



PHARMACY CREDENTIALING APPLICATION

INSTRUCTIONS

Thank you for your interest in joining the CIGNA Healthcare's Pharmacy Network. To avoid delays and ensure a timely review and response to your request, please complete this application in its entirety and provide all of the required documents listed below. If you have any questions please email them to PharmacyNetworkOperations@CIGNA.COM.

1. Complete sections I-IV and V-VI (if applicable). Please be sure to sign, initial or check the response in the Yes or No boxes.
2. Attach copies of the following documents along with your completed application:
 - i. Description (1-2 paragraphs) of the **primary and ancillary services offered to the community and types of prescription drugs regularly stocked in the pharmacy.**
 - ii. Current **State Pharmacy Operating license**
 - iii. Current **Federal DEA license**
 - iv. Current **Pharmacy (not Pharmacist) malpractice liability insurance policy certificate** showing expiration dates and liability coverage (general aggregate must be a minimum of \$2,000,000) or indicate if self-insured.
3. Mail the completed application and above noted documents to the following location (**faxed applications will not be accepted**):

**CIGNA Pharmacy Network Operations
Attn: Network Support Administrator B5PHR
900 Cottage Grove Rd
Hartford, CT 06152**

4. Please allow for 10 business days to review your credentialing application. If approved, we will fax or email you 2 copies of the Participating Pharmacy Agreement and supporting contracting documents. If denied you will be notified by mail.

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I. GENERAL INFORMATION *(Please type or print legibly)*

Legal Name: _____ DBA Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

NCPDP#: _____ NPI#: _____ Email Address: _____

Contact Name: _____ Phone Number: _____ Fax Number: _____

Pharmacy Owner Name: _____ Phone Number: _____

II. PHARMACY TYPE

1. Which description most closely describes the type of services provided by your Pharmacy and approximately what percent of your business handles the following? **(Note all that apply)**
_____ % Retail/Open _____ % Long Term Care (Complete **Section VI.** below)
_____ % Specialty _____ % Home Infusion (Medicare Only -also complete **Section VII.**)
_____ % Compounding _____ % 340B/Safety Net
_____ % Clinic/Hospital _____ % Indian Tribal Urban / Indian Health Services (Medicare Only)
_____ % Mail Order _____ % State / Government owned/operated (Medicare Only)
2. Is your pharmacy in a free-standing building, easily accessible to the general public?
Yes _____ **No** _____ (If **No**, please clarify)
3. Is there a patient waiting area adjacent to where prescriptions are dispensed? Can patients walk up to your pharmacy to pick up their prescriptions ?
Yes _____ **No** _____ (If **No**, please clarify)
4. Can you provide services to all patients or only to patients with specific clinical conditions?
Yes _____ **No** _____ (If **No**, please clarify)
5. Can your pharmacy provide the majority of commercially available retail prescription drugs to CIGNA customers or is your pharmacy limited to specific types or categories of prescription drugs?
Yes _____ **No** _____ (If **No**, please clarify)
6. Is your pharmacy located within a hospital, or other type of facility?
Yes _____ **No** _____ (If **Yes**, can general public access your pharmacy or only hospital patients-please clarify)
7. Do you provide mail order services outside of your state? If so, list the states your pharmacy is licensed?
Are you interested in participating in Medicare Part D Mail Order only?
Yes _____ **No** _____ (If **Yes**, please clarify)
8. Are you interested in participating in Medicare Part D?
Yes _____ **No** _____ (If **Yes**, please complete section V. with the mandatory initials.)
9. Are you interested in participating in 90 day at retail program? (Pricing will be included in the Agreement)
Yes _____ **No** _____
10. Are you interested in participating in Retail Specialty Pharmacy Network? (Pricing will be included in the Retail Specialty Pharmacy Addendum)
Yes _____ **No** _____
11. Does your pharmacy participate in 340B Program?
Yes _____ **No** _____

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III. STATE LICENSURE/CERTIFICATION/MALPRACTICE

1. Pharmacies are required to maintain signature logs (paper, electronic or Medication Administration Record (MAR) for all prescriptions and required to advise Members that their signatures acknowledge receipt of prescriptions and allow for the release of any and all information supporting that claim.

Indicate your agreement and compliance with this requirement by initialing here. _____

Initial Here

2. Has your pharmacy DEA registration number or operating license ever been suspended or revoked?
Yes _____ **No** _____ (If **Yes**, please clarify)
3. Has the pharmacy or any pharmacist employed by the pharmacy been involved in a malpractice suit within the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
4. Has any malpractice carrier made an out-of-court settlement or paid a judgment of professional liability claim on behalf of your pharmacy within the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
5. Has your pharmacy's malpractice coverage been denied or canceled in the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
6. Has the pharmacy or any pharmacist employed by the pharmacy been convicted of a felony within the past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
7. Has your pharmacy been expelled or suspended from service reimbursement from Medicare / Medicaid or been signed in an Enforcement Bureau Judgment by the state within the Past five years?
Yes _____ **No** _____ (If **Yes**, please clarify)
8. Are there any employees currently employed by the pharmacy who would not be covered by the company's malpractice insurance policy or their own malpractice insurance policy?
Yes _____ **No** _____ (If **Yes**, please clarify)
9. I hereby attest that the undersigned pharmacy participates in a **Quality Assurance Program**, if mandated by state law. If a Quality Assurance Program is **NOT** mandated, your Pharmacy has **formal written procedures for preventing and handling prescription errors**.

Indicate your agreement and compliance with this requirement by initialing here. _____

Initial Here

IV. CERTIFICATION & SIGNATURE

All information provided in or in connection with this application is complete and accurate to the best of my knowledge. I understand that this application does not entitle me to participation in the CIGNA HealthCare National Retail Pharmacy Network. I authorize CIGNA HealthCare to consult with and inspect all documents from individuals and organizations having information pertaining to the operation of this pharmacy. I agree that CIGNA HealthCare, its' representatives, employees and agents shall not be liable for any act or omission related to the evaluation or verification of information contained in this application. I further agree to promptly notify CIGNA HealthCare of any change to the information provided with this application.

Signature: _____ Date: _____

Sign Here

Title: _____

Reminder: Please complete the following sections **V. Additional Medicare Requirements** and **VI. Additional LTC Requirements** (if applicable) and **VII. Home Infusion State Licensure** (if applicable)

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V. ADDITIONAL MEDICARE REQUIREMENTS (if applicable)

Annual Medicare Part D Attestation for 2011

Please complete the below attestations:

Code of Conduct

I hereby attest that the undersigned entity has a Code of Conduct or ethics that is comparable or exceeds elements found in CIGNA's Code of Ethics found at http://www.cigna.com/about_us/governance/index.html and includes a provision for reporting any potential violations of the code. Additionally, Code of Conduct has a conflict of interest provision in place to ensure our managers, officers and directors responsible for the administration or delivery of Medicare benefits are free from any conflict of interest in administering or delivering Medicare benefits.

YES NO

Exclusion Review

I hereby attest that the undersigned entity has policies and procedures in place to review the Office of Inspector General (OIG) and General Services Administration (GSA) exclusions lists upon initially hiring and annually thereafter to ensure that any employee or manager responsible for administering or delivering Medicare benefits is not excluded from Federal health care programs. Additionally, if an employee is identified to be on such lists, that employee will immediately be removed from any work related directly or indirectly to all Federal health care programs and the entity will take appropriate corrective actions.

YES NO

Compliance Oversight

I hereby attest that the undersigned entity has policies and procedures in place to promptly address and correct identified compliance deficiencies in accordance with CMS rules, regulations and guidance.

YES NO

Compliance Training

I hereby attest that the undersigned entity has policies and procedures in place to delivery annual Medicare Compliance training for all persons involved in the administration or delivery of the Medicare Program benefits. To support compliance, a record of employees requiring the training, completing the training, and the materials utilized for training will be retained and available upon request by CIGNA or CMS.

YES NO

Medicare Part D Vaccine Administration Amendment will be included in your contract, unless you initial here that you are NOT interested in participating in this Program.

Indicate that you decline to participate in the Vaccine Administration Program here _____

 Initial Here

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VI. ADDITIONAL LTC REQUIREMENTS (if applicable)

As defined by the Medicare Prescription Drug Benefit Plan Final Rules, long term care (LTC) facilities include skilled nursing facilities as defined under Title XVIII of the Social Security Act (the Act), or a medical institution or nursing facility for which Medicaid makes payment throughout a month as defined under Title XIX of the Act.

Performance and Service Criteria for Network LTC pharmacies (NLTCPs) (Provided or contracted by your pharmacy, through an in network pharmacy provider)

- | | | | |
|---|-----------|----------|-------------|
| 1. Comprehensive Inventory and Inventory Capacity | Yes _____ | No _____ | Other _____ |
| 2. Pharmacy Operations and Prescription Orders | Yes _____ | No _____ | Other _____ |
| 3. Special Packaging | Yes _____ | No _____ | Other _____ |
| 4. IV Medications | Yes _____ | No _____ | Other _____ |
| 5. Compounding /Alternative Drug Composition | Yes _____ | No _____ | Other _____ |
| 6. Pharmacist On-call Service | Yes _____ | No _____ | Other _____ |
| 7. Delivery Service | Yes _____ | No _____ | Other _____ |
| 8. Emergency Boxes | Yes _____ | No _____ | Other _____ |
| 9. Emergency Log Books | Yes _____ | No _____ | Other _____ |
| 10. Misc. Reports, Forms and Prescription Ordering Supplies | Yes _____ | No _____ | Other _____ |

Low-income Subsidy Cost Sharing Certification

I hereby attest that the undersigned pharmacy(ies) do not collect cost sharing charges for LIS-eligible beneficiaries, and that any statements of such cost sharing charges submitted by the pharmacy(ies) to CIGNA Pharmacy Management are appropriate, owed and payable. The pharmacy agrees to notify CIGNA Pharmacy Management within 30 days of changes to the collection of cost sharing charges for LIS-eligible beneficiaries.

Do you collect cost sharing charges (i.e. copays) for LIS-eligible beneficiaries? Yes _____ No _____

Indicate your agreement to this by initialing here _____



VII. Home Infusion State Licensure (if applicable)

Please list all of the states in which your pharmacy is licensed to provide Home Infusion prescription services to Medicare Part D beneficiaries:

state _____, license# _____, expiration date _____; state _____, license# _____, expiration date _____;
 state _____, license# _____, expiration date _____; state _____, license# _____, expiration date _____.

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