CIGNA Pharmacy Management

MEDICARE PART D Supplement to Prescription Drug Card Program Requirements and Participating Pharmacy Manual

Updated: January 2011

TABLE OF CONTENTS

WELCOME AND GENERAL INFORMATION

Welcome to the CIGNA Healthcare * Medicare Part D Participating Pharmacy Network! This Medicare Part D Supplement ("Supplement") provides each participating pharmacy with detailed program requirements and related operational policies and procedures related to Medicare Part D (that are not defined in the Program Requirements Manual). If there is a conflict between Participating Pharmacy Agreement or the Program Requirements and this Supplement, this Supplement shall govern. By signing the Participating Pharmacy Agreement, Pharmacy has agreed to comply with the Program Requirements and this Supplement. Please be certain to orient all Pharmacy staff to these requirements.

All capitalized terms used herein shall have the meaning ascribed to them in the Participating Pharmacy Agreement, unless otherwise noted.

Conditions of Participation:

To participate in the CIGNA Medicare Part D Pharmacy Network, pharmacies must meet the following criteria:

- On-line telecommunications link with the CIGNA HealthCare claim processor;
- Willingness to accept CIGNA Healthcare's Maximum Allowable Cost (MAC) list prices;
- Willingness to accept the lower of usual and customary (U&C) or contracted rate;
- Willingness to abide by CIGNA Healthcare's policies and procedures;
- Willingness to work with CIGNA Pharmacy Management and managed care plans;
- Adherence to CIGNA HealthCare's quality management guidelines;
- Competitive price; and
- Positive reputation.

All contracted pharmacies must be licensed by their State Boards of Pharmacy, as well as registered with the National Association of Boards of Pharmacy (NABP). Each pharmacy must be in good standing with the NABP, Drug Enforcement Association (DEA), Office of Inspector General (OIG) and their State Board(s) of Pharmacy through which they are licensed. We may review State Board(s) of Pharmacy data compiled through pharmacy inspections by the Pharmacy Commission, Drug Control Agencies, and other agencies. In addition, we may review complaints on file and actions taken by the State Board of Pharmacy regarding the pharmacy and its employed pharmacists. Our pharmacy contracts also require that participating pharmacies comply with applicable state and federal laws.

PRODUCTS COVERED

- Individual and Employer PDP

PRODUCTS NOT COVERED

- Individual and Employer AZ-HMO-MAPD

ELECTRONIC CLAIMS TRANSMISSIONS

Claim Transmission Requirements: CIGNA HealthCare Medicare Part D Prescription Drug Plan prescription drug claims are processed by a vendor, Argus Health Systems (Argus) via the Online System within 90 days of the fill date (or as otherwise required by law). However, claim reversals and adjustments must be processed within 60 days of the fill date. Currently Argus uses two methods for obtaining claim data via electronic protocol: dedicated phone line (host-to-host transmission) or through use of a network switch. The switch organizations recognized by Argus are WebMD (e.g., Envoy), National Data Corporation (NDC) and QS-1.

All claim transactions must utilize the 5.1 NCPDP Standard point of sale (POS) Claim Layout. While Argus supports NCPDP versions I, II, and III, pharmacies are encouraged to submit claims in version III to receive all messaging. Each organization that acts as the switch for Argus has requirements that must be met for proper claim transmittal. This information should be obtained from the switch organization. These organizations can also offer point-of-sale devices.

During Calendar Year 2011, all pharmacies, as well as Argus, will be required to update their claims system from NCPDP version 5.1 to NCPDP version D.0. On 1/1/2012, all pharmacies will be required to submit all claim transactions through NCPDP version D.0. Any transaction submitted through NCPDP version 5.1 will not be processed. Pharmacies must submit to a one-time certification process during Calendar Year 2011, to be ready to submit claims on 1/1/2012.

Key Data Elements to be submitted to Argus in order to successfully transmit a point of sale claim are:

Argus Bin Number:	012353
Carrier/Processor Control Numbers:	03490000 – CIGNA Medicare Rx (PDP)
NCPDP/NABP Number	
Beneficiary ID	
Person/Relationship Code	
Birth Date	
Gender	
Rx Number	
Date Filled	
Prescriber ID	
NDC	
Quantity	
Days Supply	
U&C	
Ingredient Cost	

Group or account numbers are not required in order to transmit a claim. In fact, CIGNA HealthCare discourages Pharmacy from entering group or account numbers, as it may result in the rejection of potentially viable claims.
CIGNA HealthCare recognizes DAW Codes 0, 1 and 2 only. While a Dispense As Written (DAW) code is not required to be transmitted on the claim, the DAW field drives reimbursement of the prescription and the Beneficiary's copayment. Therefore, it is essential that this field be used appropriately. Additionally, DAW data entered by the Pharmacy is subject to retrospective audit.

ASSISTANCE AND KEY CONTACTS

Pharmacy Help Desk: 1.800.558.9363
Claim Processing: Argus 1.800.522.7487
Reimbursement Inquiries: PharmacyNetworkOperations@Cigna.com

Prescription Drug List (Formulary)

A Prescription Drug List is a list of covered drugs that we select to cover as part of Part D coverage. The drugs are selected in consultation with a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. We generally cover the drugs listed in our Prescription Drug List as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other plan rules are followed. The Prescription Drug List has to be approved by CMS.

Prescription Drug List (Formulary) Changes

The presence of medications and/or their tier placement on the Part D Prescription Drug List (Formulary) may have changed from the previous plan year. The Part D Prescription Drug List (Formulary) will continue to cover an extensive array of medications to treat many indications. In some instances medications that have either a direct generic equivalent or a therapeutic alternative on the Prescription Drug List (Formulary) may not be covered. Some medications may also be subject to step therapy, prior authorization, quantity limitations, or further clinical review. New and existing beneficiaries who are negatively affected by any Prescription Drug List (Formulary) restrictions will be extended coverage on their medication through the CIGNA Medicare Part D transitional benefit policy as described below.

PRODUCT OFFERINGS and STANDARD BENEFIT EXCLUSIONS

We have different Prescription Drug Lists (formularies) depending upon in which Plan the beneficiary has chosen to enroll.
IPDP: There are 2 plans in which an individual can enroll; each of these two plans is linked to a different Prescription Drug List (Formulary).
ERPDP: While there is a core Prescription Drug List (Formulary) for Employer Groups, it can vary based on client; for example, many clients buy-up the Standard Part D exclusions and offer them to their retirees.

The following summary represents therapeutic drug classes that are not covered under our Individual plans, however, can be and often times are covered via a buy-up on our employer groups.

STANDARD BENEFIT EXCLUSIONS

Drugs excluded under Medicare Part D:

a. Agents for Anorexia, Weight Loss, or Weight Gain
b. Agents used to promote fertility
c. Agents used for cosmetic purposes or hair growth
d. Agents used for the symptomatic relief of cough and cold
e. Prescription vitamins and mineral products; except prenatal vitamins and fluoride preparations
f. Nonprescription drugs
g. Outpatient drugs for which the manufacturer seeks to require that associated test or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
h. Barbiturates
i. Benzodiazepines
j. Agents when used for the treatment of sexual or erectile dysfunction (ED) unless prescribed for medically accepted indications approved by the FDA other than sexual dysfunction such as pulmonary hypertension.

ADDITIONAL PRIOR AUTHORIZATION DRUGS/PRECERTIFICATION PROCEDURES

Summary of Possible Medicare Part B vs. Medicare Part D Drugs:

DRUG	Part B or Part D
Infusible DME supply drugs	**B or D**
Other Injectables	**B or D**
IVIG	**B or D**
Hepatitis B Vaccine	**B or D**
Epogen	**B or D**
TPN	**B or D**
Nebulizing Solution	**B or D**
Immunosuppresants	**B or D**
Oral anti-cancer	**B or D**
Oral anti-emetic	**B or D**

Diabetic Supplies	**B**
Antigen	**B**
Flu Vaccine	**B**
Pneumococcal Vaccine	**B**
Blood Clotting Factors	**B**
Blood Products	**B**

Medicare Part B vs. Part D Coverage Determinations:

For the upcoming plan year, Part B vs. D coverage determinations will be managed as follows:

1. When claims for drugs that should be covered under Medicare Part B benefit are submitted, they will be rejected with **error code 221 "Part B Only"**.
2. Drugs that require further review to determine coverage eligibility under Part B vs. Part D will be rejected with **error code 195 "PA Required – Determine B or D".** Certain drugs that will reject with error code 195 may require the pharmacist to contact the CIGNA Pharmacy Service Center for further review. For other drugs, that are more commonly used for Part D eligible indications, in addition to error code 195, a PAC code will be provided in the free form text field. Pharmacist should carefully review the free form text message and assess eligibility for Part D coverage. When deemed eligible, the rejected claims should be resubmitted using the provided PAC code for payment under the Medicare Part D benefit.

In all situations where a drug should be processed under Medicare Part D Prior Authorization Code (PAC) 34910 should be used pending pharmacy review that such drug is Part D eligible. The PAC 34910 applies to all pharmacies and will only work in situations where a PAC code has been requested in the requirements to be returned to the pharmacy to allow the submission of the drug as eligible for coverage under Part D.

Compound Prescriptions:

Compound prescription drug products can contain all Part D components, some part D components or no Part D components. Only those ingredients that satisfy the definition of a Part D covered drug are eligible for reimbursement. Compounded products as a whole do not satisfy the definition of a Part D drug are not eligible for payment under Part D. Claims should be submitted using the NDC of the Part D covered drug with the most expensive ingredient and entering compound indicator "2".

Parenteral Nutritions:

Require Prior Authorization. Submit claims for parenteral nutrition using the NDC of the most expensive ingredient and entering compound indicator "2". Claims billed under compound NDC (99999-9999-96) will be denied.

Note: Network pharmacies are subject to audit for appropriate billing of prescription drug claims submitted under Medicare Part B, Medicare Part D and for compounds and TPNs.

Medication Therapy Management Program: Employer and Individual

The Medication Therapy Management Program (MTMP) is part of CIGNA HealthCare's Medicare Part D Prescription Drug program. MTMP is a voluntary program designed to help high-risk beneficiaries effectively manage their prescription drug benefits. Beneficiaries identified for the program take multiple prescription drugs, have chronic illnesses, and are expected to spend a significant amount of money on medications each year. The individual beneficiary, although enrolled automatically if they qualify, may opt-out of participation in the program if he/she so chooses.

CIGNA HealthCare has a team of pharmacists who may communicate with MTMP eligible beneficiaries to help them understand their chronic conditions and the prescriptions they take. The pharmacists may also

perform either comprehensive and/or targeted medication reviews for program beneficiaries. Furthermore, this program will also alert prescribing physicians about potential medication and safety issues identified.

Quality Assurance and Beneficiary Grievance

Pharmacy must fully cooperate with CIGNA HealthCare Quality Assurance Programs and as may be required by CMS, with prompt reply to any quality of care and quality of service issues pertaining to the delivery of Covered Services by the Pharmacy.

Pharmacy shall follow all applicable formal procedures for quality assurance programs as may be required by CMS or mandated by applicable state law. If there are no such CMS or applicable state law mandates, Pharmacy shall follow the formal procedures for preventing and handling prescription errors as submitted by Pharmacy in its Application to participate in the CIGNA HealthCare pharmacy network.

Transitional Benefit

CIGNA Pharmacy Management will administer a transition process that will help facilitate new and existing beneficiary's coverage for those beneficiaries that may be changing from another Part D plan or continuing from the previous plan year. The transitional process will apply to any drug subject to a clinical edit that result in a claim denial. Types of edits include Prior Authorization, Step Therapy, Quantity Limits, age, or gender edits. Drugs covered through the transitional process will adjudicate at the non-preferred brand copay. The transition process will NOT apply to drugs excluded from the standard Medicare Part D benefit. Drugs potentially covered under Medicare Part B will continue to be subject to coverage determination edits.

New Beneficiaries One-Time Transition Supply:
For each drug that has a limitation, new beneficiary will be eligible for a temporary one-time supply (up to 31 days) within the initial 90 days of their plan effective date for prescriptions filled at a network pharmacy. After the first transitional fill supply, these drugs will no longer be covered under the transitional benefit and will be subject to all utilization edits for the remainder of the calendar year.

Existing Beneficiaries One-Time Transition Supply:
Current beneficiaries with a CIGNA Medicare Part D benefit should have received the Annual Notice of Change (ANOC) packet by October 31. The packet contains information, which the beneficiary may use, to determine if a Prescription Drug List (Formulary) medication they are taking will either carry a different cost share, have limited coverage, or will be subject to prior authorization, quantity limits or step therapy in the coming year. Beneficiaries are instructed to work with their doctors to either find an appropriate alternative therapy on our new Prescription Drug List (Formulary) or request a formulary exception prior to January 1. If the exception request is approved, we will authorize payment prior to January 1 and provide coverage beginning January 1.

If beneficiaries have not received approval for their formulary exception request prior to January 1, those beneficiaries will be eligible to receive a temporary one-time transition supply (up to 31 days) while continuing to work with their doctor to find an appropriate alternative therapy.

Long Term Care Beneficiaries:
New and existing beneficiaries residing in long term care facilities will be eligible for a temporary transition supply (up to a 34-day supply) with multiple refills (up to a 102-day supply) within the first 90 days of their plan eligibility. After this transitional period has passed, the medication will be subject to all utilization edits for the remainder of the calendar year.

Emergency supply for Current Enrollees in a Long Term Care Facility:
During the first 90 days of beneficiary enrollment, long term care residents will receive a transition supply as described above. However, to the extent that a beneficiary is outside his or her 90-day transition period, that member will be eligible for a 31-day emergency supply of non-formulary drugs or drugs subject to utilization management edits while an exception is being processed. This emergency supply should only be allowed once per calendar year, and once per beneficiary, per facility, per drug.

Level of Care Changes:
An extended transition process will be provided in circumstances involving Level of Care changes in which a beneficiary is changing from one treatment setting to another. An override for the "Refill Too Soon" edit will be provided to allow appropriate coverage. Since there may be some period of time in which beneficiaries with Level of Care changes experience a temporary gap in coverage while going thought the exception process, beneficiaries will be eligible for up to a 31-day supply of medication while an exception is being processed.

Beneficiary and Provider Communication:
Following the first fill of a prescription during the transition period, letters will be generated and mailed to the beneficiary and his or her prescriber to advise of possible future denials and to communicate the medical necessity exception process. For those patients residing in long term care facilities, these letters will be generated and mailed to the long term care pharmacy instead of the beneficiary's prescribing physician. We strongly encourage long term care pharmacist to work with the physician to make the necessary changes or initiate the exception process. After the transition period, all drugs subject to utilization management will be subject to exception/prior authorization review, unless coverage approval was obtained during the transition period.

Transitional Benefit Prior Authorization Codes (PAC):
Pharmacist will receive online messaging at the point of sale providing the appropriate override code for beneficiary transitional period. Override codes will displayed for the following categories:

1. Network Pharmacies (Retail, ITU, Home Infusion Therapy or Specialty Claims:
    - Claim will be initially rejected with online message: "NON –LTC TRAN BFT USE PAC 21000." Dispensing pharmacist can resubmit claim using override PAC code 21000 and fill for the one time 31-day transitional supply.
2. Long Term Pharmacy Claims:
    - Claim will be initially rejected with online message: "LTC TRAN BFT USE PAC 41000." Dispensing pharmacist can resubmit claim using override PAC code 41000 and fill for the 34-day transitional supply.
3. Emergency Supply for Current Enrollees in a Long Term Care Facility:
    - Claim will be initially rejected with online message: "LTC EMERGENCY FILL USE PAC 42000." Dispensing pharmacist can resubmit claim using override PAC code 42000 and fill for the 31-day emergency supply.
4. Level of Care Changes:
    - Claim will be initially rejected with online message: "LOC CHANGE LTC USE PAC 43000" **OR** "LOC CHANGE NON-LTC USE PAC 23000." Dispensing pharmacist can resubmit claim using override PAC codes 43000 **OR** 23000.

The above PAC codes will not override CMS-excluded drugs, Part B drugs or B vs. D rejections. Claims that require prior authorization due to clarification of B vs. D will have to go through the standard prior authorization process.

Administrative Edits and Safety Edits

CIGNA Medicare Part D will continue Administrative Edits and Safety Edits for this plan year. Administrative edits will reject for claims for non-compound drugs with an ingredient cost of greater than $2000 per fill for up to a 30-day supply or greater than $6000 for a three month supply. This edit will also be generated for compounded drugs that are greater than $200 per 30- day supply or greater than $600 for a three month supply. Administrative edits will be used to determine coverage eligibility of the prescribed drug as well as monitor any safety issues associated with prescribed drug utilization. Once rejected, pharmacist will be instructed to contact the CIGNA Pharmacy Service Center for further review of rejected claims. Pharmacist will either receive an authorization which will allow the rejected claim to pay, or instruction on how to request an exception for coverage.

Safety edits will be generated for those claims that exceed a certain quantity limit threshold above the FDA approved maximum dose. When safety edits are generated, pharmacist should first verify the correct quantity and rebill if an error is discovered. If the quantity submitted is verified to be correct, then the pharmacist should notify the prescriber to obtain prior authorization for coverage, or receive the correct billable quantity for the prescribed drug. We encourage our network providers to carefully review the online message in the free form text field which assist with further processing of claims that are rejected due to administrative or safety edits.

Long Term Care Claim Override Codes

- Pharmacies serving residents of Long Term Care should submit such Part D claims with "3" for location code.
- Pharmacies serving residents of Assisted Living Facilities should submit Part D claims with "5" for location code.
- Leave of absence, max 7 days supply – NCPDP code 420-DK = 3
- Lost Medications, max of 3 days supply – NCPDP code 420-DK=4
- Therapy change (Dose change or treatment frequency change for the same drug) – NCPDP code 420-DK=5
- Medically necessary (Allow billing for same drug in different dosage form) – NDCPD code 420-DK=7

Long Term Care Audit Requirements

CIGNA HealthCare will monitor performance through a review of paid prescription claim data. Examples of reviews that CIGNA HealthCare may conduct include but are not limited to the following:

- Compound prescriptions to validate the accuracy of the submitted ingredient cost.
- The number of paid prescriptions in excess of defined amounts.
- Claims for controlled substances.
- Claim histories to detect claim submission errors (e.g., double billings and split prescriptions).
- Dispense as Written (DAW) code billings to ensure that brand drugs are only billed when either prescribed by the physician or requested by the beneficiary.
- Signature logs to detect prescriptions not picked up by the beneficiary.
- Billings to ensure that prescriptions, including partial fills not picked up by the beneficiary have been reversed

In addition, CIGNA HealthCare will monitor performance through random audits, patient satisfaction surveys, and patient complaints.

Medicare Part D Coverage Gap Discounts

Brand Drugs:

Effective 1/1/2011, the Coverage Gap Discount Program will provide manufacturer discounts on brand name drugs, with certain exceptions, to Part D enrollees when they reach the coverage gap.

- The drugs must be identified as brand name drugs by the Food and Drug Administration (FDA), otherwise they will be classified as a generic drugs.
- The 50% manufacturer brand discount applies to the negotiated price
    - Negotiated price = ingredient cost + sales tax
    - Dispensing fees and vaccine administration fees are not included in the negotiated price and, therefore, are not eligible for manufacturer discount
- If a member has a plan, where brand coverage is available in the coverage gap, the 50% brand discount will apply to the co-pay, as long as it is an FDA classified brand drug
- If a claim straddles the coverage gap and initial coverage or catastrophic coverage, the manufacturer discount is only applicable to the portion of the drug cost that falls within the gap
- The dispensing fee for any straddle claim is to be paid under the initial coverage or catastrophic coverage

- Individuals receiving low-income subsidy are not eligible for the manufacturer brand discount since they already are receiving coverage in the gap
- If the manufacturer does not sign the agreement, CMS will not allow their drug to be covered, effective 1/1/2011
- Reject Error Code 283 – "CMS Part D Non-Participating Manufacturer" will appear if a non-participating manufacturer's drug is entered for claim submission
- In most instances, for non-participating manufacturers' drug, a similar drug is available through a different manufacturer/NDC

Generic Drugs:
Effective 1/1/2011, as part of a gradual reduction in beneficiary expenses, members will be responsible for 93% of generic drug costs while in the 'Coverage Gap', depending on their benefit plan. However, there are plans in which generic coverage is available in the coverage gap; this will yield in a 'richer' benefit for the member

Medicare Part D Sanctioned Provider Denial Error Code

Effective January 21, 2010 the "sanctioned provider" edit will be reinstated for Medicare Part D claims with a denial error code "**261 Prescriber currently sanctioned**." The denial is due to the prescriber being identified as excluded from participation in Medicare, Medicaid and all Federal health care programs by the Office of Inspector General. The Center for Medicare and Medicaid Services requires that Part D plans prevent payment for any claims for sanctioned prescribers.
Please contact the affected provider to make them aware of the denial. If necessary, advise patients to obtain a new prescription from a different provider or ask them to provide the name of an alternate provider to contact to obtain an authorization for that prescription.

Prescribers and pharmacies can find more information regarding sanctioned providers at:
Online: http://oig.hhs.gov/fraud/exclusions.asp
Email: sanction@oig.hhs.gov
Phone: 410-281-3060

Compliance with Medicare Requirements

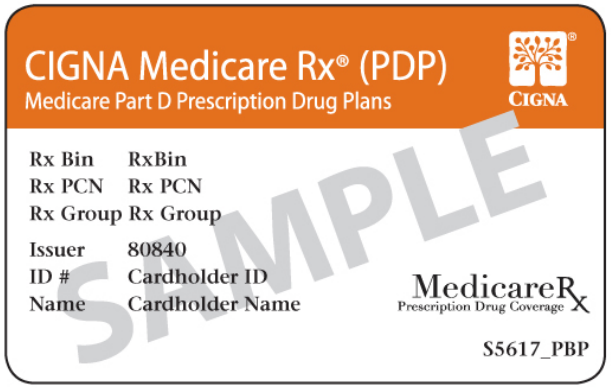
Pharmacy agrees to provide to CIGNA all information and data related to Pharmacy's provision of services under the Agreement and the Medicare Part D Addendum as such services pertain to Medicare Part D, required for CIGNA's compliance with audits conducted by CMS or its designees, including but not limited to information and data on prescription drugs claims, utilization, and medication therapy management ("CMS Audit Data"). Pharmacy shall provide CIGNA with CMS Audit Data promptly upon written request from CIGNA, or within such time frames as are necessary for CIGNA to meet CMS audit deadlines as communicated to Pharmacy by CIGNA. Pharmacy shall provide CMS Audit Data in the form and format required by CMS or its designee. Pharmacy acknowledges and agrees that if it is unable to fully comply with CIGNA's requests for CMS Audit Data, whether willfully or inadvertently, that results in incomplete or missing information or data, Pharmacy shall indemnify and hold CIGNA harmless from and against any and all recoveries, fines and penalties assessed by CMS against CIGNA (including possible extrapolated recoveries) as a result of such incomplete or missing information or data.

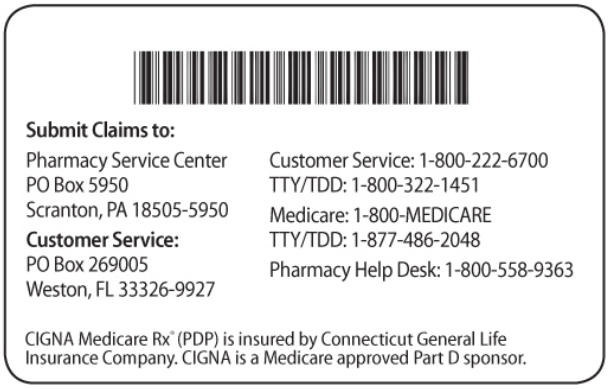
Notice of "Medicare Prescription Drug Coverage and Your Rights"

Per CMS requirement 42 CFR §423.562(a)(3), pharmacy shall either conspicuously post the notice in Exhibit B at the pharmacy or distribute the notice to enrollees.

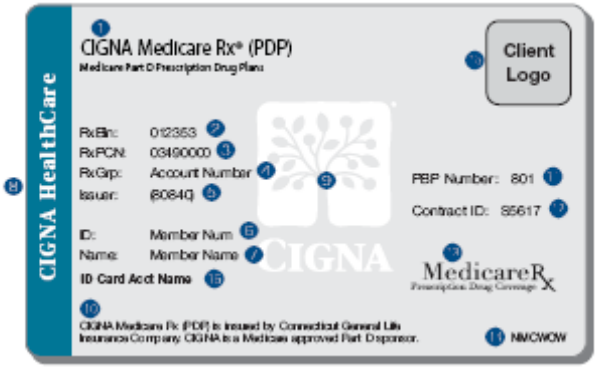
Exhibit A

Sample CIGNA Medicare Rx (PDP) Card





Sample CIGNA Medicare Rx (ERPDP) Card



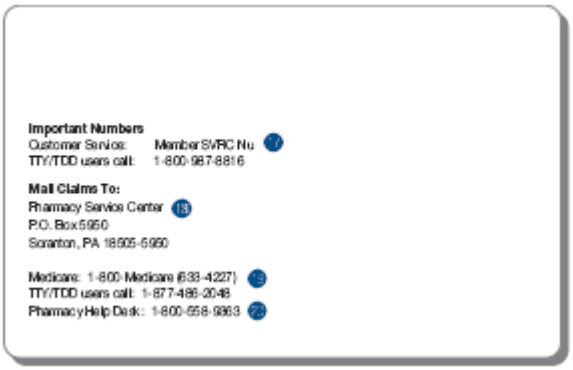


Exhibit B

OMB APPROVED # 0938-NEW

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

You have the **right to get a written explanation** from your Medicare drug plan if:

- Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription.
- You are asked to pay more than you think you are required to pay for a prescription.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription(s) are not covered and will explain how you can request an appeal if you disagree with the drug plan's decision.

You **also have the right to ask** your Medicare drug plan **for an exception** if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary."
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception. You can refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.

- When you contact your Medicare drug plan, be ready to tell them:

    1. The prescription(s) that you believe you need.

    2. The name of the pharmacy or physician who told you that the prescription(s) are not covered.

    3. The date you were told that the prescription(s) are not covered.

CMS-10147