LIVINITI

Pharmacy Services Manual

Liviniti simplifies the complexities of the PBM world.

www.liviniti.com

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Table of Contents

I. LIVINITI OVERVIEW 1

II. PHARMACY PROVIDER RELATIONS DEPARTMENT 2

Contact Information 2

Pharmacy Resources Webpage 2

Liviniti Pharmacy Help Desk 2

Hours of Operation and Contact Telephone Numbers 3

III. PHARMACY ENROLLMENT 4

Credentialing 4

Expectations of Liviniti Network Pharmacies 5

Pharmacy Licensure 5

Confidentiality and Proprietary Rights 5

Pharmacy Changes in Documentation and Other Information 5

Reporting of Investigations and Disciplinary Actions 6

Federal and State Databases 6

Termination Criteria for Removing a Pharmacy from Liviniti's Pharmacy Network 6

IV. PHARMACY PROVIDER RIGHTS & RESPONSIBILITIES 7

Rights 7

Responsibilities 7

V. CLAIMS ADJUDICATION 9

Claims Processing System 9

General Submission Policies 9

Claims Processing Coding 11

Payer Sheet 12

- General Information 12
- Transactions Supported 12
- Field Legend for Columns 12
- Claim Billing Transaction 13
- Claim Reversal Transaction 17

Member Eligibility 19

- Member ID Card 19
- Newborn Eligibility 19

Information Needed to Process a Claim 19

- Member Date of Birth 19

Cardholder ID 19
Group Number 20
Dependent Coverage 20
National Provider Identifier (NPI) 20
Days' Supply 20
Quantity Dispensed 21
National Drug Code 21
Dispense As Written ("DAW") Codes 21
Prior Authorization 21
Collection of Copayments 22
Timely Filing Limits 22
Reversals 22
Refills 22
Claim Edits 22
Pharmacy Provider Fees, Care Taxes, and Other State Fees 23
Down-Time Procedures 23
Compound Prescriptions 23
Processing Compound Prescriptions 24
Example of the NCPDP D.0 Fields for Submitting a Compound Claim 24
Vacation or Lost Medication Overrides 24
Emergency Override for Refill Too Soon Due to Natural Disasters 24
Vaccines 25
Coronavirus (COVID-19) Vaccine Billing 26

VI. PHARMACY PROVIDER REIMBURSEMENT 27

Elements of Reimbursement 27
Usual and Customary Price (U&C) 27
Maximum Allowable Cost (MAC) 27
Average Wholesale Price (AWP) 27
Member Cost Share 27
Reimbursement Formula 28
Paper Claim Submission 28
Pricing Appeals 28
Appeal Process 29
Sales Tax 29
Payment Cycle 29
Remittance and Payments 29
Reimbursement Not Received by a Pharmacy Provider 30
Payment Responsibility: Limitation of Liability 30

Disputed Claims 30

VII. ADDITIONAL INFORMATION 31

Formularies 31

Brand and Generic Drug Standards 31

Specialty Pharmacy Provider 31

Concurrent Drug Utilization Review 31

Pharmacy Drug Utilization Review 32

Reason for Service Codes 32

Professional Service Codes 33

Result of Service Codes 33

Compliance and Auditing: Fraud, Waste, and Abuse 35

Examples of Fraud, Waste, and Abuse 35

Examples of Prescriber Fraud, Waste, and Abuse 36

Member Complaints 37

Pharmacy Audits 37

Procedure 37

Overpayment 38

Incorrect Information 38

Audit Considerations 38

Audit Recoveries 38

Protected Health Information (PHI) 39

VIII. GENERAL PROVISIONS 40

Dispute Resolution 40

Notices 40

Professional Judgment 40

Manual Most Recent Version and Amendments 40

IX. FREQUENTLY ASKED QUESTIONS 41

X. GLOSSARY/DEFINITIONS 42

XI. REGULATORY APPENDIX 46

I. LIVINITI OVERVIEW

Southern Scripts, Inc. d/b/a Liviniti ("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 this Pharmacy Services Manual to serve as a guide for its pharmacy network in claims processing, and provides overall terms, conditions, policies, and procedures of Liviniti.

Liviniti provides a prescription benefit management service for different types of self-insured plans, each which may have its own guidelines. Liviniti's self-insured Plans determine their own coverage which includes items such as copays/coinsurance, and quantity limitations. Liviniti's claims processing system will provide accurate information regarding individual Members, groups, and pricing.

Answers to most of your questions may be obtained through this Pharmacy Services Manual or your Pharmacy Network Agreement. For all other questions or further clarification, please contact our Pharmacy Help Desk.

Please contact Liviniti's Pharmacy Provider Relations Department for additional information relating to this Manual.

Nothing in this Pharmacy Services Manual shall prohibit a Pharmacy's pharmacists from exercising professional judgment in the dispensing of Covered Prescription Services; and any such pharmacist may refuse to dispense any Covered Drug based upon their professional judgment.

II. 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, Liviniti is available 24/7. The Pharmacy Provider Relations Department is available to assist you with:

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

Contact Information

Phone:	Liviniti Pharmacy Helpdesk: 1-(800) 710-9341
Email:	pharmacynetwork@liviniti.com
Mail:	Liviniti 411 Bienville Street Natchitoches, LA 71457
Fax:	(318) 214-4190

Pharmacy Resources Webpage

https://liviniti.com/pharmacy-resources/

Liviniti Pharmacy Help Desk

Pharmacy Providers shall contact the Liviniti Pharmacy Help Desk to ensure prompt resolution to pharmacy claims issues, including claim rejections or prior authorization.

The 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.

Hours of Operation and Contact Telephone Numbers

If a Pharmacy Provider has difficulty in transmitting claims for Plan Members due to host processing or claim submission errors, please contact the Pharmacy Help Desk.

Liviniti Help Desk
1-800-710-9341 **24/7/365** **EVERSANA COUPON PROGRAMS** **1-833-706-7010** **Office of Group Benefits (OGB)** **1-833.925.2770** **LIVINITI SAVEPLUS PROGRAM** **1-833-770-4430**

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

III. PHARMACY ENROLLMENT

Credentialing

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

A Pharmacy Provider may be subject to re-credentialing as required based on state and/or federal law requirements as well as pharmacy audit activities.

All standard Pharmacy information will be verified through NCPDP. It is the Pharmacy's responsibility to ensure its information with NCPDP is correct.

In order to become a participating network Pharmacy Provider, a pharmacy must complete Liviniti's credentialing process This includes executing a copy of a Pharmacy Network Agreement between the pharmacy and Liviniti, and providing all documentation that may be requested by Liviniti.

Once a Pharmacy Network Agreement has been entered into between a pharmacy and Liviniti, the Pharmacy may request a copy by contacting Liviniti's Pharmacy Provider Relations Department.

Required credentialing documents include, but are not limited to:

- Executed Pharmacy Network Agreement
- Proof of Liability Insurance
- State Pharmacy License, Permit or Registration
- Federal DEA and state-controlled substance licenses or registration
- ACH (Direct Deposit) Form (Required to receive payment).
- W-9 Form

A pharmacy will provide additional information as may be needed to document compliance with Liviniti's credentialing process.

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

Expectations of Liviniti Network Pharmacies

- Support all formularies provided by Liviniti or its payors.
- Sufficient inventory of prescription drugs commonly used in a 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 laws, regulations, industry norms, and industry best practices.
- 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 prescriber directions.

Pharmacy Licensure

Pharmacy providers must meet all standards of operation as required by Federal, State, and/or local laws and regulations. Pharmacy Providers must furnish copies of these required licenses, business permits, and/or registrations when applying for enrollment as a participating pharmacy in Liviniti's network. Pharmacy providers must maintain all licenses, permits and/or registrations required to operate a pharmacy in good standing.

Once credentialed to participate in a Liviniti Pharmacy Network, the Pharmacy Provider must notify Liviniti immediately in writing if its license, registration, and/or permit is canceled, revoked, suspended, or otherwise terminated. Failure to immediately notify Liviniti in writing of any such action may result in immediate termination from Liviniti's pharmacy network. Failure to maintain required licenses, permits and/or registrations will result in immediate termination from the Liviniti Pharmacy Network.

Confidentiality and Proprietary Rights

The Pharmacy Provider shall refer to its Pharmacy Network Agreement for information relating to confidential and proprietary rights.

All Member information related to Covered Prescription Services, including any 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 on request or upon termination of the agreement.

Pharmacy 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 may be verified through NCPDP; therefore, all changes must be submitted to NCPDP immediately in order to ensure timely processing.

Reporting of Investigations and Disciplinary Actions

In addition to requirements above, Pharmacy Providers must notify Liviniti immediately, in writing, if it receives notice of any proceeding(s) that may lead to disciplinary action against the Pharmacy Provider, 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), and/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 Liviniti network Pharmacy Provider. Liviniti periodically and routinely reviews federal and state exclusion databases to determine pharmacies which are excluded from health care programs (See below). 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 Databases

Liviniti periodically review Federal and State databases to monitor the regulatory actions of all participating pharmacies and pharmacists.

Federal databases include (but are not limited to):

- Office of Inspector General (OIG) exclusions database
- U.S. General Services Administration (GSA) database
- U.S. Drug Enforcement Administration (DEA)

If a Pharmacy Provider or its personnel are listed in the OIG or SGA databases, Liviniti will immediately terminate its Pharmacy Network Agreement with the Pharmacy Provider.

Liviniti reviews DEA database to ensure that a Pharmacy Provider can dispense controlled substances.

Liviniti reviews state databases (such as applicable Board of Pharmacy or similar/corresponding state departments) for pharmacy/pharmacist license activity and disciplinary actions. If Liviniti identifies a questionable license or disciplinary action, the information will be reviewed for further action.

Liviniti shall periodically review Federal and State databases to ensure health care prescribers are properly credentialed and have controlled substance writing authority.

Termination Criteria for Removing a Pharmacy from Liviniti's Pharmacy Network

A pharmacy will be terminated from Liviniti's Pharmacy Network under the following conditions:

- Violation of any federal, state, or local law. This includes non-compliance with any Federal, State, or Local tax laws;
- Inclusion in the Office of the Inspector General exclusions database;
- Inclusion in the General Services Administration (GSA) database;
- Failure to maintain licensure/registration to operate as a pharmacy;
- Failure to comply with pharmacy auditing activities; or;
- Ceasing pharmacy operations.

IV. 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 all applicable laws and provide services in a manner compliant with the highest industry 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.
- 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 Member, prescriber, and if appropriate caregiver.
- Obtain and maintain Member medication profiles.
- Maintain complete records related to:
  - Original prescriptions
  - Prescriber information
  - Signature and/or electronic tracking logs
  - Refill information
  - Member 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 Members or Member 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 Member 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 Member 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.

V. Claims Adjudication

Claims Processing System

The Liviniti Claims Processing System sets forth pricing, eligibility, and other information that governs participation in the Pharmacy 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 its 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 at the time of dispensing unless unusual circumstances require otherwise, in which event the Pharmacy Provider will submit claims within 90 days of the date of service. Liviniti's 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 at the time of Liviniti's next regular claims cycle. Such payment will be less the applicable co-payment/ coinsurance, deductible, or other payments, such as administrative fees for certain programs.

Any 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 shall be submitted at the time of service electronically through the Liviniti 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 laws.
- Liviniti's 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 dispensing.
- 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 Liviniti's online system for determining medication coverage and Member copays.
- Over the counter ("OTC") medications submitted as a prescription through the Liviniti 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 shall 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 shall calculate and transmit the exact number of days' supply. Days' supply must be calculated based on the directions documented on the prescription by the prescriber.
- The Pharmacy provider should transmit the exact metric quantity as indicated on the prescription.
- Pharmacy providers shall contact the Pharmacy Help Desk regarding any rejected claims or claims requiring Prior Authorization.

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, 025242, 025945, 027159, 027167, 029438	**SSN**

Note: Pharmacies must ensure they are properly set up with Liviniti's BIN numbers.

Payer Sheet

General Information

Payer Name: Liviniti		Date: 06/01/2024
Plan Name/Group Name: Liviniti	BIN: 015433, 025242, 025945, 027159, 027167, 029438	PCN: SSN
Processor: Liviniti Systems		
Effective as of: 02/01/2022		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: Robert Carney and pharmacynetwork@liviniti.com		
Certification Testing Window: N/A		
Certification Contact Information: Certification not required		
Provider Relations Help Desk Info: 1-(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.

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, 025242, 025945, 027159, 027167, 029438	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	SEGMENT 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	
323-CN	PATIENT CITY ADDRESS		O	
324-CO	PATIENT STATE/PROVINCE ADDRESS		O	
325-CP	PATIENT ZIP/POSTAL ZONE		O	
326-CQ	PATIENT PHONE NUMBER		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	

	Claim Segment			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT 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	
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	03	R	
34Ø-7C	OTHER PAYER ID		R	Required for identification of the Other Payer when necessary for claim/encounter adjudication
443-E8	OTHER PAYER DATE		R	Required for identification of the Other Payer Date when necessary for claim/encounter adjudication – CCYYMMDD
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	Required when Other Payer Reject Code (472-6E) is used
472-6E	OTHER PAYER REJECT CODE		RW	Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) – 3

353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25	RW	Required when Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	06	RW	Required when Other Payer-Patient Responsibility Amount (352-NQ) is used
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Required when Other Payer-Patient Responsibility Amount (352-NQ) is used
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	

	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	

	Facility Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
111-AM	SEGMENT IDENTIFICATION	15	M	
336-8C	FACILITY ID		M	
385-3Q	FACILITY NAME		O	
386-3U	FACILITY STREET ADDRESS		O	
388-5J	FACILITY CITY ADDRESS		O	
387-3V	FACILITY STATE/PROVINCE		O	
389-6D	FACILITY ZIP/POSTAL ZONE		O	

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

Claim Reversal Transaction

	Transaction Header Segment			**Claim Billing**
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	015433, 025242, 025945, 027159, 027167, 029438	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/CERTICATION ID	Blank Fill	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	
403-D3	FILL NUMBER		R	
308-C8	OTHER COVERAGE CODE		RW	When Liviniti is primary and secondary insurance are used with the same group ID.

Member Eligibility

Plans determine Member eligibility. Liviniti updates Member eligibility in its claims processing system on a regular basis. Member eligibility can change; possession of an ID card does not guarantee eligibility for benefits coverage or payment. A Pharmacy Provider shall confirm eligibility through the claims adjudication system at the time of dispensing.

Member ID Card

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

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

The ID field length varies by plan and may be a combination of numbers and letters. If the claims processor is unable to find a Member match, the claim will reject and show a result of "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.

Newborn Eligibility

For assistance with pharmacy claims for newborns, Members shall 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.

Information Needed to Process a Claim

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), the Pharmacy may contact the Liviniti Pharmacy Helpdesk to verify the Member's date of birth.

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

Generally, 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 Member

"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 to ensure prompt processing.

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 to 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 its 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 the Pharmacy Provider shall:

- Call the prescriber's office to request the NPI; or
- Obtain the prescriber's NPI number from the NPPES NPI Registry.

Days' Supply

The "Days' Supply" field is a key field used relative to early refill edits. Adjudicating a claim with an incorrect days' supply can cause claims to be rejected. The Pharmacy Provider shall use the correct method of determining Days' Supply.

The calculation shall 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 contact the prescribing health care provider and document the 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 set forth by the prescribing health care provider.

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

Quantity Dispensed

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 Plan Sponsor. Certain 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 the claims and do not round up. For example, a 1Ø.2 gm inhaler is dispensed, "1Ø.2" must be entered in the "Quantity Dispensed" field. This includes inhalers where the package quantity is 12.9 gm for 1 inhaler. When dispensing ophthalmic drops, include the decimal quantity and do not round up.

Drugs in "unbreakable" packages shall only be dispensed 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 shall 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 repackaged and/or relabeled NDC results in a higher cost to the plan and/or member, Liviniti may audit for overpayment.

Dispense As Written ("DAW") 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. Prior authorization criteria and approval duration are determined by Liviniti's clinical team. Information regarding drug coverage and the prior authorization submission process can be found on Liviniti's Physician Center webpage.

Pharmacy providers will submit pharmacy claims to Liviniti. All claims will be processed through an automated review to ensure plan-specific criteria are met. If all the criteria are met, the claim shall be

approved and paid, and the Pharmacy Provider may continue 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 shall receive a message that gives an explanation the reason for the rejection; in this event, the Pharmacy Provider shall contact the Pharmacy Help Desk.

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

Collection of Copayments

Plan Sponsors establish Member copays 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 (“U&C”) 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 when the Member pays 100% or pays the U&C price.

Timely Filing Limits

Point of Sale (POS) claims are generally submitted at the time of dispensing; however, there may be mitigating circumstances that require a claim be submitted after the time of dispensing. Transmission of claims using the current date for past service date is a violation of program policy and could result in an audit adjustment. Pharmacy Providers must submit Claims for reimbursement no later than ninety (90) days from the date Covered Prescription Services are rendered to a 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.

Reversals

Pharmacy providers are required to complete reversals within the same payment cycle as the submission, or up to fourteen (14) days after the claim was adjudicated, for prescriptions that have not been picked up by a 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 a partial amount of their covered prescription, the Pharmacy Provider must modify the claim via the claims processing system within fourteen (14) days to accurately represent the quantity of medication received and billed. The Pharmacy Provider must reverse the existing claim and resubmit the claim with the correct quantity and days’ supply.

Refills

Refills are determined based on Federal requirements and guidelines.

Claim Edits

Following an online claim transmission by a Pharmacy Provider, the Liviniti claims processing system will return a response which indicates the outcome of the claim processing. If the claim passes all edits, a “Paid” response will be returned with the 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. If necessary, the Pharmacy Provider will contact the Pharmacy Help Desk for assistance.

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 on a quarterly basis 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 reimbursed by third-party payors, Pharmacy Providers have the sole responsibility for submitting such fees in the flat rate tax field. For Pharmacy Providers in states that charge a flat tax rate and a provider fee, the Pharmacy Provider may contact the Pharmacy Help Desk for support.

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 thirty (30) days of receipt of Remittance Advice. If no tax amounts are disputed within thirty (30) days of receipt, Liviniti deems the Remittance Advice to be confirmed accurate by the Pharmacy Provider.

The Pharmacy Provider shall immediately notify Liviniti of any error in payment of taxes or fees.

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, Liviniti asks its our Pharmacy Providers to attempt to service Plan 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.

Compound Prescriptions

Compound prescriptions consist of two or more ingredients, one of which must be a formulary Federal Legend Drug that is weighed, measured, prepared, and/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 standards and practices.

For Liviniti to cover a compound prescription, all active ingredients must be covered on the Member's formulary. In general, drugs used in a compound prescription 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 to be reimbursed,

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.

The Pharmacy Provider may 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. The Compound Code of 02 (NCPDP field 406-D6 located in the Claim Segment on the payer sheet) is to be used 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.

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 Medication Overrides

Allowances for travel medication and/or replacement of lost, stolen, or forgotten medication vary by plan benefit design. The Pharmacy Provider may contact the Pharmacy Help Desk to obtain 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 may be 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 shall 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.

Vaccines

Upon Plan Sponsor request, certain vaccine drug products and/or administration of 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 Liviniti claims processing system in accordance with the current Liviniti Payer Sheets.

When the Pharmacy Provider dispenses and administers a vaccine drug product, the Pharmacy Provider will transmit both the drug product and administration on the same claim submission. The Pharmacy Provider will submit these as the pharmacy's U&C, the total cost of the vaccine drug product and the administration fee. The Pharmacy Provider shall not undermine the U&C price by inflating the U&C above the price the provider charges for the same vaccine product and administration a non-covered Member would have paid on the same day the prescription was dispensed, inclusive of all applicable discounts.

Plan Sponsors may elect to cover the vaccine drug product without administration under a Member's prescription drug benefit. In this case, the Member shall be responsible for any vaccine administration costs. The Pharmacy Provider may not add or represent the administration fee to a Member as a part of any 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

VI. Pharmacy Provider Reimbursement

Pharmacy Providers will receive reimbursement from Liviniti for Covered Prescription Services provided to Members as identified in the Pharmacy Network Agreement (including any and all amendments thereto), and this Pharmacy Services Manual. The net reimbursement due to the Pharmacy Provider will not include any applicable copay, co-insurance, and/or deductibles.

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

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. Our MAC is updated on average every 7 business days. For MAC inquiries contact the Pharmacy Help Desk or access the list from Liviniti's Pharmacy Resources Webpage.

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).

Member Cost Share

The Pharmacy Provider will collect from each Member the applicable co-payment/coinsurance and/or other direct payment as communicated through the Liviniti 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 other than the applicable co-payment/coinsurance and/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 Plan Sponsor, and the Pharmacy Provider will not waive or discount any applicable co-payment/coinsurance and/or other direct payment.

Reimbursement Formula

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

In general, for Covered Services, Liviniti will pay the lowest of either:

(1) Usual & Customary (U&C) Price; or

(2) 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 Plan Sponsors put into place that alters the reimbursement formula set out above.

For compound prescription claims, the Pharmacy Provider will be reimbursed the lesser of:

- The aggregated lowest price of each ingredient in the compound, plus the contracted dispensing fee; OR.
- 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 prescription.

Paper Claim Submission

If a Pharmacy Provider attempts and is unable to electronically submit a claim for reimbursement through Liviniti claims processing system, then the pharmacy may submit a paper universal claim form containing all the required NCPDP claims submission fields. Paper claims shall be sent to the Liviniti at its mailing address listed in Contact Information at page 2 of this Pharmacy Services Manual.

Pricing Appeals

Liviniti develops its own proprietary pricing and corresponding unit costs on behalf of Plan specifications. Unit costs are calculated using information from many sources, including (but not limited to): published MAC Lists; wholesaler-supplied information; and pharmacy-supplied information. MAC pricing information is available on Liviniti's Pharmacy Resources Webpage. Liviniti updates its MAC List on a weekly (or more frequent) basis.

All Pricing issues or appeals must be submitted using the proper form and supporting documentation within ninety (90) calendar days of the service date, unless state law permits a different timeframe.

When submitting a pricing appeal, all relevant information must be provided including a copy of the wholesaler invoice that lists the net acquisition cost of the product. Liviniti's timeline for responding does not start until it receives all required information. In the event Liviniti does not receive the required information, Liviniti will notify the Pharmacy Provider that it received incomplete information for an appeal and provide the Pharmacy Provider fourteen (14) days to provide the required information. If Liviniti does not receive the requested information is received, it will reject the appeal. However, the pharmacy may re-submit the appeal, with the appropriate documentation, within 90 days of the service date.

Appeal Process

If a Pharmacy Provider experiences negative reimbursement for a drug or device, or disagrees with a reimbursement price, it shall submit appeal using the following process:

1. Obtain and submit a Pricing Appeal Form. The form may be obtained and submitted from one of the following sources:
    a. Liviniti's online Pharmacy Portal found on Liviniti's Pharmacy Resources Webpage;
    b. Emailing Liviniti's Pharmacy Provider Relations Department priceappeals@liviniti.com; or
    c. Call the department directly 318.301.1906; or
    d. Calling the Liviniti Pharmacy Helpdesk 24/7.

    If the Pharmacy Provider has multiple price appeals, they may email the list of NDCs to Liviniti's Pharmacy Provider Relations Department at priceappeals@liviniti.com.
2. Once all required information is received, Liviniti will review all documentation submitted by the Pharmacy Provider;
3. Liviniti will provide the outcome of the appeal within seven (7) business days (or less) of receipt of the appeal and all required documentation.

If an appeal is approved, Liviniti shall:

1. Update the price on Liviniti's MAC List for that medication. The update shall have an effective date matching the original date of appeal.
2. Adjust the reimbursement rate of the prescription drug that is the subject of the appeal, and provide the national drug code number that the adjustment is based on to the appealing pharmacy.
3. The Pharmacy Provider may reprocess its claim within seven (7) business days of the date of the approval.

Denial of an Appeal:

Liviniti shall only deny an appeal if the ingredient cost is greater than the acquisition cost.

Sales Tax

The Pharmacy Provider shall refer to its Pharmacy Network Agreement for information relating to remittance and/or compensation of Sales Taxes.

Payment Cycle

Liviniti's reimbursement for claims submitted shall 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 day of the month,
- Date of fill 16th thru last day of month.

It is MANDATORY for all parties to complete an ACH and/or Direct Deposit Form and set up electronic deposits for payments. Forms are found on Liviniti's Pharmacy Resources webpage.

Remittance and Payments

Liviniti will provide the Pharmacy Provider with a payment record of all claims paid. 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 for which the Pharmacy Provider has not received reimbursement.

If the Pharmacy Provider has any question relating to claim payment or lost payment, it may notify Liviniti by writing or emailing to the address or email located in Contact Information at page 2 herein.

Payment Responsibility: Limitation of Liability

Liviniti only operates as an intermediary between Plans and Pharmacy Providers with respect to payment due under the Pharmacy Network Agreement; claim payment amounts due are the sole and exclusive responsibility of Plan Sponsors. Liviniti is not obligated to pay the Pharmacy Provider for Claims relating to a Plan if a Plan Sponsor 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 shall review remittance advice when received to verify accuracy. A Pharmacy Provider may dispute a claim payment or adjustment by notifying Liviniti within thirty (30) days of receipt of remittance advice. Any claim not disputed within 30 days of receipt of remittance advice is deemed to be confirmed accurate by the Pharmacy Provider.

VII. Additional Information

Formularies

In an attempt to deliver a balance between cost containment and quality of care, Plan Sponsors often adopt a formulary as part of their overall cost-containment programs. Liviniti implements a variety of formulary programs for Plan Sponsors. Pharmacy Providers are required to support all formulary programs by dispensing formulary drugs to the maximum extent possible.

Formularies may be requested by calling the Pharmacy Help Desk. Formulary listings are a general representation of products covered and 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. The Liviniti Claims Processing System contains the most accurate information regarding 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. Pharmacy Providers shall rely on Liviniti's Messaging System to reinforce the use of generic and/or preferred brand products.

In the event a brand name drug is appropriate, a Pharmacy Provider shall dispense preferred branded drug products for nonpreferred product in accordance with prevailing pharmacy laws and regulations.

Specialty Pharmacy Provider

Any Pharmacy Provider that meets Liviniti's quality standards may dispense specialty medications. A Pharmacy Provider must agree to provide all supplies required to administer a specialty drug to a patient and not charge any additional supply or shipping fees. Liviniti does not limit a Member's choice of Specialty Pharmacy provider. Liviniti's Customer Service will assist a 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.

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.

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.
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	Regiment 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.

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 means an intentional, 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 entails the exploitation of “loopholes” to the limits of the law, primarily for financial gain.

A Pharmacy Provider is required to exercise sound professional judgment with respect to the legitimacy of prescription orders received. A Pharmacy Provider is not required to dispense a prescription order if it is of doubtful origin.

Examples of 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.
- 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.

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.
- Prescriber Identity Theft: 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.

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 any situation that leads to a complaint from a Member. The Pharmacy Provider must maintain written records of events and actions surrounding each complaint.

Pharmacy Audits

All audit requirements may change based on federal and/or state law requirements.

In order to ensure Pharmacy Providers are providing Covered Services in compliance with the Pharmacy Network Agreement, and federal and state laws, Liviniti performs pharmacy audits. Pharmacies may be audited based on internal analysis, external information provided to Liviniti, or compliance calls to Liviniti. A Pharmacy Provider's failure to comply with auditing activities may result in termination from the network.

With the large volume of prescriptions processed every day, Liviniti understands human errors do occur and feel its Network Pharmacies do an outstanding job of providing Covered Services to Plan Members. Liviniti's 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.

Southern Scripts d/b/a Liviniti LLC has contracted with a third-party vendor, Healthcare Benefit Technologies (HBT) to perform its pharmacy audits which are conducted in compliance with state law. HBT provides a SaaS application for pharmacy claim audits. The system reviews claim data and selects data based on standard and customizable algorithms and based on state law criteria. All audits will be conducted under the same standards and parameters used for other similarly situated pharmacies. The application will process claims through an algorithm/edits/rules to identify high dollar amounts, prescriber, days supply, CII medications. No pharmacy or entity is targeted as part of data samples unless identified by the company/client of potentially fraudulent activity.

Procedure

Pharmacy Notice

Unless otherwise specified in the Pharmacy Network Agreement, or required by Federal or State law, Liviniti (or its agent(s)) shall send a twenty-one (21) day advance notice is provided to pharmacies prior to an audit.

In the event of suspected fraud, no notice is required or will be provided.

Requested Information

The Pharmacy Notice referenced above will include a list of requested information and/or documentation. The Pharmacy Provider shall provide copies of the requested information and/or documentation to Liviniti or its agents(s) within 30 calendar days of the date of the request.

The Pharmacy Provider shall cooperate in good faith with all record requests and audits and shall provide Liviniti, its agent(s), Plans, and/or their authorized representatives with access to the Pharmacy Providers premises and/or the requested information. All information and/or documentation shall be provided at the sole cost and expense of the Pharmacy Provider.

Liviniti and/or its agent(s) may send additional requests for information. The Pharmacy Provider shall respond to these additional requests in the same manner as above.

If any requested documentation is not furnished to Liviniti and/or its agent(s) within 30 calendar days of the request, Liviniti is entitled to recover the full amount paid or due to the provider for the claim(s) in question.

Pharmacy Providers may contact the Pharmacy Provider Relations Department with questions relating to an on-site or desktop audit

Audit Findings

Written preliminary results of an audit will be communicated to the Pharmacy Provider within sixty (60) days of receipt of all requested information, or such time as is required by state regulations.

Should an audit take place at a Pharmacy Provider's location, the Pharmacy Provider will receive written results within one hundred and twenty (120) days.

All pharmacies have the right to appeal, and the standard appeal timeline is 30 days from the date of the preliminary results letter unless otherwise stipulated by state statutes.

Final results shall be communicated to the Pharmacy Provider. The final results communication shall include assessed discrepancy codes, financial actions, and/or recovery estimates.

Overpayment

If an audit reveals actions that resulted in an overpayment, the overpayment shall become immediately due and owed by the Pharmacy Provider.

Incorrect Information

In the event an audit reveals the Pharmacy Provider submitted Claims to Liviniti with information that is inaccurate and/or unverifiable, Liviniti shall be entitled to recover an amount up to the total amount of the Claim.

Pharmacy audits may also be conducted through fax and/or email.

Audit Considerations

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

- Missing or incomplete signature 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 Days' Supply incorrectly
- Billing for the incorrect health care provider
- 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
- 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. Liviniti's 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 and/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 remunerated by:

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

Protected Health Information (PHI)

Pursuant to HIPAA requirements, 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:

- 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.
- Require subcontractors or agents to whom Liviniti provides PHI to:
  - Report promptly to Liviniti any use or disclosure of PHI not provided by any agreement or other document of which Liviniti becomes aware;
  - Agree to the same restrictions and conditions that apply to Liviniti pursuant to applicable laws and any agreement or other document;
  - 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.
- 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 United States Department of Health and Human Services for purposes of determining Liviniti's compliance with HIPAA regulations.

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

VIII. General Provisions

Dispute Resolution

The Pharmacy Provider shall refer to its Pharmacy Network Agreement for information relating to dispute resolution.

Notices

Required written notice must be provided as set forth in this Pharmacy Services Manual or the Pharmacy Network Agreement. All notices shall be effective upon receipt by the recipient.

Professional Judgment

The Pharmacy Provider is obligated to provide the Members and Prescribers whom it serves with an adequate inventory of quality drugs. The Pharmacy Provider 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; has the lowest ingredient cost; in the pharmacist's professional judgment fulfills the Prescriber's requirements; and 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 Liviniti 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 Pharmacy Provider will at all times exercise good professional judgment in the dispensing of medications and may refuse to dispense any prescription based on the Pharmacy Provider's own professional judgment.

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

Manual Most Recent Version and Amendments

Liviniti will, on occasion, provide updates to this Pharmacy Services Manual. Liviniti will maintain an updated copy of this Manual on its Pharmacy Resources Webpage. It is the Pharmacy Provider's responsibility to visit the website to view updates to the Manual.

If the Pharmacy Provider continues to submit claims after the effective date of any notice, revision, amendment, or modification of this Pharmacy Services Manual, the notice, revision, amendment, or modification will be deemed accepted by the Pharmacy Provider.

IX. Frequently Asked Questions

1. **How can a Pharmacy join the Network?**

   Please see Credentialing, located on page 4.

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

   Email Liviniti's Pharmacy Provider Relations Department.

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

   Contact the Liviniti Pharmacy Helpdesk for verification of the patient's pay amount.

4. **Where can I find the Member ID number and format?**

This information is found on the front left corner of the Member card (see at page 11.

5. **What BIN number do I enter?**

   BIN 015433, 025242, 025945, 027159, 027167, 029438

6. **What PCN number do I enter?**

   SSN (Use the letters "SSN", this does not mean Social Security Number)

7. **Does Liviniti provide a website for pharmacies?**

   Yes. The website address for Liviniti's Pharmacy Resources Webpage website is located on Page 2 of this manual.

8. **Who do I contact for payment/remit questions?**

   Call the Liviniti Pharmacy Helpdesk or email Liviniti's Pharmacy Provider Relations Department. Contact information is found on page 2 of this Manual.

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

   See Pricing Appeals at page 28.

10. **How can I file a complaint with Liviniti?**

    Pharmacy Providers can file a complaint by contacting the Pharmacy Provider Relations Department.

11. **What are some of the most common reject codes and the process to follow if received?**

    Contact Liviniti if you receive any one of the following reject codes:

    - 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

X. GLOSSARY/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 or **Covered 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.

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 Pharmacy Provider, 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 or **Plan Member**: any eligible participant (including eligible dependents) of a Plan who is participating in and entitled to receive Covered Services under a Plan.

National Drug Code ("NDC"): a unique 10-digit or 11-digit, 3-segment number, and a universal product identifier for human drugs in the United States. The code is present on all prescription, over-the-counter and insulin products and labels in the U.S. The NDC serves as the FDA's identifier for drugs.

NADA 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.

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.

National Provider Identifier or **NPI:** Numerical 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 Pharmacy Provider to Liviniti in compliance with the transaction standards set forth in applicable Law including the HIPAA Rules and, in turn, Pharmacy Provider 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 Provider or **Participating Pharmacy** or **Network Pharmacy**: Pharmacy that enters into a Pharmacy Network Agreement with Liviniti to provide Covered Services to Plan Members.

Pharmacy Network Agreement or **PNA**: Agreement entered into between a pharmacy and Liviniti allowing pharmacy to become a part of Liviniti's Pharmacy Network and to provide Covered Services to Plan 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.

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 its 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.

Practitioner means a physician or other health care provider licensed in the state where a 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. 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.

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.

XI. 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 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 Plan Sponsor and the provision of applicable Covered Services by the provider.

Generally, legal 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 in the Regulatory Appendix shall control. This Regulatory Appendix may be amended to reflect changes to applicable law(s).

Refer to a state's website for the latest laws, rules and requirements.

State	Description	Link (Ctrl-Click)
Alabama	Audit Laws And Regulations	Code Of Alabama | Pharmacy Audit Integrity Act
	Board Of Pharmacy	Alabama Board of Pharmacy
	Pharmacy Laws/Regulations	Alabama Board of Pharmacy | Statutes & Rules
Alaska	Audit Laws And Regulations	A.S. 21.27.910 | Pharmacy Audit Procedural Requirements
	Board Of Pharmacy	Alaska Board Of Pharmacy
	Pharmacy Laws/Regulations	Alaska Board of Pharmacy | Statutes and Regulations
Arizona	Audit Laws And Regulations	A.R.S. § 2-3322 | Audit Procedures
	Board Of Pharmacy	Arizona State Board Of Pharmacy
	Pharmacy Laws/Regulations	Arizona State Board Of Pharmacy | AZ State Legislature

State	Description	Link (Ctrl-Click)
Arkansas	Audit Laws And Regulations	AR Code § 17-92-1201 | Arkansas Pharmacy Audit Bill Of Rights
	Board Of Pharmacy	Arkansas State Board Of Pharmacy
	Pharmacy Laws/Regulations	Arkansas State Board Of Pharmacy | Pharmacy Lawbook
	Liviniti will issue, mail, or otherwise transmit payment with respect to a clean claim submitted by a pharmacy or pharmacist within: (1) Seven to fourteen days after the receipt of a claim for an electronic claim; or (2) thirty days after the date of the receipt of a claim for any other paper or manually submitted claim. (Arkansas HB 1620; Act 350 (2025)) **Arkansas Prompt Payment of Claims:** Liviniti will issue payment for clean claims in accordance with Ark. Code § 23-92-512.	
California	Audit Laws And Regulations	California Code | Audits Of Pharmacy Benefits
	Board Of Pharmacy	California State Board Of Pharmacy
	Pharmacy Laws/Regulations	California State Board Of Pharmacy | Pharmacy Laws & Regulations
	California Notice: Pursuant to Cal. Health & Safety Code §1385.004(a)(5), pharmacists have the right to submit complaints under Cal. Health & Safety Code §1371.39 and possess provider rights under Cal. Health & Safety Code §1375.7.	
	DHCS Medi-Cal Two Plan Contract	Organization And Administration Of The Plan (Ca.Gov)
Colorado	Audit Laws And Regulations	CO Rev Stat § 10-16-122.1 | Pharmacy Fairness Act
	Board Of Pharmacy	Colorado State Board of Pharmacy
	Pharmacy Laws/Regulations	Colorado State Board Of Pharmacy | Laws, Rules & Policies
Connecticut	Audit Laws And Regulations	CT Gen Stat § 38a-479iii | Pharmacy Audits
	Board Of Pharmacy	Connecticut Commission Of Pharmacy
	Pharmacy Laws/Regulations	CT Department of Consumer Protection | Drug Laws & Regulations

State	Description	Link (Ctrl-Click)
Delaware	Audit Laws And Regulations	18 DE Code § 3301A, et seq. | Pharmacy Audit Integrity Program
	Board Of Pharmacy	Delaware Board of Pharmacy
	Pharmacy Laws/Regulations	DE Admin Code 2500 | Board of Pharmacy
Florida	Audit Laws And Regulations	Fla. Stat § 624.491 | Pharmacy Audits
	Board Of Pharmacy	Florida Board Of Pharmacy
	Pharmacy Laws/Regulations	Florida Board Of Pharmacy | FL Statutes & Administrative Code

Florida Addendum Pharmacy Solutions Participating Pharmacy Agreement

This Florida 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 Florida 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:

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).

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).

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).

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).

State	Description	Link (Ctrl-Click)
	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). 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). 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. 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). 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). 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).	

State	Description	Link (Ctrl-Click)
	"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. "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. "COVERED PERSON" MEANS A PERSON COVERED BY, PARTICIPATING IN, OR RECEIVING THE BENEFIT OF A PHARMACY BENEFITS PLAN OR PROGRAM." FLA. STAT. § 626.8825. "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 "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 "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 "ERRONEOUS CLAIMS" MEANS PHARMACY CLAIMS SUBMITTED IN ERROR, INCLUDING, BUT NOT LIMITED TO, UNINTENDED, INCORRECT, FRAUDULENT, OR TEST CLAIMS." FLA. STAT. § 626.8825 "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 "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 "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 "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	

State	Description	Link (Ctrl-Click)
	underperformance of contractual guarantees across guaranteed line items, channels, networks, or payors, as applicable." Fla. Stat. § 626.8825 "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. "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 "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 "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 "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 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	

State	Description	Link (Ctrl-Click)
	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 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	

State	Description	Link (Ctrl-Click)
	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 "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	

State	Description	Link (Ctrl-Click)
Georgia	Audit Laws And Regulations	O.C.G.A. § 26-4-118 | Pharmacy Audit Bill of Rights
	Board Of Pharmacy	Georgia Board Of Pharmacy
	Pharmacy Laws/Regulations	Georgia Board Of Pharmacy | Laws, Policies & Rules
Hawaii	Audit Laws And Regulations	HI SB 975 | Pharmacy Audit Bill of Rights
	Board Of Pharmacy	Hawaii Board Of Pharmacy
	Pharmacy Laws/Regulations	Hawaii Board of Pharmacy | Statutes & Rules
Idaho	Audit Laws And Regulations	Idaho Code | Fair Pharmacy Audits Act
	Board Of Pharmacy	Idaho Board Of Pharmacy
	Pharmacy Laws/Regulations	Idaho Board Of Pharmacy | Statutes, Rules & Guidance
Illinois	Audit Laws And Regulations	215 ILCS 5/513b7 | Pharmacy Audits
	Board Of Pharmacy	Illinois Board of Pharmacy
	Pharmacy Laws/Regulations	Illinois Board of Pharmacy | Laws & Rules
Indiana	Audit Laws And Regulations	Indiana IN Code § 25-26-22-1, et seq. | Pharmacy Audits
	Board Of Pharmacy	Indiana Board Of Pharmacy
	Pharmacy Laws/Regulations	Indiana Board of Pharmacy | Statutes & Rules
	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").	

State	Description	Link (Ctrl-Click)
	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: 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 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. 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). 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). 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). 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	

State	Description	Link (Ctrl-Click)
	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).	
	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).	
	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	

State	Description	Link (Ctrl-Click)
	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).	
	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).	
	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 under IC 45-26; (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 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.	
	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 third party that is granted access to pharmacy's services	

State	Description	Link (Ctrl-Click)
	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. 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). 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 And Regulations	IAC 191-59.4 | Audits of Pharmacies by Pharmacy Benefits Managers
	Board Of Pharmacy	Iowa Board Of Pharmacy
	Pharmacy Laws/Regulations	Iowa Board Of Pharmacy | Laws & Rules
Kansas	Audit Laws And Regulations	KSA 65-16,121 | Pharmacy Audit Integrity Act
	Board Of Pharmacy	Kansas Board Of Pharmacy
	Pharmacy Laws/Regulations	Kansas Board Of Pharmacy | Statutes & Regulations
Kentucky	Audit Laws And Regulations	KRS § 304.17A-741 | Audit of Pharmacy Records
	Board Of Pharmacy	Kentucky Board Of Pharmacy
	Pharmacy Laws/Regulations	Kentucky Board Of Pharmacy | Statutes & Regulations

State	Description	Link (Ctrl-Click)
Louisiana	Audit Laws And Regulations	R.S. 22:1856.1 | Pharmacy Record Audits
	Board Of Pharmacy	Louisiana Board Of Pharmacy
	Pharmacy Laws/Regulations	Louisiana Board Of Pharmacy | Laws & Regulations
Maine	Audit Laws And Regulations	Title 24-A, §4317: Pharmacy Providers
	Board Of Pharmacy	Maine Board Of Pharmacy
	Pharmacy Laws/Regulations	Maine Board Of Pharmacy | Laws & Rules
Maryland	Audit Laws And Regulations	MD Insurance Code § 15-1629 | Audits by Pharmacy Benefits Manager
	Board Of Pharmacy	Maryland Board of Pharmacy
	Pharmacy Laws/Regulations	Maryland Board of Pharmacy | Laws, Regulations, Legislation & Reports
Massachusetts	Audit Laws And Regulations	M.G.L. c. 175 § 226 | Pharmacy Audits
	Board Of Pharmacy	Massachusetts Board Of Registration In Pharmacy
	Pharmacy Laws/Regulations	Board Of Registration In Pharmacy | Laws & Regulations
Michigan	Audit Laws And Regulations	MCL 550.838 | Authorization to Conduct Audit
	Board Of Pharmacy	LARA - Pharmacy
	Pharmacy Laws/Regulations	LARA - Pharmacy | Laws & Regulations
Minnesota	Audit Laws And Regulations	Minn. Stat. 62W.09 | Pharmacy Audits
	Board Of Pharmacy	Minnesota Board Of Pharmacy
	Pharmacy Laws/Regulations	Minnesota Board Of Pharmacy | Guidance & Statutes

State	Description	Link (Ctrl-Click)
Mississippi	Audit Laws And Regulations	Miss. Code Ann. § 73-21-175 | Pharmacy Audit Integrity Act
	Board Of Pharmacy	Mississippi Board of Pharmacy
	Pharmacy Laws/Regulations	Mississippi Board of Pharmacy | Laws & Regulations
Missouri	Audit Laws And Regulations	RSMo § 338.600 | Criteria for Audit
	Board Of Pharmacy	Missouri Board Of Pharmacy
	Pharmacy Laws/Regulations	Missouri Board Of Pharmacy | Rules & Statutes
Montana	Audit Laws And Regulations	MT Code § 33-2-2001, et seq. | Pharmacy Audit Integrity Act
	Board Of Pharmacy	Montana Board Of Pharmacy
	Pharmacy Laws/Regulations	Montana Board of Pharmacy | Statutes & Rules
Nebraska	Audit Laws And Regulations	N.R.S. § 44-4607 | Pharmacy Audit
	Board Of Pharmacy	Nebraska Pharmacy Professions
	Pharmacy Laws/Regulations	Nebraska Pharmacy Practice Act
	Nebraska Revised Statute 44-4606 All contractual requirements including, but not limited to, participating pharmacy contract gag clauses, MAC/pricing access (including that a pharmacy has 15 business days to complete a price appeal), and pharmacy audit stipulations are supported through all requirements of the State of Nebraska.	
Nevada	Audit Laws And Regulations	None
	Board Of Pharmacy	Nevada Board Of Pharmacy
	Pharmacy Laws/Regulations	Nevada Board of Pharmacy | Statutes & Regulations

State	Description	Link (Ctrl-Click)
New Hampshire	Audit Laws And Regulations	NH Rev Stat § 318:62 | Pharmacy Rights During Audit
	Board Of Pharmacy	New Hampshire Board Of Pharmacy
	Pharmacy Laws/Regulations	NH Board Of Pharmacy | Laws and Rules
New Jersey	Audit Laws And Regulations	NJ Rev Stat § 17B:26-2.1i
	Board Of Pharmacy	New Jersey Board Of Pharmacy
	Pharmacy Laws/Regulations	NJ Board of Pharmacy | Statutes & Regulations
New Mexico	Audit Laws And Regulations	NM Stat § 61-11-18.2 | Audit of Pharmacy Records
	Board Of Pharmacy	New Mexico Board of Pharmacy
	Pharmacy Laws/Regulations	NM Board of Pharmacy | Rules & Laws
New York	Audit Laws And Regulations	NY PBH § 280-c | Pharmacy Audits
	Board Of Pharmacy	NY Pharmacy
	Pharmacy Laws/Regulations	NY Pharmacy | Laws, Rules & Regulations
North Carolina	Audit Laws And Regulations	N.C.G.S. Article 4C | Pharmacy Audit Rights
	Board Of Pharmacy	North Carolina Board Of Pharmacy
	Pharmacy Laws/Regulations	NC Board Of Pharmacy | Legal Resources
North Dakota	Audit Laws And Regulations	NDCC Ch. 19-03.6 | Pharmacy Records Audits
	Board Of Pharmacy	North Dakota Board Of Pharmacy
	Pharmacy Laws/Regulations	North Dakota Board Of Pharmacy | Laws & Rules
Ohio	Audit Laws And Regulations	O.R.C. § 3901.811 | Pharmacy Audits
	Board Of Pharmacy	Ohio Board Of Pharmacy
	Pharmacy Laws/Regulations	Ohio Board Of Pharmacy | Laws & Rules

State	Description	Link (Ctrl-Click)
Oklahoma	Audit Laws And Regulations	59 O.S. § 356 | Pharmacy Audit Integrity Act
	Board Of Pharmacy	Oklahoma Board Of Pharmacy
	Pharmacy Laws/Regulations	Oklahoma Board Of Pharmacy | Laws & Rules
Oregon	Audit Laws And Regulations	ORS 735.542 | Pharmacy Claims Audits
	Board Of Pharmacy	Oregon Board Of Pharmacy
	Pharmacy Laws/Regulations	Oregon Board Of Pharmacy | Laws & Rules
Pennsylvania	Audit Laws And Regulations	Act 77 (2024) | Pharmacy Audit Integrity & Transparency Act
	Board Of Pharmacy	Pennsylvania State Board of Pharmacy
	Pharmacy Laws/Regulations	PA Board of Pharmacy | Laws & Regulations
Rhode Island	Audit Laws And Regulations	RI Gen L § 5-19.1-35 | Audits
	Board Of Pharmacy	RI Department of Health | Pharmacy
	Pharmacy Laws/Regulations	RI Pharmacy | Rules & Regulations
South Carolina	Audit Laws And Regulations	SC Code § 38-71-1810 | Pharmacy Audit Rights
	Board Of Pharmacy	South Carolina Board of Pharmacy
	Pharmacy Laws/Regulations	SC Board of Pharmacy | Laws & Policies
	If a pharmacy is not in agreement with the results of a pricing appeal, it has the right to contact the director or his designee and request an external review. This request must be made within: (a) sixty (60) calendar days of the pharmacy's receipt of the PBM's final determination resolving the pharmacy's initial internal appeal; or, (b) thirty (30) calendar days of the pharmacy's receipt of the PBM's final audit report. The form for submission of the request for external review is available on the department's website (https://doi.sc.gov/923/pharmacy-benefits-managers-pbms). The contact information for the director is: pbmextreview@doi.sc.gov, or by phone: (803) 734-0398. (Bulletin update)	

State	Description	Link (Ctrl-Click)
South Dakota	Audit Laws And Regulations	SDCL Ch. 58-29F | Pharmacy Audit Integrity Program
	Board Of Pharmacy	South Dakota Board Of Pharmacy
	Pharmacy Laws/Regulations	SD Board of Pharmacy | Statutes & Administrative Rules
Tennessee	Audit Laws And Regulations	TN Code § 56-7-3103 | Audit of Records of Pharmacist or Pharmacy
	Board Of Pharmacy	Tennessee Board of Pharmacy
	Pharmacy Laws/Regulations	TN Board of Pharmacy | Statutes & Rules
	Initial Appeals Process (Reimbursement)	Tenn. R. & Regs. 0780-01-95 | Initial Appeals Process
Texas	Audit Laws And Regulations	TX Ins. Code Ch. 1369(F) | Audits of Pharmacists & Pharmacies
	Board Of Pharmacy	Texas State Board of Pharmacy
	Pharmacy Laws/Regulations	TX State Board of Pharmacy | Laws & Rules
Utah	Audit Laws And Regulations	UT Code § 58-17b-622 | Auditing of Pharmacy Records
	Board Of Pharmacy	Division of Professional Licensing | Pharmacy
	Pharmacy Laws/Regulations	DOPL | Pharmacy Laws & Rules
Vermont	Audit Laws And Regulations	18 V.S.A. § 3802 | Pharmacy Audits
	Board Of Pharmacy	Vermont Office Of Professional Regulation | Pharmacy
	Pharmacy Laws/Regulations	VOPR | Pharmacy Statutes, Rules & Resources

State	Description	Link (Ctrl-Click)
Virginia	Audit Laws And Regulations	Va. Code Ann. § 38.2-3407.15:1 | Carrier Contracts with Pharmacy Providers
	Board Of Pharmacy	Virginia Board Of Pharmacy
	Pharmacy Laws/Regulations	Virginia Board Of Pharmacy | Laws & Regulations
Washington	Audit Laws And Regulations	RCW 48.200.220, et seq. | Audits
	Board Of Pharmacy	Washington Department Of Health | Pharmacy Professions
	Pharmacy Laws/Regulations	Washington DOH | Pharmacy Laws & Rules
West Virginia	Audit Laws And Regulations	WV Code Ch. 33, Art. 51 | Pharmacy Audit Integrity Act
	Board Of Pharmacy	West Virginia Board Of Pharmacy
	Pharmacy Laws/Regulations	WV Board of Pharmacy | Laws & Rules
	All claims paid to pharmacies in the State of West Virginia are priced as follows: • NADAC plus a dispense fee of $10.49 • If there is no NADAC price for the applicable drug, then WAC plus a dispense fee of $10.49. The amount charged to the plan is the same as the amount paid to the pharmacy. **Compound** medications are paid as the sum of NADAC (or if no NADAC is available, then WAC) for each individual ingredient plus a dispense fee of $10.49. **Vaccine Claims** are paid at NADAC (or if there is no NADAC then WAC) plus $10.49 dispense fee plus a vaccine administration fee of $20.00.	
Wisconsin	Audit Laws And Regulations	Wis. Stat. § 632.865(6) | Audits of Pharmacies or Pharmacists
	Board Of Pharmacy	Wisconsin Pharmacy Examining Board
	Pharmacy Laws/Regulations	WI Pharmacy Examining Board | Statutes & Administrative Code

State	Description	Link (Ctrl-Click)
Wyoming	Audit Laws And Regulations	Wyo. Stat. § 26-52-103 | Pharmacy Benefit Manager Audits
	Board Of Pharmacy	Wyoming State Board of Pharmacy
	Pharmacy Laws/Regulations	WY Board of Pharmacy | Statutes, Rules & Regulations