ABARCA

PROVIDER MANUAL

2023

Table of Contents

Introduction

Abarca Health is a provider of healthcare information technology and clinical solutions to stakeholders in the healthcare industry; a leader in pharmacy benefit management (PBM) services and is focused on using the tools of business intelligence to empower our customers to make decisions that improve their business.

Founded in 2005 as the PBM division of Pharmacy Insurance Corporation of America (PICA), the leading Medicare Part D Prescription Drug Plan (PDP) in Puerto Rico, **Abarca Health** was spun off as an independent company in early 2010. **Abarca Health** leverages its core technology capabilities to drive flexible and cost-effective PBM solutions that streamline operations, improve benefit programs, and elevate quality of care for our partners.

The **Abarca Health** staff consists of healthcare, health insurance and information technology professionals including medical doctors, pharmacists, nurses, health educators, engineers, software developers, actuaries, and economists. Our leadership team offers insight gained from decades of experience serving the needs of diverse industries ranging from pharmaceutical supply chain management to technology outsourcing and from managed care to public sector consulting. Our experience helps us create tailored solutions that generate measurable value for our clients.

This manual provides the operational guidelines for the provider's claims processing, using the "National Council for Prescription Drug Programs (NCPDP)" industry standard. Our claims adjudication and processing system, RxPlatform®, will provide pharmacies with all the eligibility, drug coverage, copayment, and necessary information they will need to process a claim.

For **Abarca Health**, your pharmacy is very important, and we appreciate your participation within our Pharmacy Network. We look forward to providing services of excellence to all our clients.

Important Contact Information

Abarca Health's Physical and Postal Address

650 Ave. Muñoz Rivera, Suite 701
San Juan, PR 00918-4115

Member Services Representatives are available 24 hours per day x 7 days per week, Atlantic Standard Time, to answer urgent and emergent calls from members, prescribers, physicians, and pharmacies. Common questions include, but are not limited to:

- Clinical Questions
- Claims Processing and Submission
- Benefit Coverage, including Co-pays and Deductibles
- Claim and Payment Status
- Complaints

General Pharmacy Help Desk:

Proveedores@abarcahealth.com
1-866-993-7422

Pharmacy Help Desk (by Client)	Phone Numbers
ACAA	1-866-224-0176
Care First	1-866-287-6156
Evertec	1-888-816-6844
First Medical	1-855-831-3591
Lilly	1-787-625-4346
Plan de Salud Menonita	1-855-831-3594
PROSSAM	1-855-831-3593
Triple S Advantage	1-855-922-2722
Triple S Salud	1-844-804-7415

ASES Help Desk (by MCO)	Phone Numbers
ASES	1-800-981-2737
ASES First Medical (GFIRST)	1-844-347-7806
ASES MMM (GMMM)	1-844-880-8820
ASES Plan de Salud Menonita (GSMEN)	1-844-832-0420
ASES Triple S Salud (GTSSS)	1-855-774-6087

Compliance & FWA	Phone Number
Hotline	1-866-991-7422

Network Strategy Department:
PharmacyContracting@abarcahealth.com
787-523-1295

Abarca's Provider Portal
https://providers.abarcahealth.com/

Definitions

- **Abuse** – practices that are not considered fraudulent and do not constitute a false representation of the facts. These practices of abuse are inconsistent with good practice and the standards accepted by the industry and the pharmaceutical profession and may result directly or indirectly in unnecessary costs for the health plan or in incorrect payment for services that are not medically necessary or that do not comply with the professional standards of healthcare.
- **ASES Data** – all Data created from Information, documents, messages (verbal or electronic), reports, or meetings involving, arising out of otherwise in connection with the ASES Contract with ABARCA.
- **Audit** – a formal review of compliance with internal standards (policies and procedures), contractual agreements, and external standards (laws and regulations). Audits of pharmacy claims include Desk-Top, On-Site, Pre-Payment Review, and Investigational.
- **Clean Claim** – a Clean Claim under 42 CFR 447.46 (b), as defined in 48 CFR 447.45 (b), is a Claim received by ABARCA for adjudication, which can be processed without obtaining additional information from the Pharmacy of the service or from a third party. It includes a Claim with errors originating in the ABARCA's Claims Processing System. It does not include a Claim from a Pharmacy that is under investigation for Fraud, Waste of Abuse, or a Claim under review for Medical Necessity.
- **Cost Avoidance** – a method of paying Claims in which the pharmacy is not reimbursed until it has demonstrated that all available health insurance, and other sources of Third-Party Liability, have been exhausted.
- **Covered Pharmacy Service** – the prescription drug benefits portion of Covered Services to which Enrollees are entitled under the GHP, the payment of indemnification of which is covered under this Contract, and all other PBM Services required under the ASES Contract, including contracted services under Art. 2.
- **Covered Services** – those Medically Necessary healthcare services provided to Enrollees by Providers, the payment of indemnification of which is covered by a Managed Care Organization of the GHP.
- "**CMS**" means the Centers for Medicare and Medicaid Services.

- **Data Analysis** – is a tool for identifying coverage and payment errors, and other indicators of potential FWA and non-compliance.
- **Dispense as Written or DAW Code** – means the code promulgated by NCPDP to indicate the reason for dispensing a multi-source brand-named medication.
- **Discrepancies** – also known as "*findings*". Cases of inappropriately billed claims are identified for non-compliance and may result in audit recoveries. See section: "***Audit Findings and Discrepancies Guidelines***".
- **Dual Eligible Beneficiary** – a Enrollee or potential Enrollee eligible for both Medicaid and Medicare.
- **E-prescribing** – the process of creation and transmittal of a prescription through electronic means from the point of care to the pharmacy.
- **Electronic Prescriptions** – an electronically generated prescription and a transmitted prescription issued by a prescribing professional to a pharmacy freely selected by the patient, through a device that authenticates the electronic signature of the prescribing professional and guarantees the security of transmittal according to the applicable rules, laws, and regulations. For the purposes of the Puerto Rico Pharmacy Act, the electronically generated and transmitted prescription shall also be known as an electronic prescription and shall constitute an original order, thus an order with a handwritten signature shall not be required.
- **Electronic Signature** – a cluster of data in electronic format contained in a message, document, or transaction attached to or logically associated with such message, document, or transaction that may be used to identify the undersigning and indicate that the undersigning approves and recognizes the information contained in the message, document or transaction.
- **Fraud** – the willful and intended false representation of a real fact. It is an intended act of deceit by one or more individuals in order to illegally obtain a U.S. benefit or privilege to which they are not entitled. Fraud may result in the suspension of services, fines, and/or jail time imposed by state and/or federal agencies.
- **GSA** – short for the General Services Administration of the U.S. federal government. For present purposes, we shall refer to this agency in the context of the Excluded Parties List System (EPLS), a list of excluded entities published by the GSA.
- **Managed Care Organization (MCO)** – an insurance company, health care organization, or any other approved health organization in Puerto Rico that meets the CMS definition of an MCO.
- **MED (Medicare Exclusion Data)** – web based online system available to search and inquire about provider sanctions and reinstatements of both current and cumulative (historical) data. It will also allow users to download monthly files, consisting of current and cumulative data of provider sanctions and reinstatements.
- **NBI MEDIC** – an organization contracted by CMS to manage CMS Integrity of Prescription Drugs Program. For Part D purposes, MEDIC oversees managing audits and all efforts against fraud, waste and abuse of the Part D benefit.
- **Medicare** – health insurance program for individuals that qualify under Title XVIII of the Social Security Act.
- **OIG** – short for Office of the Inspector General. For present purposes, we shall refer to this agency in the context of the List of Excluded Individuals/Entities (LEIE), a list of excluded

entities published by the OIG. In addition, the Inspector General is responsible for audits, evaluations, investigations, and law enforcement efforts relating to Department of Health and Human Services programs and operations, including the Medicare program.

- **Orange Book** – the publication of the FDA of approved drug products with therapeutic equivalence evaluation which identifies drug products approved by the FDA based on safety and effectiveness
- **Paid Claim** – a transaction that has been submitted and adjudicated for payment by the electronic claims processing system.
- **Prescription** – means a written instruction (whether hard copy or in electronic form "e-prescription") given by a Prescriber under certain indications to be prepared and dispatched in a pharmacy by a licensed pharmacist. It must include name and address of the person for whom the prescription was written, date, license numbers of the Prescriber (including the federal and state license to prescribe controlled substances when required to do so), signature, address, telephone number of the Prescriber, and any other information required by applicable federal or state laws.
- **Prescription Drugs** – for present purposes, drugs that require a prescription order written by an individual with prescribing authority in order to be dispensed.
- **Refills** – when a physician authorizes that a prescription prescribed is repeated in accordance with the number of times indicated in the prescription order and permitted by law.
- **Waste** – the extravagant, careless and/or unnecessary waste of funds, assets or government benefits that may result from deficient practices, systems, controls and/or decisions. The term also refers to inappropriate practices that may not involve fraud or activities that may be the subject of legal action.

Claims Processing

For the submission of pharmacy claims, **Abarca Health's** Payer Sheet must be used. Payer sheets can be found in the Provider Portal.

a. Electronic Claims Submission

To submit a claim, a pharmacy must request the beneficiary's updated Plan ID card, and the beneficiary's date of birth. This information is important since it will be validated by the pharmacy's processing and adjudication system, and **Abarca Health's** claims processing system, RxPlatform®. If there is a rejection due to patient eligibility, pharmacies can contact the **Abarca Health's** RxCustomer team at 1-866-993-7422. If there is a rejection due to pharmacy contracting issues, pharmacies can contact the Network Strategy Team at PharmacyContracting@abarcahealth.com.

The following fields are required in order to electronically process claims:

BIN	**610674**
PCN	Process Control Number. This information is independent for each client and is provided in the Payer Sheets.

RxGroup	This information is independent for each client and is provided in the Provider's Manual.

The Rx data for **Medicare, Medicaid,** and **Commercial Plans** through ABARCA includes:

Client	RxBIN	RxPCN	RxGroup
ACAA	610674	007	ACAA
Plan de Salud Menonita	610674	010	PSM
Lilly SA	610674	ABARCA	LILLYSA
Triple S Salud (Commercial)	610674	ABARCA	TSSC
Triple S Advantage	610674	ABARCAD	TSSD
PROSSAM	610674	ABARCA	PROSSAM
Lilly	610674	ABARCA	LILLY
First Medical	610674	ABARCA	FM
Evertec	610674	ABARCA	EVERTEC
ASES – First Medical	610674	ABARCA	GFIRST
ASES – MMM Holdings	610674	ABARCA	GMMM
ASES – Plan de Salud Menonita	610674	ABARCA	GSMEN
ASES – Triple S	610674	ABARCA	GTSSS

For additional fields, please refer to Payer Sheets available on the Provider Portal.

- Payer Sheet – Medicaid
- Payer Sheet – Medicare Part B
- Payer Sheet – Medicare Part D
- Payer Sheet – Commercial

b. Manual Claims Submission

Most pharmacies submit their claims electronically when the drugs are dispensed. If, for any reason, a pharmacy cannot process a claim electronically, it has 30 days from the Date of Service to submit a claim manually using the NCPDP Universal Claims Form (See Exhibit I), unless applicable law requires a longer period. For additional information, a pharmacy must contact the Network Strategy Team.

Generics Substitution Policy

Abarca Health's claims adjudication and processing system, RxPlatform®, manages different types of business rules for generic substitution of brand drugs that have a bioequivalent generic version in the market. Some plans have as their policy Mandatory Generic Substitution. Other plans allow patients to have the option of choosing the brand drug when indicated by their physicians, or when the patients themselves choose to. Even though some brand drugs have a generic version on the market, they are not classified as "AB" by the "Orange Book", so no substitution is allowed.

Utilization Management Restrictions

Utilization management restrictions are utilized to promote the appropriate and cost-effective use of medications in the provision of quality, cost-effective prescription drug benefits.

a. **Quantity Limits** – Maximum quantity allowed for the disposal of an effective dose of a specific drug. This quantity is approved by the Food and Drug Administration (FDA). This Clinical initiative can vary or can be used depending on the benefit set-up established by our clients. It serves as a guide to promote appropriate use of certain drugs.

b. **Days' Supply** – The usual drug supply for maintenance drugs is 30 days with 5 refills. For acute drugs, the usual drug supply is 15 days. Days' supply can vary depending on the benefit set-up established by each client.

c. **Step Therapy** – A utilization tool that requires the patient to first try another drug (Step drug) to treat their medical condition before covering the drug that the physician initially prescribed (Step 2 drug). The system will automatically adjudicate the drug that the physician initially prescribed when the patient has complied with the requirements of the Step Therapy Drug Utilization Management restrictions.

d. **Age Limit** – Used to guarantee appropriate drug use for medications that have been approved by the FDA for patients of a specific age group.

e. **Specialty Limitation or Health Condition** – Limits the prescription and adjudication of specific drugs to the Prescriber's Specialty and/or the patient's condition.

f. **Prior authorization** – For certain drugs, the patient will need to get approval from the plan before the drug is covered. This is called "prior authorization". This edit helps guide the appropriate use of certain drugs.

g. **Safety Edits** – For the concurrent use of drugs and/or their combination, any of the following could occur depending on the safety severity: 1) the patient will need to get approval from the plan before the drug is covered, or 2) the pharmacist is responsible for making the decision to process and dispense the drug by evaluating the case and submitting pharmacy service codes if the edit is to be solved at the POS, or 3) the claim will pay but a safety message will appear as a soft recommendation.

Clinical Information Required in a Coverage Determination Request

A coverage determination is required for any medication that is denied at the point of service and requires an evaluation by the health plan or PBM. It is important to know this information to support the medical necessity and to be able to comply with the evaluation requirements of the requested medication.

Below you will find a list of the most common denials and the minimum necessary information that must be submitted as part of the documentation to the health plan or PBM. In addition, information on times or time frames is included to evaluate a coverage determination. At the end you will find information about the drugs that are considered exclusions by Medicare regulations.

a. What clinical information must the pharmacy submit with a coverage determination request?

- Always include the diagnosis or ICD-10 code.
- Additional information:
  - Therapeutic failures or adverse effects to other alternatives.
  - Medical justification that supports the medical necessity of the requested medication.
  - Any available laboratory test results (example: tuberculin test for biologics, etc.)

Reject Code	Reject Edit	What information must be submitted with the coverage determination request?
75	Prior Authorization	It is recommended to verify the pre-authorization criteria beforehand (it can be accessed through the medical plan page) and submit the request with the required information. The most common pre-authorization criteria include diagnosis, laboratories, and prior use of therapeutic alternatives.
70	Non Formulary	Include any therapeutic failure, adverse effect, or contraindication to the formulary alternatives. Include names of drug alternatives used.
9G	Quantity Limit	Include medical justification for the amount prescribed.
76	Step Therapy	Prior use of first-line formulary alternatives. Include the names of the medications.
88	DUR – High Dose	Include medical justification of the prescribed dose.
88	DUR – Duplicate Therapy	Include the clinical reason why duplicate therapy is used in that patient. Indicate if one drug was changed for the other.
88	DUR – Generic not available	Send evidence of shortage or non-availability in pharmacies.
88	DUR – Early supply	Provide the reason why you need the supply early: change in dose or frequency, travel, theft, or loss.
88	More than seven days' supply of opioids	Provide a diagnosis of cancer or chronic pain or certification by the physician that they are aware of the potential risks of using an opioid for more than 7 days in an opioid-naïve patient for acute pain.
88	200 milligrams Morphine Equivalents (MME)	Include the diagnosis and medical justification for the prescribed dose.

b. Evaluation Times

Coverage determinations have a timeframe to be evaluated.

- Expedited cases are those that are considered urgent or in circumstances where the patient's health is at risk.
- Standard cases are all those that are not expedited.

Case Type	Max Evaluation Time
Expedite (urgent casers)	24 hours*
Standard (non-urgent cases)	72 hours*

*Evaluation times may vary according to the Medicare or Commercial line of business. It may also depend on the type of evaluation being carried out and the information with which the request was received.

c. Medicare Part D Exclusions

Medicare establishes a list of drugs that are not covered by Part D as they are an exclusion from that benefit. Medications on the exclusion list will not be approved, even if a coverage determination is submitted.

Medicare Part D Exclusions

- Drugs when used for anorexia, weight loss, or weight gain (even if used for non-cosmetic purposes).
- Agents when used to promote fertility.
- Agents when used for cosmetic or hair growth purposes.
- Agents used for the symptomatic relief of coughs and colds.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Over-the-counter or OTC drugs.
- Agents when used for the treatment of sexual dysfunction or erectile dysfunction (ED).
- Drugs under the FDA's Drug Efficacy Study Implementation (DESI) are considered less effective and do not meet the definition of a Part D drug (for example: Analpram HC).

Insulins: Stability, Dispensing and Packaging

The stability of the insulins is important to have on hand since it must be shared with the patient as part of the guidance provided when dispensing said medications. In addition, it is vital to take this information into account when dispensing and billing insulins to ensure that the patient has the adequate amount according to the prescribed dose. Below is a list of commercially available insulins with their respective brand names, dosage forms, and expiration dates after each product is used for the first time. At the end of the table, you will find some examples of how to calculate the number of vials that need to be dispensed according to the dose of insulin that the patient will use and the correct way to dispense and bill the packages of insulin pens.

Generic Name	Brand Name(s)	Presentation (Vial/Pen)	Stability after first puncture (days)
Insulin Aspart	Fiasp®	Vial	28
	Fiasp PenFill®	Pen	
	NovoLOG®	Vial	
	NovoLOG FlexPen®	Pen	
	NovoLOG FlexPen ReliOn®	Pen	
	NovoLOG PenFill®	Pen	
Insulin Glulisine	Apidra®	Vial	28
	Apidra SoloStar®	Pen	
Insulin Lispro	Admelog®	Vial	28
	Admelog SoloStar®	Pen	
	HumaLOG®	Vial	
	HumaLOG Junior KwikPen®	Pen	
	HumaLOG KwikPen®	Pen	
	Lyumjev®	Vial	
	Lyumjev kwikPen®	Pen	
Insulin Regular	HumuLIN R U-500®	Vial	40
	HumuLIN R U-500 KwikPen®	Pen	28
	HumuLIN R®	Vial	31
	NovoLIN R FlexPen ReliOn®	Pen	28
	NovoLIN R FlexPen®	Pen	
	NovoLIN R ReliOn®	Vial	42
	NovoLIN R®	Vial	
Insulin NPH Isophane	HumuLIN N KwikPen®	Pen	14
	HumuLIN N®	Vial	31
	NovoLIN N FlexPen ReliOn®	Pen	28
	NovoLIN N FlexPen®	Pen	
	NovoLIN N®	Vial	42
Insulin Degludec	Tresiba® U-100	Vial	56
	TRESIBA® U-100 FlexTouch®	Pen	
	TRESIBA® U-200 FlexTouch®	Pen	
Insulin Detemir	LEVEMIR® FlexTouch®	Pen	42
	LEVEMIR®	Vial	
Insulin Glargine	Basaglar KwikPen®	Pen	28
	Basaglar Tempo®	Pen	
	Lantus®	Vial	28
	Lantus SoloStar®	Pen	28
Insulin Glargine	Toujeo SoloStar®	Pen	56
	Toujeo Max®	Pen	
	Semglee®	Vial	28
	Semglee®	Pen	

Insulin Aspart Protamine and Insulin Aspart	NovoLOG Mix® 70/30	Vial	28
	NovoLOG Mix 70/30 FlexPen®	Pen	14
Insulin Lispro Protamine and Insulin Lispro	HumaLOG Mix® 75/25	Vial	28
	HumaLOG Mix® 75/25 KwikPen®	Pen	10
	HumaLOG Mix® 50/50	Vial	28
	HumaLOG Mix® 50/50 KwikPen®	Pen	10
Insulin NPH and Insulin Regular	HumuLIN® 70/30	Vial	31
	HumuLIN® 70/30 KwikPen®	Pen	10
	NovoLIN® 70/30	Vial	42
	NovoLIN® 70/30 FlexPen®	Pen	28

Reference: Lexicomp Online: UpToDate, Inc. 2021. https://online.lexi.com. Accessed September 2021.

Examples:

1. Patient uses insulin Humalog® 20 units with each meal (three times a day). How many vials of insulin must be dispensed per month to cover the needs of this patient?
   - According to the prescribed dose, the patient uses 60 units of Humalog® insulin per day.
   - Each 10 mL vial of Humalog® contains 1,000 units.
   - 1,000 units (1 vial) / 60 units per day = 16 days
   - To cover a month of treatment it is necessary to dispatch 2 vials:
     - 2,000 units (2 vials) /60 units per day=33 days
   - In this case, the expiration date after the first puncture does not affect, since the patient must use each vial within 16 days, so the product will be finished before it expires.

2. Patient uses Lantus® insulin 8 units when going to bed at night. How many vials of insulin must be dispensed per month to cover the needs of this patient?
   - According to the prescribed dose, the patient uses 8 units of Lantus® insulin per day.
   - Each 10 mL vial of Lantus® contains 1,000 units.
   - 1,000 units (1 vial) /8 units per day=125 days
   - However, the Lantus® vial expires 28 days after the first puncture. Therefore, one vial (1,000 units) should be dispensed for 28 days as the patient will need a new vial after this.

3. Patient uses insulin Lantus Solostar® 10 units at bedtime at night. How many pens of insulin must be dispensed per month to cover the needs of this patient?
   - Each Lantus Solostar® pen contains 300 units of insulin.
   - To cover 30 days of treatment this patient would need 1 pen (300 units) per month.
     - 300 units/30 days= 10 units per day
     - However, the product expires 28 days after opening it, so a pen must be used within 28 days and the remaining product must be discarded.

- Lantus Solostar® packaging contains 5 pens (1,500 units) and is considered unbreakable packaging (packaging cannot be opened and itemized individually). Therefore, the pharmacy must invoice for the total days that the product lasts according to the patient's dose.
- In this case, they must invoice the 5 pens for 140 days (28 days x 5 pens), which are the total days that the product will last according to the dose prescribed for this patient.
- *Clarification Note*: if the patient uses less insulin per day and the days of supply exceed the days of stability of the pen, then, it must be invoiced according to the stability established by the manufacturer.

Accurate Billing for Insulin Pens

The Federal Food and Drug Administration (FDA) has asked pharmaceutical companies that manufacture insulin pens to update the information contained in the package insert indicating that those packages must be dispensed with its instructions for use and in their original sealed packaging.

"**Dispense in the original sealed carton with the enclosed Instructions for Use."**

This FDA instruction will change the way these claims must be processed. For this reason, **Abarca Health** clarifies the following:

- Pharmacies may process the smallest available package currently available on the market (15 ml; 5 pens 3mL) for the correct day supply based on the instructions provided by the physician on the prescription.
- As Directed, or any indication like this, will not be accepted to process the claims.
- The pharmacy is responsible to correctly process the amount of medication and days' supply based on the indications in the prescription.
- If you receive a rejection for one of the following reasons:
    - High Cost
    - Days' supply greater than ninety (90)

  Please contact our Call Center to start with the corresponding evaluation process.
- Important: when processing a claim, you must select the NDC that represents the total package quantity being dispensed to the beneficiary.

Management of GLP-1 Receptor Agonists for Beneficiaries with Type 2 Diabetes Mellitus for Medicare – Triple S Advantage

We would like to remind you the following change, effective January 1st, 2023:

The Centers for Medicare and Medicaid Services (CMS) provide coverage under Medicare Part D of GLP-1 receptor agonists for the management of Type 2 Diabetes Mellitus. These agents have not been approved by the Food and Drug Administration (FDA) for weight loss management. As of January 1st, 2023, if a claim for a covered GLP-1 receptor agonist agent is processed for

beneficiaries of a Triple-S Advantage plan who do not have prior use of antidiabetic agents in their claim history, the following rejection code will appear:

> *"88 – DURRejectError, 569 - Provide Beneficiary with CMS Notice of Appeal Rights, along with the pharmacy additional message: Limited to FDA-approved indications not otherwise excluded from Part D. Please confirm Type 2 Diabetes diagnosis."*

If you receive this rejection and confirm that the use of the drug is appropriate, as it is associated with the management of Type 2 Diabetes Mellitus, you should submit a copy of the prescription with diagnosis to our fax: 1-855-710-6727.

If you need assistance or have any questions, do not hesitate to contact our **RxCustomer** Service Team at 1-866-993-7422. You may access this communication and others through our **Provider Portal** at the following link: https://abarca.darwinrx.com/operational/.

Operational Requirements

a. **Alert Messages** – when necessary, **Abarca Health** sends Alert Messages to the pharmacies according to the NCPDP standard. The NCPDP standard detail can be found at the following link: http://www.ncpdp.org/standards.aspx. The most common Alert Messages are:

Reject Code	Alert Message
40	"Pharmacy Not Contracted with Plan on Date of Service"
70	"Product/Service Not Covered"
75	"Prior Authorization Required"
88	"DUR Reject Error"
E7	"Missing/Invalid Quantity Dispensed"
7X	"Days Supply Exceeds Plan Limitation"
76	"PlanLimitationsExceeded"
73	"RefillsAre Not Covered"
79	"Refill Too Soon"
9G	"Quantity Dispensed Exceeds Maximum Allowed"
19	"Missing/Invalid Days Supply"

25	"Missing/Invalid Prescriber ID"
29	"Missing/Invalid Number Of Refills Authorized"
65	"Patient Is Not Covered"

b. **Covered and Non-Covered Drugs** – Drugs will be Covered or Not Covered depending on the pharmacy benefit provided by our clients in each of their plans.

c. **Copayment Information** – Copayment is a fixed amount that the beneficiary will pay for their drugs in a pharmacy. The copayment amount will depend on each client and each individual plan. **Abarca Health** will electronically provide this information to the pharmacy.

d. **Automatic Delivery Requirements for Medicare Plans** – The Centers for Medicare and Medicaid Services (CMS) announced that starting January 1st, 2014, pharmacies offering automatic shipments or home delivery of prescriptions that were not initiated by the beneficiary or authorized representative must obtain beneficiary or authorized representative consent before delivering the prescription. This requirement applies to new prescriptions and refills. An example of an automatic fill without consent would be a refill prompted by an auto-fill system versus the beneficiary or authorized representative requesting the fill. It is important for pharmacies to retain the beneficiary or authorized representative consent logs for audit purposes.

e. **Other requirements for automatic delivery programs:**

- Automatic delivery programs should be voluntary and opt-in only.
- Printed and/or online beneficiary materials must have easy to locate and easy to understand information on how to dis-enroll from automatic delivery programs.
- Should a beneficiary disenroll, the pharmacy should process that request and remove the beneficiary from the program within 30 days.
- If the beneficiary denies the medication upon delivery, the pharmacy should reverse the claim transaction and refund the beneficiary any co-pay or deductible paid.
- Beneficiary materials related to refunds must be easy to locate and easy to understand.
- The pharmacy should confirm with the beneficiary at least annually that they want to continue in the automatic delivery program.
- The pharmacy should promptly discontinue automatic delivery after notification that a beneficiary entered a skilled nursing facility or elected hospice coverage.

Coordination of Benefits (COB)

a. General

Coordination of Benefits (COB) refers to a specific set of rules set by Medicare and Medicaid

in order to make sure that the beneficiary is using all of their coverage in combination when getting their prescription drugs. Furthermore, COB allows plans that provide coverage for the same beneficiary to determine each of their payment responsibilities, establishing which plan is the primary payer and which is secondary. The pharmacy must submit the amount paid by the primary payer to the secondary payer, and the non-paid amount must be submitted by the secondary payer, fulfilling their payment responsibility.

b. Medicaid (ASES):

Abarca Health will adjudicate Claims submitted by Network Pharmacies based on the Pharmacy Contracts, including online edits for Prior Authorization regulation and other edits that may be necessary for the accurate payment of Claims and according to the Covered Pharmacy Services as determined by ASES. **Abarca Health's** Claims Processing System will have the capacity to handle Coordination of Benefits ("COB") with another party that is or may be liable for payment and which provides **Abarca Health** with necessary COB information daily. **Abarca Health** shall submit to ASES on the last Business Day of March, June, September, and December of each year during the Term of this Contract a report in the format to be agreed upon by ASES and the Contractor containing the Information pertaining to all COB efforts and results.

340B Drug Pricing Program – ASES

Program Overview

The 340B Program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Manufacturers participating in Medicaid agree to provide outpatient drugs to covered entities at significantly reduced prices. Eligible health care organizations/covered entities are defined in statute and include HRSA-supported health centers and look-alikes, Ryan White clinics and State AIDS Drug Assistance programs, Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers. A full list of eligible organizations/covered entities can be found at https://www.hrsa.gov/opa/eligibility-and-registration. To participate in the 340B Program, eligible organizations/covered entities must register and be enrolled with the 340B program and comply with all 340B Program requirements. Once enrolled, covered entities are assigned a 340B identification number that vendors verify before allowing an organization to purchase 340B discounted drugs.

Identification and Processing of 340B Claims

Accurate identification of 340B claims is necessary to ensure that all eligible claims are billed for MDRP (Medicaid Drug Rebate Program) rebates. States require pharmacies to identify 340B claims at a claim level.

In order to process 340B claims, pharmacy providers must register as **Carve In** for OPAIS. 340B OPAIS User Guide with information on how to register and other important information can be found by accessing: https://www.hrsa.gov/sites/default/files/hrsa/opa/public-user-guide.pdf. **Additionally, pharmacy providers should submit Submissions Clarification Code (SCC) =**

20 on 340B claims. Pharmacies may be familiar with this approach, which is commonly used for identifying 340B claims. A SCC requires a pharmacy to either identify a claim at time of adjudication or reverse and then resubmit a claim retrospectively once the dispense is determined to be 340B eligible.

340B Drug Pricing Program Integrity

Pharmacies must ensure to identify 340B claims for adjudication. These claims are subject to audit and failure to comply may make the pharmacy liable.

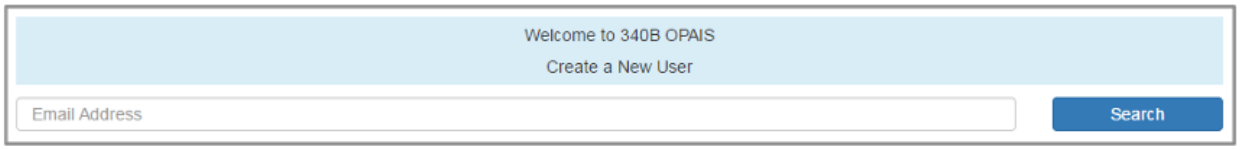
Creating a 340B OPAIS Account

- **Source: *340B OPAIS User Guide*, pages 10 – 12.**
  https://www.hrsa.gov/sites/default/files/hrsa/opa/public-user-guide.pdf

You must have a 340B OPAIS user account to initiate registrations or change requests or to respond to annual recertification requests. If you are the Authorizing Official (AO) or Primary Contact (PC) for a participating entity or you need to register a non-participating entity in the 340B Program, you may create an account as follows.

1. From the 340B OPAIS home page, click the "I am a Participant" icon or click the Login link in the top menu. The 340B login screen is displayed.

2. Click the Create new account link. The Create a New User email search page is displayed.

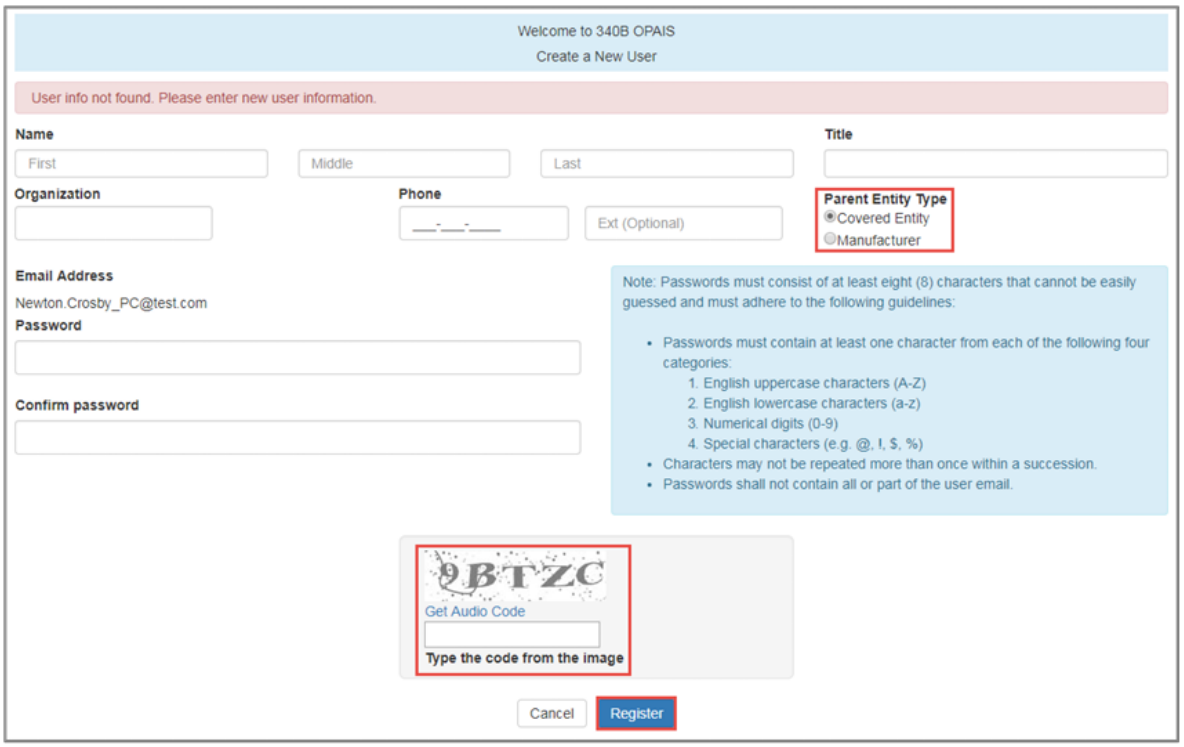


3. Type your email address in the space provided and click the Search button.

Important:	Your email address will be used as your user ID for accessing the 340B OPAIS and as the "to" address for all system-generated emails, including two-step authentication codes needed to log in, password reset messages, pending task notifications, and confirmation of your actions when using the system. It cannot be changed without creating a new user account.
Tip:	To ensure that you receive 340B OPAIS email notifications, update your email program's spam filter to allow *"no-reply@hrsa.gov."*

4. The Create a New User registration page is displayed.
   - If your email address is currently associated with an active or approved covered entity or manufacturer record as an AO or PC, your email address, name, title, organization (if available), phone number, and extension will be filled automatically.
   - If your email address has not been previously associated with a covered entity or manufacturer, enter your name, title, organization name (employer), phone number, and extension in the spaces provided before proceeding. All fields are required except middle name/initial and telephone extension.

Important:	Email addresses must be associated with the AO or the PC and must not be associated with an unmonitored or group email account (e.g., *info@CHC.org* or *340B@CHC.org).*



5. For Parent Entity Type, select either Covered Entity or Manufacturer.
6. Type your password and then type it again to confirm it.
   Your password must be at least eight characters that cannot be easily guessed. It must be a combination of alphanumeric characters containing at least one character from each of the following categories:
   - English uppercase characters (A-Z)

- English lowercase characters (a-z)
- Numerical digits (0-9)
- Special characters (e.g., @, !, $, %)

7. Type the CAPTCHA code displayed in the image in the text box.
8. Click the Register button.
9. The system will check for an existing account associated with your email address.

> **Note:** Only one account may be associated with an email address. If your email address has already been used to create an account, the system will display an error notification with a link to the 340B OPAIS home page.

10. If your account request is valid, the system will:
    - Activate your account and associate it with any entity registrations in which your email is used as a contact
    - Add any assigned tasks to your work queue
    - Send a "New Account Confirmation" notification to the email address you used to create your account
    - Display a message that your account was created successfully with a Return to Login button

11. Click the Return to Login button to go to the login page.
12. Log into the 340B OPAIS using your email address and the password you just created.

Abarca Health strongly suggests that pharmacies access the *340B OPAIS User Guide* for this and additional information.

Transition Process in Medicare

The transition process is a benefit to which applies to Medicare beneficiaries are entitled. If the beneficiary is a new enrollee and is within the first 90 days of coverage for this plan year or if it is a current enrollee since last year, affected by formulary changes implemented this year by Triple-S Advantage and are within the first 90 days of coverage for this plan year, in the outpatient setting, Triple-S Advantage is required to provide a one-month temporary supply for this drug. The temporary supply can be for several reasons, such as: 1) drug is not on our formulary, 2) drug is on our formulary, but requires prior authorization, 3) drug is on our formulary and is subject to a step therapy (ST), so we will generally only pay for this drug if the member first tries another drug, or, 4) drug is on our formulary and is subject to a quantity (QL).

It is important to understand that this is a temporary supply of this drug. Before this supply ends, the member should speak to Triple-S Advantage and/or the physician about:

- Changing the drug to another drug that is on our formulary; or
- Requesting approval for the drug[s] by demonstrating that you meet our criteria for coverage; or
- Requesting an exception from our criteria for coverage

When the member requests approval for coverage or an exception from coverage criteria, these are called coverage determinations. You should not assume that any coverage determination, including any exception, the member has requested or appealed has been approved just because it gets more fills of a drug. When Triple-S Advantage approves coverage, we send you written notice. That is, plan will provide the member with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

On the other hand, we would like to remind the pharmacies about the provision of "Medicare Prescription Drug Coverage and Your Rights" to the beneficiaries. Network pharmacies, including mail order and specialty pharmacies, must distribute this notice to Part D enrollees when a prescription cannot be covered ("filled") under the Medicare Part D benefit at the point of sale (POS). The notice must be provided to the enrollee if the pharmacy receives a transaction response (rejected or paid) indicating the claim is not covered by Part D.

Procedure for Medication Dispensing at the Pharmacy under Part B for Medicare – Triple S Advantage

During 2023, Triple-S Advantage will continue allowing pharmacies to dispense certain medications that will be used for medical procedures at point of sale by changing the PCN to the Part B (ABARCAB).

The complete medication list will contain the following medications, as during 2022:

Generic Product Name
Midazolam INJ 5 mg / ml
Midazolam INJ 10 mg / 2 ml
Fentanyl INJ 100 mcg / 2 ml
Flumazenil INJ 0.5 / 5 ml
Triamcinolone Acetonide INJ 40 MG/ML
Kenalog INJ 40 MG/ML
Dexamethasone Sodium Phosphate INJ 4 MG/ML
MethylPREDNISolone Acetate INJ 40 MG/ML
MethylPREDNISolone Acetate INJ 80 MG/ML

If the pharmacy processes these medications through the Part D PCN, the following additional message will appear along with the corresponding rejection code: For medical procedures, please submit the same claim with the following PCN code: ABARCAB.

If the pharmacy cannot distinguish if it will be used for procedure purposes, the medication will have to be sent to Abarca Health for case evaluation. Whenever the patient does not receive a prescribed medication, Pharmacy will need to distribute a written copy of the standardized CMS pharmacy notice to the enrollee. An enrollee, the enrollee's representative, or the enrollee's prescriber has the right to request a coverage determination from Abarca Health, including the right to request an expedited coverage determination. Please Fax: 855-710-6727 for case evaluation.

Pharmacy Networks: Rights and Responsibilities

a. Contract

Abarca Health contracts with any willing pharmacy provider that fully complies with federal and state laws and regulations to establish a pharmacy in Puerto Rico or any state of the continental United States of America. **Abarca Health** supports and requires compliance with federal and state laws and regulations by all participating pharmacies in its Pharmacy Network. This is done through the Company's pharmacy provider's contract and the contracting process. According to what is established in their contract, pharmacies can opt for not renewing or canceling the contract with proper notice.

All participating network pharmacies are required to abide by the following terms and conditions.

1. Description of the entities that are party to the written agreement

2. The Pharmacy shall provide one or more of the following pharmaceutical services as indicated in the Master Pharmacy Provider Agreement ("MPPA") between Pharmacy and **Abarca Health**:
    i. Retail Pharmacy Services
    ii. Home Delivery Services
    iii. Mail Pharmacy Services (not applicable to Medicaid – ASES)
    iv. Any Long-Term Care Pharmacy Care Service as defined by CMS
    v. Specialty Pharmacy Services
    vi. Home Infusion Pharmacy Services as defined by CMS
    vii. Part B Services as defined by CMS

3. The Pharmacy may be included in additional programs and services offered by **Abarca Health** to Payors, including, but not limited to the following: (i) Patient Adherence Program and cognitive services targeted to medication treatment of chronic conditions such as Diabetes, Asthma, Hypertension, and Dyslipidemia, among others, (ii) Medication Therapy Management Program, (iii) Provide consultations on drug-related issues and Patient education regarding medications administration, and (iv) Drug Discount Cards.

Abarca Health will provide Pharmacy at least thirty (30) days prior to the effective date of the program/services for Pharmacy to determine whether to provide the additional programs or services. The pharmacy may decline to participate in such additional programs by providing **Abarca Health** written notice of its intent not to participate within thirty (30) days upon receipt of notice from **Abarca Health**. Should the parties agree to the additional services/programs, the parties will execute an addendum to the Master Pharmacy Provider Agreement for said additional services.

4. Unless otherwise provided in the prescription or otherwise requested by the Eligible Member, the Pharmacy agrees to dispense 90 days' supply of Covered Drugs.

5. As a condition precedent to providing the Covered Services or dispensing the Covered Drugs, the Pharmacy shall verify and confirm the eligibility of each Eligible Member by requesting an identification card or by requesting the identification number and verifying eligibility using **Abarca Health's** online electronic network. The Pharmacy will not be paid for services provided or drugs dispensed to an individual whose eligibility was not correctly verified and confirmed through **Abarca Health's** online electronic claims processing system.

6. The pharmacy shall verify the eligibility of the Eligible Member. **Abarca Health** shall not be responsible for any claim or after its termination for any services or drugs provided by the Pharmacy to any person who is not entitled to receive such services or drugs because he/she is not a confirmed.

7. The Pharmacy shall not bill any Eligible Member for Covered Services or Covered Drugs except to the extent of any Deductible or Copayment. The Pharmacy shall notify the Eligible Member of the total amount of the Copayment and/or Deductible payment as indicated by **Abarca Health's** electronic claims transmissions system and shall collect a such amount(s) prior to providing the Covered Service or dispensing the Covered Drug. Pharmacy shall have full responsibility for the collection of such Copayment or Deductible designated as the Eligible Member's responsibility in accordance with the terms of the applicable Plan and shall not seek to collect any Co-Payment or Deductible from **Abarca Health** or Payor. The pharmacy shall not discount, waive, reduce, or defer Eligible Member's Copayment in whole or in part. The pharmacy shall not: (a) balance bill an Eligible Member; or (b) charge Eligible Members any charges other than the Copayment or Deductible related to the Covered Drug or Covered Service. The pharmacy shall ensure that Eligible Members are not held liable for fees that are the responsibility of **Abarca Health**.

8. The pharmacy shall electronically process and accept telecommunication data from **Abarca Health** in approved NCPDP-standard format or any other format designated by **Abarca Health** from time to time as the method of verification, submission, and

collection of Claims. Non-telecommunicated Claims may be sent in hard copy using the Universal Claim Form in accordance with NCPDP guidelines.

9. The Pharmacy shall submit Claims in accordance with all applicable laws. The Pharmacy must submit all required information for the Claim via the online system, including Eligible Member's identification number; quantity of the medication dispensed; days' supply dispensed; Pharmacy's NCPDP (then most current version), Provider, or NPI number; the eleven (11) digit NDC of the item dispensed based on the bottle size from which the item was dispensed; the correct DAW Code in accordance with NCPDP specifications; valid Prescriber's identification number; and the Pharmacy's Usual and Customary Charge. The Pharmacy acknowledges that DAW Code submission may change the calculation of the Claim and/or Co-payment depending on Payor specifications. Pharmacy will be liable for any miscalculations and/or adjustments resulting from incorrect submission of a DAW Code. An Eligible Member's or Pharmacy's selection of a brand name multi-source product does not constitute medical necessity. Prescriber Identification Number shall be considered invalid when the Prescriber Number submitted by Pharmacy is not the Prescriber Identification Number listed on the Prescriber's prescription. Prescriber Numbers shall be considered invalid when: (i) the Prescriber Number submitted by Pharmacy with the Claim is not the Prescriber Number listed on the prescription by the Prescriber; or (ii) no Prescriber Number is provided on the prescription, and the Prescriber Number submitted by the Pharmacy with the prescription Claim is not the "default" identification number provided by **Abarca Health**; (iii) the Prescriber Number submitted by the Pharmacy with the prescription Claim does not correspond to the actual prescriber of the prescription. **Abarca Health** reserves the right to recover 100% of Claims submitted by Pharmacy with Invalid Prescriber Identification Number as provided in the MPPA. Additionally, **Abarca Health** has the right to terminate the MPPA if **Abarca Health** determines, in its sole discretion, that Pharmacy has submitted an unreasonable number of Claims with invalid Prescriber Identification number and/or Provider Identification Numbers. Unless prohibited by Law, Pharmacy acknowledges and agrees that accurate submission of its Usual and Customary Charge is a material requirement and any failure to electronically submit an accurate Usual and Customary Charge with each Claim (including but not limited to Compounds) shall constitute a breach of this Agreement. Failure to submit the Claim electronically when the online system is operational may be considered a material breach and grounds for termination of this Agreement. Additionally, **Abarca Health** may impose a reasonable handling fee per Claim in those situations in which Pharmacy submits Claims non-electronically. Pharmacy shall provide and maintain at its expense, the equipment, software, and communications network transmission capabilities necessary to pay for its own electronic communication and switch charges incurred in the online delivery and receipt of Claims and processing messages.

10. The Pharmacy shall submit Claims promptly after providing the Covered Service or Covered Drug, and in no event later than thirty (30) calendar days after the date that

the Covered Service is rendered, or Covered Drug is dispensed (unless applicable law requires a longer period). Failure to timely submit a Claim may result in non-payment of such Claim. Each Claim submitted by Pharmacy will constitute a representation and certification by the Pharmacy to **Abarca Health** that the Covered Service or Covered Drug was provided to the Eligible Member and that the information transmitted is accurate and complete. Pharmacy agrees to submit all claims for Covered Drugs or Services, even zero balance claims for purposes of allowing DUR system checks to ensure patient safety is maintained throughout the transaction(s).

11. The Pharmacy agrees that all medications or services not received by an Eligible Member must be reversed through the online system. Pharmacy shall submit Claim reversals within fifteen (15) calendar days following the date the Claim was originally submitted. This includes (but is not limited to) reversals and resubmissions for partial fills, where the medication is partially filled and the remainder is not retrieved by the Eligible Member in a reasonable period, in which case Pharmacy must electronically reverse and resubmit the actual quantity of a medication received by an Eligible Member. In addition, this provision prohibits Pharmacy from submitting separate Claims for an Eligible Member which should have been dispensed and covered as one Claim but due to inadequate supplies or other issues, is dispensed and covered on different dates or at different times as multiple Claims.

12. The Pharmacy shall have a licensed pharmacist on duty and available during business hours for any required patient consultation.

13. The Pharmacy and its pharmacists must always exercise sound professional judgment when dispensing prescription medications, providing services to Eligible Members, and in performing its duties under the MPPA. Pharmacy or its pharmacists may refuse to provide services to an Eligible Member based on their professional judgment, which must be documented. Pharmacy shall be solely responsible for the professional and pharmacist services it renders to its clients, including Eligible Members and shall assume all liability arising in connection thereunder.

14. The Pharmacy shall comply with the standards of pharmaceutical care and agrees to offer pharmaceutical services complying with the highest industry and quality standard and with all applicable Laws, which include but are not limited to: maintaining adequate inventory of medications, reasonable waiting time for dispensing a prescription, provide orientation to Eligible Members on the use of medications, and possible interaction of medications.

15. The Pharmacy shall provide pharmacy services to all Eligible Member pursuant to the terms of the MPPA during regular hours of operation of Pharmacy and in the same manner, in accordance with the same standards, and with the same availability as that offered to all other persons. Pharmacy shall use best efforts to maintain an adequate

supply of drugs, devices, supplies, equipment, and other items to meet the reasonable demand of Eligible Members for Covered Drugs and Covered Services.

16. Any denial, unreasonable delay, or rationing of Medically Necessary services to enrollees is expressly prohibited. In the instance that **Abarca's** Network Strategy team becomes aware of any form of discrimination, the case will the referred to the Compliance Team for further investigation and action. The Network Strategy team will work in conjunction with the Compliance, Quality, and Client Success teams to review and respond to ASES or MCO reported instances of potential unreasonable delays or rationing of Medically Necessary services to enrollees.

17. The Pharmacy shall stock and dispense generic equivalent at the lowest cost if authorized or permitted to do so by the Prescriber and the Eligible Member, according to Plan parameters as established by Payor, and in compliance with all applicable Laws.

18. In providing the Covered Services or Covered Drugs to Eligible Members, Pharmacy shall use its best efforts in supporting **Abarca Health** and Payors in managing the cost and quality of Covered Services and Covered Drugs. Pharmacy shall use its best efforts to cooperate with cost containment efforts such as Formularies, prior authorization programs and drug utilization reviews which promote prescribing and dispensing of appropriate and cost-effective therapeutic alternatives, including, but not limited to the following:

- **Lowest Cost Drugs**. Pharmacy agrees to dispense the lowest cost drug that Pharmacy has in stock, consistent with the orders of the Prescriber, the requirements of Law and the professional judgment of the Pharmacy.

- **Generic Substitution**. Pharmacy agrees to promote generic utilization and will provide Covered Drugs and Services using generic medications whenever it is (a) not specifically prohibited by Prescriber or Law; (b) available at less cost than non-generic medications; and (c) in compliance with the applicable Plan and Formulary. Pharmacy shall assure compliance with the requirements of the applicable Pharmacy Law and Regulation in this process.

- **Mandatory Generic Programs**. Pharmacy shall use its best efforts to support **Abarca Health** and Payor mandatory generic programs, including, but not limited to, contacting the prescriber to encourage a change to a generic substitute when the prescription for the Covered Drug contains a DAW signature for a multi- source brand medication. Pharmacy shall use best efforts to maintain an adequate supply of generic drugs.

- **Formulary Compliance**. Pharmacy shall dispense items on the Eligible Member's Formulary to the maximum extent permitted by Law. Pharmacy shall use best efforts to contact the prescriber to encourage Formulary compliance and request authorization

to change to a therapeutic equivalent Formulary drug. Pharmacy shall maintain a record on the original prescription order of its attempt at achieving Formulary compliance.

- **Prior Authorization**. **Abarca Health** prohibits its participating pharmacies from establishing specific days for delivery of referrals and requests for Prior Authorizations for GHP Enrollees. As stated in the pharmacy contract, section 4.16: Pharmacy shall promptly attend to requests for Prior Authorizations and Referrals, when Medically Necessary, and shall meet the timeframes for such as established in 42 CFR 438.210 and the Puerto Rico Patient's Bill of Rights and notified by ASES and/or **ABARCA**. Unless otherwise instructed by **Abarca Health**, if Pharmacy receives a system message that states "Prior Authorization Required" (or similar language) when submitting a Claim for a Covered Service or Drug, Pharmacy shall use its best efforts to contact the Prescriber and inform the Prescriber of the Prior Authorization requirement or, where appropriate and permitted by the Plan, obtain additional information and contact **Abarca Health** or Payor (as applicable) prior authorization help desk to determine if the Plan Prior Authorization requirements have been satisfied. In those situations where Pharmacy must contact the Prescriber and the Prescriber is not available, Pharmacy shall notify Eligible Member and shall contact **Abarca Health,** or Payor (as applicable) prior authorization help desk to obtain a one-time emergency authorization. If the applicable Payor's or PBM's prior authorization help desk is closed or unavailable, to the extent required by Law, Pharmacy must provide an emergency supply, or, if not so required by Law, as otherwise instructed by **Abarca Health**.

- **Utilization Management.** Unless otherwise instructed by **Abarca Health**, if Pharmacy receives a Utilization Management message such as a Quantity Limit or Step- therapy for example, Pharmacy shall ensure the Eligible Member is informed of the Utilization Management message, as appropriate, and assists Eligible Member in securing another Prescription Drug in accordance with Eligible Member's Formulary, appropriate dosage from Prescriber, or with requesting an Exception, as applicable.

- **DUR**. The Pharmacy shall cooperate with **Abarca Health** in Drug Utilization Review activities to promote high standards of care in a cost-effective manner. Drug Utilization Review messages may appear in the online Claim response. Pharmacy shall act upon all such messages subject to the professional judgment of the pharmacist. To the extent that **Abarca Health** provides DUR information or messages to Pharmacy, Pharmacy acknowledges and agrees that: (a) information contained in DUR messages may be derived from third-party sources and not independently developed by **Abarca Health**; (b) the usefulness of DUR and other Formulary information is necessarily limited by the amount of patient information input into the online system as a result of Claims processing, the amount of information provided by **Abarca Health**, and the thoroughness and accuracy of industry information and information provided by third parties; (c) DUR messages and Formulary information are intended as an aid to, and not a substitute for, the knowledge, expertise, skill, and judgment of Prescribers, Pharmacy, pharmacists, and other healthcare professionals; (d) Pharmacy,

Prescribers, pharmacists, and other healthcare professionals are responsible for acting or not acting upon information generated and transmitted by **Abarca Health**; (e) **Abarca Health** does not control the healthcare decisions made or actions taken by Pharmacy, Prescribers, pharmacists, other healthcare professionals, or Eligible Members; and (f) the DUR messages and Formulary information do not contain all currently available information on healthcare or pharmaceutical practices. Failure to read DUR messages may result in termination from the **Abarca Health** pharmacy network.

19. The Pharmacy agrees to cooperate in good faith with **Abarca Health** regarding coordination of benefits and to notify **Abarca Health** promptly after receipt of information regarding any Eligible Member who may have a Claim involving Coordination of Benefits. If a Payor has been identified or determined to be other than the primary payor, the claim payment shall be based upon the total prescription cost, reduced by the amount paid for the by the primary and other tertiary plans. Pharmacy agrees to accept such amount as payment in full for the Covered Service or Covered Drug. This Section shall not require the Pharmacy to waive Co-insurance, indemnity balances and Deductibles in violation of any Medicare rule or regulation and shall not supersede any other Medicare Law.

20. The Pharmacy shall maintain an insurance claims signature log with an entry for each Covered Service rendered or Covered Drug dispensed to Eligible Members, which log shall (1) be maintained for a period of not less than ten (10) years from the date the service was rendered, or drug dispensed, and (2) be made available for inspection by **Abarca Health** and/or its duly authorized agents upon prior reasonable notice. The Pharmacy agrees that it is not entitled to receive payment for Covered Drugs or Covered Services for which the signature of the Eligible Member or his/her authorized agent is not in the logbook or for which the Pharmacy is unable to obtain a signed statement from the Eligible Member that the Covered Drug or Covered Service was dispensed or rendered and received.

21. The Pharmacy shall comply fully with the duties and requirements set forth in all federal and state laws, rules, and regulations that govern the practice of pharmacy and the provision of services under this Agreement, including the final HIPAA patient privacy standards as set forth in 45 CFR, Sections 160 and164, as amended.

22. The Pharmacy shall be responsible for the payment of any and all transaction charges or fees associated with the transmission of Claims or Claim information to **Abarca Health**.

23. The Pharmacy agrees to treat all Eligible Members in all respects no less favorably than Pharmacy treats all other non-Eligible Members. Pharmacy will not set discriminating conditions, or conditions that may reasonably be expected to have a discriminatory effect, or that may cause dilation or rationing of services, against Eligible

Members, or that places a lower priority on Eligible Members than other non-Eligible Members. Pharmacy further agrees that it shall provide all services to Eligible Members in a culturally competent manner, and consistent with the prevailing community pattern of health care delivery. Pharmacy shall not discriminate against an Eligible Member for reason of race, nationality, economic status, social status, gender, sexual orientation, age, origin, religion, color, political ideology, health status or need for health care services, veteran status, physical or mental incapacity.

24. Pharmacy warrants and represents that Pharmacy and each pharmacist is in and shall maintain in good standing with all federal, state, and local regulatory bodies and has and shall maintain in good standing with all federal, state and local approvals, licenses and permits required to operate as a pharmacy at each location and to provide services under this Agreement, including, but not limited to Pharmacist Licenses, Pharmacy License, State Board of Pharmacy, and licenses issued by applicable state agency or regulatory body. Pharmacy will notify **Abarca Health** immediately of any revocation, suspension, limitation, or other action, which could materially impair performance of its obligations under this Agreement. Pharmacy shall immediately notify **Abarca Health** in writing if Pharmacy loses or voluntarily surrenders such licensure, accreditation, permits, authorizations, or approvals, or no longer meets **Abarca Health's** standards.

25. Evidence of such licenses and certifications shall be submitted to **Abarca Health** upon initial credentialing process and at any subsequent written request. The Pharmacy shall notify **Abarca Health** in writing, within not more than five (5), of the suspension, revocation, limitation, restriction, or any administrative action taken by any State Board of Pharmacy or other licensing authorities over the Pharmacy and/or its pharmacists.

26. Pharmacy warrants and represents that at the time of execution of the MPPA, neither it nor any of its employees, contractors, subcontractors or agents are included on the General Services Administrations' (GSA) List of Parties Excluded from Federal Programs and the HHS/OIG List of Excluded Individuals/Entities (collectively, the "Lists"). If The Pharmacy or any of its employees, subcontractors or agents becomes excluded or otherwise fails to divulge exclusion status, Pharmacy shall have the responsibility to: (i) immediately notify **ABARCA** in writing of any person exclusion or suspension status, and (ii) immediately remove such individual, entity, or location that is responsible for, or involved with, Pharmacy's business operations related to this Agreement. If the Pharmacy has been excluded or any employee, subcontractor or agent becomes excluded and is not removed from providing services, **Abarca Health** shall have the right to immediately terminate the Pharmacy from the network. Pharmacies sanctioned by the GSA, OIG, or other regulatory agency, that are not eligible to participate in Medicare, Medicaid, or other Federal health care programs are not eligible to participate in **Abarca Health's** Network. **Abarca Health** will constantly (monthly) monitor the Lists to ensure Pharmacy's compliance with this provision.

27. The Pharmacy agrees to cooperate fully with any applicable Eligible Member grievance, complaint, or appeal procedure, including but not limited to, informing Eligible Members of applicable grievance and/or complaint rights. Further, Pharmacy agrees to cooperate fully with, and provide information requested by **Abarca Health** to enable Payors to conduct and resolve grievances that may be raised by Eligible Members, Payors, or other providers regarding the provision of Covered Services or dispensing of Covered Drugs by Pharmacy.

28. The Pharmacy shall notify **Abarca Health** or its designated agent, of any legal or administrative claim made or action filed against Pharmacy by an Eligible Member, or otherwise which could affect the ability of Pharmacy to carry out the responsibilities required for network participation. Notification must be provided to **Abarca Health** within ten (10) calendar days of receipt of such claim or action.

29. If any taxes, assessments, and/or similar fees ("taxes") are imposed on Pharmacy by any governmental authority for the provision of the Covered Services or Covered Drugs to Eligible Members, Pharmacy shall be responsible for such taxes and shall not pass such taxes on to Eligible Members, Payors or **Abarca Health**, unless specifically required to do so under applicable Laws. In no event shall **Abarca Health** be liable for any taxes or the determination of the amount of taxes.

30. Pharmacy must promptly notify **Abarca Health** in writing of any alleged error, miscalculation, discrepancy, or basis for disputing Pharmacy the correctness or accuracy of any Claim (whether paid, denied, rejected, reversed or otherwise) within one hundred and eighty (180) calendar days after payment is due. Otherwise, Pharmacy will be deemed to have confirmed the correctness and accuracy of the Claims processed and/or paid during that financial cycle. In no event will **Abarca Health** have liability above and beyond the aggregate amount of Claims during such one hundred and eighty (180) calendar day period. To request an adjustment to a Claim payment, Pharmacy must timely submit to **Abarca Health** sufficient documentation to evidence that the Claim was paid incorrectly. This objection and time limitation do not apply with respect to any overpayments that may be made to Pharmacy.

31. For any dispute between the Network Pharmacy and **Abarca Health** arising under the Pharmacy Contract, other than a disputed denial of a Claim, **Abarca Health** shall implement an internal dispute resolution system, which shall include the opportunity for an aggrieved Network Pharmacy to submit a timely written Complaint to the **Abarca Health**. **Abarca Health** shall issue a written decision on the Network Pharmacy's Complaint within fifteen (15) Calendar Days of receipt of the Network Pharmacy's written Complaint. **Abarca Health's** written decision that is in any way adverse to the Network Pharmacy shall include an explanation of the grounds for the decision and a notice of the Network Pharmacy's right to and procedures for an Administrative Law Hearing within ASES.

32. Network Pharmacies disputing the denial of payment for a submitted Claim, or the payment of an amount that is less than the amount for which the Claim was submitted, shall be afforded a term of fourteen (14) Calendar Days to submit a written complaint. **Abarca Health** shall issue a determination regarding such Claims within fourteen (14) Calendar Days.

33. If the Network Pharmacy is not satisfied with the decision on its Complaint within the **Abarca Health's** dispute resolution system, the Network Pharmacy may pursue an Administrative Law Hearing. The parties to the Administrative Law Hearing shall be the Contractor and the Network Pharmacy. ASES shall grant a Network Pharmacy request for an Administrative Law Hearing, provided that the Network Pharmacy submits a written appeal, accompanied by supporting documentation, not more than thirty (30) Calendar Days following the Network Pharmacy's receipt of the Contractor's written decision.

34. Judicial Review. A decision issued as a result of the Administrative Law Hearing provided for in shall be subject to review before the Court of Appeals of Puerto Rico.

35. To the extent sub-contractors are used by the Pharmacy, subcontractors will be held to all the same terms and conditions as the Pharmacy.

36. **Abarca Health** shall process the clean Claims validity and timely submitted by the Pharmacy for Covered Services rendered and Covered Drugs dispensed to Eligible Members within the timeframe established by Law and the MPPA.

37. **Abarca Health** shall collect from Payor the amount necessary to pay Claims submitted to by the Pharmacy.

38. Subject to Article 2 of the MPPA, **Abarca Health** shall pay the amount of such validly submitted Claims to the Pharmacy. Payments shall be made not more than thirty (30) days after the end of each billing processing period (within fourteen (14) days after an electronic claim is received and within thirty (30) days of the date on which non-electronically submitted claims are received in the case of Medicare beneficiaries), but in all cases after receipt of complete and adequate payment to **Abarca Health** from the corresponding Payors. Pharmacy will accept as payment in full for Covered Services and Covered Drugs rendered to Eligible Members.

39. In no event shall **Abarca Health** be obligated to pay Pharmacy for Covered Services or Covered Drugs, unless and until payment for such Covered Services or Covered Drugs is received from the Payor responsible for such payment. **Abarca Health** has no liability to Pharmacy for nonpayment or for any delay in payment from a Payor. Any amounts owed by Pharmacy to **Abarca Health** (including but not limited to, overpayments from Claim reversals, errors, inaccurate submissions, or otherwise)

shall become immediately due and owing to **Abarca Health**. In such case, **Abarca Health** will have the right to set-off without notice the amount of overpayment from future payments. Pharmacy agrees not to affect any accord and satisfaction through a payment instrument or accompanying written communication and not to conditionally or restrictively endorse any payment instrument; and **Abarca Health** shall not be bound by any such attempt or endorsement. **Abarca Health** further reserves the right, in its sole discretion, to require pharmacy to assign to **Abarca Health** any collection rights Pharmacy may have against any person.

40. **Abarca Health** shall have the right to charge Pharmacy at cost, for re-issuing checks made to Pharmacies hereunder as a result of Pharmacies acts or omissions.

41. HIPAA Compliance - **Abarca Health** shall not use or disclose Protected Health Information in any manner that violates the final HIPAA patient privacy standards as set forth in 45 CFR, Sections 160 and 164, or any related rule or regulation, as amended

42. The Pharmacy shall maintain proper records and files in its system with information regarding all Covered Drugs dispensed and Covered Services rendered to Eligible Members as required by **Abarca Health**, by Law, or by appropriate regulatory authorities. All records relating to Covered Services rendered and Covered Drugs dispensed to Eligible Members must be retained for a period of at least ten (10) years, unless a longer period is required by law. For additional requirements and reimbursement to the Pharmacy in connection with the Medicare Part D Program. **Abarca Health** may withhold, deny, or chargeback payments where records and logs are not maintained as required in the MPPA.

43. For a period of five (5) years after a pharmacy leaves the **Abarca Health** pharmacy network (or such longer period prescribed by law), the Pharmacy shall provide **Abarca Health**, its clients and its duly authorized agents free access during the Pharmacy's regular business hours, and upon reasonable written notice, to all books, records, invoices, and prescription files of the Pharmacy deemed necessary by **Abarca Health** to verify any Claim information or information related to any Covered Service or Covered Drug.

44. The Pharmacy shall provide access to its records to any federal or state government agency and/or its duly authorized representatives which have jurisdiction and provide oversight to the operations of **Abarca Health** and/or the practice of pharmacy.

45. Pharmacy shall maintain the confidentiality of all records and information relating to Eligible Members in accordance with all applicable state and federal laws, rules and regulations, including, without limitation, the federal privacy regulations promulgated under HIPAA.

46. The Pharmacy's contractual term is as defined between in Pharmacy and **Abarca Health** and will continue for one (1) year increments unless terminated by either party not less than ninety (90) days prior to the end of the Agreement.

47. Either party may terminate the Agreement in the event of any breach by the other party that is not cured within thirty days (30) after written notice of such breach has been sent to the breaching party.

48. This Agreement may be terminated at any time without cause by either party by providing ninety (90) days' prior written notice to the other party.

49. In the event that (i) either party files a petition for bankruptcy, reorganization, or an arrangement with creditors, (ii) either party makes an assignment for the benefit of creditors, (iii) either party fails to pay or admit in writing its inability to pay its debts as they become due (unless there is a bonafide dispute), (iv) a trustee, or other custodian is appointed for either party, or (v) any other case under any bankruptcy is commenced with respect to either party, then the other party may terminate the Agreement effective immediately without having to give notice and an opportunity to cure.

50. **Abarca Health** shall also have the right to terminate this Agreement immediately, without prior written notice to the Pharmacy, if (i) any of the Pharmacy's licenses or certifications is revoked or suspended, (ii) the performance by the Pharmacy pursuant to the Agreement is, in the discretion of **Abarca Health**, determined to be illegal or in violation of any federal, state or state law, rule or regulation, including, cases of Fraud, Waste & Abuse; (iii); **Abarca Health's** Pharmacy Networks Provider program is terminated for any reason; (iv) Pharmacy assigns or purports to assign any of its rights hereunder to any party without **Abarca Health's** prior written consent; (v) there is any change in the underlying ownership (legal, equitable, or beneficial) of Pharmacy, whether such change of ownership is by sale, assignment, operation of law (e.g., merger or consolidation) or otherwise; or (vi) as otherwise provided in the MPPA; (vii) failure to respond to recredentialing request or audit; (viii) omitting information or providing inaccurate data on the credentialing or recredentialing application and; (ix) failure to complete and attest the annual Fraud, Waste and Abuse Training and General Compliance training.

51. In the event of termination or breach of the Agreement, in addition to all other rights and remedies **Abarca Health** may have at Law, equity, or under this Agreement, **Abarca Health** shall have the right, upon notice to Pharmacy, to: (i) deduct from any amounts owing to Pharmacy any amount which Pharmacy owes to **Abarca Health**; (ii) impose reasonable investigation, collection, audit and similar fees with respect to any breach of this Agreement; (iii) suspend performance of any and all of **Abarca Health's** obligations under or in connection with the Agreement, including, without limitation, **Abarca Health's** obligation or process claims; and/or; (iv) suspend Pharmacy's performance of any or all of Pharmacy's obligations under or in connection

with the Agreement. In the event of termination, Pharmacy shall submit all Claims for Covered Services or Covered Drugs before the date of termination within thirty (30) calendar days after the date of termination unless a longer period is required by law). Any rights to payment for any Claim submitted after such time, whether or not the same would qualify as a Claim, shall be deemed forfeited, and Pharmacy agrees to hold **Abarca Health**, Payors, and each of their respective employees, shareholders, members, officers and directors and the Eligible Member receiving the Covered Service or Covered Drug harmless for any expense associated therewith. Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. The termination rights hereunder are in addition to any and all other rights and remedies that may be available to **Abarca Health** under the MPPA.

b. Grievances and Appeals (All Clients, except ASES)

Abarca Health is committed to provide uniform, fair and prompt management of pharmacy providers' administrative complaints. **Abarca Health** is committed to ensure any pharmacy providers complaints and grievances are resolved as effectively, fairly, and as quickly as possible. The pharmacy can submit a grievance for any of the following reasons:

- Status change within the network; or
- Competency or conduct; or
- Amount paid; or
- Outcome of the Drug Price Appeal Request; or
- Audit adjustment; or
- System, operational and service problems; or
- Distribution channel contractual issues.

A grievance must be submitted in writing, via certified mail, using the **Pharmacy Provider Complaint Form** outlining the nature and extent of the problem (See Exhibit II or at www.abarcahealth.com).

1. The form must be sent via certified mail to:

   Abarca Health
   Attn: Network Strategy Team
   650 Ave Muñoz Rivera Ave, Suite 701
   San Juan, Puerto Rico 00918

2. Within 3 business days of receipt, **Abarca Health** will contact the pharmacy by phone to have an initial discussion about the complaint.

3. If necessary, **Abarca Health** will arrange for an in-person meeting with the pharmacy provider at the **Abarca Health** corporate office to further discuss the situation.

4. A written response with a proposed resolution to the complaint will be provided to the pharmacy provider within 30 days of receipt of the Pharmacy Provider Complaint Form. The response will include instructions on how the pharmacy provider can appeal the decision if the pharmacy provider is not satisfied with the resolution.

5. If the pharmacy provider is dissatisfied with the resolution, the pharmacy provider has 60 days to send a written letter, via certified mail, appealing **Abarca Health's** decision to the following address:

   Abarca Health
   Attn: Network Strategy Team
   650 Ave Muñoz Rivera Ave, Suite 701
   San Juan, Puerto Rico 00918

6. Within 15 business days of receipt, the appeal will be evaluated by **Abarca Health's** Quality Management Committee team, including a representative from the Plan Sponsor as required.

7. No less than three (3) members of the Quality Management Committee will conduct a hearing with the pharmacy provider, upon the merits of the dispute, within 30 working days of receipt of the appeal, unless the parties agree to a longer time.

8. Within five (5) working days from the date of the hearing, the Quality Management Committee shall issue, in writing, a decision on the dispute with the pharmacy provider.

No further appeal for the same issue will be permitted.

c. Grievances and Appeals (ASES – PR Medicaid)

Abarca Health is committed to ensuring all pharmacy providers' complaints and grievances are resolved as effective, fair, and quick as possible. Furthermore, Abarca is committed to ensuring that the resolution of any pharmacy provider complaints and grievance follows standard procedures and comply with federal and local government requirements. The grievances and appeals process is intended to provide a standard dispute resolution process to cover the following:

- Status change within the network;
- Competency or conduct;
- Amount paid;
- The outcome of a drug price appeal request;
- Audit adjustment;
- A system, operational and service problems;
- Distribution channel contractual issues.

1. Overview

1.1. Please refer to Exhibit IV: Dispute Resolution Workflows

1.2. When a pharmacy provider has a concern or complaint, **Abarca Health** will direct all efforts to resolve the issue to the satisfaction of the pharmacy provider.

1.3. In the event the issue cannot be resolved, the pharmacy provider may request it be handled according to the formal grievance policy.

1.4. Network Pharmacy Complaints Concerning Denied Claim: If a pharmacy and **Abarca Health** cannot agree on a denied claim, the pharmacy submits a request for a mutually agreed upon independent third party to review the denied claim. A decision is rendered within 30 days from the date of the request for mediation. The third-party fees are covered by the party adversely affected by the decision, and that party has the right to pursue an appeal.

1.5. Pharmacies disputing the denial of payment for a submitted Claim, or the payment of an amount that is less than the amount for which the Claim was submitted, shall be afforded a term of fourteen (14) Calendar Days to submit a written complaint. **Abarca Health** shall issue a determination regarding such Claims within fourteen (14) Calendar Days.

1.6. Network Pharmacy Disputes Arising Under the Pharmacy Contract: **Abarca Health's** Pharmacy Disputes process protects a pharmacy's right to submit a formal dispute. **Abarca Health** contacts the pharmacy within three business days of receipt of the formal dispute, and if feasible **Abarca Health** invites the pharmacy to meet in person. If **Abarca Health** cannot resolve the dispute after contacting the pharmacy, then we provide a written decision to the pharmacy within 15 business days from receipt of the dispute. The notification will include the pharmacy's appeal rights.

1.7. When a formal complaint is filed, the process defined below must be followed.

2. Initial Procedure

2.1. The pharmacy provider must first submit a Pharmacy Provider Complaint Form outlining the nature and extent of the problem to **Abarca Health's** Network Strategy team (See Exhibit IV).

2.2. The form must be sent via certified mail to:

Abarca Health
Attn: Network Strategy Team
650 Ave Muñoz Rivera Ave, Suite 701
San Juan, Puerto Rico 00918

2.3. The Network Strategy team will immediately upon receipt add the complaint to the Pharmacy Grievances & Appeals log housed within the **Abarca Health** SharePoint site and provide the complaint form to the Network Strategy Manager.

2.4. Within 3 business days of receipt, the Network Strategy Manager will contact the pharmacy by phone to have an initial discussion about the complaint.

2.5. If necessary, the Network Strategy Manager or delegate will arrange for an in-person meeting with the pharmacy provider at **Abarca Health's** corporate office to further discuss the situation.

2.6. A written response with a proposed resolution to the complaint will be provided to the pharmacy provider within 30 days of receipt of the Pharmacy Provider Complaint Form. The response will include instructions on how the pharmacy provider can appeal the decision if the pharmacy provider is not satisfied with the resolution.

2.7. Any additional information discovered during this process will be managed according to relevant contract provisions.

3. Appeals

3.1. The pharmacy provider must send within 30 days of **Abarca Health's** decision an appeal in writing, via certified mail, to the following address:
Abarca Health
Attn: Network Strategy Team
650 Ave Muñoz Rivera Ave, Suite 701
San Juan, Puerto Rico 00918

3.2. The Network Strategy team will immediately upon receipt add the appeal to the Pharmacy Grievances & Appeals log housed within the **Abarca Health** SharePoint site and provide the appeal letter to the Network Strategy Manager, who will in turn immediately inform the Quality Management Committee.

3.3. Within 15 business days of receipt, the appeal will be evaluated by **Abarca Health's** Quality Management Committee team, including a representative from the plan sponsor, as required. If **Abarca Health's** written decision is in any way adverse to Pharmacy, then **Abarca Health** shall include an explanation of the grounds for the decision and a notice of Pharmacy's right to and procedures for an Administrative Law Hearing within ASES.

3.4. If Pharmacy is not satisfied with the decision on its Complaint within **Abarca Health's** dispute resolution system, Pharmacy may pursue an Administrative Law Hearing within ASES. The parties to the Administrative Law Hearing shall be **Abarca Health** and Pharmacy. ASES shall grant a Pharmacy request for an Administrative Law Hearing, provided that Pharmacy submits a written appeal, accompanied by supporting documentation, not more than thirty (30) Calendar Days following the Pharmacy's receipt of **Abarca Health's** written decision, unless the parties agree to a longer time.

3.5. Within five (5) working days from the date of the hearing, the Quality Management Committee shall issue, in writing, a decision on the dispute to the pharmacy provider.

3.6. **Abarca Health** commits to full contract compliance with the ASES GHP Administrative Law Hearing process. We will ensure written notice for Complaints and Disputes properly informs the pharmacy of their right to pursue an Administrative Law Hearing with ASES GHP.

No further appeal for the same issue will be permitted.

d. Level of Effort for Compounding

1. **Abarca Health** shall reimburse the Participating Pharmacy for each covered drug dispensed at the lesser of submitted cost, "Usual and Customary," gross amount due or applicable reimbursement terms, reduced by any applicable copayment received.

2. **Abarca Health** will pay the Participating Pharmacy an administration fee as contracted.

3. Compound Drug Claims submitted to **Abarca Health** are required to be submitted with a Level of Effort (LOE) code where applicable. Compound Drug Claims that require an LOE code and are not submitted with an accepted value will be subject to claim rejection; applied default with an LOE of 1; or standard network reimbursement.

e. Provider Accreditation

Provider Accreditation is the process through which **Abarca Health** verifies pharmacy provider licenses, certificates, procedures, and other defined parameters required by federal and state laws and regulations to operate a pharmacy. The following documents must be provided to **Abarca Health** during the Credentialing Process:

- Credentialing Application
- Department of Health Pharmacy State License
- Full Unrestricted DEA Certificate 2-5
- State Controlled Dangerous Substance Certificate (ASSMCA for PR)
- Federal Tax ID Certificate
- Pharmacist-in-Charge State License
- Pharmacist-in-Charge Registration (Puerto Rico)
- Medicare ID Award Notice (if applicable)
- Medicaid Provider Notice (if applicable)
- Sterile Compounding Certification (if applicable)
- Immunization Certificate (if applicable)
- Biological Products License (Puerto Rico)
- Certificate of Good Standing
- Certificate of Incorporation (if applicable)
- Patente Municipal (Puerto Rico)
- Photos of pharmacy
- Evidence to support insurance coverage for Professional and Commercial Liability that meets the minimum defined in the Pharmacy Provider's Agreement.
- Fraud, Waste, and Abuse (FWA) and Compliance Attestation

- W9

To ensure compliance with **Abarca Health's** Credentialing Process requirements, the pharmacy is responsible for submitting any updates to the documents described above.

f. Significant Business Transactions Disclosure (ASES – PR Medicaid)

Providers should be aware that if Administración de Seguros de Salud de Puerto Rico (ASES) or the Department of Health and Human Services (HHS) requests information related to Business Transactions under 42 C.F.R. § 455.105, they must provide the requested information within 35 days. This includes any pharmacy that enters any business transaction with any Subcontractor totaling more than $25,000 in the previous twelve (12) month period and has not entered any significant business transaction with a wholly owned supplier during the previous years.

g. Pharmacy Information Update

Every pharmacy that belongs to **Abarca Health's** network must update their information in the "National Council for Prescription Drug Program" (NCPDP). Provider's Division will use the demographic information placed in this database to send important information to the pharmacies, including their payments.

h. Provider Payments

Abarca Health will pay the amount of such validly submitted claims to pharmacies not more than thirty (30) days after the end of each billing processing period (within fourteen (14) days after an electronic claim is received and within thirty (30) days of the date on which non-electronically submitted claims are received in the case of Medicare beneficiaries), but in all cases after receipt of complete and adequate payment from the corresponding payors.

i. Document Retention

Pharmacies must retain all original prescriptions and Signatures Logs (paper or electronic). This information must be available in case of an audit made by **Abarca Health** or any other regulatory agency (state or federal). For more details, please refer to Exhibit III.

j. Confidentiality and Discrimination

According to the "Health Insurance Portability and Accountability Act" (HIPAA), the pharmacy must not discriminate against a beneficiary for reason of race, color, national origin, sex, creed, civil status, sexual orientation, and age, physical or mental disability. The pharmacy must comply with the final HIPAA patient privacy standards as set forth in 45 CFR, Sections 160 and 164.

Medication Safety

▲ Consumer Safety Communication

As necessary and upon contracting by our clients, **Abarca Health** will send out a communication to the pharmacy network when there is a ug recalls, drug shortages, drug discontinuations, or any safety alerts to secure the appropriate use of drug therapy and to

safeguard the beneficiaries' quality of life. This communication will contain information on the specific risk, consumer-level education, and the proper handling and disposal of the product. **Abarca Health** will send this communication via email and fax blast as well as upload it in the Operation Portal within five (5) calendar days from Federal Drug Administration (FDA) notification for Class I or Class II recalls. Depending on the impact of a drug shortage in the market, communication via email and fax blasts will be sent as well as uploaded the Operational Portal.

▲ Medication Error

A medication error is any preventable event that could lead to the inappropriate use of medications or cause harm to the patient, while the medication is under the control of a professional, patient and/or caregiver. This could occur but is not limited to mistakes in the process of prescribing, dispensing, or administering a drug. According to the Academy of Managed Care Pharmacy (AMCP), medication errors affected the safety of patients, impacting at least 1.5 million people each year. In turn, the Institute of Medicine (IOM) warns the cost of treating medication errors in hospitals raised to $ 3.5 billion a year.

TYPES OF ERRORS IN MEDICATION:

Medication errors are subdivided into two major categories: **omission errors** and **commission errors.**

- **Error of Omission: stop doing an activity voluntarily or involuntarily that is necessary for safety.**
  - Example: Failing to warn the patient about a significant side effect with a new medication in their therapy.
- **Commission error: incurring a fault for an action taken.**
  - Example: Prescribe and/or dispatch bupropion to a patient with a history of epileptic seizures.
    - Bupropion lowers the threshold of an epileptic attack predisposing the patient to suffer one.

SOME COMMON CAUSES OF MEDICATION ERRORS

Cause	Error Type
Illegible prescription	The medicine, dose or route of administration is selected incorrectly.
Allergies	Allergies are not asked, and medications are prescribed that the patient cannot tolerate or are contraindicated, causing adverse effects.
Concomitant use of medications	If the patient is not asked or their medication history is verified, they can omit interactions, duplicities, and contraindications.
Instruments used by pharmacies	Poorly calibrated scales, poorly calibrated automatic pill counters, and poorly stored medications in medication dispensing robots.

Patient education	No education is offered on the proper use of the medication.

MEDICATION ERRORS IDENTIFIED IN ABARCA

At **Abarca Health**, we have a process to identify and report medication errors. Errors can be identified in the Coverage Determinations Department, the Pharmacy Call Center, or in the Clinical Programs Department.

- A quarter of these errors occur at the pharmacy, either because the medication was processed incorrectly (although being written correctly by the prescriber, 14%), or the medication was processed correctly but was incorrectly dispensed (11%).
- Most errors occurred in the administration of the medication (55%), either by the patient or by the caregiver. This points out the importance of proper patient education on the indicated use of the drug.
- Errors can be prevented at any stage in the medication delivery process.

RECOMMENDATIONS TO AVOID MEDICATION ERROR

1. Prescriptions should always be reviewed by a pharmacist to validate medications before dispensing. Any prescription that is incomplete, illegible, or with error must be clarified before being dispensed.
2. Having access to the medical profile of the patients can allow a complete review of the prescription.
3. The patient should be educated to perform a reconciliation of his/her medications monthly.
4. When dispensing medications, the dispensing area should be avoided to prevent mistakes. It must have adequate lighting, temperature control, and noise level and not cause distractions. Regarding the workflow, the pharmacy must have an adequate number of resources and employees according to the volume of prescriptions.
5. Pharmacy inventory should be organized in a way that helps to differentiate between one medicine and another. Consider separating those medications that have a similar label or a name that is like another.
6. The pharmacy must have a dispensing procedure with multiple checkpoints to identify error and prevent errors from going beyond the point of sale.
7. Patients must be educated regarding the physical appearance of medications so that they can recognize if it is appropriate at the time of delivery, thus adding additional checkpoints at the end of the chain. Educating patients if their medication looks different due to changes in manufacturer helps to avoid medication errors.
8. Avoid using non-recommended medical abbreviations and if there are any and have doubts, check with the doctor for the correct medication instructions prior to dispensing.

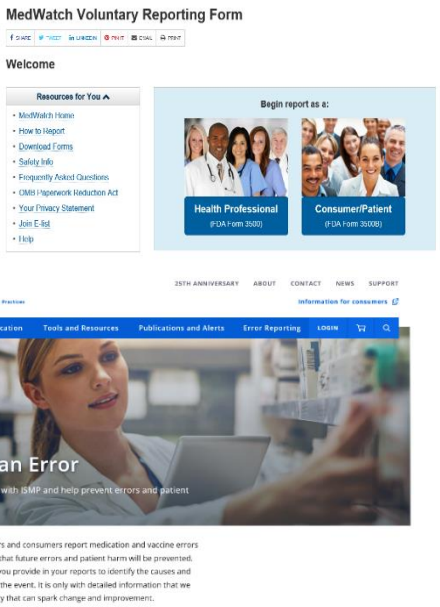
WHAT TO DO WHEN MEDICATION ERRORS OCCUR?

Medication errors should not be deliberately made. When these occur, there is a misconception of judging the professional involved in the incident, including administrative criticism, suspension, or revocation of licenses. However, we must ask ourselves, which checkpoint of the system was the one that failed? Capturing a medication error and preventing it from reaching the patient should set a precedent that helps recognize areas of opportunity to optimize the medication delivery process.

HOW TO REPORT ERRORS IN MEDICATION?

Reporting errors is important to identify patterns and possible strategies to promote safe drug use practices. Two main portals where serious medication errors can be reported include:

- The **FDA MedWatch** program allows healthcare professionals and patients to voluntarily report adverse events, therapeutic failure, medication errors, problems with product quality, and therapeutic equivalency failures of FDA regulated products. In the case of medication errors, the FDA reviews over 1,400 errors monthly, which are then analyzed to determine the cause and type of error. You can report medication errors through the MedWatch website:



https://www.accessdata.fda.gov/scripts/medwatch/index.cfm

- The Institute for Safe Medication Practices (ISMP) is a nonprofit organization notified of the evaluation, reporting, and handling of medication errors. Through its functions, the ISMP evaluates the causes of medication errors to recommend changes in clinical practices, public policy, labels, and packaging of medicines to promote safe practices in the use of medicines. You can report medication errors through the ISMP Medication Error Reporting Program (MERP) website: https://www.ismp.org/report-medication-error

Fraud, Waste, and Abuse

Health care fraud is a major policy concern. The impact of health care fraud and abuse is widespread, resulting in higher healthcare costs. The National Health Care Anti-Fraud Association (NHCAA) estimates conservatively that 3% of all health care spending is lost to health care fraud. As fraud and abuse cases are on the rise, several regulations have been strengthened or

amended for the purpose of preventing improper payments, detecting vulnerabilities, and increasing program oversight.

Abarca Health has a policy of zero tolerance against fraud, waste, and abuse of pharmacy benefits. To prevent, detect, and control possible cases of fraud, waste, and abuse, the **Abarca Health** has developed and implemented specific processes and requirements that ensure pharmacies within our Network comply with state and federal laws and regulations that apply. Accordingly, Pharmacies should be aware of the following situations:

- ***Altered or forged prescriptions*:** Occurs when a prescription shows different handwriting, signatures, orthographical errors, and misspelling in drug names.
- ***Prescription pad or Prescriber's DEA license Theft and Forgery*:** Usually these are stolen to write fraudulent prescriptions or altering a prescription to obtain an unauthorized quantity of prescribed drugs.
- ***Identity theft*:** It takes place when the health insurance cards, or identifications of eligible members are used to obtain services or prescriptions for a different person.
- ***Doctor or Pharmacy Shopping*:** Occurs when beneficiaries obtain multiple prescriptions for drugs of abuse from different physicians/pharmacies.
- ***Inappropriate billing practices*:**
  - Incorrectly billing for secondary payers to receive increased reimbursement.
  - Billing for non-existent prescriptions.
  - Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions.
  - Billing for brand when generics are dispensed.
  - Billing for non-covered prescriptions as covered items.
  - Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up).
  - Prescription splitting to receive additional dispensing fees.
  - Drug diversion.
  - Inappropriate use of Dispense as Written ("DAW") codes.
- ***Prescription drug shorting:*** happens when 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*:** 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.
- ***Unauthorized refills*:** occurs when existing prescriptions are altered, by an individual without the prescriber 's permission to increase the number of refills.
- ***Troop manipulation:*** occurs when a pharmacy manipulates Troop to either push a Medicare Part D beneficiary through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible or manipulates Troop to keep a beneficiary in the coverage gap so that catastrophic coverage is never realized.

a. Anti-Fraud Program

To comply with state and federal laws and regulations as well as CMS guidelines, the **Abarca**

Health has developed and implemented an *Anti-Fraud Program* to help in the prevention, detection, and control of possible cases of fraud, waste, and abuse of the pharmacy benefit. The following elements are part of the FWA Program:

- ***Monitoring/Auditing Activities and Data Analysis:***

  Monitoring/Auditing activities are performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. Data analysis includes the comparison of claim information to identify unusual patterns suggesting potential errors and problem areas.

- ***Fraud, Waste and Abuse Training:***

  The pharmacy staff of pharmacies participating in the **Abarca Health's** pharmacy network are required to receive training on the detection, prevention and control of fraud, waste and abuse and compliance related to the pharmacy benefit. Such training must take place at least on an annual basis. Currently, **Abarca Health** uses the training provided by CMS. The training can be found on the Provider's Portal at: https://providers.abarcahealth.com/

- ***Sanctions/Exclusions Provider Reviews:***

  Abarca Health has established procedures that will reject at the Point of Sale (POS) claims submitted or prescribed by individuals or entities excluded by the Office of Inspector General (OIG) and/or the General Service Administration (GSA). In addition, **Abarca Health** will not contract with any provider that is included in such exclusion's lists.

  Finally, per CMS requirements, these lists are revised monthly to ensure none of the current employees, delegated entities or contractors have been recently excluded.

- ***FWA Hotline:***

  The **Abarca Health** Compliance and FWA anonymous hotline number is 1-866-991-7422. Employees and delegated entities (including participating pharmacies) can also report Compliance /FWA issues anonymously.

  In addition, for confidential reports, employees and Delegated entities may report FWA or Compliance Issues to the following email address: fwareferrals@abarcahealth.com or issuealert@abarcahealth.com

  Or to the following mailing address:
  Abarca Health

Compliance Department
Suite 701, 650 Ave. Muñoz Rivera
San Juan, PR 00918-4115

Informants are reminded that the information they provide will be treated as confidential. Reprisals are prohibited when reporting an act in good faith.

Pharmacy Audits

Abarca Health has developed and implemented a *Program* to help in the prevention and detection of fraud, waste, and inappropriate payments of the pharmacy benefit. Auditing of pharmacy claims is an essential part of the *Program*. Pharmacy audits help ensure consistent and accurate electronic submission of prescription claims, by the pharmacy network.

According to the *Master Pharmacy Provider Agreement* between **Abarca Health** and the pharmacies participating in the Network, ABARCA, Payor, the Comptroller General of the United States, the Department of Health and Human Services and CMS, and their respective duly authorized representatives or designees, as applicable, shall have the right, to review, audit, examine, and reproduce any of Pharmacy's books, records, prescription files, and other documentation pertaining to Covered Services rendered or Covered Drugs dispensed to Eligible Members and/or Pharmacy's compliance with the Agreement.

Pharmacy Audits are directed to identify any Claims discrepancy, which include, but are not limited to: Pharmacy billed for brand, but dispensed generic; days' supply or quantity dispensed different from the written prescription, missing hard copy prescriptions, bioequivalent exchange without Eligible Member's signature, Claim submission with erroneous DAW Code, incorrect refills submission, submission of Claims with National Prescriber Identification Numbers that do not correspond to the prescribing Physicians, incorrect NDC number or number of units billed; Claims billed as a compounds that are not written as compound or vice versa, among others.

a. Types of Audits

The following types of audits are contemplated in the audit program. **Abarca Health** reserves the right to employ other types of audits as deem pertinent.

Retrospective Audits may be conducted using a detailed analysis of the total volume of claims submitted by a pharmacy during a specific period.

Desk Audits:

Abarca Health's audit program establishes a plan for desk audits in accordance with utilization analyses that may help to identify certain claims that were incorrectly submitted by the pharmacy and irregular patterns for specific drug classes, among others. Some examples of Desk Audits include:

- Unusually high quantities or daily supply.

- Discrepancies between the submitted quantity of a drug, the unit of measure and the product packaging.
- Errors in the ingredients and quantities when processing compound prescriptions.
- Beneficiaries/physicians with high utilization of controlled drugs (i.e., narcotics, benzodiazepines, etc.)
- The appropriate submissions for the Opioids override Safety edits
- Beneficiaries that obtain multiple prescription drugs from different physicians outside the geographical area of their residence.
- The appropriate billing during the Coordination of Benefits (COB)

On-site Audits:

Abarca Health's Pharmacy Integrity Program sets forth the number of pharmacies to be physically audited during the year. As part of the on-site audit process, the Company shall examine the following documents and/or parameters (among others):

- Prescription orders and claims files
- Invoices
- Pharmacy licenses
- Signature Logs (for prescription drugs dispensed to beneficiaries and/or beneficiary representatives)
- Records of purchases
- Compliance with the pharmacy's good practice
- Others, as required
- Daily Claims Review

The purpose of this process is to identify claims that were incorrectly submitted by the pharmacy so that these claims can be corrected prior to payment through a reversal and rebilling process. Some examples of situations identified during the concurrent review are:

- Overbilled Quantities or Day's Supply.
- High-Cost Drugs
- Refill Too Soon and Duplicate Therapies
- Compounds

Referral or Investigational Audits:

Referral Audits are audits based on specific information and/or requests from our clients, **Abarca Health** employees, or beneficiaries and which may refer to possible cases of fraud, waste, and abuse.

b. Audit Triggers

Several situations may conceivably trigger an audit of a pharmacy, including:

- Pharmacy billing history.
- Requests or referrals received from clients, plan sponsors, pharmacies, beneficiaries, and government agencies.
- Referrals for potential Fraud, Waste and Abuse.

- Routine monitoring, identification of compliance risks and risk assessment of pharmacies.
- Patterns of errors or discrepancies identified during concurrent claims reviews.
- A succeeding audit as part of a *Corrective Action Plan (CAP)*. Corrective actions are designated to eliminate problems accountable for program violations and to prevent future misconduct.

c. Record Maintenance and Access

Pharmacies must maintain proper records and files in its system with information regarding all covered drugs dispensed and covered services rendered to eligible members as required by A **Abarca Health**, by Law, or by appropriate regulatory authorities. All records relating to covered services must be retained for a period of at least ten (10) years unless a longer period is required by law.

Abarca Health will use commercially reasonable efforts to minimize the disruption that such audit may cause to a pharmacy's operation. For on-site audits, pharmacies are encouraged to designate a suitable area to conduct the on-site audit. For example, a secure, clean and private workspace near an electrical outlet is ideal for an on-site audit. This will minimize interruption with the daily operation of the pharmacy. In addition, during on-site Audits, the pharmacy must guarantee enough personnel to assist with the process.

Pharmacies must maintain the confidentiality of all records and information relating to eligible members in accordance with all applicable state and federal laws, rules, and regulations, including, without limitation, the federal privacy regulations promulgated under HIPAA.

If **Abarca Health** is denied admission to the pharmacy or if the pharmacy does not timely present requested documentation and records, **Abarca Health** may deem 100% of the claims to be audited as noncompliant and a recovery of the payment for those claims will be made.

Additionally, if the pharmacy refuses to collaborate with the audit process they could face penalties and or termination of the contract.

d. Audit Timeframe

Unless fraud is suspected, the period of claims subject to audit and recoveries can go back for a period of up to twenty-four (24) months. However, in the event of suspicion of fraud, the audit can go back to a period of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

e. Document Requirements

Participating network pharmacies agree to allow **Abarca Health's** auditors to review all the necessary and relevant information for the audit process, including copy, photocopy, photograph, or use digital camera photography, for all prescriptions, profiles and other records relating to the rendering of covered services or dispensing of covered drugs to eligible

members.

Following industry standards, applicable laws, rules and regulations, auditable documents that may be required or requested could include:

- All prescription order copies in the original form (paper or e-prescription).
- Patient signature logs.
- Pharmacy records stored electronically.
- Compounded information of prescriptions.
- Pedigree invoices.
- Wholesaler, manufacturer, or vendor invoices.
- Prescription labels.
- Bill of Sale.
- All applicable licenses for the pharmacy, pharmacist(s) and technicians:
  - Drug Enforcement Agency (DEA) License
  - State Licenses
- Prescriber information.

f. Insufficient Documentation

The following documents will not be accepted as the equivalent of a valid prescription order:

- Records of medication administration.
- Prescription labels.
- Physician progress notes or medical records without the elements required for a valid prescription.
- Systems screens or images; excluding electronic prescriptions.
- Prescriptions sent by fax, electronic mail or digital images without the original prescription presented.

g. Signature Log Requirements

Participating network pharmacies must maintain a “Signature Log” that contains the fill date, prescription number, and date of delivery, pharmacist’s signature, and signature of the covered person (or valid designated representatives) receiving the prescriptions. The signature logs will be required to confirm the delivery of the prescriptions processed by the pharmacy by pick-up or delivery. **Abarca Health** accepts either paper or electronic signatures as proof of delivery. For those cases in which the medication must be delivered by other means, the following will be required:

- Home Delivery Pharmacy: the pharmacy must obtain the signature of the member of his/her designee at the time of delivery
- Mail Order Pharmacy: the pharmacy must obtain the tracking of the shipment and confirmation of delivery.

Abarca Health requires timely reversals of processed prescriptions when a patient or a patient's authorized representative has not picked up his/her medication within 15 days of the date of service. A pharmacy is required to reverse the claim and the amount paid adjusted.

Pharmacies must retain all the Patient's Signatures Logs (paper or electronic) for a period of ten (10) years or as required by law. If the signature log is not provided during the audits, the claim will be adjusted, and paid amounts recovered.

h. Prescription Requirements

Abarca Health will accept as a valid documentation during the audit, the written hard copy prescription, fax prescription, telephone prescription electronically generated prescription written by a licensed physician.

- The prescription order must have the date on which it was prescribed by the physician. If the prescription does not have the date the claim will be adjusted.
- The prescription orders must have the complete name, age (date of birth could be accepted) and address of the patient. If the prescription is for a controlled substance medication and does not contain this information, the claim will be adjusted.
- The prescription order must have the complete name, address, telephone number, signature, and licenses of the prescribing physician (state license, and/or DEA and/or NPI and/or the NPI must coincide with the electronic transmission). If none of the physicians' licenses are written in the prescription or if the submitted license is different from the written license information, the claim will be adjusted.
- Name of the medication prescribed with its form, dosage, potency, and amount.
- Quantity dispensed must be equal to quantity written on the prescription order. If quantity dispensed is greater than the quantity prescribed an adjustment will apply equal to the quantity dispensed in excess.
- The prescription order must have quantity of the drug and indications for use by the patient (dosing) and include refills, if applicable. This information shall not be altered and shall be submitted correctly through the electronic system for adjudication. Any modification to the prescription order shall carry the initials of the prescribing physician, or the pharmacist in consultation with the physician. If initials of the physicians or the pharmacist are not in the prescription order, the claim will be adjusted.
- The prescription order must have the signature and license of the pharmacist dispensing the order.
- In the event of a bioequivalent exchange, the prescription order must contain the signature of the pharmacist dispensing the prescription and the patient that authorizes the substitution. Such generic substitutions take place if the prescribing physician does not expressly indicate the contrary on the prescription order ("no substitution"/"do not substitute"). If the patient's signature or the pharmacist's signature does not appear on the prescription order, the claim will be adjusted.
- The pharmacist may complete any information not appearing on the prescription by recording the same on the back of the prescription, after having verified the same with the prescribing professional or the patient, as may correspond.

- After verification with the patient, the pharmacist may complete the following information:
  - Patient's name, address, and age.
- After verification with the prescriber, the pharmacist may complete the following information:
  - Written date of the prescription, name of the medication prescribed with its form, dosage, potency, amount, and indications.

- Prescriptions transmitted by fax, electronic mail, verbally or digital images:
  - To speed up filling a prescription, the information may be transmitted verbally or by electronic means by the patient, representative or by the prescribing professional to the pharmacy.
  - The pharmacist shall transcribe the prescription transmitted orally upon receipt. Both the prescription transmitted orally, and the prescription transmitted by electronic means (fax, e-mail, image) shall include all the data required for a valid prescription, and record date and time of the transmission.
  - The patient or representative shall hand over the original prescription to the pharmacist at the time of receiving the prescribed medication.
  - This will not be applicable to prescriptions generated and transmitted electronically (e-prescriptions).

- Dispensing Prescriptions for Emergency cases transmitted by fax, electronic mail, verbally or digital images:
  - In emergency cases, a prescription may be transmitted orally or by electronic means directly by the prescribing professional to the pharmacy selected by the patient. The pharmacist shall transcribe the prescription transmitted orally or by electronic means upon receipt.
  - The pharmacist shall record the date and time when the transmission was made and shall dispense a limited amount of the medication which shall not exceed the amount needed for a period of one hundred twenty (120) hours.
  - The prescribing professional who provided the contents of the prescription orally or by electronic means shall deliver the original prescription to the pharmacy that filled the prescription not later than one hundred twenty (120) hours from the time it was communicated to the pharmacy.
  - This will not be applicable to prescriptions generated and transmitted electronically (e-prescriptions).

i. Electronic Prescription Requirements

Different regulations require pharmacies to maintain accurate records of the dispensation of prescription drugs. This requirement shall apply to electronic prescriptions and all the information needed shall be recorded in the same device that receives and stores electronically transmitted prescriptions.

Electronic prescriptions must include the following information, in addition to any other information requires by different regulations:

- Date of issue.
- Beneficiary's full name, address, and age.
- Prescribing professional Full name, address, telephone number, license numbers, and electronic signature.
- o the electronic signature of the prescribing professional shall be deemed to be authenticated when the prescription is electronically generated and transmitted as established in the different federal and state regulations.
- Medication name with its form, dosage, potency, and amount.
- Use indications for the beneficiary.

During the course of filling an electronic prescription or verifying the filling of an electronic prescription a pharmacy technician, a pharmacist intern or a pharmacy technician intern has intervened in the prescription process, the device that receives and processes the electronic prescription shall also authenticate the identity of the pharmacist assuming responsibility for such dispensation.

Bioequivalent Medication Exchange

For electronically generated and transmitted prescriptions, the patient's consent to the exchange shall be documented in the patient's pharmacy record and the signature of the patient will be waived.

j. Special Considerations for LTC Pharmacies and Specialty Pharmacies

Specialty Pharmacies:

Documentation requirements for specialty pharmacies necessary to satisfy the audit which can include some or all the following:

- Prescription order copies, either original prescription orders or electronic scanned images
    - Regardless of the copy type, it is important for the prescription copy to be legible and contain any pertinent documentation on the prescription. For the electronic copies, documentation for the prescription may be in electronic transaction notes with a date and time stamp. It is important that all necessary information related to the prescription order dispensing is provided.
- Proof of pick up or delivery of the prescription:
    - Electronic date and time stamp in the pharmacy software system of the sold prescription.
    - Electronic signature and/or paper signature.
- Physician Progress Notes
- Additional Documentation
    - Electronic documentation on the dispensing of the prescription order with a date and time stamp of when the documentation occurred.

- Written documentation on the dispensing of the prescription order that is dated as to when the documentation occurred.

LTC Pharmacies:

Abarca Health utilizes the *Joint Report: Model Rules for Long-term-care (LTC) Pharmacy Practice* published by the National Association of Boards of Pharmacy and the American Society of Consultant Pharmacists to determine the types of documents that will validate the claims. Some of the documents subject to review are:

- Original Prescriptions or Electronic Prescriptions with all the elements required under the Puerto Rico Pharmacy Act.
- Documentation or combination of documentation that shows all the prescription elements and corroborates clearly that the prescription originated from a valid prescriber.
- Physician Progress notes will be accepted as a prescription if all the required elements are included. For example, beneficiary name, written date or date of service, drug name, strength, and dosage form of the medication prescribed, directions for use, quantity prescribed, number of refills, DEA or NPI of the prescriber, and the prescriber's signature.

k. Partial Fills

Abarca Health shall rely on plan members' complaints and/or grievances and on plan members' confirmation of service at the point of sale in order to identify cases of partial fills that could well represent cases of fraud related to prescription drug shorting.

A *Partial Fill* occurs when a pharmacy provides a beneficiary with less than the prescribed quantity for a drug, regardless of whether the beneficiary is billed or not for the prescription and regardless of the amount the pharmacy bills the beneficiary (if any).

Prescription Drug Shorting is when a pharmacy provides a beneficiary with less than the prescribed quantity for a drug but bills the beneficiary for the fully prescribed amount without making any arrangements for providing beneficiary with the remainder of the prescription. If pharmacy does not provide fill for remainder of prescription and fails to reverse claim, this may be an indicator of a potential case of fraud, waste, and abuse.

For identified cases of prescription drug shorting, **Abarca Health** shall reverse the pharmacy claim in its claims processing and adjudicating system and recover the amount paid.

l. Billing Guidelines

Quantity and Days' Supply:

- Pharmacies must process claims with the correct drug quantity based on the physician directions.
- If a pharmacy receives a "Days' Supply Exceeds Plan Limitations" rejection the drug quantity must be recalculated according to the days' supply indicated in the rejection.

The claim must be submitted again with the new calculation of drug quantity and days' supply.

- If a pharmacy receives a "Days' Supply Exceeds Plan Limitations" rejection for an unbreakable package, the pharmacy must dispense the smaller package presentation for the same drug available in the market closer to the days' supply requested.
- If the pharmacy receives a "Days' Supply Exceeds Plan Limitations" rejection and the package size is not reduced the overbilled medication will be adjusted in an audit.

Dispense as Written (DAW):

Pharmacies must process claims with the appropriate DAW code that represents the reason a particular drug presentation is selected. The DAW code will determine the amounts paid.

DAW Code	Description
0	No product Selection indicated
1	Substitution Not Allowed by Prescriber
2	Substitution Allowed - Patient Requested Product Dispensed
3	Substitution Allowed - Pharmacist Selected Product Dispensed
4	Substitution Allowed - Generic Drug Not in Stock
5	Substitution Allowed - Brand Drug Dispensed as Generic
6	Override, used to indicate MAC Pricing applies
7	Substitution Not Allowed - Brand Drug Mandated by Law
8	Substitution Allowed - Generic Drug Not Available in the Marketplace
9	Other

Creams, Ointments, Lotions, and Gels Calculation

- The following table serves as a guideline when calculating quantities and days' supply for drugs in these formulations.
- Calculations are based on one (1) gram per application. See table below:

Package Presentation	Applications Per Day					
	1	2	3	4	5	6
15 G	15	8	5	4	3	3
22.5 G	22	11	8	6	5	4
30 G	30	15	10	8	6	5
45 G	45	23	15	11	9	8
60 G	60	30	20	15	12	10
100 G	100	50	33	25	20	17

- If a pharmacy receives a "Days' Supply Exceeds Plan Limitations" rejection for an unbreakable package, the pharmacy must dispense the smaller package presentation for the same drug available in the market closer to the days' supply requested.

- If the pharmacy receives a “Days’ Supply Exceeds Plan Limitations” rejection and the package size is not reduced the overbilled medication will be adjusted in an audit.
- For the Smallest Available Manufacturer Package, the pharmacy must submit the correct day’s supplies based on the prescriber’s indications for use.

Ophthalmic and Optic Drops

- **Abarca Health** uses twenty (20) drops per milliliter as a measurement to calculate Optic and Ophthalmic drops day supply.
- Optic and Ophthalmic Drops Chart based on twenty (20) drops per milliliters:

Package Presentation	Drops per day											
	1	2	3	4	5	6	7	8	9	10	11	12
2.5ML	50	25	17	13	10	8	7	6	6	5	5	4
5	100	50	33	25	20	20	14	13	11	10	9	8
7.5	150	75	50	38	30	25	21	19	17	15	14	13
10	200	100	67	50	40	33	29	25	22	20	18	17
15	300	150	100	75	60	50	43	38	33	30	28	25
30	600	300	200	150	120	100	86	75	67	60	55	50

- If a pharmacy receives a “Days’ Supply Exceeds Plan Limitations” rejection for an unbreakable package, the pharmacy must dispense the smaller package presentation for the same drug available in the market closer to the days’ supply requested.
- If the pharmacy receives a “Days’ Supply Exceeds Plan Limitations” rejection and the package size is not reduced the overbilled medication will be adjusted in an audit.
- For the Smallest Available Manufacturer Package, the pharmacy must submit the correct days supplies based on the prescriber indications for use.

Unbreakable Package

- For all those unbreakable packages the exact days’ supply must be required based on the physician’s directions.

Prescription Origin Codes:

- Pharmacies must use a valid prescription origin code when processing a written, electronic, fax, oral (telephone) prescription.

Description	Prescription Origin Code
Written	1 - Written
Text, Oral	2 - Telephone
Electronic	3 - Electronic
Email, Fax	4 - Fax

Prescription received by phone or text must be sent by the prescriber and NOT by the patient.

Prescriber ID:

Abarca Health requires an active and valid individual prescriber NPI on all claims submitted for payment.

Management of Refill Too Soon (RTS) during the emergency:

Usually during an emergency declaration federal and state agency (ie) require to relaxing some system edits at the point of sale to ensure access to patients to their required prescription drugs. To guarantee this access, most of our clients change the system configuration at the POS from a hard rejection to a soft rejection.

In the event a patient request refills early, the system will issue a rejection (79-Refill Too Soon) that can be overridden with the codes displayed in the message.

Reject Message	Steps to Follow
Refill too Soon. Pharmacist, please validate with the member reason for an early refill. Submit appropriate PAC code 99999 to override claim. If needed, call 1-855-831-3593 for more information.	• Prior Auth Type Code: Add “1”” • Prior Auth ID: Add PAC code “99999”

Before resubmitting the claim with the override codes, please consider the following:

- Within the patient's claim history, verify the service date of the previous claim and the amount previously dispensed. If the previous claim was not at your pharmacy, please verify this information with the patient.
- Please validate the reason the patient is attempting to request an early refill. There are legitimate circumstances to provide this early refill such as a dose increase or patient travel. Please keep the override supporting documents attached to the prescription.
- The pharmacist may override the RTS rejection with the PAC code 99999.
- Prior Auth id field should be sent blank if no valid value is added to the claim. Sending incorrect Prior Auth Id values will cause EV: Missing/Invalid PriorAuthorizationNumberSubmitted rejections.

- However, in the instances where the client requests to lift the edits at the point of sale and not to implement override codes for RTS claims. Therefore, pharmacies are required to take appropriate actions and help prevent improper billings.

m. Audit Process

- For Onsite Audits, the pharmacies to be audited will be notified via certified mail with acknowledgment of receipt, electronic mail, or via fax with thirty (30) calendar days in advance. The pharmacy will also receive via fax or email a list of prescription numbers and dates of service.
- On the day of the audit, the auditor first meets with the owner of the pharmacy being audited or the pharmacist in charge, to indicate the purpose, scope, and process of the on-site audit. o Review of Pharmacy Credentials: The credentialing process is carried out by verifying the existence and validity of the licenses required to operate a pharmacy establishment in accordance with the different state and federal regulations.
- For Desk Audits, the pharmacy will receive via electronic mail or via fax, a letter with the list of claims to be audited and must submit the required documentation within fifteen (15) business days.
- During the Daily Claim Review, once a claim with a potential error is identified, the pharmacy will be contacted by an auditor from Abarca Health.
- As part of the audit process, prescriptions, physician notes or additional documents may be requested.
- The Pharmacy will have a period of three (3) days to submit the supporting documentation.

Contact Information:

- E-mail: PharmacyAudit@AbarcaHealth.com
- Fax: 787-777-1373
- Address: Abarca Health Pharmacy Integrity Division
  Suite 701, 650 Ave. Muñoz Rivera
  San Juan, PR 00918-4115

n. Discrepancy List

Audits that do not reveal discrepancies:

- A letter is sent to the pharmacy within thirty (30) calendar days after the on-site audit is completed indicating that the audit has been successfully completed with satisfactory results

Audits that reveal discrepancies:

- A letter is sent to the pharmacy within thirty (30) calendar days after the on-site audit is completed. Such notification includes details on the prescriptions or claims and the discrepancies found:
  - Prescription number
  - Date of service
  - Drug description
  - Cardholder ID

- Claim Reference Number (AP Claim ID)
- Internal Control number (ICN)
- Plan Paid
- Finding

The letter sets forth the pharmacy's right to refute any of the findings revealed by the audit within a thirty (30) calendar day's period from the date of receipt of the acknowledgment of receipt.

Pharmacies shall send any appeal documentation by fax, email and/or mail along with evidence supporting their claim.
Contact Information:

- E-mail: PharmacyAudit@AbarcaHealth.com
- Fax: 787-777-1373
- Address: Abarca Health Pharmacy Integrity Division
  Suite 701, 650 Ave. Muñoz Rivera
  San Juan, PR 00918-4115

If the pharmacy submits evidence showing that the audit findings are not valid, **Abarca Health** shall notify the pharmacy in writing that the evidence submitted on its behalf was not valid.

o. Audit Resolution and Outcomes

- Accepted - the audit is closed. A notification shall be sent within thirty (30) calendar days
- Partially accepted or rejected - notification shall be sent within thirty (30) calendar days. This letter will contain educational information that shall help pharmacies and their staff avoid incurring in such practices in the future.
  - Condition
  - Criteria
  - Cause
  - Effect
  - Recommendations
- If after thirty (30) calendar days the Pharmacy Integrity Division does not receive evidence from pharmacy demonstrating that the audit findings are invalid, the auditor shall proceed to:
  - Send a letter to the pharmacy notifying the pharmacy that findings are final, and an audit adjustment process will be processed.
- If the pharmacy requests an extension to submit evidence on findings, an extension period of five (5) business days may be granted, after receiving request from pharmacy.
- After closing an audit, the details of claims with discrepancies must be sent within five (5) business days to the Department of Information Systems and the Software Developer in charge of attending requests submitted by the Pharmacy Integrity Division, information related to the discrepancies so that adjustments are made in the

claims processing and adjudication system regarding prescriptions found which were not refuted with substantiating evidence from the pharmacy.

Risk Evaluation and Mitigation Strategy (REMS) Programs

The requirements for pharmacists will vary somewhat for each REMS and may vary by setting (e.g., retail pharmacy or inpatient pharmacy). For some REMS, pharmacists and other dispensers will receive REMS communications from the manufacturers.

REMS may also require pharmacies or other healthcare settings to become certified to dispense the REMS medication. Certification generally requires that the pharmacy or the healthcare setting identify an authorized representative to complete the certification process. Generally, the authorized representative enrolls the pharmacy or setting, completes the required training, ensures that policies and procedures put in place to implement the REMS requirements are followed, and ensures staff are trained and comply with the REMS requirements.

Details about each REMS, including the roles of pharmacies and healthcare settings, can be found at REMS@FDA, in product labeling, or on REMS-specific websites.

The Pharmacy needs to put a process in place that includes verifying that the prescriber of a REMS drug is certified, patients are enrolled, and that laboratory testing or other certain safe use conditions have been carried out prior to dispensing the drug.

Clinical Edits

Our adjudication and processing system includes several Clinical Edits in accordance with Drug Utilization management. These edits help pharmacies provide safe and adequate services to beneficiaries. Some of these edits are:

- Duplicate Therapy
- Duplicate Ingredient
- High-Dose
- Low Dose
- Cumulative Dosing Logic
- Day's Supply Limit based on previous utilization
- Drug-to-Disease
- Drug-to-Gender
- Drug-to-Age
- Drug Allergy
- Drug-to-Drug Interaction
- Refill too Soon

"E-Prescribing" and Electronic Prior Authorization (ePA)

E-Prescribing: Electronic handling of the prescribing process. It is the transmission of a prescription directly to a dispensing entity, access to a patient's prescription benefit information, and history through electronic communication systems. The pharmacy must comply with all requirements established by CMS for the transmission and processing of electronic prescriptions.

Abarca Health's electronic Prior Authorization (ePA) process is a tool which prescribers can use to initiate and complete Prior Authorization (PA) requests electronically, in real time and at the point of care.

The ePA service gives prescribers the ability to initiate a PA prospectively within a member's Electronic Medical Record (EMR) or Electronic Health Record (EHR)—alternatively, through the Surescripts web-based portal—as well as securely access patient-specific information using ePrescription, which helps reduce disruption and improve clinical quality, safety and provide better member care. Some of the benefits of ePA are the following:

- improved formulary adherence;
- reduction in prescription abandonment;
- accurate and complete data.

Abarca Health's ePA program interfaces with ***Surescripts***, a connectivity vendor, to deliver this service to prescribers of contracted clients. The vendor provides the back-end enablement for electronic exchange of patient eligibility, patient-specific benefit coverage, and prescription information between the prescriber and Abarca.

Emergency Policy

An emergency is defined as a major disaster declared by the President of the United States; an emergency or disaster declared by a state Governor, including the Governor of Puerto Rico; or a public health emergency declared by the Secretary of the Department of Health and Human Services or by the Secretary of the Puerto Rico Health Department. An emergency declaration shall terminate when it no longer exists or upon the expiration of the 90-day period beginning from the initial declaration of emergency, whichever occurs first.

To comply with The Centers for Medicare and Medicaid Services (CMS), barriers preventing or limiting access to care in emergency situations will be removed.

In the event of an emergency declaration, the following procedures shall apply:

- **Abarca Health** will provide notification to network pharmacies that we are implementing our emergency plan.
- **Abarca Health** will take the following actions regarding claims processing and adjudication edits that apply to Medicare plans:
    - Lift "refill-too-soon" edits.

- Allow affected enrollees residing in emergency areas to obtain the maximum extended day supply, if requested and available at the time of refill.
- Allow enrollees to have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when those enrollees cannot reasonably be expected to obtain covered Part D drugs at a Company network pharmacy, and when such access is not routine.
- Lift, waive and/or remove other edits in accordance with clients' emergency policies.

- **Abarca Health** shall continue to lift the edits above and adjudicate claims accordingly until the termination of the emergency. The following factors will be considered when deciding whether an emergency has been terminated or not:
  - In the case of a public health emergency, it terminates when it no longer exists or upon the expiration of the 90-day period beginning from the initial declaration, whichever occurs first.
  - For major disasters or emergencies, the Company should pay particular attention to the termination of disaster or emergency incident periods listed on FEMA's web site (http://www.fema.gov/news/disasters.fema).
  - Once an emergency declaration is terminated, **Abarca Health** will provide notification to network pharmacies that we are returning to normal business procedures.

In the absence of a major disaster, emergency or a public health emergency declaration, the Company and its clients may consider lifting the edits–for instance, in advance of an impending disaster–if they determine it is appropriate to do so to ensure an adequate level of pharmacy access.

a. Processing of claims during an emergency

Our processing claim system is fully functional and available even during electricity, internet and telephone limitations that may occur in Puerto Rico. If at any time you are having difficulty processing claims at the point of service, below are some options to follow in order to process and dispense claims for members with a pharmacy benefit:

- **Option A.** Call our Pharmacy Help Center at 1-866-993-7422 and validate the eligibility of the patient and if the medication is covered (if you do not have this information available through other means). Once this validation has been completed, please manually collect certain information of the patient. To facilitate this process, we are including in this communication a sheet with basic information that you should collect. Once your pharmacy system is operating, submit the claim to **Abarca Health** so it can be processed and paid (remember that you have a period of up to 90 days). This method is much faster than Option B and requires less administrative procedures.

- **Option B.** The Pharmacy can fill out a Universal Claim Form and send it through the following fax number: 1-787-777-1372. For information on how to obtain the "UCF" form, please visit NCPDP at the following link https://www.ncpdp.org/Universal-Claim-Forms. **This only applies for emergency cases (prolonged events without electricity and/or internet) where the pharmacy cannot process the medications.**

- **Option C**. If you are not able to perform any of the options presented above, please carry out the following steps:
  - Dispense an amount no greater than 30 days of supply.
  - Document in the prescription, "Dispatched due to emergency" or once the system of your pharmacy is available, process the claim electronically.

b. Fax Numbers

In the event of an emergency, certain edits referred to as "emergency edits" will be turned on; therefore, the need to send faxes will be reduced to minimum. Nevertheless, we wish to remind you of the available fax numbers:

Client	Fax Number
Commercial (FM, Triple-S Commercial, Lilly, Evertec, PSM)	1-888-437-6541
Medicare	1-855-710-6727
ASES First Medical	1-866-728-7360
ASES MMM	1-866-349-0514
ASES Plan de Salud Menonita	1-866-728-0682
ASES Triple S	1-866-856-1847

c. Rejections at the Point of Sale

To avoid delays or problems accessing the medications in the event of an emergency, most of the rejections at point of sale will be temporarily disabled. The disabled rejections may vary per client and severity of the emergency; however, some examples of these are: "Refill Too Soon", "Prior Authorizations", "Step Therapy", "Quantity Limits", "High-Cost Threshold", "Out of Network", "Prescriber Specialty", and "DAW".

In the instance in which the "Refill Too Soon" edit is disabled at point of service, it is important that you consider the following before dispensing a medication:

- Verify the patient's claim history to determine the service date of the previous claim and the amount previously dispensed. If the previous claim was not dispensed in your pharmacy, then please verify the information with the patient.
- Verify with the patient the reason for which he or she wishes to take the refill ahead of time.
- Document the intervention somewhere that can be readily available as evidence and use your clinical judgment to determine if the refill was clinically appropriate.
- Take into consideration that claims flagged as "Refill Too Soon" will be monitored and may be audited.

Additional References

Additional information about the topics mentioned above in this document can be found on **Abarca Health's** webpage: (http://www.abarcahealth.com). Information about Fraud, Waste, and Abuse training, as well as Pre-Authorization forms, Medications Lists, Pre-Authorization

Forms, Grievances, and Appeals processes, etc. can be found in the Provider's Portal.

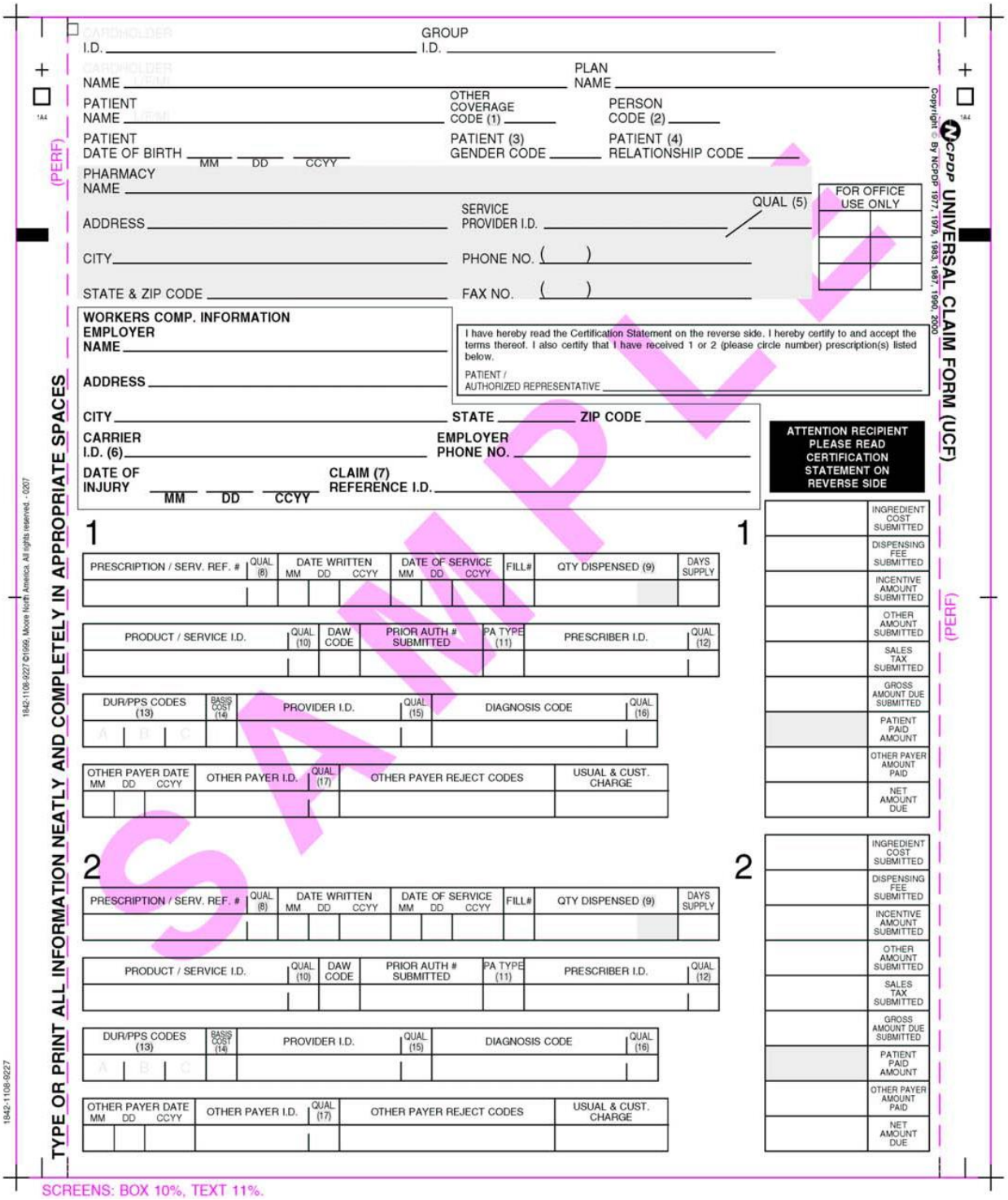
An electronic version of this Manual can also be found in **Abarca Health**'s Provider's Portal: https://providers.abarcahealth.com/.

For Guidelines and Government Resources specific to compliance and FWA topics, see:

- Prescription Drug Benefit Manual, Chapter 9: Part D Program to Control Fraud, Waste and Abuse, accessible at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf
- Puerto Rico Pharmacy Act, Law #247 from September 3, 2004. Accessible at: http://www.oslpr.org/LeyesPopUpEn.asp?year=2004
- Administrative Regulation known as "Reglamento del Secretario de Salud #142 Para Reglamentar la Operación de los Establecimientos Dedicados a la Manufactura, Distribución y Dispensación de Medicamentos" from August 3, 2010. Accessible at: http://www.salud.gov.pr/Publicaciones/Reglamentos/Pages/NuevoReglamentodeFarmacia.aspx
- Stop Medicare Fraud: http://www.stopmedicarefraud.gov
- Office of Diversion Control. Drug Enforcement Administration resources for pharmacies accessible at: http://www.deadiversion.usdoj.gov/
- General Services Administration (GSA) database of excluded individuals/ entities: https://www.epls.gov/
- Office of the Inspector General Exclusion Program and Online Searchable database: http://oig.hhs.gov/exclusions/index.asp
- Bobby Clark and Marlene Sneha Puthiyath, "The Federal 340B Drug Pricing Program: What It Is, and Why It's Facing Legal Challenges" (explainer), Commonwealth Fund, Sept. 8, 2022. https://doi.org/10.26099/c4z8-pf65

Exhibits

Exhibit I: NCPDP Universal Claims Form



Instructions For Completing NCPDP Universal Claim Form (UCF)

Field No.	Field Name	Entry	Description
N/A	**I.D.**	Required	Enter the recipient's 13 digit Medicaid ID.
N/A	**GROUP I.D.**	Not required	
N/A	**NAME**	Not required	
N/A	**PLAN NAME**	Not required	
N/A	**PATIENT NAME**	Required	Enter the Recipient's full name: First, Last.
Field 1	**OTHER COVERAGE CODE**	Not required	Complete 'OTHER COVERAGE CODE' using the values noted below: 0 = Not specified 1 = No other coverage identified 2 = Other coverage exists – payment collected 3 = Other coverage exists – this claim not covered 4 = Other coverage exists – payment not collected 5 = Managed care plan denial 6 = Other coverage denied – not a participating provider 7 = Other coverage exists – not in effect at time of service 8 = Claim is billing for a co-pay
Field 2	**PERSON CODE**	Not required	The code assigned to a specific person within a family must be entered in this field.
N/A	**PATIENT DATE OF BIRTH**	Not required	Enter the Recipient's Date of Birth in MM/DD/CCYY format.
Field 3	**PATIENT GENDER**	Not required	Complete using the values noted below: 0 = Not specified 1 = Male 2 = Female
Field 4	**PATIENT RELATIONSHIP CODE**	Required	Must be completed using a value of '**1'**, identifying a cardholder.
N/A	**PHARMACY NAME**	Not required	Enter the pharmacy name.
N/A	**ADDRESS**	Not required	Enter the Address of the pharmacy.
N/A	**SERVICE PROVIDER ID**	Required	Enter the 7-digit Medicaid Provider ID
Field 5	**SERVICE PROVIDER ID QUALIFIER**	Required	Must be completed using a value of '**05'** identifying Medicaid.
N/A	**CITY**	Not required	Enter the City name for the address of the Pharmacy
N/A	**PHONE NO.**	Not required	Enter the phone number for the Pharmacy: (999) 999-9999.
N/A	**STATE & ZIP CODE**	Not required	Enter the State code and Zip Code of the address of the Pharmacy.
N/A	**FAX NO.**	Not required	
Workers Comp.			

N/A	**ADDRESS**	Not required	Employer Address
N/A	**CITY**	Not required	Employer City
N/A	**STATE**	Not required	Employer State
N/A	**ZIP CODE**	Not required	Employer Zip Code

Field No.	**Field Name**	**Entry**	**Description**
Field 6	**CARRIER ID**	Not required	Employer Carrier ID
N/A	**EMPLOYER PHONE NO**	Not required	Employer Phone Number
N/A	**DATE OF INJURY**	Not required	Workers Comp. Date of Injury
Field 7	**CLAIM/REFERENCE ID**	Not required	Workers Comp Claim/Reference ID
SECTION 1	**FIRST CLAIM**		
N/A	**PRESCRIPTION/SERVICE REFERENCE #**	Required	Enter the prescription number
Field 8	**QUAL.**	Required	Must be completed using a value of '**1**' identifying an Rx billing.
N/A	**DATE WRITTEN**	Required	Enter the date the prescription was written by the prescriber in MMDDCCYY format.
N/A	**DATE OF SERVICE**	Required	Enter the date the prescription was filled in MMDDCCYY format.
N/A	**FILL #**	Required	Enter 0 if new prescription; 1 for first refill, 2 for second refill, etc.
Field 9	**QTY DISPENSED**	Required	Quantity dispensed expressed in metric decimal units (*shaded areas for decimal values*).
N/A	**DAYS SUPPLY**	Required	Enter the Days Supply.
N/A	**PRODUCT/SERVICE ID**	Required	Enter the NDC for the drug filled
Field 10	**QUAL.**	Required	Must be completed using a value of **'03'** identifying National Drug Code (NDC).
N/A	**DAW CODE**	Required, if applicable	Enter valid Dispense as Written (DAW) code: 0 = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed - Patient Requested Product Dispensed 3 = Substitution Allowed - Pharmacist Selected Product Dispensed 4 = Substitution Allowed - Generic Drug Not in Stock 5 = Substitution Allowed - Brand Drug Dispensed as a Generic **6 = Override, used to indicate MAC pricing applies.** 7 = Substitution Not Allowed - Brand Drug Mandated by Law 8 = Substitution Allowed - Generic Drug Not Available in Marketplace 9 = Other
N/A	**PRIOR AUTH # SUBMITTED**		

Field No.	Field Name	Entry	Description
Field 11	**PA TYPE**	Not required	Prior Authorization Type code must be completed using the following values noted below: 0 = Not specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from co-pay **5 = indicates exemption from service limits*** 6 = indicates family planning drugs* 7 = Temporary Assistance for Needy Families (TANF) **8 = indicates co-pay exemption due to pregnancy***
N/A	**PRESCRIBER ID**	Required	Enter the 7-digit Medicaid prescriber provider number.
Field 12	**QUAL.**	Required	Must be completed using a value of **'05'** indicating Medicaid.
Field 13	**DUR/PROFESSIONAL SERVICE CODES**	Required, if applicable	Reason for Service, Professional Service Code and Result of Service Codes. For values refer to current NCPDP data dictionary. Block 1 (Reason for Service) Block 2 (Professional Service) Block 3 (Result of Service) Examples: Block 1 – ER (Early Refill) Block 2 – M0 (Prescriber Consulted) Block 3 – 1G (Filled, with prescriber approval)
Field 14	**BASIS OF COST DETERMINATION**	Not required	
N/A	**PROVIDER ID**	Not required	
Field 15	**PROVIDER ID QUALIFIER**	Not required	
N/A	**DIAGNOSIS CODE**	Required, if applicable	May be required for payment of specific drugs. See the POS Users' Manual for situations where Diagnosis Code is required.
Field 16	**DIAGNOSIS CODE QUALIFIER**	Required, if applicable	Must be completed using a value of '**01',** identifying an International Classification of Diseases (ICD9) code.
N/A	**OTHER PAYER DATE**	Required if TPL is reported.	Date other payer made payment on the pharmacy service.
N/A	**OTHER PAYER ID**	Required if TPL is reported.	Enter the Louisiana Medicaid Carrier ID
Field 17	**QUAL.**	Required	Must be completed using a value of '**99**', identifying 'Other' for a Medicaid Carrier ID.
N/A	**OTHER PAYER REJECT CODES**		

Field No.	Field Name	Entry	Description
N/A	USUAL & CUST. CHARGE	Required	Enter the billed charges for the claim (Usual and Customary Charge).
N/A	INGREDIENT COST SUBMITTED	Not required	
N/A	DISPENSING FEE SUBMITTED	Not required	Standard Medicaid payable dispensing fee will be used to calculate payment.
N/A	INCENTIVE AMOUNT SUBMITTED	Not required	
N/A	OTHER AMOUNT SUBMITTED	Not required	
N/A	SALES TAX SUBMITTED	Not required	
N/A	GROSS AMOUNT DUE SUBMITTED	Not required	Claim will be paid using Usual and Customary Charge
N/A	PATIENT PAID AMOUNT	Not required	Enter the amount of co-payment collected from the Recipient.
N/A	OTHER PAYER AMOUNT PAID	Required, if TPL amount was received.	Enter the amount paid by the Other Payer.
N/A	NET AMOUNT DUE	Not required	
SECTION 2	SECOND CLAIM		Complete this section same as above when second prescription is billed for the same Recipient.
N/A	PATIENT/AUTHORIZED REPRESENTATIVE	Required	Signature of patient or authorized representative required.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE NCPDP UNIVERSAL CLAIM FORM (UCF), PLEASE CONTACT THE PHARMACY BENEFITS MANAGEMENT DEPARTMENT AT UNISYS OR CALL 800-648-0790 or (225) 237-3381.

Exhibit II: Pharmacy Provider Complaint Form

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Pharmacy Provider Complaint Form

Pharmacy Information	
Pharmacy Name: _____	**NPI:** _____
Phone Number: _____	**NABP:** _____
Contact Person: _____	**Date:** _____/_____/_____

Please select one or more of the following reasons for the complaint you want to file. We encourage you to provide any relevant circumstances related to the situation giving rise to your complaint in the "Explanation" section below. You may use additional space if necessary. When filing your complaint, please attach to this form any additional details or relevant documents.

I (Pharmacy) am filing this complaint because of:

- ☐ Status or change in status within the network
- ☐ Competency or conduct
- ☐ Amount paid
- ☐ Outcome of a Drug Price Appeal Request
- ☐ Audit adjustment
- ☐ System, operational, or service problems
- ☐ Distribution channel contractual issues
- ☐ Denied claim

Explanation:

_____
_____
_____
_____
_____
_____
_____
_____

For Abarca Health's internal use only

Please send completed form via certified mail to:
Abarca Health
Attention: Network Strategy Team
650 Muñoz Rivera Ave, Suite 701
San Juan, PR 00918

www.abarcahealth.com

Exhibit III: Signatures LOG

ABARCA

Signature's LOG

Provider – At the moment of dispensing the prescription medication, please ask for the patient, guardian, or representative's signature.

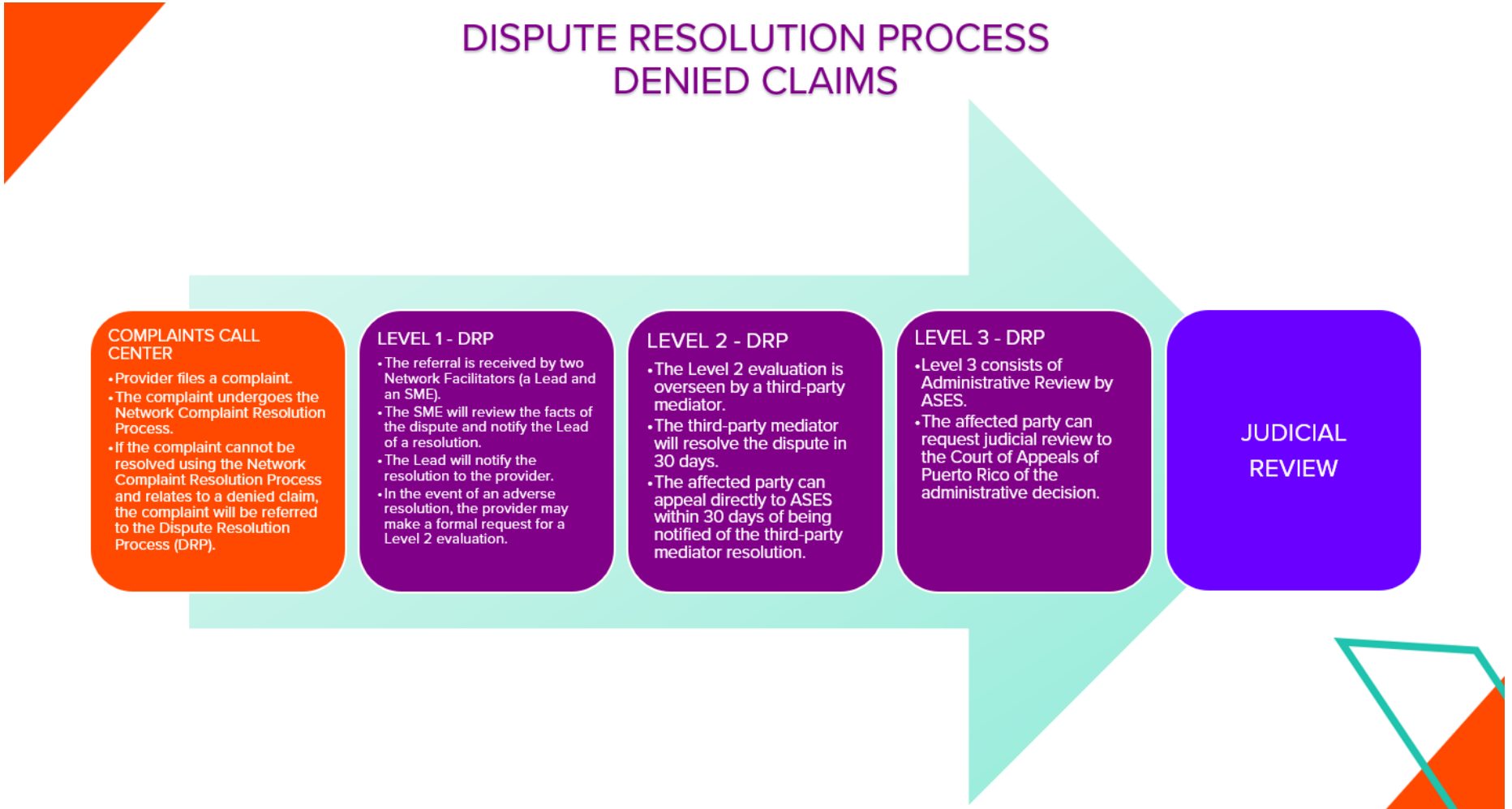
Patient – Your signature certifies that the information stated here is accurate and correct, and that the person for whom the prescription was written is eligible to receive the corresponding benefits. Thereby, you are certifying that you received the medications described below, and you are authorizing the sharing of the contents of this log to who may correspond (Plan administration, insurance company, policy owner, and/or authorized agents). You are also certifying that the dispensed medication is not for the treatment of a work-related accident, and do not authorize any payment related to this condition.

Date/ Prescription Number/ Pharmaceutical's Signature	ID Number	Accept Orientation?	Patient, Guardian, or Representative's Signature
		Yes _____ No _____	
		Yes _____ No _____	
		Yes _____ No _____	
		Yes _____ No _____	
		Yes _____ No _____	
		Yes _____ No _____	

I hereby certify that **Abarca Health's** beneficiary's prescriptions, whose signatures appear here, were dispensed, and processed correctly, complying with laws and regulations established by Regulatory Agencies. The prescriptions all follow the requirements and agreements stated within **Abarca Health's** contract. I certify that each transaction is legal, and that all documentation is available for future audit processes.

Provider Name	Address	NPI

Exhibit IV: ASES Dispute Resolution Process for Denied Claims and Other Disputes



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DISPUTE RESOLUTION PROCESS OTHER DISPUTES