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

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WELCOME AND GENERAL INFORMATION

Welcome to the CIGNA Healthcare * Medicare Participating Pharmacy Network. This Medicare Supplement ("Supplement") provides each participating pharmacy with detailed program requirements and related operational policies and procedures related to Medicare that are not defined in the Program Requirements Manual. If there is a conflict between the Participating Pharmacy Agreement or the Program Requirements and this Supplement, this Supplement shall govern. By signing the Participating Pharmacy Agreement, you have 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 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 require that participating pharmacies comply with applicable state and federal laws.

ELECTRONIC CLAIMS TRANSMISSIONS

Claim Transmission Requirements: Prescription drug claims are processed by a CIGNA HealthCare vendor, Argus Health Systems (Argus) via the Online System within 90 days of the fill date (or as otherwise required by law). 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.

* "CIGNA HealthCare" is a registered service mark and refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company and HMO service company subsidiaries of CIGNA Health Corporation.

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.

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

Argus Bin Number:	012353
Carrier/Processor Control Numbers:	03490000 – CIGNA Medicare PDP program 03500000 – CIGNA MAPD program 05000000 - CIGNA Medicare Private Fee For Service program
NCPDP/NABP Number	
Participant 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 Pharmacies 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 Participant's copayment. Therefore, it is essential that this field be used appropriately. Additionally, DAW data entered by the Pharmacy is subject to retrospective audit.

ePrescribing Claims Processing

Receipt of electronic prescriptions is not a requirement as a member of the CIGNA Pharmacy network, however, pharmacies are encouraged to consider adding ePrescribing to their systems.

CMS requests that pharmacies receiving prescriptions via ePrescribing report the Prescription Origin Code via the NCPDP 5.1 optional field 419 DJ. Note that for 2009 this requirement is optional.

PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS

If a Medicare prescription is not filled for the lowest-priced generic version of that drug available at your pharmacy, CMS requires that you inform the individual of any differential between the price of the drug on the prescription and the lowest priced generic version of that drug that is an AB-rated alternative, therapeutically equivalent and bioequivalent on the plan's formulary and available at that pharmacy. This

disclosure should be made at the time the individual purchases the drug or at the time of delivery of the drug. This requirement is applicable for all retail and mail order pharmacies except:

- MA Private Fee-For-Service pharmacies
- Indian/Tribal Unit Network pharmacies
- Network pharmacies located in any of the U.S. territories (American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the firgin Islands)
- Out-of-Network pharmacies.

ASSISTANCE AND KEY CONTACTS

Pharmacy help desk: 1.800.558.9363

Pre-enrollment customer service number: 1.800.735.1459

Post-enrollment customer service number: 1.800.222.6700

Customer website: www.cigna.com

Claim processing: Argus 1.800.522.7487

Reimbursement inquiries: PharmacyNetworkOperations@Cigna.com

Audit Questions:

PRESCRIPTION DRUG LIST

CIGNA HealthCare utilizes a formulary to manage prescription drug costs. A copy of our Medicare drug list is available at www.cigna.com

PRODUCT OFFERINGS and STANDARD BENEFIT EXCLUSIONS

CIGNA HealthCare offers different pharmacy benefit options for Medicare participants. Further details about plan options and benefit designs are available on www.cigna.com

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 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 total parenteral nutrition (TPN) 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:

The Medication Therapy Management Program (MTMP) is part of CIGNA HealthCare's Medicare Prescription Drug program. MTMP is a voluntary program designed to help high risk participants effectively manage their prescription drug benefits. Participants included in the program typically take multiple prescription drugs, have chronic illnesses and are expected to spend a significant amount of money on medications each year. CIGNA HealthCare has a team of pharmacists who may communicate with MTMP eligible participants to help understand their chronic conditions and the prescriptions they take. This program will also alert prescribing physician about potential medication safety issues that we identify.

Quality Assurance and Participant Grievance: Participating Pharmacies must fully cooperate with CIGNA HealthCare's Quality Assurance Programs and, as may be required by CMS, reply promptly to any quality of care and quality of service issues pertaining to the delivery of Covered Services by the Pharmacy.

Participating Pharmacies 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, the Pharmacy shall follow the formal procedures for preventing and handling prescription errors as submitted by the Pharmacy in its Application to participate in the CIGNA HealthCare pharmacy network.

Drug List Changes:

The presence of medications and/or their tier placement on the CIGNA Medicare drug list may have changed from the previous plan year. The CIGNA Medicare Rx drug list 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 drug list may not be covered. Some medications may also be subject to step therapy, prior authorization, quantity limitations, or further clinical review. New and existing participants who are negatively affected by any drug list restrictions will be extended coverage on their medication through the CIGNA Medicare Rx transitional benefit policy as described below. A copy of the CIGNA Medicare Rx drug list can be found at www.cigna.com

Transitional Benefit

CIGNA Pharmacy Management administers a transition process that will help facilitate new and existing participant's coverage for those participantss that may be changing from another Medicare plan or continuing from the previous plan year. The transitional processes will apply to any drug subject to a clinical edit that will result in a claim denial. Types of edits include PA (prior authorization), Step Therapy, Quantity Limits, age, or gender edits. The transition process will NOT apply to drugs covered at 3rd tier copay without a clinical edit (i.e. will not change copay to lower tier through the transition process.) Drugs potentially covered under Medicare Part B and drugs excluded from the standard Medicare Part D benefit will continue to be subject to coverage determination edits.

New Participants One-Time Transition Supply:
For each drug that has a limitation, new participants 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 31-day transitional 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 Participants One-Time Transition Supply:
Continuing participants in the CIGNA Medicare benefit should have received the Annual Notice of Change (ANOC) by October 31 informing them if a formulary medication they are taking is either carrying a different cost share, has 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 drug list or request a drug 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 participants have not received approval for their formulary exception request prior to January 1, those participants will be eligible to receive an initial 31-day transition supply while continuing to work with their doctor to find an appropriate alternative therapy.

Long Term Care Patients:
New and existing participants 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 a participant's enrollment, long term care residents will receive a transition supply as described above. However, to the extent that a participant is outside of his or her 90-day transition period, that participant will be eligible for a 31-day emergency supply of non-covered 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 participant, 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 participant 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 participants with Level of Care changes experience a temporary gap in coverage while going thought the exception process, participants will be eligible for up to a 31-day supply of medication while an exception is being processed.

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

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

1. Network Pharmacies (Retail, Indian Tribal Unit, 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 the claim using an override PAC code 21000 and fill for the one time 31-day transitional supply.
2. Long Term Care Pharmacy Claims:

- Claim will be initially rejected with online message: "LTC TRAN BFT USE PAC 41000." Dispensing pharmacist can resubmit the claim using an 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 the claim using an 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 the claim using an 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:
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 mail order 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 mail order 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, the pharmacist will be instructed to contact the CIGNA Pharmacy Service Center for further review of rejected claims. The 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, the 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 to 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 facilities should submit such Part D claims with "3" for patient location code.
- Pharmacies serving residents of Assisted Living Facilities should submit Part D claims with "5" for patient 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

Audit Requirements:

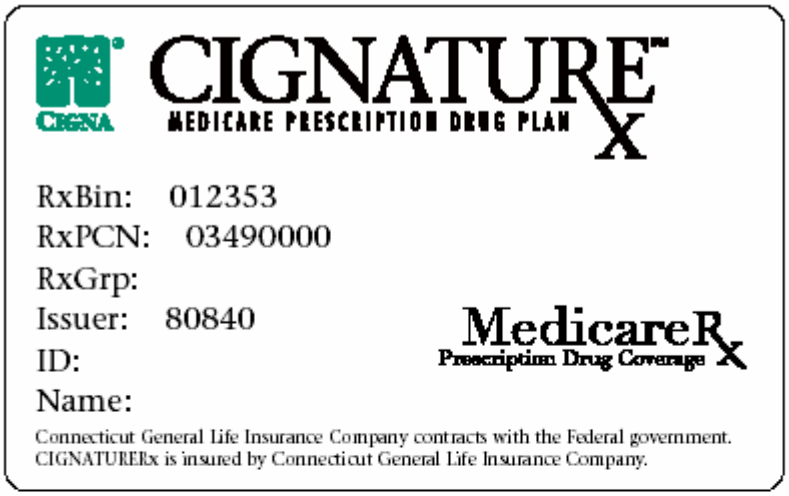
CIGNA HealthCare has contracted with Pharm/DUR Inc. to monitor performance through a review of paid prescription claim data. Examples of reviews that CIGNA HealthCare may conduct include but are not limited to the following:

- 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 participant.
- Signature logs to detect prescriptions not picked up by the participant.
- Billings to ensure that prescriptions, including partial fills not picked up by the participant have been reversed

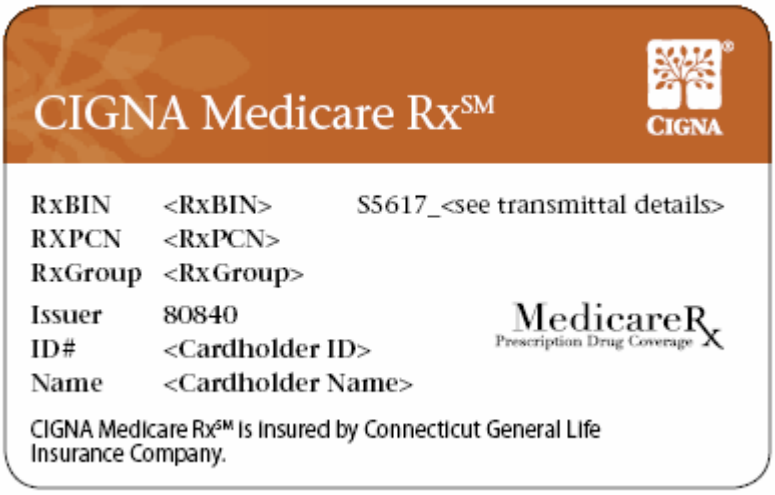
In addition, CIGNA HealthCare will monitor performance through random audits, patient satisfaction surveys, and patient complaints.

Notice of "Medicare Prescription Drug Coverage and Your Rights"
Per CMS requirement 42 CFR §423.562(a)(3), pharmacy shall either conspicuously post the notices in Exhibit B at the pharmacy or distribute the notice to enrollees.

Exhibit A
Below is a sample of the CIGNA Medicare PDP ID Card prior to 2008.



Effective January 1, 2008 the CIGNA Medicare PDP ID card will look like the below. Note that existing participantss will not be reissued new ID Cards with the new format. Both the CIGNATURERx ID Card and the CIGNA Medicare Rx ID Card are valid for claim processing.



MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

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

- Your prescriber or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed; or
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

You **also have the right to ask** your Medicare drug plan **for an exception** (a special type of coverage determination) **and get a written explanation** from your Medicare drug plan 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 a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- 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 coverage determination, including an exception request.
- 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 drug(s) that you believe you need. Include the dose and strength, if known.
2. The name of the pharmacy or prescriber who told you that the prescription drug(s) is not covered.
3. The date you were told that the prescription drug(s) is not covered.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to complete this information collection is estimated to average one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form No. CMS-10147 (10/31/2011)

SUS DERECHOS Y LA COBERTURA DE MEDICARE DE RECETAS MÉDICAS

Usted **tiene el derecho de solicitar una determinación de cobertura y recibir una explicación por escrito** de su plan de Medicare de recetas médicas si:

- Su prescriptor o farmacéutico le dice que su plan de Medicare para recetas médicas no cubre un medicamento recetado por la cantidad o forma que ha sido prescrita o.
- Le piden pagar una cantidad de costo-compartido diferente a la que usted piensa que tiene que pagar por una medicina recetada.

La explicación por escrito del plan de Medicare para recetas médicas le dará las razones específicas por las que no se cubre la receta médica y le explicará cómo solicitar una apelación si no está de acuerdo con la decisión del plan.

También tiene el derecho de pedirle a su plan de Medicare para recetas médicas **una excepción** (un tipo especial de determinación de cobertura) **y recibir una explicación** de su plan de Medicare de Recetas Medicas si:

- Usted cree que necesita un medicamento que no está en la lista de su plan de medicinas cubiertas. La lista de medicinas cubiertas se llama un "formulario;"
- Usted cree que una regla de cobertura, como la autorización previa o una cantidad límite, no es aplicable a usted por razones médicas o
- Usted cree que debe obtener una medicina que necesita a una cantidad de costo-compartido más baja.

Lo qué necesita hacer:

- Comuníquese con su plan de recetas médicas y pida una determinación de cobertura incluyendo una solicitud de excepción.
- Revise el manual de beneficios que recibió de su plan o llame GRATIS al 1-800-MEDICARE para averiguar cómo comunicarse con su plan de medicamentos.
- Cuando llame a su plan de Medicare para recetas médicas, este listo para decirles:

    1. La medicina o medicinas que usted cree que necesita.
    2. El nombre de la farmacia o prescriptor que le informó que el medicamento no está cubierto, incluyendo la dosis y fuerza, si se conoce.
    3. La fecha en que le informaron que el/los medicamento(s) no estaba cubierto.

La **Ley de Reducción de Papeleo de 1995** requiere que le avisemos que la colección de esta información se hace según las disposiciones de la sección 3507 de La Ley de Reducción de Papeleo de 1995. No podemos coleccionar ni patrocinar la colección de información, y usted no está obligado a responder a una colección de información a menos que muestre un número válido de control de la Oficina de Gerencia y Presupuesto (OMB, siglas en inglés). El número válido de control de OMB para esta colección de la información es 0938-0975. Calculamos que tardará un minuto para completar cada sección. Esto incluye el tiempo que se tardará en leer las instrucciones, reunir la información necesaria y llenar el formulario. Si usted tiene comentarios sobre la precisión del estimado que toma llenar este formulario o sugerencias de cómo mejorar este documento, por favor envíelos por escrito a: **CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05. Baltimore, Maryland 21244-1850.**

Form CMS-10147-SP (10/31/2011)