LIVINITI™
formerly Southern Scripts

Pharmacy Services Manual

Liviniti simplifies the complexities of the PBM world.

www.liviniti.com

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Liviniti Overview

Liviniti is pleased to welcome you and your pharmacy to our network. We value you as a provider of high-quality, cost-efficient pharmacy services. Liviniti publishes the Pharmacy Services Manual to serve as a guide for pharmacy staff in claims processing and provides overall terms, conditions, policies, and procedures of Liviniti. We ask that you also refer to your Pharmacy Network Agreement.

Liviniti provides a prescription benefit management service for many different plans, each with its own guidelines. Plans may vary regarding things such as covered items, copays/coinsurance, and quantity limits. The claims processing system will provide accurate information regarding the individual member, group, and pricing.

We hope that answers to most of your questions may be obtained through this Pharmacy Services Manual. For all other questions or further clarification, please contact our Pharmacy Help Desk.

Need to Talk?

Liviniti Pharmacy Help Desk

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

The Liviniti Pharmacy Help Desk will be able to resolve online, concurrent DUR claim processing issues, including but not limited to:

- Pharmacy coding errors.
- Prior authorization (PA).
- Coordination of Benefits (COB)/Third Party Liability (TPL).
- Duplicate therapy.
- Early refills and frequency limitation.
- Duplicate drugs.
- Potential drug interaction(s).
- Preferred Drug List.
- Coordination of Benefits.
- Quantity Limits.
- Reimbursement Issues.
- Network Contracting.

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Hours of Operation and Contact Telephone Numbers

If you have difficulty in transmitting claims for Liviniti members due to host processing or claim submission errors, please contact the Pharmacy Help Desk.

Liviniti Pharmacy Help Desk
1-800-710-9341 **24/7/365**

Liviniti Prior Authorization Fax Line
1-866-404-1771 **Monday-Friday** **8:00 am – 4:00 pm (CST)**

Claims Processing Coding

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

Liviniti BIN Number:	Liviniti Processor Control Number:
015433	**SSN**

Note: Pharmacies must contact their switching network to update BINs.

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Pharmacy Enrollment

Credentialing

Prior to becoming a participating network pharmacy provider, a pharmacy must complete the credentialing process and submit all required documentation to Liviniti. The pharmacy must include an executed copy of the Pharmacy Network Agreement.

A contract can be obtained by contacting the Provider Relations Department: pharmacynetwork@liviniti.com.

To request a copy of your Pharmacy Network Agreement, please contact the Provider Relations Department: pharmacynetwork@liviniti.com.

Credentialing and re-credentialing ensure participating providers abide by the criteria established by Liviniti as well as governmental regulations and standards. The applicant must comply with the credentialing and re-credentialing initiatives required by Liviniti and agree to provide Liviniti with documentation and other relevant information that may be required in association with such initiatives. All applicants are subject to the credentialing review and verification process. Liviniti has the right to determine whether the applicant meets and maintains the appropriate credentialing standards to participate as a pharmacy in the Liviniti Pharmacy Network.

Documents required, but not limited to:

- Executed Pharmacy Network Agreement
- Copy of Liability Insurance
- State Pharmacy Permit
- DEA License
- ACH (Direct Deposit) – Required to receive payment.
- W-9 Form - https://liviniti.com/providers

Upon request, the pharmacy will provide additional information that may be needed to document compliance with Liviniti credentialing review.

A pharmacy's participation in the Liviniti Pharmacy Network is voluntary. Participation in one network does not guarantee or mandate participation in another network. A pharmacy providing Covered Services to a Liviniti member affirms participation in a network and agreement with terms and conditions set forth in this Pharmacy Services Manual and the Pharmacy Network Agreement.

The Liviniti Pharmacy Agreement states that a pharmacy will be terminated immediately if it violates any federal, state, or local law. Any violation will include immediate termination if Liviniti is notified that the pharmacy has not complied with any tax laws.

A participating pharmacy may be referred to as a pharmacy provider. Each pharmacy provider may be subject to re-credentialing as required based on state and federal law requirements as well as audit activities. All standard documentation is to be submitted to NCPDP for verification.

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Expectations of Our Pharmacy Providers

- Support of all formularies published by Liviniti or its payors.
- Sufficient inventory of prescription drugs commonly used in the retail pharmacy setting and consistent with formulary.
- Responsible for accuracy, integrity, completeness, and timeliness of data and information submitted.
- Maintain all Professional Standards in accordance with applicable pharmacy law.
- Maintenance of a signature log at each pharmacy location with required member signatures or capture and store signatures electronically confirming Member's receipt of Covered Medication.
- Prescription error prevention measures and processes for handling prescription errors.
- Filling prescriptions according to the prescriber's directions.

Licensure

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

Confidentiality and Proprietary Rights

- Pharmacy provider shall maintain the confidentiality of any confidential or proprietary information of Liviniti, but not limited to, any confidential pricing, marketing, or product information; Formulary information; in-network lists; information on invoices and reports provided by Liviniti; the Pharmacy Network Agreement, its terms, conditions, and contents; and any other information designated as confidential or proprietary.
- All Member information related to Covered Prescription Services and other records identifying Member shall be treated by the participating pharmacy as confidential. All materials relating to pricing, contracts, programs, services, business practices and procedures of Liviniti are proprietary and confidential. The participating pharmacy must maintain the confidential nature of such materials and return them to Liviniti upon termination of the agreement.

Changes in Documentation and Other Information

- Participating pharmacies must notify Liviniti in writing of any changes in documentation and other information provided to Liviniti in connection with any credentialing or re-credentialing initiatives. Pharmacy updates are processed through NCPDP monthly. Please submit all changes to NCPDP immediately, to ensure timely processing.

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Reporting of Investigations and Disciplinary Actions

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

Federal and State Credential and Exclusion Databases

- Liviniti will periodically review Federal and State databases to monitor the regulatory actions of all participating pharmacies and pharmacists.
- Federal databases include the Office of Inspector General (OIG) and SGA databases that identify exclusions to federal programs. If your pharmacy or personnel from your pharmacy is listed on the OIG or SGA databases, Liviniti must immediately terminate our agreement. Liviniti will not allow any excluded pharmacy into our network. Liviniti will also review the DEA database to ensure that our participating pharmacies are able to dispense controlled substances. Liviniti also routinely reviews prescribers to ensure participation in Federal programs and controlled substance writing authority.
- State databases include applicable state Board of Pharmacy (or similar state department) to review state license activity and disciplinary actions. If Liviniti identifies a questionable license or disciplinary action, the information will be reviewed for further action.

Pharmacy Provider Rights & Responsibilities

Rights

- To be treated with respect and dignity.
- To receive prompt and courteous responses to inquiries directed at Liviniti.
- To receive timely communications from Liviniti on items affecting pharmacy services.
- To express a complaint and receive a response within a reasonable amount of time.
- To expect confidentiality of business and credentialing documents.

Responsibilities

- Comply with laws and provide services in a manner compliant with the highest standards.
- Maintain the confidentiality of members in accordance with HIPAA privacy laws.
- Maintain facility and equipment in first-class condition.
- Provide annual training for staff to mitigate fraud, waste, and abuse.
- Maintain all materials relating to pricing, contracts, programs, services, and business practices of Liviniti as proprietary and confidential.

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- Maintain and enforce comprehensive policies and procedures for operation.
- Non-discrimination against members.
- Fill prescriptions according to the prescriber's directions.
- Assure the authenticity of the Prescription Drug Order.
- Seek to prevent Prescription Drug Orders from being filled by multiple pharmacies.
- Ensure reasonable verification of the identity of the patient, prescriber, and if appropriate caregiver.
- Obtain and maintain patient medication profiles.
- Maintain complete records related to:
- Original prescriptions
- Prescriber information
- Signature and/or electronic tracking logs
- Refill information
- Patient profiles
- Wholesaler, manufacturer, and distributor invoices
- Display all DUR alerts to the dispensing pharmacist; respond to all online edits.
- Take appropriate action regarding suspected adverse drug reactions and errors.
- Inform patients or caregivers about drug recalls.
- Assure that medications and devices are maintained within appropriate temperature, light, and humidity standards during storage and shipment.
- Provide instructions to the patient on storage, dosing, side effects, potential interactions, and use of medication dispensed in accordance with professional practice guidelines.
- Collect from each member the applicable copayment or coinsurance.
- Submit claims electronically, at the point-of-sale, only for the patient for whom the prescription was written by the prescriber.
- Utilize an accurate National Provider Identifier (NPI) in the correct NCPDP data field.
- Reverse claims for products returned to stock within 14 days of the original service date.
- Notify Liviniti immediately of any status change in pharmacy or pharmacist license.
- A dispensing pharmacist is under no obligation to dispense a prescription, which in his/her professional opinion, should not be dispensed.
- Professional Judgment: nothing in this Agreement shall prohibit pharmacy's pharmacists from exercising professional judgment in the dispensing of Covered Prescription Services and such pharmacists may refuse to dispense any Covered Drug based upon their professional judgment.

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Payer Sheet

General Information

Payer Name: Liviniti		Date: 02/01/2021
Plan Name/Group Name: Liviniti	BIN: 015433	PCN: SSN
Processor: New Tech Computer Systems		
Effective as of: 02/01/2021		NCPDP Telecommunication Standard Version/Release #: D.Ø
NCPDP Data Dictionary Version Date: 07/2007		NCPDP External Code List Version Date: 04/2012
Contact/Information Source: Trent Jackson		
Certification Testing Window: N/A		
Certification Contact Information: Certification not required		
Provider Relations Help Desk Info: 800-710-9341		
Other versions supported: N/A		

Transactions Supported

Payer: Please list each transaction supported with the segments, fields, and pertinent information on each transaction. Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal

Field Legend for Columns

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	
REQUIRED	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	
QUALIFIED REQUIREMENT	RW	“Required when”. The situations designated have qualifications for usage.	
SITUATIONAL	S	The Field has been designated situational.	
OPTIONAL	O	The Field has been designated as optional and is not required.	

Fields not used in the Claim Billing transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

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Claim Billing Transaction

The following lists the segments and fields in a Claim Billing Transaction for the NCPDP Telecommunication Standard Implementation Guide Version D.Ø.

	Transaction Header Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	015433	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	SSN	M	
1Ø9-A9	TRANSACTION COUNT	01 to 04	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	

	Patient Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGEMENT IDENTIFICATION	01	M	
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5-	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	

	Insurance Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	04	M	
3Ø2-C2	CARDHOLDER ID		M	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE		S	
301-C1	GROUP ID		M	
303-C3	PERSON CODE		R	
306-C6	PATIENT RELATIONSHIP CODE		O	

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	Claim Segment			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGEMENT IDENTIFICATION	07	M	
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW) CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		R	
419-DJ	PRESCRIPTION ORIGIN CODE		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT		R	
42Ø-DK	SUBMISSION CLARIFICATION CODE		R	
3Ø8-C8	OTHER COVERAGE CODE		S	
461-EU	PRIOR AUTHORIZATION TYPE CODE		S	
462-EV	PRIOR AUTHORIZATION NUMBER		S	
996-G1	COMPOUND TYPE		O	

	Pricing Segment			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	11	M	
4Ø9-D9	INGREDIENT COST		R	
412-DC	DISPENSING FEE		R	
438-E3	INCENTIVE AMOUNT		S	
481-HA	FLAT SALES TAX AMOUNT		RW	If sales tax is required
482-GE	PERCENTAGE SALES TAX AMOUNT		RW	If sales tax is required
483-HE	PERCENTAGE SALES TAX RATE		RW	If sales tax is required
484-JE	PERCENTAGE SALES TAX BASIS		RW	If sales tax is required
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	

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423-DN	BASIS OF COST DETERMINATION		O	

	Prescriber Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	03	M	
466-EZ	PRESCRIBER ID QUALIFIER	Ø1= NATIONAL PROVIDER ID	R	
411-DB	PRESCRIBER ID		R	
427-DR	PRESCRIBER LAST NAME		R	
364-2J	PRESCRIBER FIRST NAME		O	

	Coordination of Benefits Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	05	M	
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		M	
34Ø-7C	OTHER PAYER ID		M	
443-E8	OTHER PAYER DATE		M	
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	M	
472-6E	OTHER PAYER REJECT CODE		M	
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25	M	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		M	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		M	
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	O	
393-MV	BENEFIT STAGE QUALIFIER		O	
394-MW	BENEFIT STAGE AMOUNT		O	

	DUR/PPS Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	08	M	
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	O	
439-E4	REASON FOR SERVICE CODE		O	
44Ø-E5	PROFESSIONAL SERVICE CODE		O	
441-E6	RESULT OF SERVICE CODE		O	
474-8E	DUR/PPS LEVEL OF EFFORT		O	
475-J9	DUR CO-AGENT ID QUALIFIER		O	
476-H6	DUR CO-AGENT ID		O	

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	Compound Segment			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	10	M	
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	03= National Drug Code	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		O	

	Vaccine Fee Reimbursement			Claim Billing
Field #	NCPDP Field Name	Value	Payor Usage	Payer Situation
439-E4	REASON FOR SERVICE CODE	PH	R	
44Ø-E5	PROFESSIONAL SERVICE CODE	3N	R	
441-E6	RESULT OF SERVICE CODE	MA	R	

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Claim Reversal Transaction

	Transaction Header Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	015433	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	SSN	M	
1Ø9-A9	TRANSACTION COUNT	01 - 04	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National Provider ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

	Insurance Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	04	M	
301-C1	GROUP ID		R	

	Claim Segment Identification (111-AM) = "Ø7"			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	07	M	
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
4Ø3-D3	FILL NUMBER		R	

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Claims Adjudication

Claims Processing System

The Liviniti Claims Processing System sets forth pricing, eligibility, and other information that governs participation in the network applicable to each Plan Sponsor and Member.

Each claim a pharmacy provider submits must contain complete and accurate information for each prescription dispensed. The pharmacy provider will transmit claims to Liviniti with all required fields as defined by Liviniti using an NCPDP electronic claims standard in effect on the date of service. Claims must be submitted only for the Member for whom the prescription is written by the Prescriber.

The Liviniti Claims Processing System also provides information necessary to effectively implement Liviniti's clinical and benefit management initiatives such as drug utilization review, prior authorization, and formulary management programs on behalf of Plan Sponsors. The pharmacy provider will submit all claims through the Liviniti Claims Processing System and will comply with all information communicated via the Liviniti Claims Processing System or otherwise by Liviniti.

The pharmacy provider will submit all Liviniti claims simultaneously with dispensing unless unusual circumstances require otherwise, in which event the pharmacy provider will submit Liviniti claims within 90 days of the date of service. Liviniti Claims Processing System claims can be reversed during the cycle in which the specific transaction is adjudicated and up to 90 days after the date of service. Claims submitted to Liviniti after the applicable claim's cutoff date may not be eligible for payment.

Liviniti will pay all Clean Claims in accordance with the payment rate established for the applicable plan within Liviniti's next regular claims cycle less the applicable co-payment/ coinsurance, deductible, or other payments, such as administrative fees for certain programs, to be paid directly by the Member.

The authorization code transmitted to the pharmacy provider via the Liviniti Claims Processing System does not in any way limit or preclude Liviniti's right to review or audit claims.

General Submission Policies

All claims for Covered Services are required to be submitted to Liviniti.

- Claims should be submitted at the time of service electronically through the SS Claims Processing System.
- There are no financial claw backs, reconciliation fees or offsets, or offsets to adjudicated claims other than exhibited by state or federal law-required transactions.
- The online system is generally available for claims processing 24 hours a day, 365 days a year.
- All claims must be accurate and complete.
- All claims must be transmitted using the actual date of fill.
- All pharmacy providers must comply with NCPDP standard transactions for pharmacy drug claims, coordination of benefits, and related pharmacy services.
- The submitted NDC must be the complete NDC of the medication dispensed including the actual package size used.
- Benefit design and formulary coverage may vary by Plan Sponsor. As a result, the pharmacy provider must rely on the online system for determining medication coverage and Member copays.

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- Over the counter (“OTC”) medications submitted as a prescription through the SS System should be filled pursuant to a prescriber’s prescription or order. OTC coverage will be subject to the Member’s specific plan design.
- Generic medications should be dispensed whenever possible and as permitted by law.
- Follow all guidelines and requirements when submitting claims with a Dispense as Written (DAW) Code as set forth in this manual.
- Submit accurate National Provider Identification (NPI) on all claims.
- Collect member copay/co-insurance. Pharmacy providers will not routinely waive copay/co-insurance.
- Any claim for prescription drugs not picked up by the Member (including partials) must be reversed online within the time frame stated in the Pharmacy Network Agreement.
- Pharmacy providers that are required to collect any federal, state, or local sales taxes and/or fees are required to submit those taxes and/or fees during the time of claim submission.
- The pharmacy provider should calculate and transmit the exact number of days’ supply. Day supply must be calculated based on the directions documented on the prescription.
- The Pharmacy provider should transmit the exact metric quantity as indicated on the prescription.
- Pharmacy providers should contact the Pharmacy Help Desk regarding any rejected claims or claims requiring Prior Authorization.

Member Eligibility

The Plan Sponsor determines member eligibility. Liviniti updates eligibility to our claims processing system on a regular basis. It is important to remember that a member’s eligibility can change. Remember, possession of an ID card does not guarantee eligibility for benefits coverage or payment. Eligibility should be confirmed through the claims adjudication system at the time of dispensing.

Newborn Eligibility

For assistance with pharmacy claims for newborns, Members should be directed to contact their Plan Sponsor to ensure the newborn has been enrolled. Pharmacy providers may contact the Pharmacy Help Desk to determine if Identification Numbers and/or dependent codes have been assigned. The Pharmacy Help Desk will not be able to enroll the newborn in the Plan.

Member Date of Birth

Pharmacists must enter the member’s correct date of birth on each claim. If a claim is rejected due to an incorrect date of birth (reject code 91), please contact the Pharmacy Help Desk at 1-800- 710-9341 to verify the member’s date of birth.

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Member ID Card

Members should be asked to present their Liviniti Member ID card at each visit. Prior to furnishing any Covered Prescription Service, the pharmacy shall verify that the individual receiving such Covered Prescription Service is an eligible Member. Such verification shall be performed by the pharmacy through point-of-sale ("POS") data communication between the pharmacy and claims processor. If any pharmacy is unable to confirm a Member's eligibility by POS communication, then the pharmacy shall call the Pharmacy Help Desk for verification.

Liviniti Member ID cards may vary by Plan Sponsor; Liviniti also may produce separate pharmacy or combination medical/pharmacy benefit cards for clients. When using a Liviniti ID Card, submit the number indicated by "ID" for the subscriber. Each dependent will have his or her dependent code.

The ID field length varies by plan and may be a combination of letters and numbers.
If the ID is unable to find a Member match the claim rejects "Non-matched Cardholder ID"
Group numbers are required, may vary by length, and may be a combination of letters and numbers.
The Pharmacy Help Desk phone number is printed on the back of the Member ID card.

Information Needed to Process a Claim

Cardholder ID: The ID format can consist of all numeric digits or alphanumeric digits. The National Council for Prescription Drug Programs ("NCPDP") standard for this field allows up to 20 alphanumeric characters.

Group Number: Usually a 7-character field assigned by Liviniti. This field may, however, contain up to 15 alphanumeric characters.

Dependent Coverage: May include spouse and/or children. The card may be coded to indicate which family members are covered. Covered family members are identified by the following:

Relationship Codes:
"01" Cardholder- Eligible Primary Person or Subscriber
"02" Spouse of the Cardholder
"03" Dependent Child
"04" Dependent Child

Clarification Eligibility Exception Codes:
"3" Full-time student
"4" Disabled Dependent
"5" Dependent Parent
"6" Significant Other/ Dependent Adult/ Domestic Partner

Important Note: Use of the correct Relationship Code is important.

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Collection of Copayments

Plan Sponsors establish the member's copay and/or co-insurance. Pharmacy providers are required to collect all copays/co-insurance for Covered Prescription Services. Pharmacy providers shall not routinely waive or discount copays.

The pharmacy provider shall extend the Usual & Customary Retail Price to a member if it is less than the Member's Copay amount. The pharmacy provider is still obligated to transmit all claims, including claims where the Member pays 100% or pays the U&C price.

Down-Time Procedures

Liviniti attempts to minimize planned adjudication downtime and to correct unexpected downtime issues as quickly as possible. In the rare event of unexpected downtime or in the event of planned downtime, we ask our pharmacy providers to attempt to service our members with minimal disruption. Liviniti is available to assist pharmacy providers with maintaining business operations during adjudication downtime.

When online submission is not possible, call the Pharmacy Help Desk for assistance with:

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

Reversals

Pharmacy providers are required to complete reversals within the same payment cycle as the submission or up to 14 days after the claim was adjudicated for prescriptions that have not been picked up by the Member. Failure to reverse appropriate claims may result in an audit recovery and recapture of all costs involved in the reversal. If unable to reverse a claim online, contact the Pharmacy Help Desk.

If a Member receives only a partial amount of his/her covered prescription, the pharmacy provider must modify the claim via the processing system within 14 days to accurately represent the quantity of medication received and billed. To change the claim, the pharmacy must reverse the existing claim and resubmit the claim with the correct quantity and days supply.

Timely Filing Limits

Points of Sale (POS) claims are generally submitted at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted after being dispensed. Transmission of claims using the current date for past service date is a violation of program policy and could result in an audit exception. Pharmacy providers must submit Claims for reimbursement no later than ninety (90) days from the date Covered Prescription Services are rendered to the Member. At no time shall the pharmacy provider be required to submit a Claim sooner than thirty (30) days from the date Covered Prescription Services are rendered to the Member. The pharmacy provider shall ensure that all Claims are timely and cooperate with the Claims Processor and/or Liviniti in the adjudication and processing of Claims in a timely and efficient manner.

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Claim Edits

Following an online claim transmission by a pharmacy provider, the SS adjudicating system will return a response to indicate the outcome of processing. If the claim passes all edits, a “Paid” response will be returned with the Liviniti allowed amount for the paid claim. A “Rejected” response will be returned when a claim fails one or more edits. The pharmacy provider will review any “Rejected” response and make every attempt to resolve the issue. The pharmacy provider will contact the Pharmacy Help Desk for assistance.

Days’ Supply

The "Day Supply" field is one of the key fields used relative to our early refill edits. Adjudicating a claim with an incorrect day supply can cause claims to be rejected for an early refill. Please use the correct method of determining the days' supply.

The calculation should be made using the metric quantity prescribed and the prescriber’s written directions. For prescriptions where the directions do not clearly allow for days’ supply to be calculated such “as directed” or “prn”, the pharmacy provider must call the prescriber or ask the Member for the directions and document directions on the prescription. In all cases, the pharmacist must be able to justify the Days’ Supply calculation with written documentation on the prescription if not clearly delineated by the prescriber.

The benefit limitation for the quantity of Covered Medications for each Plan Sponsor may vary according to their plan limitations. Certain benefit plans for some populations may include a limited formulary that allows up to a 90-day supply of Covered Products. You may attempt to process a claim for a Covered Product up to 90-day supply using the correct day supply field. A response that includes an NCPDP plan limitations exceeded (Reject 76) will indicate that the product does not qualify for a 90-day supply.

Quantity

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

Drugs in “unbreakable” packages should be dispensed only in the original container or package as directed. All other packages are considered “breakable” and must be dispensed in the quantity prescribed.

National Drug Code

The pharmacy provider must submit the complete NDC number of the package size dispensed. The pharmacy provider should use products that result in the lowest ingredient cost including the lowest dosage form and the lowest cost package/size container available. Claims for repackaged and/or relabeled NDCs may be rejected during processing. If a claim using a repackage and/or relabeled NDC results in a higher cost to the plan and/or member, Liviniti may audit for overpayment.

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Refills

Refills are set based on federal requirements and guidelines.

Dispense As Written Codes

DAW Codes	Definition
0	No product selection indicated
1	The prescriber requested brand; generic substitution is not allowed. Still possible for a PA if rejecting
2	Patient requested brand; Patient will be responsible for a selection penalty
3	Pharmacist selection product dispensed
4	Generic drug not in stock
5	Brand drugs dispensed as generic
6	The pharmacy will be reimbursed for the cost of dispensing a generic product, even if they dispense a brand
7	Override
8	Brand drug mandated by law
9	Generic drugs not available in the marketplace

Prior Authorization

Liviniti processes prior authorizations for Members. Drug coverage is determined by the individual plan sponsor and prior authorization criteria and approval duration are determined by the Liviniti clinical team. Information regarding drug coverage and the prior authorization submission process can be found at liviniti.com/physicians.

Pharmacy providers will submit pharmacy claims to Liviniti. All claims will be processed through an automated review to ensure that plan-specific criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy provider continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected, and the pharmacy provider will receive a message that explains the reason for the rejection. At that point, the pharmacy provider should contact the Pharmacy Help Desk.

If you receive a rejection message of “75- Prior Authorization Required,” the next step should be to initiate the prior authorization process by contacting the prescriber to provide Liviniti with the necessary clinical documentation to demonstrate that prior authorization criteria have been met.

Pharmacy provider Fees, Care Taxes, and Other State Fees

Liviniti supports all state sales tax fields in accordance with the most current NCPDP electronic claims standard. Liviniti updates its database of current tax rates quarterly to ensure optimal reimbursement to pharmacies. The pharmacy provider is required to submit the tax rate in all claims at the time of processing.

In states where provider fees are charged and are reimbursed by third-party payors, providers have sole responsibility for submitting such fees in the flat rate tax field. For providers in states that charge a flat tax rate and a provider fee, please contact the Pharmacy Help Desk for support.

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All taxes and fees will be included in the Remittance Advice supplied to pharmacy providers with payment for claims. Pharmacy providers should review Remittance Advices carefully including the stated tax amounts paid. Pharmacy providers should notify Liviniti of any errors in taxes within 30 days of receipt of Remittance Advice. If no tax amounts are disputed within 30 days of receipt, Remittance Advice is deemed to be confirmed accurate by the pharmacy provider.

The pharmacy provider is required to immediately notify Liviniti of any error in payment of taxes or fees.

National Provider Identifier (NPI)

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

The pharmacy provider must submit their NPI in NCPDP field 201-B1 (Service Provider ID) with the qualifier “01” in NCPDP field 202-B2 (Service Provider ID Qualifier).

Prescriber NPI is required to submit accurate information identifying the Prescriber for each claim submitted. Prescriber NPI must be submitted in NCPDP field 411-DB- Prescriber ID) along with the qualifier “01” in the NCPDP field 466-EZ- (Prescriber ID Qualifier).

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

- Call the prescriber’s office to request the NPI; or
- Obtain the prescriber’s NPI from the NPI registry web page: https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do

Compounded Prescriptions

A compound consists of two or more ingredients, one of which must be a formulary Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order. The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality, and purity, with appropriate packaging and labeling in accordance with good compounding practices.

For Liviniti to cover a compound, all active ingredients must be covered on the Member’s formulary. In general, drugs used in a compound follow the Member’s formulary as if each drug component were being dispensed individually. The plan must include compound drugs as a covered benefit for the member of Liviniti to allow reimbursement.

Any compounded prescription ingredient that is not approved by the FDA (e.g., Estriol) is considered a non-covered product and will not be eligible for reimbursement.

Please contact the Pharmacy Help Desk to see if a client allows compound prescriptions.

Processing Compound Prescriptions

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

The claim must include a qualifier of “03” (NDC) to be populated in NCPDP field 448-RE followed by NCPDP field 489-TE (NDC’s).

For many Liviniti payers, compounds with a cost exceeding $200 must receive an approved prior authorization from Liviniti for coverage to be considered.

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

EXAMPLE OF THE NCPDP D.0 FIELDS FOR SUBMITTING A COMPOUND CLAIM:

	Compound Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	10	M	
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	03= National Drug Code	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		O	

Vacation or Lost Med Overrides

Allowances for travel medication and/or replacement of lost, stolen, or forgotten medication vary by plan benefit design. Please contact the Pharmacy Help Desk to obtain individual member benefit information.

Emergency Override for Refill Too Soon Due to Natural Disasters

Subject to direction from Plan Sponsors, Liviniti has provisions to implement an Emergency Refill Too Soon override procedure. When a member is affected due to a natural disaster such as a flood, wildfire, hurricane or tornado, and the claim rejects with NCPDP Reject

79 (Refill Too Soon), the pharmacy provider should enter override code 99999 in NCPDP vD.0 field 462-EV (Prior Auth Number Submitted). This override code may be used to process claims ONLY for Members in the affected areas during a specified time frame.

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Vaccines

At the request of some Plan Sponsors, certain vaccine drug products and/or the administration of the vaccine drug products will be a covered service according to the Member's specific plan benefit design. For those Plan Sponsors that cover vaccine drug product administration, the pharmacy provider attests that registered pharmacists, or other healthcare professional staff, under its employer are certified, trained, and qualified to administer the covered vaccine drug products.

The pharmacy provider shall submit the vaccine drug product with the administration fee claim electronically through the SS claims processing system in accordance with the current Liviniti Payer Sheets available at https://liviniti.com/providers

When the pharmacy provider dispenses and administers the vaccine drug product, the pharmacy provider will transmit both the drug product and administration on the same claim submission. The pharmacy provider will submit as the pharmacy's U&C, the total cost of the vaccine drug product and the administration fee. The pharmacy provider must not, under any circumstances, undermine the U&C price by inflating the U&C above the price the provider charges for the same vaccine product and administration a cash patient or customer would have paid on the same day the prescription was dispensed, inclusive of all applicable discounts.

Plan Sponsors may elect to cover just the vaccine drug product under the Member's prescription drug benefit. In that situation, the Member is responsible for the administration charges. The pharmacy provider may not add or represent the administration fee to the Member as the copayment. The drug product co-payment must be represented as a separate charge.

Coronavirus (COVID-19) Vaccine Billing

At this time, the cost of the COVID-19 vaccine is covered by the federal government via funding authorized by the Coronavirus Aid, Relief and Economic Security (CARES) Act and publicly available to all members, regardless of coverage type, with $0 cost-share (copayment, coinsurance, or deductible). Providers may submit claims for the payment of the administration of COVID-19 vaccines to insurers and for exempt, and uninsured patients to the HRSA Provider Relied Fund.

	NCPDP Field Number	First Dose	Second Dose (If Applicable)	Additional Doses (If Applicable)	Booster Dose (If Applicable)
Professional Service Code	440-E5	MA	MA	MA	MA
DUR/PPS Code Counter	440-E5	1	1	1	1
Day Supply	405-D5	1 - Day	1 - Day	1 - Day	1 - Day
Submission Clarification Code (SCC)	420-DK	02 (Applicable for single-dose and two-dose vaccines)	06 (Applicable for single-dose and two-dose vaccines)	07 (Applicable for two-dose vaccines)	10 (Applicable for single-dose and two-dose vaccines)
Ingredient Cost Submitted	409-D9	$0.00 ($0.01 if system requires)	$0.00 ($0.01 if system requires)	$0.00 ($0.01 if system requires)	$0.00 ($0.01 if system requires)
Dispensing Fee Submitted	412-DC	$0.00	$0.00	$0.00	$0.00
Basis of Cost Determination	423-DN	15 (Free Product)	15 (Free Product)	15 (Free Product)	15 (Free Product)
Incentive Amount Submitted	438-E3	Varies dependent on Federal, State and contractual guidelines.	Varies dependent on Federal, State and contractual guidelines	Varies dependent on Federal, State and contractual guidelines	Varies dependent on Federal, State and contractual guidelines
Product / Service ID / NDC	407-D7	EUA approved. NDC	EUA approved. NDC	EUA approved. NDC	EUA approved. NDC
Fill Number	403-D3	00	01	02	01/ 02 /03

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Pharmacy provider Reimbursement

Pharmacy provider will receive reimbursement from Liviniti for Covered Prescription Services provided to Members as identified in the Pharmacy Network Agreement including all amendments, exhibits, and the Pharmacy Services Manual. The net reimbursement due to the pharmacy provider will be less the applicable copay, co-insurance, and any deductibles.

The provider will be reimbursed for clean payable claims transmitted electronically through the SS Claims Processing System according to a specified claim cycle, except as may be required by federal or state requirements.

Member Cost Share

The pharmacy provider will collect from each Member the applicable co-payment/coinsurance or other direct payment as communicated via the SS Claims Processing System or other methods established by Liviniti.

The pharmacy provider will not charge or collect from any Member any amount for Covered. Prescription Services more than the applicable co-payment/coinsurance or other direct payment communicated by Liviniti. The pharmacy provider acknowledges that the co-payment/coinsurance or other direct payment is an integral part of the plan design selected by the Sponsor, and the pharmacy provider will not waive or discount the applicable co-payment/ coinsurance or other direct payment under any circumstances.

Pharmacy provider Reimbursement

Pharmacy providers may be paid an amount other than what was submitted as the ingredient cost, dispensing fee, or Usual and Customary Price. Pharmacy provider reimbursement will be as follows:

For Covered Services, Liviniti will pay the lowest of either (1) Usual & Customary (U&C) or the applicable price formula described below:

- Average Wholesale Price (AWP) minus the applicable contracted discount plus the applicable contracted dispensing fee; OR
- Maximum Allowable Cost (MAC) plus the applicable contracted dispensing fee; OR
- Submitted Ingredient Cost plus the applicable contracted dispensing fee.

There may be specific reimbursement logic that Sponsors put into place that alters the reimbursement formula set out above.

Zero Balance Logic (ZBL) may apply where allowed by the Plan Sponsor.

For compounded Prescription claims, the pharmacy provider will be reimbursed the lowest of:

- The aggregated lowest price of each ingredient in the compound, plus the contracted dispensing fee.
- The Provider’s total Submitted Ingredient Cost for the compound, plus the contracted dispensing fee, OR
- The provider’s Usual and Customary Price for the compound

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Elements of Reimbursement

Usual and Customary Price (U&C)

The lowest net cash price a cash patient or customer would have paid the day the prescription was dispensed inclusive of all applicable discounts. U&C does not include sales tax.

The pharmacy provider must not, under any circumstances, undermine U&C or compound pricing as a component of the compensation contemplated in this Agreement in any way, including but not limited to, (1) owning, operating, or affiliating with a nonparticipating provider; or (2) separating cash and third-party prescription business. Pharmacy providers will not be allowed to participate in the Liviniti network if Liviniti determines, in its sole discretion, that the pharmacy provider has taken actions to undermine U&C or compound pricing.

Maximum Allowable Cost (MAC)

Liviniti's MAC program consists of a list or lists of drugs maintained by Liviniti or its Sponsors. The list(s) specify the maximum allowable ingredient cost payable for drugs on the list. Liviniti and/or Sponsor may review, and update MAC pricing frequently and as deemed necessary to reflect changes in market pricing. For MAC inquiries contact the Pharmacy Help Desk or create a log-on to access the list at https://liviniti.com/providers.

Average Wholesale Price (AWP)

"AWP" as used herein means the current Average Wholesale Price as listed in print or electronically by a nationally recognized pricing source determined by Liviniti based on the package size dispensed.

Liviniti uses the most current file available from a nationally recognized pricing source. Updates will be made no less than weekly. If the designated nationally recognized pricing source ceases publishing or replaces AWP, or if Liviniti decides to use another recognized pricing source or a pricing benchmark other than AWP, Liviniti will provide notice of such change(s).

Paper Claim Submission

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

Liviniti

P.O. Box 2482

Natchitoches, LA 71457

Pricing Appeals

Liviniti produces its own proprietary pricing and corresponding unit costs on behalf of our clients. The unit costs are ascertained from information from many sources, including published MACs, wholesaler-supplied information, pharmacy-supplied information, and other sources.

If you experience negative reimbursement for a drug or device, please complete a Pricing Appeal by visiting our website at https://liviniti.com/providers, for all pricing inquiries including downloading our recent MAC pricing.

For a pricing appeal for any drug or device, all relevant information must be provided including a copy of your wholesaler invoice that lists the net acquisition cost of the product. Contact the Liviniti Pharmacy

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Help Desk for help finding the Pricing Appeals page on our website. Liviniti will evaluate all information provided. Our timeline to respond does not start until we receive all pertinent information.

If approved, the NDC will be adjusted pricing, you can reprocess within 7 business days.

All Pricing Issues must be submitted using the proper form and supporting documentation within 90 calendar days of the service date.

Liviniti is required to respond within 7 business days turnaround time whether approved or denied.

Sales Tax

If any government authority imposes any taxes, assessments, or similar fees that are separately stated from the sales price and are triggered by the transfer for a consideration of ownership or possession of tangible personal property or the rendering of services including, but not limited to, any sales tax, gross receipts tax, retail occupation tax, health care provider tax, or value-added tax ("Sales Tax"), on the pharmacy's provision of Covered Prescription Services to any Member, then pharmacy may request reimbursement from the Plan Sponsor for such Sales Taxes that are allowed and imposed by applicable law in accordance with the Plan. Pharmacy shall be solely responsible for any other taxes or surcharges associated with its performance under this Agreement.

The pharmacy shall transmit the applicable Sales Tax amount that is allowed by law through the online claim system. Liviniti shall bill the Plan Sponsor for any federal, state, or local Sales Tax and will remit to the pharmacy any such taxes collected from the Sponsor. The pharmacy shall timely and accurately remit, or cause the pharmacy to timely and accurately remit, the applicable Sales Tax to the appropriate taxing authority. In no event shall Liviniti or the Plan Sponsor be responsible for determining the applicable Sales Tax rate or calculating the amount of the Sales Tax obligation of the pharmacy. If the pharmacy submits an incorrect Sales Tax amount to any government authority, then in no event shall Liviniti be responsible; in this event, the pharmacy shall be solely responsible for recovering any overpaid Sales Tax and promptly reimbursing Liviniti or the Sponsor on mutually agreed upon terms. In no event, including non-payment by the Plan Sponsor, shall Liviniti be liable for any Sales Tax on any Covered Prescription Services.

Payment Cycle

Liviniti reimbursement for claims submitted will be within 30 days after the close of the payment cycle subject to fund availability from the Plan Sponsor. Liviniti will pay in accordance with applicable state and federal prompt pay requirements and/or in accordance with the Member's plan.

Standard payment cycles:

- Date of fill 1st thru 15th
- Date of fill 16th thru last day of month

As of October 1, 2014, Liviniti is going paperless. It is now MANDATORY for all parties to complete the ACH and/or Direct Deposit Form and set up electronic deposits for payments.

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Remittance

Liviniti will provide the pharmacy provider with a payment record of all claims paid. Unless otherwise arranged, these reports are provided in printed-paper format and are mailed to the pharmacy provider. Electronic 835 remittance files are available upon request.

The initial remittance is provided to the pharmacy provider at no charge.

The basis for reimbursement is communicated to a pharmacy in accordance with NCPDP standards.

Reimbursement Not Received by a Pharmacy Provider

The pharmacy provider must notify Liviniti of any valid paid claim transmitted electronically through the Claims Processing System for which the pharmacy provider has not received reimbursement.

Please write to the below address should the provider have questions on claim payment or lost payment:

Liviniti
PO Box 2482
Natchitoches, LA 71457
pharmacynetwork@liviniti.com

Payment Responsibility: Limitation of Liability

Liviniti operates only as an intermediary between plans and pharmacy providers with respect to payment due under the Pharmacy Network Agreement and Claim payment amounts due are the sole and exclusive responsibility of Plans. Liviniti is not obligated to pay the pharmacy provider for Claims relating to a Plan if a Plan fails to provide Liviniti with sufficient funds related to Claims for payment, and Liviniti has no liability to the pharmacy provider for non-payment or for any delay in payment from a Plan.

Disputed Claims

Pharmacy providers are to review remittance advice when received to verify accuracy. The pharmacy provider may dispute a claim payment or adjustment by notifying in writing Liviniti within thirty (30) days. Any claim not disputed within 30 days of receipt of remittance advice is deemed to be confirmed accurate by the pharmacy provider.

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Additional Information

Formularies

Plan Sponsors often adopt a formulary as part of their overall cost-containment programs, attempting to deliver a balance between cost containment and quality of care. Liviniti implements a variety of formulary programs for Plan Sponsors. The pharmacy provider is required to support all formulary programs by dispensing formulary drugs to the maximum extent possible.

Formularies may be available online at www.liviniti.com or may be requested by calling the Pharmacy Help Desk. Formulary listings are a general representation of products covered but are not exhaustive.

Brand and Generic Drug Standards

Liviniti administers many plans. Each has its own guidelines as to such things as days supply, ingredient cost pricing, co-payment/coinsurance, drug coverage, and informational drug utilization messaging. Therefore, rely on the SS Claims Processing System to receive accurate information regarding the specific Member, group, prescription drug, co-payment/coinsurance, and pricing pertaining to the claim submitted.

For all plans, the use of generics is encouraged. In some instances, a Plan Sponsor may have a preferred brand product rather than a generic. Thus, a pharmacy provider should rely on the SS System messaging to reinforce the use of generic and preferred brand products with Liviniti Members and Prescribers.

If a brand drug is appropriate, a pharmacy provider should dispense preferred co-branded drug products for nonpreferred co-branded drug products where applicable, in accordance with prevailing pharmacy laws and regulations.

Specialty Pharmacy provider

Any pharmacy provider that meets our quality standards may contract through our Specialty Pharmacy Network. The pharmacy provider must agree to provide all supplies required to administer the drug to the patient and not charge any additional supply or shipping fees. Liviniti does not limit a member's choice of Specialty Pharmacy provider. Customer Service will assist the Member in locating the most convenient specialty pharmacy provider.

Concurrent Drug Utilization Review

Liviniti Concurrent Drug Utilization Review (C-DUR) consists of various levels of responses, depending upon the level of severity of the interaction being measured. Liviniti's claims adjudication system may review potential Drug-Drug Interactions, Dose Check (high/low, maximum/minimum) Drug-Sex Interactions, Drug-Age Interactions, Duplicate Therapy, and Duplicate Prescription. If DUR is active, Liviniti may return a DUR message based on the severity of the interaction. This may include passive messaging, soft rejects requiring input of outcome and intervention codes, or a hard reject requiring a call to our Pharmacy Help Desk.

Hard Rejects cannot be overridden and require a call to the appropriate call center.

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Pharmacy Drug Utilization Review

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

Reason for Service Codes

The following codes will be accepted by Liviniti:

Code	Description
AR	Adverse Drug Reaction- Code indicating an adverse reaction by a patient to a drug.
AT	Additive Toxicity- Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself.
DD	Drug- Drug Interaction- Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately.
DI	Drug Incompatibility- Indicates physical and chemical incompatibilities between two or more drugs.
ER	Overuse- Code indicating that the current prescription refill is occurring before the days' supply of the previous filling should have been exhausted.
EX	Excessive Quantity- Code that documents the quantity is excessive for the single time for which the drug is being prescribed.
HD	High Dose- Detects drug doses that fall above the standard dosing range.
ID	Ingredient Duplication- Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected.
LR	Underuse- Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted.
MX	Excessive Duration- Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.
PA	Drug Age- Indicates age-dependent drug problems.
SC	Suboptimal Compliance- Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated because of non-compliance.
SX	Drug-Gender- Indicates the therapy is inappropriate or contraindicated in either males or females.
TD	Therapeutic- Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected.

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Professional Service Codes

Select Professional Service Codes from the NCPDP External Code List:

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

Result of Service Codes

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

1A	Filled as is, False Positive- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is incorrect for that filled prescription for that patient and fills the prescription as originally written.
1B	Filled Prescription as is- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is not relevant for that prescription for that patient and fills the prescription as originally written.
1C	Filled, with Different Dose- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dose than was originally prescribed.
1D	Filled, With Different Directions- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with different directions than were originally prescribed.
1E	Filled, With Different Drug- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different drug than was originally prescribed.
1F	Filled, With Different Quantity- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different quantity than was originally prescribed.

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1G	Filled, With Prescriber Approval- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription after consulting with or obtaining approval from the prescriber.
1K	Filled with Different Dosage Form- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed.
2A	Prescription Not Filled- Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written.
2B	Not Filled, Direction Clarified- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription, and counsels the patient as to the prescriber's instructions.
3A	Recommendation Accepted- Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen, and then dispenses the alternative after consultation with the prescriber.
3B	Recommendation Not Accepted- Code indicating cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), and recommends a more appropriate product or regimen but the prescriber does not concur.
3C	Discontinued Drug- Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen.
3D	Regimen Changed- Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen, and then dispenses the recommended medication(s) after consultation with the prescriber.
3E	Therapy Changed- Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen, and then dispenses the alternative after consultation with the prescriber.
3G	Drug Therapy Unchanged- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written.

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For specific edits, Liviniti will accept:

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

Compliance and Auditing: Fraud, Waste, and Abuse

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

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

Abuse defined here as a subset of waste, entails the exploitation 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. On the contrary, the pharmacist who deliberately turns the other way when there is every reason to believe that the purported prescription order had not been issued for a legitimate medical purpose may be prosecuted, along with the issuing physician, for knowingly and intentionally distributing controlled substances.

Examples of Fraud, Waste, and Abuse

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

- Inappropriate billing practices: inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices:
- Incorrectly billing for secondary payers to receive increased reimbursement.
- Billing for non-existent prescriptions.
- Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions.
- Billing for a brand when generics are dispensed.

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- Billing for non-covered prescriptions as covered items.
- Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up).
- Billing based on “gang visits,” e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients.
- Inappropriate uses of dispense as written (“DAW”) codes.
- Prescription splitting to receive additional dispensing fees.
- Drug diversion.
- Prescription drug shorting: The pharmacist provides less than the prescribed quantity and intentionally does not inform the patient or make arrangements to provide the balance but bills for the fully prescribed amount.
- Bait and switch pricing: Bit and switch pricing occurs when a beneficiary is led to believe that a drug will cost one price, but at the point of sale the beneficiary is charged a higher amount.
- Prescription forging or altering where an individual without the prescriber’s permission increases the quantity or number of refills and alters existing prescriptions.
- Dispensing expired or adulterated prescription drugs: Pharmacies dispense drugs that are expired or have not been stored or handed in accordance with manufacturer and FDA requirements.
- Prescription refill errors: A pharmacist provides the incorrect number of refills prescribed by the provider.
- Illegal remuneration schemes: The pharmacy is offered, paid, solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch patients to different drugs, influence prescribers to prescribe different drugs, or steer patients to plans.

Prescriber Fraud, Waste, and Abuse

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

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

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Member Complaints

The pharmacy provider is required to cooperate with Liviniti, payors, and/or any state or federal entity to resolve complaints by members. The pharmacy provider must make a reasonable effort in a timely manner to rectify the situation that leads to the complaint from a member. The pharmacy provider must maintain written records of events and actions surrounding each complaint.

Auditing

As the pharmacy benefit manager for various plans, Liviniti has an obligation to ensure all contracted services are being provided. Compliance with the Pharmacy Network Agreement is critical. Liviniti will perform pharmacy audit functions to ensure program integrity.

Audited pharmacies are identified based on internal analysis, external information provided to Liviniti, or compliance calls to Liviniti. A twenty-one-day advance notice is provided to pharmacies unless otherwise specified in the Pharmacy Network Agreement or required by applicable State or Federal law, or suspected fraud has been identified. Regarding suspected fraud, no notice is required. Failure to comply may result in termination from the network.

The pharmacy provider shall cooperate in good faith with all record requests and audits and shall provide Liviniti, Plans, and their authorized representatives with access to the pharmacy's premises and Records for such purposes. The pharmacy provider shall provide copies of records requested by Liviniti within thirty (30) calendar days from the date of a written request for such records. All records shall be provided at the sole cost and expense of the pharmacy provider. Records will be audited for actions that have resulted in overpayment; any such overpayment shall become immediately due and owed by the pharmacy provider. If an audit reveals actions that have resulted in an overpayment, the overpayment shall become immediately due and owed by the pharmacy provider. In the event that an audit reveals that the pharmacy provider submitted Claims to Liviniti with information that is inaccurate and/or unverifiable, Liviniti shall be entitled to recover up to the total amount of the Claim.

An iterative process in which the auditor and pharmacy manager exchange information via fax and/or telephone. For example, if there is a question and clarification is possible over the phone, then the question will be resolved as necessary based on the information provided. Auditing of pharmacy provider's records may also be conducted through the mail. Pharmacy providers are frequently asked to furnish photocopies of specific documents in such cases.

The pharmacy provider is to supply requested documentation within 30 calendar days of the request. In the event the requested documentation is not furnished within 30 days of the request, Liviniti is entitled to recover the full amount paid or due to the provider for the claim(s) in question.

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

- Missing signature logs, or incomplete logs
- Dispensing an incorrect drug
- Billing the wrong member
- Missing hard copy of prescription
- Using a dispense as written (DAW) code incorrectly.
- Overbilling quantities
- Calculating the day supply incorrectly
- Billing incorrect physician
- Using an NCPDP/NPI number inappropriately
- Dispensing unauthorized, early, or excessive refills
- Pharmacy purchasing invoices that do not correspond with the NDCs of submitted claims for reimbursement.
- Review of pharmacy credentials (licensures, etc.)

Should an audit take place at your pharmacy, you will receive written results. With the large volume of prescriptions processed every day, we realize human errors do occur and feel our partner pharmacies do an outstanding job of providing pharmacy services to Liviniti's members. Our intentions are to audit for fraudulent behavior and NOT to seek recoupment for technical errors unless excessive or errors that otherwise result in an overcharge to the Plan Sponsor and/or member.
Audit Recoveries: Recoveries may be necessitated by claim errors resulting from poor documentation or filing procedures. Premature destruction, incomplete records, or missing records will not be accepted as reasons for incomplete documentation. All unsubstantiated claims are subject to recovery as Liviniti overpayment.

Audit recoveries can be handled by:

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

If you have any questions regarding an on-site or desktop audit, contact our Provider Relations Department (1-800-710-9341) or pharmacynetwork@liviniti.com.

All requirements might change based on federal and state law requirements.

Protected Health Information (PHI)

In accordance with its Business Associate Agreement with its clients, Liviniti follows the following procedure regarding the disclosure of PHI.

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

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

All changes in the format and distribution of PHI data must be made in writing by the pharmacy.

Pharmacy Provider Relations Department

The Liviniti pharmacy provider Relations Department's main hours of operation are Monday through Friday 8:00 am- 5:00 pm CST. For emergency calls, we are available 24/7. We are available to assist you with:

- Important Documentation Requirements
- Reimbursement/ Network set-up
- MAC pricing

Contact us at: pharmacynetwork@liviniti.com or call 1-800-710-9341.

Optional Clinical Programs

Liviniti clinical and professional services programs aim to advance pharmacy practice and improve health for Liviniti members. There may be instances where a pharmacy provider agrees, by signing a specific Clinical Program Schedule, to provide additional clinical services. These Clinical Program Schedules will specifically reference the Pharmacy Services Manual and the provisions of this section applicable only to the services provided under that specific schedule. The language in this section does not apply to any other services provided by the provider.

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General Provisions

Severability

In the event that any provision in this Agreement shall be found by any government agency, court or arbitrator of competent jurisdiction to be invalid, illegal, or unenforceable, such provision shall be construed and enforced as if it had been narrowly drawn so as not to be invalid, illegal or unenforceable, and the validity, legality, and enforceability of the remaining provisions of this Agreement shall not in any way be affected or impaired thereby.

Dispute Resolution

The parties agree that they will attempt in good faith to resolve any dispute that may directly or indirectly arise out of or relate to this Agreement. If the parties are unable to resolve such dispute within thirty (30) calendar days after initial notice, each party may, by notice to the other, have such dispute referred to a senior officer of each party. Such an officer shall attempt to resolve the dispute by good faith negotiation within thirty (30) calendar days after receipt of such notice. If the designated officers are not able to resolve such dispute within such thirty (30) calendar-day period, then the dispute shall be submitted, upon the motion of either party, to arbitration to be conducted in accordance with the appropriate rules of the American Arbitration Association (“AAA”) in Natchitoches, Louisiana. All such arbitration proceedings shall be administered by the AAA. The arbitration panel shall consist of three arbitrators. One arbitrator shall be appointed by each party. The third arbitrator, who shall act as chairman of the arbitration panel, shall be appointed by the other two arbitrators. If any arbitration is commenced against any party hereto with respect to the subject matter contained in this Agreement, the party prevailing in such arbitration shall be entitled, in addition to such other relief as may be granted in such proceeding, to a reasonable sum from the non-prevailing parties for attorney's fees, expenses, and costs in such arbitration, which sum shall be determined in such arbitration. The parties agree that the decision of the arbitrators should be final and binding to each of them.

Notices

Unless otherwise provided for in the Agreement, written notice must be provided as set forth below. All notices called for hereunder shall be effective upon receipt. Notices required to be given pursuant to this Agreement related to breach, dispute, non-payment by Liviniti, and termination shall be in writing, postage prepaid, and shall be sent by certified mail, return receipt requested, or by an overnight delivery service which provides a written receipt evidencing delivery, to the address listed below. All other notices shall be given in the manner described above, or by facsimile, email, or US Mail, postage prepaid, to the other party at the facsimile, email or mail address designated below.

Liviniti, LLC
P.O. Box 7391
Natchitoches, LA 71457 Phone: (800) 710-9341 Fax: (318) 214-4190
Email: legal@livinti.com

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Intellectual Property

The pharmacy provider will not use for its own commercial purposes any trademark, service mark, or corporate name of Liviniti without prior written consent. Liviniti may use the pharmacy's name and the name, address, and telephone number in any promotional or advertising brochure, media announcement, or other marketing information or benefit information packages in connection with the Covered Prescription Services distributed by Liviniti to Plan Sponsors, Members, or Physicians.

Professional Judgment

The pharmacy provider is obligated to provide the Members and Prescribers whom it serves with an adequate inventory of quality drugs. The pharmacist is by profession uniquely qualified to judge the integrity and the quality of manufactured sources. Where a prescription is written in such a manner that the pharmacy provider is provided an option with respect to the brand name, manufacturing source, or package size of the drug to be supplied, the pharmacy provider will supply and charge for that drug that meets official compendium specifications, if listed therein; that has the lowest ingredient cost; that in the pharmacist's professional judgment fulfills the Prescriber's requirements; and that meets formulary requirements.

All professional services provided by the pharmacy provider must be rendered only under the direct supervision of a licensed pharmacist and each prescription must be dispensed in accordance with a lawful Prescriber's directions, the terms and conditions contained in the Pharmacy Network Agreement with Liviniti, including the Manual and/or communicated via the SS claims processing system, and applicable State and Federal laws.

Pharmacy providers must clarify and document ambiguous dosage directions regarding utilization prior to dispensing and must not combine Prescriber-authorized refills. The provider will at all times exercise good professional judgment in the dispensing of medications and may refuse to dispense any prescription based on the dispensing pharmacist's own professional judgment.

The provider will inform Members as to the proper storage, dosing, side effects, potential interactions, and use of the medication dispensed within professional practice guidelines.

Manual Updates and Amendments

Liviniti will, on occasion, provide updates to the Manual. Liviniti will maintain an updated copy of the Manual via the website: www.liviniti.com. It is the pharmacy provider's responsibility to visit the website to view updates to the Manual.

Liviniti will provide revisions, amendments, or modifications to the pharmacy providers.

Agreements with Liviniti from time to time. The pharmacy provider will abide by the terms of the Pharmacy Network Agreement with Liviniti, and all notices, revisions, amendments, and modifications thereto.

If the pharmacy provider continues to submit claims after the effective date of any notice, revision, amendment, or modification by Liviniti to the pharmacy provider, the notice, revision, amendment, or modification will be deemed accepted by the pharmacy provider and will become part of Pharmacy Network Agreement with Liviniti as if pharmacy provider had given its express written consent thereto.

Disparagement

The pharmacy provider agrees not to disparage Liviniti or its Plan Sponsors or encourage Members to use another Plan Sponsor based on Confidential Information.

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Governing Law and Jurisdiction

All disputes and matters between the pharmacy provider and Liviniti arising out of the Pharmacy Network Agreement with Liviniti shall be litigated before the U.S. District Court for Louisiana, or, as to those lawsuits to which the Federal Court lacks subject matter jurisdiction, before a court located in Natchitoches, Louisiana. The Pharmacy Network Agreement with Liviniti shall be governed, construed, and enforced in accordance with the laws of the State of Louisiana.

Information is the Property of Liviniti

Liviniti is the owner of the information obtained by and through the administration and processing of any prescription claim by the pharmacy provider through Liviniti.

All Confidential Information will remain the exclusive property of Liviniti. No right, title or interest in the confidential information is conveyed to the pharmacy provider by release of Confidential Information to it. Pharmacy providers may not sell data or information that is adjudicated through the SS system. The pharmacy provider will promptly notify Liviniti if it becomes aware of any use of the Confidential Information that is not authorized by the pharmacy provider's Agreement with Liviniti. The pharmacy provider understands that in the event the pharmacy provider or any of its employees do not adhere to this provision, Liviniti will suffer irreparable damages that cannot be fully remedied by monetary damages. Accordingly, Liviniti will be entitled to seek and obtain injunctive relief against any such non-adherence in any court of competent jurisdiction. Liviniti's rights under these confidentiality requirements will not in any way be construed to limit or restrict Liviniti's rights to seek or obtain other damages or relief available under the Pharmacy Network Agreement with Liviniti or applicable law.

Third-Party Requests for Information or Data

If a pharmacy provider receives a subpoena or third-party request for Liviniti information or data, the pharmacy provider will inform Liviniti prior to disclosing the information or **data and** will give Liviniti an opportunity to file objections, if appropriate.

The pharmacy provider will inform Liviniti within 14 days of the removal of prescription records from the pharmacy provider's custody by an authorized Federal, State, or local agency. Upon request, a receipt provided by the agency removing the records and/or the name and phone number of the agent removing the records must be furnished to Liviniti.

If Liviniti receives a subpoena or third-party request for information about a pharmacy provider, the pharmacy provider will bear the cost of complying with the subpoena or third-party request.

Third-Party Requests for Information or Data

Liviniti shall have the right to assign this Agreement without prior written notice to any affiliated entity, or in connection with a merger, reorganization, transfer, sale of assets, or a change of control or ownership.

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Frequently Asked Questions

1. How can a Pharmacy join the Network? Contact the pharmacy provider Relations Department at pharmacynetwork@liviniti.com.
2. How can I change my address and/or Tax ID number? Contact the pharmacy provider Relations Department at pharmacynetwork@liviniti.com.
3. What do I do if a customer states the amount charged for their prescription is incorrect? You may contact the Pharmacy Help Desk for verification of the patient's pay amount. 1-800-710-9341
4. What is the Member ID number and format? On the front left corner of the member card.
5. What BIN number do I enter? BIN 015433
6. What PCN number do I enter? SSN (Use the letters "SSN", this is not Social Security Number)
7. Does Liviniti provide a website for pharmacies? Yes, it is https://liviniti.com/providers.
8. Who do I contact for payment/remit questions? Contact Liviniti at 1-800-710-9341
9. Who do I contact if I want to file a dispute or appeal? Contact Liviniti at 1-800-710-9341 or via email at pharmacynetwork@liviniti.com.
10. How can I file a complaint with Liviniti? A verbal complaint may be filed by contacting Liviniti. A written complaint may be submitted to P.O. Box 2482 Natchitoches, LA 71457.
11. What are some of the most common reject codes and the process to follow if received? Contact Liviniti if you receive the following:

    Missing/ Invalid cardholder ID- reject 07

    Missing/ Invalid Date of Birth- reject 09

    Missing/ Invalid Group Number- reject 06 Invalid Day Supply- reject 19

    Refill too soon- reject 79

    Missing/ Invalid NDC (National Drug Code) Number- reject 21

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Definitions

Affiliate shall mean and refer to any entity, whether partnership, corporation, individual, or otherwise, in which either Liviniti or pharmacy works within a business relationship.

Average Wholesale Price or "AWP" means the benchmark price established by a nationally available reporting service as selected by Liviniti based on the 11-digit National Drug Code ("NDC") of the Covered Medication dispensed by the pharmacy.

Brand Drug Product means a Covered Drug or Medication with a proprietary name or trademark and/or has been determined a Covered "brand" Medication by Liviniti.

Claim shall mean and refer to a pharmacy's billing or invoicing following NCPDP standards for a single prescription for Covered Prescription Services dispensed to a Member enrolled with a plan sponsor or group in accordance with this agreement.

Claims Processor shall mean and refer to Liviniti or a pharmacy Claims.
Processor with which Liviniti may contract. The Claims Processor shall provide Claims processing, eligibility verification, and other mutually agreed upon administrative and reporting services for Plans in connection with the administration of their respective pharmacy benefits.

Clean Claim shall mean and refer to a Claim prepared in the standard format promulgated by the National Council for Prescription Drug Programs ("NCPDP") which contains all the information necessary for processing that has been successfully electronically transmitted to Liviniti for processing and a positive response received by pharmacy.

Co-payment means the amount (which may be expressed as either a percentage of the cost of a specific service or a specific dollar amount) communicated electronically by Liviniti that a Member is obligated to pay for a Covered Medication at the time the Covered Medication is provided, pursuant to his or her Plan, which amount shall be deducted from pharmacy's reimbursement hereunder, including any deductibles and/or other ancillary charges.

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

Covered Drugs or Medications or Products means those pharmaceutical products to which a member is entitled to receive in accordance with and subject to the terms and conditions of the Plan.

Covered Prescription Services shall mean the services usually and customarily rendered by a pharmacy in the normal course of business, including but not limited to dispensing, counseling, pharmaceutical care, product consultation, and pharmacy services as otherwise defined by the state in which the pharmacy is licensed.

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

Dispensing Fee shall mean the component of the Prescription Drug Compensation added to the Ingredient Cost and associated with the delivery of Covered Products or Covered Medications.

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

Formulary means a list of preferred Prescription Drugs developed, published, and periodically revised by Liviniti's pharmacy and therapeutics committee or a payor, which practitioners are encouraged to prescribe, and participating pharmacies are required to dispense, consistent with their professional judgment and applicable Law, and which members are encouraged to use.

Generic Drug Product means a drug identified by its chemical or non-proprietary name considered to be bioequivalent to the Brand Drug Product that has been determined to be a Covered "generic" Medication by Liviniti.

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

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

Ingredient Cost shall mean the component of Prescription Drug Compensation associated with the reimbursement of the Covered Medication dispensed.

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

MAC shall mean the maximum allowable cost at which the pharmacy will be paid for a Covered Medication as established and amended by Liviniti and/or Plans.

Member means an individual who is enrolled with a Plan Sponsor and is entitled to receive Covered Prescription Services.

NADAC means the rate that is established by CMS or its contractor by rolling surveys of pharmacies nationwide to verify the actual invoice amount paid by the pharmacy or corporate entity to wholesalers, manufacturers, or distribution centers for the product. The NADAC is the average of invoice amounts for individual drug products based on the Generic Sequence Number (GSN)

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

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Negotiated Price means the "negotiated price," established by the Plan Sponsor and Liviniti and agreed upon by the pharmacy for Covered Drugs dispensed to Members.

Network Pharmacy means a pharmacy that has entered into a Pharmacy Network Agreement with Liviniti to provide Covered Prescription Services to members.

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

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

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

Pharmacy Benefit means the benefit portion that establishes coverage for pharmaceuticals and services on an outpatient basis to qualifying Members.

Pharmacy Services Manual or "PSM" shall mean and refer to those written descriptions of Liviniti's expectations regarding standards of practice as they relate to the Covered Prescription Services provided by the pharmacy under this Agreement, which includes, without limitation, Claim submission guidelines, description of Covered Drugs, and other Covered Prescription Services offered by the Plan Sponsors for which Liviniti provides pharmacy benefit management services, and other policies and procedures by which Liviniti and the Plan Sponsors require pharmacy to adhere. The PSM is available electronically and is incorporated fully herein to this Agreement. The Plan Sponsor or Liviniti may amend the PSM by notice or posting on Liviniti's website which amendment shall become effective after sixty (60) calendar days.

Plan(s) shall mean any one or more of the various funded health plans or benefits operated, offered, or provided by Liviniti/Plan Sponsors that entitle Members to receive reimbursement for, or payment of, medical expenses, including, without limitation, the Covered Prescription Services.

If at any time, your pharmacy would like a list of our plans/clients, please contact us at pharmacynetwork@liviniti.com.

Plan Sponsor shall mean, including, but not limited to, an employer, health insurer, managed care organization, union health and welfare trust, government agency, or third-party administrator that operates, offers or provides the Plan(s) through Liviniti.

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

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

Prescription Drug Compensation means the actual amount which Liviniti contractually required to reimburse pharmacy, on behalf of a Plan Sponsor, for the dispensing of a Covered Drug to a Member, which amount shall be determined in accordance with Exhibit A or Exhibit B. Liviniti may from time to time amend the Prescription Drug Compensation which amendment shall become effective thirty (30) calendar days after such notice is received by pharmacy unless, prior to such time, pharmacy rejects the amendment in writing to Liviniti. Liviniti will never unilaterally change an agreement, all changes will be with prior notification to the pharmacy.

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

PSAO is a Pharmacy Services Administration Organization that has the authority to contract with Liviniti on behalf of multiple, independently owned pharmacies. PSAOs shall distribute all relevant documentation and amendments to this Agreement to all member pharmacies, within five (5) business days of PSAO's receipt of such documentation or amendment from Liviniti.

Rebates means any discounts, direct or indirect subsidies, rebates, other price concessions, and/or direct or indirect remunerations that a Plan Sponsor has elected to apply or take into account in arriving at the Negotiated Price and/or to pass through at the point of sale for a Covered Drug, including, but not limited to, estimated or actual rebates paid by drug manufacturers or Affiliate Rebate Partner.

Specialty Drugs are those scientifically engineered Covered Medications deemed specialty by Liviniti used to treat certain complex and rare medical conditions and are often self-injected or self-administered, which are set forth in Exhibit "B."

Usual and Customary or "U&C" shall mean the price the pharmacy would charge a cash-paying customer for the same prescription.

Wholesale Acquisition Cost or "WAC" means the price, as reported by a drug manufacturer, at which wholesalers may purchase drug products from that manufacturer. Liviniti shall update WAC pricing on at least a weekly basis with data received from the pricing source.

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Regulatory Appendix

Many states require that pharmacy providers comply with certain statutes and regulations when providing Covered Services to Members in that state. The following Regulatory Appendix, which is attached hereto and made a part of this Pharmacy Services Manual, contains various regulations, requirements, and laws ("Requirements") that may apply to the arrangement between Liviniti, pharmacy provider, and/or Sponsor and the provision of applicable Covered Services by the provider.

Generally, the Requirements are applicable to Covered Services for Sponsors that are insurance companies, HMO(s), and governmental agencies and are usually not applicable to Sponsors that have self-funded plans. Provider is required to comply with all applicable Requirements. By providing Covered Services to an individual subject to any of these requirements, this Provider Agreement is modified as set forth in the applicable state-specific provision. If there is a conflict between a provision in this Manual and a provision in the Regulatory Appendix, the provision I the Regulatory Appendix shall control. This Regulatory Appendix may be amended to reflect any changes to the applicable law(s).

If any pharmacy provider disagrees with the manual and/or any updates as necessary, please contact the following: pharmacynetwork@liviniti.com.

Please refer to a state's website for the rules and requirements that pertain to Fee-for-Service Medicaid.

Alabama

- AUDIT LAWS/REGULATIONS
  - Code of Alabama | Article 8 - Pharmacy Audit Integrity Act | Casetext
- BOARD OF PHARMACY
  - http://www.albop.com/
- PHARMACY LAWS/REGULATIONS
  - http://www.albop.com/ (Click on "Resources" on top of page, then click on "Statutes & Rules")

Alaska

- AUDIT LAWS/REGULATIONS
  - Alaska Statutes 2020 (akleg.gov)
- BOARD OF PHARMACY
  - Board of Pharmacy (alaska.gov)
- PHARMACY LAWS/REGULATIONS
  - Statutes & Regulations, Board of Pharmacy, Professional Licensing, Division of Corporations, Business and Professional Licensing (alaska.gov)

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Arizona

- AUDIT LAWS/REGULATIONS
  - View Document (azleg.gov)
- BOARD OF PHARMACY
  - Arizona State Board of Pharmacy(az.gov)
- PHARMACY LAWS/REGULATIONS
- Arizona State Board of Pharmacy (Hover over “Resources” and click on “Rules and Statutes

Arkansas

- AUDIT LAWS/REGULATIONS
  - Arkansas Pharmacy Audit Bill of Rights
- BOARD OF PHARMACY
  - Arkansas State Board of Pharmacy
- PHARMACY LAWS/REGULATIONS
  - Pharmacy Lawbook – Arkansas State Board of Pharmacy

California

- AUDIT LAWS/REGULATIONS
  - Bill Text - SB-1195 Audits of pharmacy benefits. (ca.gov)
- BOARD OF PHARMACY
  - California State Board of Pharmacy
- PHARMACY LAWS/REGULATIONS
  - Laws and Regulations - California State Board of Pharmacy
- DHCS Medi-Cal Two Plan Contract
  - Organization and administration of the plan (ca.gov)

Colorado

- AUDIT LAWS/REGULATIONS
  - Pharmacy Benefit Manager And Insurer Requirements | Colorado General Assembly
- BOARD OF PHARMACY
  - Pharmacy HOME | Division of Professions and Occupations (colorado.gov)
- PHARMACY LAWS/REGULATIONS
  - State Board of Pharmacy: Laws and Rules | Division of Professions and Occupations

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Connecticut

- AUDIT LAWS/REGULATIONS
  - AN ACT CONCERNING PHARMACY AUDITS
- BOARD OF PHARMACY
  - The Commission of Pharmacy (ct.gov)
- PHARMACY LAWS/REGULATIONS
  - Microsoft Word - Drug Laws 4-15-14 WEB (2) (ct.gov)

Delaware

- AUDIT LAWS/REGULATIONS
  - Chapter - Delaware General Assembly
- BOARD OF PHARMACY
  - Board of Pharmacy - Division of Professional Regulation - State of Delaware
- PHARMACY LAWS/REGULATIONS
  - 2500 Board of Pharmacy (delaware.gov)

Florida

- AUDIT LAWS/REGULATIONS
  - Chapter 465 - 2011 Florida Statutes - The Florida Senate (flsenate.gov) (Scroll to 465.188)
- BOARD OF PHARMACY
  - Florida Board of Pharmacy-(floridaspharmacy.gov)
- PHARMACY LAWS/REGULATIONS
  - Florida Board of Pharmacy » Links and Resources- Information (floridaspharmacy.gov) Click on "Florida Statutes & Administrative Codes"

FLORIDA ADDENDUM PHARMACY SOLUTIONS PARTICIPATING PHARMACY AGREEMENT

This Indiana Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, health maintenance organizations ("HMOs"), limited service HMOs, Medicaid managed care organizations, preferred provider organizations, or other third party payers under Indiana law (collectively and/or individually, "Plan Sponsor").

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

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1. Pharmacy shall be required to exhaust internal dispute-resolution processes set for in the Agreement as a prerequisite to submission of a claim by PHARMACY to the statewide provider dispute resolution program pursuant to Florida Statute § 408.7057. Fla. Stat. § 408.7057(2)(c).
2. The Agreement shall be canceled upon issuance of an order by the Florida Department of Insurance pursuant to Florida Statute §§ 624.4411(3), 641.234(3), and 636.036(3).
3. PHARMACY shall not bill or otherwise seek reimbursement from or recourse against any Covered Persons, with the exception of any supplemental charges or coinsurance amounts stated in Covered Persons' Benefit Plan with Plan Sponsor. Fla. Stat. § 627.6472(4)(e).
4. To the extent PHARMACY provides Covered Drugs to Covered Persons of a health maintenance organization under Florida law, PHARMACY agrees:
    - Covered Persons shall not be liable to PHARMACY for any services for which Plan Sponsor is liable, as specified in Florida Statute § 641.3154. Fla. Stat. § 641.315(1).
    - PHARMACY shall provide no less than 60 days advance written notice to PBM and the Florida Department of Insurance before terminating the Agreement for any reason. Nonpayment for goods or services rendered by PHARMACY shall not be a valid reason for avoiding the 60 days advance notice of cancellation. Fla. Stat. § 641.315(2)(a)(1), (2).
    - PBM shall provide 60 days advance written notice to PHARMACY and the Florida Department of Insurance before terminating the Agreement, without cause, except where a patient's health is subject to imminent danger or PHARMACY's ability to practice is effectively impaired by an action by a governmental agency. Fla. Stat. § 641.315(2)(b).
5. To the extent PHARMACY provides Covered Drugs to Covered Persons of a prepaid limited health service organization under Florida law, PHARMACY agrees:
    - In the event PBM or Plan Sponsor fails to pay for Covered Drugs already rendered to Covered Persons by PHARMACY, Plan Sponsor is liable for such fees rather than Covered Persons. Fla. Stat. § 636.035(1).
    - Covered Persons shall not be liable to PHARMACY for any services covered by Covered Persons' Benefit Plan with Plan Sponsor, except for any deductible or copayment which is not covered by Covered Person's Benefit Plan or for services not authorized by Plan Sponsor. Fla. Stat. § 636.035(4), (5).
    - PHARMACY shall provide no less than 90 days advance written notice to PBM before canceling the Agreement for any reason. Nonpayment for goods or services rendered by PHARMACY shall not be a valid reason for avoiding the 90-day advance notice of cancellation. Fla. Stat. § 636.035(6)(a), (b).
    - PBM shall provide 90 days advance written notice to PHARMACY before canceling, without cause, the Agreement, except where a Covered Person is subject to imminent danger or PHARMACY's ability to practice is effectively impaired by an action by a governmental agency. Fla. Stat. § 636.035(8).
    - If any provision of the Agreement is held to be unenforceable or otherwise contrary to any applicable laws, regulations, or rules, such provision shall have no effect and shall be severable without affecting the validity or enforceability of the remaining provisions of the Agreement. Fla. Stat. § 636.035(9).
6. To the extent PHARMACY provides Covered Drugs to Covered Persons of a prepaid health clinic under Florida law, in the event Plan Sponsor fails to pay for Covered Drugs already rendered to a Covered Person by PHARMACY, Plan Sponsor is liable for such fees rather than Covered Person. Fla. Stat. § 641.43.
7. Notwithstanding anything to the contrary in the Agreement, to the extent PHARMACY provides Covered Drugs to Covered Persons of a discount medical plan organization under Florida law, the rates charged by the PHARMACY for services rendered to Covered Persons shall not be in excess of the rates set forth in the Agreement and any related attachments. Fla. Stat. § 636.214(2)(c).

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8. PHARMACY shall post a consumer assistance notice, prominently displaying the notice in the reception area of PHARMACY so that the notice will be clearly noticeable by all patients. The consumer assistance notice must state that the addresses and toll-free telephone number of Plan Sponsor's grievance department shall be provided upon request. Fla. Stat. § 641.511(11).
9. PBM shall update the maximum allowable cost pricing information at least every 7 calendar days, and shall maintain a process that will, in a timely manner, eliminate drugs from its maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability. All data is available through our pharmacy portal on our website. Fla. Stat. § 465.1862(2)(a), (b).
10. "Adjudication transaction fee" means a fee charged by the pharmacy benefit manager to the pharmacy for electronic claim submissions." Liviniti does not charge pharmacy transaction fees. Fla. Stat. § 626.8825.
11. "Brand name or generic effective rate" means the contractual rate set forth by a pharmacy benefit manager for the reimbursement of covered brand name or generic drugs, calculated using the total payments in the aggregate, by drug type, during the performance period. The effective rates are typically calculated as a discount from industry benchmarks, such as average wholesale price or wholesale acquisition cost. Fla. Stat. § 626.8825.
12. "Covered person" means a person covered by, participating in, or receiving the benefit of a pharmacy benefits plan or program." Fla. Stat. § 626.8825.
13. "Direct and indirect remuneration fees" means price concessions that are paid to the pharmacy benefit manager by the pharmacy retrospectively and that cannot be calculated at the point of sale. The term may also include discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, upfront payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits from manufacturers, pharmacies, or similar entities. Fla. Stat. § 626.8825
14. "Dispensing fee" means a fee intended to cover reasonable costs associated with providing the drug to a covered person. This cost includes the pharmacist's services and the overhead associated with maintaining the facility and equipment necessary to operate the pharmacy." All dispensing fees are established within the Participating Pharmacy Agreement. Fla. Stat. § 626.8825
15. "Effective rate guarantee" means the minimum ingredient cost reimbursement a pharmacy benefit manager guarantees it will pay for pharmacist services during the applicable measurement period." Fla. Stat. § 626.8825
16. "Erroneous claims" means pharmacy claims submitted in error, including, but not limited to, unintended, incorrect, fraudulent, or test claims." Fla. Stat. § 626.8825
17. "Incentive payment" means a retrospective monetary payment made as a reward or recognition by the pharmacy benefits plan or program or pharmacy benefit manager to a pharmacy for meeting or exceeding predefined pharmacy performance metrics as related to quality measures, such as Healthcare Effectiveness Data and Information Set measures." Liviniti does not have any performance-based networks. Fla. Stat. § 626.8825
18. "Maximum allowable cost appeal pricing adjustment" means a retrospective positive payment adjustment made to a pharmacy by the pharmacy benefits plan or program or by the pharmacy benefit manager pursuant to an approved maximum allowable cost appeal request submitted by the same pharmacy to dispute the amount reimbursed for a drug based on the pharmacy benefit manager's listed maximum allowable cost price. Fla. Stat. § 626.8825
19. "Monetary recoupments" means rescinded or recouped payments from a pharmacy or provider by the pharmacy benefits plan or program or by the pharmacy benefit manager." Fla. Stat. § 626.8825
20. "Network reconciliation offsets" means a process during annual payment reconciliation between a pharmacy benefit manager and a pharmacy which allows the pharmacy benefit manager to offset an amount for overperformance or underperformance of contractual guarantees across guaranteed line items, channels, networks, or payors, as applicable." Fla. Stat. § 626.8825

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21. "Pass-through pricing model" means a payment model used by a pharmacy benefit manager in which the payments made by the pharmacy benefits plan or program to the pharmacy benefit manager for the covered outpatient drugs are:" Fla. Stat. § 626.8825
    - Equivalent to the payments the pharmacy benefit manager makes to a dispensing pharmacy or provider for such drugs, including any contracted professional dispensing fee between the pharmacy benefit manager and its network of pharmacies. Such dispensing fee would be paid if the pharmacy benefits plan or program was making the payments directly.
    - Passed through in their entirety by the pharmacy benefits plan or program or by the pharmacy benefit manager to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation.
22. "Pharmacy benefits plan or program" means a plan or program that pays for, reimburses, covers the cost of, or provides access to discounts on pharmacist services provided by one or more pharmacies to covered persons who reside in, are employed by, or receive pharmacist services from this state." Fla. Stat. § 626.8825
23. "Rebate" means all payments that accrue to a pharmacy benefit manager or its pharmacy benefits plan or program client or an affiliated group purchasing organization, directly or indirectly, from a pharmaceutical manufacturer, including, but not limited to, discounts, administration fees, credits, incentives, or penalties associated directly or indirectly in any way with claims administered on behalf of a pharmacy benefits plan or program client. Fla. Stat. § 626.8825
24. "Spread pricing" is the practice in which a pharmacy benefit manager charges a pharmacy benefits plan or program a different amount for pharmacist services than the amount the pharmacy benefit manager reimburses a pharmacy for such pharmacist services." Liviniti is a transparent Pharmacy Benefit Manager and has no Spread pricing models. Fla. Stat. § 626.8825
25. "Usual and customary price" means the amount charged to cash customers for a pharmacist service exclusive of sales tax or other amounts claimed." Fla. Stat. § 626.8825
26. In addition to other requirements in the Florida Insurance Code, a participation contract executed, amended, adjusted, or renewed on or after July 1, 2023, that applies to pharmacist services on or after January 1, 2024, between a pharmacy benefit manager and one or more pharmacies or pharmacists, must include, in substantial form, terms that ensure compliance with all of the following requirements, and that, except to the extent not allowed by law, shall supersede any contractual terms in the participation contract to the contrary: Fla. Stat. § 626.8825
    - At the time of adjudication for electronic claims or the time of reimbursement for nonelectronic claims, the pharmacy benefit manager shall provide the pharmacy with a remittance, including such detailed information as is necessary for the pharmacy or pharmacist to identify the reimbursement schedule for the specific network applicable to the claim and which is the basis used by the pharmacy benefit manager to calculate the amount of reimbursement paid. This information must include, but is not limited to, the applicable network reimbursement ID or plan ID as defined in the most current version of the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, or its nationally recognized successor industry guide. The commission shall adopt rules to implement this paragraph. Fla. Stat. § 626.8825
    - The pharmacy benefit manager must ensure that any basis of reimbursement information is communicated to a pharmacy in accordance with the NCPDP Telecommunication Standard Implementation Guide, or its nationally recognized successor industry guide, when performing reconciliation for any effective rate guarantee, and that such basis of reimbursement information communicated is accurate, corresponds with the applicable network rate, and may be relied upon by the pharmacy. Fla. Stat. § 626.8825
    - A prohibition of financial clawbacks, reconciliation offsets, or offsets to adjudicated claims. A pharmacy benefit manager may not charge, withhold, or recoup direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or

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recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when a fee may be recouped from a pharmacy. This prohibition does not apply to: Fla. Stat. § 626.8825

- Any incentive payments provided by the pharmacy benefit manager to a network pharmacy for meeting or exceeding predefined quality measures, such as Healthcare Effectiveness Data and Information Set measures; recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a pharmacy audit pursuant to s. 624.491. Fla. Stat. § 626.8825
- Any recoupment that is returned to the state for programs in chapter 409 or the state group insurance program in s. 110.123. Fla. Stat. § 626.8825

- "A pharmacy benefit manager may not unilaterally change the terms of any participation contract." Fla. Stat. § 626.8825
- "Unless otherwise prohibited by law, a pharmacy benefit manager may not prohibit a pharmacy or pharmacist from:" Fla. Stat. § 626.8825
  - "Unless otherwise prohibited by law, a pharmacy benefit manager may not prohibit a pharmacy or pharmacist from:" Fla. Stat. § 626.8825
  - "Mailing or delivering a prescription drug to a covered person upon his or her request." Fla. Stat. § 626.8825
  - Charging a shipping or handling fee to a covered person requesting a prescription drug be mailed or delivered if the pharmacy or pharmacist discloses to the covered person before the mailing or delivery the amount of the fee that will be charged and that the fee may not be reimbursable by the covered person's pharmacy benefits plan or program. Fla. Stat. § 626.8825
- The pharmacy benefit manager must provide a pharmacy, upon its request, a list of pharmacy benefits plans or programs in which the pharmacy is a part of the network. Updates to the list must be communicated to the pharmacy within 7 days. The pharmacy benefit manager may not restrict the pharmacy or pharmacist from disclosing this information to the public. Fla. Stat. § 626.8825
- The pharmacy benefit manager must ensure that the Electronic Remittance Advice contains claim level payment adjustments in accordance with the American National Standards Institute Accredited Standards Committee, X12 format, and includes or is accompanied by the appropriate level of detail for the pharmacy to reconcile any debits or credits, including, but not limited to, pharmacy NCPDP or NPI identifier, date of service, prescription number, refill number, adjustment code, if applicable, and transaction amount. Fla. Stat. § 626.8825
- The pharmacy benefit manager shall provide a reasonable administrative appeal procedure to allow a pharmacy or pharmacist to challenge the maximum allowable cost pricing information and the reimbursement made under the maximum allowable cost as defined in s. 627.64741 for a specific drug as being below the acquisition cost available to the challenging pharmacy or pharmacist. Fla. Stat. § 626.8825
  - The administrative appeal procedure must include a telephone number and e-mail address, or a website, for the purpose of submitting the administrative appeal. The appeal may be submitted by the pharmacy or an agent of the pharmacy directly to the pharmacy benefit manager or through a pharmacy service administration organization. The pharmacy or pharmacist must be given at least 30 business days after a maximum allowable cost update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal. Fla. Stat. § 626.8825
  - "The pharmacy benefit manager must respond to the administrative appeal within 30 business days after receipt of the appeal." Fla. Stat. § 626.8825
  - "If the appeal is upheld, the pharmacy benefit manager must:" Fla. Stat. § 626.8825

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- "Update the maximum allowable cost pricing information to at least the acquisition cost available to the pharmacy;" Fla. Stat. § 626.8825
- "Permit the pharmacy or pharmacist to reverse and rebill the claim in question;" Fla. Stat. § 626.8825
- "Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and" Fla. Stat. § 626.8825
- "Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable maximum allowable cost pricing information." Fla. Stat. § 626.8825
- "If the appeal is denied, the pharmacy benefit manager must provide to the pharmacy or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state which have the drug currently in stock at a price below the maximum allowable cost pricing information." Fla. Stat. § 626.8825
- "Every 90 days, a pharmacy benefit manager shall report to the office the total number of appeals received and denied in the preceding 90-day period, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted pursuant to this paragraph." Fla. Stat. § 626.8825

Georgia

- AUDIT LAWS/REGULATIONS
  - C:\pdf\153810.wpd (ga.gov)
- BOARD OF PHARMACY
  - Georgia Board of Pharmacy
- PHARMACY LAWS/REGULATIONS
  - Laws, Policies & Rules | Georgia Board of Pharmacy

Hawaii

- AUDIT LAWS/REGULATIONS
  - SB975 (hawaii.gov)
- BOARD OF PHARMACY
  - Professional & Vocational Licensing Division | Board Of Pharmacy (hawaii.gov)
- PHARMACY LAWS/REGULATIONS
  - Hawaii Revised Statutes Chapter 461-Pharmacy

Idaho

- AUDIT LAWS/REGULATIONS
  - SENATE BILL NO.1336 (2018) - Pharmacy, benefit managers (idaho.gov)
- BOARD OF PHARMACY
  - Welcome to State Board of Pharmacy (idaho.gov)

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- PHARMACY LAWS/REGULATIONS
  - Pharmacy Code & Administrative Rules | State Board of Pharmacy (idaho.gov)

Illinois

- AUDIT LAWS/REGULATIONS
  - Illinois General Assembly - Full Text of HB5591 (ilga.gov)
- BOARD OF PHARMACY
  - State of Illinois | Department of Financial & Professional Regulation (idfpr.com)
- PHARMACY LAWS/REGULATIONS
  - State of Illinois (idfpr.com) Under “Laws and Rules”

Indiana

- AUDIT LAWS/REGULATIONS
  - Indiana Pharmacy Laws and Regulations (page 245)
- BOARD OF PHARMACY
  - PLA: Indiana Board of Pharmacy
- PHARMACY LAWS/REGULATIONS
  - Indiana Pharmacy Laws and Regulations
- MAC PRICING 760 IAC 5-4-1
- In accordance with the Indiana Code, MAC pricing will be updated at least every seven (7) calendar days.

INDIANA ADDENDUM PHARMACY SOLUTIONS PARTICIPATING PHARMACY AGREEMENT

This Indiana Addendum applies to the extent that PHARMACY provides Covered Drugs to Covered Persons of insurers, health maintenance organizations (“HMOs”), limited service HMOs, Medicaid managed care organizations, preferred provider organizations, or other third party payers under Indiana law (collectively and/or individually, “Plan Sponsor”).

In the event of a direct conflict between this Addendum and the Agreement, the applicable provisions of this Addendum shall control if required. This Addendum may be modified from time to time pursuant to the Agreement.

Without limiting the generality of the foregoing, and notwithstanding anything in the Agreement to the contrary, PHARMACY and PBM agree as follows:

27. To the extent that PHARMACY participates in the federal 340B Drug Pricing Program as a 340B Covered Entity, the following shall not apply: (a) A reimbursement rate for a prescription drug that would diminish the 340B benefit to PHARMACY as a 340B Covered Entity; (b) A fee or adjustment that is not imposed on a pharmacy that is not a 340B Covered Entity; (c) A fee or adjustment amount that exceeds the fee or adjustment amount imposed on a pharmacy that is not a 340B Covered Entity; (d) Any provision that prevents or interferes with an individual's choice to

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receive a prescription drug from PHARMACY as a 340B Covered Entity, including the administration of the drug; (e) Any provision that excludes a 340B Covered Entity from PBM's networks based on the PHARMACY's participation in the federal 340B Drug Pricing Program; and (f) Any provision that discriminates against PHARMACY as a 340B Covered Entity. Ind. Code §§ 27-1-24.5-19.5.

28. PBM shall identify to PHARMACY (and its Pharmacy Services Administrative Organization (PSAO) if applicable) the sources used by PBM to calculate the drug product reimbursement paid for Covered Drugs available under the pharmacy health plan administered by PBM. Ind. Code 27-1-24.5-22(a)(1).

29. PHARMACY and its PSAO have the right to obtain from PBM, within ten (10) calendar days after a request, a current list of the sources used to determine maximum allowable cost pricing. PBM will update the maximum allowable cost list at least every seven (7) calendar days and provide to PHARMACY and its PSAO maximum allowable cost list updates in a format that is readily available and accessible. 760 Ind. Admin. Code 5-4-1(a); Ind. Code 27-1-24.5-22(a)(3).

30. PBM shall determine that a prescription drug: (a) Is not obsolete; (b) Is generally available for purchase by pharmacies in Indiana from a national or regional wholesaler licensed in Indiana; and (c) Is not temporarily unavailable, listed on a drug shortage list, or unable to be lawfully substituted before the prescription drug is placed or continued on a maximum allowable cost list. Ind. Code 27-1-24.5-22(a)(4).

31. PBM's process for PHARMACY, its PSAO, or its Group Purchasing Organization to appeal disputes concerning maximum allowable cost pricing shall: (a) Include the right to appeal a claim up to sixty (60) days following the initial filing of the claim; (b) Investigate and resolve the appeal within thirty (30) calendar days after the appeal is received; (c) In the case of an appeal denial, provide the reason for the denial and the national drug code number of the prescription drug that is available from a national or regional wholesaler operating in Indiana; and (d) In the case of an appeal approval: (i) change the maximum allowable cost of the drug for PHARMACY as of the initial date of service that the appealed drug was dispensed; (ii) adjust the maximum allowable cost of the drug for PHARMACY and for all other contracted pharmacies in the same network of PBM that filled a prescription for patients covered under the same health plan beginning on the initial date of service the appealed drug was dispensed; (iii) notify each pharmacy in PBM's network that the maximum allowable cost for the drug has been adjusted as a result of an approved appeal; (iv) adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost, if applicable; (v) allow PHARMACY and all other contracted pharmacies in the network that filled the prescriptions for patients covered under the same health plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed; and (vi) make retroactive price adjustments in the next payment cycle unless otherwise agreed to by PHARMACY. Ind. Code 27-1-24.5-22(b)(1)-(4).

32. PBM's process for PHARMACY, its PSAO, or its Group Purchasing Organization to appeal disputes concerning maximum allowable cost pricing shall: (a) Include the right to appeal a claim up to sixty (60) days following the initial filing of the claim; (b) Investigate and resolve the appeal within thirty (30) calendar days after the appeal is received; (c) In the case of an appeal denial, provide the reason for the denial and the national drug code number of the prescription drug that is available from a national or regional wholesaler operating in Indiana; and (d) In the case of an appeal approval: (i) change the maximum allowable cost of the drug for PHARMACY as of the initial date of service that the appealed drug was dispensed; (ii) adjust the maximum allowable cost of the drug for PHARMACY and for all other contracted pharmacies in the same network of PBM that filled a prescription for patients covered under the same health plan beginning on the initial date of service the appealed drug was dispensed; (iii) notify each pharmacy in PBM's

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network that the maximum allowable cost for the drug has been adjusted as a result of an approved appeal; (iv) adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost, if applicable; (v) allow PHARMACY and all other contracted pharmacies in the network that filled the prescriptions for patients covered under the same health plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed; and (vi) make retroactive price adjustments in the next payment cycle unless otherwise agreed to by PHARMACY. Ind. Code 27-1-24.5-22(b)(1)-(4).

33. PBM's process for PHARMACY, its PSAO, or its Group Purchasing Organization to appeal disputes concerning maximum allowable cost pricing shall: (a) Include the right to appeal a claim up to sixty (60) days following the initial filing of the claim; (b) Investigate and resolve the appeal within thirty (30) calendar days after the appeal is received; (c) In the case of an appeal denial, provide the reason for the denial and the national drug code number of the prescription drug that is available from a national or regional wholesaler operating in Indiana; and (d) In the case of an appeal approval: (i) change the maximum allowable cost of the drug for PHARMACY as of the initial date of service that the appealed drug was dispensed; (ii) adjust the maximum allowable cost of the drug for PHARMACY and for all other contracted pharmacies in the same network of PBM that filled a prescription for patients covered under the same health plan beginning on the initial date of service the appealed drug was dispensed; (iii) notify each pharmacy in PBM's network that the maximum allowable cost for the drug has been adjusted as a result of an approved appeal; (iv) adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost, if applicable; (v) allow PHARMACY and all other contracted pharmacies in the network that filled the prescriptions for patients covered under the same health plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed; and (vi) make retroactive price adjustments in the next payment cycle unless otherwise agreed to by PHARMACY. Ind. Code 27-1-24.5-22(b)(1)-(4).

34. PBM's claims auditing procedures (or claims auditing procedures of PBM's contracted auditor): (a) Will not use extrapolation or any similar methodology; (b) Will not allow for recovery by PBM of a submitted claim due to clerical or other error where the patient has received the drug for which the claim was submitted; (c) Will allow for recovery by PHARMACY for underpayments by PBM; and (d) Will only allow for PBM to recover overpayments on claims that are actually audited and discovered to include a recoverable error. Ind. Code 27-1-24.5-22(b)(5).

35. PBM (or PBM's contracted auditor) will comply with the following in conducting an audit of PHARMACY: (a) The contract under which the audit is performed will provide a description of audit procedures that will be followed; (b) For an onsite audit conducted at PHARMACY's location, the auditor that conducts the audit will provide written notice to PHARMACY or pharmacist at least fourteen (14) calendar days before conducting the initial onsite audit for each audit cycle; (c) The auditor will not interfere with the delivery of pharmacist services to a patient, and must use every effort to minimize inconvenience and disruption to PHARMACY operations during the audit (although audits may be performed during normal business hours of PHARMACY); (d) If the audit requires use of clinical or professional judgment, the audit must be conducted by or in consultation with an individual licensed as a pharmacist; (e) The auditor must allow the use of written or otherwise transmitted hospital, physician, or other health practitioner records to validate a PHARMACY record; (f) The auditor must perform the audit according to the same standards and parameters that the auditor uses to audit all other similarly situated pharmacies; (g) The period covered by the audit must not exceed twenty-four (24) months after the date on which a claim that is the subject of the audit was submitted to or adjudicated by PBM (unless a longer period is required under federal or state law), and PHARMACY will be permitted

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to resubmit electronically any claims disputed by the audit for a period of at least thirty (30) calendar days; (h) The auditor will not schedule an audit to begin during the first seven (7) calendar days of a month without the voluntary consent of PHARMACY; (i) Payment to the auditor for conducting the audit must not be based on a percentage of the amount recovered as a result of the audit; (j) Within twenty-four (24) hours of receiving the notice of an audit, PHARMACY may reschedule the audit to a date not more than fourteen (14) calendar days after the date proposed by the auditor (although if the auditor is unable to reschedule within the fourteen (14) calendar day period, the auditor must select and reschedule the audit for a date after the fourteen (14) calendar day period); and (k) The auditor must allow PHARMACY or pharmacist to produce documentation to address a discrepancy found during the audit. 760 Ind. Admin. Code 5-3-3.

36. PHARMACY acknowledges and agrees that PBM may lease, rent, or otherwise grant access to PHARMACY's services under the Agreement to third parties that are: (a) Employers or entities providing coverage for Covered Drugs to their employees or members when such employers and/or entities have contracted with PBM or its affiliate for the administration or processing of claims for payment or service provided under the Agreement; and (b) Affiliates or subsidiaries of PBM or entities providing or receiving administrative services from PBM or its affiliates or subsidiaries. Any such third party that is granted access to PHARMACY's services under the Agreement shall be obligated to comply with the applicable terms of the Agreement. PHARMACY further acknowledges and agrees that contemporaneously with the execution of the Agreement, PBM has identified to PHARMACY those third parties known at the time of contracting to which PBM will grant access to PHARMACY's services. Ind. Code §§ 27-1-37.3-7, 27-1-37.3-8.
37. In the event Plan Sponsor or PBM fails to pay for Covered Drugs for any reason, including insolvency or breach of the Agreement, Covered Persons shall not be liable to PHARMACY for any sums owed by Plan Sponsor or PBM. This provision does not prohibit the collection of copayments or uncovered charges consented to by Covered Persons. This provision survives termination of the Agreement, regardless of the reason for termination. Ind. Code §§ 27-13-15-1(a)(4), 27-13-34-15(1).
38. PHARMACY or its trustee, agent, representative, or assignee shall not bring or maintain a legal action against a Covered Person to collect sums owed to PHARMACY by Plan Sponsor or PBM. If PHARMACY brings or maintains a legal action against a Covered Person for an amount owed to PHARMACY by Plan Sponsor or PBM, PHARMACY shall be liable to the Covered Person for costs and attorney's fees incurred by the Covered Person in defending the action. This provision does not prohibit the collection of copayments or uncovered charges consented to by the Covered Person. This provision survives termination of the Agreement, regardless of the reason for termination. Ind. Code §§ 27-13-15-3(a), 27-13-34-15(2).

Iowa

- AUDIT LAWS/REGULATIONS
  - 191.59.pdf (iowa.gov)
- BOARD OF PHARMACY
  - Iowa Board of Pharmacy
- PHARMACY LAWS/REGULATIONS
  - Rules/Laws | Iowa Board of Pharmacy

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Kansas

- AUDIT LAWS/REGULATIONS
  - Statute | Kansas State Legislature (kslegislature.org)
- BOARD OF PHARMACY
  - Kansas Board of Pharmacy - Homepage (ks.gov)
- PHARMACY LAWS/REGULATIONS
  - Kansas Board of Pharmacy - Statutes - Regs (ks.gov)

Kentucky

- AUDIT LAWS/REGULATIONS
  - statute.aspx (ky.gov)
- BOARD OF PHARMACY
  - Kentucky Board of Pharmacy
- PHARMACY LAWS/REGULATIONS
  - Kentucky Board of Pharmacy

Louisiana

- AUDIT LAWS/REGULATIONS
  - Louisiana Laws - Louisiana State Legislature
- BOARD OF PHARMACY
  - Louisiana Board of Pharmacy | State of Louisiana (la.gov)
- PHARMACY LAWS/REGULATIONS
  - Louisiana Board of Pharmacy | State of Louisiana (la.gov)

Maine

- AUDIT LAWS/REGULATIONS
  - Title 24-A, §4317: Pharmacy providers (mainelegislature.org)
- BOARD OF PHARMACY
  - Board of Pharmacy | Office of Professional and Occupational Regulation (maine.gov)
- PHARMACY LAWS/REGULATIONS
  - Board of Pharmacy - Laws & Rules (maine.gov)

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Maryland

- AUDIT LAWS/REGULATIONS
  - Article - Insurance, Section 15-1629 (maryland.gov)
- BOARD OF PHARMACY
  - Pages - Maryland Pharmacy Board
- PHARMACY LAWS/REGULATIONS
  - Pages - laws-regulation-legislation-reports (maryland.gov)

Massachusetts

- AUDIT LAWS/REGULATIONS
  - Session Law - Acts of 2014 Chapter 441 (malegislature.gov)
- BOARD OF PHARMACY
  - Board of Registration in Pharmacy | Mass.gov
- PHARMACY LAWS/REGULATIONS
  - Laws and regulations of the Board of Registration in Pharmacy | Mass.gov

Michigan

- AUDIT LAWS/REGULATIONS
  - standards for pharmacy auditing practices; (mi.gov)
- BOARD OF PHARMACY
  - LARA - Pharmacy (michigan.gov)
- PHARMACY LAWS/REGULATIONS
  - LARA - Laws/Regulations (michigan.gov)

Minnesota

- AUDIT LAWS/REGULATIONS
  - SF 278 5th Engrossment - 91st Legislature (2019 - 2020) (mn.gov) (Scroll to Sec 12 “Pharmacy Audits”)
- BOARD OF PHARMACY
  - Minnesota Board of Pharmacy / Minnesota Board of Pharmacy (mn.gov)
- PHARMACY LAWS/REGULATIONS
  - Laws Rules Guidelines / Minnesota Board of Pharmacy (mn.gov)

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Mississippi

- AUDIT LAWS/REGULATIONS
  - PBM_Audit_Integrity.pdf (ms.gov)
- BOARD OF PHARMACY
  - Welcome to the Mississippi Board of Pharmacy (ms.gov)
- PHARMACY LAWS/REGULATIONS
  - Regulations (ms.gov)

Missouri

- AUDIT LAWS/REGULATIONS
  - Missouri Revisor of Statutes - Revised Statutes of Missouri, RSMo Section 338.600
- BOARD OF PHARMACY
  - Board of Pharmacy (mo.gov)
- PHARMACY LAWS/REGULATIONS
  - Board of Pharmacy rules/statutes (mo.gov)

Montana

- AUDIT LAWS/REGULATIONS
  - SB0235.pdf (mt.gov)
- BOARD OF PHARMACY
  - Board of Pharmacy (mt.gov)
- PHARMACY LAWS/REGULATIONS
  - Statute/Rule Information (mt.gov)

Nebraska

- BOARD OF PHARMACY
  - Pharmacy Professions (ne.gov)
- PHARMACY LAWS/REGULATIONS
  - Pharmacy.pdf (ne.gov)

Nevada

- BOARD OF PHARMACY
  - Board of Pharmacy Home (nv.gov)
- PHARMACY LAWS/REGULATIONS
  - Nevada Statues & Regulations (nv.gov)

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New Hampshire

- AUDIT LAWS/REGULATIONS
  - SB 0038 (state.nh.us)
- BOARD OF PHARMACY
  - Board of Pharmacy | NH Office of Professional Licensure and Certification
- PHARMACY LAWS/REGULATIONS
  - Board of Pharmacy Laws and Rules | NH Office of Professional Licensure and Certification

New Jersey

- AUDIT LAWS/REGULATIONS
  - S2880 (state.nj.us)
- BOARD OF PHARMACY
  - Pages - Board of Pharmacy (njconsumeraffairs.gov)
- PHARMACY LAWS/REGULATIONS
  - Pages - Statutes and Regulations (njconsumeraffairs.gov)

New Mexico

- AUDIT LAWS/REGULATIONS
  - 59A ARTICLE 61.pdf (nmpharmacy.org) (Search 61-11-18.2)
- BOARD OF PHARMACY
  - Pharmacy | NM RLD
- PHARMACY LAWS/REGULATIONS
  - Pharmacy Rules and Laws | NM RLD

New York

- AUDIT LAWS/REGULATIONS
  - Legislation | NY State Senate (nysenate.gov)
- BOARD OF PHARMACY
  - NYS Pharmacy (nysed.gov)
- PHARMACY LAWS/REGULATIONS
  - NYS Pharmacy:Laws, Rules & Regulations (nysed.gov)

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North Carolina

- AUDIT LAWS/REGULATIONS
  - Article_4C.pdf (ncleg.net)
- BOARD OF PHARMACY
  - North Carolina Board of Pharmacy : NCBOP Homepage
- PHARMACY LAWS/REGULATIONS
  - North Carolina Board of Pharmacy : Pharmacy Law and Rules (ncbop.org)

North Dakota

- AUDIT LAWS/REGULATIONS
  - ARTICLE 61-01 (nodakpharmacy.com) (page 194)
- BOARD OF PHARMACY
  - North Dakota Board of Pharmacy (nodakpharmacy.com)
- PHARMACY LAWS/REGULATIONS
  - North Dakota Board of Pharmacy (nodakpharmacy.com)

Ohio

- AUDIT LAWS/REGULATIONS
  - Section 3901.811 - Ohio Revised Code | Ohio Laws
- BOARD OF PHARMACY
  - State of Ohio Board of Pharmacy
- PHARMACY LAWS/REGULATIONS
  - State of Ohio Board of Pharmacy

Oklahoma

- AUDIT LAWS/REGULATIONS
  - Section 3901.811 - Ohio Revised Code | Ohio Laws
- BOARD OF PHARMACY
  - Oklahoma State Board of Pharmacy - Home
- PHARMACY LAWS/REGULATIONS
  - Oklahoma State Board of Pharmacy - Laws & Rules

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Oregon

- 0570 (oregonlegislature.gov)
- BOARD OF PHARMACY
  - Oregon Board of Pharmacy : Welcome Page : State of Oregon
- PHARMACY LAWS/REGULATIONS
  - Oregon Board of Pharmacy : Laws & Rules : State of Oregon

Pennsylvania

- AUDIT LAWS/REGULATIONS
  - 2016 Act 169 - PA General Assembly (state.pa.us)
- BOARD OF PHARMACY
  - Home (pa.gov)
- PHARMACY LAWS/REGULATIONS
  - Board Laws and Regulations (pa.gov)

Rhode Island

- BOARD OF PHARMACY
  - Pharmacy Licensing: Department of Health (ri.gov)
- PHARMACY LAWS/REGULATIONS
  - webserver.rilin.state.ri.us/Statutes/TITLE5/5-19.1/INDEX.HTM

South Carolina

- AUDIT LAWS/REGULATIONS
  - SC S0359 | 2019-2020
- BOARD OF PHARMACY
  - SCLLR
- PHARMACY LAWS/REGULATIONS
  - SCLLR Laws and Policies

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South Dakota

- AUDIT LAWS/REGULATIONS
  - SDLRC - Codified Law 58-29F (sdlegislature.gov)
- BOARD OF PHARMACY
  - South Dakota Board of Pharmacy - SD Dept. of Health
- PHARMACY LAWS/REGULATIONS
  - SDLRC - Codified Law 36-11 (sdlegislature.gov)

Tennessee

- Tennessee Code | Part 31 - Pharmacy Benefits Managers | Casetext
- BOARD OF PHARMACY
  - Pharmacy (tn.gov)
- PHARMACY LAWS/REGULATIONS
  - 1140 - Board of Pharmacy (tnsosfiles.com)
- INITIAL APPEALS PROCESS (REIMBURSEMENT) 0780-01-95

Texas

- NA

Utah

- AUDIT LAWS/REGULATIONS
  - C58-17b-S622_1800010118000101.pdf (utah.gov)
- BOARD OF PHARMACY
  - DOPL - Pharmacy (utah.gov)
- PHARMACY LAWS/REGULATIONS
  - DOPL – Pharmacy-Laws and Rules (utah.gov)

Vermont

- AUDIT LAWS/REGULATIONS
  - Vermont Laws
- BOARD OF PHARMACY
  - Vermont Secretary of State - Office of Professional Regulation Pharmacy Section
- PHARMACY LAWS/REGULATIONS
  - Pharmacy Statutes, Rules & Resources (vermont.gov)

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Virginia

- AUDIT LAWS/REGULATIONS
  - Code of Virginia Code - Article 9. Pharmacy Benefits Managers
- BOARD OF PHARMACY
  - Virginia Board of Pharmacy - Home
- PHARMACY LAWS/REGULATIONS
  - Virginia Board of Pharmacy - Laws & Regulations

Washington

- AUDIT LAWS/REGULATIONS
  - Chapter 19.340 RCW: pharmacy benefit managers (wa.gov)
- BOARD OF PHARMACY
  - Pharmacy Professions Licensing Information :: Washington State Department of Health
- PHARMACY LAWS/REGULATIONS
  - Pharmacy Laws: Washington State Department of Health

West Virginia

- AUDIT LAWS AND REGULATIONS
  - West Virginia Code (wvlegislature.gov)
- BOARD OF PHARMACY
  - Home - WV Board of Pharmacy (wvbop.com)
- PHARMACY LAWS/REGULATIONS
  - Pharmacy Law and Rules - WV Board of Pharmacy (wvbop.com)

Wisconsin

- AUDIT LAWS AND REGULATIONS
  - Wisconsin Legislature: 2021 Wisconsin Act 9
- BOARD OF PHARMACY
  - DSPS Pharmacy Examining Board (wi.gov)
- PHARMACY LAWS/REGULATIONS
  - DSPS Pharmacy Examining Board (wi.gov)

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Wyoming

- AUDIT LAWS AND REGULATIONS
  - Pharmacy benefit manager audits, Wyo. Stat. § 26-52-103
- BOARD OF PHARMACY
  - Pharmacy (wyo.gov)
- PHARMACY LAWS/REGULATIONS
  - Pharmacy - Laws (wyo.gov)

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