissa Schulman's team.

They do have a consumer card product. I am aware that on the consumer card side of their business that CVS Retail terminated a relationship with them several years ago. My understanding is that neither CVS, WAG nor RAD participate with/accept Blink.

Bill Wellman | Vice President, Network Development, CVS/caremark
[redacted]
9501 E. Shea Blvd, Mail Code 022, Scottsdale, AZ 85260

CVSHealth.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Courtman, Steve [redacted]
Sent: Wednesday, November 13, 2024 3:22 PM
To: Lynch, Christine [redacted]; Moore, Jim [redacted]; Wellman, William H [redacted]; Lynch, John H [redacted]; Mccall, Steven D [redacted]
Cc: Blando, Phillip J [redacted]; MAGNINO, LISA [redacted]; Peters, Rachel M (Sr Mgr,Corporate Comms) [redacted]; Kissick, Scott B [redacted]
Subject: RE: Time sensitive: Blink question

+Jim, Bill, John, Steve M

Not on my radar as discount card.

Steve M / Bill – was Blink part of the hub pharmacy work you were looking into?

…….Steve

From: Lynch, Christine [redacted]
Sent: Wednesday, November 13, 2024 2:40 PM
To: Courtman, Steve [redacted]
Cc: Blando, Phillip J [redacted]; MAGNINO, LISA [redacted]; Peters, Rachel M (Sr Mgr,Corporate Comms) [redacted]; Kissick, Scott B

[redacted]
Subject: Time sensitive: Blink question
Importance: High

Hi Steve, We are working on a time sensitive request for external affairs. Do you know if we have any talking points about our work with or POV on Blink? It appears they are a pharmacy discount program, somewhat similar to GoodRx that operates outside of insurance. Thank you for any insights or direction you can provide.
Thank you, Christine

Christine Lynch | Executive Director of Corporate Communications
CVS Caremark
[redacted]

Exhibit 61:
CVS_HJC_00012827 Internal email discussing which medications are associated with Blink Rx

From: Thomas, Jennifer A [redacted]
Sent: 11/26/2024 6:14:37 PM
To: Mccall, Steven D [redacted]
Subject: FW: 2238005 Village Fertility -- 2024
Attachments: CORE_DETAIL.xlsx; DRUGSUM.xlsx

Steve

Please see the 2024 claims data for Village Fertility. I highlighted the two known Blink items.

Drug Name	First Fill	Last Fill	Total Claims	Total Amt Paid
GONAL-F RFF INJ 900/1.5	1/1/2024	11/25/2024	1884	$ 12,188,979.09
MIEBO DRO 1.3GM/ML	7/16/2024	11/25/2024	11114	$ 7,498,047.84
MENOPUR INJ 75UNIT	1/1/2024	11/25/2024	1612	$ 5,737,076.97
XDEMVY DRO 0.25%	8/20/2024	11/25/2024	1482	$ 2,168,011.04
FOLLISTIM AQ INJ 900UNIT	1/4/2024	11/25/2024	205	$ 1,304,719.73
GANIRELIX AC INJ 250/0.5	1/1/2024	11/25/2024	1618	$ 1,020,833.03
CRINONE GEL 8% VAG	1/16/2024	11/25/2024	1194	$ 802,697.46
LEUPROLIDE INJ 1MG/0.2	1/1/2024	11/25/2024	1168	$ 367,126.77
GONAL-F RFF INJ 300/0.5	1/5/2024	11/22/2024	82	$ 274,927.90
OVIDREL INJ	1/2/2024	11/25/2024	1448	$ 246,200.93

Jennifer Thomas, CPhT | Sr. Manager Pharmacy Audit • Investigations • CVS Caremark
[redacted]
CVS Health | 9501 East Shea, MC 020 Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender

Exhibit 62: CVS_HJC_00012860 Audit file for Postmeds Inc (January 24, 2019)

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

POSTMEDS INC

NCPDP/NPI: 5660091 / 1295182590

AUDIT TYPE: On-Site

AUDIT DATE: 01/24/2019

AUDIT PROFILE ID: 53282

AUDITOR: Lauren Dotzler

Finalized 3/14/19 (Yes, docs) CR.

Number of Claim in original profile: 31,903

Number of Claim marked for audit: 344

Discrepancy Code	DESCRIPTION	Count
OBQ	Over billed quantity	4
RTS	Refill too soon	19
	TOTAL	23

✓ ✓ CB

Total Descrepancy Amount: $10,048.60

CMS Signage Checked: Printed notice is given to patient

Auditor Comments:

This pharmacy was selected based on a FWA Referral for billing high reimbursing topicals and applying for non-resident pharmacy licenses. The pharmacy is located in an industrial complex and not clearly marked. The pharmacist provided all of the state licenses and a printout of them organized alphabetically, I added in the date it became valid when possible and all the dates allowed for valid fills for out of state claims reviewed for the 50 states and DC, see attached list. The pharmacy provided shipping logs for a majority of the prescriptions and most were shipped via USPS, some by FedEx and GSO. The pharmacy is listed as Independent / Community Retail in RxClaim so I did not send the unmasked list until that morning but they did have everything prepared despite being a closed door mail order facility with a new address of 3121 Diablo Ave, Hayward, CA 94545 which the pharmacist provided well before the audit. I audited 121 unique prescriptions. The pharmacy had the Top 25 Drugs by Amount Paid in stock, a majority of the medications were in one room and all of the birth controls were in another room next door. I reviewed all of the 19 RTS and 4 OBQ discrepancies and left sticky notes including the prescription number, discrepancy type, and additional supporting information (dates of fill/qty billed vs qty allowed) and provided suggestions such as adding (should last 60 days) on the label / in system notes or ordering institution packs. I then reviewed the post audit guidelines and educational materials with the Staff Pharmacist assisting me with the audit. Wholesalers - Mckesson

ERxs Transferred from PhilRx in OH show Never Filled under Fill History whereas transfers from other pharmacies such as Puccis show fill history. See attached examples #1,2,3 after list of state licenses. Refill Authorization Request was sent TO PhilRx from a 240 (Maryland) fax number but both patient and prescriber have 925 (California) area codes and it looks a bit like a verbal but the annotations are very confusing. See attached example #4.

Redacted - PHI - Prescriber Location NURX at 81 Langton St Suite 11, San Francisco, CA 94103 and Shipping location listed on USPS label shows THE OPERATIONS TEAM at that same address (81 Langton St Suite 11, San Francisco, CA 94103). See attached example #5,6,7 and when I searched the tracking number, it says "Label Created, not yet in system"

When I Googled 81 Langton St Suite 11, San Francisco, CA 94103 it is listed as a condo and I cannot

PHARMACY NAME

POSTMEDS INC

find any link to NURX or POSTMEDS
I Googled NURX and their website says "Nurx is a telemedicine company offering a safe and easy solution for getting birth control and HIV prevention medication prescribed and delivered to your door." with an address of 1125 Mission St 2nd floor, San Francisco, CA 94103
Redacted - PHI Prescriber Location NURX at 1125 Mission St 2nd floor, San Francisco, CA 94103 but the FROM address on USPS Label shows "THE OPERATIONS TEAM 6838 Ellicott Dr STE 1, East Syracuse, NY, 13057" which Google shows as the address for Propel Pharmacy. See attached example #8, 9
Redacted - PHI Prescriber Location NURX at 81 Langton St Suite 11, San Francisco, CA 94103 and Shipping location listed on USPS label shows THE OPERATIONS TEAM at that same address (81 Langton St Suite 11, San Francisco, CA 94103) and USPS Tracking states "Label Created, not yet in system". See Example #10, 11, 12
When I asked the Pharmacist about multiple shipping addresses from The Shipping Team (81 Langton St Suite 11, San Francisco, CA 94103 // 6838 Ellicott Dr STE 1, East Syracuse, NY, 13057) he stated that they were all shipped out of the from their location on Diablo Ave.
When I asked the Pharmacist about NURX he said it is a company the doctors work for.
Redacted - PHI Rx sent to Phil Pharmacy, note on template "**If Prior Authorization or step edit, run COB cash**". See Example #12
Redacted - PHI - Transfer from PhilRx - Patient Delivery Confirmation Electronically signed, shows PHIL at the bottom. When I attempted to track the package, it says "Not Trackable" - See Example #13
Redacted - PHI - OBQ for Targadox 50mg - Patient Delivery Confirmation from PHIL, USPS says "Label Created, not yet in system" - see attached, verify patient received - Per peoplesafe pt fills other medications at Rite Aid
Redacted - PHI - OBQ / RTS - Electronic prescription with PHIL at the bottom - Per peoplesafe pt fills other medications at local CVS in TX, verify pt requested medications / dr patient relationship as Kim Ross only prescribes Sernivo for this patient per claim history.
PHIL logo at the bottom of most prescriptions faxed in for high reimbursing topicals and oral medications.
I googled the pharmacy address (3121 Diablo Ave, Hayward CA 94545) and True Pill: A Modern Pharmacy is the result. You select your medication, from a list of common, low cost generic medications then enter your information, some of which you are supposed to obtain from the prescription. If you have the prescription it prompts you to enter the doctors info so that they can request the rx or get it transferred from another pharmacy. Once you enter your doctor or pharmacy info it then asks for your shipping information followed by a prompt to enter your credit card information. It did not ask about insurance and the CASH price for #90 Furosemide 20mg tablets was $517.50.

I am referring this pharmacy for an investigative audit because it appears to be operating as a mail order pharmacy, and to verify doctor/patient relationship for high dollar topical and oral medications with inconsistent tracking information.

Reason Audit Initiated: FWA Report

Exhibit 63:
CVS_HJC_00012924 Audit file for Sterling Specialty Pharmacy

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

STERLING SPECIALTY PHARMACY

NCPDP/NPI: 2433693/1225548480

AUDIT TYPE: Focused Audit

AUDIT DATE: 12/22/2021

AUDIT PROFILE ID: 77230

AUDITOR: [redacted]



Number of claims in original profile : 4,360

Number of claims marked for audit : 217

Discrepancy Code	DESCRIPTION	Count
RTS	Refill too soon	2
	TOTAL	**2**

Total Descrepancy Amount: $328.54

CMS Signage Checked:

Auditor Comments:

2433693 Sterling Specialty Pharmacy
Sterling Specialty Pharmacy is located in Mendota Heights, Minnesota. Sterling Specialty Pharmacy was a referral for: Aetna Premier Audit report June 2021billed 25 rxs paying $35,031 for Nurtec. Multiple Sterling pharmacies enrolled in MN, but this is on the only specialty. Their website has templated rx forms for various drugs including injectables and some high reimbursing products. Enrolled in 2018. No audit history.
Sterling Specialty Pharmacy has a PEAR score of 35.96. They are a Performance Guarantee for Centene, St of Florida- OTH, AVERA, FEP, and Ingenio.
There were a total of 217 claims reviewed during this audit. The majority of the prescriptions were 2 documents- pre-printed templates that are titled Sterling Specialty Pharmacy- Psoriasis Prescription Referral Form, Psoriasis Prescription Referral Form (S to Z), Atopic Dermatitis Prescription Referral Form, Women's Health Prescription Referral Form, and Hepatitis C Prescription Referral Form and transfers from ASPN- Asembia Specialty Pharmacy Network. Some of the prescriptions provided to me were e-prescriptions as well.
Sterling Specialty Pharmacy's Top 5 Drugs by Amount Paid are: NURTEC 75MG ODT TOTAL PAID: $2,794,002.18 QTY: 28,338, XYOSTED 100/0.5 INJ TOTAL PAID: $326,548.03 QTY: 1,430, XYOSTED 75/0.5 INJ TOTAL PAID: $269,352.77 QTY: 1,212, HUMIRA 40/0.4 PEN INJ TOTAL PAID: $210,529.47 QTY: 68, and SKYRIZI 150DOSE INJ TOTAL PAID: $141,081.78 QTY: 8.
The only discrepancy that was found was a RTS on a patch the days supply should have been 28 days and it was billed as 21 days. Twirla Patch should be applied once a week for three weeks then patch should be off for 1 week. Pharmacy filled patch on 6/22 and 7/26 making 7/8 and 8/11 too soon.
The pre-printed templates has the following medications on them:
1. Psoriasis Prescription Referral form- COSENTYX, ENBREL, HUMIRA, ORENCIA, OTEZLA, SIMPONI, STELARA, and TREMFYA.
2. Psoriasis Prescription Referral form (S to Z)- SILIQ, SIMPONI, SKYRIZI, STELARA, TALTZ, and TREMFYA.

PHARMACY NAME

STERLING SPECIALTY PHARMACY

3. Atopic Dermatitis Prescription Referral Form- DUPIXENT and EUCRISA.
4. Women's Health Prescription Referral Form- TWIRLA
5. Hepatitis C Prescription Referral Form- DAKLINZA, EPCLISIA, HARVONI, MAVYRET, OLYSIO, XXX (IMAGE GETS BLURRY AT THE BOTTOM SOME MEDICATIONS I CAN NOT MAKE OUT), MODERIBA, RIBAVIRAN, SOVALDN, VOSEVI, XIFAXAN, and ZEPATYER.
All the pre-printed templates already has directions and quantities. Prescriber just has to check the boxes of the product prescribing.

COVID Pharmacy Questions (independents):
1. How did COVID affect your pharmacy? Very hard to hire people, making people quarantine, and trying to keep everyone safe. The Board of Pharmacy gave us some allowances to keep us afloat. Training at times was rough.
2. Did you stay open during COVID? yes
a. If you closed, what dates?
3. Were you more or less busy? We are a newer business so I think we were more busy.
4. Did you do any closed door, curbside, or increased delivery? No closed door and no curbside. With the volume going up we have increased deliveries.
5. Did you experience any drug supply issues? There were some but not a lot.
6. Did you buy from any new drug suppliers? No
7. Did you have to trade any inventory with other pharmacies? No
8. Did the pharmacy have to hire any new employees due to COVID? Due to growth but not due to COVID.
9. How did COVID affect customer payment method? We tried to do credit card up front because it was more secure for us.
a. Was there an increase in debit/credit?
b. Did the pharmacy still accept cash? yes

General Questions:
1. Who owns pharmacy? Any other locations? Other Sterling LTC and Retail
2. How is your OIG and FWA training managed? Get copy of most recent if you can.
3. Who are your wholesalers? Amerisource, Cardinal, Jams Wholesale
4. How often do you order? We place an order everyday. We try to keep 2 weeks of inventory on hand maybe even one week.
5. Do you deliver? If yes, what is the delivery radius and who delivers? Yes, we deliver. There is not a specific delivery radius. We have a group called JBs that we use and also an employee of the pharmacy in an urgent matter.
6. What percentage of your patients pick up their rxs in person? Not sure what percentage that is. Most of our prescriptions go through mail.
7. When was the last time a patient walked in to pick up their rx? Tuesday
8. Is the pharmacy licensed in other states? Can you show me licenses? We are licensed in ALL 50 states.
9. Do you ship out of state? yes
10. Do you accept returned RXs on those mailed? No if something goes wrong then pharmacy is at risk for being responsible for something that goes wrong.
11. How many scripts on average do you fill a day? Between 400 and 500 rxs/day
12. How do patients find out about your pharmacy? Any marketing or advertising? We do have a sales person who goes out and goes to the clinic. We market to physicians. We work with some Health Systems here. Utilizing ASPN as a Hub.
13. Do you do any compounding? Well uh rarely. Insurance does not pay for compounds
14. How is PHI disposed of? We use a third party shredding company called Veteran's Shredding LLC I think.
15. What is RTS policy and procedure? If we haven't heard from a patient in 12 days, we call to see if the patient wants it. If it is not picked up then it is reversed and put back on the shelf.
16. How many Nurtec 75mg ODT is on your shelf? Xyosted 100/0.5 inj? Xyosted 75/0.5 inj? Humira 40/0.4 pen inj? Sykrizi 150 dose inj? Nurtec ODT 75mg- Mckesson tote full, rolling rack of 6 cases as well (has a manufactuer relationship with them), Xyosted 100/0.5 INJ- Rolling rack of 18 boxes,

PHARMACY NAME

STERLING SPECIALTY PHARMACY

Xyosted 75/0.5 INJ- rolling rack of 18 boxes, Humira 40/0.4 INJ – 8 of those, and Sykrizi 150 dose- a couple different ndcs 3 of 1 and 2 of the other.
17. How does the pharmacy obtain these preprinted template prescriptions? WE uh have a sale marketing team just like CVS. We are creating these prescriptions to give to prescribers. It is better for the pharmacy because this ensures the patient gets the correct dose and correct quantities.
18. Who decides what medications go on these templates? The pharmacy
19. How many different prescription templates does the pharmacy use? I would have to look but I think we only commonly used maybe 4 or 5. A lot of the diseases that we used to specialize in was not beneficial because the pharmacy could not provided superior service to patient. Like ophthalmology for example
20. How do you obtain prescriptions from ASPN? We work with them we do a pharmacist to pharmacist transfer because we are in the program. And we use their clinical database for taking care of patients so we have some shared information as well.
21. If mailing rxs, how do you accept returned rxs? no

22. Where are returned medications sent (to pharmacy or alternate address?) no

23. Can you show me examples?

24. In the last year, did you have any significantly large purchases or buy-outs? We probably have purchased Nurtec ODT in large purchases.
a. If stock buy out- what documentation did you receive along with the drug stock buy out?
b. If large purchase- what drugs and why? Ordering 1 to 2 weeks at a time due to COVID and not being able to get the drug in a few times.

25. Describe your process for collecting copays. We talk to a patient and we set payment with credit card/debit card. Then we process the prescription and send it out.

26. Is there ever a situation where you would NOT collect a copay or collect a partial copay? No we wouldn't waive copays. We have had some errors where sometimes technicians would forget but we check weekly. We collect copays because we have to for a lot of different reasons.

27. What if a patient cannot afford to pay a copay? What is your process. We would work with a patient to set up a payment plan but that is rare.

28. Describe any financial assistance programs, coupons, or other programs that would reduce a member's copay amount. Patient Access Network, Healthwell, and coupons if the patient are eligible for it.
a. How do you determine who qualifies?
i. Is it financially based? What documentation do you get from the patient?

29. For rxs that are picked up in person, how do you collect copays? Mostly credit card/debit card

30. Do you ship rxs? What percentage? Shipping – I can't say for sure, but I would say maybe 80% or more.

Affiliated manufacturers- Antares, BioHaven, Agile, Mann Kind, Xeris, Idsa, and I am sure I am forgetting one off the top of my head. Most of these we are just buying directly from the manufacturer.

Reason Audit Initiated:

Exhibit 64: CVS_HJC_00012953 Audit file for White Drug (August 17, 2021)

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

WHITE DRUG 61

NCPDP/NPI: 3504138/1003906942

AUDIT TYPE: Routine

AUDIT DATE: 08/17/2021

AUDIT PROFILE ID: 75329

AUDITOR: Stefanie Moses

Finalized
NOV 1 0 2021
SM

Number of claims in original profile : 1,278

Number of claims marked for audit : 285

Discrepancy Code	DESCRIPTION	Count
OBQ	Over billed quantity	3
	TOTAL	**3**

MOC

Total Descrepancy Amount: $75.41

CMS Signage Checked:

Auditor Comments:

This pharmacy was selected from sharepoint due to State of FL Premier Audit report May 2021 show White Drug billing XHANCE for members in FL when members have rxs at their local pharmacy and only XHANCE at this ND pharmacy. Due to COVID-19 the documents were emailed to me on 7/29/2021 and saved under the pharmacies NCPDP. The pharmacy is owned by Thrifty Drug Stores, Inc. and the CEO is Robert Narveson. They have locations in MN, MT, ND, SD, IA, WI. I reviewed all of the discrepancies, as well as post audit guidelines and educational materials with Rachel Buelow/TP & Audit Sup. All discrepancies were faxed to the pharmacy on 8/16/21.

All Tosymra, Zembrance, and Xhance prescriptions were transferred in from Blink Health Pharmacy, Pittsburg, PA.

Their pharmacists are [redacted] Their technicians are [redacted]

The following questions were answered by [redacted]/Director.

Can you also please explain how you came in contact with Blink Health and how the prescriptions were transferred to your pharmacy. [redacted] We participate in Blink Health's Pharmacy Network, which allows patients to select Thrifty White for prescription fulfillment.

Is the owner associated with Blink Health and who is the owner of White Drug? White Drug (Thrifty White) is an employee owned (ESOP) company. We have no ownership in Blink Health.

PHARMACY NAME

WHITE DRUG 61

What other pharmacies does the owner own? [redacted] Thrifty Drug Stores, Inc. is the corporate ESOP ownership of all Thrifty White pharmacies, for Chain code 00216.

Who are your wholesalers? [redacted] McKesson is our primary wholesaler.

Do you use a reverse distributor and if so their name? [redacted] Inmar

What percentage of prescriptions do you mail? [redacted] 10-11%

Regarding COVID, Thrifty White was able to remain open throughout the pandemic, which we are very proud of. We did not have any employee layoffs, and continue to provide the COVID 19 vaccine to those who request it.

State shipping licenses:
AK PHAO1409 6/30/2022
AL 114345 12/31/2022
AR OS02521 12/31/2021
AZ Y005849 10/31/2021
CA NRP 1463 11/1/2021
CO OSP.0006440 10/31/2022
CT PCN.0002714 8/31/2022
DC NRX0000521 5/31/2023
DE A9-0001464 9/30/2022
FL PH 27263 2/28/2023
GA PHNR001011 6/30/2023
HI PMP-987 12/31/2021
IA 3722 12/31/2021
ID 35705MS 12/31/2021
IL 54.018687 3/31/2022
IN 64001649A 12/31/2021
KS 22-44533 6/30/2022
KY ND1839 6/30/2022
LA PHY.006994-NR 12/31/2021
MD P06483 5/31/2022
ME MO40001642 12/31/2021
MI 5301010468 6/4/2022
MN 262425 6/30/2022
MN 262910 6/30/2022
MO 2014013252 10/31/2021
MS 13647/7.1 12/31/2021
MT PHA-MOP-LIC-2679 11/30/2021
NC 12048 12/31/2021
ND Phar404 6/30/2022
NE 831 7/1/2022
NH NR1119 12/31/2021
NJ 28RO00099400 6/30/2022
NM PH00003692 12/31/2021
NV PH03182 10/31/2022
NY 32836 4/30/2023
OH NRP.022423000-03 3/31/2023
OK 99-6721 4/30/2022
OR RP-0002975-CS 3/31/2022
PA NP000764 8/31/2023
RI PHN10623 9/30/2022

PHARMACY NAME

WHITE DRUG 61

SC 15477 6/30/2022
SD 400-0780 6/30/2022
TN 5390 5/31/2022
TX 29197 4/30/2022
UT 9025789-1708 9/30/2023
VA 214001641 11/30/2021
VT 36.0103045 7/31/2023
WA PHNR.FO.60468739 5/31/2022
WI 62-43 5/31/2022
WV MO0560717 6/30/2023
WY NR-50799 6/30/2022

Reason Audit Initiated:

Exhibit 65: CVS_HJC_00012979 Audit file for Postmeds Inc (September 28, 2021)

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

POSTMEDS INC

NCPDP/NPI: 5660091/1295182590

AUDIT TYPE: Investigative

AUDIT DATE: 09/28/2021

AUDIT PROFILE ID: 75111

AUDITOR: Marie Wilson

Finalized
MAR 04 2022

Number of claims in original profile : 96,070

Number of claims marked for audit : 384

Discrepancy Code	DESCRIPTION	Count
CPY	Copay	78
DIS	Drug invoice shortage	2,008
INV	Invalid prescription	124
MP	Missing prescription	11
	TOTAL	**2,221**

Refinalized
4/12/22

Total Descrepancy Amount: $656,018.32

CMS Signage Checked:

Auditor Comments:

INVESTIGATIVE AUDIT NOTES
5660091 – POSTMEDS INC - CA
Pharmacy profile contained out of state Medicaid claims so approval was required. Approval granted; 7/7/21/ " This audit has been released. You will have mixed access to mark out of State Medicaid claims based on various state responses. notified 06/22/2021; AZ medicaids notified 06/23/2021;

Do not mark:
- affinity (NY) = no 6/24; 4211, 6418, 4212
- fidelis (NY) = no 6/25;
- metroplus (NY) = no 7/1
- mvp (NY) = no 6/25; OK to proceed:
- healthfirst (NY) = no response - proceed;
- Molina (NY) = no response - proceed;
- aetna NJ - yes 6/30;
- wellcare nj - yes 6/30;
- Ingenio (IA) = no response - proceed;
- AZ clients approved per OIG 7/7/2021

REASON FOR AUDIT
Pharmacy was selected for audit due to appearing on migrating member report for Alto Pharmacy in CA. Trending is high and billing high$ topicals. It was also referred for investigative audit after last onsite because it appeared to be operating as a mail order pharmacy, and to verify doctor/patient

PHARMACY NAME

POSTMEDS INC

relationship for high dollar topical and oral medications with inconsistent tracking information. Pharmacy has been on MIR since March 2019 with over 75% of prescriptions being shipped.
8/26/21 – FEP report indicates member denials received for female condoms and Ella. Member only requested birth control pills and were told it's a "packaged deal" or they were being sent as a "courtesy". Member survey and full report included in audit packet.
Also
Top 10 drugs are:
DRUG_LBL_NM CLNT_BILL_AMT TOT_CLAIMS
FC2 FEMALE MIS CONDOM $5,428,043.04 16208
TRUVADA TAB 200-300 $1,378,481.95 826
IMVEXXY MAIN SUP 10MCG $1,153,155.33 10677
ANNOVERA VAG RING $1,057,752.43 565
ETONOGESTREL VAG ETHY EST $586,800.08 4354
VITAPEARL CAP $422,682.38 5666
BIJUVA CAP 1-100MG $405,125.90 2979
ELLA TAB 30MG $348,497.31 10152
LO LOESTRIN TAB FE 1/10 $337,783.50 1686

Audit will consist of hard copy review, copay collection verification, license review and signature logs.
Past audit history:
Last audit was onsite 1/24/19. Audited for billing high reimbursable topicals. It was referred for investigative audit because it appeared to be operating as a mail order pharmacy, and to verify doctor/patient relationship for high dollar topical and oral medications with inconsistent tracking information.

OWNERHIP/AFFILIATIONS
CICS: Owner listed in Recap is [redacted]
Wholesaler/Employee worksheet: Owners are [redacted] as owners
NPI: NPI registry also lists [redacted] as owner and PIC. www.truepill.com
Linked In: Co-Founder & President is [redacted].
Shared ownership with: LA Pharmacy, LLC, River City Pharmacy, LLC, Overlake Pharmacy, LLC. [redacted] is listed as an authorized official for these pharmacies on the NPI registry.

Current trending:

STLMNT Date	DBRS Type	PMCY DBRS Amount
2021-09-22	CHK	459,898.90
2021-09-15	CHK	438,690.81
2021-09-08	CHK	440,303.37
2021-09-01	CHK	372,572.49
2021-08-25	CHK	407,149.22
2021-08-18	CHK	360,738.87
2021-08-11	CHK	368,448.35
2021-08-04	CHK	412,199.08

MEMBER STATES/SIG LOG
Core detail report showed claims billed from members in multiple states. Pharmacy provided state licenses for 50 states. 135,386 of 196,291 claims were out of state members
INVOICE REVIEW
Invoices were initially received from: Afaxys, Bonita, IPC, Keysource, Mayne, Metuchen, Parmed, Prasco, Sun Pharma, TopRX, Veru, Western Wellness.
Shorts were found for

DRUG LABEL NAME
ANNOVERA VAG RING LANTUS SOLO PEN 100U/ML

PHARMACY NAME

POSTMEDS INC

BASAGLAR KWK PEN 100U/ML LARIN FE TAB 1/20
BIJUVA CAP 1-100MG LO LOESTRIN TAB FE 1/10
BLISOVI FE TAB 1/20 NORETHINDRON TAB 0.35MG
DESCOVY TAB 200/25MG NOVOLOG F/P PEN 100U/ML
DROSPIR/ETHI TAB 3-0.02MG NUVARING VAG RING(#1)
ELIQUIS TAB 5MG OZEMPIC PEN 0.25/0.5
ELLA TAB 30MG PRENA1 PEARL CAP
ELURYNG VAG RING SAXENDA3MLX5 PEN 6MG/ML
EPIDUO FORTE PUM 0.3-2.5% SLYND TAB 4MG
FC2 FEMALE CONDOM TRADJENTA TAB 5MG
FREESTYLE LT TES STRIPS TRULICITY(4) PEN 1.5/0.5
GVOKE HYPO 2 INJ 1MG/.2ML TRUVADA TAB 200-300
IMVEXXY MAIN SUP 10MCG VALACYCLOVIR TAB 1GM
IMVEXXY MAIN SUP 4MCG VICTOZA 3'S PEN 18MG/3ML
IMVEXXY STRT SUP 10MCG VITAMEDMD CAP ONE RX
JANUMET TAB 50-1000 VITAPEARL CAP
JANUVIA TAB 100MG WELLBUTRN XL TAB 300MG
JANUVIA TAB 50MG XARELTO TAB 20MG
JARDIANCE TAB 10MG LANTUS SOLO PEN 100U/ML
JARDIANCE TAB 25MG LARIN FE TAB 1/20

8/16/21 – 1st invoice short letter sent.
Additional invoices were received from Acella, Camber, McKesson, HRA Pharma
8/27/21 - 2nd Invoice short letter sent. Pharmacy remains short on the following:
DRUG LABEL NAME
ANNOVERA VAG RING JARDIANCE TAB 10MG
BIJUVA CAP 1-100MG JARDIANCE TAB 25MG
BLISOVI FE TAB 1/20 NOVOLOG F/P PEN 100U/ML
ELURYNG VAG RING PRENA1 PEARL CAP
IMVEXXY MAIN SUP 10MCG SLYND TAB 4MG
IMVEXXY MAIN SUP 4MCG TRADJENTA TAB 5MG
IMVEXXY STRT SUP 10MCG VICTOZA 3'S PEN 18MG/3ML
JANUMET TAB 50-1000 VITAMEDMD CAP ONE RX
JANUVIA TAB 100MG VITAPEARL CAP
JANUVIA TAB 50MG WELLBUTRN XL TAB 300MG

8/19 and 8/25/21 - Pedigree information was requested on: Acella, Camber, Lupin and Veru.
• 8/20/21 – Pedigree documents were received for Veru. Distributed by Specialty Pharmaceutical Services (Cord Logistics) License, pymt and invoices were provided.
• 9/23/21 – received pdf files of invoices from Cardinal/Cord Logistics. Responded back on 9/26 advising I would need to have Excel files.
• 9/26/21 – received excel file from Cord Logistics for purchases from Vitamed MD, Bocagreen MD and Therapeutics MD
**some purchases in this report were not accepted due to the "Ship to" column reflecting the name of other pharmacies: LA Pharmacy, LLC, River City Pharmacy, LLC, Overlake Pharmacy, LLC. Co-owned by [redacted].
9/27/21 - Final invoices were reviewed and pharmacy remains short on the following
BLISOVI FE TAB 1/20 113288
JANUMET TAB 50-1000 8250
JANUVIA TAB 100MG 1710
JANUVIA TAB 50MG 1320
JARDIANCE TAB 10MG 60
JARDIANCE TAB 25MG 9570
LEXETTE AER 0.05% 5543
NOVOLOG F/P PEN 100U/ML 1254
SLYND TAB 4MG 19488

PHARMACY NAME

POSTMEDS INC

VICTOZA 3'S PEN 18MG/3ML 306

PRESCRIBER DENIALS
Verifications were sent to 50 prescribers. No denials were received.
COPAY
Some CC receipts had sale date prior to dof and some had it after dof.
Coupons are being used on non-FDA approved drugs such as Vitamedmd Caps, Vitapearl Cap, Vitatrue PAK, Strata XRT gel
Screenshots with COB transaction information were provided; however, majority of claims still had copay balance and CC receipt sent did have any transaction details. Also, half of information on the screenshot page for COB transaction was cropped out.
A large majority of CC receipts appear to have been made on something similar to a Word document and contained no authorization information. Due to majority of transfers coming from PhilRX, there is a concern that claims are being adjudicated by PhilRX. I will ask for merchant reports along with patient attestations to verify full copay is being collected by Postmeds and will also inquire about copay collection process during exit interview.
There were a few instances in which receipts for copay documentation were in a different format. In some instances the field values did not match up. Name was under RX# and CC # was listed under patient name. Examples below:

I also noticed that in some instances the Payer and patient ID did not match our system; however, the Group/PCN did match. Example below indicates Silverscript Plus Med D plan and RXClaims lists Delltech with ID Redacted - PHI Carrier ID does not indicate Med D. I will inquire about the discrepancy in Exit Interview. This is also an issue because the pharmacy is using a coupon on this claim. It's for a Non-FDA drug and will be INV for that reason but it would also be INV if it's a Med D plan.

HARD COPY REVIEW
Profile consisted of 96,070 claims. 9/16/21 – requested additional hard copies for Ella tab due to patient denials stating they were offered as a courtesy. All but one claim reviewed were prescriptions transferred from Simple Care Pharmacy in Fl from various prescribers in NY. Patients were located in various states throughout the US. One RX was transferred from Overlake Phcy LLC in Wa. Patient was in CA and prescriber in NY
All of the prescriptions in the profile were transfers from the following pharmacies: Pharmca, PhilRX OH(majority), VitaCare prescription services-FL (2nd majority), Meds In Motion LLC- UT, Simple Care Phcy -FL
While researching a mfctr coupon for Aplenzin, I found this info on the manufacturer site. "The PhilRx

PHARMACY NAME

POSTMEDS INC

program can help you get your APLENZIN prescription fast. Ask your doctor to send your APLENZIN prescription to PhilRx. PhilRx will process it and text you for insurance and delivery information. A good majority of prescriptions were transferred from Phil RX.

RX Redacted - PHI came on a fax template from Advanced Derm of Oregon written to Phil Pharmacy with a phone # 855-977-0975. A Google search for that number links back to PhilRX. LLC in Columbus OH and https://phil.us/ in San Francisco, CA. The automated voicemail says "thank you for calling Phil. A prescription management service"

Prescriptions for Female Condoms were transferred from Simple Care Pharmacy in FL and were for patients in various states with prescriber from NY

- RX Redacted - PHI Pt in Colorado, Prescriber in NY
- RX Redacted - PHI Pt in TX, Prescriber in NY
- RX Redacted - PHI Pt in CT, Prescriber in NY

FINAL RESULTS

CPY – 78, DIS 2008, INV 24, MP 11, PTD 5

Inv were due to using coupon on non FDA drugs and 2 were due to hard copy being on fax template to another Phil pharmacy, not Postmeds. –"Provider must not allow an entity to submit a claim on Provider's behalf."

Exit interview was conducted via phone with [redacted], Compliance Pharmacist and [redacted], Compliance Manager on 9/28/21. I asked questions regarding pharmacy operations and reviewed discrepancies.

- Where are the claims adjudicated? In Haywood, CA
- Is Postmeds 100 % mail order? Yes. Do you allow for walk ins? No.
- There were no prescriptions sent directly to pharmacy. All were transfers from other pharmacies.

What is relationship with transferring pharmacies? Pharmca, PhilRX OH(majority), VitaCare prescription services-FL (2nd majority), Meds In Motion LLC- UT, Simple Care Phcy -FL -

o "We fulfill prescriptions for them. We are a fulfillment center. We are the middleman between pharmacy and patient. Doctors do not send scripts to us directly. If I'm a Phil RX customer, Phil RX will send it to us to fulfill order.

- What is relationship with Phil RX? They are "one of our customers"

o How was partnership developed? "I don't know, assume there is a contract."

- Is the pharmacy licensed in any other states? Yes, all 50 states
- What is your process for collecting copays? A few of the receipts that were sent were different formats. [redacted] said " If we are filling for Phil Rx the patient pays the copay to Phil RX.
- Is it collected before prescription is mailed? I'm not sure.
- Where did you obtain the copay documents that were sent to me for the audit? I got them from each of the transferring pharmacies. So in preparation for audit, you reached out to each of the transferring pharmacies to get the copay documentation? "Yes".

I asked questions to get a clear understanding of how the pharmacies collect copays and how patients were contacted to verify insurance and advise of copay, but [redacted] said that the process varies from company to company. She then said she wanted to add her manager to the call so she didn't tell me the wrong thing because she wasn't sure. [redacted] is compliance manager and joined the call at this point. [redacted].

I asked Charlotte to explain the process for collecting patient copays. For example, if a patient is with PhilRX and they transfer the prescription to you for fulfillment, how is that copay collected? She said " We do that with in conjunction with Phil, but I'm not sure of the technical pieces." We fulfill the order and have PhilRx collect payment. "We do it through APIs, the websites." I asked what websites and she said "I don't know. I'll have to look into it because it's different for each client.

I asked who contacts the patient to verify the insurance information and she said the pharmacies do that prior to the transfer. But then she said that Postmeds might do it as well. It depends. I was not able to get a clear understanding of the adjudication or copay collection process and will follow up with an email to obtain more information on procedures.

INV

I went over the reasons for INV and explained that they were due to coupon being used in non-FDA approved drugs. I asked about the claims in which the Payer and patient ID did not match our

PHARMACY NAME

POSTMEDS INC

system; however, the Group/PCN did match. Charlotte explained that *Our pioneer system does not always reflect accurate names and that is a work in process. She pulled up the claim and the group name had been updated.
We ended the call in agreement that I would send an email with an outline of the specific information I needed in regards to copay collection and [redacted] would get that information back to me within a few days.
10/1 /21 – email was received by legal counsel for Postmeds asking for an extension on the time to produce the additional information stating the turnaround time was unreasonable and also requested that any further requests be run by counsel. Management and legal were copied on email so I deferred to them for a response.

Reason Audit Initiated: Client

Exhibit 66: CVS_HJC_00013296 Audit file for White Drug (January 24, 2023)

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

WHITE DRUG 61

NCPDP/NPI: 3504138/1003906942

AUDIT TYPE: Routine

AUDIT DATE: 01/24/2023

AUDIT PROFILE ID: 82994

AUDITOR: Stefanie Moses

Number of claims in original profile : 14,449

Number of claims marked for audit : 426

Discrepancy Code	DESCRIPTION	Count
CPY	Copay	3 ✓
	TOTAL	**3**

Finalized 4/6/23 MM

Total Descrepancy Amount: $25,362.07

CMS Signage Checked:

Auditor Comments:

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

WHITE DRUG 61

This pharmacy was chosen from SharePoint for "appearing as outlier on BCBSTN premier audit reports. Top drugs billed on report: Horizant, Gimoti Spr, Nextstellis and billed 8 rxs ($2,526) for 6 unique members; 6 unique prescribers. Only medication billed is Nextstellis Tab 3-14.2mg and Zembrace Sym Inj 3/0.5ML. Pharmacy recently audited due to appearing on STFL reports (May 2021); billing Xhance for FL members." Actively licensed in FL ? (YES 2/28/2023 061 FL PH 27263). The owner is White Drug Company of Jamestown, INC and Robert Narveson is the CEO. I reviewed all of the discrepancies, as well as post audit guidelines and educational materials with Lindsey Cizek-Cribb-Tech. They use McKesson and ABC as their wholesalers and Inmar as their reverse distributor. Lindsey estimated they mail out about 10% of their prescriptions and deliver 1%. They average about 600 scripts per day. All signature logs were accounted for during the audit.

There were 3 discrepancies for copay collection (8193283, 8170175 , 8161161) and the pharmacy stated a Grant was used to reduce the copay to $0.00. I advised they would need to provided further documentation during the appeals process as to what the grant entails and if it is part of a Financial Hardship Program.

Majority of the prescriptions were transferred from:

BlinkRX
4696 W Overland Rd Ste 274
Boise, ID 83075

Blink Pharmacy Plus
3 Penn Ctr W Ste 320
Pittsburgh, PA 15276

Asembia Referral HUB (prescriptions for Auvi-Q)
290 West Mount Pleasant Ave
Livingston, NJ 07039

Vitacare Prescription Services (prescriptions for Gimoti)
951 Yamato Rd Ste 160
Boca Raton, FL 33431

I asked the pharmacy if BlinkRx, Asembia or Vitacare Pharnacies are collecting the copays for Nextstellis, Zembrance, Xhance,Tosyrma and Horizant.

I am recommending this pharmacy for investigations due to some copays are being written off by a grant program and that the majority of the prescriptions were transferred in from Blink RX. Lindsey Cizek-Cribb stated that Blink refers members to their pharmacy and White Drug collects copays from the member.

[redacted] is the PIC and licensed in AL, DC, KY, MN, ND, KS, OR, ID, MD, OK, NV, TN, AR, IA LA, MS, VA, MS, NE, WV, TX, MI. Their staff pharmacists are [redacted]

Reason Audit Initiated:

Exhibit 67: CVS_HJC_00013336 Audit file for Carepoint Pharmacy (July 18, 2022)

PHARMACY NAME

CAREPOINT PHARMACY

NCPDP/NPI: 1487330/1598013864

AUDIT TYPE: Investigative

AUDIT DATE: 07/18/2022

AUDIT PROFILE ID: 80096

AUDITOR: Korinne Frey

Finalized 2/21/23 JC

Number of claims in original profile : 25,190

Number of claims marked for audit : 135

Discrepancy Code	DESCRIPTION	Count
CPY	Copay	118 ✓
PRD	Prescriber denied	4 ✓
	TOTAL	**122**

JT

Total Descrepancy Amount: $181,031.57

CMS Signage Checked:

Auditor Comments:

An audit was initiated after receiving a referral from an onsite audit with concerns regarding the pharmacy's use of coupons on non-FDA approved products. Carepoint Pharmacy, NCPDP 5931755 which has the same owners is also currently undergoing an expanded audit.
This audit will include drug invoice review, prescription hard copy and delivery/signature log review, copay collection verification, and prescriber verifications.
The top paid drugs billed by the pharmacy are Alinia 500mg – paid amount $1,904,369.89, Xhance – paid amount $1,145,364.91, and Addy 100mg – paid amount $1,054,007.08.
Per the employee worksheet, [redacted] have 50/50 ownership. [redacted] is listed at the pharmacy manager. The pharmacy also provided their March 2022 OIG list.
[redacted] also has 100% ownership in Carepoint FL – NCPDP 5736410, Carepoint GA – NCPDP 1167964, Carepoint IN – NCPDP 1568382, Carepoint OH – NCPDP 3685154, and Carepoint TX – NCPDP 5918391.
The wholesaler worksheet lists the following wholesalers: Alk-Abello, APD, Amerisource, Anda, Artesa Labs, Bausch Health, Biofrontera, Blupax, Encore Dermatology, EPI Health, EVOFEM Biosciences, FFF Enterprises, Galderma Labs, IMPEL Neuropharma, JG Pharma/Journey Medical, Marnel Pharmaceuticals, Mayne Pharma, Medimetriks, Medisol Plus, ParMed, Prasco Labs, Primus Pharmaceuticals, Real Value Products, Romark Distribution, Sonoma/EMC Pharma, Upsher-Smith, Western Wellness Solutions, and Inmar (reverse distributor).
I received and reviewed purchase information from EMC Pharma, Bausch Health, ParMed, Real Value Products, Romark, Biofrontera, EPI Health, Alk-Abello, Western Wellness Solutions, APD, Medisol Plus, Galderma, Blupax, Impel Neuropharma, Anda, Evofem, Mayne Pharma, Primus Pharmaceuticals, Marnel Pharmaceuticals, Opti Nose, Upsher-Smith, Artesa Labs, Prasco, Journey Medical/JG Pharma, Amerisource, FFF Enterprises, and Medimetriks.
In an email that I was copied on from Upsher-Smith to the pharmacy, they told the pharmacy that they could not provide an excel because excels could be altered and that they could provide PDF

PHARMACY NAME

CAREPOINT PHARMACY

copies instead. [redacted] from the pharmacy emailed them back and explained that since they would be sending me the excel directly that there was no risk of it being altered. Upsher-Smith stated that they wouldn't be able to enter the orders into an excel manually and that they would provide PDF copies instead. The email between the pharmacy and Upsher-Smith is saved in the audit folder. Upsher-Smith did in fact send PDF copies of the invoices.
The purchase information from Artesa Labs, Evofem, and Opti Nose contained purchased for all of the Carepoint locations, so just the IL location was filtered out and reviewed.
The purchase information from Primus Pharmaceuticals contained purchases made through 4/4/2022. Only purchases made during the audit time frame were accepted.
APD provided 2 sets of purchase information. In the email they stated one of the excels was for Carepoint AndMed and the other excel was for Carepoint Direct. I emailed [redacted] back at APD to clarify which specific Carepoint the purchase information was for. [redacted] emailed me back and verified that both of the excels are for the IL Carepoint and that they have 2 accounts with them. Since the excels didn't list the account numbers, I saved them as account 1 and account 2.
After reviewing all of the purchase information provided from the pharmacy's wholesalers, all of the drugs being reviewed for the audit cleared.
The pharmacy provided the requested audit documentation electronically, so everything is saved in their audit folder in the shared drive.
Fidelis sent a referral for the pharmacy after data analysis showed Carepoint was billing claims for members throughout NY. They also received a tip from the Prior Authorizations operations team in which they noted that the date submitted, and the fill date are different. In the example provided they also noted that the claim number was different from the rest for Medicaid members. Fidelis also noted that one of the prior authorization forms was submitted directly from Carepoint. They also have concerns that prescribers are routing prescriptions for Odactra to Carepoint Pharmacy.
I received electronic hard copies and transferred prescriptions from Blink Health, PhilRx, OnePoint Patient Care, and DermaDash as well as a couple of faxed prescriptions. All of the prescriptions that were filled for PhilRx were for Tyrvaya 0.03mg solution.
The pharmacy provided FedEx tracking for the requested claims. All of the FedEx tracking that was provided showed that the prescriptions were shipped from the IL location.
Copays: For copay documentation, the pharmacy sent a page that listed the card type, last four digits, expiration date, balanced owed, and payment total. There was nothing on it showing a transaction number, date/time paid, or authorization number showing that the transaction was approved. I noticed that for the 13 claims that were transferred from PhilRx, the pharmacy provided a generic looking receipt that lists the prescription number, member name, last 4 digits of the credit card number, date, time, transaction number, and total amount. It does not include the type of credit card used or an authorization number showing the transaction was approved. 10 of the 47 transferred prescriptions from Blink Health had the following information listed on the transfer page: billing name (all said Blink Health USA), credit card number (full number), expiration date, CV code, zip code, and copay amount. For the rest of the claims that were transferred from Blink Health the transfer page just listed the billing name, zip code, and copay amount. The copay documentation provided for the Blink Health transfers was the same as the other documentation provided by the pharmacy. The zip code listed for the payment information on all of the transfers was 10013. I also wanted to note that the card type used to pay for all of these claims was a Mastercard and the card expiration date for 37 of the claims was 4/25.
After the exit interview for the onsite audit on 2/2/2022, the auditor sent the pharmacy a list of additional questions. One question that the pharmacy was asked was, "list the programs or drugs where the copay are collected by an entity other than Carepoint". The pharmacy responded with, "MD2RX, PhilRx, and Blink Rx". Another question that the pharmacy was asked was, "Prescriptions filled for Blink Health, who bills the claims? Who collects the copays? And how is Carepoint reimbursed"? The pharmacy responded with, "Carepoint bills the claim to PBM. Blink collects the copay as the patient experience is through Blink. Blink creates a single-use 'Credit Card' for Carepoint for the value of the copay".
Since the pharmacy said that they don't collect the copays for PhilRx and Blink Health these claims were charged back
CPY: 30 claims were charged back for copay because the billing information provided for the secondary payers was missing the billing information for the secondary payer as well as the

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

CAREPOINT PHARMACY

authorization number showing the claim was paid. One of these claims was for a Med D member and 8 of the claims were for non-FDA approved drugs which I noted in the internal comments. 28 claims were charged back for copay because the receipts provided were missing the date of the transaction and the authorization number showing that the transaction was approved. 60 claims were charged back because they were for claims for Blink Health and PhilRx in which they collect the copay, not Carepoint.
PRD: 4 claims were charged back after receiving a prescriber denial from a physician.
I went over the results of the audit with [redacted] the pharmacy manager. I let [redacted] know when the pharmacy could expect to receive the initial discrepancy report and how the post audit process will work, which he is familiar with. I explained the prescriber denials to [redacted] and let him know what the pharmacy would need to provide for appeal documentation. He asked if I would be able to let him know who the physician was and what the prescription number was, so I gave him that information. Next, we went over the copay discrepancies and I explained what would need to be provided for post audit. [redacted] wasn't too surprised about the claims needing more information for the secondary payer and the copay receipts because these were same types of discrepancies that were found in the Texas audit too. He said it wouldn't be a problem though to get the complete billing information and the copay receipts. The last thing we went over were the discrepancies for the claims for Blink Health and PhilRx and why they were charged back. When I told [redacted] about these discrepancies, he didn't sound surprised. He asked if they could provide a business-to-business agreement between that they had with these pharmacies in order to appeal them. I told him that they were more than welcome to, and post audit would review it, but I could not guarantee that it would be accepted, and [redacted] understood. [redacted] went through the notes that he took to make sure he didn't miss anything and then verified one more time when the pharmacy would get the initial discrepancy report and about how long they had to provide appeal documentation. He didn't have any additional questions at this point and thanked me for letting him know the outcome of the audit.

Reason Audit Initiated: Internal Review

Exhibit 68:
CVS_HJC_00013373 Audit file for Nomi Pharma LLC

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

NOMI PHARMA LLC

NCPDP/NPI: 4615223/1669123279

AUDIT TYPE: Investigative

AUDIT DATE: 10/15/2024

AUDIT PROFILE ID: 97591

AUDITOR: Niyati Ralhan

Finalized 12/27/24
RS
appeals_yes

Number of claims in original profile : 475

Number of claims marked for audit : 86

Discrepancy Code	DESCRIPTION	Count
CPY	COPAY	3
INV	INVALID	48
OTH	OTHER	11
	TOTAL	**62**

17

Total Descrepancy Amount: $116,094.24

CMS Signage Checked:

Auditor Comments:

UT STATE LAWS: May not audit a pharmacy during the first five business days of the month, unless the pharmacy agrees to the timing of the audit.
Reason for Audit
** An expanded audit was conducted due to a referral from HMS. We received information from Health Mart. The pharmacy has been removed from their affiliation.
I do want to provide notification to Caremark that during a review of the pharmacy's claims HMA discovered that a large percentage of the claims filed with Caremark, as of the date of HMA's review, did not appear to originate in Utah where Nomi is solely located (as reflected on the pharmacy's NCPDP profile). In addition, the pharmacy stated to HMA that it was doing more mail order on a particular drug. Pharmacy is only billing for two items Trudesa and Auvi Q. Requesting tracking and shipping to verify where items have been shipped from.
** Expanded audit include invoices, hardcopy, siglogs, copay collection documents, prescriber verifications.
Timeline-
** Initial notice sent to pharmacy on 08/20/2024 via fax & mail.
** Wholesaler & employee list received from pharmacy via e-mail on 08/20/2024.
**Owner- Nomi Health INC.
Employees listed- [redacted] (Sr Director), [redacted] (PIC), [redacted] (tech) & [redacted] (Vice President).
**List of other pharmacies owned, operated, or affiliated with the pharmacy owner- Nomi Pharma LLC (4615754).
Wholesalers- McKesson, Bioridge, TopRX & Pharma Link.
The pharmacy has billed 499 claims for total paid amoun of $1,351,058.25. RXD only pulled claims

PHARMACY NAME

NOMI PHARMA LLC

for AUVI-Q, AFLURIA, TRUDHESEA & WEGOVY.
DRUG_LBL_NM Total
AFLURIA QUAD INJ 2023-24 158.65
AUVI-Q 2 PK KIT 0.15MG 42,808.95
AUVI-Q 2 PK KIT 0.1MG 19,622.73
AUVI-Q 2 PK KIT 0.3MG 141,021.14
CLONIDINE TAB 0.1MG 10.98
HYDROXYZ HCL TAB 50MG 5.47
MIRTAZAPINE TAB 7.5MG 27.48
NORTRIPTYLIN CAP 50MG 14.98
OMEPRAZOLE CAP 40MG 11.78
ORPHENADRINE TAB 100MG ER 26.47
PAIN RELIEVE TAB 500MG 9.43
PILOCARPINE TAB 5MG 24.59
PREGABALIN CAP 150MG 15.26
TIZANIDINE TAB 4MG 5.5
TOPIRAMATE TAB 50MG 12.62
TRUDHESA AER 0.725MG 1,146,068.08
WEGOVY (4) INJ 0.5MG 1,214.14
(blank)
Grand Total 1,351,058.25

Past audit history: None
CURRENT TRENDING:-

INVOICE REVIEW
Invoices were initially received from- Bio ridge pharma, Pharma Link, TopRX & McKesson.

The pharmacy was not short any of the top50 drugs billed.

DOCUMENT REVIEW - Hard copies, sig logs, copays
Almost all the prescription copies submitted were transfers from ASPN pharmacy to the Nomi Pharmacy and appeared to be part of a marketing hub scheme. All of the copays are billed to a secondary payor (manufacturer coupon). During the exit interview, I asked [redacted] about these coupons he stated that the hub pharmacies work with the manufacturer to obtain the coupons. During the exit interview, I asked [redacted] about any relationship with ASPN, and I was told they are a hub that transfers RXs to them. I asked if they were purchased or if the patient was calling to request the transfer. [redacted] responded that these were just transfers and not purchased. For RX # Redacted - PHI the rx copy submitted shows that the rx is transferred to a different pharmacy and not to the pharmacy that is being audited. These claims are marked as INV. During the exit interview, I asked [redacted] about these transfers, he stated that they must have submitted the wrong document. [redacted] said possibility is that the other pharmacy was unable to fulfill the order so the prescription must have transferred over to them. [redacted] said that he will look into this.

I asked about copay collection and asked them to explain the process of what happens when an RX comes in and there is a copay. [redacted] stated that the pharmacy processes the claim and bills the insurance. If there is a copay, then ASPN collects the copay from the patient. The copay is then transferred to the pharmacy monthly.
I informed [redacted] that all copay collection must occur at the provider's location, Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts was performed by another entity (e.g., a pharmaceutical hub). I asked [redacted] to refer to CVS CAREMARK provider manual for more details.
I discussed this with Jenn Thomas, and it was decided to charge any one of those that has a copay

PHARMACY NAME

NOMI PHARMA LLC

(even for copays under $50.00) CB as INV for violating CVS Caremark provider manual.

For RX **Redacted - PHI** the pharmacy has not provided any copay collection documentation. The pharmacy is asked to provide copy of a patient invoice showing the member copay amount and DOF along with evidence the copay was paid in full, such as a signed member statement listing the rx, DOF, and copay pd amt, CC receipt including auth #. Post Audit please watch, if copay collection document submitted by the pharmacy shows that the copay was collected by ASPN then CB these as INV as well.
The pharmacy has submitted trackable proof of delivery that shows that the prescription was shipped from the pharmacy location. However, some of the POD shows questionable estimated delivery date and pick up date. Due to the conflicting information on the POD, the pharmacy is asked to provide signed patient attestation confirming how & when RX was delivered.

Prescriber Verifications-
Prescriber verifications were sent to 72 physicians. I received 15 approvals & zero denial.
NO REVERSALS
FINAL RESULTS-
48-INV, 3- CPY, 11-OTH
The audit was conducted with Justin Bryner (Sr. Director) on 10/15/2024 at 1:37pm (ET). I asked him the below listed questions-
• Can you tell me a little about your pharmacy? [redacted] stated that this a open door pharmacy. 20 % of the prescriptions are picked up in-person and other 80% is delivered via USPS or UPS or they also hand deliver the prescriptions to the patients to their home.
• Is this pharmacy licensed in any other states? Yes, all except the state of California.
• Do you ship/mail prescriptions out of state? YES
I discussed all the discrepancies and the next steps. I asked [redacted] if he has any questions, he stated that it's pretty straight forward and he does not have any questions.
Acknowledgement form faxed and emailed to the pharmacy.

Reason Audit Initiated: Client

Exhibit 69: CVS_HJC_00013451 Audit file for Postmeds Inc (January 9, 2024)

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

POSTMEDS INC

NCPDP/NPI: 5660091/1295182590

AUDIT TYPE: Focused Audit

AUDIT DATE: 01/09/2024 ✓

AUDIT PROFILE ID: 92844

AUDITOR: Cindy Tran

Finalized
2/27/24
RH

Number of claims in original profile : 80,781

Number of claims marked for audit : 427

Discrepancy Code	DESCRIPTION	Count
CPY	COPAY	3
INV	INVALID	8
	TOTAL	**11**

Total Descrepancy Amount: $7,875.57

CMS Signage Checked:

Auditor Comments:

This pharmacy an onsite referral because "Pharmacy identified as outlier for filling medications written by prescribers with no identifiable patient relationship. (i.e. [redacted] NPI (1689841744)" I faxed the unmasked list to the pharmacy the morning, prior to my onsite visit. Prescriptions were printed when I arrived. This audit took 2 days because audit went past closing time on the first day.

There were 8 INV and 3 COPAY discrepancies found in this audit. When I was reviewing the scripts and the RXs I noticed that they were mostly transfers, with very few electronic directed to this pharmacy. Transfers came from from Cabot LLC, VitaCare Prescription Services, PhillRX, Phill AZ, SimpleCare Pharmacy, BlinkRx and a couple more. The doctors, patients, and pharmacies are not located anywhere near each other and all are in different states. The pharmacy currently holds licenses in all 50 states. [redacted], the Compliance Analyst supervisor, stated that this is the reason why all the transfers come to this pharmacy, since this pharmacy can ship to all 50 states. I noticed that Cabot's address is located across of the street from Post Meds. When I questioned this, [redacted] stated that Cabot is their intake pharmacy. She also stated that VitaCare used to be theirs, but was sold. All MIEBO DRO 1.3GM/ML drugs were from BlinkRX and were transferred to their Cabot intake Pharmacy. INV were because MIEBO DRO 1.3GM/ML was transferred from Blink to Cabot with no history of Cabot transferring scripts to Post Med. [redacted] said that the button to show me the history is not working and that they would question the IT department about that during the appeals process. When I asked for proof of delivery, she provided the UPS label and all the MIEBO DRO 1.3GM/ML shows Blink as the sender, just with Post Med's address. Copies of the labels are included in the packet. The 3 CPY discrepancies was because they were not able to provide proof of copayment. The proof of copayment provided for the others did not have an authorization number, just a receipt number and the last 4 of a credit card.

On the first day, I questioned if they collected their copay for all drugs, [redacted] insisted that all copay

PHARMACY NAME

POSTMEDS INC

is collected in house. When I asked her how the process works and how they reach out to the patient for copayment collection, she stated that she has to ask, but she just knows that they handle co-payments in house. [redacted] later stated that they use Strip to collect copayment and it goes directly to them. I asked what the process is like if I was a new patient, how would I go about inputting that information. [redacted] stated that she would have to reach out to the finance team to ask how the copayment worked and could tell me the next day. I asked her how patients and doctors find this pharmacy. She stated through word of mouth or online advertisements. The next day she had one of the staff pharmacist come. I asked him the same question, how would it work if I was a new patient, how do I input my information or even gain access to Strip? The staff pharmacist said that he does not know. [redacted] later had me go on a call with [redacted], the Compliance Analyst supervisor, and she stated that patients have a profile, where they input the information themselves. They did not know the process beyond that.

It took them more than about 5 hours to get 3/4 of the 163 scripts printed. [redacted], the Compliance Analyst called me at 9:54 AM the morning of the audit to ask me questions about printing and she said that she would start print right away. However when I got there at 2PM, they just stated printing. [redacted] stated that she spent her time putting the RXs in PDF form so they could keep it for their records. When I was there, she stated that she was only 1/4 through making the PDFs and another pharmacist has been working on this as well. I was there for about 3 hours. During the audit, I asked her if I could just look at them on the computer with her, while she clicks through the images, since the PDF were ready. She said she was told that I am not allowed to look at their system. A pharmacist came and let [redacted] know that I had to leave by 6:30 because all the pharmacist would not be in the building and I have to come back tomorrow for the rest of the scripts. When it was getting towards closing, I asked her to stop printing scripts and to prioritize the proof of copay. I waited a while and she kept handing more RX hardcopies. I asked her why she was not prioritizing the proof of copays. She said that she already had the RX queue, proof of copayments would not be until the next day. I questioned why she could not just cancel the queue and start print proof of copayments first and she stated that the way the printer is structured, she is not able to do that. After this she stated that the printer is not printing and I would have to come back for the rest tomorrow.

The stock check was mostly satisfactory, they were low on female condoms and Aplenzin.

I conducted the exit interview [redacted]e, Compliance Analyst supervisor, who was on the phone and [redacted], the Compliance Analyst, on 01/10/24. I explained the next steps in the process and reviewed the discrepancies. I went over the CMS compliance requirements and OIG checks and FWA training. I explained the next steps in the process. I left an audit tip packet at the store. This pharmacy will be referred to the invesgative team for an expanded audit.

Reason Audit Initiated:

Exhibit 70:
CVS_HJC_00013583 Audit file for Southwood Pharmacy

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

SOUTHWOOD PHARMACY

NCPDP/NPI: 3159452/1609580489

AUDIT TYPE: Focused Audit

AUDIT DATE: 07/10/2024

AUDIT PROFILE ID: 96242

AUDITOR: Enas Saadeh

Finalized 10/9/24 RA

Number of claims in original profile : 1,905

Number of claims marked for audit : 169

Discrepancy Code	DESCRIPTION	Count
RTS	REFILL TOO SOON	5
	TOTAL	**5**

Total Descrepancy Amount: $983.56

CMS Signage Checked:

Auditor Comments:

PHARMACY NAME

SOUTHWOOD PHARMACY

Pharmacy was chosen based on referral from OPP team. Per the OPP referral: Pharmacy violated NOPP march 2024 with 9 NOPP claims. Total NOPP amount paid $53,597. 7 claims trudhesa aer 0.725mg, 1 claim accrufer 30mg capsules, 1 claim vascepa 1 gm.

Pharmacy was notified of audit via fax as well as through USPS 6/7/24. The pharmacy is located on a commercial road in the town. There are retail stores in the strip mall. The front store is typical of a retail pharmacy, with OTC, first aid and household items for sale.

Upon my arrival I was met by, [redacted], staff Rph. I was given space in an office adjacent to the pharmacy to set up and conduct audit. Pharmacy was prepared for audit all prescriptions and backtags were printed upon request. I gave [redacted] the signature log list while I began to review prescriptions. Pharmacy staff did not ask any questions. I reviewed the pharmacy inventory, checked their top 25 drugs. There were 10 Trudhesa in stock, an open bottle of Vascepa, and 0 accrufer. All other pharmacy drug inventory appeared to be stocked in line with claims submitted, they did not have some of the top 25 drugs in stock, reason given was they order as needed or it was just dispensed. I observed the pharmacist and staff on the phones with what seemed to be a prescriber's office, and patients. I observed customers interact with staff for prescriptions and/or front store items.

I reviewed 7 claims for Trudhesa. All of these prescriptions initiated from ASPN prescription transfer. I asked the staff rph to explain the ASPN transfers to me. She said that this is a new product to her and she called the PM who was on PTO to answer. He asked to speak to me on the phone, I accepted. He introduced himself as Hemil, the PM. He explained that ASPN is a service provider for Trudhesa. Prescribers and pharmacies enroll with ASPN to facilitate this product for their patients. He stated that in the recent month or 2, Southwood pharmacy enrolled with ASPN. He explained that ASPN receives a prescription, get insurance approvals and PA when needed. Then the fill order is sent to his pharmacy. The order is filled and either delivered or locally shipped to his patients.

Pharmacy does offer delivery w/in a 10 to 20 mile radius using Rx2go. They ship via FedEx and USPS, sparingly. Per the staff Rph they have shipped less than 3% of their orders.

OIG: checked monthly via the OIG site.

Staff: [redacted], PM (not present, but spoke to him on the phone) [redacted], staff Rph. (present)

Technicians: [redacted]

Wholesalers: ABC, McKesson

Discrepancies: 5 RTS

After audit was completed, I reviewed all discrepancies and post audit processes and provided audit tips and all educational materials to Neelam.

Staff did not have any questions for me.

Reason Audit Initiated:

Exhibit 71:
CVS_HJC_00013600 Audit file for Deadborn Hills Pharmacy

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

DEARBORN HILLS PHARMACY

NCPDP/NPI: 2377073/1356699888

AUDIT TYPE: Routine

AUDIT DATE: 04/23/2024

AUDIT PROFILE ID: 94888

AUDITOR: Shannen Lackey

Finalized 7/11/24

Number of claims in original profile : 3,308

Number of claims marked for audit : 235

Discrepancy Code	DESCRIPTION	Count
SIG	INSUFFICIENT DIRECTIONS FOR USE	1
INV	INVALID	2
RTS	REFILL TOO SOON	1
	TOTAL	**4**

Total Descrepancy Amount: $4,472.23

CMS Signage Checked:

Auditor Comments:

PHARMACY NAME

DEARBORN HILLS PHARMACY

2377073 Dearborn Hills Pharmacy
Dearborn Hills Pharmacy is in Dearborn, Michigan. They are now doing business as HealthPro Pharmacy according to [redacted]. HealthPro Pharmacy has a PEAR score of 34.7. They are a Performance Guarantee for Ingenio, State of Florida- Oth, Gateway Health Plan PA MEDD, SWSCHP, Centene, FEP, AVERA, and State of Rhode Island. Their Top 5 Drugs by Amount Paid are: TYRVAYA SPR 0.03MG TOTAL PAID: $506,960.35 QTY: 9542 IN-STOCK QTY: 44 BOXES, ADDYI TAB 100MG TOTAL PAID: $391,439.18 QTY: 26190 IN-STOCK QTY: 187 BOXES, CEQUA SOL 0.09% TOTAL PAID: $241,597.48 QTY: 37860 IN-STOCK QTY: 216 BOXES, OPZELURA CRE 1.5% TOTAL PAID: $156,249.51 QTY:6060 IN-STOCK QTY: 15 TUBES, and XIFAXAN TAB 550MG TOTAL PAID: $154,204.74 QTY: 3570 IN-STOCK QTY: 1 PARTIAL 1 FULL.
There was a total of 235 claims reviewed. There was 1 RTS and 1 SIG found. This pharmacy is using the Phil hub and I explained to [redacted] that this was a contract violation. He denies that this is a contract violation, and his lawyer has reviewed the provider manual thoroughly. I recommended that he goes to the provider portal to ensure he is reviewing the correct provider manual. There was a RTS for a written prescription written for Flovent 220mcg with the directions of 2 puffs every day. It was filled on 5/25/2023 making 6/23/2023 too soon. There was a SIG for an electronic prescription written for Potassium Chloride 20meq Packets with the directions of 1 packet with food orally once. It is written for a quantity of 1 and no refills. I am asking pharmacy to verify with prescriber how many packets the patient should be taking. I have attached the signature logs and copay documentation provided to me.

1. Who are your wholesalers? AmeriSource, WWS, MaynePherma, TopRX, Anda, ParMed, ICS, FFF Enterprises,
2. Is the pharmacy licensed in any other states? Inidiana, Arizona, Ohio, Illinois, Pennsylvania, Florida
3. Do you ship out of state? Yes, in states licensed in
4. Are you mailing prescriptions? Yes, USPS 20%, FedEX 15%, and UPS less than 1%
5. Do you deliver? If so what is the delivery radius and who delivers prescriptions. Yes, no delivery radius and third party Promed delivers
6. How many prescriptions a day do you fill? 250 rxs/day
7. How do patients find out about your pharmacy? Word of mouth, website, doctor referral
8. Do you do any compounding? no
9. How is PHI disposed of? Shred it comes twice a month
10. Who owns pharmacy? Any other locations? [redacted] no other pharmacies owned

Auditor Questions:
1. Was there foot and phone activity? no foot activity, phone activity was consistent
2. Where did you perform the audit at? Pharmacy closet
3. What type of prescriptions did you see during the audit? mostly transfers from Phil RX, different locations all over US
4. Additional information: notations written added to prescriptions that were printed the day of the audit

Reason Audit Initiated:

Exhibit 72:
CVS_HJC_00013637 Audit file for Carepoint Pharmacy (February 2, 2022)

PHARMACY NAME

CAREPOINT PHARMACY

NCPDP/NPI: 1487330/1598013864

AUDIT TYPE: Focused Audit

AUDIT DATE: 02/02/2022 ✓

AUDIT PROFILE ID: 77285

AUDITOR: Zohreh Tourani-Durtka

finalized 4/5/22 zt

Number of claims in original profile : 17,848

Number of claims marked for audit : 101

Discrepancy Code	DESCRIPTION	Count
CPY	Copay	2
INV	Invalid prescription	18
OTH	Other	6
	TOTAL	**26**

Total Descrepancy Amount: $22,174.52

CMS Signage Checked:

Auditor Comments:

Pharmacy was picked based on management referral. Pharmacy has a pear score of 38.13. Initial notification along with unmasked prescription number list and COVID-19 modification page was sent to the pharmacy via fax (8552379113@fax.cvshealth.com) and mail (9 Commerce Dr Schaumburg, IL 60173 SCHAUMBURG, IL 60173).
A copy of list of pharmacy employees are included in the packet provided to post audit team.
Drug stock
top 5 billed medications are:
Alinia Tab 500mg
Duexis Tab 800-26.6
Addyi Tab 100mg
Oracea Cap 40mg
Odactra Sub
Referral
Pharmacy was referred with concerns about billing test claims and a Aetna SIU a Med D member denial that member only paid ~$45 of the $250 copay for Dapsone gel on 2/5/21 Rx# **Redacted - PHI**
There are 4 test claims Rx#s starting with 990000:

Redacted - PHI

I requested information such dr order, backtag and prove of pick up and delivery on 1/7/2022 with a due date of 1/12/2022 [redacted] replied back that the claims cannot be found in the system. Claims were reversed on 1/21/2022.
Prove of copay collection for SIU referred claim was requested and reviewed. The claim was marked

PHARMACY NAME

CAREPOINT PHARMACY

INV due to pharmacy using a coupon on MedD claim.
While reviewing the claims it was noticed pharmacy has filled multiple non-FDA approved medications, prove of pick and copay collection for filled high copay non-FDA approved medications were requested. 18 claims were marked INV due to applying coupon for medications that are non-FDA approved.
Multiple prove of copay collection were provided without a collection location. 6 claims were marked OTH requesting to clarify location of copay collection.
Pharmacy also did not provide prove of copay collection for 2 prescriptions.
Per [redacted] pharmacy is licensed in 50 states, FedEx and UPS are used to ship 98% of filled medications. [redacted] also mentioned pharmacy does not deliver any medications and the remainder 1-2% of filled medications are picked up at the store.
[redacted] said pharmacy CP-Hub system to text and let the patient know of their prescription status. Patients can also call in or use text messaging system to pay for their copay.
Per David pharmacy fills for partner pharmacies (class D pharmacy, Blink Health and MD2Rx pharmacy) who do not have a drug stock and are fulfillment pharmacies.
[redacted] were part of the exit interview. [redacted] said he would like a list of questions he has been unable to answer to further investigate and will reply with answer. List of questions were emailed to [redacted] on 2/2/2020 after the exit interview with a screenshot of the questioned prescriptions and the response was received 2/14/2022:
1. Explain what does "216 Days Past Due" means? Can you provide Rx#/context so that I may review and confirm?
2. Explain what does "Medisol Direct Purchase//DDAS" means? This likely means we purchase that product from Medisol and/or Dermadash. If you can provide specific Rx#s, I can review and confirm.
3. Who is MD Exam? I am unfamiliar with "MD Exam." Can you provide Rx#/context so that I may review?
4. Who collects the copay for claims with MD Exam? See response to #3.
5. List the programs or drugs (none) where copay are collected by an entity other than Carepoint.
1. MD2RX (No longer in business)
2. Phil Rx
3. Blink Rx
6. Prescriptions filled for Blink Health, who bills the claims? Carepoint bills the claim to PBM. Who collects copay? Blink collects the copay as the patient experience is through Blink. And How is Carepoint reimbursed? Blink creates a single-used "Credit card" for Carepoint for the value of the copay.
7. Explain how the prescription numbers beginning with 99000* were billed. Include who billed and how they remained billed for more than 7 days when they were not dispensed. These scripts were billed with a benefits verification tool that was provided by Change Healthcare, a payment/revenue system Carepoint utilized. Carepoint was under the impression that these were test bill claims, not true adjudications. We have since learned that this is not the case and reversed the claims once we received confirmation. An error in the Change Healthcare system caused the B2 transaction to fail without be noticed by their team. We are no longer using that product, and, in fact, Change Healthcare has discontinued the product altogether.
8. Provide policy and procedure on reversing claims not dispensed. See Attached. Through CPHub, any prescription that is not dispensed is automatically reversed by the system 7 days later and placed on hold until patient calls in to authorize and fill the medication.
9. Provide policy and procedure for copay collections. See Attached
10. Who are pharmacy's wholesalers? ALK-ABELLO, American Pharmaceutical Dist., Amerisource Bergen, Anda Generics, AndMEDRX LLC, Artesa Labs, Bausch Health US, BLUPAX Pharma, Cintex Services, EPI Health, FFF Enterprises, Galderma Labs, JG Pharma, Journey Medical Corp, Marnel Pharmaceuticals, Mayne Pharma, Medimetricks Pharma, Medisol Pharmaceuticals, Phil Inc., Prasco Labs, Real Value Products, Upsher-Smith Labs
David was redirected to the screenshots for question 1, 3 and 4.
A copy of P&P on copay collection and return to stock was provided and are attached to referral in SharePoint.
Results
MedD compliance checklist and results were reviewed with David Isaac. David agreed with 2 CPY, 6

PHARMACY NAME

CAREPOINT PHARMACY

OTH and 18 INV discrepancies. A copy of audit results, post audit guidelines and audit tip packet were secure emailed to [redacted]
Pharmacy is referred to investigation for further review of coupon usage on non-FDA approved medication.

Reason Audit Initiated:

Exhibit 73:
CVS_HJC_00013689 Audit file for Sav-On Pharmacy

PHARMACY NAME

SAV-ON PHARMACY 0110

NCPDP/NPI: 0535724/1487600037

AUDIT TYPE: Routine

AUDIT DATE: 08/15/2023

AUDIT PROFILE ID: 89234

AUDITOR: Cindy Tran

Number of claims in original profile : 4,047

Number of claims marked for audit : 436

Discrepancy Code	DESCRIPTION	Count
INV	INVALID	249
RTS	REFILL TOO SOON	4
	TOTAL	**253**

Finalized 10/6/23 MM

Total Descrepancy Amount: $142,910.47

CMS Signage Checked:

Auditor Comments:

This pharmacy was selected based on PEAR, claim volume, and location. I faxed the unmasked list to the pharmacy prior to my onsite visit. I conducted this audit in the pharmacy. While conducting the audit, I noticed a lot of claims billed for Xhance. While I was reviewing the hardcopies, I noticed that most of them were transfers from another Albertson in Santa Fe Springs, all the patients were far away from both locations and some transfers from Blink Heath. I asked [redacted], the PIC where they are getting all the patients that are getting these Xhance sprays. [redacted] stated that they are just doing the fulfillment for these orders and the patients are from Blink Health. She referred me to [redacted], who is the pharmacist in charge of the fulfilment process specifically. She stated that the fulfillment center used to be at the Albertson in Santa Fe Springs, but they closed that location and moved to this Sav-On location, and she started here on 11/22/2022. [redacted] stated that they did not have the fulfillment part of the pharmacy before [redacted] started working there. [redacted] stated that she has no contact with the patient at all and does not deal with the copays at the store. [redacted] stated that the prescriptions first start at Blink health, as there are reps that reach out to the doctors and patients, then the prescription is uploaded to M-health, a network where Sav-On's cooperate team uploads the script and is where [redacted] receives the hardcopies and types of the prescriptions. The scripts come as a electronic transfers. The RXs then get shipped out through UPS/USPS. [redacted] has no idea how the copays are collected and did not know where the Shared Services agreement is. There were 4 RTS and 249 INV discrepancies found in this audit. I realized that not all the Xhance sprays were marked, only the potential RTS scripts were marked in the audit, so I went back into the profile and marked the rest of the Xhance sprays that have copays. I called the store and informed [redacted] of the new total. I conducted the exit interview with [redacted], the PIC, and [redacted], the staff pharmacist, on 8/15/2023. I explained the next steps in the process and I explained the next steps in the process and reviewed the discrepancies. I included a stack of the transferred scripts in my audit packet. I will be referring this pharmacy to the investigative team because copay collected by a Third party is not allowed.

PHARMACY NAME

SAV-ON PHARMACY 0110

Reason Audit Initiated:

Exhibit 74:
CVS_HJC_00014043 Audit file for Smartscripts

PHARMACY NAME

SMARTSCRIPTS

NCPDP/NPI: 1625093/1992186969

AUDIT TYPE: Investigative

AUDIT DATE: 01/31/2023

AUDIT PROFILE ID: 84446

AUDITOR: Joy Mills

Finalized 3/27/23 JC

Number of claims in original profile : 76,143

Number of claims marked for audit : 220

Discrepancy Code	DESCRIPTION	Count
OTH	Other	158 ✓
	TOTAL	**158**

Total Descrepancy Amount: $204,033.52

CMS Signage Checked:

Auditor Comments:

Expanded audit initiated at the request of FEP, Plan Sponsor Tip – "We saw an uptick in Vascepa claims for this pharmacy. Lettered patients and members; responses received to date indicated they either received (member) and/or prescribed (provider) the vascepa. Some members indicated that they selected Blink Pharmacy, because a "coupon was supplied." One exception: Member: [redacted] (Canyon Lake, TX). Denied receiving the medication from "SmartScripts". (See attached) I contacted the provider's office – [redacted] – New Braunfels Cardiology (New Braunfels, TX). The medical records department confirmed the [redacted] (New Braunfels Cardiology) prescribed Vascepa for [redacted], and it was sent to "Blink Pharmacy." It looks like Blink is a digital platform that farms scripts out to pharmacies – so it was likely filled and dispensed by Smartscripts. This is an MIR pharmacy, and they ship all over the US. A SIRIS inquiry returned the following: Humana investigation in 2021. Patricia Perez (Fraud Investigator) indicated that multiple members denied receiving some or all of the medications. The largest trend identified was "unsolicited contact by the pharmacy, resulting in confusion/inadvertent agreeing to switch pharmacies." Other concerns included waiving of co-pays, gift cards, and free vitamins."
MIR effective 2019
Pharmacy is licensed in and actively shipping to: AK, AR, AZ, CO, CT, DC, DE, FL, GA, Hi, IA, ID, IL, IN, KS, KY, MA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY, copies on sharedrive
I reviewed original prescriptions, proof of delivery, receipts, invoices, and pharmacy licenses. The prescriptions requested were for drugs normally associated with HUB activity and a couple routine maintenance prescriptions with copays for comparison
Received the following information from management regarding pharmacy and the drug Lyvispah "Lyvispah does have some connection to BlinkRx...so, this might be of interest to Jenn Thomas and her team. https://lyvispahhcp.com/how-to-prescribe The site does mention: "Lyvispah is also available at most local pharmacies." But, there might be some hub activity here. Note, the top 3 pharmacies are: MED CART SPECIALTY PHARMACY (2374445), WHITE DRUG (3504138), and

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

SMARTSCRIPTS

SMARTSCRIPTS (1625093). And, for all three of those pharmacies, there are multiple cert IDs (see attached file; added tabs for those 3 pharmacies)." And indicated the drug would be NOPP.

There are multiple cert ID's with 2 distinct patterns that appears to be 2 pharmacy systems

CRTFN_ID CLAIM_STATUS MIN_FILL_DT MAX_FILL_DT TOTAL_CLAIMS
Paid 20-Apr-22 24-Jul-22 28
Reject 2-Nov-21 8-Oct-22 55
5103210976 Paid 2-Nov-21 11-Nov-22 607
5103210976 Reject 1-Nov-21 11-Nov-22 640
5103210976 Reversal 8-Dec-21 14-Sep-22 82
5103277793 Paid 23-Nov-21 24-Aug-22 21
D012000047 Reject 12-Nov-21 15-Nov-22 159
D012000047 Reversal 2-Nov-21 11-Nov-22 108
D012000097 Not Avail 23-Nov-21 24-Aug-22 21
D012000097 Paid 1-Nov-21 15-Nov-22 273148
D012000097 Reject 1-Nov-21 15-Nov-22 116893
D012000097 Reversal 1-Nov-21 15-Nov-22 121970
D012000149 Paid 26-Apr-22 10-Nov-22 2
D012000149 Reject 1-Mar-22 15-Nov-22 34070
D012000149 Reversal 3-Mar-22 15-Nov-22 8375
D012500011 Reject 12-Mar-22 15-Nov-22 752
D012500011 Reversal 11-Mar-22 5-Nov-22 264

Paic 273806
Reject 152569
Reversal 130799

Pharmacy has reversed 42 claims since the audit was initiated.

Invoices: No shorts
Received and reviewed invoices from: IPC, McKesson, Optinose, Primus, Upsher Smith, Bloodworth, capital, and Shield

Rx Hardcopies were a combination of transfers from Blink and ERx's. I requested 101 unique prescriptions totaling 220 claims. 162 claims were transfers from Blink.

One Blink transfer contained internal noting that a test claim was run and passed.

Delivery: Pharmacy provided trackable proof of delivery for all claims. One exception was for a patient who's address is WI and it was delivered to IA with no noting. OTH - POD not accepted, del to IA patient address WI. Must send a trackable proof of delivery for this date of service, must include tracking number, delivery date and address item was delivered to & patient attestation confirming how & when item was received

Copay: For prescriptions with copays pharmacy provided a form with Smartscripts, the patients name, address, date, no Rx number, no authorization number, total, a credit card symbol and 4 digits. Some receipts indicating more than $1000. For Xhance, Zembrace and Vasotec, there are discount coupons available for non medicare patients to significantly reduce this. Pharmacy also provided this form for copays greater than 1000$ for NON-FDA approved items such as EPICERAM EMU PUMP and PROMISEB CRE. Example below.

Reviewed with [redacted]. Did not accept receipt forms for copays on transfers from Blink (as low as 35.00) Additional information required for copayment collection send CC merchant report & patient attestation confirming entire adjudicated copay has been paid, last 4 digits of CC and who the patient paid blink or smartscripts

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

SMARTSCRIPTS

Exit Interview:
Conducted with owner/PIC [redacted], Billing Manager [redacted], and [redacted] Director of Pharmacy Services.
Reviewed next steps in the audit process, asked if there were questions. [redacted] responded "no"
How many prescriptions a day do you fill? Approx. 1750
- How do patients find out about your pharmacy? Digital adv, work with providers,
- Do you ship out of state? yes
- Is the pharmacy licensed in any other states? Yes (on file)
- What is your process for collecting copays? Most people prepay with a credit card.

Do you call prior to shipping? Yes
What Pharmacy software system do you have? Mr. [redacted] responded "it's a hybrid of QS1" "we've made a lot of modifications to it"
I noted on one of your transfers from Blink "[redacted] ran test claim and passed" Do you run test claims?
[redacted] responded, "it depends" Can you explain? "If they've never been here before we may run it to verify. For example, they found us on social media we may run a test claim prior to transferring the prescription. But that's rarely."
I reviewed the OTH marked for patient who's address is WI and it was delivered to IA
I reviewed the OTH requesting Additional information required for copayment collection send CC merchant report & patient attestation confirming entire adjudicated copay has been paid, last 4 digits of CC and who the patient paid blink or smartscripts
I reminded them that the claim level detail would be arriving soon in the mail and asked if there were any questions and [redacted] responded "no"

Reason Audit Initiated: Client

Exhibit 75:
CVS_HJC_00014054 Audit file for Village Fertility Pharmacy

PHARMACY NAME

VILLAGE FERTILITY PHARMACY

NCPDP/NPI: 2238005/1225182595

AUDIT TYPE: Focused Audit

AUDIT DATE: 10/23/2024

AUDIT PROFILE ID: 98476

AUDITOR: [redacted]

Finalized 12/12/2024

Number of claims in original profile : 12,580

Number of claims marked for audit : 153

Discrepancy Code	DESCRIPTION	Count
CPY	COPAY	3
	TOTAL	**3**

Total Descrepancy Amount: $2,028.04

CMS Signage Checked:

Auditor Comments:

PHARMACY NAME

VILLAGE FERTILITY PHARMACY

Pharmacy was chosen based on a referral from FWA and PEAR score (23.35). The referral states "Aetna July & Aug FWA report: This pharmacy first appeared on Aetna's drug mix report in July for billing Miebo - client billed amt ~52k. Per the pharmacy's website, this pharmacy specializes in fertility meds. A further data pull showed, the pharmacy was billing miebo for members who were not already getting some sort of fertility med and appear to be shipping miebo out of sate. Pharmacy appeared on Aetna's Aug FWA report with an increase in client spend of $298,164.42 for total $350,346.09 (Miebo $305761.69 & Xdemvy $44554.4). Both of these medications are Blink Rx medications."

Pharmacy was notified of audit via fax as well as through USPS 10/7/24. The unmasked list was faxed the day before the scheduled audit.

The pharmacy is in an office complex located on the first floor. The facility fills specialty medications of fertility products. There are four locations: Boston area (this Waltham, MA location), Chicago area, Phoenix area, and Los Angeles area.

Upon entering I found a waiting room with a receptionist. I introduced myself and the PIC was called. I was met by [redacted]. Another pharmacist joined, [redacted] [redacted] introduced her as Ops Director. They led me to a conference room where I set up to conduct audit.

Pharmacy did not have any prescriptions printed even though the unmasked list was shared. I gave [redacted] the unmasked list and he went to print them. The backtags were printed upon request. I also gave him the signature log list and copay list while I began to review prescriptions. Per the referral I reviewed prescriptions for MIEBO and XDEMVY. All these prescriptions reviewed originated from BLINK. Per the PIC, Brendan, most Miebo and Xdemvy prescriptions have a zero dollar copay. If there are copays Blink collects and transfers the orders to this location to fill and ship. Per [redacted] he was unsure of how any copays related to the BlinkRx are collected. He stated he is "unsure of how the software works". He said he would have to follow up with his team. The pharmacy is licensed in 46 states. The pharmacy ships via UPS. They also use same day delivery service called AirSpace and Boston Couriers. I observed a shipping area in the pharmacy workspace. I observed techs filling and preparing packages for shipping.

I reviewed the pharmacy inventory, checked their top 25 drugs. Pharmacy drug inventory appeared to be stocked in line with claims submitted. Many of these drugs are high cost and the pharmacy orders as needed.

OIG/FWA: Cardinal Learning Bridge

Wholesalers: Cardinal, Anda, and Smart Source

Discrepancies: 3 CPY

After audit was completed, I reviewed and provided audit tips and all educational materials to the PIC. Staff did not have any questions for me.

I will be referring to expanded to review the Blink Rx prescriptions further.

Reason Audit Initiated:

Exhibit 76:
CVS_HJC_00014149 Draft of the 2020 CVS Caremark Provider Manual

Table of Contents

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED

General Information

This 2018 Caremark Provider Manual ("Provider Manual") supersedes all previous versions of the Provider Manual. Capitalized terms used in the Provider Manual not defined in the Glossary of Terms shall have the same meaning as in the Provider Agreement.

Proprietary Statement

The Provider Agreement (which includes the Provider Manual) constitutes Confidential Caremark Information and is provided to Provider for business purposes only. Provider must maintain in confidence the Provider Manual, and must not disclose, sell, assign, transfer or give to any third party the Provider Manual or any of its contents without Caremark's prior written consent. Refer to the **Confidentiality** section of the Provider Manual.

Document Adherence

The Provider Manual is a Caremark Document and is incorporated into the Provider Agreement. Provider must abide by the provisions and terms set forth in the Provider Agreement (which includes the Provider Manual and all other Caremark Documents).

Pharmacy Help Desk

Inquiries which the Provider Manual or the claims system response do not address can be directed to the Interactive Voice Response (IVR) system or the Pharmacy Help Desk. To help expedite certain responses, the IVR is available 24 hours a day, 7 days a week, excluding downtime for maintenance and service. The Pharmacy Help Desk is open every day of the year and is staffed with representatives. Following are the phone numbers corresponding with the appropriate Bank Identification Numbers (BINs):

Caremark System	RXBIN	Pharmacy Help Desk Number
Legacy ADV	004336*	1-800-364-6331
Legacy PCS	610415*	1-800-345-5413
FEP	610239	1-800-364-6331
Legacy CRK	610029*	1-800-421-2342
Caremark	610591	As communicated by plan or refer to ID card
Aetna	610502	1-800-238-6279

Secondary RXBINs and Plan sponsor-specific RXBINs and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at **www.caremark.com/pharminfo**.

*Puerto Rico Providers call toll-free 1-800-842-7331.

Pharmacy Help Desk representatives will use reasonable efforts to assist providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with respect to the provision of Pharmacy Services.

Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

Refer to the **Medicare Part D** section of the Provider Manual for detail on Medicare Part D Calls to the Pharmacy Help Desk.

Contact Information

Unless otherwise specified in the Provider Manual, Providers must send inquiries and grievances in writing to:

CVS Caremark
Attn: Network Management, MC 080
9501 East Shea Boulevard
Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014150

Top Questions Asked by Providers

1. **What date of birth, sex and/or person code do you have on file for this Eligible Person?**

   Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable attempts/efforts to obtain the necessary information for claim submission. In the event a Plan Sponsor has incorrect member eligibility information (e.g., incorrect date of birth), when a Provider submits a claim using the correct eligibility information (e.g., correct date of birth) the claim will reject. In most cases, Caremark will be able to assist the Provider at the point of service with any discrepancies with eligibility information, such as date of birth and sex. However, you should advise your patient that he/she should inform his/her Plan Sponsor of the incorrect eligibility information and that until it is corrected claims will continue to reject.

2. **What is the identification number for this Eligible Person?**

   Provider must request to see the identification card for the Eligible Person to ensure that the prescription is written by the Prescriber for an Eligible Person.

3. **Are person code and patient relationship code required for claim submission?**

   Person code (as printed on the identification card) and patient relationship code data fields are required for submission as outlined in the Caremark Payer Sheets. Many times, person code is printed on the identification card; it is important that this information is submitted accurately to Caremark in order for appropriate Drug Utilization Review (DUR) for that individual to occur.

4. **What Banking Identification Number (RXBIN) do I use for all Caremark Eligible Persons?**

   Provider should submit claims utilizing the corresponding RXBIN which, in most cases, is illustrated on the identification card. A complete list of RXBINs is located on the previous page.

5. **Is a Processor Control Number (RXPCN) required for claim submission?**

   Provider must request to see the identification card for the Eligible Person and examine the identification card to determine if RXPCN information is available. Submit the RXPCN information as it appears on the identification card. If no RXPCN appears on the identification card, submit the default RXPCN according to the RXBIN as outlined in the Caremark Payer Sheets found online at **www.caremark.com/pharminfo**.

6. **What is the Group (RXGRP) number for this Eligible Person?**

   The RXGRP number is located on the Eligible Person's identification card. Refer to the **Verification of Eligible Persons** section of the Provider Manual.

7. **What is the amount this patient must pay?**

   Provider must submit the claim through the claims system to receive the adjudicated response which will include the amount to collect from the Eligible Person as well as information about eligibility, plan coverage, pricing and applicable clinical programs and services. The representatives at the Pharmacy Help Desk cannot release information about the amount the Eligible Person must pay due to the variables that may impact cost share.

8. **Is this Eligible Person eligible to receive a vacation supply?**

   Many Plan Sponsors allow for Eligible Persons to secure an early refill for vacation supply. If the Eligible Person states that he/she is eligible for an early refill for vacation supply, Provider must submit the claim as usual. If the claim rejects, Provider should contact the appropriate Pharmacy Help Desk for coverage verification. If the Plan Sponsor does allow for an early refill for vacation supply, the representative from the Pharmacy Help Desk will enter an override.

9. **What is the prior authorization procedure for this Eligible Person?**

   Caremark only administers Prior Authorization programs for some of its Plan Sponsors. Therefore, Provider should note the adjudication response which generally includes the online retransmission instruction or appropriate contact information and telephone numbers.

10. **What are the plan limits for this Eligible Person?**

    Provider must submit the claim through the claims adjudication system to receive the adjudicated response which will include messaging about plan coverage. The representatives at the Pharmacy Help Desk cannot release plan limitation information due to the variables that may impact the coverage for a given drug.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014151

11. May I waive patient copays?

Provider must follow the requirements of the Provider Agreement (including the Provider Manual) for collection of Patient Pay Amounts. Refer to the **Collection of Patient Pay Amounts** section of the Provider Manual.

12. How do I know if the Plan allows Coordination of Benefits?

Plans may indicate if an Eligible Person's eligibility is supplemental, and Provider may receive a reject indicating that the claim should be submitted to another payer or other COB related message. For Plan Sponsors that allow Coordination of Benefits (COB), refer to the **Claims Submission** section of the Provider Manual for additional information regarding COB claim submission.

13. Do I need to bill the specific National Drug Code dispensed?

Yes. Submitted claims information must be accurate and complete. This includes, but is not limited to, billing the actual National Drug Code (NDC) used for each item within a prescription for compound recipe.

14. What data field do I use for the <specific data>?

Representatives from the Pharmacy Help Desk will reasonably assist Provider where possible to determine which data field should be used for specific data. However, due to the numerous types of software, it is difficult for the representatives to know how each system is set up. Providers should consult with their software vendor or chain headquarters for technical assistance.

15. I am a new provider owner. Am I responsible for the liabilities and obligations of the previous owner?

Yes. Refer to the **Change in Ownership** section of the Provider Manual.

For additional claim processing information, refer to the Caremark Payer Sheets at www.caremark.com/pharminfo.

Note: This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Caremark.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014152

Credentialing and Quality Management

Provider must comply with credentialing and quality management initiatives as required by Caremark, and Provider must provide Caremark with documentation and other information that may be needed in connection with such initiatives, including but not limited to, disclosure of information as set forth in "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E) and "Disclosure of Ownership and Control Information" (42 C.F.R. Part 420, Subpart C).

Caremark has the right to reasonably determine whether a provider meets Caremark's credentialing and quality management standards to serve as a provider for Caremark and its Plan Sponsors. Caremark reserves the right to terminate the Provider Agreement, or deny enrollment to a provider, based on provider's inability to meet Caremark's credentialing and quality management standards such as but not limited to, engaging in conduct that (1) may constitute a breach of the Provider Agreement (including significant audit findings or enforcement activity by any governmental regulatory or enforcement entity or agency against provider or against another provider with common ownership, officers, directors, or personnel as provider); (2) may adversely impact Caremark's relationship with, or Caremark's contractual duties to, a Plan Sponsor; (3) may adversely affect provider's ability to fulfill the requirements of the Provider Agreement; or (4) may pose a risk to the health, welfare, or safety of members or the general public (including adverse actions by a governmental regulatory or enforcement entity or agency against provider, against another provider with common ownership as provider, or any of their respective owners, officers, directors, or personnel).

Compliance with Laws.

Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable Laws (including any implementing regulations) in performing its Pharmacy Services under the Agreement, including, but not limited to: the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395nn); and Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Parts 160, 162, and 164, and the Controlled Substance Act (21 U.S.C. 801-971); and Caremark must comply with all applicable Laws (including any implementing regulations) in performing its duties under the Agreement.

Standards of Operation

A "**Retail Pharmacy**" is defined as a duly licensed and established community pharmacy or dispensing practitioner that dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. Participation in Caremark's retail networks is limited to pharmacies (or dispensing practitioners) that are a "Retail Pharmacy".

For purposes of this definition, any provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, whose number of claims submitted to Caremark for prescriptions that were mailed to Eligible Persons (including common carriers such as USPS, FedEx, UPS) exceeds 25% of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. In such case, Caremark reserves the right to exclude such provider from any retail network(s) in which the provider is participating or any new retail network(s) established, or apply other unique terms and conditions to such provider's participation in such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing.

For purposes of this definition, any provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, whose number of claims submitted to Caremark for specialty drugs exceeds 25% of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. In such case, Caremark reserves the right to exclude such provider from any retail network(s) in which the provider is participating or any new retail network(s) established, or apply other unique terms and conditions to such provider's participation in such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing.

For purposes of this definition, any provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, who is owned by a 340B covered entity or whose volume of claims filled using 340B Drug Pricing Program acquired or replenished drugs is the basis for any pharmaceutical manufacturer denying pharmaceutical rebates for claims filled by provider, is not considered a Retail Pharmacy. In such case, Caremark reserves the right to apply unique terms and conditions to such provider's participation in any retail network(s) in which the provider is participating or any new retail network(s) established, or such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014153

foregoing. Providers owned by a 340B covered entity must maintain their NCPDP Online provider ID profile services question on 340B so that it is accurate and up to date.

Commented [PT1]: 2019 PM Supplement

For mail delivered prescriptions dispensed in accordance with the Agreement, Provider must maintain for audit purposes (1) Patient Pay Amount collection documents; (2) shipping method; (3) shipment manifest; (4) medication protection method; (5) documentation of each prescription number and Covered Item delivered; and (6) tracking documentation for each Covered Item delivered.

Providers who utilize an internet site as a routine business practice in the provision of Pharmacy Services (except for refill requests) must maintain Verified Internet Pharmacy Practice Sites (VIPPS) certification through the National Association of Boards of Pharmacy (NABP), but must also otherwise comply with the terms of this subsection.

Drug Stock and Inventory

Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

Licensure

Provider must at all times maintain in good standing all Federal, State and local licenses and/or permits as required by applicable Law, including but not limited to, maintaining a valid pharmacy license in each state to which Provider dispenses prescriptions. Provider must furnish copies of said licenses and/or permits upon enrollment and as requested by Caremark. Any Pharmacy Services provided where Provider does not possess all required licenses and/or permits under applicable Law shall be deemed to be invalid, subject to recoupment, and may result in termination of the Provider Agreement. All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist and in accordance with Prescriber directions and applicable Law.

Reporting of Investigations and Disciplinary Actions

Provider must notify Caremark in writing if:

1. Any of Provider's licenses or permits that are required under applicable Law for Provider to provide Pharmacy Services is, or is in jeopardy of being, suspended or revoked;
2. There are proceedings related to Pharmacy Services that may lead to an adverse action against Provider or affiliate of Provider, or any of their respective officers, directors, current/former employees, or owners (direct or indirect);
3. Any adverse action is taken against (a) Provider; (b) officer, director, current/former employee, owner (direct and indirect) of Provider or affiliate of Provider, including but not limited to, action taken by a Board of Pharmacy, Officer of Inspector General (OIG), System for Award Management (SAM), law enforcement, Drug Enforcement Agency (DEA), or other regulatory body;
4. There is a subpoena of records related to Pharmacy Services or Provider's business practices;
5. There is a seizure by law enforcement of Provider's prescription records, computer systems, financial records, accounts, or real property;
6. Provider or affiliate of Provider, or any of their respective officers, directors, employees, or owners (direct and indirect) enters into a settlement agreement, Corporate Integrity Agreement, or consent order with a governmental or regulatory agency relating to Pharmacy Services or Provider's business practices, even if there is no admission of liability; or
7. Provider is terminated from a third-party payer's (including a pharmacy benefit manager) network based on cause.

Provider must notify Caremark in writing to:

CVS Caremark
Attn: Pharmacy Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Required notification to Caremark must be provided within ten (10) business days of the occurrence and include sufficient detail. Failure to timely and properly notify Caremark may result in termination of the Provider Agreement or suspension as a participating provider.

Caremark may immediately suspend, pending further investigation, the participation status (which may include

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider if required by applicable Law, or if Caremark has reason to believe Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; or (4) is a breach of the Provider Agreement. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement.

Criminal Offense Related to Federal Health Care Programs

Pharmacy Criminal Offense: Provider must notify Caremark in writing if Provider or any of its officers, directors, employees, contractors, agents, or volunteers who provide items or services that will be paid by Medicare, Medicaid, or other Federal or federally funded health care program or any of its owners has been, within the ambit of 42 U.S.C. § 1320a-7(a) or 1320a-7(b)(1)-(3),

1. charged with or convicted of any criminal offense
    a. related to the delivery of an item or service under any Federal or federally funded health care program (including Medicare or Medicaid);
    b. related to the neglect or abuse of a patient in connection with the delivery of a health care item or service;
    c. which is a felony and related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct;
    d. which is a felony and related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
2. proposed for exclusion or debarment from participation in Medicare, Medicaid, or other Federal or federally funded health care program.

For purposes of Provider's notification hereunder, the term "convicted" includes (1) when there has been a finding of guilt against Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner; (2) when Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner has entered and a court has accepted a plea of guilty or nolo contendere (no contest); (3) when Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner has entered into a pre-trial agreement to avoid conviction; and (4) when Provider or Provider's officer, director, employee, contractor, agent, volunteer or owner has entered into participation in a First Offender, deferred adjudication, pardon program, or other arrangement or program where a judgment of conviction has been withheld.

Prescriber Criminal Offense: Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber whom Provider knows has been convicted of any criminal offense as described above within the ambit of 42 U.S.C. § 1320a-7(a). Provider must notify Caremark in writing if Provider has knowledge or information of a Prescriber who has been charged with or convicted of any criminal offense as described above within the ambit of 42 U.S.C. § 1320a-7(a). Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

Federal Health Care Programs Participation Exclusion: Pharmacy

If Provider is excluded or debarred from participation in any Federal health care program (as defined in 42 U.S.C. 1320a-7b(f)), Provider will be immediately terminated from participation in all Caremark networks and immediately notify Caremark of any such exclusion or debarment. Provider shall not submit any claim to Caremark for a prescription dispensed by Provider if Provider is excluded or debarred from participation in any Federal health care program.

Provider shall not allow any person (whether as an officer, director, employee, contractor, agent, volunteer, owner or otherwise) who is excluded or debarred from participation in any Federal health care programs to directly or indirectly provide any item or service under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services. Provider agrees to implement a policy requiring all new and existing persons engaged by Provider (whether as an officer, director, employee, contractor, agent, volunteer, owner or otherwise) to immediately disclose to Provider any debarment, exclusion, or other event that makes them ineligible to perform work related directly or indirectly to Federal health care programs. Upon such disclosure, Provider must immediately reassign such person to work that does not involve or relate, directly or indirectly, to the provision of items or services under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014155

Provider hereby certifies that Provider will review the OIG List of Excluded Individuals/Entities (LEIE) and SAM list upon initially hiring or engaging any officer, director, employee, contractor, agent, volunteer, owner, or otherwise, and monthly thereafter and upon any change of ownership in order to ensure that Provider does not allow any person who is excluded or debarred from participation in any Federal health care program to directly or indirectly provide any item or service under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services. Provider agrees to provide such additional information or documentation in this regard as Caremark may reasonably require.

Provider hereby certifies that Provider will review the Social Security Administration's Death Master File upon initially hiring or engaging any officer, director, employee, contractor, agent, volunteer, owner or otherwise, and monthly thereafter and upon any change of ownership in order to prevent fraudulent use of social security numbers.

Provider agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

Notwithstanding anything to the contrary, if an exclusion is made by an individual state health care program or other government sponsored program, but the exclusion does not extend to all Federal health care programs, Caremark may, in its sole discretion, limit the scope of termination to termination from only certain Caremark networks.

If Provider is excluded or debarred from participation in any Federal health care program, Provider will promptly provide to Caremark upon request a list, in such detail as Caremark requires, of all Federal health care program claims submitted on or after the date of such exclusion. All such identified claims are subject to reversal by Caremark as required by Law, Plan Sponsor, or as otherwise deemed necessary or appropriate by Caremark.

If any of Provider's officers, directors, employees, contractors, agents, volunteers or owners is excluded or debarred from participation in any Federal health care program, Provider will promptly provide to Caremark upon request a list, in such detail as Caremark requires, of all Federal health care program claims for which the excluded person directly or indirectly provided Pharmacy Services on or after the date of such exclusion. All such identified claims are subject to reversal by Caremark as required by Law, Plan Sponsor, or as otherwise deemed necessary or appropriate by Caremark.

Federal Health Care Programs Participation Exclusion: Prescriber

Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other Federal or federally funded health care programs. Provider must maintain a process to identify and detect prescriptions prescribed or claims for items or services furnished by an excluded or debarred Prescriber, and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

Insurance

Provider must at all times hold policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1,000,000.00 per person and $3,000,000.00 in aggregate, unless otherwise agreed to by Caremark, or such greater amount required by Law.

Provider must furnish copies of said policies upon enrolling as a provider with Caremark and as requested by Caremark thereafter. Failure to maintain the minimum coverage may result in immediate termination.

Provider must notify Caremark immediately in writing if its insurance is canceled, lapsed or otherwise terminated. Failure to immediately notify Caremark in writing of any such termination of insurance coverage may result in immediate termination.

The requirements in this section apply to the extent consistent with applicable Law.

Quality Management

Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.

Provider Enrollment

To enroll as a provider to participate in a Caremark or Plan Sponsor Network, Provider must complete and submit

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014156

the "Pharmacy Pre-Enrollment Questionnaire" accurately in order to initiate the enrollment process, which includes disclosing information as set forth in "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E) and "Disclosure of Ownership and Control Information" (42 C.F.R. Part 420, Subpart C). To access the "Pharmacy Pre-Enrollment Questionnaire", go to **www.caremark.com/pharminfo** and select "Pharmacy Pre-Enrollment Questionnaire".

Caremark charges a $325 fee for each application of enrollment regardless of whether Caremark enrolls the provider. Caremark charges a $75 fee per pharmacy location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application. Such fees will be offset against other amounts owed to Provider. Failure to provide all required enrollment information and documentation within thirty (30) days will result in the denial of the enrollment application. Caremark may require additional pre-enrollment credentialing in established Health and Human Services-Office of Inspector General (HHS-OIG) designated Health Care Fraud Prevention and Enforcement Action Team (HEAT) areas.

Providers wishing to participate in a Plan Sponsor network may contact Caremark at 480-314-8457 and provide Provider's name, the corresponding National Provider Identifier (NPI) and National Council for Prescription Drug Programs (NCPDP) number, the contact name, the telephone number, and the reason for the call.

Change in Ownership

I. If (1) there is any change in who holds (directly or indirectly) the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (2) the right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party (any of (1) or (2), a "Change in Ownership"), Provider must notify Caremark in writing of the Change in Ownership by no later than ten (10) business days of the change.

II. In the event Provider (or any affiliate of Provider) acquires, directly or indirectly, (1) any ownership interest in any pharmacy or (2) any operating rights with respect to any pharmacy (in each case an "Acquired Pharmacy"), following such acquisition, the Agreement will not apply to the Acquired Pharmacy without Caremark's prior written consent. Absent such consent, Caremark may require Provider or Acquired Pharmacy to submit credentialing information so that Caremark may evaluate whether the Acquired Pharmacy meets Caremark's established credentialing standards, including completion of the "Pharmacy Pre-Enrollment Questionnaire" in order to initiate the enrollment process, which includes disclosing information as set forth in "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E) and "Disclosure of Ownership and Control Information" (42 C.F.R. Part 420, Subpart C). To access the "Pharmacy Pre-Enrollment Questionnaire", go to **www.caremark.com/pharminfo**, and select "Pharmacy Pre-Enrollment Questionnaire". Caremark charges a $75 fee per provider location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application, and such fee will be offset against other amounts owed to Provider. Failure to provide all required credentialing information and documentation will result in denial of the enrollment application. Caremark may require additional pre-enrollment credentialing in established HHS-OIG designated HEAT areas.

   In the event Provider acquires a controlling ownership interest in or operating rights with respect to an Acquired Pharmacy, Provider agrees to assume responsibility for and to guarantee any Acquired Pharmacy's performance of its obligations under any Caremark provider agreement, including any financial obligations, obligations to comply with applicable Law, and the obligation to cooperate with Caremark's audit requirements, whether such obligations arose before or after Provider's acquisition of an ownership interest in or operating rights with respect to such Acquired Pharmacy.

III. In the event Provider (or any affiliate of Provider) acquires, directly or indirectly, (1) any ownership interest in or (2) any operating rights with respect to (A) any chain of retail pharmacies having ten (10) or more store locations, (B) any mail order pharmacy, or (C) any specialty pharmacy, following such acquisition, Caremark may, in its sole discretion, apply with respect to such Acquired Pharmacy or Acquired Pharmacies for the remainder of the calendar year in which the acquisition closes and the following calendar year either (a) the financial terms set forth in Provider's Provider Agreement with Caremark through an amendment or (b) the financial terms under any provider agreement in effect between Caremark and the Acquired Pharmacy or Acquired Pharmacies.

Change in Documentation, Request for Documentation, Closure, and Other Information

Provider Information Updates

Unless otherwise specified, Provider must notify Caremark in writing within ten (10) business days of any change

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014157

in the documentation and other information Provider provided to Caremark in connection with enrolling as a provider, including but not limited to, change in credentialing information (e.g., change in "Pharmacy Pre-Enrollment Questionnaire" information), name, contact information, services, hours of operation, or 24-hour status. Notwithstanding the foregoing, Provider must notify Caremark of a change in the pharmacy's physical location, prior to the change. Provider is liable to Caremark for any losses that Caremark incurs (e.g., penalties to a Plan Sponsor) based on Provider's failure to comply with this sub-section.

Provider must send such notification to Caremark via either:

(1) fax to 480-661-3054; or (2) mail to:

CVS Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

Provider must be reachable by Caremark based on the contact information (as updated) Provider provided to Caremark as part of enrollment.

Provider must notify Caremark, by no later than ten (10) business days after a closure of its business, the custodian of records for all future audit-related requests for documentation and information from Caremark or a governmental agency. Provider must respond to Caremark within ten (10) business days of a request for documentation necessary to support claims processing or audits by Plan (or of Plan) and within thirty (30) days of receipt of pharmacy contact verification forms or the Pharmacy Credentialing Request Form, with accurate and complete documentation.

Caremark charges a $75 fee per provider location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application, and such fee will be offset against other amounts owed to Provider.

Diverse Retail Pharmacy Program

The Caremark Supplier Diversity Program targets diverse suppliers of products and services for Caremark's use. The program is designed to complement Caremark's commitment to providing outstanding service to its customers, and it recognizes the critical role diverse suppliers have in its continued success. The Supplier Diversity Program is founded on the principles of sound business practices and social responsibility to the community in which Caremark serves.

One component of the Supplier Diversity Program is the Diverse Retail Pharmacy Program. Under this program Caremark encourages diverse-owned, independent retail pharmacies to become certified business enterprises in order to expand and establish potential business opportunities, sustain and grow their business, take advantage of possible governmental programs, and expand and establish potential new opportunities with other business entities.

Any diverse-owned and operated retail pharmacy contracted with Caremark and certified as a diverse business enterprise by a government or third-party entity can apply for participation in the Diverse Retail Pharmacy Program. Just complete and submit the Caremark Supplier Diversity Profile Form. For more information on this program and the Caremark Supplier Diversity Profile Form, refer to **Appendix E** of the Provider Manual.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014158

Pharmacy Services and Standards

Verification of Eligible Persons

Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable efforts to obtain the necessary information for claim submission. Provider will not be reimbursed for providing Pharmacy Services to an Eligible Person whose eligibility was incorrectly submitted.

Identification Cards

In most cases, the identification card will be produced in the NCPDP format and will contain the Eligible Person's identification number, the RXBIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information.

An identification card may show coverage for the Eligible Person only or it may show coverage for the Eligible Person and his or her dependents.

Nondiscrimination

Provider must not discriminate against an Eligible Person on the basis of race, color, national origin, gender, age, religion, disability, medical condition, political convictions, sexual orientation, Eligible Person's enrollment in a Plan, source of payment, marital or family status, or any other basis prohibited by Law. Unless professional judgment dictates otherwise, Provider must deliver Pharmacy Services related to Covered Items to all Eligible Persons.

Collection of Patient Pay Amounts

Plan Sponsors determine the Patient Pay Amounts which Provider must collect from an Eligible Person for the Pharmacy Services related to a Covered Item. Patient Pay Amounts vary by Plan. Provider must disclose to each Eligible Person the Patient Pay Amount at the time the prescription is dispensed. Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system, unless otherwise authorized in writing by Caremark or except for a non-routine, unadvertised waiver of a Patient Pay Amount that does not violate applicable Law and is either: (1) a waiver based on an individualized determination of financial need made under a Financial Hardship Program that meets the Financial Hardship Program requirements set forth below; or (2) a waiver made following exhaustion of reasonable collection efforts, such as invoices, billing letters, and collection calls. Provider must document its reasonable collection efforts, and such documentation must include, at minimum, the date the collection effort was sent or contact made, the Patient Pay Amount owed by Eligible Person, results of each collection effort, and final disposition.

If a payment plan is agreed to by Provider with an Eligible Person for the payment of a Patient Pay Amount, all terms of the payment plan, including the total amounts subject to the payment plan and repayment terms, must be documented and written confirmation of such terms must be sent to the Eligible Person. The payment plan must be reasonable and expected to result in full collection of outstanding Patient Pay Amounts owed.

Provider must maintain proof of payment by Eligible Person of the Patient Pay Amount [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash], which shall be subject to Caremark audit.

In the event the first documented effort to collect a Patient Pay Amount is initiated after Provider's receipt of a Caremark audit notice, such collection effort and any thereafter shall not qualify as reasonable efforts to promptly collect Patient Pay Amounts, regardless of any resulting collection of the Patient Pay Amount. Rather, Provider shall be deemed to have waived the Patient Pay Amount in violation of this **Collection of Patient Pay Amounts** section. The foregoing shall not apply to efforts undertaken by Provider to collect Patient Pay Amounts that are initiated within thirty (30) days of the date of the prescription fill.

All collection of Patient Pay Amounts must occur at Provider's location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub).

If the Patient Pay Amount is reduced due to a coordination of benefits, Provider must provide evidence of the claim adjudication to the secondary payer.

Financial Hardship Program

Waivers based an individualized determination of financial need under a Financial Hardship Program must meet the

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014159

following requirements:

- The terms of the Financial Hardship Program must be set forth in a formal written policy adopted by Provider. The policy must specify the documentation required to establish financial need, the criteria for determining eligibility for financial hardship relief and the level of relief to be provided, the application review and approval process, and recordkeeping requirements.
- Eligible Persons seeking relief under the Financial Hardship Program must submit an application and provide reasonable and objective documentation of financial need that includes federal tax returns and other appropriate documentation.
- The criteria for determining eligibility for financial hardship relief and the level of relief to be provided must be reasonable.
- Written notice of qualification for financial relief under the Financial Hardship Program must be provided in writing to the Eligible Person. This notice must specify the amount or portion of the Patient Pay Amount that is being waived and the period of the waiver.
- Eligibility for continued financial relief under the Financial Hardship Program must be reviewed on at least an annual basis. This review shall be based on an updated application and updated supporting documentation provided by the Eligible Person.
- Records must be maintained for each Eligible Person receiving financial hardship relief under the Financial Hardship Program. The records must include, at a minimum, the application and supporting documentation submitted by the Eligible Person and a copy of the notice of qualification sent to the Eligible Person.
- Provider personnel providing final financial hardship approval must be employed by Provider and shall not be contractors or agents of Provider. The identity of the personnel granting approval must be documented and provided as requested by Caremark.
- The Financial Hardship Program may not be advertised or promoted.
- The Financial Hardship Program may not be funded, in whole or in part, by any third party.
- The Financial Hardship Program must meet all requirements and restrictions of applicable Law.

Documentation

Provider must maintain documents to demonstrate its compliance with terms of this **Collection of Patient Pay Amounts** section, and Provider agrees that such documentation is subject to Caremark audit.

Excess Collections

If Caremark determines that Provider has charged or collected from an Eligible Person in excess of the Patient Pay Amount communicated by the claims adjudication system, Provider must promptly reimburse Eligible Person for the excess amount upon Caremark request; otherwise, Caremark reserves the right to recover the excess amount from Provider (including by offset against other amounts owing to Provider) and return the recovered amounts to the Eligible Person.

Limitation on Collection

Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including non-payment by or bankruptcy of a Plan Sponsor or Caremark or where such amount is disallowed or not permitted by a governmental body. For claims of Plan Sponsors who are Medicare Advantage organizations providing Medicare Part C services, Provider must not hold any Eligible Person liable for payment of any fees that are the legal obligation of such Medicare Advantage organization.

Violations

Any act, omission, or scheme that encourages or allows conduct resulting in a violation of this **Collection of Patient Pay Amounts** section, such as but not limited to, pharmacy-sponsored coupons, advertisements, pamphlets, flyers, and website postings promoting waiver of Patient Pay Amounts, is strictly prohibited and may result in the termination of the Provider Agreement and other remedies available to Caremark. Claims submitted in violation of this section are subject to chargeback.

Patient Inducements

Provider may not offer or provide any item of value, including but not limited to, gift cards, coupons, or free goods or services, to an Eligible Person to induce or reward the purchase of Pharmacy Services or Covered Items from

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014160

Provider, unless such items are nominal in value (meaning a value of $15 or less) and the aggregate value of items given to an Eligible Person does not exceed $75 per year, as documented in Provider's records that are subject to audit. Further, notwithstanding the foregoing, Provider may not offer or provide any inducement to an Eligible Person that is prohibited by any applicable Law. This section does not apply to Pharmaceutical Manufacturer Coupons which are addressed separately in the Provider Manual.

Coupons and Other Programs

As used in this section, "Pharmaceutical Manufacturer Coupon" means any item or mechanism, including but not limited to, paper coupons, copay cards, e-vouchers, mail-in rebates, and electronic coupon codes funded by a manufacturer, repackager or supplier of pharmaceutical, chemical or compounding products, that reduces the portion of the Patient Pay Amount that an Eligible Person is required to pay for a Covered Item.

Pharmaceutical Manufacturer Coupons may be accepted by a Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:

1. the Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program, including but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program;
2. the application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider's location;
3. the Covered Item is not a compounded drug; and
4. either:
    a. the Covered Item is approved by the U.S. Food and Drug Administration (FDA) through a New Drug Application (NDA) or Abbreviated New Drug Application (ANDA), and is published in the Approved Drug Products with Therapeutic Equivalence Evaluations (or commonly known as the "Orange Book"); or
    b. a Biologics License Application (BLA) including drugs classified as biosimilars approved under section 351(k) of the Public Health Service Act and is published in the Lists of Licensed Biological Products (or commonly referred to as the "Purple Book"); or
    c. the Covered Item is an Over-the-Counter (OTC) Covered Item marketed under an official final OTC monograph; or
    d. the Covered Item is a grandfathered drug marketed pre-1938 or pre-1962, or is otherwise Generally Recognized as Safe and Effective (GRASE) by the FDA.

Provider's application of a Pharmaceutical Manufacturer Coupon to reduce a Patient Pay Amount in violation of this section constitutes a prohibited waiver of the Patient Pay Amount. Claims submitted in violation of this section are subject to chargeback.

Pharmaceutical Manufacturer Coupons that are only eligible to be used at specific pharmacies are not allowed. Certain Pharmaceutical Manufacturer Programs are specifically disallowed, including but not limited to, those from Affordable Medication Solutions, RetainRx, Phoenix PBM and all associated programs. Use of disallowed coupons will be deemed to be an unapproved waiver of copayment and may result in chargeback of claims and other remedies available to Caremark, including but not limited to, termination of the Agreement.

Commented [PT2]: 09/18 – Amendment 08

Eligible Person Solicitation

Provider must not, directly or indirectly (e.g., through a marketing agent) promote or market prescription drug products to Eligible Persons where there is not an existing pharmacist patient relationship based on prior filling of a legend drug. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives but not limited to adherence initiatives, gaps-in-care management or comprehensive medication reviews with Eligible Persons

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014161

Usual and Customary Price

Provider must disclose to each Eligible Person Provider's Usual and Customary (U&C) Price if such U&C Price is less than the applicable Patient Pay Amount. Provider must charge the Eligible Person the U&C Price or the Patient Pay Amount, whichever is lower, unless a Plan otherwise requires. Notwithstanding the foregoing, Provider must still submit a claim to Caremark, even if the Eligible Person pays the U&C Price.

Referral Fees

Provider shall not offer or pay to any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referrals of patients or other individuals to Provider for the provision of any pharmacy or other healthcare service.

Provider shall not solicit or receive from any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback or other consideration, whether in the form of money or otherwise, as compensation or inducement for Provider's referral of patients or other individuals for the provision of any pharmacy or other healthcare service.

Documents and Records Maintenance

Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons and Pharmacy Services in accordance with applicable Law and as required by the Provider Agreement, including the **Professional Audits** section of the Provider Manual.

~~With respect to Medicare Part D, Provider agrees to make its books and records available in accordance with, and for the period required by 42 C.F.R. § 423.505(i)(2), which gives HHS, the Comptroller General, or their designees, the right to audit, evaluate and inspect any books, contracts, records, including medical records, and documentation of Provider involving transactions related to CMS' contract with a Part D Plan Sponsor, and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor's contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the (ten) 10 year retention period.~~ For all lines of business, Provider must maintain its prescription records, books, other documents, and any other items that are allowed to be reviewed, in their original format for the period of ten (10) years or as required by applicable law, if any, but may, subject to applicable guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the ten (10) year retention period. Provider agrees to make its books and records available for a period of ten (10) years from the termination date of the Provider Agreement.

Commented [PT3]: Steve's Proposed 2019 PM Supplement Edits

Provider must maintain and secure records in accordance with HIPAA requirements, including disposing of any records containing Protected Health Information (PHI) in a secure manner in accordance with guidelines issued by the Secretary of Health and Human Services for rendering such records unusable, unreadable or indecipherable to unauthorized individuals.

Signature Log – Hard Copy or Electronic

Provider must utilize a third-party signature log – hard copy or electronic – which meets the following criteria: (1) contains a signature which can be individualized or directly related to each prescription dispensed, (2) maintains the date of the receipt of medication by the Eligible Person, (3) maintains a disclosure to Eligible Person of insurance billing, and (4) retrievable for the purposes of audit.

For each claim adjudicated through the claims adjudication system, Provider must obtain the signature of the Eligible Person (or his or her authorized representative) on a dated third-party signature log to confirm that he or she has received the medication recorded.

Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.

Third-party signature log options for mail-delivered prescriptions dispensed in accordance with the Agreement include:

- If delivered to a home or business address, Provider must maintain for audit purposes (1) Patient Pay Amount collection documents; (2) the shipping method; (3) shipment manifest; (4) the medication protection method; (5) documentation of each prescription number and Covered Item(s) delivered; and (6) tracking documentation for

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014162

each Covered Item was delivered.

- If Eligible Person is sent monthly billing statements, Provider may insert a form listing the dates of fill and prescription numbers; the Eligible Person or authorized representative should be instructed to sign and return the form with his or her payment

The third-party signature log must be in date order, readily accessible, and retained for such period as required by applicable Law.

Hours of Operation

Provider must maintain hours of operation that meet the needs of the community, but in all circumstances in accordance with applicable Law.

Performance Initiatives

Provider must support all Caremark performance initiatives, such as but not limited to, performance network programs (which may include adherence and drug therapy gap alerts), retrospective safety review alerts, closed formularies, Prior Authorization program, Managed Drug Limitations program, generic incentive programs, Dose Optimization program, Step Therapy program (refer to the **Clinical Programs, Services and Related Messages** section of the Provider Manual for a further description of these initiatives) and any criteria in such performance initiatives.

As part of the performance initiatives, Provider must inform Eligible Persons when a non-formulary drug has been prescribed and Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider may be paid a fee for services related to such performance initiative efforts.

Educational Materials and Efforts

Provider must utilize all educational materials to benefit Eligible Persons. All information contained in educational materials related to products, programs, services, and Plan Sponsor announcements constitute Caremark Documents and are Confidential Caremark Information.

Caremark may educate Provider about products, programs and services as well as distribute Plan Sponsor announcements. Educational materials may be distributed through various means, including e-mail, facsimile, mail, or posted on one of the Caremark websites or the Caremark Pharmacy Portal.

Eligible Person Complaints

Provider must cooperate with Caremark and Plan Sponsors to resolve Eligible Person complaints. Provider must make a reasonable effort to rectify the situation that leads to the Eligible Person complaint. Provider must maintain written records of events and actions surrounding each complaint.

Provider must participate in and comply with a Plan's applicable appeal, grievance, and external review procedures, including Medicare Part D appeals and expedited appeals procedures, and the resulting decisions of the Plan.

Provider must provide to Caremark timely responses for CMS Complaint Tracking Module (CTM), in accordance with CMS-specified response times, which are typically within 24 hours of receipt of the grievance.

Dispensing Errors

If, as a result of an Eligible Person complaint, audit review, or Prescriber verification, for example, Caremark identifies a potential dispensing error and confirms with Provider the occurrence of such dispensing error, Provider must (1) review the information with the Eligible Person, (2) document the error in accordance with Provider's internal operational procedures, (3) report the error, if required, to any appropriate regulatory agency, including but not limited to, the Institute for Safe Medication Practices (ISMP), and (4) follow all applicable Law. For paid claims that have been determined to have a dispensing error, Caremark reserves the right to charge back the entire claim amount and may request Provider refund the Eligible Person the Patient Pay Amount.

Caremark tracks all dispensing errors identified through Caremark programs and provides notice to Provider of each error. Errors identified are reported internally for clinical review and serious or multiple errors may result in the Provider being notified of a Corrective Action Required (CAR), in which case Provider may be required to provide a Corrective Action Plan (CAP) to detail mechanisms being employed to prevent future errors. Refer to the **Corrective Action Plan** section of the Provider Manual.

Professional Judgment and Conduct

All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist and in

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014163

accordance with Prescriber directions and applicable Law. Provider must at all times exercise professional judgment in providing Pharmacy Services to an Eligible Person. Provider may refuse to provide Pharmacy Services to an Eligible Person based on professional judgment.

Dispensing Covered Items to Eligible Person Agent

Provider must obtain the consent of the Eligible Person in order to dispense a Covered Item to a licensed healthcare practitioner in a non-custodial setting, except for deliveries to a family member of the Eligible Person when the Eligible Person is not present at the time of the dispensing of the Covered Item.

Referrals to Non-Retail Participating Providers

Provider must refer Eligible Persons to mail order, specialty, and/or other specified pharmacies for certain Pharmacy Services as appropriate for his or her plan benefit design and in compliance with applicable Law.

Drug Stock and Inventory

Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014164

Claims Submission

Claims submitted by Provider to Caremark must be for a prescription for a Covered Item that was written by a Prescriber and for which Pharmacy Services for a Covered Item were provided to an Eligible Person. Submitted claims information must be accurate and complete. Each claim submitted by Provider constitutes a representation by Provider to Caremark that the Pharmacy Services were provided to the Eligible Person and that the information transmitted is accurate and complete. Submission of incomplete, false, or fraudulent claims is a willful misrepresentation and intentional misconduct by Provider. If Provider knows or reasonably should know, that there is not a legitimate Prescriber/patient relationship, Provider must verify the Prescriber/patient relationship prior to dispensing and maintain a record of such verification. Provider must receive Eligible Person consent prior to each fill to dispense the prescription, but such consent is not necessary when the Eligible Person personally initiates the new prescription request or refill.

All Covered Items, including Over-the-Counter (OTC) Covered Items, with a prescription that are provided to an Eligible Person as prescribed by a Prescriber must be labeled for the Eligible Person.

Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification number or other identifiers to submit a claim (including a test claim) to Caremark. Unless Caremark expressly authorizes otherwise in writing: (a) claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person; (b) Provider must not allow an entity to submit a claim on Provider's behalf using Provider's or any other identifiers; (c) Provider is not allowed to submit claims on behalf of another entity; (d) the provider that submits the claim to Caremark must be the same provider that dispenses the Covered Item to the Eligible Person; and (e) the claim is billed with the intent to be dispensed by the billing entity.

~~Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number or NCPDP number to submit a claim (including a test claim) to Caremark. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy (defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person), unless Caremark expressly authorizes otherwise in writing. The provider that submits the claim to Caremark must be the same provider that dispenses the Covered Item to the Eligible Person, unless Caremark expressly authorizes otherwise in writing.~~

A paid claim as indicated through the claims adjudication system is not an indication by Caremark of Provider's compliance with the Agreement.

Any violation of this section is subject to audit chargeback, non-compliance fees, and/or possible termination as a Provider.

~~Any violation of this section is subject to audit chargeback.~~

Commented [PT4]: 2019 PM Supplement

Commented [PT5]: 2019 PM Supplement

Commented [PT6R5]:

Electronic Submission/Reversal/Processing Windows

Unless otherwise agreed in writing and to the extent consistent with applicable Law, all claims must be submitted electronically. Failure to submit a claim within ninety (90) days from the date of fill may result in non-payment of such claim to the extent consistent with applicable Law.

All prescriptions not received by an Eligible Person must be reversed within fourteen (14) days from original submission through the electronic claims system using data elements as defined by Caremark's payer sheets (found online at **www.caremark.com/pharminfo**) or as directed by Caremark.

Reversals and resubmits must occur within ninety (90) days of the claim's original submission date, or such other time period as communicated by Caremark or required by applicable Law. For reversals, Provider can reverse up to ninety (90) days from the date on which the claim was originally submitted, including Plan Sponsor-specific payment cycles. For Medicare Part D processing windows, refer to the **Medicare Part D** section of the Provider Manual.

Except as otherwise required by applicable Law, Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (e.g., cartridge, CD-ROM, tape, batch or paper) unless prior written approval is received from Caremark or Plan Sponsor. Caremark charges a handling fee of $2.00 per claim in those situations in which Caremark or Plan Sponsor agree in writing to non-electronic submission or reversal of claims.

Caremark reserves the right to require Provider to submit claims via a UCF, along with all supporting documentation that Caremark may require to support the claim, including medical records and Eligible Person attestations, in the event Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider's ability to fulfill

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

the requirements of the Provider Agreement; or (4) is a breach of the Provider Agreement.

Transaction Fees

Caremark charges network providers, and Provider agrees to pay, for transaction fees that represent pharmacy network management services Caremark provides to network providers. For every single transaction Provider transmits to Caremark, Caremark may deduct such amounts for the transaction fee from amounts payable to Provider. A single transaction means each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims adjudication system. Each transaction within a multi-claim transmission will be subject to individual transaction fees.

Commented [PT7]: 2019 PM Supplement

~~Caremark charges network providers, and Provider agrees to pay, for transaction fees that represent pharmacy network management services Caremark provides to network providers. For every single claim transaction Provider transmits to Caremark, Caremark charges a maximum fee of $0.17 per transaction. Caremark may deduct such amounts for the transaction fee from amounts payable to Provider. A single claim transaction means each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims adjudication system. Each transaction within a multi-claim transmission will be subject to individual claim transaction fees.~~

Transaction Submission Resolution Management Service Fees

Caremark charges network providers, and Provider agrees to pay, fees for Caremark's resolution of transactions submitted by Provider, including but not limited to, rejected claim resolution, pharmacy compliance, and claims information quality improvement. The fee charged to Provider will be commensurate to the amount of resolution management services Caremark is required to expend based on Provider's claims submissions, as measured comparatively to all other providers on a retrospective monthly basis. Caremark will determine how the fee will be measured and assessed, as communicated to network providers in writing accordingly. The Transaction Submission Resolution Management Service Fee charged will be charged per transaction, and Provider has the opportunity to reduce the amount of fees charged based on the degree of resolution of transactions required by Caremark for Provider as compared to all other providers. Caremark may deduct the fee amount from amounts payable to Provider. Providers will be charged for either a Transaction Fee (as described in the Transaction Fees section of the Provider Manual) or a Transaction Submission Resolution Management Service Fee, but not both for the same transaction.

Commented [PT8]: 2019 PM Supplement

~~Caremark charges network providers, and Provider agrees to pay, fees for Caremark's resolution of transactions submitted by Provider, including but not limited to, rejected claim resolution, pharmacy compliance, and claims information quality improvement. The fee charged to Provider will be commensurate to the amount of resolution management services Caremark is required to expend based on Provider's claims submissions, as measured comparatively to all other providers on a retrospective monthly basis. Caremark will determine how the fee will be measured and assessed, as communicated to network providers in writing accordingly. The maximum Transaction Submission Resolution Management Service Fee charged will be $0.17 per claim, and Provider has the opportunity to reduce the amount of fees charged based on the degree of resolution of transactions required by Caremark for Provider as compared to all other providers. Caremark may deduct the fee amount from amounts payable to Provider. Providers will be charged for either a Transaction Fee (as described in the above subsection) or a Transaction Submission Resolution Management Service Fee, but not both for the same transaction.~~

Software Certification

Provider must utilize software certified by Caremark and adhere to the NCPDP standards in compliance with HIPAA. Provider must support NCPDP updates as requested from time to time by Caremark. Provider is responsible for and assumes all risk arising from or related to Provider's selection and use of its software. Provider must indemnify Caremark and its affiliates from and against any claim, cause of action, liability, loss, damage, cost, fines, charges and/or expenses arising from or related to Provider's selection and use of its software.

Caremark may provide reasonable technical support to assist Provider in complying with Caremark requirements and industry standards for submitting claims through the claims system. Provider may be assessed a fee by Caremark if Provider submits claims that are not in accordance with current requirements, industry standards or in compliance with government program requirements.

Provider must not release their software certification ID to be used by any other software or other user/entity. Any violation of this rule may result in a reject of the transaction as well as the assessment of an administration fee. Refer to the Compliance Reviews section of the Provider Manual.

Commented [PT9]: 2019 PM Supplement

~~Provider must utilize software certified by Caremark and adhere to the NCPDP standards in compliance with HIPAA. Provider must support NCPDP updates as requested from time to time by Caremark. Provider is responsible for and assumes all risk arising from or related to Provider's selection and use of its software. Provider must indemnify~~

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014166

~~Caremark and its affiliates from and against any claim, cause of action, liability, loss, damage, cost, fines, charges and/or expenses arising from or related to Provider's selection and use of its software.~~

~~Caremark may provide reasonable technical support to assist Provider in complying with Caremark requirements and industry standards for submitting claims through the claims system. Provider may be assessed a fee by Caremark if Provider submits claims that are not in accordance with current requirements, industry standards or in compliance with government program requirements.~~

If Provider is not submitting claims in accordance with HIPAA-mandated data and/or standards, Caremark may reject the transaction and/or charge a minimum fee of $0.99 per transaction. In addition, Provider is required to provide Eligible Person(s) a bridge supply of medication(s) until such time occurs when Provider is compliant with HIPAA-mandated data and/or current NCPDP standard (e.g., Version D.Ø), and the claim(s) can be adjudicated.

Refer to the NCPDP standard at **http://www.ncpdp.org/Members/Standards-Lookup.aspx**. Membership to NCPDP is required to view this information online.

Data Fields and Submission Requirements

Provider should carefully review the payer sheet referenced in **Appendix A** and located at **www.caremark.com/pharminfo** since the submission of certain optional data elements in NCPDP Version D.Ø is required by Plan Sponsors and must be submitted for processing.

National Drug Code

Provider must include all eleven (11) digits of the correct National Drug Code (NDC) as dispensed even if the manufacturer of the product only indicates ten (10) digits. The NDC must be provided in a 5-4-2 format. Provider must zero-fill to the left when a number has been excluded from the format. Claim submissions utilizing an NDC other than the NDC of the Covered Item dispensed are subject to audit review and chargeback and are not eligible for reimbursement.

Prescriber Identification; Prescriptive Authority

Accurate Prescriber identification in claims submission is critical as Caremark relies upon the information such as in claims adjudication, clinical services, Plan Sponsor initiatives, and audits. A valid and active individual Prescriber National Provider Identifier (NPI) is required on all claims, and failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the original hard copy for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI or DEA number which does not represent a prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit ~~a valid~~an appropriate submission clarification code (SCC) to bypass the reject.

Commented [PT10]: 11/16 – per Heather Graham

Auto-Ship Refill Programs

Claims submitted for auto-refill programs must only be for medications used in a maintenance therapy and upon documented Eligible Person consent. Refer to the **Auto-Ship Refill Program** subsection within the **Medicare Part D** section of the Provider Manual for additional information.

~~Compounded Medications~~

~~Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.~~

~~Provider must not manipulate claims pricing or the compound indicator for inappropriate financial gain or cause a claim to inappropriately pay. Certain items are not covered and are not reimbursable. Coverage determination is performed on each and every item in the compound. Outsourcing any portion of Pharmacy Services for compounded medications not approved in advance and in writing by Caremark is prohibited.~~

~~Listed below are the requirements for compounded medications.~~

- ~~All compounds must be submitted online.~~
- ~~All compounds must be billed in the NCPDP D.Ø format.~~
- ~~Each item must have a valid and active NDC to be considered reimbursable.~~
- ~~Provider must submit the NDC, quantity, and cost of each individual item used in the compound.~~
- ~~Provider must change the Compound Indicator on the claim segment to identify the prescription as a~~

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

compound (NCPDP Field 406-D6).

- Provider must submit the dosage form of the final product dispensed (NCPDP Field 450-EF).
- Provider must submit the appropriate Level of Effort (LOE) fee; Provider must not program one code for all compounds (NCPDP Field 474-8E).
- Provider must submit the U&C price of the compounded product.
- Provider must keep compound recipes for the same time period as required for hard copy prescriptions. Refer to the **Pharmacy Services and Standards** section of the Provider Manual.
- Provider, upon request, must provide the compound formulation record, which must include at minimum, NDCs of items used, lot numbers, expiration dates, and signature of verifying pharmacist.
- Provider must maintain and provide to Caremark upon request methodology used to determine appropriate beyond-use date.
- Compounding must be performed by a qualified person as defined by applicable Law.
- If compounded claims reject for pricing edits (e.g., exceeds maximum cost for the Plan), Provider must not alter the quantity or identity of the individual components submitted to inappropriately enable reimbursement. Provider must not alter the quantity of, or omit an item dispensed to circumvent Caremark's reimbursement structure, such as providing only 83 days of a 90-day supply prescription or dispensing monthly, but billing weekly.

Utilizing the provided chart with guidance of this section will assist in proper submission of compounded medications (see **Figure 1 - Compounded Medication Submission Table**).

Figure 1 – Compounded Medication Submission Table

RX#					
Name of Compound (include strength)				Total **quantity** of final product dispensed	(gm/ml/etc)
	Dosage Form (tablet, troche, sterile product, etc.)				
Ingredient (active and inactive) – do not include labor, equipment, fees, etc.	NDC of each	Quantity	x	Cost/unit =	Extended Cost
	- -			/	
	- -			/	
	- -			/	
	- -			/	
	- -			/	
				total AWP cost of compound	$
				LOE	$
				ingredient cost submitted	$

Multi-Ingredient Processing

- Compounds must be submitted utilizing multi-ingredient functionality as required by Plan Sponsor or Caremark.
- Enter the NDC (Product/Service ID) value of "0" in the claim segment (also enter the corresponding qualifier [Product/Service ID Qualifier] as "00").
- Enter the dosage form of the final product dispensed in the compound segment (must be a valid NCPDP compound segment dosage form value).
- Enter the total quantity of the final product dispensed in the quantity dispensed field in the claim segment.
- Enter the calculated cost of the complete compound as the ingredient cost submitted—this calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the LOE. Caremark, in its sole discretion, will have final determination of professional allowance attributed to claim above the cost.
- Enter the quantity of each individual compound ingredient product dispensed as the compound ingredient

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014168

quantity in the compound segment.

- Enter the calculated cost of each individual compound ingredient as the compound ingredient drug cost in the compound segment.
- Enter the LOE in the DUR/PPS segment. The LOE must reflect the compound types which are referenced in **Figure 2 – Level of Effort Table**, unless otherwise communicated by Caremark.
- Enter the NDC of each active and inactive item used in the preparation of the compound in the compound segment, including any consumable item (e.g., capsule).

Figure 2 – Level of Effort Table

DUR/PPS (Field 474-8E) Level of Effort	Compound Type
11	Single ingredient capsule Any combination of commercially available products
12	Two ingredient capsule/suppository Transdermal gel
13	Three or less ingredient cream/ointment/gel* Three ingredient capsule/suppository* Two or less ingredient troche* Non-complex suspension Table triturate*
14	Topical containing controlled substance Three or more ingredient troche* Four or more ingredient cream/ointment/gel* Four or more ingredient capsule/suppository* Complex suspensions (e.g., pediatric/altering PH/base to salt conversion) Chemotherapy cream/ointment/gel* Hormone therapy (capsules/troches/suppositories)
15	Sterile products (limited to aqueous bronchial and nasal inhalations (this does not include nasal sprays or irrigations), injections, irrigations for wounds, and ophthalmic drops and ointments per USP <797>)

*Using bulk (powder) APIs

Additional information concerning all compounded medications:

- Compounds that have a commercially available product are not reimbursable.
  - In the event a commercially available product becomes unavailable (e.g., product is on backorder, drug shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
  - If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014169

amount.

- Provider may receive a rejected response for a compound claim when item(s) within the compound are not reimbursable; Caremark accepts SCC 08 (Process Compound for Approved Ingredients) which will result in an adjudicated response on all items. Non-Covered Item(s) within a compound are not reimbursable.
- Calculated cost may not include cost of drug product associated with waste.
- The Caremark adjudicated claim response indicates the total payment for the compound claim. Provider must not balance bill an Eligible Person if prohibited by applicable Law.
- For compounds that require a delivery device as a component of the final medication product, the device must be submitted as an item in the compound only when the device has an NDC and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.
- Provider must submit the actual NDC of each Covered/non-Covered Item. For any items in the compound, such items are only reimbursable if Provider provides, upon Caremark's request, evidence that each of the active and inactive items in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to chargeback.
- In an effort to protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.
- When a compounded product is dispensed to an Eligible Person, Provider must bill Caremark a single claim for the final compounded product using multi-ingredient functionality (including all active and inactive items used in the creation of the compounded product) and must not bill separate claims to Caremark for individual items or ingredients used in the creation of the compounded product.
- For Medicare Part D Enrollees, item cost must only include components which satisfy the definition of a Covered Part D Drug as defined in 42 C.F.R. § 423.100. Components that are not Covered Part D Drugs as defined by the Centers for Medicare and Medicaid Services (CMS) may be included in the creation of the product, but may not be included in the calculation of the item cost submitted (e.g., sterile water, compounding bulk powders, vitamins, components not utilized for a diagnosis recognized in the compendia). Provider must, however, include all items used in the creation of the compounded product on the multi-ingredient claim transmission. Caremark accepts SCC 08 (Process Compound for Approved Ingredients) which will result in an adjudicated response on all items. Non-Covered Item(s) within a compound are not reimbursable.

The following must not be billed as a compound:

- A combination of products which are not combined to make one final medication for use (e.g., a kit of individual products designed to be used independently)
- A combination of Covered Items which do not have a medical purpose in combination other than convenient dosage form
- Any product that contains an item or substance that is classified as a dietary supplement as defined by the Dietary Supplement Health and Education Act (DSHEA) of 1994
- A commercially available compound kit or commercially available product which is represented by a unique assigned NDC and contains all the items of the final product as such (e.g., kit containing a base and active items and directives for mixture)
- Compounds dispensed for human consumption or application which include items that are not approved for human use
- Medications requiring reconstitution prior to dispensing (e.g., powdered oral antibiotics, topical acne preparations)
- Flavoring of a commercially available product prior to dispensing (e.g., addition of flavor to powdered oral antibiotics), nor should the item cost submitted include flavoring cost
- Covered Items that are in a ready-to-use form that are transferred from one container to another for use (e.g., pre-filling insulin syringes, transferring multiple bottles into a single IV bag)
- Any compound that contains a drug product that has been withdrawn or removed from the market because the drug product or components of the drug product have been found to be unsafe or not effective as defined in

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014170

~~section 21 C.F.R. § 216.24 of the Code of Federal Regulations~~

Multi-Ingredient Compound Processing

Commented [PT11]: 2019 PM Supplement

- All compounds must be submitted online in NCPDP D.Ø format. Caremark payer sheets can be found online at **www.caremark.com/pharminfo**.
- Provider must submit the accurate dosage form of the final compounded product dispensed in the compound dosage form description code field, in the compound segment (must be a valid NCPDP compound segment dosage form value).
- Enter the total quantity of the final product dispensed in the quantity dispensed field in the claim segment.
- Enter the calculated cost of the complete compound as the ingredient cost submitted—this calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the LOE. Caremark, in its sole discretion, will have final determination of professional allowance attributed to claim above the cost.
- Calculated cost shall not include cost of drug product associated with waste. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
- Enter the Product/Service ID (e.g. NDC or UPC) of each active and inactive item used in the preparation of the compound in the compound segment, including any consumable item (e.g., capsule).
- Provider must submit the actual Product/Service ID (e.g. NDC or UPC) of each Covered/non-Covered Item. For any items in the compound, such items are only reimbursable if Provider provides, upon Caremark's request, evidence that each of the active and inactive items in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to chargeback.
- For compounds that require a delivery device as a component of the final medication product, the device must be submitted as an item in the compound only when the device has a Product/Service ID (e.g. NDC or UPC) and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.
- When required, Provider must submit the accurate SNOMED value (must be a Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) value) for the final compounded product in the route of administration field in the claim segment.
- Enter the LOE in the DUR/PPS Segment. The LOE must reflect the compound types which are referenced in **Figure 1 – Level of Effort Table**, unless otherwise communicated by Caremark. Provider must not program one code for all compounds.

Figure 1 – Level of Effort Table

Formatted: Indent: Left: 0.25", No bullets or numbering

DUR/PPS (Field 474-8E) Level of Effort	Compound Type
11	Single ingredient capsule Any combination of commercially available products
12	Two ingredient capsule/suppository Transdermal gel
13	Three or less ingredient cream/ointment/gel* Three ingredient capsule/suppository* Two or less ingredient troche* Non-complex suspension Table triturate*

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014171

14	Topical containing controlled substance Three or more ingredient troche* Four or more ingredient cream/ointment/gel* Four or more ingredient capsule/suppository* Complex suspensions (e.g., pediatric/altering PH/base to salt conversion) Chemotherapy cream/ointment/gel* Hormone therapy (capsules/troches/suppositories)
15	Sterile products (limited to aqueous bronchial and nasal inhalations (this does not include nasal sprays or irrigations), injections, irrigations for wounds, and ophthalmic drops and ointments per USP <797>)

*Using bulk (powder) APIs

- Coverage determination is performed on each and every item in the compound.
- Certain items are not covered and are not reimbursable.
- Provider may receive a rejected response for a compound claim when item(s) within the compound are not reimbursable; Caremark accepts SCC 08 (Process Compound for Approved Ingredients) which will result in an adjudicated response on all items. Non-Covered Item(s) within a compound are not reimbursable.
- Compounds may be a Covered Part D Drug for Medicare Part D Enrollees provided the compound contains at least one Covered Part D Drug. The item cost must only include components which satisfy the definition of a Covered Part D Drug as defined in 42 C.F.R. § 423.100. Components that are not Covered Part D Drugs as defined by the Centers for Medicare and Medicaid Services (CMS) may be included in the creation of the product, but may not be included in the calculation of the item cost submitted (e.g., sterile water, compounding bulk powders, vitamins, components not utilized for a diagnosis recognized in the compendia). Provider must, however, include all items used in the creation of the compounded product on the multi-ingredient claim transmission. Caremark accepts SCC 08 (Process Compound for Approved Ingredients) which will result in an adjudicated response on all items. Non-Covered Item(s) within a compound are not reimbursable.
- If compounded claims reject for pricing edits (e.g., exceeds maximum cost for the Plan), Provider must not alter the quantity or identity of the individual components submitted to inappropriately enable reimbursement. Provider must not alter the quantity of, or omit an item dispensed to circumvent Caremark's reimbursement structure, such as providing only 83 days of a 90-day supply prescription or dispensing monthly, but billing weekly.
- Provider must not manipulate claims pricing or the compound indicator for inappropriate financial gain or cause a claim to inappropriately pay.
- The Caremark adjudicated claim response indicates the total payment for the compound claim. Provider must not balance bill an Eligible Person if prohibited by applicable Law.
- When a compounded product is dispensed to an Eligible Person, Provider must bill Caremark a single claim for the final compounded product using multi-ingredient functionality (including all active and inactive items used in the creation of the compounded product) and must not bill separate claims to Caremark for individual items or ingredients used in the creation of the compounded product.
- Compounds that have a commercially available product are not reimbursable.
    - In the event a commercially available product becomes unavailable (e.g., product is on backorder, drug shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
    - If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount.

Formatted: Indent: Left: 0.25", No bullets or numbering

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED

- Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.
- Compounding must be performed by a qualified person as defined by applicable Law.
- Outsourcing any portion of Pharmacy Services for compounded medications not approved in advance and in writing by Caremark is prohibited.

The following must not be billed as a multi-ingredient compound:

- A combination of products which are not combined to make one final medication for use (e.g., a kit of individual products designed to be used independently)
- A combination of Covered Items which do not have a medical purpose in combination other than convenient dosage form
- Any product that contains an item or substance that is classified as a dietary supplement as defined by the Dietary Supplement Health and Education Act (DSHEA) of 1994
- A commercially available compound kit or commercially available product which is represented by a unique assigned NDC and contains all the items of the final product as such (e.g., kit containing a base and active items and directives for mixture)
- Compounds dispensed for human consumption or application which include items that are not approved for human use
- Medications requiring reconstitution prior to dispensing (e.g., powdered oral antibiotics, topical acne preparations, injectable medications)
- Flavoring of a commercially available product prior to dispensing (e.g., addition of flavor to powdered oral antibiotics), nor should the item cost submitted include flavoring cost
- Covered Items that are in a ready-to-use form that are transferred from one container to another for use (e.g., pre-filling insulin syringes, transferring multiple bottles into a single IV bag)
- Any compound that contains a drug product that has been withdrawn or removed from the market because the drug product or components of the drug product have been found to be unsafe or not effective as defined in section 21 C.F.R. § 216.24 of the Code of Federal Regulations

Over-the-Counter Products

Caremark requires a prescription for Over-the-Counter (OTC) products except in OTC programs as stated below, and Provider must label and dispense the OTC product in accordance with the prescription and applicable Law. The requirements in the **Compliance Reviews, Professional Audits** and **Prescriber Identification; Prescriptive Authority** sections of the Provider Manual are applicable to all OTC claims.

Some Plan Sponsors elect to offer a program where Covered Items include certain OTC products to be dispensed without a prescription. These programs may incorporate a monthly or quarterly maximum; in which case, in the event Eligible Persons reach the allowed maximum amount covered by the Plan, per time period, Eligible Persons are responsible for any amount over the allowed maximum including cusp claims and claims submitted after the allowed maximum is exhausted for that time period.

Upon notification of approval from Caremark, Provider may submit claims for Plan Sponsor OTC programs that do not require a prescription and do not require labeling of the Covered Item by Provider. Provider, however, must maintain a computer-generated label for the OTC product for Caremark's audit purposes. Unless otherwise specified by Caremark, Provider may submit Provider's NPI as the prescriber identification for these programs for OTC products not requiring a prescription.

Coordination of Benefits

Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any Coordination of Benefits (COB) requirements, and must engage in appropriate COB activities to the extent required by Caremark, or applicable Law.

Claim submissions with incorrect COB are subject to chargeback

Multiple Transaction Coordination of Benefits

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014173

For the majority of plans, Caremark utilizes a typical multiple transaction COB process. Multiple transaction COB consists of one claim submitted to the primary payer followed by one or more claims submitted to the supplemental payer(s). Specific COB RXBINs exist to differentiate between claims that are supplemental to Medicare Part D and claims that are supplemental to non-Medicare Part D coverage.

For COB claims that are supplemental to Medicare Part D, Provider must submit RXBIN 012114 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of plan-specific claims processing information.

For COB claims that are NOT supplemental to Medicare Part D, Provider must submit RXBIN 013089 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of Plan-specific claims processing information.

Refer to the **Medicare Part D** section of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets referenced in **Appendix A** for more information regarding COB.

Single Transaction Coordination of Benefits

Caremark may utilize a Single Transaction Coordination of Benefits (STCOB) process whereby Provider sends one transaction to Caremark and the Claim adjudicates against both primary and secondary plans before returning one final response to Provider. Single Transaction COB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for Eligible Persons. When STCOB is utilized, it is not necessary for Provider to submit a separate COB claim in order to coordinate these benefits.

Refer to the **Medicare Part D** section of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets referenced in **Appendix A** for more information.

Quantity Dispensed

Provider must submit only the quantity indicated on the prescription. Provider must enter the exact metric decimal quantity dispensed (no rounding) on all claim transactions. Provider must submit the quantity based on product description (e.g., kit, volume of medication in milliliters, weight in grams or eaches, number of capsules/tablets). Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions. Provider must not adjust the quantity dispensed to circumvent adjudication edits, reimbursement structure, prior authorization edits, clinical program or benefit design edits based on day supply.

Strength Dispensed

Provider must utilize the strength originally prescribed by the Prescriber or use an available higher strength single dose of the same medication as described in the **Dose Optimization** program description located in the **Clinical Programs, Services and Related Messages** section of the Provider Manual. Provider must not utilize a lesser strength in an increased quantity without documentation of unavailability of the prescribed strength.

Prescription Date

Prescriptions must be billed with the date the prescription was filled; billing of claims must not be pre-dated or post-dated. Provider must not bill claims for prescriptions that are not prepared and available for dispensing. If the actual dispense date exceeds seven (7) days from the date of fill submitted to Caremark, the claim must be reversed and reprocessed with the actual dispense date.

Prescription Not Received; Reversal of Claim

All prescriptions not received by an Eligible Person must be reversed within fourteen (14) days from original submission through the electronic claims system.

Dispense as Written Codes

To ensure proper payment to Provider and the correct Patient Pay Amount of Eligible Persons, all claims must be submitted with the accurate Dispense as Written (DAW) code. Provider must select from the following codes:

DAW 0 —No Product Selection Indicated

- Use DAW 0 when dispensing a generic; that is, when no party (e.g., neither Prescriber, pharmacist, nor Eligible Person) requests the branded version of a multi-source product
- Use DAW 0 when dispensing a single-source brand product

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014174

- Generic pricing may be applied to claims for multi-source products submitted with DAW 0

DAW 1—Physician Requested Product Dispensed As Written

- Must be evidenced on the prescription hard copy (original and updates) and used only when the Prescriber specifies the branded version of a multi-source product on the hard copy prescription or in the verbally communicated instructions; this documentation must occur prior to Pharmacy Services being rendered
- Computer systems that default to DAW 1 may result in discrepancies and chargebacks
- Prescription must follow state substitution Laws

DAW 2—Substitution Allowed—Patient Requested Product Dispensed

- Must be submitted when the Eligible Person requests the branded version of a multi-source product even though a generic is available and the Prescriber has authorized (or not prohibited) a generic, or when the Eligible Person requests that Provider contact the Prescriber to obtain approval for a branded version when neither the original prescription nor the verbally communicated instructions specified the branded version
- Many plans require the Eligible Person to pay the difference between the brand and the available generic

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed

- Generic pricing will be applied to claims for multi-source products submitted with DAW 3

DAW 4—Substitution Allowed—Generic Not In Stock

- Generic pricing will be applied to claims for multi-source products submitted with DAW 4

DAW 5—Substitution Allowed—Brand Dispensed As Generic, Priced As Generic

- Use DAW 5 when dispensing a branded version of a multi-source product as a generic
- Generic pricing will be applied to claims for multi-source products submitted with DAW 5

DAW 6—This Value Is Used As Communicated By Caremark

DAW 7—Substitution Not Allowed—Brand Mandated By Law

- Use DAW 7 when Law or regulations prohibit the substitution of a brand product even though generic versions of the product may be available in the marketplace

DAW 8—Substitution Allowed—Generic Not Available

DAW 9—Substitution Allowed By Prescriber But Plan Requests the Brand – Patient's Plan Requested Brand Product To Be Dispensed

Commented [PT12]: 01/15 – Amendment #01: Hardcopy of the 2018 PM had error in indentation; DAW 4 was incorrectly indented under DAW 3. This error impacted printed copy only.

Taxes

To the extent permitted under the terms of its agreement with the Plan Sponsor or as required by Law, Caremark agrees to seek reimbursement/payment from the Plan Sponsor for any Provider Taxes incurred by or imposed on Provider by any governmental authority on account of, or based upon, the provision of Pharmacy Services or Covered Items. For purposes of this Section, the term "Provider Taxes" shall include any provider fees, assessments, sales taxes, transaction privilege taxes, occupation taxes or similar fees/taxes imposed by any federal, state or local governmental authority.

Provider is responsible for submitting requests for reimbursement/payment of Provider Taxes for claims requiring such inclusion at the time of the claims submission. In no event shall Caremark be responsible for any Provider Taxes or other liability that may be imposed on Provider if Provider Taxes are not directly and timely submitted to Caremark at the time the claim is submitted for adjudication. Provider shall report and remit all Provider Taxes received hereunder to the appropriate governmental authorities.

An Eligible Person may be liable, in addition to any applicable copayment, coinsurance or deductible, for Provider Taxes, unless specifically prohibited under applicable Law; provided, however, that if the applicable governmental authority otherwise compensates Provider or makes Provider whole for any such Provider Taxes, Eligible Person shall have no obligation to reimburse Provider for the amount of Provider Taxes so compensated.

Caremark is not responsible for correcting claims for Provider Taxes for which Provider failed to submit Provider Taxes.

In no event does this section give Provider any additional rights than those allowed by Law.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014175

Long-Term Care Billing

For providers providing home health care or Long-term Care (LTC) Covered Items to Eligible Persons, each NDC of the individual drug dispensed must be billed only once to Caremark during any 30-day period unless allowed by Plan Sponsors. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws. Provider must submit claims to Caremark's claims adjudication system for LTC Pharmacy Services.

Provider must bill Caremark once during any 30-day period for medications dispensed continuously over the course of a month for an Eligible Person. One dispensing fee will be paid based on the monthly quantity dispensed of a single drug of a single strength for an Eligible Person. When the medical needs of the Eligible Person require a change in the medication order or the medication provided has a documented medical necessity for limited dispensing (including but not limited to, expiration of product) requiring an additional dispensing of the same drug, Provider may receive one dispensing fee for each new medication order or dispensed quantity limited by medical necessity. Provider must include within documentation of medical necessity for limited dispensing the diagnosis/clinical reason for the patient need from the Prescriber on the Prescriber's letterhead or prescription pad/form.

For information related to Medicare Part D LTC billing, refer to the **Medicare Part D** section of the Provider Manual.

Overrides

Caremark has developed general prior authorization numbers for some Plan Sponsors for claims that reject. A Pharmacy Help Desk representative can provide information if the Plan Sponsor allows for an override to allow the claim to adjudicate. In addition, some Medicaid Plan Sponsors provide temporary coverage of non-formulary medications. If this is the case, the claim may reject with a message that includes the temporary days supply that will be covered and the prior authorization number to enter into the NCPDP prior authorization number field in order for the claim to adjudicate. Provider must calculate the appropriate quantity for a Covered Item accordingly to correspond with prescription instructions and temporary days supply.

Natural Disasters

Caremark is dedicated to assisting Providers and Eligible Persons in response to emergencies resulting from natural disasters, severe weather, etc. where medical records are either destroyed or not accessible. In the event of a presidential (or other governmental) emergency declaration, Caremark will allow a specific submission clarification code to override the refill-too-soon edit for Eligible Persons impacted within the disaster area. A value of '13' in the submission clarification code field, 420-DK, and the displaced Eligible Person's zip code impacted by the disaster (zip code may not be where Eligible Person resides) in field 325-CP, will allow an override without requiring a call to the Help Desk. Permission may vary by Plan Sponsor. If you need assistance, call the Pharmacy Help Desk.

Refer to the **Pharmacy Help Desk** section of the Provider Manual for contact information.

Refer to the **Medicare Part D** section of the Provider Manual for additional information.

Submission Error Codes

Caremark utilizes the NCPDP submission error codes. Refer to **Appendix B** for additional information.

Schedule of Claims Systems Maintenance

Maintenance of the claims systems may be scheduled between 11 p.m. and 6:00 a.m. Eastern Standard Time (EST) every Friday or Saturday as necessary. During the scheduled maintenance, Providers will receive the message, "HOST UNAVAILABLE." If this message displays, Providers must resubmit claims after maintenance is completed.

If maintenance is not needed, Providers will be able to submit claims as usual during those hours. If any other scheduled maintenance is required outside of the published hours listed above, Caremark may notify Provider in advance.

From time to time, unscheduled system maintenance or other circumstances may occur when the adjudication platform(s) may not be available to adjudicate claims for a limited time. At any time, a Provider may contact the Pharmacy Help Desk for assistance or information regarding any claim processing related question. Pharmacy Help Desk Representatives are available 24 hours a day, 7 days a week. Refer to the **Pharmacy Help Desk** section of the Provider Manual.

Note: Providers are reminded that, pursuant to the Provider Agreement, Providers must render services unless professional judgment dictates otherwise.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014176

1. If the claims adjudication system indicates a host processing error or unexpected reject has occurred, Provider should attempt to resubmit within a few minutes. If the status continues to indicate a host processing error (downtime circumstance), Provider should hold the transaction and attempt to process it again within the next two hours.

   If two hours have elapsed and the same host processing error or unexpected reject continues to occur, call the Pharmacy Help Desk for additional information regarding system availability and other assistance that may be available at that time. The Pharmacy Help Desk is equipped to assist in guiding the pharmacy through the claim resubmission process when the system becomes available.

2. To ensure that each Eligible Person receives his/her covered prescription drugs, Provider must make reasonable attempts to obtain information necessary to fill a script.

   Provider is requested to serve the Eligible Person by establishing/confirming eligibility/coverage:

   a. If the Eligible Person is available, ask for the ID card. Call the Customer Care number on the ID card to verify eligibility, drug coverage, formulary status and associated Patient Pay Amount.

   b. If the Eligible Person is not available, call the Pharmacy Help Desk.

3. Provider should provide a bridge supply, typically covering three (3) days, for those Eligible Persons in urgent need of medication so that the Eligible Person is not delayed at the pharmacy counter during a system downtime event, or provide service to the Eligible Person and submit a Universal Claim Form (UCF) within the required timeframe.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014177

Clinical Programs, Services and Related Messages

Provider must support all clinical programs and services, and utilize software that will display all messages related to clinical programs and services and that provide for the recording of patient drug and medical information, where utilized by Caremark and as allowed by applicable Law.

Subject to applicable Law, Provider must provide Caremark any and all reasonably available information that Caremark needs to perform such clinical programs and services, and conduct drug utilization review accordingly. Provider must act upon all messages related to clinical programs subject to professional judgment.

Drug Standards

Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

Provider must dispense a generic drug whenever permitted and in accordance with applicable Law. Provider must use its best efforts to carry out Caremark and Plan Sponsor mandatory generic programs. In doing so, Provider must contact the Prescriber to encourage a change to a generic substitute when the prescription contains a "dispense as written" signature for a multi-source brand medication.

Provider must not use pre-printed prescription blanks that result in the dispensing of Covered Items that are not the most cost-effective even if they are different salts, bases, release characteristics, or additional drugs in combination.

Commented [PT13]: 2019 PM Supplement

When a multi-source brand medication is dispensed, Provider must submit the correct "dispense as written" code as set forth in **Dispense as Written Codes** section of the Provider Manual, unless otherwise specifically directed by Caremark.

Provider must not participate in programs that increase the amount billed to Plan Sponsors for Covered Items. Providers dispensing aberrant quantities of a Covered Item and/or high volume of claims within a therapeutic category (e.g. topicals, dermatologicals), inconsistent with the habits of local Prescribers or local Plan Sponsor formularies, at Caremark's reasonable determination, may result in chargeback of claims and other remedies available to Caremark, including but not limited to, termination of the Agreement.

Commented [PT14]: 2019 PM Supplement

Drug Utilization Review

Inappropriate drug therapy can cause patient injury and can lead to additional health care costs. In an effort to reduce the number of situations where an Eligible Person may receive inappropriate drug therapy, Caremark implemented a concurrent Drug Utilization Review (DUR) program that detects a potential therapeutic problem at the point of service.

Provider must adhere to the claims submission requirements outlined in the **Claims Submission** section of the Provider Manual. Provider must submit all claims for Pharmacy Services related to Covered Items for Eligible Persons electronically through the claims adjudication system, to the extent consistent with applicable Law. All DUR messages appear in the claim response. Claim submission requirements therefore allow Provider to receive and act upon the appropriate DUR conflict codes and text messaging. The requirements include, but are not limited to, Medicare Part D claims for drugs with drug-age precautions such as for High-Risk Medications (HRM) for the elderly.

The functions of the DUR program are to:

- Analyze prescriptions submitted through Caremark
- Screen prescriptions for several types of therapeutic drug problems
- Serve as a clinical information service

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional judgment of the Provider or Prescriber. The Provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims system and for performing Pharmacy Services in each jurisdiction consistent with the scope of their respective licenses.

Additional information regarding DUR review controls for Medicare Part D claims may apply as specified by Caremark.

DUR Conflict Codes and Text Messaging

All DUR messages appear in the claim response. The Provider must view all screens necessary to receive the message detail and act upon all such messages subject to the professional judgment of Provider.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014178

Provider will receive the DUR message in a format consistent with its software vendor. Provider may need to consult with the software vendor for help with identifying or accessing DUR messages. Caremark, in accordance with current NCPDP standards, returns up to nine (9) DUR messages that can be received on the same claim and requires Provider to have the capability to accept up to nine (9) DUR messages on the same claim.

Refer to the NCPDP standard at **http://www.ncpdp.org/Members/Standards-Lookup.aspx**. Membership to NCPDP is required to view this information online.

Refill-Too-Soon or Excessive Utilization Reject

Provider must call the Pharmacy Help Desk if extenuating circumstances justify payment for a claim that was denied for excessive utilization (Refill-Too-Soon). This may occur in situations such as:

- Lost or stolen prescriptions
- Dropped or broken prescription bottle containing liquid
- Vacation supplies
- Increase in dosing
- Circumstances such as natural disasters. Refer to the **Natural Disasters** section of the Provider Manual.
- Extra supply for school or similar circumstances (e.g., rescue inhalers or epinephrine auto-injectors)

Drug-Drug Interaction Reject Program

The Drug-Drug Interaction Rejects Program is a point-of-sale claim reject for selected high-risk drug combinations. The reject will occur if the current drug being submitted and another drug that was dispensed to the Eligible Person are one of the high-risk drug combinations included in the program.

When a claim is rejected for a high-risk drug-drug interaction, a standard drug-drug interaction warning message will be transmitted with the claim reject response. In addition, a secondary message will be transmitted that provides instructions regarding override options. Depending on the types of override that the Caremark Plan Sponsor has authorized, one of the following override option messages will be transmitted:

PPS Code REQD: <<Rejection Message>>

In this case, Provider may resubmit the claim with the indicated PPS code to override the reject, based on the professional judgment of Provider and in consultation with the Prescriber.

PA REQD: <<Rejected Message>>

A secondary message will include the PA contact number

In this case, a PA is required to override the reject. The message will provide further instructions on how to obtain an override.

Provider must contact the Prescriber to discuss the drug-drug interaction that has been identified for the current prescription based on the Eligible Person's other active drug therapy. If the Prescriber determines that the prescribed therapy is warranted despite the drug-drug interaction risk, or if the interacting drug has been discontinued, the Provider must pursue an override according to the instructions provided in the claim response message. Otherwise, Provider should obtain a new prescription for an alternative therapy.

Formularies

Plan Sponsor formularies provide a reference for drug therapy selections. The final choice of specific drug selection for an Eligible Person rests solely with the Prescriber.

Provider must support all formulary initiatives and inform Eligible Persons when a non-formulary drug has been prescribed. Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider agrees that for all Plan Sponsors and Eligible Persons, therapeutic programs and formularies take precedence over any agreements or programs to which Provider is a party. Provider also agrees not to implement any substitution programs for Eligible Persons that are inconsistent with such therapeutic programs and formularies.

When a claim is submitted for a non-formulary drug and the Plan has a closed formulary, it may reject with:

NDC Not Covered

or a similar message, which may include a customized drug alternative.

When a claim is submitted for a non-formulary drug and the Plan has an open formulary, the response may include

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014179

the message:

NF! Form <<XXX>>

In many cases, the Patient Pay Amount may be higher for a non-formulary medication.

Prior Authorization

For some Plans, certain medications will require prior authorization. For prior authorization, the Prescriber needs to supply additional documentation to Caremark or the Plan Sponsor to determine whether certain criteria are met for the drug to be covered under the Plan.

Provider must follow Caremark and Plan Sponsor requirements for the prior authorization process, including but not limited to, obtaining a Prescriber's signature on a prior authorization form if a Prescriber signature is required.

If a medication is designated for prior authorization, the claim may reject with the following message:

PRIOR AUTHORIZATION REQUIRED
MD Call <<XXX-XXX-XXXX>>

In most cases, the claims system response will also provide the correct contact information in the subsequent message.

If in the Prescriber's professional judgment the drug is medically necessary, Prescriber will need to call the number provided in the claim message to initiate coverage.

For RXBIN 610502 only: If no contact number is provided in the messaging, Provider should contact the Prescriber and ask him or her to contact the Precertification Unit for precertification and medical exception requests. The Precertification Unit contact information for RXBIN 610502 is:

Fax: 1-800-408-2386
Phone: 1-800-414-2386
(Hours: Monday through Friday, 8 a.m. to 7 p.m. CT)

Provider must support all clinical programs and services and inform Eligible Persons when a drug designated for prior authorization has been prescribed. Provider must use its best efforts to contact the Prescriber to inform on prior authorization messaging.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

Managed Drug Limitations/Quantity vs. Time

Some Plan Sponsors implement managed drug limitations (MDL) or quantity vs. time (QVT) programs. MDL or QVT allows an Eligible Person to receive up to a set amount of medication per designated timeframe*.

If an Eligible Person presents a prescription for an amount greater than the set amount or has accumulated an amount greater than the set amount within the designated timeframe, the claim will reject with one of the following messages:

PLAN LIMITS EXCEEDED <<# of quantity left>>*
or
MAX QUANTITY XX PER XX DAYS

If there is a remaining quantity within the designated look-back period and within the Plan parameters, Provider can resubmit the claim after the appropriate amount of time has passed using an amount equal to or less than the amount stated in the message.

*If prescribed quantity exceeds the plan parameters, call the Pharmacy Help Desk to verify if Prior Authorization is available.

Dose Optimization

Dose Optimization is a point-of-service claim reject for selected drugs where multiple daily doses of the drug are prescribed and where a higher strength single daily dose is available and clinically appropriate (e.g., Lipitor® 10 mg 2 tabs/day could be optimized to Lipitor 20 mg 1 tab/day).

For a drug subject to Dose Optimization, the claim will reject with the following message:

MISSING/INVALID DAYS SUPPLY <<use higher strength one per day>>

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

In the event there is an override option, the subsequent message will state what to do:

CALL HELP DESK <<or a specific Plan Sponsor telephone number>>

Provider must contact Prescriber for a new prescription of a higher strength at the once-daily dosing regimen, then resubmit the claim with the higher strength. If this cannot or should not be done based on the professional judgment of Provider or the Prescriber is unwilling to change the prescription, review Provider messaging for further instructions.

Step Therapy

Step Therapy requires that a set quantity of certain medication(s) be in an Eligible Person's drug history within a given timeframe before a claim will adjudicate for another drug in a specified therapeutic category. If Provider submits a claim for a Step Therapy and the conditions are not met, the claim will reject with a message similar to the below:

NDC NOT COVERED SUBOPTIMAL REGIMEN
USE <<XXXX>> 1ST
MD CALL <<XXX-XXX-XXXX>> FOR PRIOR AUTHORIZATION

If Provider receives this message, discuss the alternatives with the Prescriber. If in the Prescriber's professional judgement the originally prescribed drug is medically necessary, Prescriber will need to initiate a request for prior authorization.

A qualification period may also be in place for the targeted drug. Once an Eligible Person satisfies the Step Therapy requirements, he or she may obtain the targeted drug for a specific time period (e.g., 60 days). When the qualification period has been exceeded, the Eligible Person must requalify for the claim drug by repeating the Step Therapy requirements.

Some Plan Sponsors may choose to give Eligible Persons additional flexibility in choosing not to follow the recommended Step Therapy. A copayment option may be available for some Eligible Persons which allows them to obtain the originally prescribed drug without requiring the Prescriber to call for an override. The Eligible Person may make the decision and obtain the original drug simply by paying a higher copayment.

If this option is in place, claims not meeting the required conditions will reject with:

NDC NOT COVERED SUBOPTIMAL REGIMEN
COPAY = <<XX.XX>>
TO ACCEPT, SUBMIT PA - 99999999999

If you receive this message, discuss the alternatives with the Eligible Person and advise that the originally prescribed drug can be obtained by paying the copayment indicated in the message. If the Eligible Person accepts the copayment, resubmit the claim to Caremark using PA code 99999999999.

Plan Sponsor Programs

Provider must participate in Plan Sponsor programs as requested by Caremark and/or Plan Sponsors. Provider must maintain internal procedures for compliance with such programs and furnish an outline of such procedures to Caremark upon request. Providers are encouraged to engage in and support Plan Sponsor electronic prescribing initiatives in accordance with applicable Law.

Federal Regulatory Quality Assurance Programs

Caremark recommends Provider adhere to Federal Regulatory Quality Assurance Programs such as, but not limited to:

- Medication Errors Reporting Program (MERP) through the Institute for Safe Medication Practices (ISMP); more information can be found on the website **www.ISMP.org**
- MedWatch program through the Food & Drug Administration (FDA); more information can be found by calling 1-800-FDA-1088 or on the web-site **www.FDA.gov**

Clinical Studies/Trials

To the extent Provider participates, or is involved, in a study, directly and indirectly, for which Provider submits claims to Caremark for adjudication and payment for prescriptions obtained by study participants (e.g. Eligible Persons), Provider must obtain prior written approval from Caremark. If prior Caremark written approval is not obtained, claims submitted to Caremark for study participants are subject to chargeback. Caremark's review of the

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014181

study will be administrative in nature to determine Provider's compliance with the terms of the Provider Agreement, such as but not limited to, determining whether any compensation paid to study participants has the effect of waiving the participant's Patient Pay Amounts under the Plan (which Provider has an obligation to collect in accordance with the Provider Manual – see **Collection of Patient Pay Amounts**) or whether study premises result in changes in drug regimens that have the effect of increasing Plan Sponsor costs.

Provider requests for approval must include all of the following details:

- Study overview
  - Study duration
  - Number of subjects
  - Study locations
  - Medications involved
  - Costs for participants and Plan Sponsors
- Details of insurance for study
- Credentials of study investigators
- Source of funding for the study
- Consideration paid to all study participants, providers, and prescribers
- Copies of all documentation submitted to ethics committees, review boards, or governmental agencies
- Disclosure of any potential conflicts of interest

Requests for approval can be sent to the following address:

CVS Caremark
ATTN: Pharmacy IRB Study Review
9501 E. Shea Boulevard, MC-020
Scottsdale, AZ 85260
The requirements of this section do not apply to FDA-approved clinical trials.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014182

Network Participation and Payment

Network Participation

Caremark may make available to Provider the opportunity to participate in Caremark or Plan Sponsor networks. Provider is deemed to have accepted participation and the reimbursement rates in any Caremark or Plan Sponsor network in which Provider submits a claim for an Eligible Person in that network. Notwithstanding any prior agreements, the Provider Agreement applies to all transactions under any network or Plan for which Provider submitted a claim. Notwithstanding anything to the contrary in the Agreement, by participating in a Caremark network, Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Agreement unless professional judgment dictates otherwise; provided that Caremark reserves the right to limit Provider's participation in a network to certain Plan Sponsors based upon Plan Sponsor network design.

As previously communicated, Caremark may from time to time enter into an arrangement with a plan sponsor ("Other Entity") pursuant to which Provider's Provider Agreement (including reimbursements terms and schedules) with Caremark will be utilized by such Other Entity and such Other Entity's pharmacy benefit manager ("Other PBM") on the Other PBM's adjudication platform, as communicated by Caremark. Provider agrees to cooperate with Caremark, Other Entity, and Other PBM as needed to support such arrangement.

Pharmacy Portal

Caremark provides providers online access to information via its Pharmacy Portal at **https://rxservices.cvscaremark.com**. Provider may access the Pharmacy Portal to obtain information and services Caremark may make available from time to time.

Independent or affiliated-independent providers will be prompted to set a unique username and password as part of the initial login process. Detailed provider-specific account information must be entered as part of the initial login process, including but not limited to, pharmacy NCPDP number (seven digits), pharmacy NPI, state license number, DEA number, etc.

Pharmacy chain and PSAO headquarters who have not received login information from Caremark can contact their Caremark Network Account Manager.

Provider Payment

Notwithstanding any other provision in the Provider Agreement, in the event of a conflict between the reimbursement rate indicated through the claims adjudication system and a network enrollment form or addendum or any other agreement, the claims adjudication system reimbursement rate will apply provided there is no error in the claims adjudication system resulting in overpayment to Provider or to Eligible Person.

In the event Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) discontinues the reporting of Average Wholesale Price (AWP) or changes the manner in which AWP is calculated, then Caremark reserves the right to modify the pricing terms of the Provider Agreement, notwithstanding any other provision in the Provider Agreement. Such modification may include:

1. Modification of the AWP unit price reported by Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) by applying the Wholesale Average Cost (WAC) Mark-Up factor (in use before the effective date of a change in the calculation of AWP) to the WAC unit price reported by Medi-Span ("Pre-Settlement AWP Discount");
2. Utilization of a modified AWP Discount ("Post-Settlement AWP Discount"); and/or
3. Utilization of alternate Price Type other than AWP.

Nothing herein shall limit Caremark's rights and abilities to establish additional networks at reimbursement terms as determined by Caremark.

Notwithstanding any other provision in the Provider Agreement, claims (excluding compounded medications) submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network may be reimbursed at the lower of: (1) Price Type plus an applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee less the applicable Patient Pay Amount (or if applicable Price Type is unavailable for a given drug, Caremark will pay Provider based upon AWP minus the applicable AWP Discount plus the applicable Dispensing Fee minus the applicable Patient Pay Amount); (2) MAC plus the applicable Dispensing

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014183

Fee less the applicable Patient Pay Amount; (3) ingredient cost submitted by Provider plus the applicable Dispensing Fee less the applicable Patient Pay Amount; (4) Provider's U&C price less the applicable Patient Pay Amount; or (5) Provider's submitted Gross Amount Due less the applicable Patient Pay Amount.

The applicable Price Type plus an applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, and the applicable Dispensing Fee may be set forth in a network enrollment form, network addendum, or transmitted online via the adjudication claims system.

Compounded medications submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of: (1) ingredient cost submitted minus applicable Patient Pay Amount plus Dispensing Fee plus applicable Level of Effort (if submitted) amount (provided Provider accurately submits the ingredient cost submitted in accordance with the Provider Manual); (2) Provider's U&C price less the applicable Patient Pay Amount; (3) Plan Sponsor-specific reimbursement less the applicable Patient Pay Amount; or (4) Provider's submitted Gross Amount Due less the applicable Patient Pay Amount.

Unless otherwise required by a Plan, Provider may retain the differential between Eligible Person's Patient Pay Amount and Provider's contracted reimbursement amount with Caremark.

Maximum Allowable Cost

Caremark's analytical process to establish a maximum allowable cost (MAC) is at a product level for generics and multi-source brand products. The analytical process involves a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC lists published by CMS, and retail pharmacies. MAC prices are subject to change, which can occur at least on a weekly basis, if not more often, and are based on marketplace trends and dynamics, and price fluctuations.

For MAC paid claim appeals and as in accordance with Law, as applicable, Provider may appeal the MAC price paid by Caremark at a product level. Submission of a paid claim by Provider is required for this process. Provider must notify Caremark within the period required by applicable Law, and provide all of the following information: date of fill, prescription number, your name, Pharmacy NCPDP/NABP number, chain/affiliation code, phone number, email address, and RXBIN. Chain and Pharmacy Services Administration Organization (PSAO) pharmacies will submit MAC paid claim appeals through their respective chain or PSAO headquarters, which will then submit appropriate data to Caremark. Independent pharmacies (those which are not affiliated with a PSAO for contracting purposes) will submit MAC paid claim appeals using the Caremark Pharmacy Portal at https://rxservices.cvscaremark.com.

Provider may access the Caremark Pharmacy Portal to obtain current MAC prices and upcoming MAC prices based on Caremark's MAC price update schedule, including for Medicare Part D plans. To locate current or upcoming MAC price information, utilize the "MAC Price Look Up" feature of the Pharmacy Portal available through a secure website: **https://rxservices.cvscaremark.com**.

Eligible Person Fees and Amounts

Provider must collect at the point of service from Eligible Persons any administrative, transaction, access or other types of such fees or amounts, when applicable. The total amount to collect from the Eligible Person for providing Pharmacy Services, including any such fee or amount, will be communicated through the claims adjudication system and may be debited from Provider's claims payment account.

Claims Payment and Other Fees

Remittance Advices

Provider will receive a remittance advice for claim transactions within a payment cycle. Such reports may be distributed by mail, posted on one of the Caremark websites, or by other electronic means. Caremark payments to Provider may reflect adjustments for claims reversals, resubmissions or amounts owed by Provider to a Plan Sponsor under a provider agreement between Provider and a Plan Sponsor.

If Provider or authorized agent of Provider requires additional remittance reports, the following service fees apply:

SERVICE TYPE	MINIMUM SERVICE FEE
Paper remittance reprint	$100/NPI/cycle
Internet, network data mover (NDM), data recreate, etc.	$300/item/NPI/cycle

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014184

Research fee associated with no change in reimbursement	$100/hour
Documentation request/research	$100/hour
Check trace/stop payment	$100/check
EFT Bank Account change	$50/NPI
835 Vendor change	$50/NPI
Provider Claim Adjustment request	$5/claim

If Provider is receiving pharmacy remittance electronically, Provider must adhere to HIPAA regulations which mandate ASCX12N 835 and updates as required. Providers with questions regarding the testing, creation and receipt of the 835 data file should contact Caremark at the following address:

Caremark
Attn: Finance MC019
9501 East Shea Boulevard
Scottsdale, AZ 85260

All adjudicated claims detailed in a Caremark remittance advice are paid to Provider at one hundred percent (100%) of the reimbursement rate as in accordance with the Provider Agreement, pending audit by Caremark. All claims are subject to completion of audit. Prior to reimbursement, Caremark reserves the right to require additional documentation by Provider to validate a claim(s) including but not limited to submission of medical records and Eligible Persons attestations.

Disputed Claims

Notwithstanding any provision in the Provider Agreement, if Provider disputes a claim due to failure to pay the contractual reimbursement amount, Provider must notify Caremark in writing within one hundred eighty (180) days from date of fill, or within a longer period required by applicable Law, listing details of the disputed claim payment. The details must include the date of fill, prescription number, Eligible Person ID number and Provider NPI or NCPDP. Provider should include a copy of the remittance advice, if possible, and must provide the specific reason for the dispute. If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle, except for any overpayments made to Provider. Notifications may be mailed to:

Caremark
Attn: Network Services, MC 0023
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark may charge a research fee of $100/hour for any request in which Provider was accurately reimbursed. Caremark is not obligated to reimburse Provider for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim.

Refer to the **Maximum Allowable Cost** section of the Provider Manual for additional information.

Claims Adjustment

Notwithstanding any provision in the Provider Agreement, if Provider requests an adjustment to a claim (e.g., to correct claims information submitted by Provider), Provider must notify Caremark in writing within 180 days from date of fill, or within a longer period required by applicable Law, listing the date of fill, prescription number, Eligible Person ID number, Provider NPI or NCPDP, the specific reason for the claim adjustment requested, and the information necessary to make the requested adjustment. Provider should include a copy of the remittance advice, if possible.

If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle. Providers may be required to submit claim adjustment requests electronically. Claims adjustment requests may be mailed to:

Caremark
Attn: Pharmacy Corrections
9501 East Shea Boulevard
Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014185

Caremark is not obligated to reimburse Provider for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider. Refer to the **Professional Audits** section of the Provider Manual for additional information on audits.

Directories

Caremark and Plan Sponsors may list Provider in directories and databases for distribution to, and use by, Eligible Persons, Plan Sponsors and others as Caremark or a Plan Sponsor determines are necessary. Additionally, Caremark may display Provider, if applicable, in preferred provider performance initiatives in paper, web-based directories, or Plan Sponsor reporting. Refer to **Advertising and Trademarks** section of the Provider Manual.

Corrective Action Plan

A corrective action required (CAR) notice may be sent to Provider requiring Provider to submit a corrective action plan (CAP) concerning issues such as audit findings, dispensing errors, failure to respond to audit requests or as may be required by applicable Law. Provider must respond to any request for information and action in a CAR notice. Provider's response must include a CAP, submitted by the date provided on the CAR. Provider's CAP must include applicable documentation and policies and procedures as specified in the CAR notice to support Provider's CAP. If Provider fails to fully respond to a CAR notice or any other request for information and action as part of the CAR/CAP process, or fails to follow the CAP, Caremark reserves the right to exercise its termination rights under the Provider Agreement, along with other available remedies.

Compliance Reviews

Caremark has the right to examine Provider records (and obtain a copy as necessary) and pharmacy practices as Caremark reasonably determines are necessary to determine Provider's compliance with the terms of the Provider Agreement and applicable Law, and Provider must comply with such examination within the timeframe indicated by Caremark on the notice of the examination and without charge to Caremark. Caremark conducts examinations in accordance with the Provider Agreement and applicable Law. Examples of examinations herein include:

- Concurrent/Daily Review
- Medicare/Medicaid Compliance Review
- Telephone or Facsimile Inquiries

Refer to the **Professional Audits** section of the Provider Manual for other audit rights.

To the extent consistent with applicable Law, non-compliance of the Agreement includes, but is not limited to,

1. failure to complete and attest to annual Medicare Part D Fraud, Waste and Abuse (FWA) training and General Compliance Training (GCT);
2. failure to provide documents requested by Caremark pursuant to the Agreement;
3. refusing to accept an identification card for an Eligible Person;
4. refusing to service an Eligible Person because of the reimbursement rate;
5. failing to submit a claim for a Covered Item for an Eligible Person;
6. disclosing Confidential Caremark Information;
7. submitting the incorrect applicable DAW code;
8. submitting an inaccurate U&C;
9. submitting incorrect data in the claims submission;
10. non-adherence of the **Collection of Patient Pay Amounts** section of the Provider Manual;
11. not dispensing an emergency supply of a Covered Item to an Eligible Person as required by applicable Law; and
12. non-adherence of the **Software Certification** section of the Provider Manual.

Commented [PT15]: 2019 PM Supplement

Notwithstanding anything to the contrary in the Agreement, by participating in a Caremark network, Provider agrees

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014186

to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Agreement unless professional judgment dictates otherwise.

Provider must not separate cash and third-party prescription business or own, operate, or affiliate with a non-participating provider to manipulate claims pricing for inappropriate financial gain.

Provider is liable for all fees, interest, penalties, damages, withholds, judgments, financial obligations, or other charges imposed upon Caremark as a result in whole or in part from Provider's non-compliance or omissions of any act or responsibility assumed by Provider under the Agreement.

Caremark may assess against Provider a $325 administration fee for an initial occurrence of non-compliance or for each non-compliant submitted claim, increasing in $325 increments for subsequent non-compliant events (e.g., $325, $650, $975). Caremark has the right to offset, if consistent with applicable Law, against any amounts owing to Provider under the Provider Agreement any amounts owed to Caremark, including but not limited to, amounts for discrepant claims, charges for non-compliance and audit-related costs pursuant to the Provider Agreement or any Third-Party Agreement, claims submitted in breach of the Agreement, or any audit conducted by a third-party auditor on behalf of a Plan Sponsor.

Caremark may, in accordance with applicable Law, refer Provider's non-compliance to local/state/federal investigative and law enforcement agencies as appropriate.

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Caremark's rights under this section survive the termination of the Provider Agreement.

Concurrent/Daily Review

Commented [PT16]: 2019 PM Supplement

- Provider must be reachable by Caremark based on the contact information (as updated) Provider provided to Caremark as part of enrollment.
- Documents and records subject to review include, but are not limited to the following:
  - Original prescriptions – scanned images must include both the front and back images of the original: and the original must be retained and retrieved if requested
  - Signature logs
  - Delivery logs with tracking information for mailed or home/business delivered prescriptions
  - Prescription label and dispensing label
  - Compound Formulation Record, which must include at minimum, NDCs of items used, lot numbers, expiration dates, compounding instruction, signature of verifying pharmacist and certificate of analysis. Provider must keep Compound Formulation Records for the same time period as required for hard copy prescriptions. Refer to the Pharmacy Services and Standards section of the Provider Manual.
  - Evidence of copay collection including proof of financial transaction. Refer to the Pharmacy Services and Standards section of the Provider Manual.
  - Methodology used to determine appropriate beyond-use date.
- Provider must submit only the quantity indicated on the prescription. Provider must enter the exact metric decimal quantity dispensed (no rounding) on all claim transactions. Provider must submit the quantity based on product description (e.g., kit, volume of medication in milliliters, weight in grams or eaches, number of capsules/tablets). Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions. Provider must not adjust the quantity dispensed to circumvent adjudication edits, reimbursement structure, prior authorization edits, clinical program or benefit design edits based on day supply.
- Provider must submit the days supply accurately. If the Prescriber indicates "as directed," Provider must determine the dosing schedule in order to submit the claim correctly.
- Claims submitted to Caremark that exceed Plan limits for the days supply or quantity dispensed will reject with the message, "Plan Limitations Exceeded." The reject message includes the actual limits such as, "Maximum Days Supply = 34" or "Quantity Limit = 100". Any claims resubmitted must be entered with the accurate quantity and days supply; however, if the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-day supply),

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014187

and rejects as stated, it is allowable for Provider to resubmit the claim utilizing that quantity and the maximum days supply as provided in the reject messaging. Provider maintains responsibility to adhere to appropriate refill intervals.

- For claim submission requirements refer to the **Claims Submission** section and **Other Submission Requirements** sub-section of the Provider Manual.
- For specific drug submission requirements, refer to **Appendix D – Drug Submission Requirements** of the Provider Manual. Audit Tip Communications may be sent to Providers periodically to advise of drug submission requirement updates.
- For additional claim processing information, refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.

It is essential that Provider keep contact information up to date to ensure these reminders, and other important communications, are received. Refer to the Change in Documentation, Request for Documentation, Closure, and Other Information section of the Provider Manual.

Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance)

Formatted: Default Paragraph Font, Font: (Default) Arial, 9 pt, Bold, Not Italic

Audits By Government Agencies

Provider agrees that state and federal government agencies and their respective duly authorized representatives or designees, including but not limited to, the Department of Health and Human Services and CMS (collectively "**Government Auditors**") have the right, for the period allowed by Law, to review, audit, examine, and reproduce Provider's books, records, prescription records, and other documentation, to the extent such Government Agency Audit is required by Law or under the asserted authority of the Government Auditor ("**Government Agency Audit**"), and Provider will cooperate in good faith with such Government Agency Audit. To the extent the Government Auditor requests either of Caremark or Plan Sponsor Provider's books, records, prescription records, and other documentation as part of the Government Agency Audit, Provider agrees that it will provide such Provider's books, records, prescription records, and other documentation to Caremark within the timeframe as notified by Caremark based upon the Government Agency Audit, and agrees that Caremark has the right to produce to such Provider's books, records, prescription records, and other documentation in Caremark's possession.

Provider Suspension

Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider if required by applicable Law, or if Caremark has reason to believe Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; or (4) is a breach of the Provider Agreement.

Termination

Termination for Cause

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity. Refer to the **Compliance Reviews** section of the Provider Manual.

Caremark may immediately terminate the Provider Agreement if: (1) to the extent consistent with applicable Law, Provider makes an assignment for the benefit of creditors, files a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property or a proceeding is commenced against it which will substantially impair its ability to perform the Provider Agreement; (2) any court, governmental, or regulatory agency issues to Provider an order to cease and desist from providing Pharmacy Services; (3) (a) there is any change in who holds (directly or indirectly) the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest or (b) the right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party; (4) a levy, writ of garnishment, attachment, execution or similar item is served upon Provider and not removed within ten (10) days from the date of service; or (5) if Caremark reasonably determines that Provider is no longer active.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014188

Caremark may terminate the Provider Agreement if required by applicable Law, or if Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; or (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; or (4) is a breach of the Agreement. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement, including termination of pharmacies found to have a direct or indirect relationship with Provider or its affiliates based upon common officers, directors, current/former employee, owners (direct or indirect).

Commented [PT17]: 2019 PM Supplement

~~Caremark may terminate the Provider Agreement if required by applicable Law, or if Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; or (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; or (4) is a breach of the Agreement. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement.~~

The termination rights set forth in this section are in addition to any and all other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity. The effective date of a termination shall be determined by Caremark and as in accordance with applicable Law.

Termination Without Cause

Unless precluded by applicable Law, Caremark may at any time terminate the Provider Agreement without cause or terminate Provider from providing Pharmacy Services to specific Plans without cause upon a notice to Provider, regardless of the network(s) in which Provider participates.

Unless precluded by applicable Law, Provider may terminate the Provider Agreement without cause upon thirty (30) days' prior written notice to Caremark provided, however, that if applicable Law or a Caremark network or a Plan Sponsor network requires a longer notice period, the Provider Agreement shall not terminate until the expiration of such longer period. Unless precluded ~~as~~ by applicable Law and except as otherwise may be required with respect to any Caremark network or a Plan Sponsor network, Provider may terminate participation in any Caremark network or a Plan Sponsor network upon thirty (30) days' prior written notice to Caremark, specifying the date of termination and the names of the Caremark network(s) or Plan Sponsor network(s) in which Provider will no longer participate. Absent the prior written consent of Caremark, Provider may not elect to participate in a Caremark network or a Plan Sponsor network, for thirty (30) days or until the next solicitation period for that Caremark network or Plan Sponsor network, whichever is longer, to the extent consistent with applicable Law.

Commented [PT18]: 1/15 – Amendment #01

The terms of this **Termination Without Cause** section apply notwithstanding any other provision in the Provider Agreement.

For termination without cause by Provider from a Medicare Part D network, refer to the **Network Participation** section under the **Medicare Part D** section of the Manual.

Rights and Remedies in the Event of Termination or Breach

In the event of a termination of the Provider Agreement for any reason, Provider must (upon Caremark's request) surrender the Provider Agreement, Provider Manual, other Caremark Documents, other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control.

In the event Provider breaches any provision of the Provider Agreement, in addition to all other termination rights, Caremark shall have the right, to the extent not contrary to Law, to (1) suspend any and all obligations of Caremark, including payment to Provider, under and in connection with the Provider Agreement, (2) impose reasonable handling, investigation and/or improper use fees, and/or (3) in whole or in part, offset against any amounts owed to Provider under the Provider Agreement or under any other agreement between Caremark and Provider, any amounts required to be paid by Provider to Caremark. These rights and remedies are not exclusive and are in addition to any other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

Survival of Certain Provisions

Termination of the Provider Agreement will have no effect upon the rights and obligations of the parties accruing prior to the effective date of termination.

Workers' Compensation

Notwithstanding anything to the contrary, Caremark may utilize non-Medicare Part D networks for workers'

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

compensation claims. To the extent Caremark utilizes a non-Medicare Part D network for workers' compensation claims and Provider participates in such network, the reimbursement for such workers' compensation claim shall be as reflected in the applicable non-Medicare Part D network addendum (to the extent such network addendum does not conflict with the claims adjudication system) and the following additional terms will apply:

- Section 4.3 or Schedule A, whichever is applicable, of the Provider Agreement, is amended to add "(vi) the reimbursement amount prescribed by a state law for workers' compensation (unless otherwise permitted by such state law), if applicable for workers' compensation claims reimbursement."
- Caremark may utilize a third-party vendor for certain portions of Caremark's network services, including but not limited to, claims processing and pharmacy payments for workers' compensation claims.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014190

Professional Audits

Professional Audits Rights

During the term of the Provider Agreement and for two (2) years following the termination of the Provider Agreement (or such time permitted under applicable Law), Caremark has the right to audit Provider's records and documents, facility and practices as Caremark reasonably determines are necessary to evaluate Provider's compliance with the Provider Agreement and applicable Law. Caremark's audit may cover any claim submitted by Provider or Eligible Person to Caremark or Plan Sponsor for adjudication (regardless of the method of submission), claims for Covered Items, and U&C submissions. To the extent allowed by Law, if there is a conflict between the Provider Manual and applicable Law with respect to an audit of Provider, the audit is subject to the stricter provision.

Nothing in this **Professional Audits** section prohibits Caremark from conducting an audit of Provider that does not follow the established audit procedures set forth in this **Professional Audits** section to determine Provider's compliance with the terms of the Agreement, but in all cases compliant with applicable Law. Refer to the **Compliance Reviews** section of the Provider Manual for other rights.

Unless unusual circumstances exist, Caremark will schedule an audit in advance and work with Provider to accommodate reasonable schedule change requests made prior to the audit date to a mutually agreeable time. Notice of an audit may be communicated to Provider via facsimile, telephone, or mail.

Throughout the audit process:

- Provider is expected to be an active participant to ensure audit findings are accurate. Provider may designate an employee to facilitate the audit on behalf of Provider.
- Provider must provide the Caremark auditor with a clutter-free work area that does not disrupt the provision of Pharmacy Services, but with ease of access to records and documents required for the audit.
- Provider must maintain proper staffing during the audit to ensure that Provider is reasonably available for questions and the retrieval of records. If possible and requested by Provider, the Caremark auditor will wait a reasonable amount of time (10-15 minutes) while Provider locates any missing records and documents not found during the course of the audit.
- Provider must provide access to a Plan Sponsor (and its representatives or agents) to examine, audit, and copy Provider records and documents pursuant to its authority under contract with Caremark or by applicable Law.

Provider authorizes Caremark to release Provider's information, records, and documents to governmental authorities (and their agents), Plan Sponsors, and wholesalers upon request. Caremark reserves its rights under the **Confidentiality** section of the Provider Manual. Refer to the **Audits by Government Agencies** section of the Provider Manual.

If the Caremark auditor is denied access to Provider's records, documents, or facility, Caremark may exercise all remedies available to it, including but not limited to, payment suspension (in accordance with the terms of the Provider Manual) until the audit is completed, termination of the Agreement, and chargeback of all of the claims that are the subject of an audit.

Caremark audits do not employ extrapolation unless required under applicable Law.

Provider must notify Caremark in the event of a change in the pharmacy's physical location prior to the change. Refer to the **Change in Documentation, Request for Documentation, Closure, and Other Information** section of the Provider Manual for additional information.

Audits By Government Agencies

Provider agrees that state and federal government agencies and their respective duly authorized representatives or designees, including but not limited to, the Department of Health and Human Services and CMS (collectively "Government Auditors") have the right, for the period allowed by Law, to review, audit, examine, and reproduce Provider's books, records, prescription records, and other documentation, to the extent such Government Agency Audit is required by Law or under the asserted authority of the Government Auditor ("Government Agency Audit"), and Provider will cooperate in good faith with such Government Agency Audit. To the extent the Government Auditor requests either of Caremark or Plan Sponsor Provider's books, records, prescription records, and other documentation as part of the Government Agency Audit, Provider agrees that it will provide such Provider's books, records, prescription records, and other documentation to Caremark within the timeframe as notified by Caremark based upon the Government Agency Audit, and agrees that Caremark has the right to produce to such Provider's books, records, prescription records, and other documentation in Caremark's possession.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014191

Types of Audits

Audits may be conducted in the form of an on-site audit, investigational audit, or desktop audit. There are other compliance reviews that Caremark may conduct as described under the **Compliance Reviews** section.

On-site Audits

Caremark performs routine on-site audits.

Although written notice is not required, Caremark as a routine business practice will notify Provider two (2) weeks prior to a scheduled audit date. For an on-site audit, auditors will generally review specific documents and records related to claims paid to Provider by Caremark during the previous 24 months, unless otherwise required by applicable Law.

Investigational Audits

For an investigational audit, Provider is contacted via telephone, facsimile, or through the mail, and asked to provide specific documents and records related to claims paid to Provider or Eligible Person by Caremark during a specified period. Documentation may include, but not be limited to, original prescriptions, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications.

Desktop Audits

For a desktop audit, Provider is contacted via telephone, facsimile, or through the mail to satisfy records and documentation requirements for limited reviews (e.g., MEDIC requests, CMS audits, Plan Sponsor audit inquiries, government inquiries, and law enforcement inquiries). Records and documentation requested must be provided in a timely manner not to exceed ten (10) days or according to applicable Law.

Documents and Records Production

Provider must provide Caremark with all requested documents and records as Caremark reasonably determines are necessary to evaluate Provider's compliance with the terms of the Provider Agreement and applicable Law, and Provider must fully comply with such requests, including the delivery of all requested documents and records to Caremark by the specified due date (which may be within three (3) business days) and without charge to Caremark; if Provider fails to provide requested documents and records,, the entire amount of the paid claim for which documents and records were not provided are due and owing. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date.

Submission of false or misleading records and documentation may result in chargeback for all claims audited and any other remedies available to Caremark, including but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies.

Documents and records must be readily retrievable at the Dispensing Pharmacy.

Caremark reserves the right to not consider Provider actions (and documentation of such actions) that take place after Provider is notified of an audit as a demonstration of compliance with the Agreement. Refer also to the **Collection of Patient Pay Amounts** section of the Provider Manual.

Provider's failure to comply with document and records requests as required under the Agreement is a breach of the Agreement, subject to remedies available to Caremark, including termination of the Agreement.

Documents and Records Subject to Audit

Documents and records subject to audit include, but are not limited to, the following:

- Original prescriptions - Scanned images must include both the front and back images of the original; and the original must be retained and retrieved if requested
- Signature logs
- Delivery logs with tracking information for mailed or home/business delivered prescriptions
- Daily prescription logs
- Wholesaler, manufacturer and distributor invoices (with NDC, drug names, quantity, package size, etc.)
- Transaction Statement, Transaction History, and Transaction Information and Documentation as defined in the **Supply of Covered Items; Purchase Invoices** section
- Refill information

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014192

- Prescriber information
- Patient profiles/Prescriber orders
- Records to validate U&C
- Prescription label and dispensing label
- Provider system report of Pharmacy Services reversed, returned to stock, or not dispensed with confirmation of reversal of the claim submission
- Recorded diagnosis on hard copy or maintained in the computer system for all Medicare Part B Pharmacy Services dispensed under a Medicare Part D plan
- Record of Eligible Person location (e.g., skilled nursing, assisted living) when claim is dispensed
- Records of transfer/sale between providers of drugs and devices used for Pharmacy Services
- Records of prescription transfers, including evidence of Eligible Person's express permission to Provider to transfer his/her prescription to another pharmacy
- Medication pricing brochures for cash customers (e.g., paper pamphlet, promotional signage, internet listing)
- Patient consent and administration record of vaccine claims (combination vaccine/administration)
- Evidence of copay collection including proof of financial transaction [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash]. If the Patient Pay Amount is reduced due to a coordination of benefits, Provider must provide evidence of the claim adjudication to the secondary payer
- Documents pertaining to individualized determination of financial need or exhaustion of reasonable Patient Pay Amount collection efforts. Refer to the **Collection of Patient Pay Amounts** section of the Provider Manual
- Proof of completion of annual Medicare Part D FWA training and General Compliance Training (GCT)
- Verification that Provider has reviewed the OIG LEIE and the SAM exclusion list as required by the **Federal Health Care Programs Participation Exclusion** section of the Provider Manual
- Prescription record documentation for Medicare Part D Enrollees with diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD)
- Signed Prescriber or patient attestation legitimizing the dispensing of the prescription if a prescription hardcopy, medication order, patient signature log or patient delivery log is not retrievable. Prescriber statements must either be on Prescriber letterhead or on a written prescription for the Prescriber. Attestations provided by the Prescriber must clearly indicate the source of the attestation (i.e., clearly visible fax signature that the attestation originated from the Prescriber's office or Prescriber's stamp on the attestation.)
- All records acquired in the purchase of a pharmacy
- Documentation substantiating transmission of submission clarification codes (SCC) or override codes
- Documentation supporting SCC value submission
- Evidence of verification of legitimate Prescriber/patient relationship if Provider knows or reasonably should know that there is not a legitimate Prescriber/patient relationship
- Credit Card Merchant Account Report including evidence of settlement and payment through bank records
- Multi-Ingredient Compounds Documents
    - Full compound recipes. Provider must disclose to Caremark upon request the full compound recipe for accurate calculation
    - Formulation worksheet including NDCs of items used, lot number, expiration dates and signature of verifying pharmacist and certificate of analysis for Active Pharmaceutical Ingredients (APIs)
    - Recorded diagnosis on hard copy or maintained in the computer system for all compounds

Commented [PT19]: 2019 PM Supplement

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 C.F.R. 164.502 and 45 C.F.R. 154.501). Provider further acknowledges that in order to receive payment from Caremark, Provider is required to allow Caremark to conduct audits of its prescription and other pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws. Additionally, Provider recognizes that Caremark audit staff may be exposed to or otherwise become aware of certain

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014193

confidential, protected, and individually identifiable health information of patients who are not Eligible Persons during the course of the audit review, and that such disclosures by Provider to Caremark are incidental to the payment disclosures and are therefore permitted by HIPAA under 45 C.F.R. 164.502(a)(iii) provided that reasonable safeguards are implemented by Provider to limit such incidental disclosures. Caremark will maintain confidentiality of this information and will not disclose, publish or otherwise reveal any of this confidential information except as necessary to conduct its audit pursuant to applicable Law.

Documents and Records Requirements

Prescription Information

All prescription documentation (including electronic records within Provider system and written, faxed, telephoned, and computer-generated orders) for Covered Items written by the Prescriber and dispensed to the Eligible Person, must fulfill the requirements as set forth within applicable Law and contain additional information necessary for proper submission and adjudication of a claim transaction such as:

- Full name of the patient for whom the prescription was written by the Prescriber and the address at which the patient resides
- Full name, address, telephone number, and NPI (or other required identification number) of the Prescriber
- Name, quantity and strength of the medication prescribed
- Specific dosage directions
- Generic substitution instructions (if applicable)
- Notation when patient requests that a multi-source brand medication be dispensed
- Notation if prescription is changed including changed prescription element, time, date, name of authorizing person, and affiliation with Prescriber
- Refill instructions
- Miscellaneous or other information as required in accordance with applicable Law
- Prescription hard copies for insulin and diabetic supplies must contain complete documentation of items, quantities dispensed and directions for use

Documentation for a claim transaction which includes vaccine administration must be maintained on the original hard copy prescription or in the form of a vaccination administration record (when the administration was included within the claim transaction). Documentation must include:

- Detail regarding the administration (e.g., lot number, expiration)
- Date of the administration
- Name and NPI of Provider directly responsible for administration of the vaccine; if the Provider does not have an NPI, provide the NPI of the pharmacy
- NPI of the Prescriber of the vaccine, following applicable state and federal Law (this may be the same as the Provider administering the vaccine where applicable Law allows)
- Acknowledgement that confirms the Eligible Person received both the medication and the administration

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy or Provider systems where it can be readily retrievable.

During the audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, Caremark recommends that Provider document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the Caremark auditor or help to resolve an audit discrepancy.

Signature Log – Hard Copy or Electronic

Provider must utilize a third-party signature log – hard copy or electronic – which meets the following criteria: (1) contains a signature which can be individualized or directly related to each prescription dispensed, (2) maintains the date of the receipt of medication by the Eligible Person, (3) maintains a disclosure to Eligible Person of insurance billing, and (4) retrievable for the purposes of audit.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014194

For each claim adjudicated through the claims adjudication system, Provider must obtain the signature of the Eligible Person (or his or her authorized representative) on a dated third-party signature log to confirm that he or she has received the medication recorded.

Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.

Third-party signature log options for mail-delivered prescriptions dispensed in accordance with the Agreement include:

- If delivered to a home or business address, Provider must maintain for audit purposes (1) Patient Pay Amount collection documents; (2) the shipping method; (3) shipment manifest; (4) the medication protection method; (5) documentation of each prescription number and Covered Item delivered; and (6) tracking documentation for each Covered Item that was delivered.
- If Eligible Person is sent monthly billing statements, Provider may insert a form listing the dates of fill and prescription numbers; the Eligible Person or authorized representative should be instructed to sign and return the form with his or her payment.

The third-party signature log must be in date order, readily accessible, and retained for such period as required by applicable Law.

Supply of Covered Items; Purchase Invoices

All Covered Items used by Provider to fill prescriptions or otherwise meet requests of Eligible Persons must be sourced from an Authorized Trading Partner [which includes manufacturers, distributors, wholesalers, and other pharmacies and as defined under the Drug Supply Chain Security Act 21 U.S.C.A § 360eee ("DSCSA")] that is subject to regulatory oversight and duly licensed under all applicable Law, including but not limited to, the Food and Drug Administration, Drug Enforcement Administration and state Boards of Pharmacy. For those Covered Items that are regulated by the DSCSA and any regulations promulgated under the DSCSA, Provider must maintain the Transaction Statement, Transaction History, and Transaction Information that it receives from the Authorized Trading Partner as set forth in this section.

For those Covered Items for which a Transaction Statement, Transaction History and Transaction Information are not required by the DSCSA, Provider must maintain records of the exact quantities purchased, name of the Authorized Trading Partner, Covered Item name(s), NDC, date(s) of purchase, and proof of payment [e.g. copies of credit card receipts, canceled checks (front AND back)] (collectively "Documentation"). Unless permitted by applicable Law, Provider must not use foreign-sourced Covered Items, samples, returned, recalled, expired, or otherwise suspect Covered Items to dispense to or otherwise provide for Eligible Persons under the Provider Agreement. For diabetic testing supplies, Provider must use diabetic products that have been sourced either from within the manufacturer's authorized distribution channel or purchased directly from the manufacturer.

It is the sole responsibility of Provider to ensure that all wholesalers, manufacturers, distributors, or other pharmacies that Provider utilizes to source Provider's purchases of Covered Items are Authorized Trading Partners. Provider's receipt of Covered Items when Provider knows, or reasonably should have known, that the Covered Item is suspect may result in chargeback of claims and other remedies available to Caremark, including but not limited to, termination of the Agreement. For purposes of this section "suspect" means a Covered Item that is potentially counterfeit, diverted or stolen; is potentially intentionally adulterated such that the Covered Item would result in serious adverse health consequences or death to humans; is potentially the subject of a fraudulent transaction; or appears otherwise unfit for distribution such that the Covered Item would result in serious adverse health consequences or death to humans.

Provider must make available to Caremark Transaction Statement, Transaction History, and Transaction Information and Documentation as part of Caremark's audits. Provider must fully cooperate with Caremark in audits or in the course of investigation of suspect or reported violations of this section. Caremark's audit may involve selecting a date range for aggregate purchase invoice review. Provider's purchases occurring within the date range of the aggregate purchase invoice review must be sufficient to support the total quantity dispensed by Provider (or provided to Eligible Persons) as reflected in the claims billed to Caremark during the same date range of the aggregate purchase invoice review. If Provider has not purchased sufficient Covered Items to substantiate the quantity of claims billed, those claims may be subject to chargeback and other remedial action. If Provider fails to timely provide all the requested documentation in accordance with this section, one hundred percent (100%) of the amount for the paid claims audited is subject to chargeback and other remedies available to Caremark, including but not limited to, termination of the Agreement.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014195

Documents and Records Maintenance

Provider must maintain any Transaction Statement, Transaction History, and Transaction Information provided to Provider pursuant to the DSCSA and any regulations promulgated under the DSCSA for the period required by applicable Law and any Documentation during the term of the Agreement and for two (2) years after the termination of the Agreement.

Medicare Part D Requirements

Provider must provide documentation to demonstrate compliance with all Medicare Part D requirements (as stated in the Provider Manual, Caremark Medicare Part D Addenda, CMS guidance or under applicable Law) including, but not limited to:

- Long-term Care billing
- Accurate use of Patient Residence and Pharmacy Service Type values
- Compliance with "CMS-10147 Medicare Prescription Drug Coverage and Your Rights" pharmacy notification
- Documentation to establish coverage determinations (e.g., Hospice, Part B vs. Part D, ESRD)
- That Provider has reviewed the OIG LEIE and the SAM exclusion list as required by the **Federal Health Care Programs Participation Exclusion** section of the Provider Manual to confirm that no Prescriber transmitted on a Medicare Part D claim is on any exclusion list
- Documentation or information requested which relates to a Medicare Part D claim dispensed by Provider but reimbursed directly to other parties, including the Part D Enrollee
- Documentation substantiating any submission clarification codes (SCC) or override codes transmitted on a Medicare Part D claim
- Documentation submitted must comply with guidance set forth by CMS or any other applicable regulatory body

Medicare D claims transmitted with an invalid or inactive Provider identification number are not eligible for reimbursement and will be charged back. Provider must only dispense and bill a Covered Item under a prescriber that has prescriptive authority under applicable Law.

If a copy of a prescription or signature log is not retrievable after sufficient effort, obtain either Prescriber or Eligible Person attestations.

On-Site and Investigational Audit Resolution – Appeals Process

If there are initial discrepancies as part of an audit, Caremark provides a written appeals process. Caremark will send Provider an initial discrepancy report of all the initial discrepancies along with Documentation Guidelines (refer to **Appendix I** of the Provider Manual for a copy of the current Documentation Guidelines) that show how Provider may address an initial discrepancy and validate the audited claim.

If Provider chooses to appeal the initial discrepancies, Provider must respond to Caremark in writing within thirty (30) days, or other timeframe required by applicable Law, with supporting documentation in accordance with the Documentation Guidelines or the Provider Manual for the identified initial discrepant claim. Documentation must be transmitted to Caremark via certified mail, fax, Federal Express, United Parcel Service, or any other certified carrier (preferably with delivery confirmation), and must be received by the due date specified by Caremark. Provider may contact the Pharmacy Performance department at 1-866-488-4709 prior to the documentation due date to request an extension of the documentation due date.

Discrepant claims that are not documented and validated in accordance with the Documentation Guidelines or the Provider Manual are due and owing to Caremark at the expiration of the thirty (30) day appeal period, or other timeframe required by applicable Law; however, Caremark has the right to offset, if consistent with applicable Law, against amounts owed to Provider, before the expiration of the thirty (30) day period, or other time period required by Law, for any discrepant claims as allowed for under the **Provider Suspension** section of the Provider Manual. Audit discrepancies are detailed in a final audit discrepancy report.

Once the documentation period as outlined in the initial discrepancy report has concluded, late documentation will not be accepted. Any documentation submitted after the documentation due date (i.e., for the initial discrepancy report) or after a final audit discrepancy report is issued may be considered by Caremark as part of Caremark's evaluation of the remedies to be taken by Caremark to address the audit findings, but will not impact the final chargeback amount owed to Caremark.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014196

Refer to the **Arbitration** section of the Provider Manual for the dispute resolution process once the final audit discrepancy report is complete.

If the final audit chargeback exceeds ~~$7,500~~$10,000, Provider must reimburse Caremark ~~fifteen~~ twenty percent (~~15%~~20%) of the total final audit chargeback for the cost of the audit, where consistent with applicable Law.

Commented [PT20]: 2019 PM Supplement

Provider must notify Caremark of Provider's appeal of an initial discrepancy report, in writing to:

Caremark – Audit Manager
Attn: Pharmacy Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement any amounts owed to Caremark including, but not limited to, amounts owed for audited discrepant claims, charges for non-compliance and audit-related costs pursuant to the Provider Agreement or any Third-Party Agreement, claims submitted in breach of the Agreement, or any audit conducted by a third-party auditor on behalf of a Plan Sponsor. If the Provider fails to satisfy amounts owed related to an audit finding, certain remedies may apply, including termination of the Provider Agreement and any other available remedies.

When Caremark collects from Provider amounts due as a result of audit discrepancies, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or Plan Sponsor in relation to such adjustment or chargeback.

Once Provider is on notice of an on-site or investigative audit, Provider must not during the audit process adjust or reverse claims that are the subject of the audit as Caremark will perform appropriate adjustments and reversals at the conclusion of the audit process.

Caremark may report its audit findings to Plan Sponsors and local/state/federal investigative and law enforcement agencies (and their agents).

Pharmacy Membership Review Committee

Caremark's Pharmacy Membership Review Committee (PMRC) is a committee responsible for reviewing final audit cases to determine remedial actions that the PMRC determines are appropriate to address the audit findings. The PMRC meets regularly and is comprised of Caremark employees representing multiple departments and industry experiences.

Other Submission Requirements

Complete and Accurate Information

Claims are paid based on the information that Provider submits through the claims adjudication systems to Caremark. Provider must clarify ambiguous dosage directions regarding utilization prior to dispensing and must not combine Prescriber authorized refills. If a prescription contains ambiguous directions (e.g., no directions, "Use as Directed," or "PRN"), Provider must obtain more concise directions, as to accurately represent the days supply prior to the Covered Item being dispensed. The directions may be obtained by direct communications with either the Eligible Person or Prescriber. Documentation of the directions on the original prescription is required. The days supply should accurately reflect the documented directions and quantity dispensed. The Prescriber should be accurately identified with an applicable NPI as described in the **Claims Submission** section and within this section of the Provider Manual. The strength of the medication identified on the claim must be an accurate reflection of that which was prescribed or documentation of the unavailability of the prescribed strength will be required. If any claim was paid based on incorrectly submitted data, Caremark reserves the right to charge back, up to the amount of the entire claim, based on the type of inaccuracy in the claim data (e.g., inaccurate person would result in full claim chargeback or reversal).

Provider must not modify any claim data fields (e.g., reduce quantities or days supply) in order to bypass plan edits or Provider Agreement requirements; and Provider must not use an SCC value to inappropriately override a reject.

Dispensing Limitations

- The quantity dispensed must be entered exactly as it is written on the prescription; Provider must enter the exact metric decimal quantity dispensed only (no rounding on all claim transactions). Many products are transmitted as a kit, the volume of medication, or weight in grams. Provider should review claims submission to ascertain that the quantity is accurate on all claims based on the specificity of the product and Prescriber instructions.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014197

- Provider must submit the days supply accurately. If the Prescriber indicates "as directed," Provider must determine the dosing schedule in order to submit the claim correctly. If the quantity is uncertain, Provider must contact the Prescriber to determine the appropriate amount to dispense and document said amount appropriately on the original prescription.
- If the Prescriber indicates "as directed" for a drug that may be administered on a sliding scale, such as insulin, the Provider must obtain the dosage range, note it on the prescription hard copy, and calculate the days supply by using the maximum daily dosage; the directions may be obtained by direct communications with either the Eligible Person or the Prescriber.
- Any changes to a prescription, including but not limited to, the Covered Item being prescribed or directions for use must be approved by the Prescriber prior to dispensing and documented on the original prescription.
- Any subsequent changes in the dispensing limitations that are approved by the Prescriber must be noted on the original prescription.
- Claims submitted to Caremark that exceed Plan limits for the days supply or quantity dispensed will reject with the message, "Plan Limitations Exceeded." The reject message includes the actual limits such as, "Maximum Days Supply = 34" or "Quantity Limit = 100". Any claims resubmitted must be entered with the accurate quantity and days supply; however, if the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-day supply), and rejects as stated, it is allowable for Provider to resubmit the claim utilizing that quantity and the maximum days supply as provided in the reject messaging. Provider maintains responsibility to adhere to appropriate refill intervals. For additional information regarding Medicare Part D Claims, refer to the **Medicare Part D** section of the Provider Manual.
- Claims submitted to Caremark in accordance with a Plan Sponsor program to allow limited dispensing of a non-covered item (e.g., 3-day supply approved for a drug on prior authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable day supply.
- In an effort to protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.

Commented [PT21]: 2019 PM Supplement

U&C Validation

Provider is required to submit accurate U&C Prices for all Caremark claims, including U&C Prices which are part of a standard set price generic program offered by Provider (i.e., program that is open and requires no enrollment). Provider must provide, upon request, a record of the dispensing of a prescription (identical to the prescription being audited) that was dispensed to a cash paying customer on the same date if such dispensing occurred. Provider may redact confidential patient health information from the record in accordance with applicable Law, but the record must contain the patient charge amount. Caremark has the right to review and audit documentation and records as detailed in this section to validate that Provider's submitted U&C is in accordance with the Agreement. Provider must allow the Eligible Person to pay either the U&C or the Patient Pay Amount, whichever is lower, unless a Plan otherwise requires. Notwithstanding the foregoing, Provider must still submit a claim to Caremark, even if the Eligible Person pays the U&C.

Provider must not modify its U&C, gross amount due, or ingredient cost claimed on individual claims in order to bypass plan edits or Provider Agreement requirements; otherwise, claims in violation are subject to chargeback and other remedies available to Caremark, including but not limited to, termination of the Agreement.

Patient Receipts and Insurance Profiles

Provider may print U&C and Person Patient Pay Amount on receipts and insurance profiles provided to an Eligible Person. Provider reimbursement pricing information and prices paid to Provider for individual claims under this Provider Agreement are Confidential Caremark Information and may not be disclosed on patient receipts or insurance profiles, subject to applicable Law. Refer to the **Confidentiality** section of the Provider Manual.

Caremark has the right to review and audit documentation to validate Provider's compliance with this section.

DAW Codes

Provider must select a valid DAW code. Refer to the **Dispense as Written Codes** subsection of the **Claims Submission** section of the Provider Manual for a list of valid DAW codes. DAW or Brand Medically Necessary

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014198

requests must be at the direction of the Prescriber.

Prescriber Identification; Prescriptive Authority

Accurate Prescriber identification in claims submission is critical as Caremark relies upon the information such as in claims adjudication, clinical services, Plan Sponsor initiatives, and audits. A valid and active individual Prescriber National Provider Identifier (NPI) is required on all claims, and failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the original hard copy for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI or DEA number which does not represent a prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit ~~a valid~~an appropriate submission clarification code (SCC) to bypass the reject.

Commented [PT22]: 11/16 – per Heather Graham

Ophthalmic Products

Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. A chart to assist in calculating the appropriate days supply for a claim is provided in **Appendix D** of the Provider Manual.

Drugs with Unusual Submission Requirements

Claims for some drug products frequently result in incorrect reimbursement. To help avoid audit chargebacks, refer to the examples in the chart in **Appendix D** of the Provider Manual.

Potentially Fraudulent Activity

If Provider suspects that potentially fraudulent prescriptions are being presented or that other improprieties regarding claims are happening, Provider must notify Caremark by telephone at 1-877-841-1851 or by written correspondence at:

Caremark
Attn: Network Performance, MC020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Provide the Eligible Person's name and identification number, the Prescriber name and identification number, a detailed description of the suspected fraudulent activity and any related supporting documentation.

Examples of potentially fraudulent activity that warrant notification to Caremark may include, but not be limited to:

- Eligible Person presenting a forged or altered prescription
- Eligible Person presenting a prescription not written by the Prescriber identified
- Eligible Person calling in his/her own prescription
- Eligible Person presenting a prescription indicating a medication which is not consistent with the practice or specialty of the Prescriber
- Eligible Person presenting a prescription for an ineligible person, or fictitious family member

Provider may also consider notifying the Drug Enforcement Administration (DEA) or other related regulatory agencies.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014199

Intellectual Property, Confidentiality and Proprietary Rights

Advertising and Trademarks

Caremark, or its affiliates, retains exclusive rights to, and in, the names "CVS/caremark™" and "Caremark®" together with other distinctive trademarks or service marks that have been used by Caremark or may be adopted or used by Caremark in the future.

Provider must not advertise or use any name, symbol, trademark or service mark of Caremark or Plan in advertising or any other promotional information other than as specifically permitted by the Provider Agreement without prior written consent of Caremark or Plan respectively.

Caremark or Plan Sponsors may: (1) use the name, logos, address(es) of Provider in directories, informational brochures or other publications provided to Plan Sponsors or Eligible Persons; (2) use the information regarding Provider's services that is provided to Caremark by Provider in publications provided to Plan Sponsors or Eligible Persons; and (3) provide Plan Sponsors or Eligible Persons with credentialing information.

Upon termination for any reason, Provider must immediately discontinue the use of any name, symbol, trademark or service mark of Caremark in advertising or any other promotional information.

Non-disparagement

Provider may not place in a false light, disparage, defame, nor make any damaging, derogatory, or unfavorable public statements regarding Caremark, Caremark's products, programs, services, employees, personnel, and brands. Provider will provide appropriate and adequate training to ensure compliance with these requirements. Provider's obligations hereunder shall survive termination of the Agreement.

Confidentiality

"Confidential Caremark Information" is defined as any non-public information or data of Caremark and includes but is not limited to, (1) Caremark's products, programs, services, designs, inventions, business practices, policies and procedures, customer list, information related to a Plan Sponsor, trade secrets; (2) MAC lists; (3) reimbursement rates and terms; (4) the Provider Agreement, the Provider Manual, network enrollment forms and other addenda, and other Caremark Documents; and (5) other information relating to Caremark's business. Provider must maintain in confidence and may not disclose, sell, assign, transfer, or give to any third party, including a Plan Sponsor or Eligible Person, Confidential Caremark Information without Caremark's prior written consent. Provider may use Confidential Caremark Information only for the purpose of carrying out its obligations under the Provider Agreement. Provider may disclose Confidential Caremark Information to its employees, agents, consultants, or authorized representatives who have a need to know the Confidential Caremark Information in order to carry out Provider's obligations under the Provider Agreement and who (i) have been informed of the confidential and proprietary nature of the Confidential Caremark Information, and (ii) have agreed in writing not to disclose the Confidential Caremark Information to others and to treat the Confidential Caremark Information in accordance with the requirements of this section. Provider is responsible to Caremark for any breach of this section by its employees, agents, consultants, or authorized representatives. Provider agrees to protect the security of Confidential Caremark Information and to ensure that it is used and disclosed only as permitted herein. Provider must promptly notify Caremark if it becomes aware of any unauthorized use of Confidential Caremark Information.

No Confidential Caremark Information may be quoted or attributed to Provider or Caremark without the prior written consent of Caremark.

Provider agrees to protect the confidentiality and security of an Eligible Person's personal information (which includes any information that identifies or can be used to identify an Eligible Person), as required by applicable Law, and to use and disclose such information only as permitted by and in accordance with applicable Law.

This **Confidentiality** section applies to the extent consistent with applicable Law.

Non-Solicitation and Non-Interference

Provider must not (directly or indirectly): (1) communicate with any current Plan Sponsor about terminating its agreement with Caremark; (2) interfere with the relationship or potential relationship between Caremark and a plan sponsor or member; (3) use or disclose Confidential Caremark Information for the purpose of soliciting a Plan

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014200

Sponsor or Eligible Person, or for any other purpose not in furtherance of the Agreement; (4) communicate with a Plan Sponsor regarding Provider network participation status or network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor; (5) provide inaccurate plan benefit design information to an Eligible Person; or (6) communicate with any Plan Sponsor or potential plan sponsor about entering into an agreement for pharmacy benefit management services with any person other than Caremark.

Provider must not (directly or indirectly): (1) communicate with any Eligible Person or a Plan Sponsor's group(s) about person or group terminating its agreement with the Plan Sponsor; (2) interfere with negotiations that a Plan Sponsor is conducting for the provision of health benefits, including pharmacy benefits, to Eligible Persons or groups; (3) use or disclose to any third party, Eligible Person or Plan Sponsor group information acquired during the term of the Agreement for the purpose of soliciting Eligible Persons or Plan Sponsor groups, or for any other purpose not in furtherance of the Agreement; or (4) communicate with a Plan Sponsor's group regarding Provider's network participation status or the network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor or group.

Nothing contained herein shall prevent Provider from disclosing any information required by Law to be disclosed or otherwise required to be disclosed to an Eligible Person in the fulfillment of the Provider's professional responsibilities for an Eligible Person.

Proprietary Rights

Provider has no right to use, reproduce or adapt any information, data, work, compilation, computer program, manual, process or invention obtained from, provided by, or owned by Caremark or Plan Sponsor (including but not limited to, products, programs, services, business practices, procedures), without Caremark's prior written consent.

Provider agrees that the information contained in the claims adjudication system that was obtained by and through the administration and adjudication of a claim by Provider is the property of Caremark, and Provider agrees not to claim any right, title, or interest in said information.

Caremark, and its affiliates, have the right to use, reproduce, and adapt any information or data obtained from Provider in any manner deemed appropriate, even if such use is outside the scope of the Provider Agreement, provided such use is in accordance with applicable Law.

Remedies

Provider acknowledges that any unauthorized disclosure or use of information or data obtained from or provided by Caremark would cause Caremark immediate and irreparable injury or loss that cannot be fully remedied by monetary damages.

Accordingly, if Provider should fail to abide by the provision and terms set forth in these sections of the Provider Manual (**Intellectual Property, Confidentiality, and Proprietary Rights**), Caremark will be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and judgment for damages (including reasonable attorneys' fees and costs) caused by the breach, and all other remedies provided by the Provider Agreement and applicable Law.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014201

Miscellaneous

Assignment

Neither party may assign the Agreement without the prior written consent of the other party; provided, however, that Caremark may, without consent, assign the Agreement to any direct or indirect parent, subsidiary, or affiliated company or to a successor company.

Any permitted assignee shall assume all obligations of its assignor under the Agreement. The Agreement shall inure to the benefit of and be binding upon each party, its respective successors and permitted assignees.

If Provider's proposed assignment is approved by Caremark, Provider covenants that Provider shall enter into an agreement with such permitted successor or permitted assignee assigning Provider's rights and obligations under the Agreement in form and substance acceptable to Caremark, including naming Caremark as an express third-party beneficiary thereof. Notwithstanding an approved assignment and a permitted successor's or permitted assignee's assumption of Provider's liabilities and obligations under the Agreement, Provider will remain jointly liable for any liabilities and obligations under the Agreement until such permitted successor or permitted assignee satisfies such liabilities and obligations in full.

The terms of this **Assignment** section apply notwithstanding any other provision in the Agreement.

Independent Contractors and Third-Party Beneficiaries

Caremark and Provider are considered independent contractors, and shall have no other legal relationship under or in connection with the Provider Agreement. Neither party will act as or be deemed a representative of the other party for any reason whatsoever.

Except as otherwise provided for in the Provider Agreement, including but not limited to, the **Indemnification** and **Arbitration** sections, no term or provision in the Provider Agreement is for the benefit of any person who is not a party to the Provider Agreement, and no such party shall have any right or cause of action under the Provider Agreement.

Court Orders, Subpoenas or Governmental Requests

If Caremark receives a court order, subpoena or governmental request relating solely to Provider, Caremark may comply with such order, subpoena or request, and Provider must indemnify and hold harmless Caremark for, from, and against any and all costs (including reasonable attorneys' fees and costs), losses, damages, or other expenses Caremark may suffer or incur in connection with the responding to such order, subpoena or request.

If Provider is requested or required to disclose any Confidential Caremark Information, whether by oral questions, interrogatories, requests for information or documents, subpoenas, or other processes, Provider must promptly provide Caremark with written notice of any such request or requirement so that Caremark may seek an appropriate protective order or other appropriate remedy. If such protective order or other remedy is not obtained, Provider will disclose only that portion of the Confidential Caremark Information as to which it has been advised by legal counsel that disclosure is required by Law; and Provider must exercise its best efforts to obtain reliable assurances that confidential treatment will be accorded to the Confidential Caremark Information that is disclosed in response to such requests or requirements.

Notices

A notice pursuant to the Provider Agreement to Caremark must be in writing, be delivered in person by certified mail, courier, or first class mail, and be addressed to Network Management at Caremark at the address below:

Caremark
Attn: Network Management, MC080
9501 East Shea Boulevard
Scottsdale, AZ 85260

Any notice to Caremark must also be addressed and delivered to:

Caremark
Attn: General Counsel, MC035
9501 East Shea Boulevard
Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014202

A notice pursuant to the Provider Agreement to Provider must be in writing, delivered in person by certified mail, courier, or first class mail, at the street, mailing, or check mailing address set forth in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark. Notwithstanding the foregoing, Caremark may give notice to Provider (1) via the claims adjudication system; (2) by facsimile via the Provider's facsimile number, or by e-mail via the e-mail address provided by Provider in Provider's enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark; or (3) via Caremark's Pharmacy Portal.

Notices are deemed received on the date of delivery to the other party when delivered in person, by courier, by e-mail, by facsimile, by secure electronic message, by certified mail, or when posted via Caremark's Pharmacy Portal. If notice is sent by first class mail, the notice is deemed received on the third business day after the date such notice was mailed.

By participating as a provider in Caremark's networks, Provider acknowledges that it has a prior express business relationship with Caremark and consents to receive facsimile communications as well as automated messages from Caremark.

The terms of this **Notices** section apply notwithstanding any other provision in the Provider Agreement.

Amendments

From time to time, and notwithstanding any other provision in the Provider Agreement (which includes the Provider Manual), Caremark may amend the Provider Agreement, including the Provider Manual or other Caremark Documents, by giving notice to Provider of the terms of the amendment and specifying the date the amendment becomes effective. If Provider submits claims to Caremark after the effective date of any notice or amendment, the terms of the notice or amendment is accepted by Provider and is considered part of the Provider Agreement.

Enforceability

In the event that any provision or term set forth in the Provider Agreement is determined invalid or unenforceable, such invalidity and unenforceability will not affect the validity or enforceability of any other provision or term set forth in the Provider Agreement.

Arbitration

Any and all disputes between Provider and Caremark [including Caremark's current, future, or former employees, parents, subsidiaries, affiliates, agents and assigns (collectively referred to in this Arbitration section as "Caremark")], including but not limited to, disputes in connection with, arising out of, or relating in any way to, the Provider Agreement or to Provider's participation in one or more Caremark networks or exclusion from any Caremark networks, will be exclusively settled by arbitration. This arbitration provision applies to any dispute arising from events that occurred before, on or after the effective date of this Provider Manual. Unless otherwise agreed to in writing by the parties, the arbitration shall be administered by the American Arbitration Association ("AAA") pursuant to the then applicable AAA Commercial Arbitration Rules and Mediation Procedures including the rule governing Emergency Measures of Protection (available from the AAA). In no event may the arbitrator(s) award indirect, consequential, or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, injury to reputation, or loss of customers or business, except as required by Law. The arbitrator(s) shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of the agreement to arbitrate, including, but not limited to, any claim that all or part of the agreement to arbitrate is void or voidable for any reason. The arbitrator(s) must follow the rule of Law, and the award of the arbitrator(s) will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. Any such arbitration must be conducted in Scottsdale, Arizona and Provider agrees to such jurisdiction, unless otherwise agreed to by the parties in writing. Discovery shall be limited to documents and information for which there is a direct, substantial, and demonstrable need and where such documents and information can be located and produced at a cost that is reasonable in the context of all surrounding facts and circumstances. Further, when the cost and burden of e-discovery are disproportionate to the likely importance of the requested materials, the arbitrator may deny the requests or require that the requesting party advance the reasonable cost of production to the other side. The expenses of arbitration, including reasonable attorney's fees, will be paid for by the party against whom the final award of the arbitrator(s) is rendered, except as otherwise required by Law.

Arbitration with respect to a dispute is binding and neither Provider nor Caremark will have the right to litigate that dispute through a court. In arbitration, Provider and Caremark will not have the rights that are provided in court, including the right to a trial by judge or jury. In addition, the right to discovery and the

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014203

right to appeal are limited or eliminated by arbitration. All of these rights are waived and disputes must be resolved through arbitration.

No dispute between Provider and Caremark may be pursued or resolved as part of a class action, private attorney general or other representative action or proceeding (hereafter all included in the term "Class Action"). All disputes are subject to arbitration on an individual basis, not on a class or representative basis, or through any form of consolidated proceedings, and the arbitrator(s) will not resolve Class Action disputes and will not consolidate arbitration proceedings without the express written permission of all parties to the Provider Agreement. Provider and Caremark agree that each may pursue or resolve a dispute against the other only in its individual capacity, and not as a plaintiff or class member in any purported Class Action.

Except as may be required by Law, neither a party nor an arbitrator(s) may disclose the existence, content or results of any dispute or arbitration hereunder without the prior written consent of both parties. In the event a Provider is required by law to make such a disclosure, Provider shall notify Caremark five (5) business days in advance of such disclosure.

Prior to a party initiating an arbitration, such party shall request in writing to the other party ("Dispute Notice") a meeting of authorized representatives of the parties for the purpose of resolving the dispute. The parties agree that, within ten (10) days after issuance of the Dispute Notice, each party shall designate a representative to participate in dispute resolution discussions which will be held at a mutually acceptable time and place (or by telephone) for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner. If despite the good faith efforts of the parties, the authorized representatives of the parties are unable to resolve the dispute within thirty (30) days after the issuance of the Dispute Notice, or if the parties fail to meet within such thirty (30) days, either party may, by written notice to the other party, submit the dispute to binding arbitration. The above notwithstanding, nothing in this provision shall prevent either party from utilizing the AAA's procedures for emergency relief to seek preliminary injunctive relief to halt or prevent a breach of this Provider Agreement.

The terms of this arbitration section apply notwithstanding any other or contrary provision in the Provider Agreement, including but not limited to, any contrary language in any **Third Party Beneficiary** provision. This Arbitration section survives the termination of the Provider Agreement and the completion of the business relationship between Provider and Caremark. This arbitration agreement is made pursuant to a transaction involving interstate commerce, and shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Force Majeure

Caremark and Provider are excused from performance under the Provider Agreement to the extent that either Caremark or Provider is prevented from performing all or any part of the Provider Agreement as a result of causes that are beyond the affected party's reasonable control, including but not limited to, fire, flood, earthquakes, tornadoes, other acts of God, war, work strikes, civil disturbances, power or communications failure, court order, government intervention, a change in Law, a significant change in the industry, or third-party nonperformance.

Anti-Kickback Statute, Stark Law, and Caremark Compliance Program

Each party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C § 1320a-7b(b) ("Anti-Kickback Statute"), or the federal "Stark Law," set forth at 42 U.S.C § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Provider Agreement. In addition, Caremark's Code of Conduct and policies and procedures on the Anti-Kickback Statute and Stark Law may be accessed at **www.caremark.com/pharminfo.**

Pursuant to Caremark's obligations under a Corporate Integrity Agreement (CIA) with the Office of Inspector General of the United States Department of Health and Human Services dated March 25, 2014, Provider agrees to access the CIA through this website **https://oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp** upon enrollment, and Provider shall review the CIA in its entirety on an annual basis thereafter. Provider shall immediately notify Caremark in writing if Provider does not comply with the requirement to annually access and review the CIA in its entirety.

Rebate Programs

Caremark has the right to submit all prescriptions relating to the Provider Agreement to pharmaceutical companies in connection with Caremark's rebate programs and any similar programs. Provider must not submit any of the prescriptions relating to the Provider Agreement to any pharmaceutical company for the purpose of receiving any

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014204

rebate, discount or the like, except as authorized by Caremark in writing.

Eligible Person Communications

Provider understands and acknowledges that Caremark may communicate with Eligible Persons as required by Plan Sponsor, applicable Law, or as Caremark determines is necessary regarding matters such as plan benefits, network design and composition, formulary and clinical issues, and manufacturer recalls.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014205

Medicaid

To the extent Provider provides Pharmacy Services to a Medicaid Eligible Person and without limiting any other provision in the Agreement (including the Provider Manual), Provider must, at minimum, comply with the following terms:

Claims Submission Requirements for Medicaid

Additional Plan Sponsor-specific information, such as claims submission requirements for 340B drugs, may apply as specified in notices to Provider or in the Caremark Payer Sheets. Refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.

Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicaid Eligible Person is made, in whole or in part, from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable states laws including minimum standards of pharmacy practice. Refer to the Federal and State Laws and Regulations section of the Provider Manual, including state-specific addenda. Provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. [42 C.F.R. 438.230(c)(2)]. Provider acknowledges that Provider's ability to provide Pharmacy Services under the Agreement for Medicaid Eligible Persons may be revoked if it is determined that Provider has not performed satisfactorily [42 C.F.R. 438.230(c)(1)(iii)].

Compliance Program

Provider shall maintain a compliance program in accordance with 42 C.F.R. 438.608 to detect fraud, waste, and abuse.

Medicaid Coordination of Benefits

Medicaid is typically the payer of last resort, which pays after any other applicable primary programs have been billed. Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any coordination of benefit requirements, and must engage in appropriate COB activities to the extent required by Caremark, or applicable by Law.

Refer to the **Coordination of Benefits** section of the Provider Manual. For complete technical information on COB, refer to the Payer Specification Sheets located at **www.caremark.com/pharminfo**.

Medicaid Credentialing and Quality Management

Provider shall comply with Caremark's credentialing and quality management requirements. Provider must provide Caremark with documentation and other information that is required to comply with "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E); otherwise, Provider may be subject to termination or other available remedies. Refer to the **Credentialing and Quality Management** section of the Provider Manual for additional information.

Provider must allow CMS, its agents, its designated contractors (e.g., recovery audit contractors), or the applicable state Medicaid agency to conduct unannounced on-site inspections of Provider's location(s). 42 C.F.R. § 455.432.

Cultural Competency

Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. § 438.206(c)(2).

Denial of Services

Provider must not deny services to an Eligible Person on account of such individual's inability to pay the Patient Pay Amount to the extent consistent with applicable Law.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014206

Directories

Provider shall provide Caremark with all information that may be needed in connection with Caremark's initiatives to comply with 42 C.F.R. 438.10 concerning pharmacy directories.

Enrollment with State Medicaid

Pursuant to 42 C.F.R. 438.602(b), Provider shall ensure that it is enrolled with each state Medicaid for which Provider provides Pharmacy Services under the Agreement. Provider agrees that if it is not enrolled with the applicable state Medicaid program, it may not provide Pharmacy Services under the Agreement for that state Medicaid's enrollees.

Inspection and Audit of Records and Access to Facilities

Pursuant to 42 C.F.R. 438.3(h), Provider shall allow a state Medicaid program, CMS, the Office of the Inspector General, the Comptroller General, and their designees, to, at any time, inspect and audit any records or documents of Provider, and inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for ten (10) years from the final date of the Agreement or from the date of completion of any audit, whichever is later. See also 42 C.F.R. 438.230(c)(3).

Prescriber Identification

Accurate Prescriber identification in claims submission is critical as Caremark relies upon the information such as in claims adjudication, clinical services, Plan Sponsor initiatives, and audits. A valid and active individual Prescriber National Provider Identifier (NPI) is required on all claims, and failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the original hard copy for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI or DEA number which does not represent a prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit ~~a valid~~an appropriate submission clarification code (SCC) to bypass the reject.

Commented [PT23]: 11/16 – per Heather Graham

Prior Authorization

Where permitted by applicable state Law and the Plan Sponsor, Provider is authorized to dispense a limited number of days supply of medically necessary Covered Items if the Prescriber is unavailable to process a prior authorization request within a reasonable time period. Plan Sponsor-specific processes and contact information may apply as indicated in Caremark Documents.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

Medicaid Roster Identification

Providers must be enrolled under the Medicaid state plan as a participating provider per Section 1902 (kk)(7)(A) (42 U.S.C 1396a).

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014207

Medicare Advantage

To the extent Provider provides Pharmacy Services for an Eligible Person for a claim covered by a Plan Sponsor that is a Medicare Advantage plan, Provider must comply with the following terms, if applicable:

1. The Department of Health and Human Services, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information including books, contracts, computer or other electronic systems, including medical records, and documentation related to CMS' contract with Plan Sponsor for a period of ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. 42 C.F.R. 422.504(i) (2)(i) and (ii).
2. Provider must safeguard the privacy and confidentiality, and assure the accuracy, of beneficiary health records in accordance with CMS requirements, including 42 C.F.R. 422.118; 42 C.F.R. 422.504(a)(13).
3. Provider may not hold an Eligible Person liable for payment of fees that are the legal obligation of the Plan Sponsor. 42 C.F.R. 422.504(g)(1)(i); 422.504(i)(3)(i).
4. Any services performed will be consistent and comply with the Plan Sponsor's contractual obligations to CMS. 42 C.F.R. 422.504(i)(3)(iii).
5. Provider will be paid in compliance with the requirements of 42 C.F.R. 422.520; 42 C.F.R. 422.520(b).
6. Caremark and a Plan Sponsor may approve, suspend, or terminate the Agreement with respect to Provider's provision of Pharmacy Services for a Medicare Advantage Plan Sponsor. 42 C.F.R. 422.504(i)(5).
7. Caremark and Plan Sponsor have the right to revoke the Provider Agreement with respect to delegated activities performed or to seek other remedies in lieu of termination as provided in the Provider Agreement if Caremark, CMS or the Plan Sponsor determines that Provider has not performed its obligations satisfactorily. 42 C.F.R. 422.504(i)(4)(ii).
8. Caremark and Plan Sponsor will monitor Provider's performance hereunder on an ongoing basis. 42 C.F.R. 422.504(i)(4)(iii).
9. Caremark and Plan Sponsor will review the credentials of medical professionals affiliated with Provider. Caremark and Plan Sponsor will also review and approve the credentialing process, including audits of the credentialing process on an ongoing basis. 42 C.F.R. 422.504(i)(4)(iv).
10. Provider must comply with applicable Medicare laws and regulations and CMS instructions, and to allow audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of ten (10) years. 42 C.F.R. 422.504(i)(4)(v) and MMA Manual, Chapter 11, Section 100.4.
11. Provider must hold Eligible Persons harmless for payment of fees that are the legal obligation of the Plan Sponsor to fulfill. Such provision will apply, but will not be limited to, insolvency of Caremark or Plan Sponsor contract breach, and Provider billing. Medicare Managed Care Manual, Ch 11 (Medicare Advantage), Section 100.4.
12. Provider agrees that Caremark and Plan Sponsor oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations. 42 C.F.R. 422.504(i)(4)(iii).
13. Provider must not discriminate in the furnishing of benefits on the basis of any factor that is related to health status in accordance with 42 C.F.R. 422.110(a).
14. Provider must comply with the Plan Sponsor's policies and procedures and written standards, which in accordance with 42 C.F.R. 422.112(a)(6) require:
    a. timely access to care and member services, which is continuously monitored to ensure compliance and that Caremark and Plan Sponsor will take corrective action as necessary;
    b. compliance with the Plan Sponsor's coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations; and
    c. Provider consideration of beneficiary input into Provider's proposed treatment plan.
15. Provider must ensure that its Pharmacy Services are available 24 hours a day, 7 days a week, when medically necessary. 42 C.F.R. 422.112(a)(7).
16. Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014208

422.112(a)(8).

17. Provider must provide effective and continuous patient care and quality review, and maintain health records in accordance with standards established by the Plan Sponsor, taking into account professional standards and that there is appropriate and confidential exchange of information with other network providers. 42 C.F.R. 422.112(b)(4).
18. Provider must establish procedures to ensure that Eligible Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and systems to address barriers to Eligible Person compliance.
19. Nothing in the Agreement shall be construed as requiring Provider to indemnify Caremark or a Plan Sponsor against any civil liability for damage caused to an Eligible Person as a result of a Plan Sponsor's denial of medically necessary care to such Eligible Person.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014209

Medicare Part D

A. Medicare Part D Network Standards

To the extent Provider provides Pharmacy Services to a Part D Enrollee, Provider must comply with the following terms contained in this **Medicare Part D Network Standards** section of the Provider Manual. Unless specifically indicated otherwise, these terms apply to all providers who provide Pharmacy Services to a Part D Enrollee (including retail, home infusion, long-term care, and Indian Health Services/Tribal/Urban Providers). Provider acknowledges that CVS Caremark Part D Services, L.L.C. together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this section) are responsible for providing Part D services on behalf of Part D Plan Sponsors. All capitalized terms used in this **Medicare Part D Network Standards** section will have the same meaning as in the applicable **Addendum to the Caremark Provider Agreement: Terms of Participation in Medicare Part D,** or the **Glossary of Terms** in the Provider Manual.

Part D Reference Guide for Pharmacists

Refer to the following website: **http://www.cms.gov/Medicare/Medicare.html**which contains helpful information on a variety of Medicare Part D topics for providers. CMS occasionally updates this document, so check periodically for the latest information.

Network Participation

For any Part D plan year, and to ensure adequate access to network pharmacies for Part D Enrollees, Provider must provide Caremark with written notice by no later than March 31st of the prior calendar year if Provider will not be participating in a Medicare Part D network, including but not limited to, the retail, long-term care, and home infusion networks, for that plan year. For example, if Provider will not be participating in the Medicare Part D retail pharmacy network for the 2019 plan year, it must notify Caremark in writing by no later than March 31, 2018. If such timely written notice is not given, Provider must participate in such Medicare Part D network for the entire Part D plan year unless Provider terminates with cause its participation in accordance with the Provider Agreement.

The terms of this **Network Participation** section supersede and amend any inconsistent or contrary provision in the Provider Agreement, including the **Termination Without Cause** section of the Provider Manual, but will only apply to the extent that this section is consistent with a Part D Plan Sponsor requirement.

The deadlines set forth in this **Network Participation** section do not apply to Medicare Part D network solicitations to participate in a new Medicare Part D network for which the deadline for participation will be as stated in such Caremark written solicitation.

Compliance with Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Part D Enrollee is made, in whole or in part, from federal funds, and subjects Provider to laws, such as but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with minimum standards of pharmacy practice under applicable state law.

Plan Identification Cards

Provider must submit claims to the claims adjudication system whenever the Part D Enrollee's plan identification card is presented to or on file with Provider, unless the Part D Enrollee expressly requests that a particular claim not be submitted.

Delegated Activity

Provider must obtain prior written approval from Caremark if Provider wishes to delegate any activity or responsibility related to its Pharmacy Services to a subcontractor. Upon Caremark's written approval of such delegation, Provider must obtain written agreement from such subcontractor that the subcontractor will comply with all of the terms and conditions of the Provider Agreement (which includes the Provider Manual) applicable to Provider, including but not limited to, the requirement to comply with the contractual obligations specified for downstream entities in 42 C.F.R. 423.505(i)(2) and (i)(3) that relate to, among other things, retention of books and records, including prescription records, for at least ten (10) years or longer as specified in 42 C.F.R. 505(i)(2), the **Federal Health Care Programs Provider Participation Exclusion, Claims Submission,** and the **Professional Audits** sections of the Provider Manual. Provider's written agreement with subcontractor must provide that the agreement and/or delegated activities

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014210

may be revoked (or specify other remedies) in instances when CMS, Part D Plan Sponsor, or Caremark or any of Caremark's subsidiaries or affiliates determines that the subcontractor has not performed satisfactorily. In the event that any subcontractor is terminated by CMS or Part D Plan Sponsor, Provider must immediately notify Caremark of such termination.

Offshore Subcontracting

If Provider or any of Provider's subcontractors (or downstream subcontractors) receive, process, transfer, handle, store, or access Protected Health Information (PHI) of Part D Enrollees outside the United States or one of the United States Territories, Provider agrees to notify Caremark and to comply with the requirements specified in CMS memorandum of July 23, 2007, entitled "Sponsor Activities Performed Outside of the United States (Offshore Subcontracting)", to enable Caremark or Caremark's Part D Plan Sponsors to complete the "Attestation Concerning the Use of Offshore Contractors" form contained in the July 23, 2007, CMS memorandum in accordance with CMS requirements, which includes, but is not limited to, providing to Caremark information of Provider's own or Provider's offshore subcontractor operations, safeguards to protect PHI, and auditing to ensure protection of PHI.

Marketing

Provider must conduct marketing activity in a manner consistent with the Medicare regulation and guidelines. Provider must remain neutral when assisting beneficiaries with enrollment decisions in an objective assessment of his/her needs and potential options to meet those needs.

Commented [PT24]: 2019 PM Supplement

~~Provider must comply with all CMS Medicare marketing requirements, including but not limited to, the Marketing Guidelines applicable to the marketing of Medicare Advantage Prescription Drug Plans, Prescription Drug Plans, Employer/Union-Sponsored Group Health Plans and Medicare-Medicaid Plans. Consistent with CMS Marketing Guidelines, Provider must remain neutral when assisting with Part D Enrollee enrollment decisions. Provider must assist a Part D Enrollee in an objective assessment of his/her needs and potential options to meet those needs.~~

Performance Monitoring

Provider understands that Caremark and Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis. Provider must cooperate with Caremark and Part D Plan Sponsor as necessary to support Caremark and Part D Plan Sponsor monitoring strategies, including but not limited to, allowing Caremark and Part D Plan Sponsor to inspect, evaluate and audit Provider's documents and records.

Auto-Ship Refill Programs

Per CMS guidance, Part D Enrollees must only receive new prescriptions and refills that are requested. Provider must obtain patient consent for each prescription that is not initiated by the Part D Enrollee, whether for the initial prescription or a refill. Such confirmation is unnecessary when the Part D Enrollee personally initiates the refill or new prescription request. This requirement does not affect retail refill reminder programs that require the Part D Enrollee to pick up the prescription and does not apply to Long-term Care pharmacy dispensing and deliveries.

Fraud, Waste and Abuse Program

Provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Compliance Program Guidelines to prevent, detect and correct Fraud, Waste and Abuse (FWA), and a Part D Plan Sponsor's policies and procedures, training, and corrective action plans related to the program. Provider must submit copies of Provider's training documentation, policies and procedures, and corrective actions related to Part D activities as requested by Caremark. Provider must cooperate fully with a Part D Plan Sponsor FWA investigative activities including providing copies of prescriptions, signature logs, and other related documentation to support FWA investigations.

Annual FWA Training and General Compliance Training

To comply with CMS regulations, Provider must complete both General Compliance Training and Fraud, Waste, and Abuse Training. DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) organizations are only required to complete the Compliance portion of the training. Provider may take training on the CMS Medicare Learning Network (MLN) website or may incorporate the unmodified CMS training into a company training. Provider must confirm annually that every employee satisfactorily completed the required training by submitting the Caremark training attestation. Failure to complete the Caremark attestation within the required timeframe will result in the assessment of a non-compliance fee of $1,500. Refer to **Appendix C** in the Provider Manual for additional

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

information.

Pharmacy Certification for Medicare Part D Pharmacies

Provider agrees to comply with the following provisions:

1. Provider has reviewed the OIG LEIE and the SAM exclusion list as required by the **Federal Health Care Programs Participation Exclusion: Pharmacy** section of the Provider Manual.
2. Provider has a record retention policy in place that complies with CMS's 10-year record retention requirement or pursuant to other applicable state law.
3. Provider has in place and provides FWA training to all employees and managers (who are directly or indirectly involved with the administration of delivery of Part D benefits) within thirty (30) days of their date of hire and annually thereafter.
4. Provider tracks employee and manager attendance for any training conducted.
5. Provider must provide a copy of the training materials upon request.
6. Provider attests that if any services that support the Provider Agreement or if any of its subsidiaries or affiliates are delegated, the performance of those services is monitored by Provider to ensure compliance with the applicable Medicare Part D requirements.
7. Provider has entered into written arrangements with its subcontractors which provide for revocation of the delegation activities or specify other remedies in instances when CMS or Caremark or any of its subsidiaries or affiliates has determined that the parties have not performed satisfactorily.
8. Provider certifies that it is free of any conflicts of interest (within the meaning of the CMS Prescription Drug Benefit Manual, Chapter 9) in administering or delivering its Pharmacy Services, and will require its managers, officers and directors responsible for the administration or delivery of Pharmacy Services for Part D Enrollees to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any such conflict of interest (within the meaning of the CMS Prescription Drug Benefit Manual, Chapter 9).

Drug Pricing

Notwithstanding anything to the contrary, Caremark utilizes Medi-Span as reference for drug prices. Drug price files are updated every business day. An initial update to the drug price file occurs on January 1, or the following business day each year. Point-of-service claims are adjudicated, and Provider is reimbursed in accordance with these updates.

Provider may access the Caremark Pharmacy Portal at **https://rxservices.cvscaremark.com** to receive advance notice of changes to MAC for Medicare Part D Claims.

Payment of Clean Claims

In accordance with 42 C.F.R. § 423.520, payment for clean claims (that have been determined to be eligible for payment) will be made to Provider within fourteen (14) days (for electronically submitted claims), or thirty (30) days (for non-electronically submitted claims) from the date the claim is received, except for mail order and LTC pharmacies. A clean claim is defined as a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. Claims from a provider whose participation status has been suspended, in accordance with the **Provider Suspension** section of the Provider Manual, are not eligible for payment unless and until such time as provider's suspension has been lifted and any offset against amounts owed to Caremark has been processed.

Electronic Prescribing

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires Part D Plan Sponsors to establish electronic prescription drug programs that provide for the electronic transmittal of prescription and prescription-related information to the Prescriber and the dispenser in accordance with the final standards specified by CMS.

Providers engaged in e-prescribing must do so in accordance with all CMS and Part D E-Prescribing standards and requirements and use the NCPDP Prescriber/Pharmacist Interface SCRIPT Standard version and Implementation

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014212

Guide as specified by CMS for certain e-prescribing transactions with Prescribers (e.g., responding to receipt of a new electronic prescription and sending electronic refill requests, as well as to communicate medication history).

Refer to the following web address for specific e-prescribing requirements and their applicable compliance dates: **http://www.cms.hhs.gov/EPrescribing/**.

Additional information is also available in Section 50 of Chapter 7 of the Medicare Part D Prescription Drug Manual, **http://www.cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/Downloads/Chapter7.pdf.**

Prescription Origin Code

Provider must use the Prescription Origin Code when submitting all Medicare Part D claims. Original fill claims submitted without one of the values below will be rejected.

The Prescription Origin Code should be placed in the 419-DJ field, and the following values should be used:

1 = Written

2 = Telephone

3 = Electronic

4 = Facsimile

5 = Pharmacy

The Fill Number should be placed in the 403-D3 field, and the following values should be used:

ØØ= Original dispensing

Ø1 to 99 = Refill number

Prescriber Identification for Medicare Part D Claims

Pursuant to CMS regulations (CMS-4157 – Final Rule), identification of the Prescriber requires a valid and active National Provider Identifier (NPI). For all Medicare Part D claims, accurate Prescriber identification in claims submission is critical as Caremark relies upon the information such as in claims adjudication, clinical services, Plan Sponsor initiatives, and audits. A valid and active individual Prescriber National Provider Identifier (NPI) is required on all claims, and failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the original hard copy for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI or DEA number which does not represent a prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit ~~a valid~~an appropriate submission clarification code (SCC) to bypass the reject. Per CMS, Part D Plan Sponsors are required to only report Type 1 (Individual) NPIs on PDE records. Type 2 (group/organizational identifier) NPIs are not accepted. Providers must obtain an individual NPI. Any claim submitted with an invalid NPI will reject with the following or similar reject message:

Commented [PT25]: 11/16 – per Heather Graham

Reject Code	Reject Message
A2	Plan's Prescriber database indicates Prescriber ID submitted is associated with a deceased Prescriber and the Date of Fill/Service of the claim is one year after the deceased date for a non-controlled substance or the Date of Fill/Service of the claim is 180 days after the deceased date for controlled substance
42	Plan's Prescriber database indicates the Prescriber ID submitted is inactive or expired
43	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID is inactive
44	Plan's Prescriber database indicates the associated DEA to the submitted Prescriber ID is not found
46	Plan's Prescriber database indicates associated DEA to submitted Prescriber ID does not allow this drug DEA class
56	Plan's Prescriber database indicates the Prescriber ID submitted is not found

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014213

619	Plan's Prescriber database indicates the Prescriber qualifier is not equal to 01

Below are the various SCC values that may be used for the invalid Prescriber ID rejects once Provider has confirmed the ID submitted is valid and the reject is not appropriate (still subject to audit review and chargeback):

Reject Code	SCC Value
A2	42 - The Prescriber ID submitted has been validated and is active
42	42 - The Prescriber ID submitted has been validated and is active
43	43 - For the Prescriber ID submitted, associated prescriber DEA Renewed, or In Progress, DEA Authorized Prescriptive Rights OR 45 - For the Prescriber ID submitted, associated DEA is a valid Hospital DEA with Suffix
44	43 - For the Prescriber ID submitted, associated prescriber DEA Renewed, or In Progress, DEA Authorized Prescriptive Rights OR 45 - For the Prescriber ID submitted, associated DEA is a valid Hospital DEA with Suffix
46	46 - For the Prescriber ID submitted and associated prescriber DEA, the DEA has authorized prescriptive rights for this drug DEA Class
56	42 - The Prescriber ID submitted has been validated and is active
619	42 - The Prescriber ID submitted has been validated and is active

For additional information on identification of a foreign Prescriber, refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.

Medicare Part D Calls to the Pharmacy Help Desk

The Pharmacy Help Desk interactive voice response (IVR) system immediately routes Medicare Part D inquiries to appropriate information/pharmacy service representatives through an initial request/prompt to discover if Provider is calling on behalf of a Part D Enrollee or about a Medicare Part D Claim.

Provider will be routed to a specialized team prepared to handle and resolve Medicare Part D inquiries. If the Part D Enrollee does not have an ID card available, ask for an acknowledgement letter. If an acknowledgement letter is not available, consider calling 1-800-MEDICARE (1-800-633-4227), or send an enhanced E1 transaction to determine the processing information.

The Pharmacy Help Desk numbers are provided below:

Caremark System	RXBIN	Pharmacy Help Desk Number	Point-of-Service Assistance B vs D
Legacy ADV	004336*	1-866-693-4620	
Legacy PCS	610415*	1-800-345-5413	
FEP	610239*	1-800-364-6331	
Legacy CRK	610029*	1-800-421-2342	
Caremark	610591	As communicated by plan or refer to ID card	
SilverScript	004336*	1-866-693-4620	1-855-503-6054
Non-SilverScript	004336*	As communicated by plan or refer to ID card	1-855-238-9379
NEJE (New England Joint Enterprise)	004336*	1-866-693-4620	1-844-635-3407

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014214

Aetna	610502	1-800-238-6279	

Secondary RXBINS and Plan sponsor-specific RXBINs and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at **www.caremark.com/pharminfo**.

*Puerto Rico Providers call toll-free 1-800-842-7331.

Pharmacy Help Desk representatives will use reasonable efforts to assist Providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with the respect to the provision of Pharmacy Services. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

Federal Health Care Programs Participation Exclusion

Prescriber

In accordance with CMS guidance, Part D Plan Sponsors must have policies and procedures in place to implement a comprehensive program to detect, prevent and control fraud, waste and abuse, including a process to identify any claims that were submitted for drugs that were prescribed by an excluded Prescriber, and a process to report and properly repay any overpayments resulting from inaccurate payments in accordance with CMS policy. The guidance also states that Part D Plan Sponsors must not pay for drugs prescribed by a Prescriber excluded by either the HHS OIG or SAM.

Caremark implemented an automated point-of-sale process to deny Part D Claims for drugs prescribed by excluded Prescribers. Provider may receive the following reject:

<<Prescriber is an OIG Excluded Prescriber>>

If Provider receives this electronic message, do not resubmit the claim for processing unless, in Provider's professional judgment, it is an emergency situation. If it is an emergency situation, call the appropriate Pharmacy Help Desk contact number referenced in this section.

The Caremark point-of-sale reject is intended to assist Provider in the identification of excluded Prescribers, but does not serve as a substitute for the Provider's own comprehensive program. Provider must maintain a comprehensive program to identify claims prescribed by an excluded Prescriber in the event that a point-of-sale reject does not occur.

Pharmacy Provider

Provider must review the OIG LEIE and the SAM exclusion lists. Provider must not submit any claim to Caremark for a prescription dispensed by Provider if Provider is excluded or debarred from participation in any Federal health care program. Provider agrees that any claim submitted to in violation of this section is subject to chargeback. Refer to the **Federal Health Care Programs Participation Exclusion: Pharmacy** and **Federal Health Care Programs Participation Exclusion: Prescriber** sections of the Provider Manual.

General Procedures for Acknowledgement Letters

In order to comply with CMS requirements, Providers should honor Part D Enrollee acknowledgement of enrollment letters if presented to Provider in place of identification cards.

An acknowledgement letter is a letter that qualified Part D Enrollees receive from their Part D Plan in advance of the distribution of Part D Plan identification cards. The letter should contain sufficient information in order to verify a Part D Enrollee's eligibility and to submit claims to the appropriate location in order for adjudication to occur. Note, letters confirming initial information was received but has yet to be confirmed or processed may not constitute a Part D acknowledgement letter.

If there is insufficient/inaccurate information on the letter or if the claim rejects, the following steps may be useful whether the information was obtained from an acknowledgement letter, an identification card or from the Part D Enrollee directly:

- If a Part D Enrollee's eligibility cannot be verified, send an enhanced E1 transaction to the Transaction Facilitator (RelayHealth) to verify the Part D Enrollee eligibility and to obtain information necessary to process claims. It is Provider's responsibility to verify Part D Enrollee is the Part D Enrollee identified in the response.
- If a Part D Enrollee's eligibility cannot be verified in Step 1 but Caremark is the processor, contact the appropriate Pharmacy Help Desk phone number (listed in the front of the Provider Manual and in a table

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014215

above in this section).

- If a Part D Enrollee's eligibility cannot be verified in Step 2, call 1-800-MEDICARE to verify the Part D Plan under which the Part D Enrollee is enrolled, and if possible, verify the Part D Enrollee's eligibility information.

Medicare Part D Claims Requiring Overrides

Natural Disasters

Caremark is dedicated to assisting Providers and Part D Enrollees in response to emergencies resulting from natural disasters, severe weather, etc., where medical records are either destroyed or not accessible. In the event of a presidential (or other governmental) emergency declaration, Caremark will allow a specific submission clarification code to override the refill-too-soon edit for Eligible Persons impacted within the disaster area. A value of '13' in the submission clarification code field, 420-DK, and the displaced Eligible Person's zip code impacted by the disaster (zip code may not be where Eligible Person resides) in field 325-CP, will allow an override without requiring a call to the Help Desk. Permission may vary by Plan Sponsor. If you need assistance, call the Pharmacy Help Desk. Refer to the **Medicare Part D Calls to the Pharmacy Help Desk** section of the Provider Manual for contact information.

Network Access

Some Part D Enrollees are allowed by their Part D Plan to obtain prescriptions at out-of-network pharmacies. However, Part D Enrollees may be required to submit paper claims for reimbursement for eligible out-of-network expenses and provide documentation as to why the claims were filled at an out-of-network pharmacy. There are no changes to this process for Part D Enrollees residing in the emergency area.

Refill-Too-Soon and Excessive Utilization Rejects

CMS will ensure that rules that prevent early refills are waived. This will assist those Part D Enrollees who left or lost their prescription during emergencies.

Dispensing Limitations

Claims submitted to Caremark that exceed Plan limits for the days supply or quantity dispensed will reject with the message, "Plan Limitations Exceeded." The reject message includes the actual limits such as, "Maximum Days Supply=34" or "Quantity Limit=100". Any claims resubmitted must be entered with the accurate quantity and days supply. If the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-day supply), and rejects as stated, Provider must call the Pharmacy Help Desk to request an override and resubmit the claim utilizing that quantity and the accurate days supply. Provider maintains responsibility to adhere to appropriate refill intervals. Provider must document the details of the override granted by the Pharmacy Help Desk on the hard copy

Best Available Evidence

CMS created the Best Available Evidence (BAE) policy requiring Part D Plans to establish the appropriate cost-sharing for low-income Part D Enrollees when presented with evidence that the Part D Enrollee's information was not accurate. As a result, a CMS best practice is for Providers and Part D Plans to work to resolve these issues at the point of sale when Part D Enrollees present appropriate evidence of correct low-income status.

Provider should initiate the BAE process in order for a change to a Part D Enrollee's low-income status to occur, if Provider is presented with one or more of the following acceptable forms of evidence from Part D Enrollees:

- A copy of the Part D Enrollee's Medicaid card which includes the Part D Enrollee's name and an eligibility date during the discrepant period;
- A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
- A copy of a state document that confirms active Medicaid status during the discrepant period;
- A print out from the State electronic enrollment file showing Medicaid status during the discrepant period;
- A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
- Other documentation provided by the State showing Medicaid status during the discrepant period.

In addition, any one of the following forms of evidence from Part D Enrollees may establish that they are institutionalized and qualify for zero cost-sharing:

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014216

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

Acceptable documents that may be used as BAE for demonstrating receipt of Home and Community-Based Services (HCBS) include:

- A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the Part D Enrollee's name and HCBS eligibility date during a month after June of the previous calendar year;
- A copy of a State-approved HCBS Service Plan that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year;
- A copy of a State-issued prior authorization approval letter for HCBS that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year; or
- Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year.

Once Provider has the required acceptable form(s) of evidence, Provider should either:

- Contact the Pharmacy Help Desk for appropriate Plan Sponsor contact information; or
- Consult the annual Caremark Medicare Part D Plan Sponsor chart distributed to Providers annually.

If urgent, Caremark will work with Provider and Plan Sponsor to update eligibility and resolve the situation; otherwise, Provider should work directly with the Plan Sponsor to submit the acceptable BAE in order for a change to a Part D Enrollee's low-income status to occur through standard protocol.

Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS

In order to avoid any interruptions to receiving drug therapy for Part D Low-Income Subsidy (LICS/LIS) eligible Part D Enrollees who have received a notification from CMS indicating a status change, the Part D Enrollee must apply/re-apply through the Social Security Administration, or they may have adjusted copayment and premium liabilities in the future. Providers are encouraged to assist these Part D Enrollees by:

• Helping submit LICS/LIS applications

• Refer the Part D Enrollee to the Social Security Administration at:

1-800-772-1213
http://www.ssa.gov/medicareoutreach2/index.htm

Claims Submission Window for Medicare Part D

Providers have ninety (90) days from original date of fill to receive paid transactions including submissions, reversals and resubmissions of Medicare Part D Claims. Provider Universal Claim Forms (UCFs) will be accepted and processed up to March 31st after the close of the previous plan year in which the date of fill occurred when accompanied by a reasonable explanation why the Medicare Part D Claim could not be submitted and processed online. This timely filing window aligns with the CMS processing windows. Provider UCFs should be clearly identified as "Medicare Part D" claims and should be mailed to the following address:

RXBINs 004336, 610591, 610415:

Medicare Part D
PO Box 52066
Phoenix, AZ 85072-2066

Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:

Aetna Medicare Part D
PO Box 52446
Phoenix, AZ 85072-2446

Aetna Medicare Part D LTC
PO Box 14023
Lexington, KY 40512-4023

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014217

Refer to the **LTC Pharmacies Timely Claim Submission** subsection regarding timely submission of Medicare Part D LTC claims.

Medicare Part D Claims Adjustment

Caremark may adjust paid claims to correct errors or reflect changes in eligibility of Eligible Person, to the extent consistent with applicable Law. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider.

Provider must charge Part D Enrollees the correct cost-sharing amount in accordance with the Part D Plan benefit and as required by CMS. For all LTC claims submitted by Providers for Part D Enrollees, and therefore, for whom Caremark has assessed cost-sharing that has been borne by Provider, Caremark will reimburse Provider for such amounts. Refer to the **Patient Residence and Pharmacy Service Type Requirements** section of the Provider Manual. Provider agrees that by accepting payment from Caremark for these amounts assessed against Part D Enrollees, Provider is certifying that (1) Provider has not collected or otherwise waived such amounts from such Part D Enrollees or their representatives; (2) Provider is in fact carrying a debt for the amounts charged to such Part D Enrollee; and (3) the amounts reimbursed by Caremark are appropriate, owed, and payable. In cases where Part D Enrollees claims are retroactively identified as inappropriate overpayments to Provider, Caremark will adjust Provider for such amounts. Provider is responsible for (1) collecting outstanding Patient Pay Amount balances from Part D Enrollees; and (2) accurately debiting and/or crediting Part D Enrollees to help maintain accurate True Out-of-Pocket (TrOOP) balances for these retroactively identified claims.

Unique RXBIN/RXPCN Requirement - Medicare Part D

CMS requires Medicare Part D Plans to be identified with a unique RXBIN/RXPCN combination. Patient profiles must be updated accordingly. Caremark will continue to communicate unique RXBIN/RXPCN/RXGRP combinations of Plan Sponsors. Refer to the Caremark Payer Sheets at **www.caremark.com/pharminfo**.

General Medicare Part D Submission Requirements for COB

Provider must not hold an Eligible Person who is dually eligible for both Medicare and Medicaid liable for Medicare Part A and B Patient Pay Amounts when Medicaid is responsible for paying such amounts; Provider must accept Caremark's payment as payment in full or bill the appropriate state Medicaid.

For Medicare Secondary Payer (MSP), the primary Medicare Part D RXBIN/RXPCN combinations should be submitted on the COB claim (refer to the Caremark Plan Sponsor grid on the Pharmacy Portal at **https://rxservices.cvscaremark.com**).

For COB claims that are supplemental to Medicare Part D, Provider must submit RXBIN 012114 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of plan-specific claims processing information.

For primary Part D Plan Sponsors who have implemented STCOB, the claim adjudicates against both primary and secondary plans before returning one final response to Provider. Single Transaction COB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for eligible Part D Enrollees.

Refer to the Caremark Payer Sheets referenced in **Appendix A** for additional details on how to submit Medicare Part D COB claims.

Formulary Transition Fill Process

All Part D Plans are required by CMS to provide a formulary transition plan for Part D Enrollees who are eligible for a transition supply. The intent of the transition plan is to ensure immediate short-term coverage for Part D Enrollees who are either new to a Part D Plan or who otherwise qualify for a Transition Fill (TF). Providers are required to submit TF-eligible claims for eligible Part D Enrollees to ensure these Enrollees are able to receive the TF's to which they are entitled. This will allow Part D Enrollees to continue ongoing therapies while either transitioning to an equivalent formulary drug, or pursuing prior authorizations or formulary exceptions. Drugs excluded under Part D are not eligible for TF.

Caremark provides TF coverage to eligible Part D Enrollees under the circumstances indicated in the "Transition Fill Plan" below when Part D drugs:

1. are non-formulary; or

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014218

2. are formulary and require prior authorization or step therapy under a plan's utilization management rules; or
3. have quantity limits or daily dose limits that are not safety related.

TF-eligible claims will process and pay upon initial submission and messages will indicate when claims have paid under TF rules. Providers do not need to resubmit a TF Prior Authorization code for TF-eligible claims to adjudicate upon initial submission. The messages listed below will be returned with paid TF claims so Providers can remind Part D Enrollees of actions that should be taken to ensure access to prescription drugs in accordance with Part D formularies and benefits. Provider will receive one of the following messages with the paid claim under TF rules:

<<Paid under Transition Fill - Non-formulary>>

<<Paid under Transition Fill - PA required>>

<<Paid under Transition Fill - Other Reject>> (Note: other rejects represented by this message include Step Therapy, Quantity Limits, Daily Dose, etc.)

The following drugs are not TF eligible:

1. Drugs not covered under Part D.
2. Drugs that are dispensed for reasons other than medically accepted indications.

For submitted claims not eligible for TF, **Reject 569 << Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>** is intended to remind pharmacies to provide the required Part D Notice of Appeal Rights directly to Part D Enrollee should they want to appeal rejected claims with Part D Plans. Notice must be given directly to Part D Enrollees any time this reject occurs on a claim.

The Transition Supply is an approved month's supply for both the outpatient and the long-term-care patient. No changes were made to the long-term-care Emergency Supply, which remains a 31-day supply.

Commented [PT26]: 2019 PM Supplement

Outpatient Transition Fill

Commented [PT27]: 2019 PM Supplement

Transition Fill Condition	Description	Allowed TF Supply for the Retail Setting
Part D Enrollee who is newly enrolled in Plan	Includes, not necessarily limited to: • Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one plan to another after start of contract year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage in the new Plan ~~At least thirty (30) cumulative days supply within at least the first ninety (90) days of coverage in the new Plan~~
Some renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within the look-back period (established by the plan) from date of claim and previous claim not TF for the same reason • If Part D Enrollee has not transitioned before beginning of new Plan benefit year	An approved month's supply as specified in the patient's benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage effective at the beginning of the new Contract Year~~At least thirty (30) cumulative days supply within at least the first ninety (90) days of coverage in the new Contract Year~~
Part D Enrollee requesting exception and decision still pending	Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted	Contact the Pharmacy Help Desk for Transition Extension Overrides under this Condition

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014219

For questions, concerns or issues related to Transition Fill claim processing, refer to the **Medicare Part D Calls to the Pharmacy Help Desk** section of the Provider Manual for the appropriate telephone number to call.

Insulin Coverage

Medicare Part D Plans cover injectable insulin not used with an insulin infusion pump. Medicare Part B covers external insulin pumps and the insulin that the device uses under durable medical equipment.

Medicare Part B and Medicare Part D Drug Coverage Determinations

For specific rejects addressing (1) drugs excluded from Part D coverage as mandated by the Medicare Modernization Act; and (2) drugs that are covered under Medicare Part B for the designated Part D Enrollee, refer to the NCPDP Version D.Ø Payer Sheets at **www.caremark.com/pharminfo**.

Provider must enter an appropriate Patient Residence Code for all Part B versus Part D claims. Refer to the **Patient Residence and Pharmacy Service Type Requirements** section of the Provider Manual.

Caremark uses the following reject codes for drugs that may be covered under Medicare Part B for the designated Medicare beneficiary:

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A6	This Product/Service May Be Covered Under Part B

Secondary messaging may also be returned. The secondary message is as follows:

<<B vs D Inquiry RPH Call XXX-XXX-XXXX>>

When Provider receives a reject with secondary messaging and calls the number included in the reject, the Pharmacy Help Desk representative, who is specifically trained to handle Part B vs. Part D determinations, will present a series of criteria to Provider. Based on the information obtained from the pharmacist, the Pharmacy Help Desk representative will be able to promptly assist Provider with processing the Part D claim, if appropriate. This process only applies to certain drug categories and select Part D Plans. For drugs not handled by the Pharmacy Help Desk, the reject message will indicate that a Prior Authorization is required and include the number for initiating a coverage determination.

End Stage Renal Disease Processing

ESRD "Always" Drugs

CMS guidance requiring Part D Plans to impose a prior authorization edit for the four categories of drugs that are "always" used to treat End Stage Renal Disease (ESRD) remains in effect. CMS states that if the "always" drug was used to treat ESRD, it is payable under the Medicare Part B Bundled Payment to the dialysis center, regardless of whether or not dialysis treatment was received on the date the drug was prescribed or dispensed. Provider must maintain prescription record documentation for Part D Enrollees which contains the diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD.)

For the ESRD "Always" Drugs, Caremark uses the following reject codes for drugs that may be covered under Medicare Part B Bundled Payment for ESRD:

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A4	This Product May Be Covered Under the Medicare B Bundled Payment to an ESRD Dialysis Facility

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014220

In addition to these rejects, **secondary messaging** will be returned. The secondary message is as follows:
<< Part B vs D: To Resolve RPh Call XXX-XXX-XXXX>>

Patient Residence and Pharmacy Service Type Requirements

To ensure appropriate adjudication and reimbursement, Providers must submit valid Pharmacy Service Type and Patient Residence values on all claims. Approved Part D Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) fields must be submitted accurately to identify claim type. Refer to the NCPDP Version D.Ø Payer Sheets at **www.caremark.com/pharminfo**.

CMS Acceptable Code Values	
Pharmacy Service Type – Field 147-U7	01-08 and 99
Patient Residence – Field 384-4X	00, 01, 03, 04, 06, 09, 11

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply.

The only valid claim submission values for "Pharmacy Service Type" (Field 147-U7) and "Patient Residence" (Field 384-4X) are the supported values listed in the NCPDP External Code List (ECL). Submitted values not supported in the ECL will cause the claim to reject with **U7: << M/I Pharmacy Service Type>>** or **4X: << M/I Patient Residence >>** respectively. A blank value will not be allowed in either field for Medicare Part D claims.

As recommended by NCPDP, Caremark accepts the below values to ensure appropriate adjudication and reimbursement. Provider must be in the specific Medicare Part D network in order to submit these codes and receive appropriate payment. Home infusion and Long-term Care Claims must meet the CMS qualifications (e.g., skilled nursing unit) in order to submit these codes and receive appropriate payment.

Pharmacy Type	Claim/Service Type	Pharmacy Service Type (Field 147-U7)	Patient Residence (Field 384-4X)
Retail	Retail	01	01
Home Infusion	HIF	03	01
Home Infusion	ALF	03	04
Long-term Care	LTC	05	03
Long-term Care	ICF/IID	05	09
Assisted Living Facility	ALF	05	04

For Claims submitted for LTC Part D Enrollees with PR 03, an SCC is required for brand oral solids.

This table does not include all Patient Residence and Pharmacy Service Type combinations.

B. Special Instructions for Participating LTC Providers

The following information is applicable to providers participating in the Caremark and Part D Plan-specific LTC Medicare Part D networks, unless specified otherwise.

Pharmacies Serving LTC Facilities

Prescription Drug Benefit Manual – Section 40.3.1

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014221

Given the uniqueness of the LTC setting, Part D Enrollees will generally not present the prescription to Provider. In most instances, either the treating physician or his/her authorized agent sends the prescription to Provider. If there is an issue with a requested prescription, Provider is required to contact the treating physician or his/her authorized agent and the physician determines what course of action is appropriate (e.g., the physician may prescribe a different medication or request an exception).

If Provider is off-site, Provider must send (fax or deliver) the CMS-10147 Pharmacy Notice to the location in the LTC facility designated to accept such notices.

If Provider is on-site, Provider must deliver the notice to the location in the LTC facility designated to accept such notices. The LTC facility staff is responsible for providing the Part D Enrollee (or the Part D Enrollee's appointed representative) and the Part D Enrollee's treating physician with the notice. A copy of the notice should be placed in the Part D Enrollee's file at the LTC facility (refer to **Appendix G** for a copy of the notice in English and Spanish).

LTC Pharmacies Timely Claim Submission

Participating LTC Providers will not have less than thirty (30) days, and no more than ninety (90) days to submit claims (42 C.F.R. 423.505(b)(20)). This includes electronically submitted claims and non-electronically submitted claims from original date of fill. Non-participating LTC Providers have three (3) years to file claims.

The requirement above does not eliminate the requirement specified in CMS policy memo dated May 25, 2007, for Part D Plan Sponsors to provide new timely claims filing period for claims incurred by dual-eligible Part D Enrollees during a period of retroactive Part D enrollment.

Provider UCFs should be clearly identified as "Medicare Part D LTC" claims, include the appropriate Pharmacy Service Type and Patient Residence values and should be mailed to the following address:

RXBINs 004336, 610591, 610415:
Long-term Care (LTC) Claims:
Attn: Medicare Part D LTC
PO Box 52419
Phoenix, AZ 85072-2419

RXBIN 610502:
Aetna Long-term Care (LTC) Claims
Attn: Aetna Medicare Part D LTC
PO Box 14023
Lexington, KY 40512-4023

LTC Billing

Provider must dispense certain brand oral solid Covered Part D Drugs in quantities of fourteen (14) days or less, unless an exemption applies. Caremark has implemented a dispensing fee incentive for those LTC Part D brand and generic drugs in accordance with CMS regulation. Provider agrees to submit claims to Caremark's claim adjudication system for LTC Pharmacy Services. Provider must bill Caremark immediately after dispensing or within thirty (30) days after the dispensing event. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws.

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply. "Brand oral solids" are limited to brand products with the following exceptions to the appropriate days supply (ADS) dispensing rule:

- Generic drugs (ANDA/non-specified)
- Solid oral doses of antibiotics
- Solid oral doses in packaging that cannot be broken (e.g., oral contraceptives)

Other exceptions—providers, Part D Enrollees and coverage situations—include:

- Assisted living facilities
- Medicare as a secondary payer (MSP)
- Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) and Institutes for Mental Disease (IMD)
- Indian Health Service, Tribal 638, and Urban Indian Health (I/T/U)

Four fields have been utilized to accommodate ADS dispensing requirements; Patient Residence Code, Pharmacy Service Type, Submission Clarification Codes (SCC) and Special Package Indicator (SPI). Refer to the **Patient Residence and Pharmacy Service Type Requirements** section of the Provider Manual.

Submission Clarification Codes:

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014222

NCPDP Field 420-DK	
Code	**Description**
21	LTC dispensing: 14 days or less not applicable – 14 days or less dispensing is N/A due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e. vacation supply, leave of absence, e-kit, spitter dose). Medication quantities are dispensed as billed
22	LTC dispensing: 7 days – Pharmacy dispenses medication in 7-day supplies
23	LTC dispensing: 4 days – Pharmacy dispenses medication in 4-day supplies
24	LTC dispensing: 3 days – Pharmacy dispenses medication in 3-day supplies
25	LTC dispensing: 2 days – Pharmacy dispenses medication in 2-day supplies
26	LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1-day supplies
27	LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4-day, then 3-day supplies
28	LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2-day, then 2-day, then 3-day supplies
29	LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekends
30	LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes)
31	LTC dispensing: Per med pass dispensing – Remote dispensing per med pass
32	LTC dispensing: PRN on demand – Remote dispensing on demand as needed
33	LTC dispensing: 7 days or less cycle not otherwise represented
34	LTC dispensing: 14 days – Pharmacy dispenses medication in 14-day supplies
35	LTC dispensing: 8-14 day dispensing not listed above – 8-14-day dispensing cycle not otherwise represented
36	LTC dispensing: dispensed outside of short cycle. Claim was originally submitted to a payer other than Medicare Part D and was subsequently determined to be Part D

Refer to the NCPDP standard at **http://www.ncpdp.org/Members/Standards-Lookup.aspx**. Membership to NCPDP is required to view this information online.

LTC Days Supply Limitations

As per CMS guidance, LTC Providers in the LTC Medicare Part D networks are only allowed to dispense initially up to a 31-day supply of medication for Part D Enrollees for generics or solid oral doses of antibiotics and solid oral doses in packages that cannot be broken. In the event that a medication being provided is the smallest commercially available package size and exceeds the allowable 31-day supply, the quantity may be submitted utilizing the quantity

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014223

of the single package with the corresponding day supply.

Long-Term Care Transition Fill

Commented [PT28]: 2019 PM Supplement

(NOTE: Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills must be submitted with an appropriate LTC Pharmacy Service Type and Patient Residence Codes. See additional information in the table below).

Transition Fill Condition	Description	Allowed TF Supply
Part D Enrollee who is newly enrolled in Plan	Includes, not necessarily limited to: • Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one plan to another after start of contract year	Per CMS requirements: • Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense generic drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage in the new Plan~~Dispense generic drugs with a first fill of a maximum of 31-day supply, or less if the prescription is written for fewer days.~~ • ~~Prescriptions are allowed to have refills that accumulate to at least a 91-day supply and may be up to a maximum of a 98-day supply within at least the first 90 days of coverage in the new Plan~~

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014224

Transition Fill Condition	Description	Allowed TF Supply
Renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within 180 days from date of claim and previous claim not TF • If Part D Enrollee has not transitioned before beginning of new Plan benefit year	Per CMS requirements: • Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense generic drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage effective at the beginning of the new Contract Year~~Dispense generic drugs with a first fill of a maximum of 31-day supply, or less if the prescription is written for fewer days.~~ • ~~Prescriptions are allowed to have refills that accumulate to at least a 91-day supply and may be up to a maximum of a 98-day supply within at least the first 90 days of coverage in the new Plan~~
*Part D Enrollee residing in LTC facility (New Patient Admission)	LTC New Patient Admission/Level of Care Change within past 30 days	• Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense generic drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days. Multiple fills are allowed within 31 days of admission or change of care. • ~~Dispense generic drugs with a first fill of a maximum of 31-day supply, or less if the prescription is written for fewer days. Multiple fills are allowed within 31 days of admission or change of care.~~ • Submit Submission Clarification Code 420-DK Value "18" • Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes • If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED

CVS_HJC_00014225

Transition Fill Condition	Description	Allowed TF Supply
*Part D Enrollee residing in LTC facility (Emergency Supply)	LTC Emergency Supply	• Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.* • Dispense generic drugs with a first fill of a maximum of 31-day supply, or less if the prescription is written for fewer days. • Submit Submission Clarification Code 420-DK; Value "7" • Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance.
Part D Enrollee requesting exception and decision still pending	Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted	Contact the Pharmacy Help Desk for overrides under this condition

*Refer to the **LTC Billing** section of the Provider Manual for exceptions.

Special Package Indicator

NCPDP has created an additional field for Special Package Indicator (SPI). Caremark is not requiring SPI Codes at this time, but will accept this field if submitted. At such time Caremark requires SPI Codes, Caremark will provide Provider with written notice.

NCPDP Field 429-DT	
Code	**Description**
0	Not specified
1	Not Unit Dose - product is not being dispensed in special unit dose packaging.
2	Manufacturer Unit Dose - a distinct dose as determined by the manufacturer.
3	Pharmacy Unit Dose - when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose.
4	Pharmacy Unit Dose Patient Compliance Packaging - Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly
5	Pharmacy Multi-drug Patient Compliance Packaging - Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration
6	Remote device unit dose - drug is dispensed at the facility, via a remote device, in a unit of use package

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014226

NCPDP Field 429-DT	
Code	**Description**
7	Remote device Multi drug compliance - Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration
8	Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in LTC claims only (as defined in Telecommunication Editorial Document).

LTC Override Requests

Emergency Supply:

Note the following text from Chapter Six of the Medicare Part D manual. The requirement states to allow a one-time emergency fill (after the 90-day transition period has expired) for up to 31 days of medication, unless the prescription is written for less than 31 days.

If the prescription in question was written for less than 31 days, it is within CMS guidelines to restrict to one fill. According to CMS regulations, exceptions should be handled within three days (72 hours).

Chapter 6 of CMS Prescription Drug Benefit Manual states the following:

> **Section 30.4.6 - Emergency Supply for Current Enrollees in the LTC Setting**
> ***(Rev. 18, Issued: 01-15-16, Effective: 01-15-16; Implementation: 01-15-16)***
>
> Since, as a matter of general practice, LTC facility residents must receive their medications as ordered without delay, Part D sponsors must also cover emergency supplies of non-formulary Part D drugs for LTC facility residents after the transition period.
>
> During the first ninety (90) days after enrollment, the Part D Enrollee will receive a transition supply as described in section 30.4. However, to the extent that a Part D Enrollee in an LTC setting is outside his or her 90-day transition period, the Plan Sponsor must still provide an emergency supply of non-formulary Part D drugs while an exception or prior authorization request is being processed. These emergency supplies of non-formulary Part D drugs must be for at least 31 days of medication, regardless of dispensing increments, unless the prescription is written by a Prescriber for less than 31 days. In cases where the smallest available marketed package size is not available for less than a 31-day supply, the Plan Sponsor must still provide an emergency supply when required. Part D Sponsors and their processors must determine how best to process claims in such cases. Multiple 14-day or less supplies can be supplied for brand name drugs to meet a minimum of a 31-day emergency supply requirement. A Plan Sponsor is not expected to provide more than a one-time 31-day emergency fill of a particular drug per LTC stay.
>
> **Section 30.4.7 - Level of Care Changes (excerpt)**
> **(Rev. 10, Issued: 02-19-10, Effective/Implementation Date: 03-01-10)**
>
> In addition to circumstances impacting new Part D Enrollees who may enter a plan with a medication list that contains non-formulary Part D drugs, other circumstances exist in which unplanned transitions for current Part D Enrollees could arise and in which prescribed drug regimens may not be on sponsor formularies. These circumstances usually involve level of care changes in which a Part D Enrollee is changing from one treatment setting to another. For example, Part D Enrollees who enter LTC facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary with very short term planning taken into account (often under eight hours). Similar situations may exist, for example, for Part D Enrollees who are discharged from a hospital to a home; for Part D Enrollees who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; for Part D Enrollees who give up hospice status to revert to standard Medicare Part A and B benefits; for Part D Enrollees who end an LTC facility stay and return to the community; and for Part D Enrollees who are discharged from psychiatric hospitals with drug regimens that are highly individualized.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014227

Below are Part D Plan Sponsor's utilization management rules to LTC Part D Enrollees for LTC emergency supplies and LTC admissions/level of care changes. An emergency supply must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days. Transition supplies of non-formulary Part D drugs for LTC admission/level of care changes must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days. Provider must maintain documentation substantiating any SCC values or override codes transmitted on a Medicare Part D claim.

1. Emergency Box Dispensing: Emergency Box (E-Box) meds for emergency treatment until standard supply can be dispensed
2. First Fill Following Emergency Box Dose: Follow-up fill after Emergency Dose has been dispensed. This prescription should be filled for the full prescribed amount minus the Emergency Dosing
3. LOA (Leave of Absence) Medications: Separate dispensing of small quantities of medications for take-home use allowing Part D Enrollees to leave facility for weekend visits, holidays, etc.
4. Medication Spit Out: Medication has been "spit out"
5. Emergency Supply: Emergency supply of non-formulary drugs and formulary with PA or Step Therapy Requirements
6. LTC Admission/Level of Care Change: Newly admitted due to clinical status change. Medications may have:
   - been filled at retail pharmacy prior to admit;
   - been filled prior to transfer and discontinued;
   - not followed Part D Enrollee to new facility due to regulatory and compliance issues and same meds reordered upon re-admit

Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills are submitted with the Pharmacy Service Type (PST) and Patient Residence (PR) that designate LTC (for RXBINs 004336, 012320 and 610591 only).

- For LTC Emergency Supply: Use SCC [NCPDP Field # 420-DK] Value "07"
- For LTC New Patient Admission/Level of Care Change: Use SCC [Field # 420-DK] Value "18"

LTC Emergency and Transition Supplies for Current Part D Enrollees

D.Ø NCPDP FIELD	D.Ø VALUE/CODE	SITUATION	ALLOWANCES
SCC 420-DK	16	Emergency Box (Emergency Dose)	5-day supply
SCC 420-DK	17	First Fill Following Emergency Kit Dose	Written Rx Less E.R. Kit Dose given
SCC 420-DK	14 (use value 3 for ALF)	Leave of Absence Vacation supply	5-day supply
SCC 420-DK	15	Patient "Spit Out"	Not applicable
SCC 420-DK	07	Emergency Supply	31-day supply
SCC 420-DK	18	LTC Admission/ Level of Care Change	31-day supply with multiple fills within 31 days of admission or change of care
SCC 420-DK	19	Partial Payment under Medicare Part A	Not applicable

Refer to the NCPDP Version D.Ø Payer Sheets at **www.caremark.com/pharminfo**.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark. If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014228

Medicare Part A and Medicare Part D Drug Coverage Determinations

LTC Providers should consult their Caremark LTC Addendum regarding clarification on Medicare Part A and Medicare Part D drug coverage determinations.

Hospice care is a Medicare Part A benefit and, therefore, drugs provided by hospice and covered under the Medicare Part A payment to the hospice program are not covered under Part D. Only drugs which are used primary for relief of pain and symptom control related to an individual's terminal illness are covered by the hospice program.

When a Medicare Part D claim rejects due to hospice validation, the claim will also reject with:

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

Reject 75 <<Prior Authorization Required>>

Reject A3 <<This Product May Be Covered Under Hospice – Medicare A>>

In addition to these rejects, secondary messaging is returned. The secondary message is as follows: **<< Hospice drugs not covered under Part D. If unrelated to terminal diagnosis, call XXX-XXX-XXXX>>.**

The reject message will direct the pharmacy to the Pharmacy Help Desk. The help desk representative will verify if the Part D Enrollee is in hospice and inform Provider that written termination documentation from hospice or Part D Enrollee is required before an override can be placed.

As specified in the Social Security Act, Section 1861(dd), and Federal Regulations (42 C.F.R. Section 418 *et seq.*), hospice programs must provide individuals under hospice care with drugs and biologicals related to the palliation and management of the terminal illness as defined in the hospice plan of care.

Stand-alone prescription drug Plan Sponsors cannot easily identify and prevent Part D payment for hospice drugs. Provider should work with LTC facilities in which their patients reside or hospice providers to identify any Part D Enrollees who have elected hospice care and ensure hospice drugs are not billed to Part D.

For those Plan Sponsors utilizing Caremark coverage determination services, if the treatment is unrelated to the terminal condition, the Pharmacy Help Desk will direct the Provider to ask the Hospice Provider to fax the form to the Coverage Determinations and Appeal Department and provide the written documentation for the Part D exception. Provider must provide the Pharmacy Help Desk with the hospice Provider's contact information to help expedite the process. Caremark's Prior Authorization department will handle the documentation requests and inform Provider if an approval will be made.

For Part D Plan Sponsors not utilizing Caremark for coverage determinations, the telephone number in the message will direct Provider to the Part D Plan Sponsor's coverage determination department to initiate the process.

Per CMS guidance, for Part D Enrollees and/or caregivers who state they are no longer in hospice, Caremark requires written documentation prior to overriding the hospice reject. The four acceptable forms are outlined as the Best Available Evidence below. The documentation can be faxed to Caremark at 1-844-242-0904. Caremark requires a retail and LTC pharmacy to provide the hospice contact information to the Pharmacy Help Desk. Part D Enrollees and/or caregivers may ask Providers to fax the documentation to Caremark.

The following valid documents can be provided as Best Available Evidence of hospice disenrollment or discharge:

1. Written statement from Part D Enrollee to hospice indicating date revocation is to be effective: Applies when Part D Enrollee has chosen to no longer continue with hospice benefits.
2. Notice of Medicare Non-Coverage (NOMNC): Hospice initiates discharge because Part D Enrollee is no longer considered terminally ill.
3. Discharge summary (provided by hospice to a facility or physician): Hospice discharged Part D Enrollee for cause, or because Part D Enrollee is no longer within the hospice service area.
4. NCPDP form: Submitted by hospice or physician indicating date of discharge.

Improving Drug Utilization Review Controls

CMS discusses the need for Medicare Part D plan sponsors to employ more effective concurrent and retrospective DUR programs to address overutilization of medications in order to protect beneficiaries and to comply with drug utilization management requirements at 42 C.F.R. § 423.153, et seq.

Claims adjudication system edits have been implemented to improve control at the point of sale and ensure that DUR processes comply with CMS requirements for all classes of drugs.

The chart below describes the DUR reject edits and associated Professional Service (PPS) Codes that may be used

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

to override the reject when applicable. Enhanced reject messaging will be returned to help clarify the reason for the reject. Be sure to review the entire DUR message for instructions which may require viewing additional screens in your software. Since a single claim may trigger more than one concurrent DUR reject, Providers will need to enter the corresponding PPS codes documenting the action for each reject.

The chart below may be used to assist with entering the appropriate PPS Codes.

Edit Name and Description	Reject Message	Reason for Service Code	PPS Professional Service Code	Result of Service Code
Buprenorphine/Opioid: Identifies opioid use after treatment with a buprenorphine product	Reject 88- PPS CODE REQD: HX BUPENORP; EXCL OPIOID	"DM"	**M Ø -** Prescriber consulted **P Ø -** Patient consulted **PM -** Patient monitoring **R Ø -** Pharmacist consulted other source	1B - RPH determines alert is not relevant for the Rx and member 1C - Filled with a different dose 1D - Filled with different directions 1F - Filled with a different quantity 1G - Filled with a prescriber approval 2A - RPH determines Rx should not be filled as written
Cumulative APAP Check: Checks for excessive cumulative acetaminophen (cAPAP) utilization across multiple prescriptions.	Reject 88– PPS CODE REQD: APAP EXCEEDS 4GM/DAY	"AT"		
Cumulative MED Check: Checks for excessive opioid utilization via cumulative morphine equivalent dose (cMED) across multiple drugs and prescriptions	Reject 88- PPS CODE REQD:HI MORPH EQ DOSE &>X MDs	"AT"		
Excessive Controlled Substance Enhancement: Intended to capture multiple controlled substance (CS) claims (for the same drug or different controlled substances) within the past thirty (30) days.	Reject 88– PPS CODE REQD: MULT CII-V IN LAST 30 DAYS	"DM"		
Dose Check-Max Does Multiplier: Intended to identify claims with excessively high doses. Applies to all drugs.	Reject 88– PPS CODE REQD: MAX DOSE EXCEEDED – 5X MAX	"HD"		
Multiple Pharmacies: Designed to identify members filling multiple prescriptions for within the same drug class at four or more pharmacies. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PHARMACIES/SAME DRUG CLASS	"DM"		
Multiple Prescribers: Designed to identify members filling multiple prescriptions within the same drug class prescribed by four or more prescribers. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PRESCRIBERS/SAME DRUG CLASS	"DM"		

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014230

Do not save PPS and Result of Service Codes on any prescriptions that have previously rejected for DUR. For an initial fill or any refills, Provider cannot pre-empt the reject by entering PPS Codes prior to the first submission of the claim. Allow the reject to occur and then enter the appropriate PPS Codes on resubmission. Entering PPS Codes prior to allowing the claim to reject will cause the claim to continue to reject.

Pro-Rated Daily Cost Share

For applicable plans with a copayment benefit, Part D Plan Sponsors must establish and apply a daily cost-sharing rate whenever certain prescriptions (depending on the drug dispensed) are dispensed by Provider for less than the Part D Plan Sponsor's defined one-month supply in accordance with 42 C.F.R. § 423.153(b)(4)(i).

Effective for claims and adjustments with dates of fill on and after January 1, 2014, Caremark modified cost-sharing logic in the claims adjudication system to apply a daily cost-sharing rate for a Covered Part D Drug that is dispensed for less than the plan-defined one-month supply. If a claim applies a daily cost-sharing rate Provider may receive the following message:

<< Ø23 – Prorated copayment applied based on days supply. Plan has prorated the copayment based on days supply>>

The daily cost-sharing rate applies if the drug (brand or generic) is in the form of a solid oral dose and is dispensed for a days supply less than the plan-defined one-month supply under applicable Law, except for the following types of drugs:

- Solid oral doses of antibiotics
- Solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance
- Non-Part D drugs, unless the Part D Plan has specified that copay proration extends to covered drugs that are treated as non-Part D under their benefit plans
- Drugs dispensed by out-of-network providers

Information on CMS-10147 Pharmacy Notice

Medicare Prescription Drug Coverage and Your Rights

On behalf of all Part D Plans adjudicating through Caremark, CMS required information titled "Medicare Prescription Drug Coverage and Your Rights" is distributed to Providers by Caremark on an annual basis (Pharmacy Notice - CMS-10147) for use in instructing Part D Enrollees to contact their Part D Plan to obtain a coverage determination or ask for a formulary or tiering exception if the Part D Enrollee disagrees with the information provided by Provider.

This notice is provided in **Appendix G** in English and Spanish, and must be distributed to Part D Enrollees. Posted notices must be large enough to be easily read by a Part D Enrollee. This notice fulfills the requirements at 42 C.F.R. § 423.562(a)(3). Providers must provide the required Part D Notice of Appeal Rights directly to Part D Enrollees should they want to appeal rejected claims with Part D Plans.

Commented [PT29]: 2019 PM Supplement

This is a standard notice. Provider may not deviate from the content of the notice. Note that the OMB control number [APPROVED OMB #0938-0975] must be displayed in the upper right corner of the notice. This document is distributed to Provider annually by Caremark, and this document is also posted at:

http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/14_plannoticesanddocuments.asphttps://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html

Commented [PT30]: 2019 PM Supplement

CMS-10147 – Medicare Prescription Drug Coverage and Your Rights

Pharmacies **must** provide the required Part D Notice of Appeal Rights directly to Part D Enrollees any time the following reject occurs on a claim:

Reject 569 << Provide Notice: Medicare Prescription Drug Coverage and Your Rights >>

C. Retail Addendum to the Caremark Provider Agreement

Terms of Participation in Medicare Part D

By entering into the Provider Agreement, Provider agrees to comply with the following terms (as noted in this Retail

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

Addendum to the Caremark Provider Agreement) to the extent Provider provides Pharmacy Services to a Part D Enrollee and Provider is a retail pharmacy as that term is defined in 42 C.F.R. § 423.100. In the event any provision in this Retail Addendum to the Caremark Provider Agreement ("Retail Addendum") conflicts with the terms of the Provider Agreement (including the Provider Manual), the terms of this Retail Addendum shall govern. Provider acknowledges that CVS Caremark Part D Services, L.L.C., together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this Retail Addendum) are responsible for providing Part D services on behalf of Part D Plan Sponsors.

To the extent that Provider shall provide Pharmacy Services to a Part D Enrollee, Provider agrees to comply with any applicable Part D requirements for participation in Part D as a Dispensing Pharmacy.

Without limiting the generality of the foregoing, and notwithstanding anything in the Provider Agreement to the contrary, Provider agrees as follows:

1. Provider agrees to participate as, and perform the functions of, a Part D Retail Dispensing Pharmacy, including any reporting functions required to Part D Plan Sponsors, in accordance with the terms and conditions set forth in this Retail Addendum.
2. Provider agrees to perform its services under this Retail Addendum in a manner that is consistent with, and encompasses the services required to support Part D and in compliance with the contractual obligations of a Part D Plan Sponsor to CMS.
3. Provider agrees not to hold any Part D Enrollee liable for payment of any fees that are the responsibility of Caremark or a Part D Plan Sponsor.
4. Provider and Caremark agree that Provider is not required to accept Insurance Risk as a condition of participation as a Dispensing Pharmacy for Part D, and in the Medicare Part D Retail Network.
5. Provider agrees to comply with all applicable federal and state laws and regulations, CMS guidance or instructions relating to Part D, and any minimum standards for Provider practice established by the States in which Provider is licensed. Provider agrees to comply with all applicable State and Federal privacy and security requirements, including the confidentiality and security requirements set forth in 42 C.F.R. § 423.136, the Privacy Rule, Security Rule, and Transactions Standards.
6. Provider agrees to make its books and records available in accordance with, and for the period required by 42 C.F.R. § 423.505(i)(2), which gives HHS, the Comptroller General, or their designees (collectively, "Government Parties"), the right to audit, evaluate, collect, and inspect any books, contracts, records, computers, or other electronic systems, including medical records, and documentation of Provider involving transactions related to CMS' contract with a Part D Plan Sponsor (collectively, "Records"), and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor's contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the ten (10) year retention period. In the case of a request by a Government Party for the direct disclosure by Provider to the Government Party of Records, Provider shall (1) provide Caremark with prompt written notice of the Government Party's request so that Caremark can object or intervene as it deems proper; and (2) take all appropriate steps to protect the confidentiality of the Records, including labeling it "CONFIDENTIAL AND PROPRIETARY – FOIA EXEMPT" and attaching a statement provided by Caremark explaining the application to the Records of any Freedom of Information Act or other exemptions to disclosure; and (3) provide Caremark with the opportunity to review the Records that is subject to disclosure to the Government Party prior to Provider's release of same to the Government Party. Provider also agrees to maintain records and provide access in accordance with 42 C.F.R. 423.505(b)(10).
7. Provider agrees that, upon a Part D Plan Sponsor delegating any activity or responsibility to Caremark and Caremark in turn delegating that activity or responsibility to Provider pursuant to this Retail Addendum, that activity or responsibility may be revoked if CMS, the Part D Plan Sponsor, or Caremark determines that Provider has not performed satisfactorily. CMS, the Part D Plan Sponsor, or Caremark may also exercise any remedies available at law or under the Provider Agreement in lieu of revocation. Further, Provider agrees that such activity or responsibility shall be in accordance with 42 C.F.R. 423.505(i)(3).
8. Provider agrees that Caremark and any Part D Plan Sponsor (with respect to its enrollees only) each has the right to approve, suspend, or terminate the Agreement in their sole discretion at any time.

Commented [PT31]: 02/05 – Amendment #02.b

Commented [PT32]: 01/22 – Amendment #02

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014232

9. Provider agrees that Caremark and the Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis.
10. Provider agrees to provide Part D Enrollees with access to Negotiated Prices for Covered Part D Drugs as required by and in accordance with 42 C.F.R. § 423.104(g).
11. Provider agrees to submit Claims to Caremark's real-time claims adjudication system.
12. Provider agrees that when it dispenses a Covered Part D Drug to a Part D Enrollee, it will inform such Part D Enrollee at the point-of-sale of the lowest-priced, generically equivalent version of that Covered Part D Drug, if one exists for the Part D Enrollee's prescription, as well as any associated differential in price in accordance with 42 C.F.R. § 423.132.
13. Provider agrees to implement a method for maintaining up-to-date Part D Enrollee information such as, but not limited to, demographic and allergy (drug) information, and such other information as CMS may require.
14. Provider agrees to implement such utilization management and quality assurance programs, including concurrent drug utilization review, generic substitution and/or therapeutic interchange programs, as Caremark may require, and as consistent with and in compliance with 42 C.F.R. § 423.153(b), (c) and (d). Provider agrees to offer patient counseling to Part D Enrollees, where appropriate and/or required by law.
15. Provider agrees to fill a prescription for a 90-day supply of Covered Part D drugs for Part D Enrollees at the appropriate cost-sharing and Negotiated Price as communicated by Caremark to Provider through the real time claims adjudication process, including that which applies to individuals qualifying for the low-income subsidy.
16. Provider agrees to charge/apply the correct cost-sharing amount, including that which applies to individuals qualifying for the low-income subsidy.
17. Part D Claims may be priced using the Provider Agreement, the Caremark Medicare Part D Retail Network, or other Caremark or Plan Sponsor specific network.
18. INTENTIONALLY BLANK
19. Provider acknowledges that it is not a mail order pharmacy and it is a "retail pharmacy" as defined in 42 C.F.R. § 423.100.
20. Entire Agreement. This Retail Addendum, the Provider Agreement, the Provider Manual, and the Medicare Network Enrollment form, and all other applicable enrollment forms, constitute the entire agreement between Provider and Caremark for the purposes of Provider's participation as a Medicare Part D Network Provider, all of which are incorporated by this reference as if fully set forth herein and referred to collectively as the "Provider Agreement" or "Agreement". Any prior agreements, promises, negotiations, or representations related to the terms of this Retail Addendum are terminated and of no force and effect. Provider's non-compliance with any of the provisions of this Retail Addendum will be a breach of the Provider Agreement. All pricing terms are considered to be Caremark's confidential and proprietary information and may not be shared with any third party without express written consent from Caremark.
21. The following terms and phrases, when capitalized and when used in this Retail Addendum, have the meanings set forth below. All other capitalized terms and conditions shall have the meaning set forth in the Provider Agreement.
    a. "Claims" means those claims processed through the Caremark online, real-time claims adjudication system.
    b. "CMS" means the Centers for Medicare and Medicaid Services under the Department of Health and Human Services.
    c. "Covered Part D Drug(s)" has the same meaning as that term as defined in 42 C.F.R. § 423.100.ß.
    d. "Dispensing Fee" has the same meaning as such term is defined in 42 C.F.R. §423.100 which states that dispensing fee means costs that are incurred at the point-of-sale and pay for costs in excess of the ingredient cost of a Covered Part D Drug each time a covered Part D Drug is dispensed, and includes only pharmacy costs associated with ensuring the possession of the appropriate Covered Part D Drug is transferred to a Part D Enrollee.
    e. "HHS" means the Department of Health and Human Services.
    f. "Insurance Risk" has the same meaning as such term as defined in 42 C.F.R. § 423.4.
    g. "Medicare Part D Retail Network" means Claims priced for a Part D Enrollee pursuant to the Retail Addendum to the Caremark Provider Agreement entitled "Caremark Medicare Part D Retail Pharmacy

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

Network."

h. "Negotiated Prices" has the same meaning as such terms as defined 42 C.F.R. § 423.100.

i. "Part D" means Part D of Title XVIII of the Social Security Act, which establishes the Voluntary Prescription Drug Benefit Program under Medicare.

j. "Part D Enrollee" means an individual covered by a Part D Plan.

k. "Part D Plan" has the same meaning as such term as defined in § 423.4, but limited to those Part D Plans that have contracted with SilverScript, L.L.C. to use pharmacy providers that have contracted with Caremark to provide Pharmacy Services to Part D Enrollees.

l. "Part D Plan Sponsor" has the same meaning as such term as defined in 42 C.F.R. § 423.4, but limited to those Part D Plan Sponsors that offer Part D Plans.

m. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

n. "Security Rule" shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. parts 160, 162 and 164, subpart C. Notwithstanding anything to the contrary in the Agreement, any requirements related to the Security Rule shall be effective no earlier than the applicable Compliance Date for the Security Rule.

o. "Transactions Standard" means the Standards for Electronic Transactions under 45 C.F.R. parts 160 and 162, subparts I et.seq.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014234

Medicare-Medicaid Plan

A Medicare-Medicaid Plan (MMP), or dual demonstration plan, is a program administered by CMS and a particular state Medicaid that integrates the services provided by both the Medicare and Medicaid programs into one plan provided to eligible Medicare-Medicaid Enrollees.

Medicare-Medicaid Networks Standards

To the extent Provider provides Pharmacy Services to a Medicare-Medicaid Eligible Person, and without limiting any other provision in the Agreement, Provider must comply with CMS Medicare Part D requirements, including the components of the contract between CMS, an Individual state Medicaid, and a specific Plan Sponsor.

Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicare-Medicaid Eligible Person is made, in whole or in part, from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable states laws including minimum standards of pharmacy practice. Refer to the **Federal and State Laws and Regulations** section of the Provider Manual, including state-specific addenda.

Qualified Health Plans

For Qualified Health Plan ("QHP") Eligible Persons eligible for health benefits under a QHP ("Eligible Person") offered by a QHP Issuer (as defined in 45 C.F.R. 155.20), or "Plan Sponsor", on the Federally-facilitated Exchange or a State Partnership Exchange, Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and the Department of Health and Human Services ("HHS") guidance, including but not limited to, 45 C.F.R. 156.340(a), to the extent relevant to the Pharmacy Services provided.
2. To permit access by HHS and the Office of Inspector General ("OIG"), or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations in accordance with 45 C.F.R. 156.340(a), until ten (10) years after the final date of the Provider Agreement period.
3. For purposes of clarity, delegated activities and reporting responsibilities as described in 45 C.F.R. 156.340(b), if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.
4. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.
5. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer or Caremark, or their designees, determines that Provider has not performed the Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.
6. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

For QHP Eligible Persons eligible for health benefits under a QHP offered by a QHP Issuer on a State-based Exchange, including but not limited to, **California**, **Colorado**, **Connecticut**, **District of Columbia**, **Hawaii**, **Idaho**, **Kentucky**, **Maryland**, **Massachusetts**, **Minnesota**, **Nevada**, **New Mexico**, **New York**, **Oregon**, **Rhode Island**, **Vermont**, **Washington**, Provider agrees:

7. To comply with all applicable federal and state laws, regulations, and guidance issued by HHS, a State-based Exchange or other applicable regulatory body, to the extent relevant to the Pharmacy Services provided.
8. To perform Pharmacy Services in a manner consistent with and in compliance with the QHP Issuer's contractual obligations to the State-based Exchange or other applicable regulatory body.
9. To permit access by HHS, the OIG, the State-based Exchange or other applicable regulatory body, or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014235

downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations until ten (10) years after the final date of the Provider Agreement period.

10. For purposes of clarity, delegated activities and reporting responsibilities, if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.

11. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.

12. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer, State-based Exchange, applicable regulatory body, Caremark, or their designees, determines that Provider has not performed these services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.

13. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

CONFIDENTIALITY NOTICE: This Provider Manual contains confidential and proprietary information of CVS Caremark.
If you are not the intended recipient, you have received this Provider Manual in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this Provider Manual in error, please notify CVS Caremark immediately and destroy all copies of this Provider Manual.
©2020 Caremark. All rights reserved.

CONFIDENTIAL TREATMENT REQUESTED CVS_HJC_00014236

Exhibit 77:
CVS_HJC_00019525 Audit file for Market 32 Pharmacy

PHARMACY NAME

MARKET 32 PHARMACY 244

finalized by JC on 2/6/23

NCPDP/NPI: 2245024/1659754208

AUDIT TYPE: Investigative

AUDIT DATE: 12/05/2022

AUDIT PROFILE ID: 83408

AUDITOR: Joy Mills

Number of claims in original profile : 5,659

Number of claims marked for audit : 503

Discrepancy Code	DESCRIPTION	Count
OTH	Other	2,062
	TOTAL	**2,062**

Total Descrepancy Amount: $1,143,441.02

CMS Signage Checked:

Auditor Comments:

"Sent over by Silverscript Xhance claims billed through Market 32 Pharmacy (2245024). These are Med D members, and it appears there is member steerage and some copay waiving."
"I was also able to manually find that multiple Cert ID have been used:"
D012000029
D012000149

6 members confirmed steering

Top Drugs

81 of the Xhance claims were for Med D members

I heard from [redacted] at price chopper questioning the invoice request. "I am assuming you are only looking for purchase history for the drugs specified to support their dispensing? I can't see the need for every drug purchased for that 13-month time frame. Also possible providing purchase history for items that we might have never billed to Caremark. can you please clarify for me? Most of the drugs on this list we warehouse ourselves, so the purchase history reports will be in excel format but coming directly from me."
I clarified our request.
And [redacted] wanted Price Chopper's concerns noted "With that, the request appears to seek data that would not be the subject of the audit, but that Caremark would obtain as part of this process. While we understand the request, we feel it is important for us to make our concerns known to Caremark."

Initially [redacted] stated that they would be unable to provide a summary from their former wholesaler. [redacted] responded "What wholesaler are you referring to? Is this wholesaler refusing to

PHARMACY NAME

MARKET 32 PHARMACY 244

send reports on your behalf or are you refusing to contact the wholesaler in regard to this audit? This is a standard audit process and all major and secondary wholesalers are accustomed to this process. "I received invoice summaries from Cardinal, Mckessin and Upsher Smith. Price Chopper has a warehouse where a large portion of drug stock comes from, we requested pedigrees for those purchases. Redacted - PII was very concerned about the amount of data being requested. "I just spoke to our buyer and our Pharmacy Compliance Officer. Because we use the product for our own use and distribute only to our owned pharmacies there is no data to provide, nor are we required to under the law. Our warehouse and pharmacies are under the same common ownership" per [redacted]. A call with Jennifer Thomas, Steve McCall, [redacted] and [redacted], VP Pharmacy was scheduled.

I requested 75 additional prescriptions and proof of pay for all fill dates within the audit period. [redacted] requested an extension, gave 2 weeks. These additional prescriptions were never sent. From [redacted] "As a follow up to our call on Monday, as we discussed, we are holding off on pulling together any additional documentation related to prescription records or wholesaler records/purchases subject to your confirmation on what, if anything, further is required from CVS/Caremark's perspective. Thank you. [redacted]

Steve McCalls response: "I had some action items down for you as follows:

- Drugs from the specific manufacturer/distributor that ships you Xhance to the location under audit
- Information relating to the exact folks performing the following actions
  - o Bill claims to Caremark
  - o Apply coupons or any other offset to the adjudicated patient pay amount
  - o Inform patients of patient pay responsibility
  - o Collect copayments from patients

We will respond with the narrowed list for wholesalers upon receiving the answer to the first bullet. If you can get that one over to us today, it would be appreciated. Thanks, Steve"

Jessica Vennards Response: "As requested, a report of the shipping amount of Xhance to the pharmacy under audit along with the requested signed attestation.

In response to the rest of the inquiry, you've asked for information relating to who performs the following functions in the filling of Xhance prescriptions. Our responses are below:

1. Bill claims to Caremark. The dispensing pharmacy, Price Chopper/Market 32 Pharmacy Store #244 in Sutton, MA, bills the claim to Caremark.
2. Apply Coupons or Other Offsets to the Adjudicated Patient Pay Amount. Blink Health coordinates applying coupons to the patient pay amount pursuant to a Shared Services Agreement.
3. Inform Patients of Patient Pay Responsibility. Blink Health performs that function under the previously mentioned Shared Services Agreement.
4. Collect Copayments from Patients. Similarly, pursuant to that Shared Services Agreement, Blink Health directly collects copayments from the patient. Price Chopper Pharmacy subsequently invoices Blink Health for the collected copayment amount.

Please be advised that we are aware that revisions that have been made to the Provider Manual in recent years contain certain requirements on who and where patient pay amounts are to be collected and similar requirements relevant to coupons and other offsets. Please consider this a formal request for Caremark's authorization to continue with the process as outlined above. We will also submit a more formal request to this effect. Please also be advised that we have officially paused the process outlined above for copayments and coupons with respect to CVS/Caremark claims until we have CVS/Caremark's written authorization to proceed. Please do not hesitate to contact me if you have any questions or if a discussion is helpful. Regards,

Jess" Steve McCall's response" Hi [redacted] At this point we are not granting your request to waive the Provider Manual requirements. At the conclusion of the final audit review including results of the pharmacy(s) that were in breech you may resubmit. Thanks, Steve"

I was directed to chargeback all Xhance claims OTH - Pharmacy outsourced collection of copayments to third-party, which is specifically prohibited by contract.

81 or 0.39% of the 2062 Xhance claims were MedD claims

Prescriber Verifications

PHARMACY NAME

MARKET 32 PHARMACY 244

Two Denials received – both verified as refill dates
One prescriber noted Rx sent to Blink

Invoices
There were no reversals that changed the Sum QTY billed
I applied Invoices from Cardinal, McKessin and Upsher Smith. Anda confirmed no purchases. After receiving the attestation regarding Xhance as discussed, internal warehouse purchases were applied and pharmacy the pharmacy had the remaining invoice shorts still unaccounted for.

FLOWFLEX KIT TEST 455.000 (455)
JARDIANCE TAB 25MG 690.000 (690)
NOVOLOG F/P PEN 70/30 165.000 (15)
RYTARY 48.75 CAP 195 1230.000 (30)

Rx Hardcopies
I requested Xhance Rx's and a large portion were transfers from Blink sent via fax. Many of the Xhance documents along with a fax transfer from Blink, had a fedex trackable proof of delivery but no receipt.

Copay Collection
Along with the PDF of Rx's was an excel file titled: Chopper Audit Funding Reconciliation. The email was from [redacted] and noted at the bottom "Joy, Please see attached. Notice the 2 tabs in the excel sheet. In any instance where the Patient Paid an amount to Blink, their name is highlighted in Yellow, and the 2nd tab shows the Credit Card information and date paid."
Of the receipts I did receive they included detailed register credit card transaction

Sig Logs
Pharmacy provided signatures or fedex trackable delivery confirmation.

Exit Interview
[redacted] requested the exit interview be on Monday December 5th at 10a. I informed her I would need the request in writing as MA law states no audit the first 5 calendar days. Requested in writing.
Call scheduled for Monday December 5th with an email request from [redacted] re 5th of the Month.
Scheduled on the call is myself, Jennifer Thomas, [redacted] and [redacted] forwarded invite to [redacted].
Also on the call was [redacted]
I verified who was on the call.
I noted I did not receive a completed Employee worksheet, and asked for the name of PIC? [redacted] responded "[redacted]"
I verified the states the states the pharmacy is licensed in? RI, OH, NY, PA, CT, and Fl. [redacted] said she would send a copy of the FL license.
I asked if they were shipping Xhance to and [redacted] responded she wasn't sure.
I turned the call over to Jennifer Thomas and she reviewed that the Xhance claims were being charged back for outsourcing the copay collections in direct violation of the Provider Manual. Pharmacy outsourced collection of copayments to third-party, which is specifically prohibited by contract.
[redacted] asked if there were other options than full take back.
Jenn Thomas responded "no"
[redacted] asked about next steps in the audit process and Jenn Thomas reviewed.

Reason Audit Initiated: Client

CONTAINS CAREMARK CONFIDENTIAL AND PROPRIETARY INFORMATION - DO NOT DISCLOSE - FOIA EXEMPT

PHARMACY NAME

MARKET 32 PHARMACY 244

Exhibit 78: CVS_HJC_00020368 Internal email thread discussing the “no hubs” language in CVS’s provider manual

From: Walker, Wendy H. [redacted]
Sent: 8/2/2021 3:18:06 PM
To: Correia, Brian J. [redacted]; Mccall, Steven D. [redacted]
Subject: RE: Amazon - Phoenix location - interesting discussion on Auvi-Q dispensing

Hi Brian, we do have "no hubs" language in the manual. Would the limited distribution relationship he described meet the definition of a hub? I'll bring this up to Steve in our meeting this morning as I think Steve had someone (Amy?) draft a cease and desist to Amazon already, so this can be a part 2 . . . !

From: Correia, Brian J. [redacted]
Sent: Saturday, July 31, 2021 10:52 AM
To: Walker, Wendy H. [redacted]; Mccall, Steven D. [redacted]
Subject: Amazon - Phoenix location - interesting discussion on Auvi-Q dispensing

Didn't we put "hub" language in the Provider Manual...thou shall not change a drug to a more expensive drug?

Like other hubs we find, please send a cease and desist and they will need to provide a CAP. Recall, Lavin approved shutting off WM Specialty when they did not comply to stop filling Auvi-Q.

Thanks,

Brian J. Correia, CFE | SVP, Network Business Services, CVS/Caremark
[redacted]
CVS Health | 9501 E Shea Blvd., Mail Code 025, Scottsdale, AZ 85260-6719

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Walker, Wendy H. [redacted]
Sent: Friday, July 30, 2021 8:07 AM
To: Mccall, Steven D. [redacted]
Cc: Correia, Brian J. [redacted]
Subject: Amazon - Phoenix location - interesting discussion on Auvi-Q dispensing

Steve,
I talked with Amazon yesterday re: Auvi-Q and have a follow up call with Rich this morning on the claims research:
Auvi-Q:

- So when I asked Rich about Auvi-Q and that the top 3 of 5 drugs by amt paid in his Caremark BOB for his Phoenix pharmacy were Auvi-Q - he was aware that they are dispensing it - I asked him why was Amazon electing to dispense such a high-cost drug when there are other more cost effective alternatives. He said they have a limited distribution deal with Kaleo.
- It felt so bizarre for me telling Rich that our clients do not like this, and he said that they should not cover it then; it was a "switch places" moment for me . . . I told him "so you want to be known as the Auvi-Q pharmacy to our clients?"
- I reminded him that it is not always easy for a client to update covered items as the process can be lengthy for some of the market segments. I also let him know - as he is well versed - that many of our premier clients have rights in their contracts (and have reject networks in place) and can and will decide to potentially place a pharmacy in their reject network if they determine a pharmacy is not providing cost-effective solutions - I explained it can be

tough to try and climb out of that type of situation once a pharmacy is in it. He said he would check in with John about it

About the claims research:

- I have received a few sample claims from Amazon a few times over the course of 2021 – these claims come from their "analytics area" which I'm guessing is in their finance/reconciliation dept; they do not have a problem retrieving data from their 835, but it appears challenging for them to match up and reconcile their claims – for instance, they seem to have an issue matching up claims when their own pharmacy has reversed a claim, so to Amazon, it appears (1) a claim was adjudicated as paid; (2) a claim was reversed, and Amazon does not see another paid claim, so they assume the PBM reversed it
- In every case where Paul researched this, the claim appears to have been reversed by the pharmacy and either a) resubmitted later (it could be with the same Rx number or even a different one – which might explain their inability to match it some of the time if they are resubmitting with a different Rx#); or b) the pharmacy never resubmits the claim
- We have researched less than 15 or so claims so it is difficult to detect what the pattern is; however, we do have an interesting situation in the 2 claims (Amazon thinks it's 3 claims, but it's actually 2 claims) that Paul pulled up yesterday:

First claim:
Asking about a claim they believe was paid and then reversed on 3/03/2021 – Humira - paid $5868.66 on 3/11 according to our EFT – Wellcare MAPD – nothing in the member copay field which is probably typical of this type of drug for a Med D MAPD member (I just don't do a huge amount of claims research) – end result, the claim is paid by Caremark.

Second claim(s):
This one is interesting –

1. RX Redacted - PHI – Fill Date: Redacted - PHI NPI 1821438862 / NCPDP 3061582 - Descovy

One paid claim, one reversal (not by Caremark)
THEN…
The Rx number was changed to RX Redacted - PHI and it rejected, apparently because the Redacted - PHI ate of fill was not reversed until Redacted - PHI
Redacted - PHI is next available fill date is 2021-02-02
Redacted - PHI is maximum days supply is 30; a 36 days supply was submitted
Claim was resubmitted under the second Rx number and paid on 1/22/2021

Strange to have the two different Rx#s for the same drug product during the same time period for the same person, but there could be explanations for this – we didn't research member copays to see if those changed as the member copay was $291 on an HSA plan; we did notice within the month period of the 8+ transactions, that the quantity varied from 7 to 30 to 36, along, with the 2 different Rx numbers used. Bottom line, Caremark paid Amazon pharmacy $1491.99 and the patient copay was $291.98 for a total of 1783.97 (they submitted 2316.85 + $0.90 DF, which paid at 77% of AWP or AWP – 23% (MIR) rate.

Thanks,
Wendy

Exhibit 79:
CVS_HJC_00020700 Internal email thread discussing hub pharmacy activities

From: Mccall, Steven D. [redacted]
Sent: 9/2/2022 12:20:35 AM
To: Correia, Brian J. [redacted]
CC: Mone, Michael A [redacted]
Subject: RE: Truepill - Cease and Desist

Trudhesa is hyperinflated DHE. It is believed that the copay is being collected by PhilRx – a hub.

We will handle.

Thanks, Steve

Steven McCall, R.Ph., M.B.A. | Vice President, Network Services, CVS/caremark
[redacted]
CVS Health | 9501 E. Shea Blvd, MC-020, Scottsdale, AZ 85260

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication end any attachments.

From: Correia, Brian J. <Brian.Correia@CVSHealth.com>
Sent: Thursday, September 1, 2022 5:10 PM
To: Mccall, Steven D. <Steven.McCall@CVSHealth.com>
Subject: Fwd: Truepill - Cease and Desist

Brian J. Correia, CFE | SVP, Network Business Services, CVS/Caremark
[redacted]
CVS Health | 9501 E Shea Blvd., Mail Code 025, Scottsdale, AZ 85260-6719

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by email or telephone and destroy all copies of this communication and any attachments.

From: Samantha Brown [redacted]
Sent: Thursday, September 1, 2022 8:04 PM
To: Correia, Brian J. [redacted]
Subject: [EXTERNAL] Truepill - Cease and Desist

****** External Email - Use Caution ******

Hi Brian,

Hope you are doing well and had a good flight. Following up on our earlier exchange, I'm reaching out regarding an issue that has come up between Caremark and one of our clients, Truepill. I'm hoping you can help us navigate a quick resolution or perhaps point me to someone I can talk to.

Earlier this week, CVS/Caremark sent cease and desist letters to four of Truepill's pharmacies, noting alleged violations of two sections of the Caremark Provider Manual and demanding reversal of some claims. A copy of one of the cease and desist letters is attached for your reference. Specifically,

Caremark noted that Truepill's clients were improperly using Truepill's NPI/NCPDP numbers when submitting claims to Caremark for adjudication and that Truepill's clients were improperly collecting copayments on behalf of Truepill.

The issue that I'm reaching out to you about is the collection of the copayment issue. Earlier this year, the former Head of Trade Relations and Network Strategies for Truepill, Tom Gibbons (another blast from the past), had communications with Steven McCall, Vice President of Network Services at CVS/Caremark, about copayment collections. Tom shared a flowchart of Truepill's business model with Steven, noting that CVS/Caremark and Truepill were "aligned on the need to both collect copayments and ensure appropriate documentation of that collection." Steven responded that what Tom shared with him "looks fine and aligns with our intent". Steven then added additional information related to evidence of copayment collection from an audit perspective, which Tom responded to, noting that Truepill "clients will be collecting copays in the majority of scenarios, however proof of copay collection will be required by Truepill before we dispense/ship the product. And I can confirm Truepill retains proof of copay collection for audit purposes (as well as internal controls)." A copy of the email exchange is attached.

Based on the emails between Tom and Steven, Truepill understood that CVS/Caremark had authorized Truepill's copay collection process (as permitted under the Caremark Provider Manual). As noted in the cease and desist letter, the collection of copayments must occur at the pharmacy's location and not be outsourced "unless otherwise authorized in writing by Caremark". We are hopeful that perhaps the authorization that Truepill received from Caremark just didn't make its way to the individuals who issued the cease and desist letter. Truepill will do what is necessary to comply with CVS/Caremark's requirements in its cease and desist letter, but is asking for confirmation of (1) whether a change to its business practice with regard to copay collection is in fact required in light of the prior email exchanges between Tom and Steven; and (2) if CVS/Caremark insists that a change is required to Truepill's practices with regard to copay collection, is it possible to get additional time (perhaps through the end of the year) so that Truepill can implement the coding and other changes necessary to accomplish that requirement.

We hope this isn't a major ask of CVS/Caremark. Please let me know if this is something you can assist with.

Either way, I'm glad to connect with you again, and hope your flight today was smooth and uneventful.

Thanks so much,
Sam

Samantha Brown
[redacted]

The information contained in this e-mail is confidential and is intended only for the named recipient(s) and may contain information that is privileged, attorney work product or exempt from disclosure under applicable law. If you have received this message in error, or are not the named recipient(s), please notify us and immediately delete this e-mail and any attached files from your system. Thank you.

IRS CIRCULAR 230 DISCLOSURE: To comply with requirements imposed by the Department of the Treasury, any U.S. tax advice contained in this communication (including any attachments) is not intended or written by the practitioner to be used, and that it cannot be used by any taxpayer, for the purpose of (i) avoiding penalties that may be imposed on the taxpayer, and (ii) supporting the promotion or marketing of any transactions or matters addressed herein.