Pharmacy Manual

Revised December 2008
CONFIDENTIAL AND PROPRIETARY

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Walgreens Health Initiatives' Overview

Walgreens Health Initiatives, Inc. is pleased to welcome you to our network of participating pharmacies. We look forward to working with you to provide accessible, cost-effective, quality pharmacy services to our clients' members.

This manual is intended as a guide for your pharmacy staff in claims processing, and provides general terms, conditions, procedures, and policies of Walgreens Health Initiatives. Online claims adjudication and messaging reflect the most current benefits. Please also refer to your most recent Pharmacy Network Agreement for network participation requirements, which will control in the case of any conflict between this manual and the Pharmacy Network Agreement.

We hope that your day-to-day questions concerning Walgreens Health Initiatives' pharmacy programs are adequately addressed in this manual. If you have questions or require additional information, please refer to the "Provider Relations Department" section of this manual.

Walgreens Health Initiatives entered the PBM industry in January 1996 and services local, regional, and national clients via a network of pharmacies nationwide. We appreciate your participation in our provider network, allowing us to extend our services to patients in your area

Member Eligibility

Any questions regarding member eligibility should be directed to the Walgreens Health Initiatives Customer Care Center (toll free) at 800-207-2568.

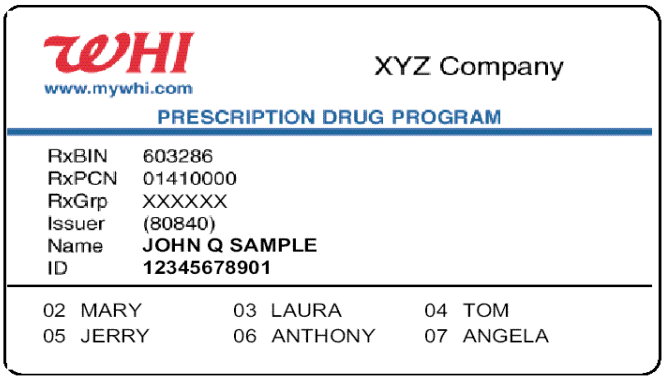
Identification Card

Walgreens Health Initiatives' members are provided an identification card. Members are instructed to present their ID card when obtaining a prescription from a network pharmacy. When submitting a claim for services, it is important that you ask to see the member's ID card and the name of the member. If no ID card is presented, and eligibility for which the prescription is written cannot be confirmed through the POS System or through our Customer Care Center, then the patient should be notified, and the pharmacy may apply its standard operating procedure.

A pharmacist can verify a member's coverage by submitting the information noted on the member's ID card. If an "invalid" response is received, please check that all submitted information matches the elements on the ID card.

Here is the Information that generally appears on the member's Walgreens Health Initiatives Identification Card (Figure 1 below is an example ID card). This information is required to file a claim:

Figure 1. Walgreens Health Initiatives' Identification Card



- **Cardholder's Name**
  The subscriber name associated with the cardholder's ID number.
- **Cardholder's ID Number**
  The subscriber identification number. This will usually be either a nine-digit number, or nine-digit number with a two-digit suffix, or other alpha-numeric variation. (The patient's birthdate must also be submitted with claim.)
- **Group Number**
  A six-digit numeric code assigned to the plan must be submitted with each claim.

Please note the processing information for the plan above:
BIN: 603286
PCN: 01410000

Formulary Changes

Please refer to your Pharmacy Network Agreement with Walgreens Health Initiatives for specific requirements regarding compliance with WHI or a plan sponsor's formulary and related WHI programs. For information regarding formulary changes, including but not limited to removal of a covered drug from a formulary or changes to the preferred or tiered cost-sharing status of a covered drug, please refer to WHI's website or, as applicable, the website of the plan sponsor. Notwithstanding the foregoing, immediate removal of a drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer may be necessary.

General Walgreens Health Initiatives Policies

Access to and Retention of Records

Unless otherwise set forth in your Pharmacy Network Agreement with Walgreens Health Initiatives, records are required to be maintained and accessible for: (i) ten years following each year of the term in which the pharmacy provides Services under the

Pharmacy Network Agreement or longer as mandated by CMS (Centers for Medicare and Medicaid), for Medicare Part D; (ii) six years for the Medicare Drug Discount Card; and (iii) five years or per applicable federal or state law, whichever is longer, for any other Walgreens Health Initiatives' business records. Please refer to your Pharmacy Network Agreement with Walgreens Health Initiatives and applicable state and federal law for specific record retention requirements.

Compliance with Laws and Regulations

Pharmacies will comply with the terms of its Pharmacy Network Agreement with Walgreens Health Initiatives, as well as all applicable laws, rules, and regulations, including, without limitation, the Social Security Act, Medicare Part D implementing regulations, 42 CFR Parts 400-423, CMS instructions and the federal anti-kickback statute, 42 USC §1320a-7b(b), as any of which may be amended from time to time. The pharmacy represents that neither it nor any of its owners, directors, officers, employees, or contractors are subject to sanction under the Medicare /Medicaid program or debarment, suspension, exclusion under any other federal or state agency or program, or otherwise are prohibited from providing services to Medicare or Medicaid beneficiaries. The pharmacy will notify PBM immediately of any change in such status. Any breach of the requirements and representations set forth in this paragraph is grounds for immediate termination by Walgreens Health Initiatives of the Pharmacy Network Agreement.

Signature Logs

The pharmacy shall maintain a signature log at each location listing the Plan Name, Prescription Number, and date of receipt, and require an eligible member or representative who receives a covered drug to sign the log. In certain situations delivery manifests may be acceptable, as determined by Walgreens Health Initiatives in its sole discretion. Other acceptable means of maintaining these data may be appropriate with Walgreens Health Initiatives' written consent.

Confidentiality Requirements

Please refer to your Pharmacy Network Agreement with Walgreens Health Initiatives for specific confidentiality requirements, including HIPAA requirements and requirements regarding Walgreens Health Initiatives' confidential and proprietary information.

Liability Coverage

Please refer to your Pharmacy Network Agreement with Walgreens Health Initiatives for specific insurance requirements.

Prescription Medication Fraud, Waste, and Abuse

Walgreens Health Initiatives takes health care fraud, waste, and abuse (FWA) seriously. CMS published a final rule entitled, "Revisions to the Medicare Advantage and Part D Prescription Drug Contract Determinations, Appeals, and Intermediate Sanctions Processes," FR Doc. 07-5946 (72 FR 68700 through 68741) in December 5, 2007. The

revised rule **requires** appropriate FWA training be conducted by first tier, downstream, and related entities, including pharmacies, of Medicare Advantage (MA) organizations and Medicare Part D Sponsors. This change in the training requirement becomes effective January 1, 2009 and must be completed by December 31, 2009 and annually thereafter.

It is the responsibility of the pharmacy to ensure appropriate FWA training is provided to its employees, including managers and directors, using a FWA training program which meets the requirements of CMS and Walgreens Health Initiatives. It is also the responsibility of the pharmacy to maintain a log of pharmacy personnel who have received FWA training and a copy of FWA training materials, all of which are available to WHI for review upon request. Additionally, the network pharmacy must provide an attestation to the fact that all its employees, including managers and directors, receive such training at the time of hire and annually thereafter.

Guidance on Medicare Part D FWA can be obtained from CMS' Chapter 9 - Part D Program to Control Fraud, Waste and Abuse of the Prescription Drug Benefit Manual. This chapter provides both interpretive rules and guidelines on how to implement the regulatory requirements under 42 C.F.R. § 423.504(b)(4)(vi)(H) to have in place a comprehensive fraud and abuse plan to detect, correct and prevent FWA as an element of a compliance plan. Additionally, this chapter outlines CMS' guidelines for operational issues such as handling complaints, and coordinating with CMS and law enforcement.

How to Report Potential Fraud, Abuse, or Suspicious Activity

If you suspect fraud, abuse, or suspicious activity has occurred, is occurring, or will occur, please report it immediately through any of the following ways:

Twenty-four hour Toll Free Hotline:	1 (800) 666-5677
Email:	Compliance@walgreens.com
Fax Information to WHS Compliance:	1 (847) 964-6950
Mail:	Walgreens Health Services Attn: WHS Compliance 1415 Lake Cook Road, MS L346 Deerfield, IL 60015

In addition to the above reporting resources you may report potential Medicare Part D drug violations to the:

HHS OIG:	1-800-HHS-TIPS (1-800-447-8477) e-mail: HHSTips@oig.hhs.gov fax: 1-800-223-8164
Medicare Program directly at:	1 (877) 772-3379

When reporting suspected fraud, please remember to include the names of all applicable parties involved. Specify which person you believe is committing the fraud,

identify the dates of service or issues in question and describe in detail why you believe a fraudulent act may have occurred. If possible, please include your name and telephone number so we may contact you if we have any questions during our investigation. All reports are treated as confidential and will be investigated as appropriate, including applicable referral to law enforcement and regulatory bodies. Reports may be made anonymously.

Provider Relations Department

All communication, contracting, and pharmacy updates and concerns can be submitted to the Provider Relations general group email box at ***Provider.Relations@walgreens.com***, faxed to Provider Relations at 847-572-4160, or. mailed to:

Walgreens Health Initiatives
PO Box 545, Mail Stop 4340
Deerfield, IL 60015-0545
Attn: Provider Relations

Network Participation

Pharmacies become eligible to participate in the Walgreens Health Initiatives network when a Pharmacy Network Agreement with Walgreens Health Initiatives is executed by both parties or by affiliating with a Pharmacy Services Administration Organization/ Third Party Administration (PSAO/TPA) that is contracted with Walgreens Health Initiatives.

Pharmacies will provide services to WHI's eligible members in a timely and courteous manner, as provided to other customers, and shall have pharmacy services available for a minimum of eight hours a day, six days a week.

Medicare Part D Participation

To participate in the Medicare Part D plans administered by Walgreens Health Initiatives, pharmacies are required to sign Walgreens Health Initiatives' Medicare Prescription Drug Addendum along with any other applicable Medicare addendums, in addition to the Pharmacy Network Agreement.

Pharmacies must post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist in accordance with the the CMS-Approved **MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS** document OMB #0938-0975. If you need a copy of this document, Walgreens Health Initiatives would be happy to provide it.

Contracts and Amendments

All Walgreens Health Initiatives' contracts are only valid for the dispenser or pharmacy type declared on the contract. Walgreens Health Initiatives' standard contract is for

COMMUNITY RETAIL pharmacies only. For contracting purposes, outpatient hospital, clinic, and dispensing physicians are considered "retail." Each Pharmacy is required to designate its pharmacy type in the Pharmacy Network Agreement; misrepresentations are grounds for termination from the network.

Walgreens Health Initiatives requires separate contracts and/or amendments for the following types of pharmacies: LTC, Home Infusion, Indian Tribunal, and 340B.

In addition, providers interested in participating in the MTM program and other unique programs and networks may be required to sign an additional contract addendum.

Pharmacy Demographic Database

Walgreens Health Initiatives subscribes and adheres to the monthly pharmacy file developed and maintained by NCPDP.

When new pharmacies are loaded into the system, Walgreens Health Initiatives acknowledges the PRIMARY chain affiliation only and the payment center code provided by NCPDP. Subsequent changes for existing pharmacies are not pulled from the NCPDP data files, but rather Walgreens Health Initiatives expects the individual pharmacies or chains to notify Walgreens Health Initiatives of any changes in affiliation or chain code. The policy for these affiliation changes is outlined in the section labeled "PSAO/TPA Affiliation Guidelines."

Address Changes

Please be sure that your demographic data are accurate and complete with NCPDP, as this is used for important notifications, payment information, clinical programs, and plan-specific solicitations.

If you need to notify us of an address change, these changes are ONLY accepted in writing via email or fax to the Provider Relations Department.

PSAO/TPA Affiliations Guidelines

Please note that Walgreens Health Initiatives is unable to accept chain code affiliation changes at this time from the monthly NCPDP file we receive. PSAO/TPAs are required to notify Walgreens Health Initiatives in writing, preferably utilizing the NCPDP "Pharmacy Affiliation Relationship Affidavit." Walgreens Health Initiatives is only able to honor ONE affiliation per pharmacy.

Terminations

If the PSAO/TPA notifies Walgreens Health Initiatives of terminations that would result in a termination date from the 1st of the month through the 15th, the effective date of termination will be at the END of that month.

If the notification results in a termination date between the 16th and the end of the month, the effective date of termination will be at the END of the following month.

This will allow Walgreens Health Initiatives time to notify the pharmacy that we have received a termination notice from their PSAO/TPA and notify them of their options. If they express a desire to continue with Walgreens Health Initiatives or they have simply changed affiliations, we will process the termination and the new arrangement (if any) at the same time to avoid disruption of care to our members.

Additions

If Walgreens Health Initiatives receives a notification from a PSAO/TPA of additions to their network from the 1st of the month through the 15th, the effective date will be the FIRST of the following month.

If Walgreens Health Initiatives receives the notification from the 16th through the end of the month, the effective date will be the FIRST of the next month. For example–all notification received 08/01-08/15 will have an effective date of 09/01/2008. Notification received 08/16-09/15 will have an effective date of 10/01/2008.

EXCEPTION: If the pharmacy holds an independent contract with Walgreens Health Initiatives, there is a 90-day termination notice required. The PSAO/TPA's affiliation will be processed as soon as a termination notice is received from the pharmacy. The affiliation with PSAO/TPA will be effective the 1st of the month following the 90-day notification requirement.

Billing and Reimbursement

Prescription Claims Submission Guidelines

Pharmacies are required to submit a billing record of service for all covered prescriptions provided to a member, including those where no balance is due from the plan sponsor.

Pharmacies must submit claims via electronic data interchange using NCPDP Version 5.1, as required under HIPAA.

In the event of prolonged system downtime, pharmacy may submit claims within 30 days of service via either electronic transmission or 90 days of service via Universal Claim Form (UCF) or batch-file transmission.

POS System

"POS System" means the online or real time (point-of-sale) telecommunication system used to communicate information regarding covered drugs, eligible members, claims, drug utilization, copays, and/or other amounts to be collected from an eligible member by the pharmacy and the amounts payable to the pharmacy.

Pharmacy Vendor and POS System: Point-of-sale claims can be submitted to Walgreens Health Initiatives through a pharmacy computer system or POS System. Please contact your pharmacy system or POS System vendor if you have any questions about how to submit claims.

Phone Number: Please contact your software or communication network vendor to obtain the phone number that allows you to access the processor and submit claims.

Claims Submission: Walgreens Health Initiatives will identify whether a claim has been accepted or rejected. If the claim is accepted, Walgreens Health Initiatives will identify the amount paid and the copay to collect from the member. Walgreens Health Initiatives will provide additional messaging (e.g., quantity limitations exceeded). If the claim is rejected, Walgreens Health Initiatives will identify the reason(s) via POS System messaging.

BIN Number and Carrier ID: When submitting claims through a POS System, you are required to submit a BIN number and carrier ID. The BIN number is 603286; the carrier ID (PCN) for Walgreens Health Initiatives is 01410000, unless otherwise specified by plan. These numbers must be submitted with every claim. Your system vendor can tell you how to input these numbers.

Reversals: If you need to resubmit a claim previously accepted through the POS System, you must first submit a reversal. You must also submit a reversal when a member fails to pick up a filled prescription within ten days. Please refer to your system documentation or vendor for information about submitting reversals.

Troubleshooting: If your pharmacy system or POS System is unable to make a connection with the claim processor's computer system, contact your communication network vendor or switch vendor. If you have any questions regarding a rejected claim or reimbursement please contact the Walgreens Customer Care Center (800-207-2568). Please have your NCPDP number and other relevant claims processing information available.

Billing Compounds

A compounded prescription contains two or more ingredients in which at least one of the ingredients is a federal legend drug and the compound being made is not available commercially. When submitting a compound claim to Walgreens Health Initiatives:

- Identify the claim as a compound utilizing the appropriate compound indicator per the NCPDP 5.1 compound code field
- The pharmacy may submit the NCPDP 5.1 Compound Segment to support the multiple ingredients
- If the pharmacy cannot submit multiple ingredients, it may enter the valid NDC number of the most expensive legend drug per unit (tablet, capsule, vial, ml, and gram) that is in the compound. In such case:
    i. The total quantity entered should be equal to the total amount (tablet, capsule, vial, ml, and gram) of the most expensive NDC used.
    ii. When calculating and submitting the ingredient cost, enter the combined cost for all ingredients used during the compounding procedure, not to include any costs for labor, equipment fees, professional fees, flavoring, and/or products that are used to administer compounds (e.g., Hep-loc, NS 0.9% flush syringes).
- Medications requiring reconstitution prior to dispensing (e.g., powdered oral antibiotics, etc.) will not be recognized as compounded medications.

Payor Sheet

Walgreens Health Initiatives supplies the pharmacies, through the Walgreens Health Initiatives website and upon request, a payor sheet that lists each field in the POS claims transaction and the requirements for each field. Please refer to this document if you are experiencing difficulty with point-of-sale transmissions.

NCPDP Standard Universal Claim Form (UCF)

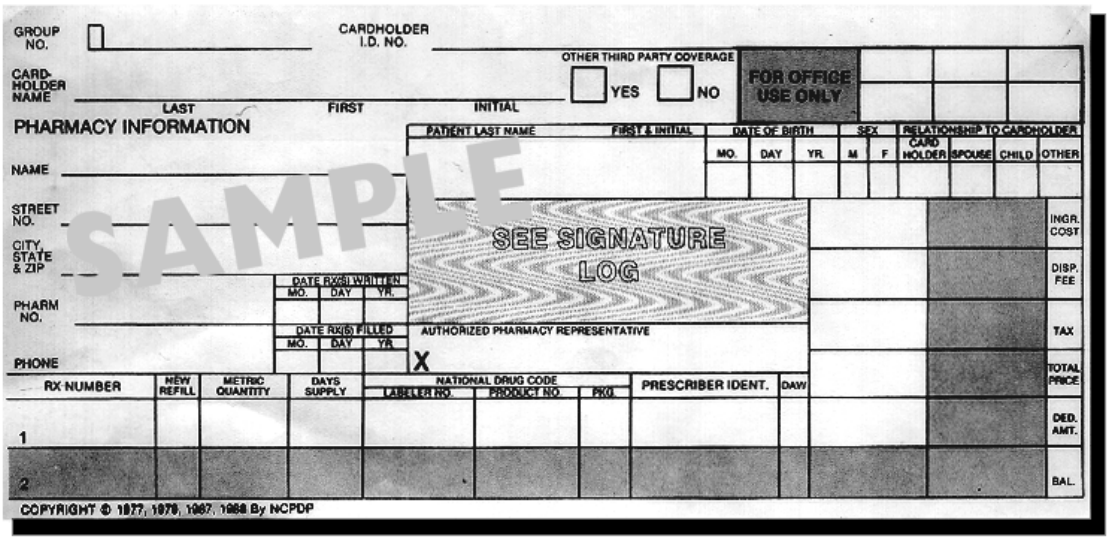
There are two types of forms as listed below—handwritten and computer generated. When forms are completed by hand, the last copy is sent to the claims processor at the address below. For computer generated, submit only the original (top) copy. The continuous form paper used by computers when printing claims on Universal Claim Forms (UCFs) should be separated (burst) and the tractor strips must be removed from the edges prior to sending to the claim processor. The member's signature in a prescription log should be noted as "Signature on File" in the appropriate space on the UCF. There may be a fee reduction per claim for processing UCFs.

All UCFs must be **legible, accurate,** and **complete.** Please type or neatly print all the UCF information. Claims and corrections to prior claims must be forwarded to Walgreens Health Initiatives via first-class mail within 90 days of original service date. Claims information submitted in any manner other than the procedure described above may be subject to loss, processing delays, or rejection. To assure receipt by the proper department, the following address should be used when mailing claims information:

Walgreens Health Initiatives
Attn: Claims Department
PO Box 545, Mail Stop 4355
Deerfield, IL 60015

Customer Care Center Phone: 800-207-2568

SAMPLE OF UNIVERSAL CLAIM FORM BELOW



Note: Upon release, new versions of the UCF will be accepted. The following information applies to the UCF.

1. **Group No.** - group number designated on the ID card.
2. **Cardholder ID No.** - subscriber ID number from the Prescription Drug Benefit Card.
   IMPORTANT: Please include the complete ID number, which may include a suffix at the end of the subscriber's ID.
3. **Cardholder Name** - Member's name from the Prescription Drug Benefit Card.
4. **Name** - The name of the pharmacy submitting the claim.
5. **Pharmacy No.** - NCPDP number of the pharmacy submitting the claim. If you do not know your NCPDP number, it can be obtained by calling the National Council of Prescription Drug Programs at 480-477-1000.
6. **Patient Name** - patient's full name should correspond to ID card and prescription order.
7. **Date of Birth** - birthdate of patient (MMDDYYYY).
8. **Sex** - place an "X" in the appropriate box to identify patient's sex.
9. **Relationship to Cardholder** – place an "X" in the Cardholder, Child, Spouse, or other box as appropriate.
10. **Date Rx(s) Written** - month, day, and year the prescription(s) was\were written (MMDDYYYY).
11. **Date Rx(s) Filled** - month, day, and year the prescription(s) was\were filled (MMDDYYYY).
12. **Rx Number** - prescription number consisting of up to seven digits.
13. **NEW or REFILL** - place an "N" in the box if this pertains to an original prescription, or "R" in the box if it is a refill.
14. **Metric Quantity** - number of tablets, capsules, etc., dispensed.

a) When liquids are dispensed, use ml or cc and decimals if appropriate (i.e., 2.5).
b) When original packages (ointments, drops, etc.) are dispensed, use metric units dispensed such as grams or cc. For example, Aristocort Cr ½ oz. should show "15" - referring to the number of grams.
c) Do not write the metric form being used (e.g., ml or cc) on the UCF.

15. **Days Supply** - number of days the medication will last the patient when taken according to directions. If the days supply is not applicable or not known, enter "1."
16. **National Drug Code** - The national drug code for the drug being dispensed. If the drug is a compound, enter the NDC of the most expensive legend ingredient, and detail the compound on the back of each claim form. Include the NDC number of each ingredient in the compound.
17. **Prescriber Identification** - the prescriber's ID number. A valid DEA number must be submitted for each claim. If the DEA number is not available, please provide the prescriber's name.
18. **DAW (dispense as written)** – Standard NCPDP Codes are:
    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
    7 = Substitution not allowed - brand drug mandated by law
    8 = Substitution allowed - generic drug not available in marketplace
    9 = Other
19. **Ingr. Cost** - billed amount for the dispensed quantity of drug only ($$$.¢¢).
20. **Disp. Fee (optional)** - professional fee charged for dispensing the drug ($$$.¢¢).
21. **Tax** - appropriate city, county, and state tax, where applicable.
22. **Total price (required)** - total of the ingredient cost, dispensing fee, and tax ($$$.¢¢), or the usual and customary retail, whichever is less.
23. **DED. Amt. (Optional)** - copay amount collected ($$$.¢¢).
24. **Bal** - The total billed amount ($$$.¢¢).

Processing of Prescription Paper Claim Forms

Each individual claim will be processed as received by the claims processor. Extensive edit checks are made to help ensure proper reimbursement. Claims containing one or more errors will be rejected. The pharmacy may resubmit claims in error within 60 days of original service date to the claim processor for further processing. Adjustments can be made to paid or denied claims. The pharmacy should submit to Walgreens Health Initiatives documentation supporting the pharmacy's request for a correction, and a copy of the claims processor's reconciliation highlighting the claims for which you are requesting adjustments.

Payment Cycles

Medicare Part D checks will be mailed to the pharmacies weekly, while commercial checks will be mailed to pharmacies twice a month. As stated in the Pharmacy Network Agreement, payment will be issued to the pharmacy following receipt of payment from the plan sponsor.

Checks

All checks are printed and mailed to the pharmacy entity according to the payment cycles specified above. At this time, no direct deposit or electronic funds transfer options are available.

Remittance Advices

For each check, Walgreens Health Initiatives will provide a remittance advice. Unless otherwise arranged with Walgreens Health Initiatives, these reports are provided in printed paper format and are mailed to the pharmacies within 10 calendar days of the date of the paper check.

Electronic 835 remittance files are available upon request. Walgreens Health Initiatives can "push" these files to your FTP site or mail them on a CD to your remittance address. This setup process can take up to four weeks to complete as it requires the coordination of both the security and IT Departments on both sides (pharmacy and PBM). Please contact our Provider Relations Department to make these arrangements.

Personal Health Information (PHI) Data Transmission Policy

In order to maintain HIPAA compliance, Walgreens Health Initiatives has several verification steps in place for the transmission of PHI, performed by several Walgreens Health Initiatives' departments. In order to allow for sufficient time for the verification process, Walgreens Health Initiatives instituted the following policy **effective 02-01-08:**

1) All changes in format and distribution of PHI data must be made in writing by the pharmacy
2) If the pharmacy is retaining a payment service or PSOA/TPA to reconcile their accounts, our affiliation policy will apply as listed below

Additions

If Walgreens Health Initiatives received notification from a PSAO/TPA of a new service relationship starting between the 1st of the month and the 15th, the **effective or start date will be the FIRST of the following month**. If Walgreens Health Initiatives receives notification of a new service relationship starting between the 16th and the end of the month, the effective date will be the FIRST of the next month. For example – all notifications received between 08/01-08/15 will have an effective date of 09/01/2008. Notification received between 08/16-09/15 will have an effective date of 10/01/2008.

Terminations

If Walgreens Health Initiatives receives notification from a PSAO/TPA of a service relationship that is ending between the 1st of the month and the 15th, the **termination or end date will be**

effective at the END of that month. If Walgreens Health Initiatives receives notification of a service relationship that is ending between the 16th and the end of the month, the termination date will be effective at the end of the following month.

For more information regarding this policy, please contact Provider Relations at Provider.Relations@walgreens.com.

Pricing

Each submitted claim will be priced using the specific guidelines established by the plan sponsor using the average wholesale price (AWP) set forth in the POS System based on pricing files received by Walgreens Health Initiatives from First Data Bank (or other nationally recognized price source selected by Walgreens Health Initiatives), as updated not less frequently than every seven days.

Medication Classification

Walgreens Health Initiatives reserves the right to classify medications as generics, provided the medications meet certain criteria.

Questions Regarding Claims Submission or Status

Any questions regarding claims status should be directed to our Customer Care Center available toll free at 800-207-2568. Please identify your pharmacy as a provider for Walgreens Health Initiatives and have your NCPDP number available, as well as any other relevant information.

Please direct all other claim-related inquiries to:

Walgreens Health Initiatives
Attn: Claims Department
PO Box 545, Mail Stop 4355
Deerfield, IL 60015

Customer Care Center Phone: 800-207-2568

Walgreens Health Initiatives' MAC Pricing Appeal Process

If your pharmacy holds an independent contract with Walgreens Health Initiatives, you may appeal directly to Walgreens Health Initiatives. If you are part of a chain, franchise, PSAO/TPA, please direct your appeals to your corporate office, PSAO/TPA.

Criteria for MAC Appeal

1. Claim was paid based on maximum allowable cost (MAC) pricing
2. Total paid (Walgreens Health Initiatives' payment plus patient copay plus dispensing fee) must be less than the acquisition cost (verified via First DataBank or other pricing source vendor selected by WHI, wholesale pricing or your invoice)

Documentation required for MAC Appeal

1. Claim Information: Rx number, NCPDP number and pharmacy name, Rx date, drug name, drug NDC
2. Contact name and contact information for individual appealing
3. Copy of invoice for specific NDC you are appealing

If MAC appeals are being sent by chains or PSAOs/TPAs, it is expected that they will be screened by the chain or PSAO/TPA PRIOR to being forwarded to Walgreens Health Initiatives. Claims reimbursed at contracted rates based on AWP discounts, usual and customary or ingredient costs submitted by the pharmacies do NOT qualify for review or appeal unless it is suspected that our claims adjudication system processed incorrectly.

MAC appeals can be requested at Provider.Relations@walgreens.com group email. In the subject, please put REQUESTING MAC APPEAL FORM.

Long-Term Care

Some pharmacies have executed a long-term care pharmacy (LTC) agreement with Walgreens Health Initiatives. Please see the guidance below specific to LTC pharmacies. For further guidance please also see the NCPDP Guidelines, located at www.ncpdp.org.

LTC Signature Logs

Walgreens Health Initiatives recognizes that LTC pharmacies have different practice requirements than community retail pharmacies. While individual patient signatures are not practical for LTC pharmacies, Walgreens Health Initiatives expects there to be a signed record for ALL medications delivered to a facility by a pharmacy. These logs can be signed by facility staff members with the authority to receive these medications. These logs should be made available to Walgreens Health Initiatives as requested during onsite audits or from desktop audits. Failure to produce a signed log may result in a charge back to the pharmacy.

LICS Status

If you believe a patient has been retroactively assigned an institutionalized Low Income Cost Subsidy (LICS) status from CMS, we recommend you proceed to reverse and resubmit the claims for the member.

If you feel a patient's LICS level has not been updated, LTC pharmacies are strongly encouraged to submit the Best Available Evidence, as defined in CMS guidelines, to WHI and the respective Part D plan sponsor, per CMS guidelines, as quickly as possible, to request the member's LICS status be changed to institutionalized.

If you have any questions, please feel free to contact the Provider Relations Department at Provider.Relations@walgreens.com or the applicable Plan Sponsor, as appropriate.

LTC Rebate Reporting

Per Section XIII of the Medicare Part D Reporting Requirements for Contract Year 2008:

". . . Part D Sponsors must require disclosure of access/performance rebates or other price concessions received by their long-term care (LTC) network pharmacies designed to or likely to influence or impact utilization of Part D drugs. The term "access/performance rebates" refers to rebates manufacturers provide to pharmacies that are designed to prefer, protect, or maintain that manufacturer's product selection by the pharmacy or to increase the volume of that manufacturer's products that are dispensed by the pharmacy under its formulary (referred to as 'moving market share'). As evidence that they are managing and monitoring drug utilization, Part D Sponsors must report these data to CMS for oversight. CMS recognizes the importance of maintaining confidentiality of these records."

According to CMS, "Access/performance rebates received and reported by pharmacies will be reported at either the CMS Part D Sponsor or Contract level. Data should include rebates received for all Part D drugs, not limited to formulary/covered drugs. Rebate information should be reported for each applicable NDC. The quarterly reported totals are not cumulative YTD totals."

As such, all LTC pharmacies in Walgreens Health Initiatives' network must submit an Excel file containing the following fields and information, as may be updated by CMS, unless otherwise approved by Walgreens Health Initiatives in writing:

1. LTC Pharmacy Name: Provide the name of the LTC pharmacy for each rebate.
2. LTC Pharmacy NCPDP Number: Indicate the contracted LTC pharmacy NCPDP number. This should be a numeric field.
3. NPI Number: Indicate the contracted LTC pharmacy NPI (National Provider Identifier) number. This should be a numeric field.
4. NDC: Provide the 11-digit NDC associated with the each rebate.
5. Manufacturer name: Provide the contracting manufacturer name for each rebate. This should be a character field.
5. Drug name: Provide the drug name for each rebate. This should be a character field.
6. Rebate $ per unit: Provide the contractual per unit rebates received during the reporting period (cash basis) associated with the listed drug.
7. Technical notes: Provide any technical notes regarding the LTC pharmacy rebate calculations.

For specific field type and length requirements, please contact the Provider Relations Department.

If you have received correspondence requesting this data, and are NOT an LTC provider, please send a note to us to indicate that you do not or no longer service LTC Medicare Part D patients.

If your buying group or PSAO/TPA is reporting on your behalf, it is NOT necessary for you to report individually. If you have a question about who is reporting on your behalf, please contact your buying group or PSAO/TPA or the Walgreens Health Initiatives Provider Relations Department.

LTC Rebate Reporting Due Dates for 2008/2009 (please refer to CMS guidance for current/updated reporting due dates):

2008 Q3	due to CMS on or before 11/15/2008
Annual	due to CMS 120 days after the end of the calendar year or within 10 days of the receipt of the Annual Audited F/S whichever is earlier
2009 Q1	due to CMS on or before 05/15/2009
2009 Q2	due to CMS on or before 08/15/2009

LTC pharmacy must provide Walgreens Health Initiatives with the reporting information not less than 60 days before the CMS due date.

Be sure to send your EXCEL files to Walgreens Health Initiatives-pbm-partd-reporting@walgreens.com. DO NOT fax your rebate date to Walgreens Health Initiatives. It will not be accepted.

If you have no data to report for this quarter, you must still communicate that you have nothing to report. Failure to do so will result in your pharmacy being reported as noncompliant.

Medicare Part D Vaccines

Effective 01/01/2008, certain Vaccines and their administration moved from Part B coverage to Part D coverage.

Pharmacies or other medical providers will be required to bill Part D plans (through the Walgreens Health Initiatives) for the drug, the administration (professional charge), or both.

WHI requires a special Addendum be signed for providers that administer this vaccine in addition to the regular Pharmacy Network Agreement to receive reimbursement for the administration.

If you wish to be contracted to administer these vaccines, contact our Provider Relations department via email at Provider.Relations@walgreens.com. Remember, if

you are part of a chain or buying group, you will need to work through your corporate office.

Submitting claims POS (Point of Sale):

- To submit claims for the DRUG only, no changes are required.
- To submit claims for BOTH the drug and the administration, the provider must ALSO bill value greater than zero in the "Incentive Fee" field 438-E3 and submit a Professional Service Code of "MA" in field 44Ø-E5.
- To submit a claim for the ADMINISTRATION fee only, the provider must submit the NDC for the drug administered, submit a value of ZERO in the Ingredient Cost, and value greater than zero in the "Incentive Fee" field 438-E3 and submit a Professional Service Code of "MA" in field 44Ø-E5.

All claims submitted with NDC's for vaccines will receive the messaging "Call 1-800-207-2568 if No Admin Fee Pays". Please call our help desk if you encounter problems processing for these vaccines and or their administration.

Pharmacy Audit Program

Overview

Walgreens Health Initiatives or its delegate has the right to inspect, review, audit, and obtain copies of the pharmacy's prescription files, signature logs and records. Claims submitted by the pharmacy and adjudicated by Walgreens Health Initiatives are subject to desktop and/or onsite audit. Incorrectly submitted and adjudicated pharmacy claims may result in an adjustment. Walgreens Health Initiatives may recover overpayments identified through the audit by the following methods: reversing and submitting claims reflecting the overpayment, adjustment against future payment(s), billing or invoicing for amount(s) due, and using collection services. Also, Walgreens Health Initiatives has the right to charge reasonable penalties and fees to cover additional costs associated with the Pharmacy's unpaid audit responsibilities and the pharmacy must pay these charges within 15 days of receipt of invoice. The pharmacy's refusal or denial to submit to and/or comply with Walgreens Health Initiatives audit process will result in the total charge back of paid claims. Failure to comply with the Walgreens Health Initiatives audit process may also result in suspension of payment and/or possible termination from the network.

Audit Notification

Desktop audit requests are sent via U.S. mail, fax, and/or electronic mail, or via a centralized and designated pharmacy chain contact. Onsite audit notification shall be distributed pursuant to the desktop audit request distribution and shall allow for an approximate two week advance notice of the on-site visit.

Signature Logs

Signature logs are defined as the permanent dispensing log of prescriptions. They are defined in the Signature Log portion herein and according to the Pharmacy Network Agreement. Delivery logs are accepted according to Walgreens Health Initiatives' discretion and must contain the elements held by the signature log requirements. Incomplete and/or unsigned signature logs may result in chargebacks.

Required Documentation

In accordance with the Access to and Retention of Records set forth in the Pharmacy Network Agreement, the pharmacy is required to make available and/or furnish Walgreens Health Initiatives or its delegate with the following documentation upon request: prescription files, signature logs and records, and policies and procedures of the pharmacy. Documentation must be readily available and retrievable. Hardcopy prescriptions must be authorized and updated annually, unless otherwise required by applicable state or federal law, in order for refills to be valid post the original hard copy's expiration.

Dispensing Limits

a) Quantity
The quantity submitted should be the number of units (e.g., tablets, capsules, milligrams, or milliliters) dispensed according to the metric decimal quantity of the medication or product and in accordance with the actual medication specifications or NCPDP guidelines and the client-specific plan design limitations.
b) Days Supply
The days supply submitted should correlate to the number of days the medication will last the patient when taken according to directions and in accordance with the actual medication specifications and the client-specific plan design limitations.
c) Insulin
Prescription claims for insulin products must be submitted for each individually prescribed insulin or insulin product. If the directions are "as directed," missing, or indicate a sliding scale, the pharmacy should verify the maximum number of units prescribed daily with the prescriber or member, and document accordingly on the prescription hard copy.
d) Inhalers
Prescription claims for inhalers must be submitted with the appropriate metric decimal quantity per prescribed quantity and in accordance with the actual drug specifications and the client-specific plan design limitations.
e) Ophthalmic Drops- Ophthalmic drop products should be calculated according to a standard of 15-20 drops/ml or according to the actual drug specifications and in accordance with client-specific plan design limitations.
f) "As directed" and prescriptions missing or without directions- Prescriptions indicated with "as directed" or missing directions must be clarified with the prescriber and/or member. The pharmacy must verify, document, and submit the appropriate quantity and days supply for the prescription claim. "As directed" and prescribed claims lacking instructional documentation or clarification are subject to chargeback.

U&C- Usual and Customary

The usual and customary price refers to the cash price including all applicable customer discounts, coupons or sale price which a cash-paying customer would pay at the pharmacy.

DAW (dispense as written) Codes

Walgreens Health Initiatives recognizes the Standard NCPDP 5.1 Codes:

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
7 = Substitution not allowed - brand drug mandated by law
8 = Substitution allowed - generic drug not available in marketplace
9 = Other

- Submission of DAW 0 should be utilized when dispensing a prescribed generic drug. Additionally, single-source brands should be submitted with a DAW 0.
- DAW 1 should be submitted when the prescriber has indicated only the brand-name drug may be dispensed, and is documented on the hard-copy prescription. For telephone orders, the DAW- brand only, no generic substitution per prescriber must be documented accordingly on the hard copy. Pharmacy software should never default to DAW 1.
- DAW 2 should be submitted when the member requests the brand drug and the pharmacy should document the hard copy accordingly.
- Incorrectly submitted prescription claims or claims lacking the proper DAW documentation may result in charge back. Failure to submit appropriate DAW-coded claims may result in the removal from the network.

Compounds

Compounds must be submitted in accordance with the requirements of the “Billing Compounds” section of this Pharmacy Manual.
Audited prescription compound claims may require the pharmacy to complete supplemental Compound Ingredient Worksheet to validate the claim submission.

Reversals

Prescriptions not dispensed to the member, or the member’s authorized representative, within 10 calendar days must be reversed by the pharmacy at point-of-sale. Failure to abide by this practice may result in chargebacks, additional financial penalties, and/or the possible removal from the network.

Results and Appeals

Walgreens Health Initiatives or its delegate shall furnish the pharmacy with the results of audit findings. The pharmacy will have the time set forth in the audit findings notice to

appeal audit discrepancies. During the appeal period, the pharmacy may provide documentation to support or justify the identified discrepant audited claims. Requests for pharmacy audit appeals will be reviewed according to Walgreens Health Initiatives' audit guidelines and the provisions contained within the Pharmacy Network Agreement. False or fabricated documentation will result in charge backs and the possible suspension of payment and/or removal from the network.

Medication Therapy Management Program (MTM)

Service Overview

Medication Therapy Management (MTM) seeks to optimize therapeutic outcomes and help reduce the risk of adverse medication events through ongoing review of patient medication records and consultation through patient interviews. In recognition of the value that MTM provides in improving member outcomes and managing overall health cost, CMS mandated that the delivery of these services commence in 2006 for Medicare Prescription Drug coverage.

Benefits

MTM therapy seeks to optimize member treatment by monitoring their medication records, identifying potential issues and, when necessary, providing interventions. The goals of our MTM program are to help patients understand their medications, avoid inappropriate or potentially dangerous medications, and increase compliance with medication regimens. A successful MTM program is intended to optimize member outcomes by reducing:

- The use of duplicative medications
- The use of medications without indication
- The use of multiple medications where a combination product can be used
- The instances of complex regimens, if appropriate
- The instances of members with a chronic-disease state not on medications recommended by national practice guidelines
- The dispensing of inappropriate medications to the elderly
- The instances of members not adhering to medication regimen as prescribed by their doctor
- The instances of members incorrectly taking medications in drug therapies that are new to them

By working to achieve these goals, the quality of patient care increases while overall healthcare costs may decrease.

Walgreens Health Services' MTM program complies with the guidelines set by CMS. Our comprehensive program is supported by custom-designed technology solutions, instore, face-to-face interventions with pharmacists, and telephone interventions with pharmacists in our clinical care center. Although discouraged, both physicians and patients are given the option to decline MTM services.

Program Design and Components

Our MTM program offers the following components:

Appropriateness of therapy (AOT): Pharmacists are notified when therapeutic additions are recommended to optimize treatment. This notification is based on the member's disease state and nationally recognized guidelines (e.g., a patient with diabetes not on an ACE inhibitor or a lipid-lowering agent). When required, the pharmacist will contact the prescribing physician regarding the rationale and benefits of the intervention. If approved by the physician, the pharmacist will then discuss the medication addition with the member and explain the health benefits associated with the therapy change. If the physician does not approve the therapy change, the pharmacist will only dispense the physician's original prescription.

Inappropriate medications in the Elderly (IMIE): With age, a person's metabolism of medications slows. Our MTM clinical pharmacists have developed a list of drugs based on the Beers', Zhan's and McLeod's lists which outline medications with the highest risk of potential harm to the member (e.g., dicyclomine – a medication with uncertain effectiveness and strong anitcholinergic properties, which are poorly tolerated in the elderly). The IMIE intervention will notify pharmacists that one of their patients is currently taking one of these high-risk medications and prompt them to call or fax the physician to request a safer prescription medication.

Compliance and persistency (C&P): These interventions are designed to promote patient adherence to their medication regimen as prescribed by their physician. There are three types of compliance and persistency interventions:

- Type 1 – Pharmacists are notified when prescription is processed for a patient who is new to therapy (NTT) for that particular drug. The pharmacist then provides new-to-therapy compliance counseling while dispensing the medication.

- Type 2 – Patients who are seven days late requesting refills of a medication are contacted with reminders and counseled on the importance of being compliant.

- Type 3 – Patients who request a prescription refill more than seven days after its renewal due date, and whom the pharmacist was unable to contact for a Type 2 intervention, are counseled at the point-of-service to educate them on the importance of compliance.

Polypharmacy: Pharmacists at our MTM clinical care center utilize the Medication Appropriateness Index (MAI) developed by Fitzgerald, et al., a widely recognized tool used to guide the evaluation of a patient's medication therapy. Pharmacists use the MAI to review the member's medication regimen to identify opportunities for possible interventions. Pharmacies then contact the prescribing physician(s) with the proposed changes to therapy. After approval by the physician, the primary pharmacy is notified,

and the local pharmacist sets up an appointment with the member to review their medications. If the doctor does not approve the intervention, the pharmacist will indicate this in the patient's record, and does not intervene. To support the consultation, all members in a polypharmacy review are provided with a Personal Medication Record (PMR) as well as a Medication Action Plan (MAP) that includes a full description of their medications, including appearance (e.g., color, shape, dosage form) and directions on how best to take the medications (e.g., time of the day, with or without food).

Member Access to MTM Services

When they become eligible for MTM services, members may receive a telephone call from their local pharmacist to participate in a one-on-one review and discussion of their medications at their local pharmacy.

Anytime during the MTM process, a patient may decide to opt out of the MTM program. A form is provided in the retail pharmacist guide instructing the pharmacist on how to opt out a patient.

During polypharmacy interventions, the pharmacist will talk with the member face-to-face and provide them with:

- A medication list – noting all of the member's medications, their names, strengths, and purpose
- A dosing calendar – noting when the member should take the medications

MTM Outcomes Reporting for Network Pharmacies

MTM offers outcomes reports that can be generated to "scorecard" the outcomes of the MTM services. Their reports can be compiled using the pharmacy NABP number or other similar identifier to compare a particular store against another store, district, region, etc., provided those identifying numbers are available.

Provider Participation and MTM Guide

For MTM participation and guide, please contact the Provider Relations Department.

MedMonitor®, Complete Medication Utilization Evaluation

Service Overview

Walgreens Health Initiatives' MedMonitor® Complete Medication Utilization Evaluation is a valuable clinical tool that both protects patients from potential adverse medication events and enhances their quality of care. By integrating and monitoring prescription and medical histories, our MedMonitor program offers a view of the whole health picture and is designed to prevent adverse medication events before they can become costly and dangerous issues.

Program Benefits

As with all of our clinical services, MedMonitor offers flexibility to meet our clients' cost-containment goals, while providing for our members' individual needs. The ultimate goal of MedMonitor is to create long-term, outcomes-oriented benefits such as less frequent hospitalizations and more efficient disease management.

MedMonitor utilizes a state-of-the-art operating system that integrates medical claims with prescription claims to identify patients at risk for dangerous and expensive medication-related problems and medical outcomes. Our operating system contains more than 1100 conflict edits designed to detect patterns of overutilization and/or abuse, underutilization and/or noncompliance, therapeutic duplication, medication-medication interactions, no diagnosis/indication, medication-disease interactions, and clinical appropriateness of therapy, including *Senior Safe Prescribing*.

Program Design and Components

Every day, MedMonitor's software analyzes the merged prescription and available medical claims, from the prior 72 hours, to identify those patients who may be at risk for potential medication-related problems. Higher-risk patients, or those patients who have potentially severe conflicts identified, will have their profile reviewed by a clinical pharmacist. If the pharmacist determines that the conflict is significant and has the potential to cause an adverse outcome, an alert is presented to the provider(s) involved in the patient's care. Providers may include the prescriber or dispensing pharmacy. The providers may be alerted by phone, fax, or letter.

The alert informs the provider of the situation by stating the medications involved and any possible outcomes that may be observed. Each of our alerts includes the citation(s) to the relevant medical literature from which the specific conflict edit was created, as well as a patient prescription and medical profile. A voluntary provider feedback form is included to allow the provider the opportunity to give information to update the patient's healthcare history for future clinical evaluations and offer comments used for the continuous quality improvement of our program. It is important to know that all communications with providers are intended solely to supplement the information they may have about their patients; they do not take the place of a provider's extensive medical knowledge or expertise.

Our program consists of the following clinical interventions:

Medication-Medication Interactions

These interventions identify patients who are receiving two or more medications that, when taken together, can cause unpredictable or undesirable effects. For example, the use of warfarin with a nonsteroidal anti-inflammatory drug (e.g., ibuprofen) can increase the patient's risk of bleeding.

Medication-Disease Interactions

These interventions identify patients who are receiving medications that may worsen medical conditions. For example, the use of a nonsteroidal anti-inflammatory drug (e.g.,

ibuprofen) in patients with a history of gastric ulceration can lead to recurrence or further progression of the disease.

Therapeutic Appropriateness

These interventions identify patients who are not receiving certain medications that are considered standard therapy for a medical condition. A majority of these interventions are in compliance with and promote HEDIS (Health Plan Employer Data and Information Set) and NCQA (National Committee for Quality Assurance) guidelines.

Senior Safe Prescribing Program

The Senior Safe Prescribing Program is designed to identify and decrease utilization of potentially inappropriate medication use in those age 65 years and older, based on recommendations stated in the *Beers Consensus Report*.

Overutilization, High Dose, or Duration of Therapy

These interventions identify patients who receive medications above the recommended dosing guidelines or for extended periods of time that may be inappropriate. Because of the growing concern over the abuse of prescription medications, MedMonitor contains specific criteria that identify patients who may be overusing habit-forming medications. The medications with the highest potential for abuse are those used to treat pain, anxiety, and attention-deficit hyperactivity disorder. Our goals are to improve patient care and appropriate use, and deter the costs and adverse clinical outcomes associated with the abuse of prescription medications.

Underutilization or Sub-therapeutic Dosing

These interventions identify patients who may be noncompliant with their maintenance medication or those who may be receiving doses below recommended guidelines.

Therapeutic Duplication

These interventions identify patients who are receiving two or more agents from the same therapeutic class of medications.

Medication-Pregnancy

These interventions identify patients who may be at risk for teratogenic effects or pregnancy complications from the use of certain medications.

No Indication

These interventions identify a patient as taking a prescription medication without a valid diagnosis present.

Other Resources

Web sites

Walgreens Health Initiatives' web site: MyWHI.com

NCPDP web site: www.ncpdp.org

Web portal for physicians to submit vaccine administration claims: www.dispensingsolutionsinc.com

General Email

Provider Relations	Provider.Relations@walgreens.com
LTC Rebate Reporting	whi-pbm-partd-reporting@walgreens.com
Accounting	WHI-PBM-PAYMENT-analysis@walgreens.com

Fraud, Waste and Abuse Contact Information

Twenty-four hour Toll Free Hotline:	1 (800) 666-5677
Email:	Compliance@walgreens.com
Fax Information to WHS Compliance:	1 (847) 964-6950
Mail:	Walgreens Health Services Attn: WHS Compliance 1415 Lake Cook Road, MS L346 Deerfield, IL 60015

In addition to the above reporting resources you may report potential Medicare Part D drug violations to the:

HHS OIG:	1-800-HHS-TIPS (1-800-447-8477) e-mail: HHSTips@oig.hhs.gov fax: 1-800-223-8164
Medicare Program directly at:	1 (877) 772-3379