PERFORMRx℠

Pharmacy Provider Manual 2022

www.performrx.com

HOW THIS MANUAL IS ORGANIZED

This pharmacy provider manual has been organized by topic which includes a table of contents. This manual is an administrative program guide to assist network retail, mail order, long-term care, and home infusion pharmacy providers with an understanding of the Pharmacy Benefit Management services administered by PerformRx, LLC.

CONTENTS

INTRODUCTION

PerformRx strives to partner with clients to reduce cost, increase performance, and better coordinate health care with cutting-edge, proprietary technology. Our goal is to provide continuous improvement in the quality and efficiency of health care management to improve patient outcomes and financial performance.

urac ACCREDITED
Pharmacy Benefit Management
Expires 11/01/2022

urac ACCREDITED
Drug Therapy Management
Expires 04/01/2024

PROGRAM CONTACT INFORMATION

Department	Phone/Fax	Email
General Inquiries	Phone: 1-866-533-5492	General Inquiries
Request a PerformRx Information Pack	Phone: 1-866-533-5492	PerformRx Sales & Marketing
Media-related Inquiries	Phone: 267-298-2410 Fax: 1-215-937-8776	Corporate Communications
Pharmacy Network & Contracting	Phone: 1-800-555-5690 Fax: 1-800-684-5504	Pharmacy Network Management
Pharmacy Help Desk	Phone: 1-866-533-5492	
Pharmacy Reimbursement Appeals	Phone: 1-800-555-5690 Fax: 1-800-684-5504	Pharmacy Pricing
Specialty Drug Management Services	Phone: 1-800-555-5690	
Providers Portal	https://prx.darwinrx.com/providers	

SUMMARY OF PLAN BENEFITS

Transitional Supplies
New members are eligible to receive a transitional supply within the first 90 days of coverage. Transitional supplies should be dispensed for the quantity written, not to exceed a **30 day supply**.

Over-the-counter Medications
Visit the plan's website to search the formulary.

Early Refill Policy
The plan will allow a lost, stolen, spilled, and vacation early refill per rolling 12 months for all medications with the exception of Schedule II drugs.

Pharmacies may accept a member's refill request at **85% utilization**.

Mail Order
Mail Order services are available for the plan. Contact the Pharmacy Help Desk for more information.

Coordination of Benefits (COB)
If the member states that they have a primary insurance, the pharmacy must first bill the claim to the primary insurance.

If a member indicates that there is no primary insurance, the pharmacy may submit the claim with an Other Coverage Code of "01" to override a COB rejection.

Note: To obtain additional information about COB claims, visit our website https://www.performrx.com/who-we-help/providers/provider-resources.aspx and reference the client's payer sheets.

POINT OF SERVICE CLAIM PROCESSING

BIN
Reference the plan prescription card for BIN specifics.

PCN
Reference the plan prescription card for PCN specifics.

Group ID/Person Code
No Person Code or Group ID is required for claims processing.

Multi-ingredient Submission
The pharmacy will submit compound claims through the claims processor using the Multi-Ingredient Compound (MIC) prescription logic. See the payer sheet for a list of the processing requirements.

https://www.performrx.com/who-we-help/providers/provider-resources.aspx

Product Service Codes/Dispense As Written Codes
The claims processor supports the standard NCPDP/NPI Dispense as Written (DAW) product service codes. To ensure accurate reimbursement and compliance with regulatory requirements, always use the correct DAW codes during the submission of a claim.

- **DAW 0:** No product selection indicated
- **DAW 1:** Substitution not allowed by prescriber
- **DAW 2:** Patient requested product dispensed
- **DAW 3:** Pharmacy-selected product dispensed
- **DAW 4:** Generic drug not in stock
- **DAW 5:** Brand Product dispensed as generic
- **DAW 6:** Override
- **DAW 7:** Brand drug mandated by law/regulation
- **DAW 8:** Generic drug not available in marketplace
- **DAW 9:** Other

Prescription Origin Codes
CMS requires pharmacies to submit a valid prescription origin code on Medicare prescription claims. All claims will be denied at the point-of-sale when submitting an invalid or missing prescription origin code. If the pharmacist is not able to populate these values within the pharmacy's practice management system, the pharmacist should contact the pharmacy's current software vendor for assistance.

Prescription Origin Code	Description
1	Written Prescription
2	Telephonic Prescription
3	Electronic Prescription
4	Facsimile Prescription

Hospice

Contact the Pharmacy Help Desk for assistance with claim rejections related to the member's hospice status.

Long Term Care (LTC)

See page 10 for processing requirements.

Maximum Day Supply

The maximum day supply for the plan is up to 90 days depending on the pharmacy setting.

Vaccines

Pharmacists in participating pharmacies may administer vaccines if allowed by state law. See the payer sheet for a list of the processing requirements.

https://www.performrx.com/who-we-help/providers/provider-resources.aspx

Electronic Claims Submission

Pharmacies are required to submit claims electronically to the claims processing system in NCPDP Version D.0 format. Pharmacies can submit and reverse claims online up to **90 days** from the original date of service based on the client's benefit design.

If a pharmacy attempts and is unable to submit a claim for reimbursement electronically through the claims processing platform, the pharmacy may submit the claim information via a paper universal claim form (UCF) up to **180 days** from the original date of service.

Universal Claims Forms

Universal claim forms may be submitted up to **180 days** from the original date of service.

The mailing address:

PerformRx
P.O. Box 516
Philadelphia, PA 19029

Online Claim Billing Requirements

Pharmacies are required to submit claims with a valid prescriber NPI number, BIN/PCN, and member identification number on all pharmacy claims. Refer to the specific client's payer sheets located on our website at https://www.performrx.com/who-we-help/providers/provider-resources.aspx

CLAIMS PROCESSING INTERPRETATION TOOL

The Claims Processing Interpretation Tool can be used as a guide to understand what a rejection means when a pharmacy receives a rejection message after processing a pharmacy claim.

Rejection	Reasons
National Drug Code (NDC) number is not on file	The NDC number that the pharmacy is using is not on file with Medi-Span. To resolve this issue, the pharmacy will use an alternate NDC number or call the Pharmacy Help Desk for assistance.
The member is not eligible	The pharmacy will contact the Pharmacy Help Desk for verification.
The member has other insurance	The member may have primary insurance. The pharmacy will bill the claim to the primary insurer and bill the Medicaid plan second. If the member states coverage with the primary is no longer active, the pharmacy will process the claim with an Other Coverage Code of "01".
The claim rejects for duplicate therapy	The pharmacy needs to verify the drug therapy with the prescribing physician and call the Pharmacy Help Desk for assistance.

Rejection	Reasons
The claim rejects for "refill too soon"	Dosage Increase: The pharmacy should submit the claim with Submission Clarification Code "5." If the claim does not pay, check the free-form messaging for the next refill date. For all other refill reasons, verify the reason for the early refill and contact the Pharmacy Help Desk.
The medication requires a prior authorization/product service not covered/step-therapy	The pharmacy will call the Pharmacy Help Desk for assistance.
The claim rejects for quantity limit/dosing	The pharmacy will call the Pharmacy Help Desk for assistance.
The claim rejects for an obsolete medication	The NDC number that the pharmacy is using is obsolete. To resolve this issue, the pharmacy will use an alternate NDC number or call the Pharmacy Help Desk for assistance.
The medication may be covered under Part B	The pharmacy needs to verify the diagnosis and payer of transplant, if applicable and call the Pharmacy Help Desk for assistance.
The claim rejects for invalid prescriber ID	The prescriber ID number on the claim may not be the prescriber's National Prescriber Identification (NPI) Number. The pharmacy will verify the information, update, and resubmit the claim. If additional assistance is required, the pharmacy will call Pharmacy Help Desk.
The claim rejects for invalid days' supply	The supply on the claim is more than/less than the plan's allowable days' supply. *Please review the maximum days' supply guidelines found on page 5.*
The claim rejects for invalid date of birth	The pharmacy needs to verify the member's date of birth. If the date of birth is incorrect, the pharmacy will update their system and reprocess the claim. If the date of birth in the system matches the member's actual birthdate, the pharmacy will contact the Pharmacy Help Desk for assistance.

MEMBER ELIGIBILITY

Member Eligibility
A covered member's eligibility can be verified through the claims processor during claim adjudication or by contacting the Pharmacy Help Desk.

Member Identification Number
The member identification number can be found above the member's name on the identification card. If the member does not have their identification card, contact the Pharmacy Help Desk for assistance.

PRIOR AUTHORIZATIONS

Prior Authorization/Coverage Determination
For medications that require pre-authorization/coverage determination, inform the prescriber of the requirement. A member or their appointed representative may also initiate a coverage determination.

If the member does not have a prior authorization/coverage determination on file for the medication, the pharmacy will provide the member with a copy of the *Medicare Drug Coverage and Rights* form.

Status of a Prior Authorization/Coverage Determination
To check on the status of a member's prior authorization/coverage determination, contact the Pharmacy Help Desk.

SPECIALTY MANAGEMENT

Coverage Procedure for all High Cost Self-injectable Medications
All high cost injectable medications require pre-authorization/coverage determination. For assistance with injectable medications, please contact the Pharmacy Help Desk.

Home Infusion Billing
For assistance with home infusion billing, contact the Pharmacy Help Desk.

FORMULARY

A list of medications covered by the plan can be found on the plan's website.

Part D Coverage

The following medications may be covered by the plan under Part D (this is not an all-inclusive list):

- Most prescription drugs
- Insulin (excludes insulin used in a pump)
- Insulin supplies, such as standard and needle-free syringes, needles, gauze, alcohol swabs and insulin pens.
- Most vaccines (product and administration); exceptions include flu and pneumonia vaccines, Hepatitis B vaccines (when they meet CMS coverage requirements for Part B coverage) and vaccines used for the treatment of an injury or illness (e.g., tetanus vaccine).
- Prescription-based smoking cessation products
- Injectable drugs that may be self-administered
- Injectable or infusible drugs administered in the home setting and not covered by Medicare Part A or Part B
- Infusion drugs not covered under Medicare Part B and administered in the home via intravenous (IV) drip or push injection. Examples include, but are not limited to, intramuscular drugs, antibiotics, parenteral nutrition, immunoglobulin and other infused drugs.
- At-Home COVID-19 Test Kits

**If a claim rejects for any of the aforementioned products, contact Pharmacy Help Desk for assistance.*

Part B Covered

Pharmacy Help Desk provides assistance with the following items thru Medicare Part B billing (this is not an all-inclusive list):

- Diabetic testing supplies, such as blood glucose meters, test strips and lancets
- Oral immunosuppressive drugs secondary to a Medicare-approved transplant
- Oral antiemetic drugs for the first 48 hours after chemotherapy
- Inhalation drugs delivered through a nebulizer with the service location being the patient's home.
- Certain drugs administered in the home setting that require the use of an infusion pump, such as certain antifungal or antiviral drugs and pain medications
- Flu, pneumonia, and COVID-19 vaccines
- Insulin used in a pump
- Physician-administered injectable drugs

If a claim rejects for any of these products, contact the Pharmacy Help Desk for assistance. Also, contact the Pharmacy Help Desk regarding formulary alternatives for diabetic supplies.

LONG-TERM CARE (LTC)

Long term care claims must be submitted with the patient location code of '03' in the NCPCP Patient location field to assure correct LTC reimbursement.

LTC Codes

Type of Service	Patient Residence	Pharmacy Service Type
Long-term care resident	03 or 09	05
Assisted living resident	04	05
Home infusion (at home)	01	05
Home infusion therapy (at assisted living facility)	04	05
Assisted living facility as retail	04	01
ICF/MR	09	05
Hospice	11	05

Override Codes

The pharmacy should use the applicable processing code to process the claim.

Reason	Claims processor POS Code
Dose change (maximum day supply)	5
Leave of absence (maximum of 7-day supply)	14
Emergency Box Kit (maximum 4-day supply)	16
Re-admission or Level-of-Care change	Contact Pharmacy Help Desk
Medically Necessary	7

Long-Term Care (LTC) Oral Solid Brand Processing Requirements

LTC claims for Oral Solid Brand Drugs are limited to a 14 day supply and must be processed with an appropriate combination Submission Clarification Code (SCC) and Specialty Package Indicator (SPI)for the claim to pay.

To qualify, a drug must be:

- Brand name
- Oral medication
- Solid drug form (tablets, capsules, etc.)
- Non-mail order
- Member resides in a nursing facility or intermediate care facility (Patient Residence Code = 03 or 09)

Claims will reject with **NCPDP Error 612 - LTC Appropriate Dispensing Invalid Submission Clarification Code (SCC) Combination** or **Error 613 - The Packaging Methodology or Dispending Frequency is Missing or Inappropriate for LTC short cycle.**

Day Supply	Submission Clarification Code Requirements	Specialty Package Indicator Requirements
14 days or less	SCC 16 or 22-35	SPI 1-9
Up to a 31 day supply	Both SCC 21 and 36	No SPI required

Long-Term Care (LTC) Transitional Supply

Medicare Part D members who reside in long-term care who are new to the Part D program or new to the plan may be entitled to up to a 31 day supply for Part D medications that are non-formulary or formulary with criteria within the first 90 days of enrollment.

Pharmacies experiencing problems with processing transitional supplies should contact the Pharmacy Help Desk for assistance.

PHARMACY NETWORK

Pharmacy Payment Cycle

The claims processor manages check payments four times per month. The cycles run the 8th, 16th, 24th and the last day of the month. Checks are mailed within eight business days from the end of each cycle. Please contact Pharmacy Network Management if additional information is needed.

Pricing Information

The claims processor updates the PerformRx pricing file, including average wholesale prices (AWPs) and wholesale acquisition costs (WACs), routinely with updates from Medi-Span.

Pharmacies can now access our web portal PerformMAX to view PerformRx's Maximum Allowable Cost (MAC) list, which is updated on a weekly basis.

Registering for PerformMAX:

1. Visit https://pmax.performrx.net/ to go to the PerformMAX login screen.
2. Click "Register here" to go to the "Create Membership" screen.
3. Select "Pharmacy" as your user type, then fill out the fields and click "Submit."
4. You will receive a notification that your request has been submitted and is being reviewed by PerformRx.
5. PerformRx will review and verify your application.
6. Upon verification, you will receive an automated email from PerformMAX notifying you of your approval.
    a. When you login, PerformMAX uses the email as the login name and the password that you selected when creating your membership.

Utilizing the MAC list search:

1. Click on the "Medicare Part D" menu, on the top right of the screen.
2. Click on "MAC Price List".
3. Enter the NDC number.
4. Click Search.

Pharmacy Reimbursement Appeals

Pharmacies may request reimbursement appeals related to the MAC by contacting the PerformRx pricing department. Appeals can be submitted by fax to 1-800-684-5504, by calling 1-800-555-5690, or emailing PerformRxPharmacyPricingDept@performrx.com.

Pharmacy Credentialing

Credentialing and re-credentialing initiatives exist to ensure that participating providers abide by the criteria established by PerformRx, as well as government regulations and standards.

Participating pharmacies are responsible for ensuring that all pharmacy credentials are valid and up-to-date. Participating pharmacies are responsible for informing PerformRx Pharmacy Network Services of any changes in their credentialing information and ensuring their pharmacy certificates are up-to-date. Updates should be faxed to 1-866-935-3499 or via email PharmacyNetworkCredentials@performrx.com.

Pharmacy Audits

Pharmacies must cooperate with PerformRx auditors and promptly provide access to all information/documents needed by auditors, including copies of prescriptions, patient signature logs, purchase invoices and documentation, including without limitation all computer data. PerformRx provides authorized representatives to audit the pharmacy's records pertaining to member's prescriptions and the provision of covered services with 30 days' notice. The audit record must be maintained for 10 years.

PerformRx may notify pharmacies of complaints it receives with respect to customer service, any irregularities in billing practices or procedures, overpayment, fraud or abuse, non-compliance with PerformRx policies and procedures, or any other issues that PerformRx may discover by audit or otherwise. The pharmacy must comply with PerformRx for resolution and provide responses to PharmacyAudit@performrx.com.

A third-party audit vendor conducts audits on behalf of PerformRx. On-site and/or desktop audits are randomly conducted on a routine basis.

The criteria used in conducting retrospective on-site and/or desktop audits include:

1. Excessive quantity dispensed for days' supply limitations
2. Early refill
3. Duplicate dispensing for school/work/Letter of Agency
4. Drug billed is different than what was dispensed
5. Possible prescription splitting
6. Package billing errors
7. Valid prescriptions
8. Dispense as Written parameters
9. Duplicate therapy/prescriptions
10. Temporary supply
11. Diagnosis codes

Pharmacy records may be requested and reviewed by PerformRx at any time.

Signature Logs

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

- Member name
- Prescription/medication reference number
- Date medications were picked up, and or delivered to a member
- The signature of the member to whom the prescription was dispensed or the member's representative

Signature logs and/or electronic facsimile signatures must be retrievable for in-store or desktop audits upon request or written notice. A pharmacy is not entitled to payment for any claim for which there is no signature of the eligible person or authorized representative on the Third-Party Signature Claim Log. *PerformRx may reverse any claim for which the pharmacy does not produce this information for an audit.*

Audit Appeals Process

Pharmacies wishing to appeal the results of an audit may do so in writing within 30 calendar days from the date of the audit letter by emailing PharmacyAudit@performrx.com or in writing to:

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

Once all documentation from the audit is received PerformRx's third-party audit vendor contacts the pharmacy via an appeal letter. To ensure an impartial review, finalized pharmacy audit documentation is independently reviewed by the third-party audit company. PerformRx's audit vendor is responsible for the appeal's process which ensures unbiased pharmacy auditing practices.

Pharmacy Complaints

The pharmacy shall promptly investigate all concerns or complaints related to the quality of pharmaceutical services provided under the pharmacy's contractual agreement. The pharmacy shall provide written reports to PerformRx of the actions taken in response to such quality issues, within 10 days of PerformRx' s referral of such issues to the pharmacy, and thereafter as necessary until resolved. The pharmacy network email is pharmacynetwork@performrx.com and the fax number is 1-800-684-5504.

Cultural Competency

Our pharmacies are required to offer cultural and linguistic service when providing counseling and consultation to members.

Participating Pharmacy Responsibilities

- Prescription verification - Prior to dispensing any covered medications, the pharmacy shall verify the accuracy and authenticity of all prescriptions.
- Eligibility verification - Prior to delivering pharmaceutical services, the pharmacy shall verify that the person requesting the services is an eligible member by using the PerformRx authorized Online Claims Adjudication System (OCAS) or by contacting PerformRx.
- Dispensing - The pharmacy agrees to dispense covered medications and provide pharmaceutical services to members as authorized by the claims processor via OCAS.
- Signature Logs - The pharmacy shall maintain a signature log that shows the receipt of covered medications and services, including the receipt date, in accordance with pharmacy laws and standards. The log shall be signed by the member or an authorized representative.
- The pharmacy must notify PerformRx of changes in location, ownership, or any changes that could impact member access to the pharmacy.

Compliance to Policy and Procedures

- A third-party audit vender will verify if the pharmacy is maintaining prescription record-keeping which also follows the most current CMS guidelines. The pharmacy will document Federal Tax ID, State Tax ID, pharmacy insurance information, Drug Enforcement Agency, state board, and employee licenses and expiration dates.
- The pharmacy's compliance program shall be subject to audit by PerformRx and/or the plan in accordance with the audit provisions of this agreement. The pharmacy shall, upon reasonable request of PerformRx, provide PerformRx with certification of its compliance with the training and conflict of interest requirements. The pharmacy represents that it complies with minimum standards for pharmacy practices as established by the state in which it operates.
- The authority of the Physical Health – Managed Care Organization (PH-MCO) to ensure the pharmacy's participation and/or compliance with the PH-MCO's quality management, utilization management, member grievance and other policies and procedures, as amended.
- All participating pharmacies are required to adhere to all regulatory and contractual requirements. Refer to your pharmacy agreement.

FRAUD, WASTE, AND ABUSE

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

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

ABUSE is defined as a subset of waste and entails the exploitations of "loopholes" to the limits of the law, primarily for financial gain.

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

How to Report Suspected Fraud or Abuse

To report suspected fraud or abuse or other compliance violations anonymously, contact PerformRx:

Source	
Online	https://www.performrx.com/contact/fraud-waste-abuse.aspx
Telephone	1-800-575-0417

To find additional information about fraud and abuse, visit http://www.cms.hhs.gov/FraudAbuseforProfs/.

MEMBER RIGHTS

Member Rights and Responsibilities

The plan is committed to treating its members with respect. The plan, its network providers, and other providers of service, may not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis prohibited by law.

Member Rights

Our plan must honor your rights as a member.

- We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.).
- PerformRx, in partnership with network pharmacies, provides support and facilitates communication in languages including Spanish, Arabic, Mandarin, Vietnamese, Haitian Creole, and others via language line vendor services.
- We must treat you with fairness and respect at all times.
- We must ensure that you get timely access to your covered services and medications.
- We must protect the privacy of your personal health information.
- We must give you information about the plan, its network of providers, and the services we cover.
- We must support your right to make decisions about your care.
- You have the right to file complaints and to ask us to reconsider decisions we have made.
- You have the right to know what you can do if you believe you are being treated unfairly or your rights are not being respected.
- You are able to get more information about your rights.

You also have some responsibilities as a member of the plan.

- Familiarize yourself with the covered services and the rules you must follow to get these services.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan.
- Help your doctor and other providers help you by giving them information, ask questions, and follow through on your care.
- Be considerate.
- Pay what you owe.
- Tell us if you move.