Pharmacy Benefit Services for The Empire Plan Prescription Drug Program, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs

New York State Department of Civil Service

Primary Contacts:

Stephen Dunleavy
Vice President - Sales
Public Sector
[redacted]

Barry Rosenthal
Vice President - Sales
Public Sector
[redacted]

Kathy Bonnell
Vice President - Sales
Workers Compensation
[redacted]

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NYSIF
Section IV – Technical Proposal
Request for Proposals #2012RX-1

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May 8, 2012

TABLE OF CONTENTS

SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

The Procuring Agencies seek to award two separate Agreements to a qualified Offeror to provide Pharmacy Benefit Services for the respective agencies prescription drug programs. The Department is seeking to secure the services of a qualified Offeror to administer The Empire Plan, Excelsior Plan, and Student Employee Health Plan Prescription Drug Programs (collectively referred to as DCS Program(s)). NYSIF is seeking to secure the services of a qualified Offeror to administer the NYS Workers' Compensation Prescription Drug Program (referred to as NYSIF Program). The purpose of this section of the RFP is to set forth the programmatic duties and responsibilities required of the Offeror and to pose questions concerning those duties and responsibilities. The Offeror's Technical Proposal must contain responses to all questions (i.e. Required Submissions) in the format requested. Each Offeror may submit only one Technical Proposal. The proposals will be evaluated based on the Offeror's responses to the questions contained in this section. Therefore, it is critical that Offerors fully respond to each of the questions presented in this section. Evaluation of all Proposals and the selection of the Successful Offeror shall be based only upon the Offeror's Proposal regarding the duties and responsibilities set forth in the RFP, and shall not be based upon any supplemental material.

Notes:

1. **Unless otherwise stated, all of the requirements contained in this section pertain to both the DCS and NYSIF Programs.**

2. **Numbers, data, or statistics which may appear in the Exhibits referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.**

   The Procuring Agencies will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP.

   Please note that Offerors may not include any cost information in the Technical Proposal including exhibits or attachments. This cost information pertains to Ingredient Cost discounts, dispensing fees, discount and pharma rebate guarantees, and administrative fees requested in the Cost Proposal. Performance guarantee amounts are to be included in the Technical Proposal. Specific savings estimates (dollars or percentages) should not be

quoted in the Technical Proposal or in any exhibits or attachments submitted with the Technical Proposal.

A. Program Administration

1. Executive Summary

The Offeror must describe its capacity to administer the DCS and NYSIF Prescription Drug Programs (also hereafter collectively referred to as the "Programs").

a. Required Submission

The Offeror must submit an Executive Summary that describes its capacity to administer the DCS and NYSIF Prescription Drug Programs. The Executive Summary must include:

(1) The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account;

(2) A description demonstrating its understanding of the requirements presented in the RFP, and how the Offeror can assist the Procuring Agencies in accomplishing their objectives;

(3) A statement explaining previous experience managing the Prescription drug plans of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a Self-Funded Prescription Drug Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP;

(4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions:

(a) Network Management

(b) Specialty Pharmacy Program

(c) Mail Service Pharmacy Process

(d) Claims Processing

(e) Retrospective Coordination of Benefits

(f) Customer Service

(g) Enrollee Communication Support

(h) Enrollment Management

(i) Reporting

(j) Clinical Management/ Prior Authorization

(k) Drug Utilization Review (concurrent, retrospective and narcotics)

(l) Flexible Formulary and Preferred Drug List Development and Management

(m) Rebate Administration

(n) Account Management

(o) Consulting

(p) Mandatory Generic Substitution & Generic Appeals Process

(q) Pharmacy Audit and Responses to NYS Audits

(r) Drug Lawsuits/Settlements

(s) Medicare Part D Prescription Drug Program Administration

(t) Half Tablet Program

(u) Drug Recall Notification

(v) Financial Support Services

(w) Transition and Termination of Contract

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client as a reference as required in Exhibit I.V.

In developing Express Scripts dedicated Workers' Compensation division, we drew on best practices gained from our extensive PBM experience and adapted them to the Workers' Compensation marketplace. These principles include a focus on providing competitive discounted pricing to clients, encouraging the use of high-quality and less expensive generic drugs, and offering a skilled team of Workers' Compensation professionals to manage NYSIF's program.

Express Scripts offers plan sponsors several key benefits within the Workers' Compensation arena:

- Extensive Workers' Compensation Pharmacy Network –NYSIF and injured workers currently benefit from greater network penetration beginning with the first fill and increased savings when injured workers access the ExpressComp National (ECN) Network of more than 61,000 pharmacies—The largest Workers' Compensation-specific network in the industry.

- Focused on Increasing the Use of Generic Drugs –Because Express Scripts has never been owned by a pharmaceutical manufacturer, we always align our interests with those of NYSIF in both philosophy and practice. Our Workers' Compensation division has incorporated many of Express Scripts' approaches to encourage injured workers to use less expensive generic drugs when clinically appropriate. Our generic fill rate of more than 74.3% in the Workers' Compensation division shows that this approach is working.
- Our People are Our Product – seasoned team of experienced Workers' Compensation professionals stand ready to assist you and your injured workers with any needs you might have. Whether it's consultative advice regarding the future of your benefit or an injured worker with a question regarding a prescription, we have a team of professionals ready to help.

Extensive Workers' Compensation Pharmacy Network

The two greatest opportunities for our clients to save money are through maximizing use of network pharmacies beginning with first-fill prescriptions, and greater use of generic drugs in lieu of more expensive brand-name drugs that are no more effective. To help clients take advantage of these opportunities, Express Scripts offers an extensive Workers' Compensation retail network and aggressively encourages greater use of generic alternatives.

Our ECN Network is among the largest, most comprehensive retail Workers' Compensation-specific pharmacy network available with whom we directly hold the pharmacy relationship. With more than 61,000 large national chain and independent pharmacies, the likelihood that an injured worker will use an ECN network pharmacy increases greatly. This broad range of pharmacy options helps our clients reduce costs and exclude third-party billers, who often drive up costs. Our contracted pharmacies offer discounted prices, guaranteed on lesser of AWP-minus or state fee schedule basis to plan clients.

"First Fill" Program

Unlike the Group Health benefit, the single greatest determinant of effective cost management in the Workers' Compensation arena is the ability to capture the first-time prescriptions that injured workers fill in a Workers' Compensation network pharmacy.

When an injured worker fills a first-time prescription outside of the network or pays out of pocket, it becomes difficult to manage prescription costs and to encourage the use of cost-effective generic alternatives. For

instance, if an injured worker fills a Workers' Compensation prescription outside of the ECN Network, the non-network pharmacy submits the claim to a third-party biller, many of whom assess charges to the client of AWP-plus basis. In addition, a third-party biller has little incentive to encourage injured workers to try a more cost-effective generic alternative. It is also difficult to direct injured workers to change pharmacies during the course of treatment.

Express Scripts is willing to go "at risk" for injured workers filling a first-time prescription. This means, if you have not yet submitted eligibility for that injured worker, we will assume risk for the cost of the first prescription. This approach ensures that your injured workers can begin taking their medication as quickly as possible while also minimizing risk should you determine the injured worker's prescription to be ineligible.

Encouraging the use of Generic Products

More than two out of every three prescriptions processed by Express Scripts is for a less expensive generic drug. Our book of business generic fill rate of more than 74.3% translates into very substantial savings: every 1% increase in generic drug use results in about a 4% reduction in client drug costs. Our Step Therapy program also has a proven track record of increasing generic utilization fill rates to 80% ranges.

In a growing number of situations, generics provide equivalent efficacy, at lower costs than brands. Every time a more expensive brand-name drug is used instead of an equally effective but lower cost generic, waste grows: the client spends more money, but the injured worker doesn't enjoy any additional health benefits. As many brand-name drugs are set to lose patent protection in the coming years, opportunities for savings through greater use of generics will continue to grow.

Express Scripts is committed to designing programs to assist clients in managing trend. Specifically, these programs will help our clients by educating physicians and injured workers on generic alternatives and lower cost brand products, and implementing appropriate utilization management controls. Choosing generics over more expensive brand-name counterparts provides significant savings opportunities with no compromise to injured workers' health.

Express Scripts currently offers a full toolbox of programs designed and proven to minimize waste and to enhance consumerism. Customized Formulary Management with Injury Specific formularies, Script Alert and Retrospective DUR are among programs we recommend to clients seeking to reduce waste.

Our People are our Product

We recognize that our success largely depends on yours. To ensure we meet the needs of you and your injured workers, Express Scripts employs a team of seasoned professionals ready to administer your Workers' Compensation pharmacy program.

Experienced Account Team

Express Scripts Workers' Compensation division provides NYSIF with an account management team to represent your interests and ensure quality management of your program. Our account service approach effectively combines strategic relationship management with the tactical management of your account.

Dedicated Contact Center

A dedicated Express Scripts Workers' Compensation Contact Center team responds to calls from injured workers, pharmacists and claims payers 24 hours a day, 365 days a year through your -specific toll-free phone number. This team has information at their fingertips to assist with a broad range of questions.

Research & Education

Knowledge is Express Scripts' most powerful tool. For more than a decade, Express Scripts has employed a company-paid professional research staff, dedicated to independently developing new knowledge about how our nation uses prescription drugs.

Express Scripts is dedicated to using this research to design programs to control drug cost trend through injured worker and physician intervention. These programs will help Workers' Compensation clients by educating physicians and injured workers on generic alternatives and lower cost brand products, and implementing appropriate utilization management controls.

Our research is:

- Published in medical literature and peer-reviewed journals
- Reported to the national media
- Presented at scientific and professional conferences

Importantly, we do not accept any outside financial support for our research work. Few other organizations in the United States, and no other pharmacy benefit manager, conduct such extensive, objective, and

rigorous research programs dedicated to the analysis of drug costs and cost trends.

Evidence-Based Consultative Advice

Express Scripts provides the information and counsel that clients need to make good decisions. We help our clients define their Workers' Compensation goals and create strategic plans for success. Our independence and proven expertise allow us to provide constant evaluation and identification of opportunities for you to reduce drug spend while maintaining excellent health outcomes for injured workers.

Because we handle all Workers' Compensation claims for both retail and home delivery, Express Scripts can provide you with comprehensive strategic recommendations regarding your Workers' Compensation program.

You and Express Scripts' Workers Compensation: A Great Fit

Express Scripts works hard to align its interests with those of its clients, to ensure that every dollar our clients spend for their injured workers makes a difference, to be prepared to serve our clients in an ever-changing pharmacy landscape, and to help our clients succeed by offering great service through seasoned, intelligent, and compassionate professionals.

We have much more to discuss, including our advanced web portal technology and reporting capability, our approach to specialty medications, and the care with which we will serve your injured workers. We look forward in the near future to discussing these areas and answering any questions you may have.
Most of all, we look forward to continuing to partner with you to ensure that your injured workers receive the right drug, at the right time, for the right reason, so that they are able to return to the workplace as quickly as possible.

2. General Qualifications of the Offeror

The DCS Prescription Drug Programs cover over one million lives and incur costs in excess of $1.5 billion annually. Over 50,000 NYSIF Workers' Compensation claimants fill approximately 700,000 prescriptions annually and incur costs in excess of $75 million annually.

The Offeror must have the experience, reliability and integrity to ensure that each Program member's health care needs are addressed in a clinically appropriate and cost effective manner.

The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the Programs duties and responsibilities set forth in this RFP, ensuring full compliance with the respective Programs Services.

a. Required Submission

The Offeror must demonstrate that it has the financial and administrative wherewithal to administer the Programs as required by this RFP. Please provide detailed responses to the following:

(1) What experience does the Offeror have in managing/supervising a Prescription drug program similar to the Programs described in this RFP?

We have managed the New York State Injured Workers' Fund worker's compensation program uninterrupted since implementing in 1999.

(2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational, and clinical aspects of the Programs?

Your current account team will continue to serve NYSIF and your injured workers with the level of quality, attentiveness, and efficiency that you've come to expect from us over the duration of our relationship.

(3) What internal systems or procedures does the Offeror have in place to provide financial, legal, and audit oversight of the Programs?

As your current PBM, Express Scripts will continue to provide whatever is contractually necessary for NYSIF to validate all aspects of the plan design.

B. DCS and NYSIF Prescription Drug Program Services

In this section, the Offeror must demonstrate its capacity to provide the required services for administration of the Programs.

1. Account Team

The Department expects the successful Offeror to have a proactive, experienced account leader and team(s) in place who are dedicated solely to the Programs and who have the authority and expertise to coordinate the appropriate resources to implement and administer the Programs.

NYSIF's account management team is available during normal business hours. Express Scripts also offers toll-free phone services to NYSIF's claims staff through our Client Support Center from 7 a.m. to 7 p.m., with voicemail service after business hours. Additionally, our Contact Center and Pharmacy Help Desk assist injured workers, physicians, and pharmacists 24 hours a day, seven days a week.

Additionally, Express Scripts' service model empowers NYSIF's account management team to resolve issues through highly-developed thought processes and policies. Issues are tracked and reported through Houston, our online account management tool, and related service requests are submitted to Express Scripts personnel as appropriate. Each service request receives an electronic priority stamp as part of the Houston request process. Additionally, our account teams maintain an internal action log that tracks current and resolved issues.

Express Scripts designates each client issue as strategic, operational, or clinical and assigns the issue to the appropriate account management team injured worker. The assigned account management team injured workers collaborate with senior leadership in the Workers' Compensation division to provide NYSIF a report of the issue, including risk assessment, plan of action for resolution, and results measurement. NYSIF's executive sponsor is debriefed at regular intervals on all escalated issues, intervention, and communication plans toward effective resolution.

In addition to these efforts, and to keep you informed of industry changes and program opportunities, Express Scripts maintains an action plan log and conducts regular conference calls with NYSIF. Your account team works with you to schedule these calls according to your needs.

a. Duties and Responsibilities

(1) The Offeror must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the Programs during implementation and operation.

(a) The account team(s) must be comprised of qualified and experienced individuals who are acceptable to the Procuring Agencies and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the Programs in an efficient manner;

(b) The Offeror must ensure that there is a process in place for the account team(s) to gain immediate access to appropriate corporate resources and senior management necessary to meet all Programs requirements and to address any issues that may arise during the performance of the separate resultant Agreements.

(2) The Offeror's dedicated account team(s) must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

(a) provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council of Employee Health Insurance, or NYSIF, or union representatives regarding member-specific claims issues for the duration of the separate Agreements to the satisfaction of the Procuring Agencies;

(b) immediately notify the Procuring Agencies in writing of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees (for example, drug recalls and withdrawals, class action settlements, and operational issues).

(3) The Offeror's dedicated account team(s) must ensure that the Programs are in compliance with all legislative and statutory requirements. If the Offeror is unable to comply with any legislative or statutory requirements, the Procuring Agencies must be notified in writing immediately. The Offeror is required to work with the Department to develop accurate Summary Plan Descriptions (SPDs) and/or Program material.

Express Scripts agrees with the Duties and Responsibilities set forth in items a.1 through a.3.

b. Required Submission

(1) Provide an organizational chart and narrative description illustrating how you propose to administer, manage, and oversee all aspects of the Programs. Include the names, qualifications, and job descriptions of the key individuals selected to comprise the account management team(s) for the Offeror. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed account management team(s); where key individuals are not named, include qualifications of the individuals that you would seek to fill the positions. Include the following:

(a) Reporting relationships and the responsibilities of each key position of the account management team(s); how the team will interact with other departments such as customer service, clinical services, reporting, auditing, and network management, within your organization.

NYSIF's core account management team includes key professionals experienced in the diverse needs and issues of the pharmacy benefit. We have outlined your designated team below:

Extended Service Team

Additionally, your designated account management team is supported by an extended service team, which represents the following Express Scripts divisions:

- Eligibility Support — An eligibility specialist works with NYSIF's account team and provides support for file loads, as well as verification and correction of issues with eligibility information accessed online. The eligibility team provides reporting as requested by your account management team.
- Express Scripts Pharmacy — Inquiries regarding the Express Scripts Pharmacy, including performance metrics reporting, are handled through our Express Scripts Pharmacy Operations team, which answers questions

on accuracy rates detailed in the NYSIF client report and arranges pharmacy tours as appropriate.

- Finance — NYSIF pricing issues, billing reporting questions, and important AWP information and changes are addressed through finance staff assistance. Finance team members work through inquiries regarding the billing dispute process and answer questions related to detail file extracts.
- Formulary Management — Members of Formulary Management provide updates to the formulary and work out details on participant communications that outline formulary changes. Formulary Management helps with issues related to changes, helps NYSIF determine the best type of formulary interventions for your participants, and helps answer complicated questions related to the formulary.
- Information Technology — Members of Information Technology assist with questions and issues related to adjudication, data exchange and file transfers, and the identification and pursuit of system enhancements. Information Technology relays team-scheduled system downtimes and upgrades and works with your team to meet requests, such as file transfer method changes.
- Legal — Our Legal staff provides important legal information that affects NYSIF to account management for dissemination as appropriate. Additionally, Legal evaluates and provides judgment on requests, such as those asking Express Scripts to serve as an expert witness.
- Marketing & Corporate Communications — Members of this team collaborate with account management to assist with NYSIF needs, such as helping answer outside audit questions related to Express Scripts' services. The team also coordinates client and injured worker communications and website services and organizes relationship management events, such as our annual Outcomes Conference.
- Communications Fulfillment — NYSIF questions, requests, and issues related to injured worker materials are addressed by communications fulfillment staff. Members of the team work with account management to coordinate introductory injured worker packets and all other injured worker materials. Team members also work with your account team to handle ID card changes.
- Contact Center — NYSIF's account team receives call tracking metrics from the Contact Center and provides these to you via the Operational Performance Report. As required, Contact Center staff forwards information on injured worker issues received by the Contact Center to account management. Additionally, the Contact Center arranges for clients to listen to recorded calls to ensure satisfaction.

- Pharma & Retail Strategy — Changes to NYSIF's pharmacy network are handled and reported through Pharma & Retail Strategy. This group notifies NYSIF of pharmacy additions and terminations, network audit findings, fraud and abuse cases, and subsequent ramifications. Additionally, Pharma & Retail Strategy evaluates client requests to add specific pharmacies to the network and provides special reporting, such as identifying pharmacies that offer compounding services.

(b) Describe how the dedicated account management team(s) interfaces with senior management and ultimate decision makers within your organization to ensure that all Program requirements are met and to address any issues that may arise during the performance of the resultant Agreements;

- Monitors NYSIF's account performance
- Analyzes Contact Center and Express Scripts Pharmacy metrics
- Tracks turnaround time of program implementations and service requests
- Facilitates client surveys to assess team performance and program satisfaction

(2) Please confirm that the account team(s) will be readily accessible to the Programs. State where the account team will be based. Describe:

Confirmed. Your Express Scripts Account Team will continue to be based in Minneapolis, Minnesota and St. Louis, Missouri.

(a) How will you ensure that timely responses (1 to 2 Business Days) are provided to administrative concerns and inquiries?

Express Scripts handles NYSIF's service requests and issue resolution in a timely fashion by:

- Tracking requests and issues in Houston, our online account management tool
- Logging all correspondence with NYSIF, including phone calls, emails, faxes, and letters
- Analyzing Houston reports and forwarding such reports to senior management for scheduled reviews

- Providing NYSIF with detailed primary and back-up contact information
- Surveying clients at least annually to measure satisfaction
- Maintaining regular contact between senior staff and NYSIF to ensure we address your concerns
- Tying a portion of the account management team's compensation to NYSIF satisfaction

Express Scripts account management resolves 97% of issues within 24 hours. Turnaround time varies depending on the complexity of the issue.

(b) The protocols in place to ensure the Procuring Agencies will be kept abreast of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees. Provide a representative scenario.

Express Scripts understands that changes to the market, such as patent expirations, can affect convenience, cost, and other factors that drive plan performance. To support NYSIF's response to marketplace changes, Express Scripts notifies NYSIF of marketplace changes through our Emerging Therapeutics communications. These publications include:

- **Issues Documents –** When a clinical issue emerges in the marketplace, we prepare an issues document, which provides background and take-away points for plan sponsors.
- **RxWatch Top 20 Pipeline Report –** This monthly publication follows the top 20 drugs that we anticipate to significantly impact plan sponsors. The list reflects products that are likely to receive Food and Drug Administration approval within the next two years.
- **Top 20 Specialty Pharmacy Pipeline Report –** This monthly publication lists the top 20 pipeline drugs that have the potential for distribution through a specialty pharmacy. The list reflects products that are likely to receive Food and Drug Administration approval within the next four years.
- **Workers' Compensation Matters Clinical Newsletter –** This monthly publication highlights issues specific to this market as well as outlines new programs.
- **Workers Compensation Compliance Communication –** This e-letter is published by our compliance officer to alert clients about changes in the Workers' Compensation law that may affect them as these changes occur.

Evaluates the potential impact of plan design changes made to accommodate a marketplace change and proactively makes recommendations to our clients.

Express Scripts has been a market leader with the adoption of new generics such as Zocor, Ambien, and Cozaar.

(3) Describe the Corporate resources available to the account team(s) to ensure compliance with all legislative and statutory requirements. Confirm your commitment to notify the Procuring Agencies immediately if you are unable to comply with any legislative or statutory requirements and to work with the Procuring Agencies to take the appropriate remedial action(s) to come into compliance as soon as practicable. Confirm your commitment to work with the Department to develop accurate SPDs and/or Program material.

To ensure your program is comprehensive, compliant, and aligned with their injured workers' needs, Express Scripts offers a wide range of consultation services, plan guidance, and support in key areas such as benefit design, quality assurance and government compliance, and utilization management.

We are committed to notifying the Procuring Agencies immediately if we are unable to comply with any legislative or statutory requirements, and to work with the Procuring Agencies to take the appropriate remedial action to come into compliance as soon as practicable.

2. Premium Development Services (Exclusive to DCS)

The Offeror must provide underwriting assistance and support to the Department in the development of premium rates chargeable to DCS Program participants consistent with the interests and goals of the DCS Program and the State. Premium rates must be as realistic as possible, taking into account all significant elements that can affect Program costs including, but not limited to trend factors, projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formularies and Traditional PDL. The development of premium rates that closely match the actual costs enables the plan to provide rate stability, one of the primary goals of the State, and to meet the budgetary needs of the State and local governments that participate in NYSHIP.

a. Duties and Responsibilities

The Offeror will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

(1) Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the DCS Program and the State;

(2) Development of claim, trend and administrative fee projections for each DCS Program Year. Analysis of all DCS Program components impacting the DCS Program cost shall be performed including, but not limited to claims, trend factors, administrative fees, projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy Drug list, as well as changes in the formularies including the Empire Plan's Specialty Drug list, Flexible Formularies and the Traditional PDL; and

(3) Working with the Department and its contracted actuarial consultant through the annual rate renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

(1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the DCS Programs. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit

I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.

Please see our DCS-specific Technical Proposal binder.

(2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.

Please see our DCS-specific Technical Proposal binder.

(3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual rate renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

Please see our DCS-specific Technical Proposal binder.

Note: The responses to the above three questions should be general descriptions of the financial methodology you intend to use for the assisting and supporting the Department with the DCS Program. Responses may NOT include any specific cost information or values relative to the development of cost/rate projections and trends for the DCS Programs; that information must be restricted to your Cost Proposal.

3. Implementation

The Offeror must ensure that the Programs are fully functional on January 1, 2014. The Offeror's must propose two implementation plans, one for the Department and one for NYSIF. The plans must be detailed and comprehensive and exhibit a firm commitment by the Offeror to complete all implementation activities by December 31, 2013.

a. Duties and Responsibilities

(1) The Offeror must commence an implementation period beginning on or around October 1, 2012 upon approval of the resultant separate Agreements by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth below. Such implementation activities must be completed no later than December 31, 2013 so that the Programs are fully operational on January 1, 2014.

(2) Implementation and Start-up Guarantee: The Offeror guarantees that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Offeror can assume full operational responsibility for the Programs. For the purpose of this guarantee, the Offeror must, on January 1, 2014, have in place and operational:

(a) A contracted Retail Pharmacy Network that meets the access standards set forth in Section IV.B.11.b. of this RFP, under the subheading "Retail Pharmacy Network." Additionally, in order to meet the Offeror's implementation guarantee, the network implemented on January 1, 2014 must include all chain pharmacies with more than 20 locations and all groups of 20 or more independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, as identified in the Offeror's Proposed Retail Pharmacy Network File, to the extent the subject chains and/or independent Pharmacy groups continue in operation on and after January 1, 2014.

The Program requires that all chain pharmacies with less than 20 locations, groups of less than 20 independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, and all independent pharmacies, as identified in the Offeror's Proposed Retail Pharmacy Network File, be included in the Offeror's Retail Pharmacy Network implemented on January 1, 2014. Acceptable reasons for non-participation of independents, smaller chains or groups of individual pharmacies contracting collectively on January 1, 2014 include, and are limited to: a Pharmacy's

violation of state and/or federal laws; a Pharmacy's failure to meet the Offeror's credentialing criteria; or a Pharmacy's failure to fulfill its contractual obligations and no remedy can be achieved. On January 1, 2014, the Retail Pharmacy Network must meet all requirements set forth in Section IV.B.11. of this RFP, under the subheadings "Retail Pharmacy Network," "Pharmacy Credentialing" and "Pharmacy Contracting" and be available to fill Enrollee Prescriptions for all Covered Drugs including Specialty Drugs/Medications(for those Enrollees that do not participate in the Specialty Pharmacy Program);

(b) A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs/Medications (for those Enrollees that do not participate in the Specialty Pharmacy Program) as set forth in Section IV.B.11. of this RFP, under the subheading "Mail Service Pharmacy Process." The Offeror must have a plan in place to facilitate the transfer of Prescription information, including open refills, prior authorizations and generic appeals from the previous Program administrators and outline the procedures that will be utilized to ensure a smooth mail service transition for Enrollees;

(c) A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs/Medications (for those Enrollees that participate in the Specialty Pharmacy Program) as set forth in Section IV.B.11. of this RFP under the sub heading "Specialty Pharmacy Program." The Offeror must have a plan in place to facilitate the transfer of specialty Prescription information, including open refills and prior authorizations, from the previous Program administrator and outline the procedures that will be utilized to assure a smooth Specialty Pharmacy Program transition for affected Enrollees;

(d) A fully operational call center providing all aspects of customer support and services as set forth in Section IV.B.4. of this RFP;

(e) An on-line claims processing system that applies the Procuring Agencies' approved edits and point of service edits, including drug utilization review edits, as set forth in Section IV.B.12. of this RFP;

(f) An on-line claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Procuring Agencies to correctly pay claims for eligible Enrollees/Dependents consistent with the Programs benefit designs and contractual obligations; and

(g) (Exclusive to DCS) A fully functioning customized Program website with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV.B.4.a.(7) of this RFP.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.2, with the exception of a.2.g which is exclusive to DCS, and, therefore, not applicable to NYSIF. We have provided clarifications to our approach to a.2.g in our response to b.4.a.7 in the DCS Technical Proposal Binder.

b. Required Submission

(1) Provide separate implementation plans (narrative, diagram, and timeline) upon each Agreement's approval, on or around October 1, 2012 that results in the implementation of all Program Services by the required date of December 31, 2013, indicating: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as member and Pharmacy communications, training of customer service staff, report generation, Flexible Formulary and Preferred Drug List development, mail service and specialty Pharmacy transition, customized website design, eligibility feeds, claims testing, and EGWP approval and transition.

NYSIF is currently a client of Express Scripts Workers' Compensation division, therefore implementation is not necessary.

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on or before December 31, 2013. The Offeror shall propose, separately for each Program, the forfeiture of a percentage of the 2014 Claims Administration Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the DCS or NYSIF Program are not met is fifty percent (50%) of the 2014 Claims Administration Fees (prorated on a daily basis). However, Offerors may propose higher or lesser percentages.

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is percent (%) of the 2014 Claims Administration Fee (prorated on a daily basis) for the DCS Program and percent (%) of the 2014 Claims Administration Fee (prorated on a daily basis) for NYSIF's Program.

NYSIF is currently a client of Express Scripts Workers' Compensation division, therefore implementation is not necessary. The Offeror's quoted amount to be credited against the Claims Administration Fee in the event all Implementation and Start-Up requirements for the DCS or NYSIF Program are not met is $1,000,000 per day, subject to a maximum credit of $5,000,000.

4. Customer Service

The Programs require that the Offeror provide quality customer service to Enrollees/Claimants. The DCS Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number members access representatives who respond to questions, complaints and appeals regarding DCS Program benefits, mail order services, Network Pharmacies, the Specialty Pharmacy Program, processing point of sale Prescriptions, drug status, claim status, etc. NYSIF's Program provides 24 hour, 7 day a week telephone support via a toll-free number, to assist its claimants with locating participating pharmacies, eligibility and benefit verification. The Offeror is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.L of this RFP illustrates the current Pharmacy Benefit Manager's call center volume for the DCS Program. Exhibit II.K.1 provides the number of members who have utilized the current DCS customized Program website from October 2010 through October 2011.

a. Duties and Responsibilities

The Offeror will be responsible for all customer support and services including, but not limited to:

(1) Providing Enrollees access to information on all Prescription drug benefits and services related to the Programs through separate toll-free numbers 24 hours a day 365 Days a year.

(2) (Exclusive to DCS) The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's Medical Insurer and is available to callers 24 hours a Day, 365 Days a year. The Offeror is required to establish and maintain a transfer connection (currently an AT&T T-1 line), including a back-up system which will transfer calls to the Offeror's line at their customer service site. The Offeror is required to sign a shared service agreement with The Empire Plan's Medical Insurer (currently UnitedHealthcare) and AT&T. In addition, the Offeror is also required to provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to customer service as required by this Section of the RFP;

(3) Maintaining separate call centers for the Programs located in the United States staffed by fully trained customer service representatives and supervisors available 24 hours a day 365 Days a year. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00am and 7:00pm ET. During off hours, calls

may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The call centers must also provide immediate access to Pharmacist(s) 24 hours a day 365 days a year. The call centers must meet the Offeror's proposed customer service telephone guarantees set forth in Section.IV.4.b.(8)(a) through (d) of this RFP.

(4) Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions.

(5) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: Program benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services, and Flexible Formulary and Preferred Drug List alternatives.

(6) Maintaining a backup customer service staff located in the United States with Program-specific training to handle any overflow when the dedicated customer service center is unable to meet the Offeror's proposed customer service performance guarantees. This back-up system would also be utilized in the event the primary customer service center(s) become unavailable;

(7) (Exclusive to DCS) Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available 24 hours a Day, 7 Days a week, except for regularly scheduled maintenance, which will provide, at a minimum, access to information regarding: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, comparative drug check functionality, Prescription drug history for both retail and mail claims, and the Flexible Formulary and Preferred Drug Lists (including alternatives for Non-Preferred Brand Name and excluded drugs). The Department shall be notified of all regularly scheduled maintenance at least one Business day prior to such maintenance being performed. The Offeror must establish a dedicated link to the customized website for the DCS Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the DCS Program. Any links should bring a viewer back to the Department website. No other links are permitted without the written approval of the Department. Access to the online Network Pharmacy locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the

website or establishing a dedicated link for the DCS Program shall be borne by the Offeror. Also, the Offeror shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal;

(8) Call Center Telephone Guarantees: The Offeror must provide separate guarantees for the DCS and NYSIF Programs for the following four (4) measures of service on the toll-free customer service numbers:

(a) Call Center Availability: The Programs' service level standard requires that the Offeror's telephone line will be operational and available to Enrollees, Claimants, Dependents, and pharmacies at least ninety-nine and five-tenths percent (99.5%) of the Offeror's Call Center Hours. The call center availability shall be reported monthly and calculated quarterly;

(b) Call Center Telephone Response Time: The Programs' service level standard requires that at least ninety percent (90%) of the incoming calls to the Offeror's telephone line will be answered by a customer service representative within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Offeror's telephone line to be answered by a customer service representative.

The call center telephone response time shall be reported monthly and calculated quarterly;

(c) Telephone Abandonment Rate: The Programs' service level standard requires that the percentage of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated quarterly; and

(d) Telephone Blockage Rate: The Programs' service level standard requires that not more than three percent (3%) of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated quarterly.

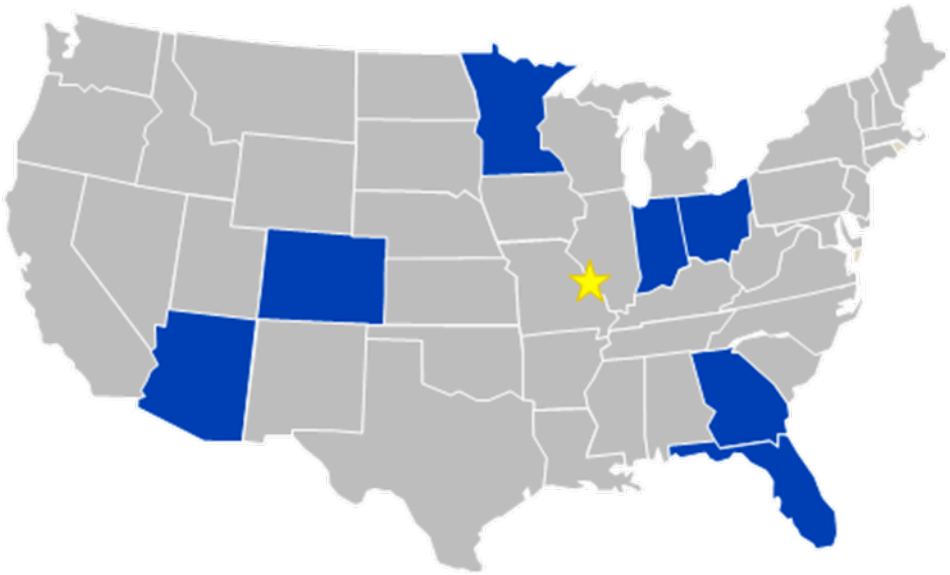
Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.8, with the exceptions of a.2 and a.7 which are exclusive to DCS, and, therefore, not applicable to NYSIF. Please see our DCS-specific Technical Proposal binder for our response to items a.2 and a.7.

b. Required Submission

(1) Confirm that you will provide Enrollees access to Programs information on Claimants through separate consolidated toll-free numbers 24 hours a day 365 Days a year, as described above.

Confirmed. Express Scripts provides customer service through our nationwide, integrated system of Contact Centers. Through our NYSIF network, your injured workers, claims staff, and pharmacists can reach our patient care advocates via a toll-free line 24 hours a day, 365 days a year.

The network includes Contact Center sites in Phoenix, Arizona; Pueblo, Colorado; Orlando, Florida; St. Marys, Georgia; Minneapolis, Minnesota; and Cincinnati, Ohio (Member Choice Center and Prior Authorization).. NYSIF calls are handled in our Workers' Compensation Contact Center in Pueblo and St. Marys. Patient care advocates in Orlando, Florida, and Indianapolis, Indiana, take calls from injured workers with specialty prescriptions. Please see a map of our locations below.



To ensure quick and accurate resolution to injured worker inquiries, our courteous advocates have injured worker-specific information readily available, including up-to-the-minute information about orders from the Express Scripts Pharmacy, retail pharmacy transactions and NYSIF's Prior Authorization policies. By offering around-the-clock access to expert support, exceeding CMS staffing requirements, Express Scripts has achieved a 95% overall injured worker satisfaction rating.

To support your injured workers' needs, we have assigned a designated team of patient care advocates specially trained on your pharmacy benefit program. This team operates from our designated Contact Center sites. Multi-site handling of calls capitalizes on our first-available agent technology, thereby providing a more consistent service level and a robust business continuity plan should a weather, disaster, or technology issue occur in one location. Patient care advocates at both sites provide assistance and issue resolution to plan sponsors, injured workers, and pharmacists 24 hours a day, 365 days a year.

Our Contact Center supports all NYSIF injured worker calls via your dedicated toll-free number.

Contact Center Differentiators

Express Scripts' Contact Centers offer NYSIF:

- Injured Worker-Specific Support – Express Scripts has developed an unmatched ability to communicate with your injured workers regarding safety, savings, and convenience opportunities. When an injured worker calls our Contact Center for any reason, the patient care advocate sees injured worker-specific opportunities via the Message Center and shares these details with the injured worker.
- Around-the-Clock Access – Patient care advocates provide assistance and issue resolution to plan sponsors, injured workers, and pharmacists 24 hours a day, 365 days a year. Express Scripts offers NYSIF a dedicated, toll-free number for your injured workers.
- Integrated Contact Center Network – The ability to leverage our integrated Contact Center network ensures that we quickly answer client and injured worker calls during peak calling periods. Our ability to route calls to other sites also protects callers from service interruptions in the event of a natural disaster or regional telecommunications problems. Touch-Tone Access to Services—Injured Workers can access an interactive voice response (IVR) system 24 hours a day, 365 days a year. Through IVR, injured workers can order Express Scripts Pharmacy prescription refills, check prescription status or, locate the nearest participating pharmacy, and order new injured worker identification cards. Injured workers are also automatically notified of their refill opportunities and order status upon entering the IVR system. At any time during an IVR call, callers can choose to speak with a patient care advocate.
- Help with the Express Scripts Pharmacy and Retail Pharmacies – Express Scripts patient care advocates manage inquiries regarding both the Express Scripts Pharmacy and our retail pharmacy networks, eliminating the need for coordination between separate contact centers.

Service

Express Scripts works closely with plan sponsors to develop and achieve service performance goals consistent with their objectives. We work to attain world-class service goals through:

- Quick Issue Resolution – Advocates strive to resolve injured worker inquiries during the initial call. When injured worker inquiries require follow-up, advocates provide an expected resolution time and personally ensure issue resolution and communication with the injured worker.

- Performance Accountability – Comprehensive monthly reporting of call volume, average speed of answer, and calls abandoned (via the Operational Performance Report delivered to you by account management) provides NYSIF with demonstrated performance results.
- Accurate Forecasting – Express Scripts routinely conducts extensive analysis of call patterns to proactively ensure we meet the needs of the more than 60 million members and injured workers we serve. We forecast call volume with 97% accuracy.

Technology

Express Scripts is proud of the best-in-class technology we have implemented within our Contact Center. Examples include:

- An encyclopedic Knowledge Management System that maintains up-to-date, client-specific information. Advocates utilize this system to obtain information specific to each client to help them answer member and injured worker questions regarding coverage, plan design, and contact information.
- Compass, our central location for member and injured worker information. The system provides injured worker-specific information on coverage, claims, eligibility, refills available, and more.
- Call recording technology that captures 100% of inbound calls for quality assurance and advocate training
- Call routing technology to ensure we direct your claims handlers and injured workers to advocates specially trained to handle their inquiries
- Scheduling software to ensure we are effectively staffed to serve your members and injured workers

In addition, real-time monitoring provided by CMS allows us to evaluate all activities coming in and out of the Contact Center. This system also provides historical data, detailing call patterns and potential anomalies.

(2) (Exclusive to DCS) Confirm you will enter into a shared service agreement with the Empire Plan Medical Insurer and AT&T. Confirm you will provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.

Please see our DCS-specific Technical Proposal binder.

(3) Confirm that you will maintain separate Dedicated Call Centers for each Program located in the United States, employing a staff of Pharmacists and a staff of fully trained customer service representatives (CSR's) and supervisors available 24 hours a day 365 Days a year.

Confirmed. It is important to note that these markets are handled as separate units each with the expertise concentric to that line of business. The following lists Contact Center staff positions, qualifications, and responsibilities for both the Group Health and Workers' Compensation markets.

Patient Care Advocates

Responsibilities include: handling inquiries from members, injured workers and physicians related to prescription and eligibility issues, gathering information necessary to resolve issues or effectively respond to questions and escalating issues as necessary.

Qualifications include: thorough knowledge of the Express Scripts prescription processing and knowledge management tools, excellent customer service and written and verbal communication skills, attention to detail, computer application skills (Microsoft Excel, Word, and Access), strong problem-solving skills, excellent reliability, and high school diploma or General Educational Development (GED) equivalent.

Senior Patient Care Advocates

Responsibilities include: serving as support person for patient care advocates, aiding patient care advocates with technical questions, providing knowledge of current procedure and benefit information to patient care advocates, acting as point of contact for escalated issues, researching and following through on complex issues, supporting external customer service calls during high volume, and serving as backup in the absence of the team supervisor.

The qualifications for senior patient care advocates are the same as those for patient care advocates, with the following additions: leadership skills, positive attitude, self-motivation, and time management skills. A minimum of one year of experience as an Express Scripts patient care advocate is preferred.

Team Leaders

Responsibilities include: managing all patient care advocates in a single Contact Center or multiple Contact Centers, overseeing call volume and service standards, and directing the hiring and development of staff. Qualifications include: college degree in business administration or related field preferred, five years to seven years of experience in a contact center environment (including two years to three years of contact center supervisory experience or management), demonstrated understanding of operating in a contact center environment (including ability to manage average call time, response time, and call volume), knowledge of the pharmacy benefit management or healthcare industry preferred, ability to motivate employees and handle difficult employee relations issues,

focus on quality customer service, demonstrated ability to meet multiple deadlines and manage heavy workload, excellent verbal and written communication skills, computer application skills (including knowledge of Microsoft Office suite and contact center platforms), and ability to handle sensitive or confidential information.

Client Support Center Staff

Responsibilities include: responding to prescription-drug benefit inquiries from client representatives, assisting as a designated team member to a variety of clients to meet or exceed customer service expectations, assisting pharmacies with expert technical support needed to perform online claims processing, providing accurate and prompt issue resolution, assisting injured workers in resolving issues for orders from the Express Scripts Pharmacy, and ensuring the most efficient and effective use of Express Scripts processes and procedures.

The qualifications for Client Support Center associates are the same as those for patient care advocates, with the addition of pharmacy benefit management expertise and a demonstrated ability to function as part of a team.

Resource Operations Manager

Responsibilities include: managing call volume and resources, planning short-term staffing based on business needs, developing and maintaining work schedules, managing time-off allocations, identifying call volume trends on a daily basis, reporting system and phone issues to response center and communicating status to the virtual team, coordinating staffing for all platforms for planned system outages, creating weekend strategies, analyzing operational and workforce data to review and reforecast requirements, analyzing call volume patterns to manage staffing, generating forecasts for Contact Center scheduling, serving as frontline manager for all patient care advocates, and developing and motivating staff.

Qualifications include: two years of customer service or contact center experience, working knowledge of automatic call distributor technology, understanding of call software tools and programming requirements (for example, CMS for Medicare and Medicaid, vectors, VDNS), understanding of call queuing theories and random arrival algorithms, excellent verbal and written communication skills, ability to multi-task in a fast-paced environment, proven leadership ability, high school diploma or GED equivalent, leadership skills, contact center operations and systems experience, and computer application skills (including Microsoft Word and Excel proficiency).

Inquiries Requiring Pharmacist Assistance

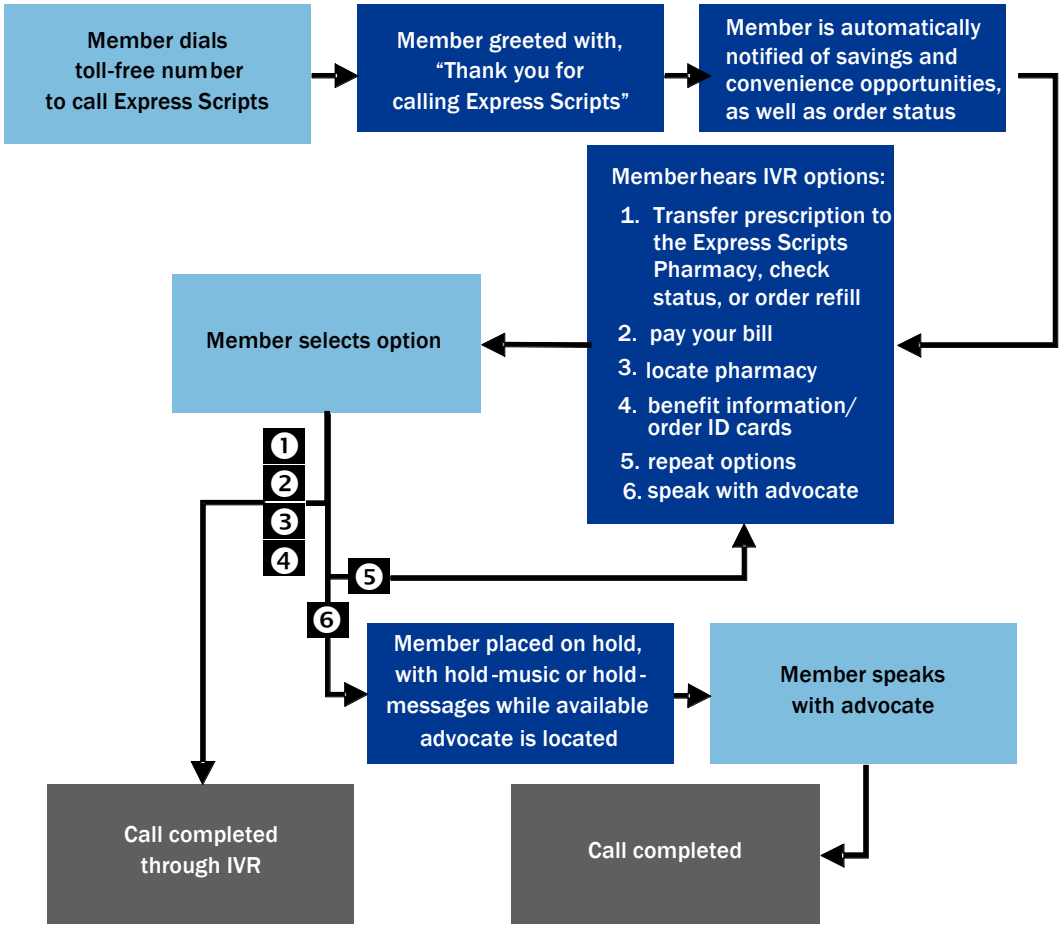
Members and Injured workers have access to Express Scripts' registered pharmacists 24 hours a day, 365 days a year. If an injured worker needs to speak with a pharmacist, the patient care advocate transfers the call to an in-house pharmacist. After an injured worker or member has spoken with a pharmacist about any clinical concerns, the pharmacist can route the injured worker or member's call back to an advocate for follow-up if necessary.

In addition to the registered pharmacists handling injured worker and member inquiries, full-time clinical pharmacists assist Express Scripts' Prior Authorization service specialists from 8 a.m. to 5 p.m. Central Time, Monday through Friday. These specialists also can contact clinical pharmacists after hours. All on-call pharmacists respond to after-hours calls within one hour.

(4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:

(a) Whether any Interactive Voice Response (IVR) system is proposed.

Express Scripts uses Nuance for our interactive voice response (IVR) system. The following flowchart illustrates the typical flow of an incoming call. Express Scripts would be happy to work with NYSIF to modify the available options. At all times, we route Medicare Part D calls to Medicare-trained patient care advocates at our Contact Center—this typically is not a concern in the Workers' Compensation market.



When members and injured workers call the Contact Center, they first reach the Interactive Voice Response (IVR) system, which automatically notifies each caller of any savings or convenience opportunities, as well as order status (if applicable). The IVR interacts with the claim processing system and allows the member or injured worker to order refills from the Express Scripts Pharmacy, check on prescription status, make a payment, access benefit information, transfer a prescription to the Express Scripts Pharmacy (and check conversion status), locate a pharmacy, and order a new ID card. After completing any transaction through the IVR, injured workers hear an electronic voice confirmation. At any point during the call, members or injured workers can transfer to a patient care advocate. When an injured worker or member chooses to do so, our call routing system ensures the call is routed to an available agent. Advocates receive support from a staff of team leaders, quality coaches, trainers, and managers.

NYSIF's dedicated toll-free number routes calls to advocates specifically trained on NYSIF's benefit plan design and unique issues. Our enhanced IVR system includes the following features:

- Speech Recognition – Translates spoken word into text, automating activities and allowing injured workers to complete tasks that would otherwise require a visit to our website or transfer to a patient care advocate
- Menu Optimization – Minimizes the number of prompts to increase efficiency
- Proactive Messaging for Retail, Order Status, and Select Home Delivery – Compares caller identification to member or injured worker records so that our IVR system immediately advises members or injured workers of relevant updates, such as order status
- Permanent and Temporary Address Changes – Allows Injured Workers injured workers to change shipping addresses (also available through Express-Scripts.com for Members)

(b) A sample of the IVR script and a description of customizable options, if any, you propose for the Programs.

IVR customization is limited to NYSIF-specific messaging prior to or following the injured worker reaching the Express Scripts automated system. For example, you can work with your account manager to include custom messaging that states, "Thank you for calling Express Scripts, serving NYSIF," which would then route to our automated IVR system. Custom messaging is available at no additional cost. Express Scripts also can remove IVR options not applicable to NYSIF's benefit (for example, we can remove the "locate pharmacy" option for mail-only clients).

(c) A description of the management reports and information available from the system including the key statistics you propose to report.

The Operational Performance Report, which can be broken out by group and benefit plan level, tracks key measures of our service to DCS or NYSIF. Specifically, the Operational Performance Report provides the following information:

- Express Scripts Pharmacy – Total prescriptions, refills by source, new fills, percent of clean prescriptions handled in two days, percent of interventions handled in five days, overall intervention rate, reject rate, top reject reasons
- Contact Center – Call reasons, total calls by month, average seconds to answer, abandonment rate, call service level
- Client-Reported Issues – Total client issues, client call reasons
- Retail – Reject rate, total retail prescriptions, top reject reasons
- Member Portal – Website refills, logins, users, new registrations
- Specialty – Total claim volume, average seconds to answer, abandonment rate, call service level, total client issues, client call reasons
- Conclusions, Detail Report, & Glossary of Terms – Reporting period, report generated date, book of business definition, detailed table of reported metrics, and Operational Performance Report terminology definitions

Please note that plan activity information outlined in the Operational Performance Report may vary depending on your contracted performance guarantees. DCS and NYSIF will receive the Operational Performance Report according to the schedule you determine. The report is available at no cost by the 15th of the month following the designated activities.

(d) A description of the capabilities of your phone system to track call types, reasons and resolutions.

Express Scripts tracks each incoming call using our online interface, Compass. Information tracked and maintained for each call includes:

- Patient, pharmacy, or physician detail information
- Name of the advocate who answered the call
- Date and time of the call
- Reason for the call

- Special comments or notes about information offered or issues requiring resolution

Express Scripts' teams retrieve call histories by advocate names, injured worker ID numbers, social security numbers, names of plan sponsors, Drug Enforcement Administration numbers, National Council for Prescription Drug Programs numbers, or National Provider Identifier numbers.

Electronically tracking call histories enables continuity of service for follow-up issues. It also allows Express Scripts to forecast call volume, proactively resolve issues, enhance processes, and identify education opportunities for advocates. Express Scripts handles NYSIF's service requests and issue resolution in a timely fashion by:

- Tracking requests and issues in Houston, our online account management tool
- Logging all correspondence with NYSIF, including phone calls, emails, faxes, and letters
- Analyzing Houston reports and forwarding such reports to senior management for scheduled reviews
- Providing NYSIF with detailed primary and back-up contact information
- Surveying clients at least annually to measure satisfaction
- Maintaining regular contact between senior staff and NYSIF to ensure we address your concerns
- Tying a portion of the account management team's compensation to NYSIF satisfaction

(5) Describe the training that is provided to CSR and Pharmacist staff before they go "live" on the phone with Enrollees. Include:

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;

To drive a first-class patient experience, Express Scripts monitors an average of four calls to six calls per advocate per month. Our state-of-the-art call monitoring technology provides a range of auditing options, including voice data and screen image capturing.

The Contact Center Quality Management team reviews call data to identify trends, strengths, and areas for improvement. Our proprietary software enables us to explore information in greater detail, "peeling back" layers of data to reveal precise details about a particular call, patient care advocate activity, or customer

interaction. In addition, we have invested in enhanced reporting that allows us to proactively identify and act upon training opportunities for our patient care advocates.

As needed, the Quality Management team partners with relevant departments to implement improvement strategies.

Ensuring Quality by Recording Calls

We use state-of-the-art technology to digitally record 100% of the voice portion of calls coming into our Contact Center. We use these calls to assess the quality of our interactions with injured workers and as a development tool during coaching sessions with patient care advocates. We notify callers that we may record their calls for quality purposes. We store these calls at the Contact Center where they were answered for up to 45 days in the application and up to 180 days on the server. We can keep them longer if specifically required by DCS and NYSIF and stipulated in your contract.

Site management teams and selected injured workers of corporate staff retrieve these calls for quality, compliance, and analytical purposes. Through specialized analytics, we improve operational efficiency and increase injured worker satisfaction.

If NYSIF asks us to retrieve a call, we do so at no additional charge, subject to compliance with HIPAA regulations. NYSIF - During a five-week initial training program, advocates are trained to understand the caller's inquiry and seek solutions that will create win-win outcomes. This initial training program blends together a variety of training methodologies to include instructor-led training, computer-based training modules, and problem-based learning.

Advocate performance is assessed frequently during the initial training program. Advocates also take 80 hours of live calls during the initial training program in a mentored environment. In addition to the initial training, the training organization contributes to advocates' continued development through the delivery of client-specific training. The length of client-specific training varies by client. NYSIF call center advocates are more senior associates and undergo additional training specific to the Workers' Compensation environment.

Express Scripts patient care advocates receive special services training (for example, serving elderly members and individuals with disabilities). Program features include the following:

- Training program developed by the American Association of Retired Persons
- Call simulations to train patient care advocates to understand both sides of a call. For instance, the patient care advocate might assume the role of a

caller with a hearing deficit. This experience promotes empathy in the patient care advocate trainee.

Advocates receive specific training to enhance communication through tone of voice, vocabulary, etiquette, empathy, active listening, and prompt follow-up when needed. Additionally, advocates complete a "Managing Difficult Interactions" module, which includes call simulation. Upon completion, advocates practice appropriate call-handling techniques during sample call scenarios.

(b) The first call resolution rate for the proposed call centers;

In 2011, our First Call Resolution was [redacted]

(c) The call center locations, average staff and turnover rate for call center employees; (d) Ratio of management and supervisory staff to customer service representatives and;

The network includes Contact Center sites in Phoenix, Arizona; Pueblo, Colorado; Orlando, Florida; St. Marys, Georgia; Minneapolis, Minnesota; and Cincinnati, Ohio (Member Choice Center and Prior Authorization).. Patient care advocates in Orlando, Florida, and Indianapolis, Indiana, take calls from injured workers with specialty prescriptions.

To ensure quick and accurate resolution to injured worker inquiries, our courteous advocates have injured worker-specific information readily available, including up-to-the-minute information about orders from the Express Scripts Pharmacy, retail pharmacy transactions, NYSIF's Prior Authorization policies, and the individual injured worker's specific savings opportunities.

By offering around-the-clock access to expert support, exceeding CMS staffing requirements, Express Scripts has achieved a 95% overall injured worker satisfaction rating. At all times, we route Medicare Part D calls to Medicare-trained patient care advocates who have been extensively trained to understand Medicare Part D beneficiary issues.

The voluntary turnover rate for 2011 [redacted] as measured after an initial 90-day probationary period. Workers' Compensation division has an even higher retention rate because the advocates are more senior level employees.

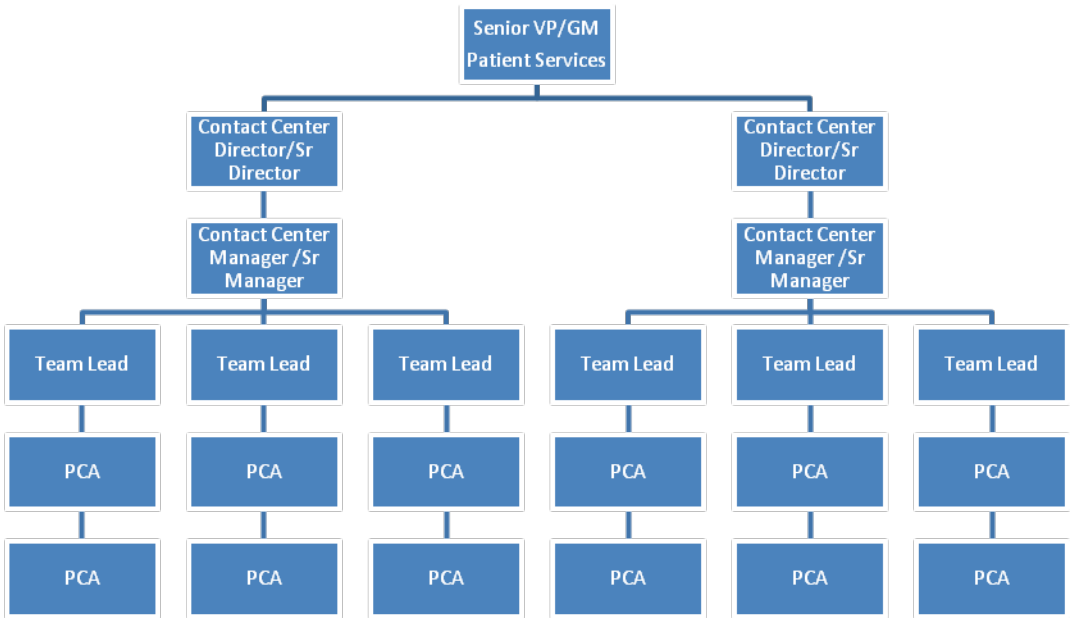
(d) Ratio of management and supervisory staff to customer service representatives and;

To ensure Express Scripts is staffed appropriately to provide a first-class customer experience, the Resource Management Group utilizes sophisticated forecasting, scheduling, and modeling tools to determine Contact Center workforce requirements. We maintain the following staffing levels:

[redacted]

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels.

The following organization chart is designed as an overview only. It does not reflect actual headcount, except at the executive levels.



Proactively Monitoring Staffing Levels

Express Scripts uses Aspect's eWorkforce Management™ software to accurately forecast call volume. We perform the following analyses to ensure adequate staffing 24 hours a day, seven days a week:

- Call History – Each month, Express Scripts reviews 18 months of historical call volume data from our book of business and from select clients.
- Membership and Benefit Changes – Express Scripts continuously reviews changes affecting membership, including the addition of new injured

workers, implementation of unique benefit plans, or deductible renewal dates for clients.

- Peak Calling Periods – Express Scripts identifies peak calling period trends, such as holidays, seasonal changes, and annual year-end sales and enrollment cycles.

Using these analyses, Express Scripts determines appropriate staffing levels and schedules advocates to meet forecasted call volume. Our advance planning ensures ample time in the event that performance targets require additional hiring or training.

(6) Describe the back-up systems for your primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a back-up system is needed, explain how and in what order calls from Enrollees will be handled. Confirm that backup staff will have DCS Program and NYSIF Program specific training. Indicate the number of times the back-up system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by your Dedicated Call Centers and that the backup call center would only be used in case of system failure or call overflow.

Confirmed. Express Scripts' Contact Center has built-in redundancy that ensures and protects callers from service interruptions due to a natural disaster or regional telecommunications problem. The Contact Center is integrated with the prescription adjudication system and with the mail-service facility through a shared data platform. This approach means orders, prescriptions, and other pharmacy program information can be tracked from any point in the system. Because of the operational redundancy that exists within our Contact Center structure, we have not had to enact any backup system in the past two years.

(7) (Exclusive to DCS) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop a customized website for the DCS Program. Also, confirm that the following information, at a minimum, will be available on the website: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, Prescription drug history for both retail and mail claims, and the Flexible Formulary and Preferred Drug List (including alternatives for Non-Preferred Brand Name and excluded drugs). Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website.

Please see our DCS-specific Technical Proposal binder.

(8) Call Center Telephone Guarantees: For each of the four (4) Call Center Telephone Guarantees above, the Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fees, for failure to meet the Offeror's proposed guarantee.

(a) Call Center Availability:

The Standard Credit Amount for each .01 to .25% below the standard of ninety- nine and five-tenths percent (99.5%) that the Offeror's telephone is not operational and available to

Enrollees, Claimants, Dependents and Pharmacies during the Offeror's Call Center Hours calculated on a quarterly basis, is $100,000 per quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available to Enrollees, Claimants, Dependents, and Pharmacies during the Offeror's Call Center Hours calculated on a quarterly basis, is $ per quarter for DCS and $ per quarter for NYSIF;

(b) Call Center Telephone Response Time:

The Standard Credit Amount for each .01 to 1.0% below the standard of ninety percent (90%) of incoming calls to the Offeror's telephone line that is not answered by a customer service representative within sixty (60) seconds is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) that is not answered by a customer service representative within sixty (60) seconds, calculated on a quarterly basis, is $ per quarter for DCS and $ per quarter for NYSIF;

(c) Telephone Abandonment Rate:

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on a quarterly basis, is $ per quarter for DCS and $ per quarter for NYSIF; and

(d) Telephone Blockage Rate:

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of three percent (3%) is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's Quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that is blocked by a busy signal, in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on a quarterly basis, is $ per quarter for DCS and $ per quarter for NYSIF.

[redacted]

[redacted]

[redacted]

5. Medicare Part D – Employer Group Waiver Plan PDP (Exclusive to DCS)

a. Duties and Responsibilities

The Offeror will be responsible for implementing and administering a Center for Medicare and Medicaid Services (CMS)-approved and compliant Employer Group Waiver Plan (EGWP) and Medicare D supplemental wrap Prescription Drug Plan (PDP) for the Empire Plan's Medicare-eligible retirees beginning on January 1, 2014. Such services shall include at least the following tasks and such other tasks as may be added in guidance and further regulation by CMS:

(1) Disclosing to CMS, on a timely basis and on behalf of the Department, any filings, applications, reports, formularies, and other DCS Program material necessary for the Department to comply with the requirements of an "800-series" Medicare PDP EGWP, plus Medicare D supplemental wrap;

(2) Fully supporting the Department with all operational aspects of a fully compliant Medicare PDP EGWP, plus Medicare D supplemental wrap including but not limited to: (a) Medicare PDP EGWP premium development

(b) Enrollment

(c) Enrollee Opt-Out process

(d) Health Insurance Claim Number (HICN) administration

(e) Formulary management

(f) Issuing of Medicare PDP EGWP member identification cards

(g) Member Communications, including required explanation of benefits statements

(h) Claims Processing

(i) Administration of a Medicare D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible the prescription drug benefit design for non-Medicare primary retirees in The Empire Plan;

(j) Timely administration of catastrophe re-insurance claims

(k) Administration of Low Income Subsidy requirements

(3) Prepare timely reconciliations of administrative fees, forecast versus incurred prescription drug claims, CMS (Part D) capitated and reinsurance fees, CMS enrollee low-income subsidy payments and pharmacy rebates. The Offeror must provide such records and reports in a manner, form, and timeliness acceptable to the Department;

(4) Promptly credit the Department for all CMS premium subsidy payments and all pharmacy rebates received by the Offeror under the Medicare PDP EGWP; plus Medicare D supplemental wrap;

(5) The Department acknowledges and agrees that it shall be responsible solely (1) for providing creditable coverage notices required with respect to the EGWP; and (2) for determining whether enrolled individuals are qualifying covered retirees. The Offeror will work with the Department to obtain HICNs for all eligible Medicare-primary members enrolled in the EGWP.

(6) The Offeror acknowledges that the information furnished in connection with the administration of the Medicare PDP EGWP is being provided to obtain federal funds. The Offeror shall require all sub-contractors, including any plan administrators, if applicable, that submit information required by CMS to obtain any subsidies or payments on behalf of the DCS Program to acknowledge that information provided in connection with the key subcontract is used for the purpose of obtaining federal funds; and

(7) The Offeror acknowledges that its provision of services pursuant to this section of this RFP is subject to audit and evaluation by the U.S. Department of Health and Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal government, as well as by the State of New York pursuant to Appendix A and Appendix B of the resultant Agreement. The Offeror shall comply with any record retention requirements required pursuant to 42 CFR SubPart R in this regard.

(8) The Offeror is required to act as consultant to the Department in analyzing its experience with the Medicare PDP EGWP, and recommending as well as implementing other permitted options under Medicare Part D which may be of advantage to the Department, agencies participating in NYSHIP and NYSHIP Enrollees;

(9) Upon finalization of a subrogation process by CMS, the Offeror will be required to identify and recover claim payments made by the DCS Program from other plans that should have been the primary payor.

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

(1) Describe your experience in implementing and administering a Medicare PDP EGWP plus Medicare D supplemental wrap for customers of similar scope and size to The Empire Plan.

Please see our DCS-specific Technical Proposal binder.

(2) Confirm your understanding of the requirements to support the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap for The Empire Plan on behalf of the Department, including the Offeror's proposed approach for the following:

(a) Medicare PDP EGWP premium development

(b) Enrollment

(c) Enrollee Opt-Out process

(d) Health Insurance Claim Number (HICN) administration

(e) Formulary management

(f) Issuing of Medicare PDP EGWP member identification cards

(g) Member Communications, including required explanation of benefits statements

(h) Claims Processing

(i) Administration of a Medicare D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible with the prescription drug benefit design for non-Medicare primary retirees in The Empire Plan;

(j) Timely administration of catastrophe re-insurance claims

(k) Administration of Low Income Subsidy requirements

Please see our DCS-specific Technical Proposal binder.

(3) Confirm that you will develop, and timely submit to, CMS and /or Enrollees all required filings and DCS Program material related to the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap on behalf of the Department.

Please see our DCS-specific Technical Proposal binder.

(4) Provide a copy of your proposed Medicare Part D formulary and provide a side by side comparison to the proposed Empire Plan flexible formularies included in this RFP. Comment on reasons for variances.

Please see our DCS-specific Technical Proposal binder.

(5) Provide a sample member communications package, including proposed benefit card, for the EGWP PDP plus Medicare D supplemental wrap.

Please see our DCS-specific Technical Proposal binder.

(6) Describe in detail the transition services you will utilize to assist members who are newly eligible for the EGWP plus Medicare D supplemental wrap, including formulary disruption, prior authorization, mail order and retail pharmacy refills, Specialty Program medications, and quantity limits.

Please see our DCS-specific Technical Proposal binder.

(7) Describe the member termination process under the EGWP PDP, including the timing of termination after the termination date is received by the Department.

Please see our DCS-specific Technical Proposal binder.

(8) Describe your capability to provide the consulting and accounting services necessary to support and assist the Plan Sponsor in determining what Medicare Part D option the Department should select so that the DCS Program realizes maximum savings.

Please see our DCS-specific Technical Proposal binder.

(9) Confirm your understanding and describe your ability to identify and recover claim payments made by the DCS Program from other Medicare Part D plans that should have been the primary payor, upon finalization of the subrogation process by CMS.

Please see our DCS-specific Technical Proposal binder.

6. Enrollee Communication Support

The Department regularly provides information regarding DCS Program benefits to members through various publications, the Department's website and attendance at various meetings. The successful Offeror will be required to assist the Department with the creation, review and presentation of DCS Program materials that will enhance a member's understanding of DCS Program benefits. Please see Exhibit II.N for a summary of DCS Program presentations that took place in the past 12 month period. The Offeror will also be required to assist NYSIF with various Claimant communications including the issuing of ID cards, information packets, forms and letters, as requested.

a. Duties and Responsibilities

(1) All Enrollee communications developed by the Offeror are subject to the Procuring Agencies' review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone. The Department or NYSIF in its sole discretion reserves the right to require any change it deems necessary.

(2) (Exclusive to DCS) The Offeror will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

- **(a) Developing language describing the DCS Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;**
- **(b) Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing DCS Program benefit features and/or highlighting trends in drug utilization;**
- **(c) Timely reviewing and commenting on proposed DCS Program communication material developed by the Department;**

(3) (Exclusive to DCS) Upon request, subject to the approval of DCS, on an "as needed" basis, the Offeror agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. The Offeror agrees that the costs associated with these services are included in the Offeror's Claims Administration Fee.

(4) The Offeror must work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs, including

but not limited to mail order forms, Enrollee claim forms, prior authorization letters, generic appeal letters, Flexible Formulary and Preferred Drug List, disruption letters, etc. All such communications must be approved by the Procuring Agencies.

(5) (Exclusive to NYSIF) The Offeror must assist NYSIF in developing a customized Claimant information packet that will include information on available prescription drug services as well as a permanent ID card to be used when filling injury-related prescriptions. See sample ID card in Exhibit II.E.2d.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.5., with the exceptions of a.2, a.3, and a.5, which are not applicable to NYSIF. Please see our DCS-specific Technical Proposal binder for our response to items a.2 and a.3.

b. Required Submission

(1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreements. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the Programs communications you have developed for Enrollees. Confirm your understanding that all Programs communications developed by the Offeror are subject to the Procuring Agencies final approval.

Note: (Exclusive to DCS) There are specific requirements for Flexible Formulary and Preferred Drug List communications set forth in Preferred Drug List Development and Management within Section IV.B.16.a. of this RFP.

We customize all materials for NYSIF, co-branding all documents from First Fill forms to injured worker packets as well as adding pertinent language translations.

(2) (Exclusive to DCS) Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and your ability to provide input into such communications quickly.

Please see our DCS-specific Technical Proposal binder.

(3) (Exclusive to DCS)Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States.

Describe the experience and qualifications of staff that will be attending these events.

Please see our DCS-specific Technical Proposal binder.

(4) Confirm your commitment to work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs. Provide examples of how you have worked with other large clients to produce customized communications.

We have developed customized communications for NYSIF with regard to state requirements surrounding PBM and network utilization specific to New York state WC laws.

(5) (Exclusive to SIF) Confirm your commitment to develop a customizable information packet that will include a permanent ID card and other prescription drug information for the NYSIF Program. Provide samples of information packets developed and customized for other clients.

Confirmed. Express Scripts will works with NYSIF to create, customize, and distribute any necessary marketing materials or information packets for your claims professionals and injured workers. In addition to offering inclusion of NYSIF logo to the materials, we can customize the verbiage within the packets as well. Sample materials described below are included in the Attachments Section:

- Temporary Prescription Services ID form – This form is available to NYSIF for distribution to supervisors, Human Resources representatives, etc. We also can provide the template electronically for ease of distribution.
- Injured Worker Card Packet – Express Scripts mails this information to injured workers once we confirm their eligibility. The packet typically contains:
  - Information detailing the packet's primary purpose
  - Resin ID card
- Lists of participating network pharmacies and frequently asked questions about the program

7. Enrollment Management

The Programs require the Offeror to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with each of the Programs' eligibility rules.

The Employee Benefits Division of the Department of Civil Service utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.B through II.B.2.

Note: The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's card contractor issues an Employee Benefit Card. An Enrollee with individual coverage will receive one card containing the Enrollee's 9-digit alternate identification number and name. An Enrollee with family coverage will receive two cards containing the Enrollee's alternate identification number and name, as well as Dependents' names. This universal card is used by Enrollees and Dependents for all components of The Empire Plan. An example of The Empire Plan Employee Benefit Card is provided in Exhibit II.E.2a. An example of the Excelsior Plan Employee Benefit Card is provided in Exhibit II.E.2c. The Department will not accept an alternative approach to ID cards, with the exception of ID cards required for the EGWP. It is the responsibility of the Offeror to ensure that the Retail Pharmacy Network accepts The Empire Plan Employee Benefit Card as evidence of coverage and is capable of submitting claims when presented with The Empire Plan Employee Benefit Card. These cards include The Empire Plan consolidated toll free number that pharmacies may use to contact the DCS Program if they need claim submission assistance. The Offeror should not expect any modification of the current identification card as part of implementation. Separate Prescription drug cards will not be issued, with the exception of ID cards required for the EGWP.

The SEHP Employee Benefit Card displays the Enrollee's 9-digit alternate identification number and name and the expiration date of coverage. The SEHP Employee Benefit Cards are issued annually by a Department contractor and have an expiration date of August 31st of each year. An example of this card is provided in Exhibit II.E.2b.

NYSIF's Claim Eligibility process ensures that Claimants receive convenient prescription filling services and that Network Pharmacy bill the NYSIF Program with the proper Carrier Case Number (i.e. Claim Number). A sample ID card is provided in Exhibit II.E.2d.

a. Duties and Responsibilities

The selected Offeror will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department and NYSIF. These enrollment files shall be used by the Offeror to process retail, mail order and specialty pharmacy claims, provide customer service, identify individuals in the enrollment files who are enrolled in the EGWP or another Medicare Part D plan, and produce management reports and data files. The Offeror is required to provide enrollment management services including but not limited to:

(1) Initial Testing:

(a) Performing an initial enrollment load to commence upon receipt from the Department and NYSIF during Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Procuring Agencies;

(b) Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The selected Offeror shall submit enrollment test files to the Department and NYSIF for auditing, provide the Department and NYSIF with secure, online access required to ensure accurate loading of the Programs enrollment data, and promptly correct any identified issues to the satisfaction of the Department and NYSIF;

(2) (Exclusive to DCS) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Offeror shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the Department, the Offeror shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Offeror in an electronic format daily

(Monday through Friday). On occasion, the Department will release more than one enrollment file within a 24-hour period. The Offeror must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.G and II.G.1. The Offeror must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

(3) (Exclusive to NYSIF) Providing an enrollment system capable of receiving secure enrollment transactions every day, including weekends and holidays, and having all transactions fully loaded to the claims processing system within twelve (12) hours of release of a retrievable file by the NYSIF. The Offeror shall immediately notify the NYSIF of any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the NYSIF, the Offeror shall immediately load all records received (that meet the quality standards for loading) within twelve (12) hours of their release, as required. The NYSIF will release enrollment changes, including all additions, modifications and deletions since the previous transmission, to the Offeror in an electronic format daily (every day, including weekends and holidays). On occasion, the NYSIF will release more than one enrollment file within a 12-hour period. The Offeror must be capable of loading both files within the twelve (12) hour performance standard. The format of these transactions will be a fixed length ASCII text file. The ASCII text file is encrypted and transmitted each business day using a secure transmission protocol. Upon selection, the Offeror will be provided with the claim eligibility file specifications and the schedule for the transmission of the file. The latest transaction format for NYSIF is contained in Exhibit II.O.

(4) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. Any transfers of enrollment data within the Offeror's system or to external parties must be completed via a secured process;

(5) Providing a back-up system or have a process in place where, if enrollment information is unavailable or not current at the point of service, Enrollees can obtain Prescriptions without interruption, at the point of service. Short fill policies should be included in the Pharmacy Provider manual;

(6) Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement resulting from this RFP;

(7) (Exclusive to DCS) Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Offeror's staff with access to current Program enrollment information. Offeror's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 9:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website;

(8) (Exclusive to DCS) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Offeror must make payment for covered benefits or reimbursement directly to such party. An Offeror will be required to store this information in their system so that any claim payments or any other plan communication distributed by the Offeror, including access to information on the Offeror's website would go to the person designated in the QMCSO;

(9) Ability to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation. Occurrences of these situations are very rare; and,

(10) (Exclusive to NYSIF) The Offeror must provide an instant enrollment or "short fill" service to injured workers of NYSIF policyholders. This service should allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network in order to provide a limited number of cost-effective medication benefits to the injured worker.

(11) Enrollment Management Guarantee: The Offeror must propose a performance guarantee. The Programs' service level standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of releases by the NYSIF.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.11 with the exception of a.2, a.7, and a.8, which are exclusive to DCS. Express Scripts agrees to a.1.a.; however, for a.1.b. we are unable to provide access to our enrollment system as requested; however, we can arrange for a screen share that would allow for NYSIF to view the enrollment load.

b. Required Submission

(1) Describe your testing plan to ensure that the initial enrollment loads for the DCS and NYSIF Programs are accurately updated to your system and that they interface correctly with your claims system.

As a current client, NYSIF should have no need for further implementation and currently meets NYSIF enrollment requirement standards.

(a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?

Your Express Scripts eligibility administrator monitors eligibility updates, address individual enrollment issues, and work to resolve file and data errors. In the event of an error, we take immediate corrective action. Your eligibility administrator works with NYSIF's designated contact to determine whether to correct errors systematically or manually.

Eligibility Support

Express Scripts assigns administrative and systems professionals to provide daily support for activities such as scheduling updates and resolving data discrepancies. Your assigned eligibility analyst will provide service continuity and prompt resolution of any issues that arise.

Administrative Support

Eligibility analysts help clients schedule and monitor eligibility updates, address individual enrollment issues, and work to resolve data errors. Our analysts also review and analyze eligibility reports to identify trends and unusual patterns in data, then work with NYSIF to resolve any issues. Eligibility analysts are available from 8 a.m. to 5 p.m. Central time and typically resolve issues within four hours.

Systems Support

Eligibility systems analysts ensure the integrity of eligibility systems and the supporting technology. This team's wide range of technical skills, coupled with solid business experience, provide clients with high-quality systems solutions.

(b) How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?

Please refer to the response to Question 1.d, above, for a description of the fault tolerance exceptions that would cause enrollment transactions to not load into the enrollment system.

Express Scripts' account team members will be available by 7 a.m. the next business day to work through any enrollment exceptions and determine the next steps necessary to add any exception records to the enrollment file.

(2) Describe your system capabilities for retrieving and maintaining enrollment information within twenty-four (24) hours of its release by

the Department and within twelve (12) hours of its release by NYSIF as well as:

We offer clients several options for sending eligibility data. Our preferred method is electronic transmission to Express Scripts using one of the following secure electronic methods:

- Internet FTP with PGP file encryption
- Secure web-based file transfer through Express Scripts' client portal using digital certificates and SSL encryption
- Internet AS2 (HTTPS/SSL) secure encrypted file transfer
- Connect:Direct (NDM) over AT&T's secure Global Network Services

We recognize that not all clients have the capabilities to send electronic files. We are extremely flexible in how we customize the program eligibility interface. If the client and/or claims staff must change information on an existing injured worker, or add a new injured worker, they can mail, phone, or e-mail the information to Express Scripts.

- Phone – Patient care advocates, client support center team members, and your account manager can assist with entering eligibility data online at the time of the call.
- E-mail – Messages are picked up every 30 minutes; eligibility will be entered into Express Scripts' system by the end of the same business day.
- Real-Time System Access – If necessary, the client (claims staff) may obtain access to our system to add, update, or terminate eligibility records.
- The following table identifies average turnaround time for normal maintenance files between receipt of eligibility information and when it is supported at the point of service.

Eligibility Type	Turnaround Time
Online Eligibility	Real-time
FTP batched file	Checked every 20 minutes; updates applied within an hour depending on file size.
Manual Eligibility — e-mail	Checked every 30 minutes; generally completed within an hour
Manual Eligibility — phone	Real-time
Manual Eligibility — fax	Checked every 30 minutes; generally completed within an hour

Eligibility File Format

The eligibility file is one of the most important elements in ensuring a smooth implementation of the client's program. Express Scripts' eligibility experts can assist you

in developing a timely and accurate transfer of information for initial eligibility and for ongoing updates. Express Scripts has two eligibility file formats that clients can use:

- Workers' Compensation Injured Worker Standard Eligibility File Layout – Clients will provide eligibility data for this file based on their claims database.
- Workers' Compensation Group Eligibility File Layout – This expanded file has been created to support more than one group. It allows clients to provide savings reports to your policyholders or risk management clients.

Express Scripts provides real-time access to our system, allowing your staff to enter eligibility. Your staff may also call or e-mail our Contact Center for assistance in adding eligibility to our system—a process that takes place in a matter of minutes.

(a) How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept on-line?

NYSIF can access all injured worker coverage timelines and a complete history of timeline changes online while a client with Express Scripts. Should you decide to terminate business, we will retain data for seven years following termination in compliance with state laws. Express Scripts retains 24 months of data on our Stratus system.

(b) How your system handles retroactive changes and corrections to enrollment data;

Currently NYSIF sends eligibility to Express Scripts in one of four status codes: Approved, Approved with Term date, Denied or Pending. Prescriptions filled on Approved and Approved with Term date are processed as long as the date filled is prior to the closure; Denied status claims will have no prescriptions processed regardless of the fill date and Pending claims are held until an Approved or Denied status eligibility record is received on an injured worker.

(c) (Exclusive to DCS) Detail how your enrollment system captures the information necessary to produce the reports entitled "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims" required in the Reporting Section of this RFP.

Please see our DCS-specific Technical Proposal binder.

(d) Confirm your enrollment and claims processing system has the capacity to administer a social security number, Employee identification number and an alternate identification number assigned by the Department or NYSIF. Does your system have

any special requirements to accommodate these three identification numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system (DCS Only).

Confirmed.

(3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

While Workers' Compensation does not have to be HIPAA compliant, as part of Express Scripts the Workers' Compensation division is compliant.

(4) Describe the backup system, process or policy that will be used to ensure that Enrollees receive needed Prescription drugs in the event that enrollment information is not immediately available at the point of service;

Express Scripts' comprehensive Business Continuity program responds to risks and threats to business operations. This allows us to sustain and quickly resume operations—ensuring uninterrupted pharmacy benefit services for NYSIF' injured workers.

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Business Continuity Planning

Using industry best practices to meet the needs of a growing and successful enterprise, Express Scripts' Business Continuity program continues to improve and mature. Our program:

- Mitigates risk to protect staff safety and welfare
- Prevents or diminishes the disruption of business following a disastrous event
- Sustains or rapidly recovers business functions following a disruptive event
- Provides uninterrupted pharmacy benefit services to our members
- Meets obligations to our clients
- Complies with Health Insurance Portability and Accountability Act (HIPAA) regulations and Sarbanes-Oxley requirements

Emphasizing communication, thoughtful action, and uninterrupted service, the Business Continuity program focuses on four key areas of recovery: people, operations, technology, and facilities. The program documents the coordination of safety, continuity, and recovery responses to disruptions ranging from minor to major.

The foundation of our Business Continuity Program is described below:

Operational Risk Management

Express Scripts' defense against unplanned business process disruptions starts with risk mitigation, which can affect the outcome of an event by preventing a disruption or automatically responding through specialized equipment and procedures. Risk mitigation can avert problems in a manner that is transparent to the business processes.
The Operational Risk Management process includes four main phases:

Phase	Details
Identification	Cross-functional teams identify risks and responsibilities through a series of operational leadership brainstorming sessions.
Planning	Teams prioritize, define, and plan risk mitigation strategies using Project Management Office best practices.
Execution	Project teams implement risk mitigation plans and strategies, execute detailed plans, and hold frequent reviews. The Operational Leadership and Operational Risk Steering Committees hold program dashboard reviews.
Exercise	Operational areas practice mitigation plans. Leadership validates and approves the final results. The Operational Risk Steering Committee approves risk mitigation and communicates results to operational areas.

We perform facility risk assessments, which include threat analysis, on a regular basis to identify potential situations and allow for mitigation and preparedness. We also achieve risk mitigation through the intelligent design of business processes and strategic training and placement of resources. Additionally, the identification of potential weaknesses allows us to avoid or diminish business disruptions.

Business Continuity Planning

Strategic business continuity planning ensures that critical business processes resume operations within a specific time frame or recovery time objective. The Business Continuity plan provides viable recovery action alternatives appropriate for re-establishing operations after a disruption. Our annual Business Impact Analysis process identifies the financial exposure and operational impacts of each critical business process. This drives and supports the establishment of a target recovery time objective for each critical process or group of related processes.

To ensure the program meets the requirements to continue or recover critical business processes, we organize Business Continuity Planning into five major phases:

Phase	Details
Business Impact Analysis and Risk Assessment	Identifies critical business processes and recovery time objectives, as well as risks and threats to Express Scripts' regions, surrounding areas, campus, facilities, and work areas
Recovery Strategy Development	Uses a variety of alternatives, which include internal Express Scripts alternate sites, workload shifting, work area recovery sites, and work from home
Plan Development	Business Recovery, Technical Recovery, and Executive and Emergency Response Management plans are developed for the safety of personnel, protection of assets, and continuity of critical business units
Plan Testing	Business Recovery, Technical Recovery, and Executive and Emergency Response Management plans are scheduled and tested regularly with Express Scripts' testing methodology to ensure accuracy and feasibility
Plan Implementation/Education	Business Recovery, Technical Recovery, and Executive and Emergency Response Management plans are added to Express Scripts' library of plans. We develop a plan maintenance schedule for all new plans. Leadership meets with employees to promote awareness of emergency procedures and continuity and recovery plans.

Disaster Recovery Planning

Express Scripts manages disaster recovery using world-class business continuity and disaster recovery. Our data center operations, which control information flow between our facilities, are located in Plano, Texas and Auburn Hills, Michigan. We also have IT operations in Plano and Auburn Hills to provide geographic distance and continuous access and availability to relevant information.

System and Application Data — The process for data backups includes:

- Incremental backups of member, client, and relevant data are performed daily. Full-volume backups of all relevant information are performed weekly.
- Backup files of patient information are stored at our vendor's site; a second set is copied and stored offsite at the vendor's storage facility. Express Scripts retains multiple generations of data backups offsite to prevent the loss of information in the event of a disaster.
- System and database files are copied and saved daily and stored in an offsite vault, using program-specific data formats. This ensures security and recovery if the data is needed at a later time.
- Retail Claims Adjudication — Express Scripts utilizes our vendor for retail claims adjudication recovery. We test this process annually to ensure recovery requirements, including the recovery time objective, and procedures remain current and valid. The adjudication system has four separate load-balancing systems for redundancy within a data center. The four-plex system is designed and sized to ensure full-volume retail claims adjudication will continue processing in a production environment even if

one of the four systems experiences an outage. In addition, Express Scripts maintains a remote recovery site with replicated data for disaster recovery.

- Internet/Website — Express Scripts and our vendor provide Internet connectivity for clients and members. We test this process annually to ensure recovery requirements, including the recovery time objective, and procedures remain current and valid. Geographically dispersed load-balancing equipment ensures constant access. In addition, backup capability for these services is provided through Interactive Voice Response technology, voice calls to Patient Care Contact Center advocates, and the use of Express Scripts Pharmacy prescription refill forms.

Business Continuity Program Oversight

The Business Continuity program has four key oversight committees:

Business Continuity Steering Committee

- Membership — Chief administration officer, chief financial officer, chief technology officer, chief information officer, executive vice president of Operations and Technology, Internal Audit vice president, Human Resources vice president, Sales and Account Management vice president, and director of Business Continuity
- Responsibilities — As a governance committee, this group sets corporate business continuity policy and oversees the program to ensure business continuity plans are developed, tested, and maintained. The committee also ensures risk mitigation and considers business continuity planning for all new business and IT projects, changes to existing business and IT processes, and all moves, expansions, mergers, and consolidations for business units and IT equipment.
- Meeting Frequency – Quarterly

Disaster Recovery Steering Committee

- Membership – Vice presidents representing all IT areas
- Responsibilities – This group aligns Disaster Recovery direction with corporate IT and business strategy. The committee promotes and participates in open communication and collaboration among the committee, Disaster Recovery teams, and our data center manager. Additionally, the team enables escalation and resolution of gaps and provides the management focal point for planning, testing, and execution.
- Meeting Frequency – Quarterly

Operational Risk Steering Committee

- Membership – Senior operational leadership
- Responsibilities – The committee focuses on Express Scripts' Business Continuity and Disaster Recovery Operational Risk process. It directs risk mitigation strategies from identification to execution.
- Meeting Frequency – Quarterly and as required for approvals and reviews

Board of Directors Audit Committee

- Membership – Board of Directors subcommittee
- Responsibilities – The committee monitors the overall status of the Business Continuity program and receives leadership direction based on company goals.
- Meeting Frequency – Annually

Situation Management

Express Scripts' highest priority is providing uninterrupted service to members. When the U.S. Department of Homeland Security's Federal Emergency Management Agency declares a Federal Disaster Area or a state governor issues a state of emergency, Express Scripts implements a series of strategic measures within our Patient Care Contact Center, Express Scripts Pharmacy, and retail pharmacies to ensure continued service to our clients and their members, including Medicare beneficiaries. Strategic measures include lifting Refill Too Soon edits and blocking ZIP codes for prescriptions dispensed through the Express Scripts Pharmacy.

Contact Center

The Source, Express Scripts' Contact Center communication tool, is updated with the latest information in regard to situations that could impact our clients and their members. The Source provides our patient care advocates with the processes and procedures to best serve members located in a federal or state disaster area. Express Scripts continuously monitors Contact Center call volume, modifying call flow during the crisis to facilitate service automation and making appropriate staffing changes.

Our Contact Center assists members in need of immediate medication refills during emergency situations. However, during a disaster when high call volume is expected in regard to requesting overrides, we implement our retail refill-too-soon override functionality. This allows network pharmacists in impacted counties to automatically override refill-too-soon rejects for members residing in emergency areas.

When the United States Postal Service blocks ZIP codes, Express Scripts notifies affected members with in-house orders and directs them to our Contact Center, which maintains a

special support queue. Patient care advocates then determine the best way to deliver the medications.

Retail

When Express Scripts implements standard emergency procedures for refill-too-soon edits, we notify and instruct retail pharmacies on how to override these edits at the point of sale. Express Scripts' Pharma & Retail Strategy department communicates our procedures and expectations to network pharmacies via blast fax and monitors rejects to verify that pharmacies complied with these special processes.

Home Delivery from the Express Scripts Pharmacy

When Federal Express, UPS, or the United States Postal Service reports service delays in a county or counties, the Express Scripts Pharmacy blocks prescription delivery for impacted ZIP codes and relaxes the 30-day return policy to accommodate replacement orders. In addition, we implement customized procedures to ensure the safe delivery of prescriptions.

CuraScript, the Express Scripts Specialty Pharmacy, follows standard procedures for temperature-sensitive medications to avoid major patient disruptions. When working with CuraScript, each patient receives the services of a patient care advocate responsible for proactively coordinating ongoing prescription needs and delivery. By following standard processes, patient care advocates contact patients to coordinate the most convenient time, day, and location for medication delivery.

Medicare

Express Scripts guarantees immediate refills of Medicare Part D medications to any beneficiaries residing in emergency areas, regardless of where the member attempts to fill the prescription. In accordance with communicated requirements from CMS, beneficiaries obtain the maximum extended days' supply, if requested and available, at the time of refill.

Communications

The Source, Express Scripts' Patient Care Contact Center communication tool, is updated with the latest information about situations that could impact our clients and their members. The Source provides our patient care advocates with the processes and procedures to best serve members located in a federal or state disaster area. Express Scripts continuously monitors Contact Center call volume, modifying call flow during the crisis to facilitate service automation and making appropriate staffing changes.
When Express Scripts implements procedures for refill-too-soon edits, we notify and instruct retail pharmacies on how to override these edits at the point of sale. Express Scripts' Pharma & Retail Strategy department communicates our procedures and expectations to network pharmacies via blast fax and monitors rejects to verify that pharmacies comply with these special processes. Account Management staff provide clients with detailed communications regarding our actions to support impacted patients.

Business Continuity

Express Scripts continuously monitors and discusses the declared disaster with Account Management, the Express Scripts Pharmacy, the Patient Care Contact Center, and Pharma & Retail Strategy. We update and publish standard operating procedures during the declared disaster. We distribute any updated procedures to Contact Center and Express Scripts Pharmacy personnel.

(5) (Exclusive to DCS) Confirm that you will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of NYS holidays.

Please see our DCS-specific Technical Proposal binder.

(6) (Exclusive to DCS) Describe your ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the QMCSO.

Please see our DCS-specific Technical Proposal binder.

(7) Describe your ability and the process to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation.

Express Scripts' First Fill program allows for a 14-day supply to be filled with minimal eligibility requirements loaded. When a Temporary ID form is presented for the First Fill the system checks our edits to make sure that a claim does not already exist for the injured worker and then goes through our Concurrent DUR (CDUR) edits to valid the prescription for appropriateness and injured worker safety. If the process passes the edits then 14 days of medication is approved to be dispensed to the injured worker.

Additionally, our approval process for medications outside the formulary is an electronic web based tool known as OASIS. In Workers' Compensation, non-formulary medications require communication with the claims staff, which ultimately determines whether the medication is approved for the injury. This process can delay the fill, leading to frustration on the part of the injured worker. Express Scripts has developed OASIS, our proprietary, web-based authorization system to maximize productivity and improve pharmacy turnaround time. The net effect is improved patient care and a meaningful reduction in out-of-network fills due to processing and authorization delays. OASIS also allows for claims staff to update eligibility in real time.

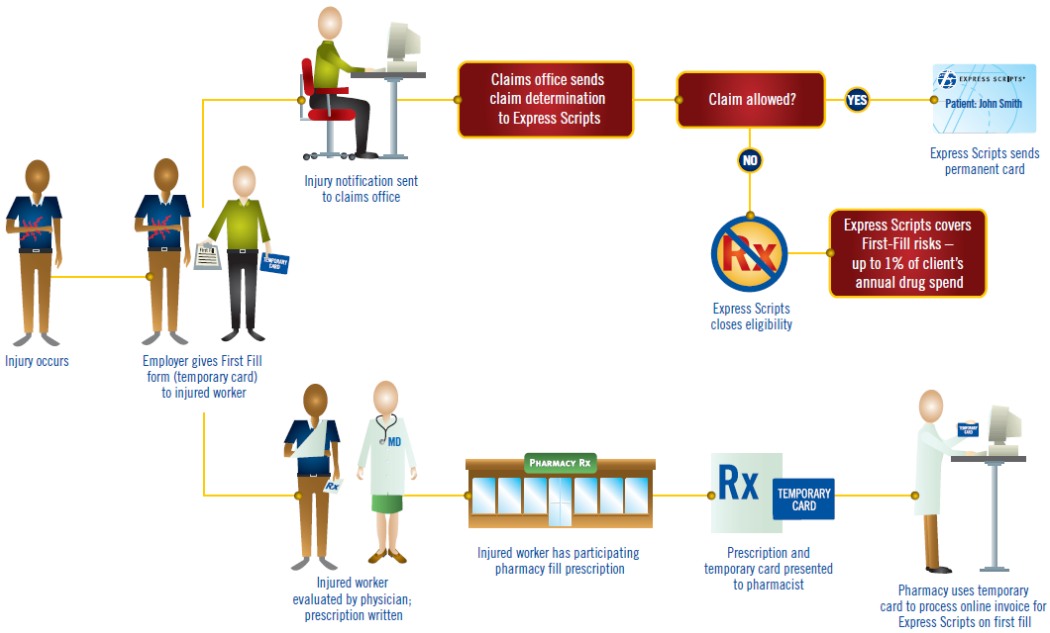
(8) (Exclusive to NYSIF) Describe in detail how you will administer the instant enrollment or "Short Fill" service to allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network in order to provide a limited number of cost-effective medications to the injured worker.

We offer a best-in-class First Fill program for prescriptions where eligibility has not yet been determined. Our First Fill process runs differently than that of the approved claims process. Typically, with the First Fill the claim has not yet been reported to you and been assigned an injury code or claim number. In the past, Express Scripts has done mass policyholder mailings, added the form to the client's website reporting portal, as well as added it to the claims examiner's toolkit. We have a great deal of experience and will be offering options to insure successful distribution of the forms.

When a Temporary ID form is presented for the First Fill the system checks our edits to make sure that a claim does not already exist for the injured worker and then goes through our Concurrent DUR (CDUR) edits to valid the prescription for appropriateness and injured worker safety. If the process passes the edits then 14 days of medication is approved to be dispensed to the injured worker.

Using the eligibility prescription information captured at the point of service, Express Scripts notifies claims payers within hours of a prescription being filled. This early notification allows claims administrators to get an early start on any additional return-to-work processes or programs for the injured worker. Our program allows for the application of customized formularies and business rules.

The flowchart below illustrates our First Fill process:



We track network penetration for our clients which includes the first fill. In 2011, our network penetration rate reached 93%. We accomplish this by working closely with our clients to determine the communication touch points with their clients to get the Temporary ID form in the hands of the injured worker as quickly as possible. We also handle all paper bills for our clients reviewing, processing and redirecting back into the network for refills. We have developed a formulary of medications that are customarily used in acute trauma situations, such as antibiotics, analgesics or anti-inflammatories. We can however, expand or restrict the listing dependent upon NYSIF's needs. For example, with many of our government accounts they cover first responders and require that prophylactic medications be allowed for treatment of HIV exposure. Our formulary flexibility is unparalleled in the industry. Our formularies are:

- Workers' Compensation-specific and judged to be most appropriate by our Workers' Compensation Clinical Advisory Committee.
- Clinically sound and regularly reviewed and updated
- Fully customizable by NYSIF

First Fill Risk Share

Express Scripts is willing to assume the cost of all non-compensable first fill prescription claims with no expiration date. This process is extremely successful because our book of business write off of non-compensable claims is 0.05%.

(9) Enrollment Management Guarantee: The Programs service level standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of release by NYSIF. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet the standards.

The Standard Credit Amount for each 24 hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $5,000. However, Offerors may propose higher or lesser amounts.

The Standard Credit Amount for each 24 hour period beyond twelve (12) hours from the release by the NYSIF that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $375. However, Offerors may propose higher or lesser

amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each 24 hour period beyond twenty-four (24) hours from the release by the Department, and for each 24 hour period beyond twelve (12) hours from the release by the NYSIF, that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $_ for DCS and $ _ for NYSIF.

[redacted]

8. Reporting (Exclusive to DCS)

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the Agreements resulting from this RFP. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the DCS Program and its administration.

All electronic files received by the Department are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

a. Duties and Responsibilities

The selected Offeror will be responsible for accurate reporting services including, but not limited to:

(1) Ensuring that all financial reports including cycle claim reports are generated from amounts billed to the DCS Program, and tie to the quarterly and annual financial experience reports, and Rebate reports;

(2) Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the DCS Program. These reports must tie to the amounts billed to the DCS Program. The final format of reports is subject to the Department review and approval;

(3) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed in this section of the RFP under Annual, Semi-Annual, Quarterly, Monthly and Ad-Hoc Reports and include the time frames for submittal to the Department;

(4) Providing direct, secure access to the Offeror's claims system and any online and web-based reporting tools to the Departments' offices;

(5) Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing:

(a) Forecasting and trend analysis data

(b) Data necessary to track drug pricing

(c) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program

(d) Utilization review savings

(e) Benefit design modeling analysis

(f) Reports to meet clinical program review needs

(g) Reports segregating claims experience for specific populations

(h) Reports to monitor Agreement compliance

(6) Management Reports and Claim File Guarantees: The Offeror must propose a performance guarantee. The DCS Program's service level standard requires that accurate management reports and claim files as specified in Section IV.B.8.a.(7) (DCS Reporting) of this RFP will be delivered to the Department no later than their respective due dates inclusive of the date of receipt.

(7) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Semi-Annual, Quarterly, Monthly, Weekly, and Ad-Hoc Reports and include the time frames for submittal to the Department:

Annual Reports

Annual Financial Summary Report: The Offeror must submit an annual report of the DCS Programs' charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. These statements must detail, at minimum, claims paid during the year, claims administration costs, performance credits, audit credits, drug settlement proceeds, rebates (earned and paid), and coordination of benefit (COB) savings. Such detail must include all charges by the Offeror to the DCS Program;

Annual Rate Renewal Report: The Offeror must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This renewal package must detail all assumptions utilized to back up the rate renewal request, including, but not limited to: paid claim amounts, administrative fees, projected Pharma Revenue, COB recoveries, changes in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formularies and the Traditional PDL;

Annual Mail Service Pharmacy Process Satisfaction Survey Summary Report: The Offeror must submit a report which details, in summary form, the results of Enrollee satisfaction surveys designed to evaluate

the level of DCS Program Enrollee satisfaction with the Mail Service Pharmacy Process. The surveys should cover areas of order processing, quality of services, and timeliness. The format of the survey instrument and reports is subject to NYS input and approval. The report is due annually, on May 1st of the year following the Calendar Year being surveyed. The report must include Enrollee comments and an accounting and resolution of any Enrollee issues;

Annual Summary Reporting: The Offeror must prepare and present an annual report that details DCS Program performance, industry trends and anticipated market developments including the introduction of generics and potential new product developments. This presentation should include comparisons of the DCS Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues as well as strategies and opportunities for plan savings are to be comprehensively addressed. In addition, the Offeror should be proactive by reporting any areas that need improvement, potential problem areas, and any solutions that can be implemented. The annual presentation and report is due each August after the end of each complete Calendar Year;

Annual Report of Claims and Credits Paid by Agency: The Offeror must submit a report that details claims and credits paid by agency. The Offeror is required to submit this report in the current format specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the Calendar Year. The report must accurately reflect only Final Paid Claims.

Mail Service Pharmacy Process Accuracy Annual Report: The Offeror is required to submit an annual report that provides a breakdown of the various errors and calculates the accuracy rate of transactions processed using the Offeror's Mail Service Pharmacy Process. The Offeror is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the Calendar Year.

Rebate True-up File: The Offeror is required to transmit a computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by the Department. The true-up rebate file must match all of the billing records provided by the Offeror in the bi-weekly pharmacy billing files. The report is due one hundred fifty (150) Days after the end of the Calendar Year.

Catastrophe Reinsurance Reconciliation Report: The Offeror is required to submit an annual reconciliation of the Catastrophe Reinsurance receipts for the EGWP by December 31st of the year following year of incurral.

Semi-Annual Reports

Top 100 Brand Name and Generic Drugs – Retail Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Retail Pharmacy Network sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e. cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of Enrollees utilizing the drug, Rx cost, average cost per script, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.7. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 20 Therapeutic Categories Report: The Offeror is required to submit a semi- annual report that details the top 20 therapeutic categories by drug spend on the Offeror's Flexible Formularies and Preferred Drug List (broken down by drug) utilized by Enrollees of the DCS Program (combined Retail, Mail Service and Specialty Pharmacy). The report should include fields such as: drug name, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.8. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 100 Brand Name and Generic Drugs – Mail Service Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Mail Service Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.9. The numbers should be provided on a year-to- year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 100 Specialty Drugs – Specialty Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100

Specialty Drugs dispensed to Enrollees of the DCS Program through the Offeror's Designated Specialty Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc) , preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.6. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Quarterly Reports

Quarterly Financial Summary Reports: The Offeror must submit quarterly financial reports which present the DCS Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of:

annual financial performance;

assessment of DCS Program costs;

incurred claim triangles;

Pharma Revenue;

coordination of benefit recoveries;

audit recoveries;

drug settlement and litigation recoveries;

administrative expenses;

trend statistics; and

such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

Quarterly Performance Guarantee Report: The Offeror must submit quarterly the DCS Program's Performance Guarantee report that details the Offeror's compliance with all of the Offeror's proposed Performance Guarantees. The report should include the areas of: Implementation; system availability; customer service (telephone availability, response time, blockage rate, abandonment rate); claims processing; management reports and claim files; enrollment; mail service turnaround; and, Pharmacy composition and access. The Offeror should closely follow the current format specified by the

Department in Exhibit II.F.11. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

Quarterly Network Access: The Offeror must submit a measurement of the Network access (using Exhibit I.Y.4) based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

Quarterly Audit Report: The Offeror must submit a quarterly audit report detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Offeror. The report should include fields such as: Pharmacy name, NABP number, recovery amounts, audit method or type, and basis for and method of recovery. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.12. The report is due thirty (30) Days after the end of the quarter;

Quarterly Coordination of Benefit Report: The Offeror must submit a report that details the amount of recoveries received as a result of coordinating benefits with other Plans including Medicare. The Offeror's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The Offeror is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the quarter;

Quarterly Rebate and Other Pharma Revenue Report: The Offeror is required to submit a quarterly rebate and other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Offeror during the quarter. The report must include breakdowns by each manufacturer and drug with quarterly and year-to-date numbers, as well as any adjustments that are performed. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.13. The Offeror's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the DCS Program should not exceed one hundred fifty (150) Days from the end of the quarter in which the initial claims were processed. This report is due at the time the rebates and other Pharma Revenue are paid to the Program;

Quarterly Participating Agency Claims: The Offeror is required to submit a quarterly report that details claims by Participating Agency. The Offeror is required to submit this report in the current format specified by DCS in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter;

Generic Appeals and Prior Authorization Quarterly Report: The Offeror is required to submit a quarterly report that provides the number of generic appeals and prior authorization requests, by individual drug. The report must include numerical breakdowns on the number of generic appeals and prior authorization requests made by the individual drug as well as the success/declination rate of these requests. The Offeror should closely follow the current format specified by the Department in Exhibits II.J and II.H.1. The report is due thirty (30) Days after the end of the quarter;

Rebate File: The Offeror is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by the Department. The pharmacy rebate records in the Rebate File must match all prescriptions billed to the Department by the Offeror. The report is due one hundred fifty (150) Days after the end of the quarter; and

Quarterly Website Analytics Report: The Offeror is required to submit a quarterly report that provides comprehensive performance information for the Offeror's customized DCS Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter.

Monthly Reports

Monthly Report of Paid Claims by Month of Incurral: The Offeror is required to submit a monthly report that provides summarized paid claims by month of incurral. The Offeror is required to submit this report in the current format specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

Monthly Report of Paid Claims by Pharmacy and Rx Type: The Offeror is required to submit a monthly report that provides summarized paid claims by Pharmacy type by Rx type. This report must distinguish reversals and allow the Department to verify Guaranteed Discounts. The Offeror is required to submit this report in the current format as specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

Monthly Report of DCS Program MAC List: Each month the Offeror is required to submit an updated DCS Program MAC List that details all the drugs included on the DCS Program MAC List and the corresponding prices used to charge the DCS Program. The following information shall be included: GCN, drug name, form, strength, reference product, FDA rating, date the product was initially MAC'd,

initial MAC price, previous MAC price, current MAC price, effective date of current MAC price and the change in price from the previous DCS Program MAC List. Drugs that are added or deleted from the DCS Program MAC List shall be clearly marked or highlighted. The Offeror is required to submit this report in the current format specified by DCS in Exhibit II.F.4 unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

MAC Saving Reports: Each month is required to submit a year-to-date and annualized savings projections of the MAC price increases and decreases based on expected utilization. The following information shall be included: GCN, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings.

The Offeror is required to submit this report specified by the Department in Exhibit II.F.14 unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month; and Program Customer Service Monthly Reports: Each month the Offeror is required to submit a customer service report that measures the Offeror's customer service performance including customer service availability, customer service telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and mail service turnaround. The Offeror is required to work out the final format of these reports with the Department. The reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement resulting from this RFP, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Selected Offeror.

Bi-Weekly Reports

Detailed Claim File Data: The Offeror must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records in the format specified by the Department in Exhibit II.F.1 unless otherwise specified by the Department, to support the bi-weekly invoice. The Department requires that all claims processed, reversed and adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the DCS Program and include the current status of the claim (i.e. fields identifying claims as paid, adjusted, reversed). A rejected claim file is also required upon request by the Department. The Offeror is required to securely forward the required claims data on a claims processing cycle basis to the Department and/or its DSS vendor within fifteen (15) Days after the end of each claims processing cycle, and submit a summarized report by claims processing cycle broken down

by drug type (generic/brand) utilizing the fields and the format specified by the Department in Exhibit II.F.5. Based upon the analysis of the information contained in the report any important programmatic information, trends or abnormalities should be provided in a narrative.

Reports Required at Other Frequencies

Mac Alert Notice: The Offeror is required to submit a report of the financial impact of enforcing mandatory generic substitution via a "Mac Alert Notice" utilizing the current format specified by the Department in Exhibit II.F.10. This report must be submitted in accordance with the time frames specified in Section IV.B.14.a.(4) of this RFP, under the subheading "Mandatory Generic Substitution at Retail and Mail."

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

(1) How will reversed, rejected, and adjusted claims be reflected in the reconciliation of the cycle claim reports to the quarterly and annual financial experience statements? Will this process be the same for claims billed within the cycle or outside of the cycle? Please describe in detail how reversed or modified claims are identified within your claims data. Please describe how your system allows the Department to identify only Final Paid Claims within your claims data. Explain how a claim reversed in a different billing cycle would be identified in your claims data.

Please see our DCS-specific Technical Proposal binder.

(2) The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the DCS Program. Provide an overview of your reporting capabilities with the value you believe this will bring to the DCS Program.

Please see our DCS-specific Technical Proposal binder.

(3) Confirm that you will provide reports in the specified format (paper and/or electronic– Microsoft Access, Excel, Word), as determined by the Department.

Please see our DCS-specific Technical Proposal binder.

(4) Confirm that you will provide direct, secure access to your claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement you propose for Department staff to execute in order to obtain systems access.

Please see our DCS-specific Technical Proposal binder.

(5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

Please see our DCS-specific Technical Proposal binder.

(6) Management Reports and Claim File Guarantees: The DCS Program's service level standard requires that accurate management reports and claims files will be delivered to the Department no later than their respective due dates. For the management reports and claim files listed in Section IV.B.8.a.(7) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $1,000 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the DCS Program's Claims Administration Fee for each management report or claim file that is not received by its respective due date, is $ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt.

Please see our DCS-specific Technical Proposal binder.

Reporting (Exclusive to NYSIF)

Reporting must be structured to provide assurances that Claimant, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the separate Agreements resulting from this RFP. The selected Offeror may on occasion be

requested to provide ad-hoc reporting and analysis within very tight time frames.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the NYSIF Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the NYSIF Program and its administration.

All electronic files received by NYSIF are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

Upon selection, the contractor will be provided with detailed specifications for all files exchanged between NYSIF and the contractor. In general, these specifications include the use of:

Either fixed length ASCII text format and/or delimited ASCII text files; Standard structure for all including order:

- **Header record;**
- **Detail records;**
- **Footer record containing defined control totals, e.g. record count, hash totals, etc.;**

Standard encryption/decryption methodology;

Standard secure file transfer protocol.

a. Duties and Responsibilities

The selected Offeror will be responsible for accurate reporting services including, but not limited to:

(1) Generating and submitting monthly, quarterly, semi-annual and annual reports per NYSIF specification. Specifications will be provided upon contractor selection;

(2) Capturing and providing NYSIF with electronic files of eligibility and authorization on the GC3, or similar code level. The Offeror should have the capability to capture drug denials on the GCN and NDC code levels;

(3) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to NYSIF's offices;

(4) Providing NYSIF with an on-line decision support tool with ad-hoc query capability;

(5) Providing Ad Hoc Reports and other data analysis at no additional

cost. The exact format, frequency, and due dates for such reports shall be specified by NYSIF. Information required in the Ad Hoc Reports may include but is not limited to providing:

(a) Forecasting and trend analysis data;

(b) Data necessary to track drug pricing;

(c) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program; (d) Utilization review savings;

(e) Benefit design modeling analysis;

(f) Reports to meet clinical program review needs;

(g) Reports segregating claims experience for specific populations; and

(h) Reports to monitor Agreement compliance.

(6) The Offeror must work with NYSIF to resolve reporting issues according to the timeframes described in Section IV.B.8.a.(8) (NYSIF Reporting) of this RFP;

(7) Management Reports and Claim File Guarantees: The Offeror must propose a performance guarantee. The NYSIF's Program service level standard requires that accurate management reports and claim files as specified in Section IV.B.8.a.(8) (NYSIF Reports) of this RFP will be delivered to NYSIF no later than their respective due dates inclusive of the date of receipt;

(8) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by NYSIF. The primary reports and data files are listed in this section of the RFP under Annual, Semi-Annual, Quarterly, Monthly, Weekly, and Daily Reports and include the time frames for submittal to NYSIF;

Annual Reports

Rebate True-up File: The Offeror is required to transmit a computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by NYSIF. The true-up rebate file must match all of the billing records provided by the Offeror in the weekly pharmacy billing files. The report is due one hundred fifty (150) Days after the end of the Calendar Year. Issue resolution timeframe: within 1 week of the original submission.

Quarterly Reports

Rebate File: The Offeror is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by NYSIF. The pharmacy rebate records in the Rebate File must match all prescriptions billed to NYSIF by the Offeror. The report is due one hundred eighty (180)

Days after the end of the quarter. Issue resolution timeframe: within 1 week of the original submission.

Monthly Reports

Card Issuance File: The Offeror is required to submit a computerized file via secure transfer with the names of all NYSIF Claimants who have been issued a permanent ID card that is used when filing their injury-related prescriptions. The Offeror is required to submit this report in the current format specified by NYSIF in Exhibit II.E.2d unless otherwise specified by NYSIF. The report is due no later than fifteen (15) calendar Days after the end of the month being reported. Issue resolution timeframe: within 1 week of the original submission.

Weekly Reports

Established Claim Billing File: The Offeror is required to transmit a computerized file via secure transfer containing only those pharmacy bills that are in accordance with the defined NYSIF business rules for pharmacy bill submission and contains only those pharmacy bills that have been successfully matched to an established NYSIF claim. Upon Offeror selection, NYSIF will provide a comprehensive list of edit rules and rejection codes that are based on the structure or content of a pharmacy bill record, as well as the specified file format. The report is due on the Monday following the week reported. Issue resolution timeframe: prior to the next scheduled submission;

Weekly Invoice: The Vendor Invoice submission consists of two parts:

Hard copy of the Vendor Invoice submitted to NYSIF via USPS.

Electronic submission of a Vendor Invoice Detail file supporting the charges on the Vendor Invoice.

The Offeror must submit the Vendor Invoice Detail file in the form an ASCII text file. The purpose of the detailed invoice file is to provide NYSIF with the information needed in order to programmatically reconcile the Vendor Invoice. The report is due on the Monday following the week reported. Issue resolution timeframe: within 1 week of the original submission;

Aging Bill Report File: The Offeror is required to submit a computerized pharmacy billing file via secure transfer with bills previously submitted in the Instant Enrollment/"Short Fill" file that remain unmatched to an established NYSIF claim. In the event there are not records meeting the above criteria, an empty file should be transmitted. The report is due each Monday. Issue resolution timeframe: prior to the next scheduled submission.

Daily Reports

Short Fill Report File: The Offeror is required to submit a

computerized file via secure transfer with pharmacy bills for those injured workers of NYSIF policy holders where the bill cannot be matched to an established NYSIF claim. The report is due daily. Issue resolution timeframe: prior to the next scheduled submission.

Express Scripts agrees to the duties and responsibilities set forth in item a.1 through a.8.

b. Required Submission

(1) Confirm your agreement to generate and submit all daily, weekly, monthly, quarterly, semi-annual, and annual reports per NYSIF specification;

As a Workers' Compensation benefit provider, you have unique reporting and consultative needs; Express Scripts understands this. We know data reporting provides you with the necessary information to support your decision-making needs, and your client reporting needs to document your savings. As your ideal Workers' Compensation benefit solution, Express Scripts offers NYSIF a suite of reporting resources at no additional cost.

Our reporting and analytics continuum ranges from self-service reporting via our web-enabled tool Trend Central, to full-service benefit consultation via your experienced account management team, and our PharmacoAnalytics and Workers' Compensation IT departments. We ensure proactive service and management of your benefit, as well as effective and ongoing data reporting to manage your experience throughout the continuum. NYSIF can access our benefit and clinical consultants at any time to improve your understanding of your trend management and data evaluation.

Self-Service Tools

NYSIF will be able to accomplish much of its Workers' Compensation program reporting through Trend Central. This interactive, web-enabled, business intelligence tool uses industry-leading software, Express Scripts' thought-leadership in research and innovative program designs, intimate knowledge of our customer characteristics, and interpretation of key industry trends. Trend Central allows NYSIF to quickly and easily determine utilization by policyholder or injured worker, physician prescriber patterns, and costs, as well as view early eligibility reporting.

Trend Central offers 35 Workers' Compensation-specific reports, with capacity to create ad hoc reporting at any time via Advanced Trend Central. The online reporting tool uses information from Express Scripts' Enterprise Data Warehouse, which stores all relative data elements of a processed prescription, including, but not limited to: claim number, injured worker name, injury date, prescription number, medication name, strength, quantity, NDC, prescriber information, pharmacy information, and cost details. NYSIF will generate reports as needed and download Trend Central reporting in PDF, or Microsoft Excel for additional manipulation.

Unique Reporting Resources

In addition to self-service online reporting, we support your Workers' Compensation reporting requirements and provide reporting that includes the following:

- Monthly report card
- Billing report package
- Electronic activity reporting
- State fee savings analysis
- State EDI reporting
- Custom reports

Monthly Report Card

In addition to the reports available to NYSIF through Trend Central, Express Scripts offers a client-specific report card. This report provides an overall monthly summary of the program, as well as information on:

- Program Utilization — electronic bills processed, paper bills processed, and network penetration
- Savings — rejections, brand vs. generic, and applicable discounts
- Risk Share — unmatched claims, and total dollars

Express Scripts can provide this report on a monthly, quarterly, or annual basis, in accordance to NYSIF' business needs.

Billing Report Package

At the end of each period, payers receive billing for covered drugs dispensed by our Home Delivery pharmacy and participating network pharmacies. Bills include a billing report and an electronic claim file for the billing period.

Electronic Activity Reporting

Express Scripts can provide the following activity reports via electronic data interchange (EDI). Typically, these are sent through FTP:

- Card Report — Details injured workers who received ID cards. This is a daily report.
- Claim Reject — Describes prescriptions that have been rejected. This is a daily report
- First Fill Report — Identifies injured workers who received First Fills. This is a daily report.

- Aging Report — Details prescriptions that have been on the pending file for a number of days as defined during plan design set up. This is a weekly report.

State Fee Savings Analysis

On a monthly basis, we will send NYSIF a state fee savings analysis report. This report provides actual billed drug costs compared to the greater of the pharmacy-submitted charge, or the scheduled state fee amount. NYSIF can use the report to analyze your program's potential cost savings provided to reduce overall prescription costs. Additionally, your account management team can provide consultation to help you better understand the report's details and your available program options.

State EDI Reporting

If NYSIF has claims processed in states in which state reporting is required, Express Scripts can provide state reporting, which transmit via EDI. Please note that we can initiate transmissions with other states as requested by our clients:

State	Date Implemented
Texas	June 1, 2004
Florida	January 1, 2005
Texas	August 31, 2006
California	June 15, 2008
Oregon	July 2009
Tennessee	September 2009

Custom Reports

If your reporting needs are not already met by Trend Central, our online client reporting tool, your account management team can arrange for custom report development through collaboration with NYSIF and our PharmacoAnalytics and Workers' Compensation Information Technology departments. Our wide range of high-touch capabilities ensures you receive specialized full-service assistance as well as custom reporting through Trend Central.

Turnaround time for ad hoc requests varies according to complexity. It usually takes no more than 10 business days to provide customized analysis and reporting. During time-critical situations, we can provide customized reporting in an expedited manner according to the turnaround timeframe discussed with your account management team.

Historically, we have been able to easily meet our clients' data analysis, ad hoc reporting, and custom reporting needs. In rare instances, reports that require extensive programming might be subject to a one-time charge, which would be negotiated with NYSIF. Your account management team will work with NYSIF on an ongoing basis to address additional ad hoc requests and reporting delivery methods as needed.

Reporting Formats

Please see the table below for our reporting formats:

Report	Media Type
Account management reporting	Electronic
Billing report package	Electronic and paper
Electronic activity reporting	Electronic
State fee savings analysis	Electronic and paper
State EDI reporting	Electronic

(2) Confirm you will provide NYSIF with electronic file of eligibility and authorization on the GC3, or similar code level. Indicate your capability for capturing drug denials on the GCN and NDC code levels. If unable to capture denials on the GC3 code level, provide a detailed description of your denial coding system;

Confirmed. We are able to accept GC3 codes on the eligibility from NYSIF to authorize those categories for the patient automatically. We also have the ability to add or remove medications from the NYSIF drug list at the GC3 level, as well NDC level if necessary. We are also able to enter authorizations or denials on an individual basis at all three levels.

Quarterly we also provide NYSIF with a complete GC3 code listing, showing all GC3 codes and their description to assist them with providing authorizations at the GC3 level on the eligibility file.

Oasis will have the ability to create authorization at the drug strength (NDC), drug name (GPI 10) or drug class (GPI 4). However, there are no plans to allow GCN in Oasis for authorizing a Prior Authorization. You can look up a drug by name, NDC, GPI, or GCN.

(3) Confirm that you will provide reports in the specified format (paper and/or electronic– Microsoft Access, Excel, Word), as determined by NYSIF;

Confirmed.

(4) Confirm that you will provide NYSIF with an on-line decision support tool with ad- hoc query capability;

Confirmed. Designed to assist claims adjusters or nurses with their decision-making for drugs requiring authorization, OASIS provides insight into the drug's indications, therapy class, side effects, etc. In addition, the adjuster can see the full patient history of medications previously filled or rejected, which can also help with making authorization determinations. In addition to the reporting capabilities within OASIS, ad hoc reports are available.

(5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

Confirmed. If your reporting needs are not already met by Trend Central, our online client reporting tool, your account management team can arrange for custom report development through collaboration with NYSIF and our PharmacoAnalytics and Workers' Compensation Information Technology departments. Our wide range of high-

touch capabilities ensures you receive specialized full-service assistance as well as custom reporting through Trend Central.

Turnaround time for ad hoc requests varies according to complexity. It usually takes no more than 10 business days to provide customized analysis and reporting. During time-critical situations, we can provide customized reporting in an expedited manner according to the turnaround timeframe discussed with your account management team.

Historically, we have been able to easily meet our clients' data analysis, ad hoc reporting, and custom reporting needs. In rare instances, reports that require extensive programming might be subject to a one-time charge, which would be negotiated with NYSIF.

Your account management team will work with NYSIF on an ongoing basis to address additional ad hoc requests and reporting delivery methods as needed. Examples are included in the Attachments Section.

(6) Describe how your proposed system will accept pharmacy bills from the Offeror's network pharmacies;

Each Express Scripts network pharmacy utilizes our electronic claims adjudication system, including our home delivery pharmacies. Within three seconds, our adjudication system reviews a prescription request for eligibility, plan design, formulary compliance, and Concurrent DUR, messaging approval or rejection back to the dispensing pharmacy. If a network pharmacy submits a paper bill, it receives all clinical edits and is billed like any online claim. Express Scripts then contacts the pharmacy and requests the next fill to be submitted online. Express Scripts has 100% capability to receive and adjudicate bills in NCPDP version D.0 format. We pay the pharmacy and then electronically bill NYSIF.

Electronic Claims Process

1. The injured worker submits the pharmacy ID card/Temporary Prescription Services ID form to a network pharmacy, which is connected to Express Scripts' adjudication processing system either directly or through a switching company.

2. The pharmacist enters information from the ID card/Temporary Prescription Services ID form into the pharmacy's computer system and submits the injured worker's prescription information to Express Scripts' adjudication system. The prescription processing system verifies that the person is eligible for pharmacy coverage and then applies program design and Express Scripts' CDUR edits to the prescription. At a minimum, pharmacies transmit the following information to Express Scripts:

Bin number	NDC number of drug dispensed
Version/release number	Quantity of drug dispensed
Transaction code	Compound code
Group number	Days supply of drug dispensed

Client identification code	Prescription number
Date of injury	New or refill indicator (optional)
Gender code (optional)	U&C cost of drug dispensed
Cardholder ID	Submitted cost of drug dispensed
Date filled	Prescriber ID number
Date of birth of injured worker	Processor Control Number
NPI	Pharmacist License number (dependent upon state regulation)

3. The system checks the prescription against the injured worker's prescription history to identify possible clinical concerns. Prescription histories include those prescriptions submitted to Express Scripts for processing. The prescription processing system contains each injured worker's pharmacy prescription history for the period covered. Information for the new prescription is added to the injured worker's prescription history file.

   If the client implements the First Fill program, the system will build a pending status eligibility record for injured workers who do not have an eligibility record. This pending status eligibility allows the pharmacy to dispense a first fill based on your program design and can limit the first prescription to a one-time fill of up to 14 days until actual eligibility is submitted.

4. Calculated program information is sent back to the pharmacy. The participating pharmacy receives the following information:

Version/release number	**Total amount payable**
Dispensing fee payable	Ingredient cost payable
Transaction code	Reference number
Sales tax payable	Response status (payable/not payable)
Client ID number	Message
Copayment (if apportionment claim or state mandate applicable)	

If the prescription is rejected, Express Scripts' system provides the pharmacy with the appropriate NCPDP error code number and the reason for the rejection. This information is automatically added to the online prescription history of the injured worker. Our system completes processing within three seconds for 99% of prescriptions. A few additional seconds are needed to transmit prescription information from the pharmacy to our system and back.

Once the prescription claim is approved, the pharmacist dispenses the drug to the injured worker along with a receipt. However, if the prescription is rejected, OASIS, our proprietary automated-authorization process, will manage the request in accordance with your program design developed during implementation. We will work with the Programs to offer our expertise insuring the program design aligns with your goals and objectives. This process is the same for prescriptions processed in our home delivery and retail network pharmacies.

(7) Describe how your proposed system will edit these pharmacy bills in accordance with NYSIF business rules;

Once the paper bill process is finally installed for NYSIF bills received from pharmacies and third-party billing agencies will be are reviewed, adjudicated, paid, and then billed to the client. If the processing pharmacy is part of the Express Scripts Network, we will contact the pharmacy to communicate proper billing protocols; thereby ensuring future transactions are sent electronically and routed within the network, minimizing cost and administrative burden.

Our best practice recommendation is to pay the initial bill at the lesser of state fee schedule or billed rate. At that point we complete the adjudication process, pay the pharmacy or third party biller and commence the conversion process for redirection back into the network for subsequent fills.

(8) Describe how the proposed system will reject, with reason, any pharmacy bills that do not adhere to NYSIF business rules;

For all medications that require authorization, Express Scripts automatically sends the pharmacy an electronic message stating that Express Scripts is in the process of determining whether the medication is authorized (messaging states: "The rejected medication is NOT denied, but requires authorization"). No further action is required on the pharmacy's part.

Authorization requests automatically populate our authorization system via electronic reject feed. Notification of a pending authorization request is generated to NYSIF.
Claims staff reviews the authorization request and input the approval decision, which is instantly released into the processing system.

A fax is then auto-generated to the pharmacy, conveying authorization or denial for the medication. This web-based process can significantly reduce turnaround time. In many cases, prescriptions are processed within five minutes. In addition, NYSIF can enter Prior Authorizations into our system proactively, so that when the injured worker attempts to fill the prescription, the approval is already in the system.

(9) Describe the method for notification of your network pharmacy in the event of rejection;

NYSIF Claims staff reviews the authorization request and input the approval or denial decision, which is instantly released into the processing system. A fax is then auto-generated to the pharmacy, conveying authorization or denial for the medication.

(10) Describe how the pharmacy bills submitted will validate against the claim eligibility information provided by NYSIF;

Our Paper Bill Process follows the same parameters as on online script because our CDUR system is integrated with the Retail Network and Home Delivery. Within three seconds the script runs through more than 160 potential edit with the first being eligibility.

(11) Identify the format of your pharmacy billing file, i.e. national standard, proprietary, etc;

Express Scripts requires our network pharmacies to submit claims using the HIPAA-compliant NCPDP Version D.0 standard or the most recent industry version. If a pharmacy transmits a claim in a different format, Express Scripts rejects the claim. We also accept 5.1 format.

(12) Describe the encryption and secure transmission protocol for the pharmacy billing files;

Express Scripts is committed to protecting the confidentiality, integrity, and availability of client and injured worker data through vigilant focus on prevention, detection, and response. For protection of sensitive information, including personal health information and personally identifiable information of injured workers, we have implemented multiple safeguards. In addition, we rely on regular audits of its security processes and procedures as a key component of continually identifying and reducing risk in its environment.

Express Scripts utilizes commercial firewalls and router Access Control Lists at all public network access points to appropriately restrict network traffic. We conduct regular vulnerability scans against our Internet points of presence in order to ensure no vulnerabilities exist.

Vulnerability scans are also conducted monthly by Express Scripts' Payment Card Industry auditor. Express Scripts is also audited annually by the U.S. Department of Defense against the DoD Information Assurance Certification and Accreditation Process.

Internet Security

Express Scripts' Internet-accessible systems have hardened operating systems and are located in a firewall-protected DMZ, which means it is isolated from both the Internet and Express Scripts' internal network. In addition, commercial Host Intrusion Detection Software has been deployed on the DMZ system. An additional layer of commercial firewalls separates Express Scripts' web portal DMZ from the internal network.

Strong Encryption

Express Scripts utilizes SSL 128-bit encryption for web session security. For all portals, data access is authenticated and authorized. Express Scripts also utilizes digital certificates for client-side authentication and authorization to perform business and other transactions with its systems via the Internet.

Other Tools

Inside our internal network, Express Scripts utilizes a variety of tools and methods for additional protection:

- Internal systems are regularly scanned utilizing commercial tools to identify potential security vulnerabilities, which are then addressed.
- Security software patches are applied on a regular basis to all platforms after evaluation and testing.
- Authentication and authorization controls are in place at the platform and application to limit data access to authorized users.
- All Express Scripts workstations have current antivirus protection and are kept up-to-date with security patches.
- All Express Scripts laptops have encrypted hard drives.
- Express Scripts' employees can only access Express Scripts' websites through secured logins with VPN access.

Data Center Security

Our data center operation has established rigorous procedures to safeguard the security of computer equipment and operating environment. The operations center is located in a physically secure, controlled-access campus and is equipped with proximity detector systems, key locks, and video cameras at all building entrances and exits.
Strict identification and access protocols are in place for employees and visitors, and the facilities are monitored 24 hours a day. Authorized personnel in designated systems and database administrative roles have access to the data on the systems that they support. Personnel operate under established Express Scripts policies and procedures and are required to complete annual acknowledgement of those procedures.

(13) Describe how the system will be monitored for performance;

Express Scripts has invested heavily in perfecting the fault tolerance, monitoring, and performance of our claims processing platform. Express Scripts engineered our systems for reliability, with a dual-site, fault-tolerant infrastructure and automated failover built into our applications. Backup power systems, including diesel generators, minimize downtime should Express Scripts experience a power failure. We use mirrored storage and redundant web servers, networks, and mainframes to provide a highly reliable infrastructure foundation for our applications.

As part of our strong focus on system reliability, Express Scripts formed a Performance and Reliability department, which reports directly to Express Scripts' chief information officer (CIO). This department ensures that the organization maintains a strong focus on systems reliability, as evidenced by the following day-to-day and weekly interactions:

- Meeting weekly with the CIO to drive continuous reliability improvements across all Information Technology functional areas
- Leading a daily cross-functional meeting to resolve and prevent any reliability concerns
- Meeting daily to evaluate all changes occurring in the environment, ensuring that every change has been thoroughly tested, is properly scheduled and communicated, and that any risks are mitigated
- Sharing systems performance and reliability scorecards on a daily basis with the Information Technology management team

Express Scripts' claims processing system operates with a history of consistency and stability, providing a positive patient experience at the point of service. Our focus on delivering reliable systems greatly reduces the likelihood of a service disruption.

(14) Describe how NYSIF will be notified in the event of a system and/or transmission failure;

Our online reporting applications experience minimal downtime. During any unexpected outages, users receive a "system down" message upon the user's attempt to log in. Express Scripts offers our network pharmacies two means of communication to verify member eligibility during adjudication system downtime: the Pharmacy Help Desk and Express-Scripts.com for Pharmacists.

- Pharmacy Help Desk – Our Pharmacy Help Desk is available 24 hours a day and has real-time access to eligibility, benefits, and claims adjudication data.
- Express-Scripts.com for Pharmacists – Pharmacies can also log into Express-Scripts.com and query on member eligibility based on the information found on a member's prescription drug card.

At the pharmacist's discretion, the prescription can then be dispensed with the appropriate benefit applied and the claim submitted to Express Scripts when the system becomes available.

(15) Describe how it will be determined into which file Established Claim or Instant Enrollment/"Short Fill," the pharmacy bill will be placed;

When a pharmacy processes a prescription to Express Scripts using a First Fill Temporary ID form, the system checks our edits to make sure that a claim does not already exist for the injured worker. If the system identifies a matching claim (using date of injury, and social security number), the prescription is processed according to the benefit design. Otherwise, if no record exists for the injured worker, the prescription will process according to the First Fill benefit design parameters as detailed above.

(16) Describe the process for tracking Aging Bills and how it will be determined whether or not a bill is to be placed in the Aging Bill files;

This falls under our First Fill process, described at length above. Additionally, if after 21 days there is no match, we notify NYSIF. If there is still no match after 30 days we write off if there is no claim match or validation by NYSIF.

(17) Describe how card issuance information is tracked in your system;

We can provide a daily card report to NYSIF. If a claim is reopened, the system validates if a card has been issued. If there is no card, we issue one then. Claims staff can trigger new card issuance through our OASIS portal.

(18) Describe your encryption and secure transmission protocol for your electronic files;

Express Scripts is committed to protecting the confidentiality, integrity, and availability of client and injured worker data through vigilant focus on prevention, detection, and response. For protection of sensitive information, including personal health information and personally identifiable information of injured workers, we have implemented multiple safeguards. In addition, we rely on regular audits of its security processes and procedures as a key component of continually identifying and reducing risk in its environment.

Express Scripts utilizes commercial firewalls and router Access Control Lists at all public network access points to appropriately restrict network traffic. We conduct regular vulnerability scans against our Internet points of presence in order to ensure no vulnerabilities exist.

Vulnerability scans are also conducted monthly by Express Scripts' Payment Card Industry auditor. Express Scripts is also audited annually by the U.S. Department of Defense against the DoD Information Assurance Certification and Accreditation Process.

Internet Security

Express Scripts' Internet-accessible systems have hardened operating systems and are located in a firewall-protected DMZ, which means it is isolated from both the Internet and Express Scripts' internal network. In addition, commercial Host Intrusion Detection Software has been deployed on the DMZ system. An additional layer of commercial firewalls separates Express Scripts' web portal DMZ from the internal network.

Strong Encryption

Express Scripts utilizes SSL 128-bit encryption for web session security. For all portals, data access is authenticated and authorized. Express Scripts also utilizes digital certificates for client-side authentication and authorization to perform business and other transactions with its systems via the Internet.

Other Tools

Inside our internal network, Express Scripts utilizes a variety of tools and methods for additional protection:

- Internal systems are regularly scanned utilizing commercial tools to identify potential security vulnerabilities, which are then addressed.
- Security software patches are applied on a regular basis to all platforms after evaluation and testing.
- Authentication and authorization controls are in place at the platform and application to limit data access to authorized users.
- All Express Scripts workstations have current antivirus protection and are kept up-to-date with security patches.
- All Express Scripts laptops have encrypted hard drives.
- Express Scripts' employees can only access Express Scripts' websites through secured logins with VPN access.

Data Center Security

Our data center operation has established rigorous procedures to safeguard the security of computer equipment and operating environment. The operations center is located in a physically secure, controlled-access campus and is equipped with proximity detector systems, key locks, and video cameras at all building entrances and exits.

Strict identification and access protocols are in place for employees and visitors, and the facilities are monitored 24 hours a day. Authorized personnel in designated systems and database administrative roles have access to the data on the systems that they support. Personnel operate under established Express Scripts policies and procedures and are required to complete annual acknowledgement of those procedures.

(19) Confirm your agreement to create specified electronic files in the form of an ASCII text file;

Confirmed.

(20) Describe how rebate information is tracked in your system; and

Express Scripts provides quarterly rebate-payment reports that summarize overall rebate allocations by client division. Additionally, we provide plan type-level reporting and all-group reporting. Reports include:

Quarterly Reports	
Report	**Format Provided**
Rebate Payment Summary	Hard copy, encrypted CD, or both
Plan/Group Level Report	Encrypted CD

The reporting NYSIF receives depends on the type of rebate arrangement you select. Express Scripts has the ability to run various aggregate-level rebate reports in Trend Central based on the invoiced rebate amount that is stamped at the time of adjudication. This amount may not include all future adjustments. The PharmacoAnalytics team can provide both aggregate and detail-level rebate reporting. This type of reporting would also be based on the Express Scripts-invoiced rebate amount.

(21) Describe the process that determines when a rebate is included in the quarterly rebate and annual true-up files.

Express Scripts pulls all of the scripts billed for the specific quarter, which have an "estimated rebate amount" reflected in the system. Then we assign the "credit" proportionally by the amount billed. The annual true-up file is completed the same way.

(22) Management Reports and Claim File Guarantees: The NYSIF Program's service level standard requires that accurate management reports and claims files will be delivered to the NYSIF no later than their respective due dates. For the management reports and claim files listed in Section IV.B.8.a.(8) (NYSIF Reports) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the NYSIF Claims Administration Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $75 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the NYSIF Claims Administration Fee for each management report or claim file that is not received by its respective due date, is $ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the NYSIF inclusive of the date of receipt.

9. Consulting

The Procuring Agencies require the selected Offeror to be an expert in the Prescription drug industry. Thus, the Procuring Agencies may request the advice and recommendations of the selected Offeror to provide the Procuring Agencies with up-to-date developments in the prescription drug field. The Procuring Agencies expect the selected Offeror to proactively provide advice and recommendations that are related to the clinical quality and cost management of the Programs. Such recommendations must include preliminary analysis of financial, therapeutic and Enrollee impact of proposed and contemplated benefit design changes.

a. Duties and Responsibilities

The selected Offeror will be responsible for providing advice and recommendations regarding the Programs. Such responsibility shall include, but not be limited to:

(1) Informing the Procuring Agencies in a timely manner concerning such matters as cost containment strategies, new drugs, conversion from Brand Drugs to Generic Drugs and how it will impact cost, Flexible Formulary and Preferred Drug List configuration, technological improvements, e-prescribing, Pharmacy innovations, and state/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the Programs. The Offeror must provide information and recommendations to the Procuring Agencies on Flexible Formulary or Preferred Drug List (PDL) placement of new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm. The Offeror must also make available to the Procuring Agencies one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The Procuring Agencies are not under any obligation to act on such advice or recommendation; and

(2) Assisting the Procuring Agencies with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed Program modifications and contemplated benefit design changes on Enrollees.

In the event of a design change and the Offeror requests any change in compensation such change will be in accordance with Section V.C.12.a. of this RFP.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.2.

b. Required Submission

(1) What resources will you utilize to ensure the Programs are kept abreast of the latest developments in the Prescription drug field? How do you propose to communicate trends, pending legislation and industry information to the Programs?

As one of the country's largest pharmacy benefit managers, Express Scripts maintains industry leading research and analytical operations to keep clients up to date with the latest pharmaceutical industry developments and what they mean for their prescription drug programs.

DCS and NYSIF will benefit from the following research resources provided through Express Scripts' account management team:

- Account Management Consultation
- The Express Scripts Research & New Solutions Lab
- Compliance Officer Communications
- Drug Trend Report
- Emerging Therapeutics
- Drug Evaluation Unit
- PharmacoAnalytics
- Workers' Compensation Matters Clinical Newsletter
- Workers' Compensation Compliance Communication –

Account Management Consultation

Express Scripts uses meetings to analyze trends, goals, and concerns related to your unique program. We can conduct meetings face-to-face, by conference call, or using video teleconference technology, depending on your needs.

Client meetings are cooperative efforts between your core account management team and the extended service team. Your account team works with our PharmacoAnalytics department to manage your claims data and trend information, design NYSIF-specific reports, and formulate program recommendations for analysis during scheduled meetings. Additionally, PharmacoAnalytics consultants work with clinical staff to monitor and report your pharmacy claim trends, benchmark claims against our book of business and other related pharmacy claims experience, and pinpoint opportunities for strategic interventions.

Your account team meets with you quarterly and schedules additional meetings as necessary. During the first quarterly meeting, your team presents a formal Collaborative

Planning Session. This meeting clearly defines program objectives, recommended services, expected results, and actual outcomes.

The Express Scripts Research & New Solutions Lab

Express Scripts believes effective management of the pharmacy benefit depends on alignment with clients and their injured workers. With this in mind, we have elevated the pharmacy benefit from an understudied component of healthcare to a more efficient discipline by devoting the resources necessary to sustain an unparalleled research team. Since 1993, our Research & New Solutions department has produced more than 100 abstracts at professional meetings (including the annual Express Scripts Outcomes Research Conference), published dozens of manuscripts in peer-reviewed literature, and generated hundreds of studies to support new and existing products for our clients. In addition, the annual Express Scripts Drug Trend Report, first published in 1997, has earned national recognition as the most comprehensive publicly available examination of U.S. prescription-drug trend.

Located within the Express Scripts Technology & Innovation Center, The Express Scripts Research & New Solutions Lab studies how people interact with their drug therapy: what medications they take, whether they comply with their therapy and why, what health outcomes result, and more. These detailed insights into how patients use medication and the pharmacy benefit provide significant value, enabling us to build products that better suit our clients' needs. We rapidly translate our research findings into real-world applications, creating solutions that drive down costs and improve health outcomes.

The Research & New Solutions Lab:

- Establishes a dedicated test-and-learn environment
- Develops product enhancements and new product solutions
- Uses mapping tools to pinpoint specific opportunities to reduce waste
- Operationalizes and monitors performance

Turning Points: Research in the Real World

There have been well-documented milestone moments when our emphasis on evidence-based research drove us to take positions unpopular with companies in the supply chain. The most recognized of these turning points resulted from the availability of generic Zocor (Simvastatin) in 2006. Express Scripts combined financial incentives with an advanced and aggressive communications program to encourage injured workers to switch to the new generic formulation of the drug.

Another study took a controversial approach by addressing concerns about switching between A-rated anti-epileptic drugs after earlier findings suggested an association between seizure activity and drug switching, particularly to lower-cost generic medications. The study provided evidence that switching to generic drugs in this therapy class is not associated with increased seizure activity.

In addition, findings from Express Scripts research led to the original discussion regarding overuse of COX-2s. This research suggested that COX-2s, drugs prescribed for their gastroprotective effects, were being overprescribed, particularly in patients with short-term musculoskeletal conditions who are not at risk for gastrointestinal events and who had not tried lower-cost alternatives.

The Express Scripts Research & New Solutions department continues to conduct studies that help you better understand the pharmacy benefit:

- **Trend Management: Do specific prescription drug cost-effectiveness models reflect real world practice?** Express Scripts researchers sought to validate economic models with data from actual clinical practice for COX-2s and proton pump inhibitors. Researchers found that, in both instances, the models overstated the cost-effectiveness of more expensive treatments. These findings led to the development of aggressive trend management programs to manage these therapy classes.
- **Prior Authorization: How do specific prior authorization protocols affect utilization and costs?** We examined the clinical and financial impact of a plan sponsor's prior authorization program for high-cost proton pump inhibitors.

Patients who did not receive a proton pump inhibitor incurred no troublesome medical consequences or increased medical spend. These findings provide evidence that plan sponsors can implement prior authorization programs to manage rising drug costs.

Drug Trend Report

Express Scripts believes that greater insights lead to greater value in the pharmacy benefit. For more than 20 years, we have served as a leader in evidence-based clinical research. Our annual Drug Trend Report, first published in 1997, has earned national recognition as the most comprehensive publicly available examination of U.S. prescription-drug trend.

The Drug Trend Report is dedicated to explaining the underlying market forces that influence prescription-spending patterns — historically, cost and utilization. Each year, the Drug Trend Report summarizes the results of our scientific research and advances innovation in the pharmacy benefit. Last year, the Drug Trend Report led the industry by quantifying how common behaviors, such as procrastination, increase wasteful spending in the pharmacy benefit.

The latest Drug Trend Report and Workers' Compensation Drug Trend Report are, available online http://www.express-scripts.com/research/research/dtr/, presents the findings of a landmark study that identifies a gap between what consumers want to do and how they actually behave. We quantify the savings that can be achieved by closing

this gap and draw on the behavioral sciences for proven solutions that lower costs and improve health outcomes while maintaining member and injured worker choice.

Emerging Therapeutics

The Express Scripts Emerging Therapeutics Department monitors the pharmaceutical landscape for new generic drugs, including any generic versions of specialty drugs. Those efforts are shared with clients via the account management team. The company's Emerging Therapeutics Issues Program tracks potentially troublesome issues such as Class 1 drug recalls, market withdrawals and labeling changes, and implements a detailed action plan to preserve public safety. Included in the plan are notifications to plan sponsors, patients and physicians. When appropriate, Express Scripts' claims processing system applies edits and online messaging to help prevent retail pharmacies from filling prescriptions for a drug of concern.

Drug Evaluation Unit (DEU)

This Express Scripts organization evaluates drugs newly approved by the FDA and creates PDL evaluation documents used by the company's Therapeutic Assessment Committee and the Express Scripts National P&T Committee. In conjunction with the Emerging Therapeutics Issues clinical team, the DEU provides drug information services daily to account teams. The DEU also compiles and prepares Clinical News, a monthly newsletter that provides clients with up-to-date information on new drug approvals and indications and other important clinical news items.

Express Scripts will communicate important trends and industry information to the DCS through the account management team. Such information, and recommendations for appropriate action based on that information, will be delivered to the DCS through various measures, including e-mail, as agenda topics at weekly operational meetings, as part of quarterly review meetings, or during the Annual Strategic Planning Sessions depending upon the urgency of any potential action steps.

PharmacoAnalytics

Express Scripts' PharmacoAnalytics department has an unmatched legacy of experience with pharmacy claims data. Our team of more than 80 data analysts, clinical consultants, and benefit consultants works closely with our clients to provide trend management consultation, benchmarking comparisons, ad hoc reporting and analysis, and customized strategic account planning. Working with your account team, PharmacoAnalytics provides data-driven decision support—delivering accurate and actionable recommendations to improve your prescription-drug plan's performance.

We proactively leverage all available information to identify opportunities for improvement for our clients and their injured workers. Depending on your goals, these recommendations can include channel management or clinical programs, such as Step Therapy, that drive to lowest net cost.

Because every client has unique needs and goals for its plan, we offer client-specific solutions. We provide the balance of cost-effectiveness, injured worker satisfaction, and plan performance that today's pharmacy landscape requires.
The PharmacoAnalytics team:

- Delivers clear, accurate information in a timely manner
- Analyzes and interprets industry trends and their implications for your program
- Generates proactive benefit design performance reviews and industry analyses
- Supports your strategic business plan through regularly scheduled performance reviews
- Develops and uses modeling tools to measure the cost and member impact of benefit design changes
- Recommends benefit design choices to maximize savings and minimize member disruption
- Utilizes its vast experience in working with clients and account teams to develop and disseminate new data reports and models

In addition to the above, your clinical program manager will continue to serve as NYSIF' contact on all clinical issues, including drug review and utilization management. and monitors clinical programs and services, and leads formulary management initiatives. She performs NYSIF-specific data analysis to identify and provide consultative solutions to effectively manage medication trends, monitors and acts upon emerging therapeutic issues, and participates in scheduled client reviews, including annual collaborative planning sessions.

10. Transition and Termination of Agreements

The Offeror shall ensure that upon termination of the separate Agreements, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their Prescription drug benefits and associated customer services through the final termination of the respective Agreements resulting from this RFP. This includes, but is not limited to: ensuring Enrollees/Claimants can continue to fill their Prescriptions through network pharmacies, the Mail Service Pharmacy Process and the Specialty Pharmacy Program; the processing of all non-network claims; verification of enrollment; and, providing sufficient staffing to ensure Enrollees continue to receive good customer service even after the termination date of the Agreements resulting from this RFP. It is also imperative that the Programs continue to have dialogue with key personnel of the Offeror, maintain access to online systems and receive data/reports and other information regarding the Programs after the effective end date of the Agreements. In addition, the Offeror and the selected successor shall fully cooperate with the Department and NYSIF to create and establish separate transition plans in a timely manner for each Program.

a. Duties and Responsibilities

(1) The Offeror must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the Programs.

(2) The Offeror must, within one hundred twenty (120) Days of the end of the Agreements resulting from this RFP, or within forty-five (45) Days of notification of termination, if the Agreements resulting from this RFP are terminated prior to the end of their term, provide the Procuring Agencies with separate, detailed written plans for transition, which outline, at a minimum, the tasks, milestones and deliverables associated with:

(a) Transition of Program data, including but not limited to a minimum of one year of historical Enrollee claim data, detailed COB data, report formats, Mail Service Pharmacy, Specialty Pharmacy and retail scripts with available refills, prior authorization approved through dates, generic appeal approved through dates and exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Procuring Agencies approve during implementation of the Programs in the format acceptable to the Procuring Agencies. The transition of open refill prior authorization and generic appeal files should include but not be limited to the following:

(i) Providing a test file to the successor contractor in advance

of the implementation date to allow the new contractor to address any potential formatting issues;

(ii) Providing one or more pre-production files at least four 4 weeks prior to implementation that contains Enrollee Prescription refill availability, one year of claims history and prior authorization and appeal approved-through dates as specified by the Procuring Agencies working in conjunction with the successor contractor;

(iii) Providing a second production file to the new Contractor by the close of business January 2nd (or 2 days after the Agreements resulting from this RFP terminate) that contains all Enrollee Prescription refill availability as specified by the Procuring Agencies, working in conjunction with the selected successor contractor; and

(iv) Providing a lag file due seven (7) Days after the implementation date to capture any refills that may have been in process but not yet shipped at the Offeror's Mail Service and Designated Specialty Pharmacy(ies) after the end of the year.

(b) Transition of Enrollee information on all non-transferable compounds and controlled medications.

(3) Within fifteen (15) Business Days from receipt of the Transition Plan, the respective Procuring Agency shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department or NYSIF.

(4) Within fifteen (15) Business Days from the contractor's receipt of the required changes, the Contractor shall incorporate said changes into the respective Transition Plan and submit such revised Transition Plan to the Department or NYSIF.

(5) The selected Offeror shall be responsible for transitioning the Programs in accordance with the approved Transition Plans.

(6) To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to their Prescription Drug benefits and associated customer services, and to enable the Department or NYSIF to effectively manage the separate Agreements resulting from this RFP, the Offeror is required to provide the following Contractor-related obligations and deliverables to the Programs through the final financial settlement of the Agreements resulting from this RFP:

(a) Provide all Contractor-provided services associated with claims incurred, as applicable to the respective Programs, on or before

the scheduled termination date of the Agreements resulting from this RFP, including but not limited to paying network claims, Mail Service Pharmacy claims, Specialty Pharmacy claims, manual submit claims including but not limited to: Medicaid, VA , Skilled Nursing Facility claims, out-of-network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy process and Specialty Pharmacy Process issues, repaying or recovering monies on behalf of the Program for Medicare claims, retaining NYBEAS access, continuing to provide updates on pending litigation and settlements and claims/rebate data for class action litigation that the Contractor or the NYS Attorney General's Office has/may file on behalf of the Programs. In addition, the Offeror must continue to provide the Procuring Agencies access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Procuring Agencies notify the Offeror that access may be ended at an earlier date;

(b) Complete all required reports in the reporting Section IV.B.8. of this RFP;

(c) Provide the Programs with sufficient staffing in order to address State audit requests and reports in a timely manner;

(d) Agree to fully cooperate with all the Department, NYSIF or Office of the NYS Comptroller (OSC) audits consistent with the requirements of Article XIX of the resulting Agreements and Appendices A and B;

(e) Perform timely reviews and responses to audit findings submitted by the Department, NYSIF and the Comptroller's audit unit in accordance with the requirements set forth in Article XIX "Audit Authority," Section VII, Contract Provisions;

(f) Remit reimbursement due the Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XIX "Audit Authority" and Article XV "Payments/(credits) to/from the contractor" of Section VII, Contract Provisions and Appendix B; and

(g) (Exclusive to DCS) Assist the Department in all activities necessary to ensure the correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS) with respect to the administration of the EGWP in accordance with Subpart R of 42CFR423 and the Medicare Prescription Drug Improvement and Modernization Act (P.L.

108-173). Such assistance includes, but is not limited to the provision of accurate data within the Offeror's control.

(7) The selected Offeror is required to reach separate agreements with the Procuring Agencies on receiving and applying enrollment updates, keeping dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreements resulting from this RFP, adjusting phone scripts, and transferring calls to the successor contractor's lines.

(8) The selected Offeror is required to transmit point of service messaging to their Retail Pharmacy Network upon the termination date of the Agreements resulting from this RFP instructing Pharmacists to submit Enrollee claims to the appropriate RXBIN, RXPCN, RXGRP or other claim identification information as specified by the Department and NYSIF working in conjunction with the selected Offeror.

(9) If the selected Offeror does not meet all of the Transition Plan requirements in the time frame stated above, the selected Offeror will permanently forfeit 100% of all Claims Administration Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Procuring Agencies.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.9, with the exceptions of a.6.a., a.6.f, and a.9. We have provided clarifications to our approach to a.6.a, a.6.f, and a.9 as provided in our responses below.

6.a) Express Scripts and its affiliated companies (including Medco Health Solutions) are occasionally parties to legal or administrative proceedings arising out of the ordinary course of our business. As a publicly traded company, we are prohibited by law and regulation from providing information on significant legal proceedings except through public announcements. We report significant legal proceedings in accordance with Securities and Exchange Commission (SEC) rules. You can access our SEC filings, including those previously filed by Medco, through the Investor Information link of our company website at www.express-scripts.com

6.f) Express Scripts agrees to provide reimbursement within 15 business days upon final audit determination. Express Scripts looks forward to the opportunity to negotiate mutually agreeable contract language in Appendix B and Section VII upon award of contract.

9) Express Scripts agrees to the penalty above from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are reasonably completed.

b. Required Submission

(1) Provide an outline of the key elements and tasks that would be included in your separate Transition Plans to ensure that all the required duties and responsibilities are completed if you were the incumbent contractor. Include a brief explanation on how you would accomplish this with the successor contractor.

Express Scripts assists in the transition to a new contractor by transferring prescription claim history data, open Home Delivery prescriptions, notifying the Contact Center of the new contractor, and adding adjudication messaging to notify pharmacies of the new contractor. Each of these items assists clients in managing the transition to a new contractor and mitigating any potential member or injured worker disruption associated with the change.

(2) Please detail the level of customer service that you will provide after the termination date of the Agreements resulting from this RFP.

We will work with the incoming PBM to provide smooth transition which may involve supplemental messaging to the dispensing pharmacy to reprocess the request to the new PBM, thus minimizing disruption to members or injured workers.

11. Network Management

The selected Offeror must have a comprehensive nationwide Retail Pharmacy Network in place to allow adequate access for Enrollees to obtain all Covered Drugs through the Retail Pharmacy Network. Through this RFP, the Programs are seeking a Pharmacy Network that delivers the most aggressive discounts possible, while meeting the minimum guarantees for Network Pharmacy access. In addition, the selected Offeror is required to have a fully functioning Mail Service Pharmacy Process that allows Enrollees to obtain all Covered Drugs and is capable of handling the mail service Prescription volume of the Programs:

Retail Pharmacy Network

The current Programs include a nationwide Retail Pharmacy Network through which Enrollees can obtain all Covered Drugs including any and all drugs that could be classified as Specialty Drugs/Medications as required by Section IV.B.11. of this RFP, under the subheading "Specialty Drugs/Medications." The Offeror must propose a Retail Pharmacy Network that meets or exceeds the Programs' minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the Programs' Retail Pharmacy Network commencing on January 1, 2014. The Offeror may choose to enter into Program-specific Pharmacy contracts that are contingent on award and/or utilize existing Pharmacy agreements that can be made applicable to the Programs to meet the Programs' requirement that the Offeror have executed contracts with all the Network Pharmacies included in the Offeror's Proposed Retail Pharmacy Network File upon the submission date of their Proposal. (Note: Because the Procuring Agencies provide significant purchaser volume, the Department and NYSIF expect each Offeror will present a Proposal with network contracts at reimbursement rates more favorable than the Offeror's standard pharmacy contracts.)

All Brand Drug Retail Pharmacy Network claims shall be charged to the Programs at Pass- through Pricing subject to the Offeror's proposed overall Guaranteed Minimum Discount off of AWP for all Brand Drugs dispensed, as set forth in Exhibit V.A, plus the applicable brand dispensing fee. All Generic Drug Retail Pharmacy Network claims shall be charged to the Program at Pass-through Pricing subject to the Offeror's proposed overall Guaranteed Minimum Discount off of AWP for all Generic Drugs dispensed, as set forth in Exhibit V.A plus the applicable generic dispensing fee. Retail and Mail Service Pharmacy Process claims meeting the Programs' definition of Compound Drugs shall be charged to the Programs utilizing Pass-through Pricing in accordance with the Offeror's proposed (and Procuring Agencies' approved) methodology plus the

applicable compound dispensing fee. Do not include any cost information in the technical proposal.

a. Duties and Responsibilities

(1) The Offeror must maintain a credentialed and contracted Retail Pharmacy Network that meets or exceeds the Programs' minimum access standards throughout the term of the resultant Agreements.

(2) The Programs require that the Offeror have available to Enrollees on January 1, 2014 its proposed Retail Pharmacy Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Retail Pharmacy Network.

(3) The Offeror is required to include Independent Pharmacies in its Proposed Retail Pharmacy Network. In developing its proposed Retail Pharmacy Network, the Offeror is expected to use its best efforts to substantially maintain the composition of independent Network Pharmacies included in the Programs' current Retail Pharmacy Network provided such Pharmacies meet the requirements of Pharmacy Credentialing and Pharmacy Contracting of this RFP, and are willing to accept the proposed aggressive reimbursement rates.

(4) The selected Offeror shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's or NYSIF's request, where such inclusion is deemed necessary by the Procuring Agencies to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below.

(5) The Offeror must effectively communicate the content (including any subsequent changes) and requirements of the Program's Flexible Formularies and Preferred Drug Lists to their Retail Pharmacy Network.

(6) Prior to January 1, 2014, the selected Offeror must ensure that their Network Pharmacies have the correct claim identification information (i.e. RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for Enrollees.

(7) Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs through the Retail Pharmacy Network.

(8) Network Pharmacy Access Guarantee: The selected Offeror must propose a Retail Pharmacy Network that throughout the term of the Agreements resulting from this RFP meets or exceeds the Procuring Agencies' minimum access guarantees as follows:

(a) Ninety percent (90%) of Enrollees in urban areas will have at least one (1) Network Pharmacy within two (2) miles;

(b) Ninety percent (90%) of Enrollees in suburban areas will have at least one (1)Network Pharmacy within five (5) miles; and

(c) Seventy percent (70%) of Enrollees in rural areas will have at least one (1) Network Pharmacy within fifteen (15) miles.

Note: In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no Enrollee may be excluded even if a Pharmacy is not located within the minimum access area.

Offerors should provide a guarantee, separately for each Program, for each of the three (3) measurements and areas (urban, suburban, and rural). These guarantees are based on the distance, in miles, from a Program Enrollee's home (zip code) to the nearest Network Pharmacy location.

Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the access guarantees must follow the same structure as the above minimum (i.e., access guarantees for each of the three (3) areas based on the entire Program population).

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.8. Express Scripts is not offering pass-through pricing for medications filled through the Mail Service. Express Scripts' compound drug methodology is not subject to client approval.

b. Required Submission

(1) Propose access guarantees for the Programs' Retail Pharmacy Network that meet or exceed the minimums set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

Express Scripts agrees to the pharmacy access guarantee as requested by the Programs, and would like to offer an enhanced guarantee as follows:

% of Enrollees with Access to Retail Pharmacies	Enrollee Location	Access Guarantee -1 Pharmacy at least
[redacted]	**Urban**	2 miles
[redacted]	**Suburban**	5 miles
[redacted]	**Rural**	15 miles

(2) Complete Exhibit I.Y.1 to indicate whether certain chain pharmacies will or will not participate your Retail Pharmacy Network on January 1, 2014. The completion of Exhibit I.Y.1 must be consistent with the contents of the Offeror's Proposed Retail Pharmacy Network File, Exhibit I.Y.3.

(3) Please compare the current DCS Program network pharmacies that have submitted claims in 2010/2011 with your Proposed Retail Pharmacy Network File. Identify whether each of the Program's current network pharmacies will or will not participate in the Offeror's proposed Retail Pharmacy Network in accordance with the instructions provided in Exhibit I.Y.5, entitled "Comparison of Current Program Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network." The file containing the DCS Program's current network pharmacies and instructions for completing the exhibit can be obtained by following the instructions included in Exhibit I.Y.5 and meeting the requirements specified in Section III.B.5. of this RFP.

[redacted]

(4) Please confirm that if selected, you will provide an updated Exhibits I.Y.1, I.Y.3, I.Y.4 and I.Y.5 on December 1, 2013 confirming that the Offeror's proposed Retail Pharmacy Network will be implemented as required on January 1, 2014. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Retail Pharmacy Network along with a detailed explanation for all deviations.

Confirmed.

(5) Describe the approach(es) you would use to solicit additional pharmacies to enhance your proposed Retail Pharmacy Network or to fulfill a request to add an individual independent Pharmacy.

At NYSIF's request, Express Scripts can solicit a pharmacy that is not in our Express Scripts National Network, provided the pharmacy meets the credentialing requirements. Our goal is to have a pharmacy within five miles for the majority of your injured worker population, provided a pharmacy exists. During our recruitment process, we contact the appropriate retail chain or independent pharmacy contracting representatives directly via phone, fax, or e-mail.

NYSIF can e-mail requests for network additions to your account manager. Once we receive NYSIF's recommendation, a pharmacy contract is sent to the pharmacy the next business day. Any pharmacy that agrees to the terms and pricing of the contract and meets our credentialing requirements can be a part of the Express Scripts National Network.

Express Scripts can add new pharmacies as quickly as the next business day, provided we have received certification and a completed, signed contract from the pharmacy. Our contracts for the Express Scripts National Network are Workers' Compensation specific.

(6) Please identify Limited Distribution Drugs and indicate the authorized distributors that will participate in the Retail Pharmacy Network proposed for the Programs. If you are unable to secure the participation of the authorized distributors in your Retail Pharmacy Network, describe the process you will utilize to provide Enrollees with access to these drugs placing no additional steps or burdens on the Enrollee.

As a result of CuraScript's reputation and long-term experience in the specialty pharmacy industry, we participate in a number of preferred and exclusive distribution networks. To date, we have access to more than 97% of all specialty medications. We have access to all therapeutic categories.

The specialty medications that CuraScript handles as part of a limited distribution network are provided in the Attachments Section. In most instances, prescribing physicians know which pharmacies have access to the limited distribution drugs. Thus, most prescriptions go directly to the appropriate pharmacy. However, if we receive a prescription for a product that we cannot access, we contact the prescribing physician and ask permission to forward the prescription to the appropriate pharmacy. We then fax the prescription to that pharmacy for the patient.

We work with manufacturers daily to acquire distribution rights for the full spectrum of specialty products. Please refer to Attachment Section for a list of limited distribution drugs to which we do not have access.

(7) Network Pharmacy Access Guarantees: You must guarantee that throughout the term of the Agreements resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Pharmacy.

The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the "Retail Pharmacy Network" Section of this RFP. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet these guarantees.

The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee, for any quarter, in which the Network Pharmacy Access for Urban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee is $ for DCS and $ for NYSIF for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee (or

the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Urban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee is $ for DCS and $ for NYSIF for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Suburban Areas Guarantee, is not met by the Offeror.

The standard credit amount for each .01 to 1.0% below the seventy percent (70%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee is $ for DCS and $ for NYSIF for each .01 to 1.0% below the seventy percent (70%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Rural Areas Guarantee, is not met by the Offeror.

Measurement of compliance with each access guarantee will be based on a "snapshot" of the Retail Pharmacy Network taken on the last day of each quarter within the current plan year. The results must be provided in the format contained in Exhibit I.Y.4. The report is due thirty (30) Days after the end of the quarter.

[redacted]

[redacted]

[redacted]

[redacted]

Pharmacy Credentialing

Offerors must ensure that their Network Pharmacies meet the licensing standards required by the state in which they operate. Network pharmacies are also required to meet the credentialing criteria established by the Offeror. This criteria should be designed to ensure quality pharmaceutical care.

a. Duties and Responsibilities

(1) The selected Offeror must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

(2) The Offeror must credential Pharmacies in a timely manner and shall have an effective process by which to confirm Network Pharmacies continuing compliance with credentialing standards.

(3) The Offeror must maintain credentialing records and make them available for review by the Procuring Agencies upon request.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.3.

b. Required Submission

(1) Describe the Offeror's process to ensure that network pharmacies meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?

Express Scripts maintains strict URAC-sanctioned credentialing and re-credentialing policies for participating network pharmacies to ensure injured worker safety, to meet requirements of government agencies, and to provide best-in-class patient care services. All prospective network pharmacies must complete the quality assurance and credentialing forms included in the pharmacy contracting process. Our policies apply to all pharmacy types, including:

- Retail pharmacies
- Home infusion
- Hospitals
- Clinics
- Long-term care
- Dispensing pharmacies
- Medicaid agencies
- Tribal pharmacies

Independent Pharmacies

An independent pharmacy that wishes to participate in any Express Scripts network must complete an application, sign a pharmacy agreement, and respond to questions regarding past and present license status and actions taken against it. If a disciplinary action has been taken against a pharmacy, an Express Scripts Pharma & Retail Strategy professional follows up with the state board of pharmacy.
After Express Scripts conducts a thorough analysis to ensure that the pharmacy meets our qualifications, the pharmacy can join our network. During initial credentialing and re-credentialing, Express Scripts requires each independent pharmacy to:

- Present a current and valid state pharmacy license, the pharmacist-in-charge's state license, a Drug Enforcement Administration certificate, and a letter for National Provider Identifier number assignment
- Prove current malpractice/liability insurance coverage showing at least $1 million per occurrence and $3 million aggregate. The pharmacy's insurance company must submit a summary sheet directly to Express Scripts.
- Not be currently listed on the Office of the Inspector General or the General Services Administration exclusions lists
- Provide its National Council of Prescription Drug Plans (NCPDP) number, appropriate pharmacy demographic data, e-mail address, pharmacy website, hours of service, switching company, software vendor, and type of pharmacy
- If a pharmacy has been cited for disciplinary action, it must provide documentation of the issue. Our internal Audit Compliance team and Pharmacy Disciplinary Action Committee review this documentation. We then re-examine the pharmacy's network contractual status.

Express Scripts re-credentials our pharmacies every three years. For re-credentialing, we require pharmacies to re-submit the above materials.

Pharmacy Chains and PSAOs

Existing Express Scripts network pharmacy chains and PSAOs must sign an affidavit every three years, stating that all of their credentials are in order. The affidavit form requests that the chain headquarters personnel acknowledge that they have an ongoing policy to ensure their pharmacies maintain the following:

- Current state pharmacy licenses
- Drug Enforcement Administration licenses
- General comprehensive and professional liability coverage

- Good standing with all governing entities

Pharmacy Provider Agreement Highlights

In addition to meeting the credentialing and re-credentialing policies, a network pharmacy must sign the pharmacy provider agreement. Pharmacies contractually agree to:

- Accept set reimbursement levels and dispensing fees
- Accept the full payment from Express Scripts, with the exception of member or injured worker contributions as appropriate, as determined by the benefit design
- Collect the copayment and other applicable fees from member injured workers as appropriate at the point of service
- Allow Express Scripts to use the pharmacy's name in advertising and other published materials
- Be subject to trade secret and nondisclosure clauses
- Participate in Express Scripts' audit programs to ensure accuracy and prevent fraud
- Display DUR messages and respond or act upon these messages appropriately
- Provide prescription consultation services for member and injured workers as appropriate
- Support formulary compliance and stock all drugs included on the formulary
- Adjudicate claims online in the current NCPDP format
- Submit usual and customary prices on all claims
- Dispense generic substitutes when permitted by state law and according to plan sponsors' benefit designs

(2) Describe your approach for credentialing Network Pharmacies.

To drive out waste in the retail channel, Express Scripts negotiates competitive network pricing for our plan sponsors while building and maintaining stable networks and services through collaborative and strategic relationships with retail pharmacies. Express Scripts integrates convenient network pharmacy programs with superior management systems to provide national provider networks that offer:

- Client Support
- Network design consultation

- Flexible benefit designs
- CMS-compliant Medicare and Medicaid networks
- Workers' Compensation network
- Management reports
- Member and Injured worker eligibility control
- Reduced Cost
- Discounted drug costs
- Limited provider networks to maximize savings
- Clinical Expertise
- Online claims adjudication and drug utilization review
- Immunization programs
- Medication therapy management
- Pharmacist access to the Contact Center, Pharmacy Help Desk, and Express-Scripts.com for Pharmacists
- Convenience
- Process to easily add pharmacies based on member and injured worker access needs
- Stable networks with low turnover
- Online pharmacy locator

We reduce unit costs for prescription drugs by negotiating discount rates with retail pharmacies across the country, increasing the use of preferred products, promoting generics, and encouraging formulary adherence. Additionally, we have built our value-enhanced networks so that injured workers have convenient access to local pharmacies while limiting the number of participating pharmacies to maximize discounts for NYSIF. If concerns related to network access are identified, Express Scripts can contract with additional pharmacies that meet our URAC-sanctioned credentialing requirements and contract terms.

(a) Specify if you utilize an external credentialing verification organization. When was the credentialing verification process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?

Express Scripts maintains our own proprietary, strict, URAC-sanctioned credentialing and re-credentialing policies for participating network pharmacies to

ensure member and injured worker safety and to meet requirements of government agencies.

All prospective network pharmacies must complete the credentialing forms included in the pharmacy contracting process. After a careful analysis is performed and qualifications are met, pharmacies can join our pharmacy network. Additionally, Express Scripts re-credentials our network pharmacies every three years.

Participating pharmacies are contractually bound to quality standards and agree to adjudicate all injured worker prescriptions online in NCPDP format rather than outsource them to third parties. Express Scripts follows NCPDP standards, which enable electronic documentation, storage, and transmission of clinical and billing data that describe the delivery of pharmacy services.

Our Workers' Compensation Retail Pharmacy Help Desk advocates make outbound calls to any participating pharmacy that submits a claim through a third-party billing company or sends a paper bill directly to the client. The call educates the pharmacy on how to process the prescription online with Express Scripts. We provide adjudication information and remind the pharmacy of its contractual obligation to process prescriptions online. Pharmacies that are in breach of their contract are subject to termination.

(b) What steps do you take between credentialing periods to ensure that Network Pharmacies that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Retail Pharmacy Network as soon as possible? What steps, if any, do you take to advise members when a Pharmacy has been removed from the Retail Pharmacy Network?

Disciplinary action against pharmacies is handled by our Pharmacy Disciplinary Action Committee (PDAC). The PDAC is made up of seven senior-level professionals from various departments and background within Express Scripts who meet regularly to review serious pharmacy issues that may result in disciplinary action, including possible termination from Express Scripts' network.

When a pharmacy is terminated involuntarily, our contract requires Express Scripts to give the store a written notification (except in the case of claims fraud) and 10 days to resolve the sited defect. If the defect is not corrected, the pharmacy is automatically terminated 30 days after the end of the 10-day notification period. During the 30-day period preceding termination, Pharma & Retail Strategy sends a list of affected injured workers to the Account Management team. This team, in turn, notifies the plan sponsor and provides a list of the five alternative pharmacy stores nearest each member or injured worker affected by this termination.

Pharmacy Contracting

Contracts with pharmacies should be written to utilize the Programs' market strength to obtain maximum discounts while also ensuring the Programs' access guarantees are met. This could include reimbursement provisions which are lower than the Offeror's standard reimbursement rates for Network Pharmacies. Contracting staff should keep abreast of current market conditions and have the wherewithal to adjust contracts with pharmacies to reflect the best interests of the Programs. The Offeror must ensure that all Network Pharmacies contractually agree and comply with the Programs' requirements and benefit design. The Program expects Offerors to negotiate aggressive discounts off of AWP for Brand Drugs and manage a Program MAC List for Generic Drugs dispensed to Enrollees. Contracts should be consistent with and support proposed access guarantees to ensure long- term stability of the Retail Pharmacy Network.

Note: Do not include any cost information in the Technical Proposal.

a. Duties and Responsibilities

The Offeror will be responsible for providing Pharmacy contracting services including but not limited to:

(1) Ensuring that all Network Pharmacies contractually agree to and comply with all of the Programs' requirements and benefit design specifications;

(2) (Exclusive to DCS) Ensuring all Network Pharmacy contracts include a provision prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments;

(3) (Exclusive to DCS) Recruiting licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program administered by The Empire Plan's medical carrier. These licensed pharmacies are provided in Exhibit II.E.3 of this RFP;

(4) Ensuring that Network Pharmacies accept as payment-in-full the Offeror's reimbursement for all claims processed based on the Program's Lesser of Logic detailed in Section VII of the RFP, Article 12.6.0.

(5) Notifying the Department and NYSIF in writing of any plan to renegotiate the financial terms of any Network Pharmacy contract utilized by the Programs for any Pharmacy that is located in the State of New York, or for any such Pharmacy located outside the NYS that accounts for more than 0.25% of total Program final paid claim Ingredient Costs;

(6) Notifying the Procuring Agencies in writing within one (1) Business day of any changes to contracts with Retail Pharmacy Network chain Pharmacies or independent Pharmacies negotiating collectively with the Offeror, including but not limited to, those identified as participating in the Offeror's proposed network;

(7) (Exclusive to DCS) Upon the request of the Department, resoliciting the entire Pharmacy Network to obtain more aggressive reimbursement rates that would pass- through to the Program in exchange for a smaller, select network that meets proposed access guarantees, as modified;

(8) Committing to administering Pharmacy contracts consistent with all representations made in the Offeror's cost proposal, including all representations regarding the administration of generic pricing and maintenance of MAC list(s); and

(9) (Exclusive to NYSIF) Ensuring there are mechanisms in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.8, with the exception of a.5 and a.6. We have provided further clarifications to our approach to a.6 in our response to b.4 in the DCS Technical Proposal binder. Please see our DCS-specific Technical Proposal binder for our response to items a.2, a.3, and a.7.

b. Required Submission

(1) Confirm that your agreements with Network Pharmacies require their compliance with all the Programs' requirements and benefit design specifications. Provide a copy of the Offeror's proposed Pharmacy contract, rate sheet, and provider manual.

[redacted]

(2) (Exclusive to DCS) Confirm that licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program are, or will be, recruited into your Retail Pharmacy and Specialty Pharmacy network, if applicable.

(3) Please confirm that your Network Pharmacy contracts require the Pharmacy to apply the Program's Lesser of Logic to all the Programs' claims.

Confirmed. This requirement is formalized in our Workers' Compensation-specific pharmacy contracts with the network. The contract also stipulates that an enrollee will never be charged more than a cash-paying customer.

(4) Please confirm that you will notify the Procuring Agencies in writing of any changes to the Network Pharmacy contracts or any plans to renegotiate the financial terms of the contracts utilized by the Programs for any New York State Pharmacy or significant out-of-state Pharmacy.

Confirmed. Express Scripts agrees to notify NYSIF of any significant change which impacts NYSIF's members.

(5) (Exclusive to NYSIF) Describe in detail the mechanisms you will put in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

Our direct contractual relationship with our pharmacies requires them to process online and not through a third-party biller once notified of our eligibility. The Express Scripts Workers' Compensation patient care advocate will make outbound calls to each

participating pharmacy that submits a claim through a third-party billing company. The purpose of the call will be to educate the pharmacy on how to process the prescription online with Express Scripts. We will provide adjudication information and remind the pharmacy of their contractual obligation to process prescriptions online. In the event a pharmacy refuses to bill online going forward, the Contact Center will forward that pharmacy's information, along with the name of the pharmacist/technician they spoke with, to Provider Relations to discuss the contractual obligation and seek resolution with the pharmacy.

Third-Party Biller Paper Bill Adjudication Process
Express Scripts has established the following process for third-party paper bill adjudication:

1. NYSIF sends all third-party paper bills to Express Scripts. We recommend NYSIF send this information on a weekly, bi-weekly or monthly basis. We will work with you to determine an appropriate timeline for the submission of paper bills.

2. Express Scripts adjudicates all third-party bills and will pay based on client adjudication logic, if deemed eligible. The bills are paid according to client preference. Following is the recommended process for third-party bill payment; however, Express Scripts will work with the client to customize a program in accordance with their business rules:

    - Express Scripts will process third-party bills at the lesser of the submitted rate and State Fee Schedule for up to 14 days. A letter is sent to inform the third-party biller that they were paid this time, but going forward they will receive the contracted rate.
    - A letter is also sent to the pharmacy and the injured worker. When additional prescriptions come in after 14 days, they are re-priced to the Express Scripts contracted rate. This is Express Scripts' recommended best practice solution.

3. Paper bills are entered into our adjudication system, where the same administrative edits at the point of service are applied to verify eligibility and program design compliance. Concurrent edits are also applied and in the event of a rejection, Express Scripts will contact the claims handler for authorization to process.

Paper bill information is stored in the injured worker's electronic profile for future concurrent review at the point of service. The process continues from here just as it does for the network and non-network paper bills. Both of the above processes can be administered for retail and home delivery programs and are administered by our dedicated Paper Bill team in St. Louis, Missouri.

Why That Matters To NYSIF: Express Scripts conducts the entire bill review, processing and conversion process—creating efficiencies that save time and money.

Pharmacy Audit

The protection of the Programs' assets must be a top priority of the selected Offeror. The selected Offeror must have a strong audit presence throughout its organization. The Offeror is responsible for the oversight and audit of pharmacies that dispense drugs for Enrollees. Staff should be well-trained and experienced. Claims systems should have logic programmed which help to focus audit resources.

a. Duties and Responsibilities

The selected Offeror must have a staffed and trained audit unit employing a comprehensive Pharmacy audit program that includes but is not limited to:

(1) Providing ample audit resources including access to the Offeror's on-line claims processing system to the Department, NYSIF and OSC at their respective offices through the date of the final financial settlement of the Agreement resulting from this RFP;

(2) Providing the Procuring Agencies with access and monthly updates to the Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) that the Offeror will be utilizing for the Programs;

(3) Conducting routine and targeted on-site audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Days supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Procuring Agencies, or when information is received by the Offeror that indicates a pattern of conduct by a Pharmacy that is not consistent with the respective Programs design and objectives. Periodic, on-site audits must be conducted at least once during the course of the resultant Agreements for Pharmacies that fall into the top fifty (50) in terms of total dollar spend for the Programs. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the State;

(4) Providing reports to the Procuring Agencies detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Offeror. The Offeror must inform the Procuring Agencies in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of such allegations or identification. The Procuring Agencies must be fully informed of all fraud and abuse investigations impacting the Programs upon commencement,

regardless of whether the individual fraud and abuse investigation has a material financial impact to the State;

(5) The capability and contractual right to effectively audit the Programs' Retail Pharmacy Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

(6) Agreement to fully cooperate with all Department, NYSIF and/or OSC audits consistent with the requirements of Appendices A and B as set forth in Section VII, Contract Provisions including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Offeror must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Offeror must perform timely reviews and respond in a time period specified by the Department or NYSIF to preliminary findings submitted by the Department, NYSIF or the Comptroller's audit unit in accordance with the requirements of Article XIX "Audit Authority" in Section VII, Contract Provisions. Such audits may include, but are not limited to: mail order claims; Enrollee-submitted paper claims; and on-line Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Offeror shall facilitate audits of network pharmacies, including on-site audits, as requested by the Department, NYSIF and/or OSC;

(7) Remitting 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII, Contract Provisions;

(8) Utilizing the auditing tools and performance measures proposed by the Offeror to identify fraud and abuse by Network Pharmacies and/or Enrollees; and,

(9) Permitting the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

Express Scripts agrees to the duties and responsibilities set forth with the exceptions of items a.3, a.5, and a.6 as provided above. We have provided further clarifications to our approach to a.3 in our response to b.3, clarifications to our approach to a.5 in our response to b.5, clarifications to our approach to a.6 in b.6, and clarifications to our approach to a.9 in b.9 in the DCS Technical Proposal binder.

3) Agree with the understanding that Express Scripts will not complete onsite audits of our Mail Service Pharmacy and Specialty Pharmacy. As part of our Network Audit Program, Express Scripts currently conducts desktop audits of our Mail Service Pharmacy and Specialty Pharmacy to validate compliance with the Provider Manual.

5), 6) Not confirmed for statistical sampling audit techniques and extrapolation. Express Scripts, audits based on actual claim discrepancies not samples or extrapolations, as outlined in the Exhibits Section of III. Administrative Proposal.

b. Required Submission

(1) Confirm that ample audit resources will be made available to Department, NYSIF and OSC staff to conduct audits, including access to the Offeror's on-line claims processing system.

Confirmed.

(2) Confirm that current Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) will be made available for the duration of the Agreement resulting from this RFP by the Offeror for access up to 3 (three) Department Staff.

Confirmed.

(3) Describe the Pharmacy audit program you would conduct for the Programs including a description of the criteria you use to select pharmacies for audit and a description of the policy that you follow when a Pharmacy audit detects possible fraudulent activity by the Pharmacy or an enrollee. Include all types of audits performed and offered by your organization.

Express Scripts' ability to seamlessly monitor pharmacy, physician, and patient patterns enables clients to reduce wasteful spending and risk associated with Fraud, Waste and Abuse (FWA). The Express Scripts FWA program integrates with our advanced clinical programs, such as Retro DUR and ScriptAlert, to identify potential issue patterns. Advanced analytics and a highly accredited team identify aberrant situations and personally investigate with the parties involved to determine whether a fraudulent activity is taking place. Partnering with our clients to resolve these issues speak to the model of Express Scripts business: Alignment with our clients.

Fraud, Waste and Abuse Program Overview

Express Scripts is strongly committed to the detection and prevention of Workers' Compensation Fraud, Waste and Abuse (FWA). The FWA program was designed to ensure safety for your injured workers while controlling waste and subsequently saving you costs. Our Fraud, Waste and Abuse program features the identification of injured workers and prescribers with unusual or excessive utilization patterns. Express Scripts employs a team of highly trained auditors and an industry-leading Special Investigations Unit (SIU) who specialize in claim review and investigative services.

The workers' compensation FWA program is an aggressively managed quality assurance system designed to increase the overall effectiveness and quality of Express Scripts' services. The FWA program has three primary components discussed in this overview:

- Injured Worker and Physician Proactive Analytics and Data Mining
  - Advanced Analysis
  - Client Consultation and Collaboration
- Investigative Procedures
  - Pharmacy Verification
  - Prescriber Verification
- Client-Directed Injured Worker Verification
- Fraud Tip Hotline

The end result is that our workers' compensation clients and their injured workers have the robust FWA offerings through best in class analytics, investigations, and guidance on interventions.

Injured Worker and Physician Proactive Analytics & Data Mining

Express Scripts has a number of effective resources available to indentify possible fraud, waste, and abuse. This program is designed to identify:

- Injured workers who appear to be abusing their medications or participating in fraudulent activities
- Prescribers who patterns indicate fraud or abuse
- Identity theft

Resources include data mining programs, use of proprietary FWA identification software, and special reports designed to allow the investigator to determine whether injured workers' or physicians' patterns are appropriate.

Advanced Analysis

Potentially fraudulent activity identified using the means listed above is the basis for our workers' compensation ongoing Fraud, Waste, and Abuse analytics. Express Scripts' SIU identifies prescribers and injured workers who appear to have aberrant utilization or prescribing patterns relative to their peers. These prescribers and injured workers will be compared to other injured workers and prescribers within the respective client's program as well as to the entire Express Scripts population. For flagged cases resulting from analytics, Express Scripts may contact the client to request medical claims or diagnosis to help substantiate or dismiss the allegation.

Express Scripts' FWA data mining and analytics is industry-leading and uses proven fraud identification techniques. Express Scripts constantly updates proactive analytical scenarios to remain current with evolving fraud scams. Focus areas include:

- Identification of possible drug seeking (injured worker doctor shopping)
- Controlled substance fraud and abuse
  - Overlapping therapies or inconsistent days supplies
  - Narcotic drug combinations
  - Patients exceeding maximum daily dosage
  - Physician overprescribing
  - Possible forged prescriptions
- Geographic concerns – patients travelling long distances to prescribers or pharmacies
- Regional/national prescription fraud and abuse trends

Ongoing data mining and analysis is performed throughout the year. It is important to note that any known fraud, waste, or abuse will be immediately reported to you. Investigative case updates and metrics are provided in a quarterly report. Reports are made available to the client no later than 45 days after the end of the quarter.

- *Annual Performance and Trending Report:* On an annual basis, Express Scripts will provide reporting that assesses our performance related to injured worker and physician proactive data mining and investigations. This report will include referral counts, referred dollars, case metrics, case outcomes, preliminary investigation results, and fraud tip line demographics.

Client Consultation and Collaboration

Express Scripts will seek to work in an ongoing collaborative manner with clients enrolled in the FWA program. Our clients have varying levels of investigational support, and therefore, we will seek guidance from our clients as to the desired level of collaboration. As part of the injured worker and physician FWA program, Express Scripts' Special Investigations Unit offers optional consultation calls, usually held three to five weeks after distribution of the quarterly update. During this call, investigators are available to discuss recommended actions on case referrals and current cases as needed to develop next steps.

Express Scripts will work directly with clients and members of law enforcement for reporting and investigative support as directed by our clients. Alternatively, Express Scripts will support clients that choose to work directly with these entities.

Report and auditing protocols will continually be refined to address the findings specific to the population. As more data becomes available, Express Scripts will strive to enhance the reporting and analysis efficiencies and will work with clients to meet their specific needs.

Investigative Procedures

Pharmacy Verifications

In cases where it is necessary to view actual hard copy prescription, Express Scripts' contractual relationship with the network pharmacies ensure necessary copies of documentation pertaining to the prescription submission, such as original hard copy prescriptions, signature logs, and compounding logs are provided when requested.

Physician Verifications

Similarly, it is sometimes necessary to obtain information from the original prescriber of the prescription in order to verify the accuracy of the prescription submitted by a pharmacy. In such cases, a letter is sent to the physician who was attributed to the prescription. The following are the main components of physician verifications:

- The validity of the entire prescription (e.g., is the injured worker a patient, did the prescriber write the prescription, etc.)
- Verification of prescription dates
- Quantities and strengths
- Authorization for generic dispensing, as allowed by plan design and state statues
- Dosage instructions
- Authorization for refills

Injured Worker Verifications

In certain cases, when directed by the client, Express Scripts can verify prescriptions with the injured worker in question. The standard injured worker verification procedure includes preparation of an injured worker's prescription drug file statement which lists all prescriptions processed by Express Scripts for the injured worker at specific pharmacies. The injured worker is requested to verify the prescriptions listed on the report and return in a prepaid envelope.

Injured worker verifications are typically performed in support of an investigation of identity theft. Information to be verified includes the date the prescription was received, drug received, and quality assurance data.

Fraud Tip Hotline

Express Scripts proactively solicits tips from injured workers, clients, claim adjusters, law enforcement officials and other sources. For example, www express-scripts.com for injured worker, Client and Pharmacy Portals include links that provide information on reporting FWA as well as a toll-free Fraud Tip Hotline number and a Fraud Tip e-mail address:

Phone: (866) 216-7096
E-Mail: FraudTip@express-scripts.com

Express Scripts documents each report of potential fraud, waste, and abuse received through these venues and the actions taken as a result of these reports.

(4) Describe the corrective action, monitoring and recovery efforts that take place when you find that a Pharmacy is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether you have a fraud and abuse unit within your organization and its role in the Pharmacy audit program. In the extreme case of potentially illegal activity, what procedures do you have in place to address illegal or criminal activities by the Pharmacy?

Express Scripts uses the following guidelines when assessing audit results.

Minor Infractions

We report minor infractions to the pharmacy owner, the district manager, or the chain headquarters audit contact. Minor infractions include:

- Keying errors
- Filing errors
- Infrequently recurring documentation errors

Beyond recovery of overpaid amounts and pharmacy education, further action is generally not required in these situations.

Significant Violations

We report significant violations to the pharmacy owner, district manager, or chain headquarters audit contact. Significant violations include:

- Overpaid claims resulting in large dollar recoveries
- Breaches of plan design parameters
- Statutory violations
- Widespread violations of the Pharmacy Provider Agreement

- Significant or high-volume prescription submission errors

We notify the pharmacy that good-faith efforts must be conducted to cure defaults. If issues are not corrected within 10 days of receipt of the written notice, Express Scripts has the right to terminate the pharmacy agreement. Such termination takes place not less than 30 days from the date of the termination notice. This process is also used for all breaches of the Pharmacy Provider Agreement.

Serious Violations

We report serious violations to the pharmacy owner, the district manager, or chain headquarters audit contact and, when appropriate, the relevant law enforcement officials. Serious violations of plan guidelines include fraudulent prescriptions. The Pharmacy Disciplinary Action Committee (PDAC) is responsible for ruling on recommended pharmacy actions, and recouping any overpaid funds. With the plan sponsor's knowledge, the pharmacy provider may be removed from Express Scripts' retail pharmacy network for very serious compliance issues or in cases of fraud.

(5) Provide a copy of the audit language that is contained in your standard contract(s) for Network Pharmacies.

[redacted]

(6) Confirm that the Offeror will fully cooperate with all Department, NYSIF and/or Office of the NYS Comptroller (OSC) audits, as described in RFP Section IV.B.11.a.(6) and (7) of this RFP, under the subheading "Pharmacy Audit."

Express Scripts agrees to let the Programs audit anything reasonably necessary to confirm compliance with the contract terms. Express Scripts, audits are based on actual claim discrepancies not samples or extrapolations, as outlined in the Exhibits Section of III. Administrative Proposal.

(7) Confirm that the Offeror will remit 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII.

Confirmed.

(8) Describe the Offeror's proposed auditing tools and performance measures for identifying fraud and abuse by Network Pharmacies and/or Enrollees.

Our proprietary audit algorithm involves a continuous automated review of the entire Express Scripts claims database, identifying outlier pharmacies and claims, as well as a variety of other audit procedures. The process involves:

- Importing pharmacy-level claims data by book of business
- Database queries for a multitude of dispensing indicators, including:
  - Average claim amounts
  - Quantity versus days' supply submission
  - Generic and brand fill rates
  - Proper use of DAW codes
  - Other variables
  - Identifying and ranking pharmacies based on dispensing indicators for initial fill and recurring refills
  - Review of pharmacies based on this initial analysis
  - Based on the report and proprietary queries, auditors determine if claims require further scrutiny.

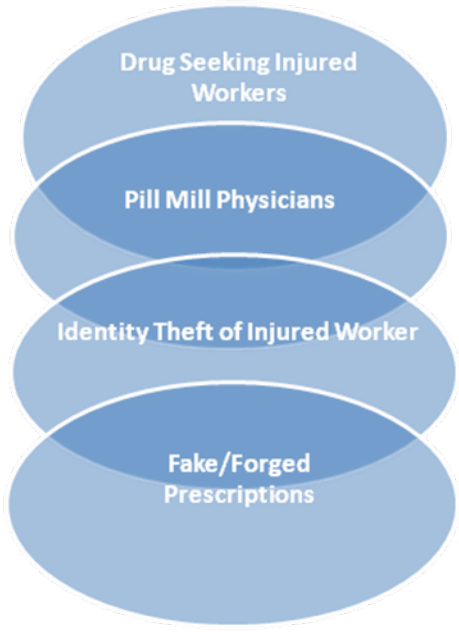
This tool's primary purpose is to aid in the selection of pharmacies for onsite audits. The program performs complex calculations on numerous data elements derived from our

data warehouse and calculates standard deviations from the norm for each data element analyzed. These individual standard deviations are then weighted and summed, resulting in an overall score from which confidential, pharmacy-specific rankings are produced.

Fraud and Abuse

Express Scripts fraud detection methodologies are proprietary and confidential. We continuously expand our analytics and case management system to assist in identifying potential fraudulent activities based on data trends, field and desk audit results, onsite investigations, and more.
In addition, we participate in drug tasks force groups that include diverse entities, such as health plans, government agencies, and law enforcement officials.

Express Scripts' ability to seamlessly monitor pharmacy, physician and patient patterns enables clients to reduce wasteful spending and risk associated with Fraud, Waste and Abuse (FWA). The Express Scripts FWA program integrates with our advanced clinical programs, such as Retro DUR and ScriptAlert, to identify potential issue patterns. Advanced analytics and a highly accredited team identify aberrant situations and personally investigate with the parties involved to determine whether a fraudulent activity is taking place. Partnering with our clients to resolve these issues speak to the model of Express Scripts business: Alignment with our clients.



Injured Worker #1 - Potential Drug Seeker

- October 2010 – September 2011: Obtained 75 pain or anxiety related medications from 44 MDs
- Injured worker rarely utilized the same prescriber within the year
- Majority of prescriptions obtained from different stores within one pharmacy chain
- Lack of physician-patient relationship
  - Two prescriptions received from physician with previous sanctions and disciplinary actions: ***Offense:*** *Professional Misconduct, Negligence, Incompetence, Substandard Care or Abuse of Patient*
- Utilized 7 different prescribers for 11 pain therapy medications in September 2011
- Enrolled in Commercial plan with Express Scripts; no claims processed within timeframe
- *Recommended further investigation for drug seeking behavior*

Total Prescription Exposure: **$1,671**	Potential Medical Exposure: **$66,840***

Injured Worker #2 - Potential Drug Seeker

- January 2010 – January 2011: 71 controlled substances, 41 prescribers, 15 pharmacies
- 29 total unique offices – 12 physicians in same office
- Small quantities prescribed with low day supplies
  - Average Day Supply: 9 days
- Frequent Emergency Room and Urgent care visits
- Six different prescribers within two months for Vicodin and Norco
- No consistent pain management regimen
- *Recommended further investigation for drug seeking behavior*

Total Prescription Exposure: **$4,897**	Potential Medical Exposure: **$200,777***

Injured Worker #3 - Potential Geographical Concern

- January 2010 – January 2011:
  - Injured worker receives controlled substances from prescribers & pharmacies in different states
    - Injured Worker in California
    - Prescribers in California, Arizona & Nevada
    - Pharmacies in California & Arizona
  - Consistent day supply and quantities across all controlled substances prescribed
  - Injured Worker fills new prescriptions within days from interstate prescribers
  - *Recommended further investigation to verify validity of prescriptions*

Total Prescription Exposure: **$7,300**	Potential Medical Exposure: **$299,300***

(9) Confirm that you will permit the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

Confirmed, provided that NYSIF selects an independent, objective, and unbiased third-party auditor that does not have a conflict of interest with Express Scripts or its affiliates, such as being associated with past or present litigation against Express Scripts. We require the auditor to sign a standard confidentiality agreement before conducting an audit. Express Scripts agrees to let the Programs audit anything reasonably necessary to confirm compliance with the contract terms.

Mail Service Pharmacy Process

The current Programs include a Mail Service Pharmacy Process by which Enrollees can obtain all Covered Drugs through the mail including any and all drugs that could be classified as Specialty Drugs/Medications or require special preparation or handling for enrollees who do not have the Specialty Pharmacy Program benefit. To fulfill this requirement, the Offeror may use compounding or specialty pharmacies provided that they meet all Mail Service pricing provisions and service standards with no additional steps or burdens placed on the Enrollee. Enrollees are entitled to fill Prescriptions for up to a ninety (90) day supply with refills up to one year. The Mail Service Copay (DCS only) shall apply when the Enrollee utilizes the Mail Service Pharmacy Process to obtain medications. Exhibit II.K of this RFP presents the mail service Prescription volume from October 1, 2010 through October 28, 2011.

a. Duties and Responsibilities

The Offeror must provide all aspects of Mail Service Pharmacy Process. Such responsibility shall include, but not be limited to:

(1) Having a fully staffed and fully operational Mail Service Pharmacy Process throughout the term of the resultant Agreements, utilizing one or more Mail Service Pharmacy Process Facilities meeting all New York State legal requirements. The Mail Service Pharmacy Process must be capable of dispensing all covered, FDA approved medications including any drug that could be classified as Specialty Drugs/Medications or requires special preparation or handling for up to a 90-day supply. Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs placing no additional steps or burdens on the Enrollee. Prescriptions are considered to be "submitted through the Mail Service Process" if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility, regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the Program based on the Offeror's mail service pricing terms and dispensing fees (if any) applicable to Brand Name, Generic, and Compound Drug claims as set forth in Exhibit V.A, including Specialty Drugs/Medications for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the Program based on the Offeror's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Exhibit V.A. The Mail Service Pharmacy Process shall apply the same

Programs' benefit design features as the Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Flexible Formulary and Preferred Drug List, and application of appropriate Copayments;

(2) Ensuring that all the Procuring Agencies' approved edits including, but not limited to, enforcing utilization edits (i.e. refill too soon, duplicate therapy, etc.) are built into the Prescription fulfillment system to protect an Enrollee's safety as well as to control Programs' costs;

(3) Ensuring that all Mail Service Pharmacy Process Facilities utilized in the Offeror's Mail Service Pharmacy Process meet all Prescription drug packaging regulatory requirements. Any facility located outside New York State that will provide service for the Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Mail Service Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law;

(4) Providing a simple, user friendly method(s) of ordering, reordering, or transferring Prescriptions from retail to mail. Maintaining a Dedicated Call Center located in the United States employing a staff of Pharmacists, and a staff of fully trained customer service representatives, and supervisors available 24 hours a day 365 Days a year that must meet the Offeror's proposed Mail Service Pharmacy Process guarantees set forth in Section IV.B.11.b.(19) and (20) of this RFP, under the subheading "Mail Service Pharmacy Process."

(a) The Offeror must have an integrated system for customer service staff to utilize to respond to, log and track all Enrollee inquiries. The system must create a record of the Enrollee contacting the call center, the call type and all customer service actions and resolutions.

(b) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints, and inquiries including but not limited to: Programs' benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services and complaints, and Flexible Formulary and Preferred Drug List alternatives. Callers must be able to reorder and check order status through both the customized website (DCS only) and the consolidated telephone line. Enrollees must also have access to their Prescription drug history file (both retail and mail) via the customized website;

(5) Providing pre-addressed, postage-paid mail service envelopes to Enrollees, health benefit administrators and for inclusion in Empire Plan publications, at the request of the State.

(6) Having efficient procedures in place to handle routine Prescriptions, "urgent" Prescriptions, and Prescriptions that require "special" handling (i.e. temperature control, limited shelf life, high cost, etc.);

(7) Providing standard mail service delivery using packaging that is appropriate for the drug dispensed and the address it is shipped to at no additional cost to the Programs or the Enrollee. Easy open caps also must be provided to Enrollees upon request at no additional cost;

(8) Having a system in place to track all Prescriptions (both intervention and non- intervention) received for processing through the Mail Service Pharmacy Process from the date the Prescription is received to the date the mailing agent picks up the package. The Offeror must also be able to track fill accuracy rates;

(9) Maintaining a process to collect information necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis;

(10) Maintaining a system that notifies Enrollees/Claimants about potential health and safety issues with their Prescriptions;

(11) Maintaining efficient procedures regarding inventory management of the Mail Service Pharmacy Process Facility(ies) including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.;

(12) Providing prompt notification to Enrollees regarding out of stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of generics instead of Brand drugs). In out of stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. If necessary, the Offeror shall call the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription.

If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription;

(13) (Exclusive to DCS) Calling the prescribing Physician when a DAW-1 is indicated on the Prescription to confirm that the Physician understands the financial impact to the Enrollee and/or the DCS Program to determine if the Physician is willing to allow the generic version of the drug to be dispensed to the Enrollee. If the Physician

was previously contacted regarding the same Prescription for a particular Brand Drug for the same Enrollee and required that the Brand Drug be dispensed, no call is required. If the Physician authorizes use of the generic version of the drug, a phone call shall be made to the Enrollee to advise of the approved change before the medication is shipped or the Offeror shall include a letter with the Prescription informing the Enrollee of their Physician's approval. If the Enrollee has indicated on the mail service order form that they do not wish their Physician to be contacted for such determinations, no call shall be made;

(14) (Exclusive to DCS) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments of the same medication that exceed the maximum amount specified. If the brand name drug is dispensed, the Offeror shall cause the dispensing facility to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program.

(15) (Exclusive to DCS) The Offeror is expected to assist Enrollees, upon request, to establish a payment plan so that Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Offeror's proposed maximum limits.

(16) Notifying the Procuring Agencies of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment;

(17) Utilizing best efforts to complete Physician clarification, verification, or other interventions within the five (5) Business Day service level standard. Should this require more than eight (8) Business Days, the Offeror shall call the Enrollee and offer the Enrollee the option of returning the prescription or continuing the intervention attempt;

(18) Ensuring that the consent of the Enrollee is obtained prior to calling the prescribing Physician with the exception of calls made for purposes of clarification, verification, settlement of other intervention claim issues or DAW-1 confirmations;

(19) Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Mail Service Pharmacy Process, including Enrollees taking injectable, infusion or other drugs requiring special handling or special administration;

(20) Having a back-up mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable;

(21) Promoting the utilization of the Mail Service Pharmacy Process through targeted mailings, Physician communications, etc., if the Department determines that such promotions are in the best financial interests of the Programs. All such activities, including mailings, are subject to change and require the prior written approval of the Procuring Agencies. Any regular direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone must be submitted for the Procuring Agencies' approval. The cost of any approved promotion shall be borne by the Offeror, unless the Procuring Agencies specifically request a particular activity not required to be performed under the resultant Agreements. The Procuring Agencies will not approve any mail order promotions that it determines will not result in a reduced net cost to the Programs;

(22) The Offeror shall act in the best interests of the Programs when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible;

(23) Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Non- Intervention Mail Service Prescriptions performance guarantee. The Program's service level standard requires at least ninety-five percent (95%) of all non- intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014, by the Mail Service Pharmacy, must be received by the mailing agent no later than Thursday, January 9, 2014; and

(24) Turnaround Time for Intervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Intervention Mail Service Prescriptions performance guarantee. The Programs service level standard requires at least ninety-five percent (95%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday,

January 6, 2014, by the Mail Service Pharmacy, must be received by the mailing agent no later than Tuesday, January 14, 2014.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.24 with the exception of a.18. We have provided clarifications to our approach to a.21 in our response to b.6, clarifications to our approach to a.22 in our response to b.19, and clarifications to our approach to a.23 in our response to b.20 in the DCS Technical Proposal binder. Please see our DCS-specific Technical Proposal binder for our response to items a.13, a.14, and a.15.

18) Not confirmed. Patient contact in trend only occurs on Call for Generics. Call for Generics is a soft block program where the originally prescribed product is covered but a less expensive alternative has been identified. Trend will outreach to the prescriber first to attempt to convert the medication, and then upon physician conversion reach out to the patient for their approval to change based on their prescribers recommendation. All other conversions do not require patient outreach which include Step Therapy, and Valsol. The patient is informed of the conversion with a letter.

b. Required Submission

(1) Identify and describe the facility(ies) that the Offeror will use in the Mail Service Pharmacy Process for the Programs including the following:

(a) Location(s) of all facilities owned, operated, or subcontracted by the Offeror that are capable of filling Prescriptions through the Mail Service Pharmacy Process including, but not limited to, any compounding or Specialty Pharmacies that fill or dispense Prescriptions through the mail;

Express Scripts Pharmacy locations include:

- Order-processing pharmacies in Albuquerque, New Mexico; Cincinnati, Ohio; Fort Worth, Texas; Philadelphia, Pennsylvania; St. Louis, Missouri; Phoenix, Arizona; and Troy, New York
- Dispensing pharmacies in St. Louis, Missouri and Phoenix, Arizona

Additionally, specialty prescriptions are dispensed from our eight CuraScript pharmacies in seven states: California, Delaware, Florida, Indiana, Nebraska, New York, and Texas. Specialty prescription processing occurs at these same sites, excluding Delaware.

Express Scripts uses enhanced fulfillment technology that dispenses and ships most prescriptions from the pharmacy closest to the member's mailing address. Some prescriptions, such as controlled substances, are not subject to this technology.

(b) Location(s) of all other facilities including, but not limited to, any compounding or Specialty Pharmacies that the Offeror is proposing to utilize in the normal course of the Mail Service Pharmacy Process to dispense all mail order Prescriptions to Enrollees;

In addition to the locations in our previous response, Express Scripts' specialty pharmacy subsidiary, CuraScript, is headquartered in Orlando, Florida, and operates specialty pharmacies in the following locations:

- Pleasanton, California
- New Castle, Delaware
- Oldsmar, Florida
- Orlando, Florida
- Louisville, Kentucky
- Byfield, Massachusetts
- Omaha, Nebraska
- Brewster, New York
- Pittsburgh, Pennsylvania
- Houston, Texas

Express Scripts' mail order pharmacies, fills most types of compound prescriptions, as noted in the following table. Express Scripts does not maintain separate compounding facilities.

Compounding Service	Express Scripts' Mail Pharmacy
Oral dosage type	All locations*
Topical dosage type	All locations*
Rectal dosage type	All locations
Injectable dosage type	Not offered**
Ophthalmic dosage type	Not offered**

* Excluding some estrogen compounding, per regulations
** This type of compounding requires a sterile environment

Due to the nature of compounding, no procedures in compounding areas are automated.

When Express Scripts receives a prescription for a compound drug, the pharmacist determines the components of the compound. If any of these items are not in stock, they are ordered for next-day delivery. A pharmacist then prepares the compound drug per the prescriber's specifications. Express Scripts packages the order for shipping, following the prescriber's specifications. If there are temperature-sensitive ingredients in the prescription, Express Scripts follows guidelines on shipping these items. Express Scripts sends the item to the injured worker with educational materials and standard forms.

Only pharmacists skilled in compounding are assigned to this area, along with technicians who are trained and closely supervised. Express Scripts maintains a formula and procedures file for all compound drugs to ensure consistent preparation at each fill. In addition, an independent lab analyzes a sample of compound prescriptions each month to confirm that Express Scripts has prepared the medications according to the prescriber's directions.

(c) Confirmation that the facilities listed in b.(1)(a) or (b) above that are utilized to fill any Enrollee Prescriptions submitted through the Mail Service Pharmacy Process will be priced in accordance with the Offeror's Guaranteed Mail Order Pharmacy Process pricing as proposed in Exhibit V.A;

Confirmed.

(d) The total capacity of all facilities identified in response to question (a) including, but not limited to the total number of scripts dispensed in 2011 and customers serviced. Describe any technology changes and/or staffing changes that would be necessary to service the Mail Service Pharmacy Process Prescription volume of the Programs;

The capacity and dispensing levels are provided below:

2012			
Pharmacy	Operating Level	Daily Capacity	Monthly Capacity
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

The operating level remained the same for both sites in 2011.

(e) Describe the backup mail order process facility(ies) that you would utilize to handle any overflow, out of stock situations and/or situations where the primary mail order facility is unavailable. Provide any other alternative methods you would utilize to meet the mail service Prescription drug delivery requirements of the Programs; and

Express Scripts actively manages workload volume within the Express Scripts Pharmacy to prevent delays. We carefully review client service agreements and work to maintain service levels within those boundaries. We also have the ability to adjust work flow and resources to balance unexpected increases in capacity. If needed, Express Scripts can extend shifts, increase the output of current shifts, or move work between various processing centers. At no point in our history have we invoked our business continuity plans for overflow processing from one facility to another.

Express Scripts uses a demand-forecasting system to manage purchases and inventory at Express Scripts' mail order pharmacies. Express Scripts keeps mail service pharmacies stocked with more than $100 million in medication, which enables us to fill more than 99% of prescriptions the day they come in to the pharmacy production area. The remaining prescriptions are generally filled the next day.

The Express Scripts Pharmacy stocks all formulary products. If a member sends in a prescription for a non-formulary medication that we do not stock, we generally obtain the medication if the client's benefit plan allows it. Some medications considered "limited distribution products" are available only from specific providers. When a member sends a prescription for a limited distribution product to the Express Scripts Pharmacy, we advise the member of ways to obtain

the drug.

f) Identify the facilities listed in b.(1)(a) or (b) above that have a commercial compounding license and indicate if they compound all drugs covered by the Programs. If there are any drugs that your facilities are unable to compound or do not compound, please detail the process you will utilize to provide Enrollees with access to all Compound Drugs through the Mail Service Pharmacy Process when the Prescription is submitted through the Mail Service Pharmacy Process.

Each Express Scripts mail order pharmacy is licensed for compounding as required by the regulations of the state in which the pharmacy is located. All Express Scripts mail order pharmacies perform compounding. The facilities listed in b.1.a and b above, have the compounding licenses required to fill the types of compound prescriptions shown in the following table:

Compounding Service	Express Scripts' Mail Pharmacy
Oral dosage type	All locations*
Topical dosage type	All locations*
Rectal dosage type	All locations
Injectable dosage type	Not offered**
Ophthalmic dosage type	Not offered**

* Excluding some estrogen compounding, per regulations
** This type of compounding requires a sterile environment

Compounds Requiring a Sterile Environment

While Express Scripts fills most compound prescriptions, most of our mail order locations do not fill orders for compounds that require a highly sterile environment, such as ophthalmic drugs. Select retail pharmacies do provide this service. Additionally, the Orlando, Florida, specialty mail order pharmacy maintains licensing to fill compounds requiring a sterile environment.

When Express Scripts receives a prescription for a compound drug that cannot be filled due to an issue such as compounding dosage type, Express Scripts returns the original prescription to the injured worker along with a letter detailing how they can make alternate arrangements for a fill.

(2) Provide a flow chart describing each step in the Mail Service Pharmacy Process taken prior to dispensing the medication. Describe the system edits for eligibility, prior authorization, utilization,

including refill too soon and duplicate therapy utilized to ensure Enrollee safety and Programs' cost control.

The Express Scripts Pharmacy blends advanced technology with pharmacist oversight to ensure quality dispensing. The Express Scripts Pharmacy achieves an accuracy rate greater than 99.99%, compared to an average retail pharmacy rate of 98.3%.

Data Entry and Drug Utilization Review

Our order processing system is a state-of-the-art imaging and workflow process that provides scanning capabilities and electronic workflow queues. This system provides an accurate and efficient environment and a foundation for future electronic prescribing.
As soon as we receive a patient's order, the prescription data is imaged and entered into the system. Data captured includes the injured worker's address, allergies, patient profile, and payment. When the data has been entered, our internal mail-order and online claim adjudication systems perform a series of edits, including:

- Drug utilization review – integrated with retail and Express Scripts Pharmacy prescriptions
- Formulary compliance
- Integrated claims processing edits such as eligibility confirmation and NYSIF's benefit plan design parameters

Upon completion of those processes, the order is forwarded to the appropriate area for processing or exception resolution. At exception resolution, a registered pharmacist reaches out to the prescribing physician as necessary to clarify missing information or discuss generic opportunities.

Pharmacist Oversight

Express Scripts supports the partnership of registered pharmacists and technicians throughout our dispensing process. We believe it is vital to have a registered pharmacist available in data entry, when we first review a prescription against an injured worker's history and the client's benefit design. It is also where we spot prescriptions that are illegible or missing vital information.

Express Scripts pharmacists also are in contact with physicians regarding 25% to 30% of all new prescriptions received. When the opportunity to convert a new prescription to a lower-cost drug exists, our pharmacists succeed more than 65% of the time.

Registered Pharmacist Verification

Each new prescription is verified by a registered pharmacist. The following data elements are checked against the image of the physician hard-copy prescription:

- Injured worker's name

- Injured worker's home and shipping address
- Drug prescribed
- Quantity prescribed
- Directions for use
- Prescribing physician
- Generic substitution requirements
- Date written

The verification pharmacist must check all of the above items for accuracy before sending the prescription to the pharmacy for dispensing. Each prescription record must be affirmed as "Approved by Pharmacist" in the injured worker profile before further processing of the prescription can occur.

Order Fulfillment Process

Dispensing

All dispensing occurs under the direct supervision of a registered pharmacist. Drug dispensing areas are designed to use the safest and most accurate system for the type of medication prescribed. More than 80% of all Express Scripts Pharmacy prescriptions are filled via the high-volume filler. Narcotics, controlled substances, compounds, and all other medications are dispensed from a secured manual dispensing area.
The high-volume filler labels the appropriate vial, dispenses the correct quantity and type of medication into the container, and captures a digital image of the bottle contents and label. Our pharmacists oversee the operation of the high-volume filler and its replenishment processes. This system has a 100% accuracy rate on specific drug selection.

Manual Fills

Our manual fill areas also include rigorous accuracy checks. Pharmacy technicians check the mail-packet order code with a hand-held scanner, which identifies the correct medication. The technician then scans the NDC bar code on the stock supply bottle. If the codes match, the system automatically generates a prescription label for the vial. This scanning system ensures that the right drug is selected and also records the pharmacy technician's ID numbers for accountability and quality control.

Controlled substances are dispensed manually using the same barcode technology described above in a secured area staffed by a limited group of registered pharmacists and technicians. The orders are filled, labeled, and sealed for shipping in packages that do not indicate that any type of medication is enclosed.

Pharmacist Inspection

All manually filled orders undergo a final inspection by a registered pharmacist at the manual inspection station. For additional quality control, a sampling of prescriptions filled by the high-volume filler is routinely routed to the manual inspection station. At this station, a pharmacist inspects each vial individually, including opening the vial to visually inspect the contents, thus ensuring the prescription has been filled correctly.
Each label is then scanned by the pharmacist to verify an order match. The pharmacist approves the order, recording his or her name for accountability, and sends the order on for shipment.

Conveyance to Shipping

Another order check takes place during conveyance to shipping. We confirm the order number, verify that all items in the order are present and filled, and confirm that all have passed inspection by the pharmacist. If any step has been skipped or if some drugs in the order are missing, the packet cannot be processed by the system. The order stops and returns to the appropriate processing point. This ensures that the injured worker receives a complete order that has passed our rigorous quality checks.

(3) (Exclusive to DCS) What steps would a member need to follow to establish their initial order and set up their billing account, when transitioning from the previous contractor's Mail Service Pharmacy? Describe the process that a member must follow when ordering, reordering Prescriptions via mail or moving Prescriptions from a retail Pharmacy to the Mail Service Pharmacy Process. How do you assist the Enrollee with this process?

Please see our DCS-specific Technical Proposal binder.

(4) Describe the capabilities of the Mail Service Pharmacy call tracking system.

Express Scripts strives to maximize the savings our clients can achieve through home delivery by proactively identifying injured workers who are ideal candidates for the service. Our Home Delivery Education program can be initiated as soon as the second refill, and includes the following steps:

1. Express Scripts identifies injured workers who continually refill prescriptions through the retail network when home delivery dispensing would be more appropriate.

2. After potential candidates are identified, Express Scripts will contact NYSIF for approval to contact the injured workers about moving their prescriptions to Express Scripts Workers' Compensation Home Delivery.

NYSIF can also choose to automate this process to provide additional ease of administration by eliminating the need for the claims staff approval to contact the injured worker. NYSIF would simply provide Express Scripts with a blanket approval on all identified home delivery candidates, bypassing Step 2.

3. Upon approval, Express Scripts sends a letter to the targeted injured workers, outlining the benefits of using home delivery. In addition, Express Scripts will call the injured worker to discuss the home delivery option, explain the benefits of the program, and inquire if Express Scripts can arrange to move their prescriptions from retail to home delivery. If the injured worker agrees, Express Scripts will contact the physician for the prescription.

4. The injured worker will receive the initial prescription approximately 10 to 14 business days after it is received by our home delivery pharmacy and will receive refills within three to five business days after the order is placed.

(5) Confirm that you will supply sufficient quantities of mail order forms and pre-paid envelopes to encourage mail service utilization.

Confirmed.

(6) Describe the process to be utilized to handle the following types of Prescriptions including any instructions provided to the Enrollee:

(a) Urgent Prescriptions; will there be additional handling or delivery costs for these Prescriptions?

Yes. In most cases, Express Scripts pays for shipping. However, member or injured workers who request rush delivery incur a charge of $21 per order.

(b) Prescriptions that require "special" handling (i.e., temperature control, special preparation, controlled substances, limited shelf life, etc.);

Refrigeration-required products need constant temperature control. These products include:

- Growth hormones
- Insulins
- Immunity-stimulation products
- Certain eye-care products

We keep these products in a refrigerated compartment in the pharmacy, removing them only for dispensing, packaging, and shipping. Prescriptions ship in insulated

containers with frozen gel blocks for sufficient cooling during the transportation process. Our patent-pending process leverages National Weather Service data to determine the appropriate number of ice packs for a given order.

There are possible exceptions affecting Home Delivery of certain medications at this time (see chart below for examples). These medications may be filled through Home Delivery from the Express Scripts Pharmacy, if you prefer. For information, contact an Express Scripts patient care advocate (PCA) at the toll-free number on the back of your member or injured worker ID card.

(c) Narcotics for the original fill for an Enrollee; and

Please see the chart in our response to the previous question.

(d) Prescriptions requested to be mailed in easy open caps;

Confirmed. NYSIF's injured workers can request non-child resistant caps on the home delivery order form.

(7) Please detail the system in place to track Prescriptions received through the Mail Service Pharmacy Process. Include the time from the receipt of the order until the delivery agent picks up the package. Specifically, detail how the actual date of receipt of the Prescription and the date the delivery agent picks up the package are recorded.

Express Scripts' state-of-the-art home delivery dispensing facilities allow for ease of processing as well as rigorous quality-control standards. All prescriptions filled through our home delivery services are verified against DCS and NYSIF's formulary edits and go through the following process:

Prescription Dispensing Process

- Order Receipt and Processing – Express Scripts offers several options for ordering and refilling prescriptions for both injured workers and physicians. Physicians can place initial orders by phone, mail, or dedicated fax line. Injured workers can place initial orders by mail. Refills can be placed by phone, mail, or online at Express-Scripts.com.
- Data Entry and Drug Utilization Review (DUR) – Express Scripts' order processing system is a state-of-the-art imaging and workflow process that provides scanning capabilities and electronic workflow queues. This system provides an accurate and efficient environment and a foundation for future electronic prescribing.
- As soon as we receive a Home Delivery request, prescription data is entered into the system. This includes the member or injured worker's address, allergies, and injured worker profile. When the data has been entered, a series of edits are performed:

- DUR, which is integrated with retail and Home Delivery prescriptions
- Inventory verification
- Claims processing audits, including eligibility confirmation and formulary parameters

Upon completion of these edits, the order is forwarded to the appropriate area for processing or exception resolution. Express Scripts supports the partnership of registered pharmacists and technicians throughout our dispensing process. We believe it is vital to have a registered pharmacist involved with the data entry process when we first review a prescription against a member or an injured worker's history and the client's formulary. At that point, we also screen for prescriptions that are illegible, missing vital information, or have other problems, triggering the need for an exception resolution. At exception resolution, a registered pharmacist will call the prescribing physician to clarify missing information or discuss generic opportunities.

- Registered Pharmacist Verification – Each new prescription is verified by a registered pharmacist. The following data elements are checked against the image of the physician hard-copy prescription:

Patient's name	**Directions for use**
Quantity prescribed	Prescribing physician
Drug Prescribed	Generic substitution requirements
Patient's home & shipping address	Date written

The verification pharmacist must check all of the above items for accuracy before the prescription may be dispensed in the pharmacy. Each prescription record must be marked "approved by pharmacist" in the member or injured worker's profile for further processing to occur.

- Dispensing – Dispensing is performed under the direct supervision of a registered pharmacist. Drug dispensing areas are designed to use the safest and most accurate system for the type of medication prescribed. More than 80% of all Home Delivery prescriptions are filled via the automated High-Volume Filler (HVF) System. Narcotics, controlled substances, compounding, and all other medications are dispensed from a secured manual dispensing area.

The HVF labels the appropriate vial, dispenses the correct quantity and type of medication into the container, then captures a digital image of the

contents to verify against a computer-generated reference image of the appearance of the medication. This automated process has led Express Scripts' pharmacies to achieve 99.99% accuracy in pharmaceutical dispensing.

Our manual fill areas also include rigorous accuracy checks. Pharmacy technicians check the mail-packet order code with a hand-held scanner that identifies the correct medication. The technician then scans the NDC barcode on the stock supply bottle. If the codes match, the scanning system automatically generates a prescription label for the vial. This scanning system ensures that the right drug is selected and also records the pharmacy technician's ID numbers for accountability.

Controlled substances are dispensed manually in a secured area, known as the "control cage". This area is staffed by a designated group of registered pharmacists and technicians who use the barcode technology described above. Orders are filled, labeled, and sealed for shipping in the "control cage" in packages that conceal the fact that the contents are a controlled substance or a prescription drug.

- Pharmacist Inspection – All manually filled orders undergo a final inspection by a registered pharmacist at the manual inspection station. For additional quality control, 5% of prescriptions filled by the HVF System are routinely routed to the manual inspection station. At this station, a pharmacist inspects each vial individually, including opening the vial to visually inspect the contents, ensuring the prescription has been filled correctly.

  Each label is then scanned by the pharmacist to verify an order match. The pharmacist approves the order, recording their name for accountability, and sends the order on for shipment.

- Conveyance to Shipping – Another order check takes place on the packet's journey to shipping. We confirm the order number, verify that all items in the order are present and filled, and confirm that the order has passed inspection by the pharmacist.

  If any step has been skipped or if some drugs in the order are missing, the packet is stopped and sent back to the appropriate processing point. This ensures that the injured worker receives a complete packet that has passed our rigorous quality checks.

- Packaging and Mailing – Shipping personnel perform a series of quality control edits. These edits monitor correct injured worker, correct quantity, current address, and resolution of all pharmacy-related issues. Upon verification, an address label is printed for placement on the shipping package. This step provides the final quality checkpoint.

We also produce a comprehensive mail packet. This packet includes a prescription order label, a refill notice indicating how many refills remain as well as the earliest refill date, a shipping label, patient advisory and educational inserts, and a customized message section designed specifically for that patient's prescription.

All prescriptions are shipped in tamper-deterrent packaging that bears no indication that medications are enclosed. The package proceeds to a manifest system that gauges weight and considers how long the order has been in processing, and then determines the most cost-effective, time-sensitive shipping option.

Express Scripts' standard methods of shipping, First Class and Priority U.S. mail, account for more than 99% of our orders. Packages up to two pounds are shipped U.S. Priority Mail. Those over two pounds are shipped on second-day status. Medications requiring refrigeration are shipped in cold packs using an expedited shipping method. There is no additional cost to the patient or client when such prescriptions are shipped on ice via overnight carrier. The patient is contacted and the overnight shipment is prearranged to ensure delivery. Expedited shipping is available at any time for an additional fee.

We carefully track all Express Scripts Pharmacy prescriptions, from receipt to shipping. For orders received by mail, we stamp the date of receipt on the front of the envelope. Faxes automatically capture a date and time stamp. We key prescriptions into the mail system during data entry. For orders received by mail or fax, we record the data entry date and time. Date and time information for electronic requests (Internet and IVR) is automatically logged. In all cases, we use the date and time stamp to calculate turnaround and processing times in order to better manage fulfillment.

(8) Please describe how your system tracks mail service fill accuracy rates including all error types tracked by the system. In addition, detail the error types your system reports and include a mail service fill accuracy report for 2011. How are member reported errors tracked and reported? What type of investigations and process modifications would you undertake to address accuracy errors that have the potential to critically impact the Enrollee's health and safety?

[redacted] This means that for every [redacted] prescriptions switched to our home delivery pharmacy, one clinically significant error is eliminated. To ensure we maintain high safety standards, we scan each prescription barcode six times throughout the dispensing process and double-check every step.

Because accuracy rates vary among our pharmacy sites by hundredths of a percentage point, we do not report the accuracy rate of each pharmacy separately. Also, because our dispensing accuracy rate consistently exceeds [redacted] each month, we provide formal error reporting only at year-end via the Performance Guarantee report. The accuracy rate is calculated based on total annual prescription pharmaceuticals dispensed by our home delivery pharmacy.

Dispensing Errors

If we dispense a prescription incorrectly, we consult with the patient and then send a new order via overnight mail at no charge. We also have the ability to send a prepaid envelope to the patient to facilitate return of the incorrect order.

Please note that many reported errors result from miscommunication between patients and their physicians. For example, when a physician authorizes a therapeutic or generic switch, we enclose a letter explaining the switch with the order. However, patients sometimes report errors because they have not read the letter.

Dispensing Errors 2011	
Type of Error	Percentage of Total Prescriptions
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Shipping Accuracy

[redacted] Orders shipped in error and damaged in shipment are not the financial responsibility of NYSIF. For lost orders, Express Scripts ships the prescription again and bills NYSIF for the replacement order. If the patient has not received the initial order after 30 days, we credit NYSIF.

(9) Please detail when a Prescription is designated as requiring intervention, and how the system tracks the point at which an intervention is deemed necessary. Describe how your system tracks these Prescriptions and calculates turnaround times for intervention claims. What is the definition of a Prescription that requires external intervention? Would that ever include a Prescription for a medication that is out of stock or a Prescription that has simply aged in the processing system?

Express Scripts defines Intervention and Clean as follows:

- Intervention Prescription — A prescription identified as needing additional information in order to process. Information must be obtained from an outside source (such as the prescriber).

- Clean Prescription — A prescription that has all the necessary information clearly provided so that the prescription can process without error messages.

The following table shows our turnaround times in 2011:

Average Turnaround Time in Business Days 2011			
Pharmacy	Average Turnaround Time (No Intervention)	Average Turnaround Time (Intervention)	Average Turnaround Time (All Prescriptions)
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

A medication that is out of stock, or an aged prescription in the system do not qualify as "Intervention Needed."

(10) Describe the process that you will utilize to provide Enrollees with access to Limited Distribution Drugs when the Prescription is submitted through the Mail Service Pharmacy Process.

CuraScript, Express Scripts' wholly owned specialty home delivery pharmacy, does not determine whether a drug is launched into an exclusive, limited, or open distribution channel. The Food and Drug Administration (FDA) makes this determination.
Factors that influence this decision include:

- Risk Evaluation and Mitigation Strategy (REMS) programs manage a known or potential risk associated with the drug to ensure that the benefits of the drug outweigh its risks. Through a REMS program, the FDA may require that pharmacies, practitioners, or healthcare settings that dispense the drug be certified. Additionally, a REMS may require a drug be distributed to patients only in certain healthcare settings, such as hospitals. CuraScript has experience successfully dispensing medications with REMS, as well as Risk Minimization Action Plans.
- The manufacturer may choose to designate the drug as limited distribution and may select one pharmacy (exclusive) or a small number (limited) to distribute the product based on the pharmacy's ability to support and manage the FDA requirements imposed on that product.
- Manufacturers may choose to limit drugs to select specialty pharmacies in order to monitor safety and usage of the medication. Manufacturers often choose limited distribution arrangements instead of open distribution arrangements for drugs identified as having orphan status (less than 200,000 patients that could be treated) or ultra-orphan status (less than 100,000 patients that could be treated).

To date, we have secured access to more than 97% of all specialty medications on the market. In most instances, prescribing physicians know which pharmacies have access to the limited distribution drugs. Thus, most prescriptions go directly to the appropriate pharmacy. However, if we receive a prescription for a product that we cannot access, we contact the prescribing physician and ask permission to forward the prescription to the appropriate pharmacy. We then fax the prescription to that pharmacy for the patient.
We work with manufacturers daily to acquire distribution rights for the full spectrum of specialty products.

(11) Please describe/present the process in place to ensure that Enrollees receive all necessary clinical information and support related to Prescriptions dispensed through the Mail Service Pharmacy Process. Please detail the role of licensed Pharmacists in the Mail Service Pharmacy Process clinical program. Is the process for providing clinical support to Enrollees utilizing the Mail Service Pharmacy Process integrated with or independent of the customer service call center?

Express Scripts offers an array of communication tools to educate NYSIF's injured workers about the pharmacy benefit plan, appropriate utilization, compliance, formularies, generic medications, and cost-effective therapy. These include:

- Blank Prescription Order Form — With each order, we provide injured workers a blank order form they can take to their doctor to fill out and fax to Express Scripts. The form is pre-populated with the injured worker's required identification and an assigned fax number where the doctor can submit the order. Once received, the doctor's origin is automatically verified.
- Patient Advisory Leaflet — We enclose educational literature with each prescription. We also include other materials relevant to the order or disease state when appropriate.
- Renewal Form — When we send the final refill of a medication, we also send a pre-printed renewal form containing patient, physician, and drug information that the injured worker can take to the physician. The physician then signs the form and faxes it to us.
- Drug Substitution Notices — We notify patients of physician-approved drug substitutions.
- Prescription Denied Letters — We send the injured worker a letter when a prescription fails drug utilization review edits at a fatal or hard-block level. In some cases, we also call the injured worker to discuss issues such as expired coverage or drugs not available.

- Other Letters — We send injured workers other informational letters as needed. For example, we notify injured workers if their medication changes appearance due to a change in generic manufacturer.

In addition, NYSIF's injured workers can interact with the Express Scripts Pharmacy via the Contact Center.

(12) Describe the process and channels (web, phone access, hard copy, etc.) you utilize to collect the information necessary to develop and maintain an Enrollee safety profile.

To facilitate mail service utilization, enrollees can access the Express Scripts mail service program 24 hours a day, seven days a week in three different ways—via mail, the website member portal, or via the toll-free contact center number. Once a profile is created, enrollees may submit a prescription using the pre-addressed postage paid mail envelope to be supplied by Express Scripts. The profile information required is:

- Enrollee's name, address, and phone number
- Enrollee's ID number
- Allergies, gender, and date of birth
- Physician's name and phone number
- Employer's name and group number
- Original written prescription(s)
- Preference to pay either by check, money order, credit card, or debit card, provided it is a national card (e.g., MasterCard or Visa)

In addition, enrollees may log onto the website and link to the www.express-scripts.com website to place an order. At their initial log on, they will need to provide profile information, such as information regarding health conditions, allergies, shipping information, and payment information. Profile information can be edited at any time.

(13) Describe your drug purchasing and inventory philosophy including:

(a) What are the time frames as they relate to back orders or shipment from an alternate mail order facility;

If an order is delayed in-house, Express Scripts ensures the member or injured worker has necessary medication by authorizing a 10-day supply at a retail pharmacy. Express Scripts flags the prescription as a rush order and ships it via express delivery at Express Scripts' expense.
Typically Express Scripts can obtain drugs from an alternative source within one to three days.

(b) What are the time frames as they relate to backorders or shipments that are from your primary supplier;

Please refer to the previous response; the process is the same. When Express Scripts' mail order pharmacies receive an order (new prescription) for a drug that is on manufacturer backorder or has been discontinued by the manufacturer, we will contact the patient to inform them of the situation. The following table outlines our process for following up with enrollees when handling backorders, including timeframes.

Reason for Intervention	Resolution
Backorder	• We can hold the prescription for five days to see if the medication comes in. • We can contact the patient's physician to obtain authorization for an alternative drug, if available. • We can return the prescription to the patient so the patient can attempt to obtain the medication at a retail pharmacy.
Discontinued	• We can contact the patient's physician to obtain authorization for an alternative drug, if available. • We can return the prescription to the patient.

All contact attempts, conversations, and actions taken will be recorded in our computer system. If contact attempts are unsuccessful, we will return the prescription to the injured worker with a letter of explanation.

(c) What is the percentage of Prescriptions that are filled when initially submitted to the primary mail service pharmacy facility you are proposing; and

Express Scripts uses a demand-forecasting system to manage purchases and inventory at Express Scripts' mail order pharmacies. Express Scripts keeps mail service pharmacies stocked with more than $100 million in medication, which enables us to fill more than [redacted] the day they come in to the pharmacy production area. The remaining prescriptions are generally filled the next day.

(d) How are backorders and out of stock situations handled with members?

When the Express Scripts Pharmacy receives a prescription for a drug that is on manufacturer backorder or has been discontinued, we hold and fill the prescription if the medication is expected at the pharmacy within five business days. If not, we attempt to contact the patient. If we reach the patient, we offer to contact the prescribing physician to discuss an alternate medication. If the patient declines, we return the prescription. If we are unable to reach the patient, Express Scripts reaches out to the physician to obtain authorization for an alternative drug, if available. If we are unable to fill the original prescription and the physician does not authorize an alternative drug, we return the prescription to the patient

with a letter of explanation. The patient can then attempt to obtain the medication at a retail pharmacy.

(14) (Exclusive to DCS) Describe your Enrollee communication process for out-of-stock items, partial fill orders, when an Enrollee appears to be ineligible, when there are changes to a Prescription that would result in Ancillary Charges, and when there are billing issues that prevent a Prescription from being immediately shipped. Confirm that the Offeror will arrange payment plans with Enrollees, on request.

Please see our DCS-specific Technical Proposal binder.

(15) New York State Law does not require, but permits substitution of B-rated or unrated generics. Will the Mail Service Pharmacy Process facilities utilized for the Programs fill a Prescription written for a Brand Drug with a B-rated or unrated Generic Drug or will the Enrollee have to obtain a Prescription from the prescribing Physician written for the B-rated or unrated Generic Drug in order to avoid receiving the Brand Drug and paying the higher Brand Drug Copayment?

Express Scripts does not substitute non-A-rated generics for brand drugs without prescriber authorization, even if the prescriber has indicated "substitution permitted" on the face of the prescription. If the patient wants to use a B-rated or unrated generic drug, then the patient will have to obtain a prescription written for the B-rated or unrated generic.

(16) Are there any situations where a Prescription written for a Brand Drug is submitted through the Mail Service Pharmacy Process and the Mail Service Pharmacy Process facilities utilized for the Programs are prevented from substituting an A-rated or authorized Generic Drug in accordance with the Programs' benefit design?

The FDA does not prohibit Express Scripts from substituting any drugs. However, it is Express Scripts' policy not to substitute drugs for patients on Synthroid, Lanoxin, and Levoxyl if the prescriber has indicated "dispense as written" on the face of the prescription. Please note that if a physician indicates "substitution permitted" on the face of a prescription for one of these drugs, Express Scripts dispenses a generic.

In addition, Express Scripts does not substitute non-A-rated generics for brand drugs without prescriber authorization, even if the prescriber has indicated "substitution permitted" on the face of the prescription. Express Scripts substitutes generic products according to state regulations and client plan design.

(17) Please describe how the Days supply is determined for the following forms of Prescription Drugs, dispensed by the Mail Service Pharmacy:

Eye/Ear Drops

Lotions and Ointments

Syrups

Eye/Ear drops: If a doctor puts specific directions, we can calculate the days supply by knowing how many drops are in the bottle (which we have for certain eye drops) or by using Industry standard of 16 drops per ml. We also have a calculator that the techs can use to determine quantity and days' supply.

Lotions and ointments: If the prescriber writes specific directions, we usually calculate by using 1g/dose/day standard. For example: TMC cream with directions to apply twice daily would result in the following formula: 2g/day X 30 days = 60 gm tube for 30 days.
Syrups: This depends on what the prescriber writes. If there are no specific directions, an outreach would be made on this.

(18) Please describe what proposed strategies you would implement with your Mail Service Pharmacy to compete with Low-Cost 30 and 90 Day programs offered by Retail Pharmacies?

Our mail pricing includes hundreds of items that offer 90 days supplies for $10 or less, which is a better value than is typically offered by retail store programs for low-cost generics. Not all items that are on every retail low-cost generic program are as deeply discounted at mail because many of the retail items are not maintenance medications and each retail pharmacy offers deep discounting on different items. The low-cost generics in our mail pricing vary over time in response to market conditions. The value of deeply discounted generics is built into the aggregate discount guarantees.

(19) Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee: The Programs' service level standard requires that at least ninety-five percent (95%) of all non-intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee, for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below the ninety-five percent (95%) of all non intervention mail service Prescriptions not turned around within two (2) Business Days, is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-five percent (95%) (or the Offeror's proposed guarantee) of all non-intervention mail service Prescriptions not turned around within two (2) Business Days, calculated on a quarterly basis, is $ for DCS and $ for NYSIF.

(20) Turnaround Time for Intervention Mail Service Prescriptions Guarantee: The Programs' service level standard requires that at least ninety-five percent (95%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the date the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below the ninety-five percent (95%) of all intervention mail service Prescriptions not turned around within five (5) Business Days is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-five percent (95%) (or the Offeror's proposed guarantee) of all intervention mail service Prescriptions not turned around within five (5) Business Days, calculated on a quarterly basis, is $ for DCS and $ for NYSIF.

[redacted]

Specialty Drugs/Medications

The Programs provide coverage for Medically Necessary Drugs including Specialty Drugs/ Medications. Specific to the DCS Program, drugs dispensed and billed by a Physician's office or drugs dispensed in a hospital setting are not the responsibility of the DCS Program and are covered under the Medical or Hospital portion of The Empire Plan.

Enrollees in most Employee groups receive Specialty Drugs/Medications benefits through the Specialty Pharmacy Program. All other Enrollees receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process. See Exhibit II.C for a breakdown of groups that participate in the Specialty Pharmacy Program and those that receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process.

Specialty Drugs/Medications Received Through the Retail Pharmacy Network or the Mail Service Pharmacy Process

For those groups that receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process, the Programs make no distinction for Specialty Drugs/Medications for pricing purposes and the Offeror is strictly prohibited from proposing an alternative pricing arrangement for any FDA approved drug or class of drugs. All drugs shall be classified as either brand name, generic, or compound for pricing purposes based on the methodologies set forth in Section V of this RFP. Proposals that exclude Specialty Drugs/Medications from proposed pricing for brand name, generic and Compound Drugs, whether by omission or by the submission of an alternate pricing proposal will be removed from consideration. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications.

a. Duties and Responsibilities

(1) The Offeror must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications covered by the Programs through its proposed Retail Pharmacy Network and through the Mail Service Pharmacy Process in accordance with each Enrollee group benefit design as set forth in Exhibit II.C. In the case of Limited Distribution Drugs, the Offeror shall provide Enrollees with access in accordance with the following:

(a) Retail Pharmacy Network Access

The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs

consistent with the Offeror's contracted discount off of AWP for the Limited Distribution Drug, plus any dispensing fee.

The Enrollee shall be charged the applicable retail Copayment.

(b) Mail Service Pharmacy Process Access

The Offeror must facilitate the Enrollee's receipt of the Limited Distribution Drug. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable mail order Copayment.

(2) (Exclusive to DCS) Individuals receiving home infusion services through the Home Care Advocacy Program (HCAP), a component of The Empire Plan's Medical/Surgical Program, have their home infusion drugs covered under the Prescription Drug Program.

Currently the DCS Program has a network of licensed pharmacies affiliated with home care agencies participating in The Empire Plan's HCAP Program administered by The Empire Plan's medical carrier. The Offeror is expected to secure contracts with the licensed pharmacies provided in Exhibit II.E.3 of this RFP to ensure continued utilization of a network Prescription drug benefit for those Enrollees utilizing the HCAP Program. An Offeror may propose to utilize entities owned by or affiliated with the Offeror to serve as an HCAP Provider. The Department at its sole discretion shall determine whether it is in the best interests of the DCS Program to allow the entity to participate in the HCAP Program. The Prescription drugs dispensed to Enrollees via the entities or pharmacies owned by or affiliated with the Offeror must be charged to the DCS Program based on the Offeror's mail service pricing terms and dispensing fees applicable to brand name, generic, and Compound Drug claims as proposed in Exhibit V.A.

Express Scripts agrees to the duties and responsibilities set forth in item a.1. Please see our DCS-specific Technical Proposal binder for our response to items a.2.

b. Required Submission

(1) Explain how your proposed network provides access to all medically necessary covered Specialty Drugs/Medications.

NYSIF has the option to allow dispensing at retail or requiring that the medication be filled at CuraScript.

(2) Explain the mechanisms in place to facilitate the delivery of Limited Distribution Drugs to Enrollees. Confirm that Enrollees will be charged the Mail Service copayment for Limited Distribution Drugs submitted to the Mail Service Pharmacy (DCS only).

Please see our DCS-specific Technical Proposal binder.

(3) (Exclusive to DCS) Confirm that you will solicit participation in the Retail Pharmacy Network all licensed pharmacies affiliated with the Empire Plan Home Care Advocacy Program. Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical insurer.

Please see our DCS-specific Technical Proposal binder.

(4) (Exclusive to DCS) For those HCAP providers that do not have affiliated pharmacies, how do you propose coordinating with HCAP and supplying the medication to the Enrollee? Will you utilize the Mail Service Pharmacy Process?

Please see our DCS-specific Technical Proposal binder.

(5) Confirm that necessary ancillary supplies that accompany certain Specialty Drugs/Medications will be delivered to the Enrollee at no additional cost to the Programs or Enrollee.

Ancillary supplies including syringes, alcohol pads, needles, tubing, and solutions, are provided at no cost. Sharps containers are available at no cost upon request. For the majority of specialty drugs, Express Scripts' specialty pharmacy has developed supply kits that are included with the medication. When the prescription line for the drug is entered into the adjudication system, an additional line is added for the supply kit. Express Scripts contacts the injured worker prior to delivery and discusses any injured worker needs for an additional sharps container or other supplies. Express Scripts ships needles in the manufacturer‘s package with caps; they would be included with the Styrofoam cooler for refrigerated products or the cardboard shipper for non-refrigerated drugs. We provide ancillary supplies, including syringes, alcohol pads, needles, tubing, and solutions, at no cost. Sharps containers also are available at no charge upon request.

(6) Indicate the licensed pharmacies in Exhibit II.E.3 with whom you have a current Network Pharmacy contract.

We have a current Network Pharmacy contract with the following licensed pharmacies listed in Exhibit II.E.3:

Specialty Pharmacy Program

NYSIF Claimants and most DCS Program Employee groups participate in the Specialty Pharmacy Program, which provides an enhanced level of clinical management for Enrollees taking Specialty Drugs/Medications. Under the current plan design, after the first Specialty Drug/Medication Prescription is filled through either the Retail or Mail Service Pharmacy, future fills are subject to a Hard Edit (DCS only), meaning that Enrollees are required to obtain the drug through the Specialty Pharmacy Process, subject to the mail service copayment (DCS only) when dispensed by the designated Specialty Pharmacy. In addition to the first fill at Retail, certain Specialty Drugs/Medications available through the Specialty Pharmacy Program are also available through the Retail Pharmacy Network, because of their clinical requirements and/or urgent dispensing timeframe. All Specialty Drugs/Medications filled at a Retail Pharmacy Network are subject to the Retail Network Pharmacy Pass-through Pricing and Copayments (DCS only). For those drugs available only through the Specialty Pharmacy Program, the Offeror may propose dispensing fees on a drug by drug basis, commensurate with the clinical services provided for each. All drugs shall be classified as either Brand name, Generic, or Compound for pricing purposes based on the methodologies set forth in Section V of this RFP. The Program shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications Drugs to be included in the Specialty Pharmacy Program, Specialty Drugs/Medications are:

1 **"orphan drugs";**

2. **drugs requiring special handling, special administration and/or intensive Enrollee monitoring/testing;**

3. **biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or,**

4. **other drugs identified by the Programs as used to treat Enrollees with chronic or life threatening diseases.**

The Offeror must provide a Special Pharmacy Program where Enrollees receive their Specialty Drugs/Medications through one or more designated pharmacies that offer enhanced clinical management. The process must provide extensive clinical support in the most cost effective manner possible for the Programs.

a. Duties and Responsibilities

The Offeror must provide all aspects of the Specialty Pharmacy Program. Such responsibility must include, but not be limited to:

(1) Developing a listing of the Specialty Drugs/Medications proposed for

inclusion in the Specialty Pharmacy Program;

(2) Having a fully staffed and fully operational Specialty Pharmacy Program in which Specialty Drugs/Medications are provided by one or more Designated Specialty Pharmacies. All Designated Specialty Pharmacies must meet all New York State legal requirements. Any facility located outside New York State that will provide service for the Programs must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Specialty Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law.

(3) The Offeror must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable retail Copayment.

(4) Providing a fully staffed and fully operational customer support call center available to Enrollees 24 hours a day, 365 Days a year including Pharmacists, clinicians, and registered nurses trained in an Enrollee's specific Specialty Drug/Medication therapies. The Offeror must provide callers with access to customer service staff and Pharmacists through The Empire Plan consolidated line and the NYSIF Program toll-free line who are able to respond timely to questions, complaints and inquiries including but not limited to: Programs' benefit inquiries, refills, order status, price estimates, billing, point of service issues, Specialty Pharmacy Process complaints, preferred drug status, and claim status. Callers must be able to reorder and check order status through both the customized website (DCS only) and the Programs' telephone lines. Enrollees must also have web access to their Prescription drug history file (retail, mail, and specialty) via a customized website (DCS only).

(5) Administering a safety monitoring system that complies with the Food and Drug Administration (FDA) Amendments Act of 2007 which requires a Risk Evaluation and Mitigation Strategy (REMS) from the Specialty Drugs/Medications manufacturers to ensure the benefits of a drug outweigh its risks.

(6) (Exclusive to DCS) Contracting a nationwide network of appropriately licensed clinicians and/or coordinating with appropriately trained HCAP clinicians to administer the Specialty Drugs/Medications to Enrollees in a home setting and providing Enrollees with education on proper treatment regimens and possible side effects.

(7) Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis.

`(8) Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Specialty Pharmacy Process, including but not limited to explaining the treatment plan and ancillary supplies, disease/drug education, side- effect management, compliance management and administration training.

(9) Applying the same Programs' benefit design features as the Mail Service Pharmacy Process, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Preferred Drug List, and application of appropriate Copayments (DCS only). Specialty Drugs/Medications that are subject to the Designated Specialty Pharmacy Passive Edit and are dispensed at a Network Pharmacy must be subject to the Network Pharmacy Copayments (DCS only).

(10) Ensuring that all the Procuring Agencies' approved edits including, but not limited to, enforcing utilization edits (e.g. refill too soon, duplicate therapy, etc.) are built into the Prescription fulfillment process system to protect an Enrollees safety as well as to control Programs' costs.

(11) Ensuring that all Designated Specialty Pharmacies utilized in the Offeror's Specialty Pharmacy Program meet all Prescription drug packaging regulatory requirements.

The Offeror must ensure that Specialty Drugs/Medications are shipped to Enrollees in appropriate packing materials so that Specialty Drugs/Medications are safe and effective and delivered on time.

(12) Providing a simple, user friendly method(s) of ordering, reordering, and transferring Prescriptions from the retail and mail setting to the Designated Specialty Pharmacy(ies) including pre-addressed postage paid Specialty Pharmacy Program envelopes. The Offeror must send a Specialty Pharmacy Program letter to Enrollees who have received a First Fill of a Specialty Drug/Medication through a Network Pharmacy. The letters must be sent within seven (7) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Hard Edit (DCS Only) and within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Period for Specialty Drugs/Medications.

(13) Maintaining a comprehensive system for the Offeror's staff to utilize to track all Enrollee inquiries including, but not limited to: Programs' benefits, refills, order and claim status, prices, billing, Preferred Drug

List inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions, and resolutions.

(14) Having a system in place to track all Prescriptions received for processing through the Specialty Pharmacy Process from the date the Prescription is received to the date the Prescription is shipped. The Offeror must also be able to track fill accuracy rates.

(15) Maintaining a process to collect information from individuals necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

(16) Ensuring that the Designated Specialty Pharmacy(ies) have efficient procedures regarding inventory management including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.

(17) Providing notification to Enrollees as soon as possible for out of stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out of stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Offeror must contact the Enrollee's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription.

(18) (Exclusive to DCS) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Specialty Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Designated Specialty Pharmacy will not be required to inform an Enrollee if there is a consistent history of the acceptance of shipments of the same medication that exceed the $100 amount specified.

(19) (Exclusive to DCS) The Offeror is expected to assist Enrollees, upon request, to establish a payment plan so that Specialty Drug/Medication Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Offeror's proposed maximum limits.

(20) Promptly notifying the State of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment.

(21) Having back-up Designated Specialty Pharmacies to handle any

overflow and/or situations where the primary Specialty Program facility is unavailable.

(22) (Exclusive to DCS) The mail order Copayment shall apply to all drugs dispensed through the Specialty Pharmacy Program as well as Limited Distribution Drugs facilitated through the Special Pharmacy Program.

(23) Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the Procuring Agencies. Prior to inclusion in the Programs, or if not accepted by the Procuring Agencies to be included in the Programs, the Offeror must bill the Programs for these Prescriptions consistent with the Offeror's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs/Medications shall have a cost-neutral or positive financial impact on the Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the Program exceed the Guaranteed Discount on Specialty Pharmacy Drugs.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.23, with the exceptions of a.4, for which we have provided clarifications to our approach to a.4 in our response to b.2.e.; and for a.17 to which we have provided modifications to the language shown below as well as clarifications to our approach in the response to b.4. in the DCS Technical Proposal binder. Please see our DCS-specific Technical Proposal binder for our response to items a.6, a.18, a.19, and a.22.

We define specialty drugs as covered drugs that are typically high cost and have one or more of the following characteristics:

- Complex therapies for complex diseases
- Requires frequent dosing adjustments and has a high potential for significant waste
- Specialized patient training and coordination of care (services, supplies, devices) required prior to therapy initiation and during therapy
- Unique patient compliance and/or clinical safety monitoring requirements
- Limited or exclusive product availability and distribution
- Unique requirements for handling, shipping, and storage

Additionally, if an innovator drug has been deemed a specialty drug, the generic equivalent or biologic follow-on will be included as a specialty drug.

17) Express Scripts agrees to the requirement as written below:

Providing notification to Enrollees as soon as possible for out of stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out of stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Offeror must contact the Enrollee's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, verbal communication will be provided to the Enrollee of the change before the medication is shipped.

b. Required Submission

(1) Provide a listing of the Specialty Drugs/Medications that you propose for inclusion in the Specialty Pharmacy Program, along with an indication of how they meet the minimum criteria. Also, please state if you propose additional criteria. Please state whether the Designated Specialty Pharmacy(ies) you propose regularly dispense any other Specialty Drugs/Medications which you are not proposing for the Programs.

Please refer to our DCS-specific Technical Proposal binder for our Specialty List. We have developed clear parameters to define specialty drugs, an important step that sets us apart in the industry. We define specialty drugs as those products that typically have one or more of several key characteristics, including:

- Limited or exclusive product availability and distribution
- Frequent dosing adjustments and intensive clinical monitoring
- Intensive patient training and adherence assistance to facilitate therapeutic goals
- Specialized product handling, administration requirements, cost in excess of $500 for a 30-day supply, or a combination of these considerations

Formulary Drug Selection and Approval Process

In addition, Express' Scripts formulary development process for specialty medications calls for a focus on clinical factors, with financial considerations coming into play only among clinically comparable or optional products. This results in clinically sound, cost-effective formularies for our plan sponsors and their patients. Our process involves three committees:

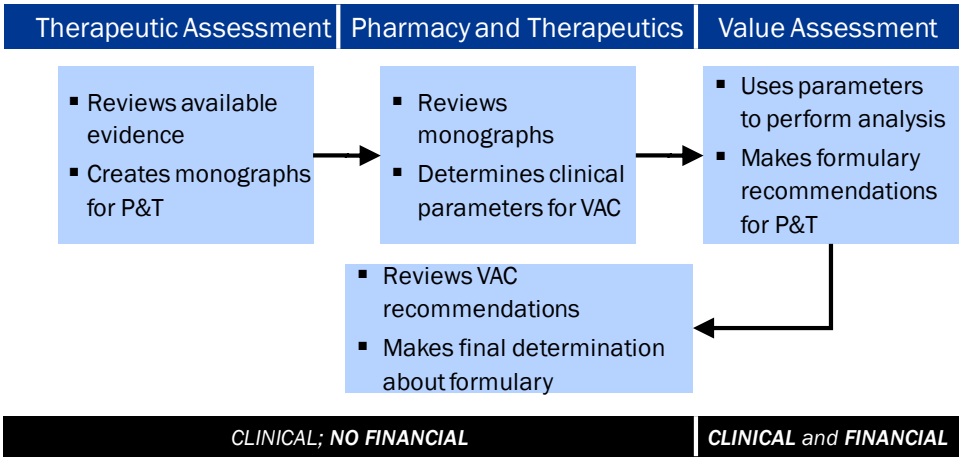
1. Therapeutic Assessment Committee, which reviews drugs based on clinical attributes. This committee includes the Office of Clinical Evaluation & Policy's vice president and medical director, the director of the Drug Evaluation Unit, and nine additional clinical pharmacists who represent areas such as product

management, account services, emerging therapeutics, clinical programs, specialty pharmacy, and utilization management services.

2. National Pharmacy & Therapeutics Committee, a fully independent body that makes final formulary determinations. The committee comprises 18 independent physicians and one independent pharmacist who are not employed by Express Scripts. Committee members ensure Express Scripts formularies remain CMS-compliant.

3. Value Assessment Committee, which evaluates the net cost of drugs to Express Scripts, our plan sponsors, and their members. This committee includes representatives from product management, formulary management, rebate, finance, and account management who evaluate current and future market dynamics, economic considerations, and client needs.

The following illustrates the formulary development process and the roles of these committees:



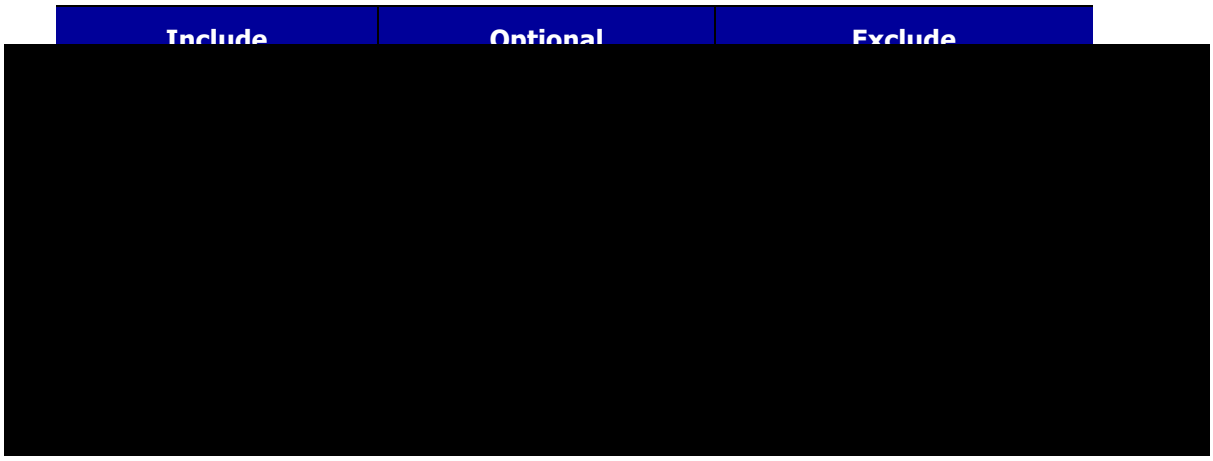
As illustrated, our Pharmacy & Therapeutics Committee is insulated from financial considerations and has ultimate authority in our formulary development process.

Formulary Committees

The following table details the composition and responsibilities of each committee involved in the formulary development process.

Formulary Evaluation Designations — Include, Optional, Exclude

Each drug evaluated for inclusion on our standard formularies receives one of three designations: include, optional, or exclude. Criteria for each designation follow:



(2) Provide a detailed description of your proposed Specialty Pharmacy Program. Include the following:

(a) Customer service call center

Injured workers with questions related to specialty medications contact the Contact Center—there is not a separate number for specialty inquiries. When an

injured worker calls the Contact Center, our online inquiry system notifies the patient care advocate whether the injured worker has a specialty medication prescription. If so, the advocate then transfers the call to our specialty Contact Center for personalized clinical assistance. By offering this coordinated patient experience, we enable greater first call resolution for injured workers.

Our two Contact Centers in Orlando, Florida and Indianapolis, Indiana, are dedicated solely to injured workers taking specialty medications. [redacted]

We utilize multi-level staffing models based on job functions and productivity rates to maintain ample staffing levels. Our patient care advocates manage outbound and inbound calls with injured workers, physicians, providers, and other entities. As appropriate, advocates route to nurse, pharmacist, or social worker staff. Our knowledgeable advocates have injured worker-specific information readily available, as well as procedural information, real-time global service updates, and other client-specific data.

Hours of Operation

Our specialty Contact Centers operate Monday to Friday, 8 a.m. to 10 p.m. Eastern Time; Saturday, 9 a.m. to 1 p.m. Eastern Time; and Sunday, 8 a.m. to 4:30 p.m., Eastern Time. Contact Centers are closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

After-hours calls are routed to an answering service. Live agents manage these calls through our on-call customer service lead personnel and clinical staff. Clinical staff, accessible 24 hours a day through a pager and auto-generated e-mail system, assist for medical intervention and emergency refills. All non-emergency calls are logged and a specialty patient care advocate contacts each caller the following business day.

(b) Administration of REMS

This does not apply to Workers' Compensation.

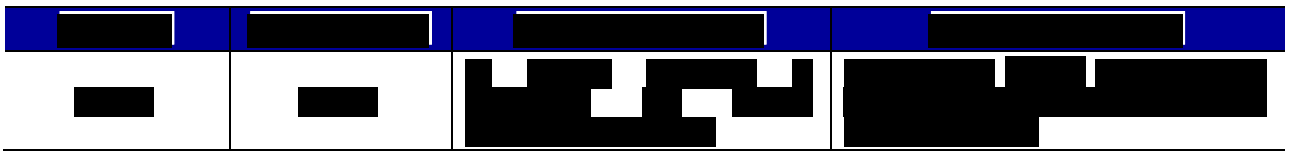
(c) (Exclusive to DCS) Whether Specialty Drugs/Medications administration will be through HCAP or a Specialty Pharmacy Program contracted network

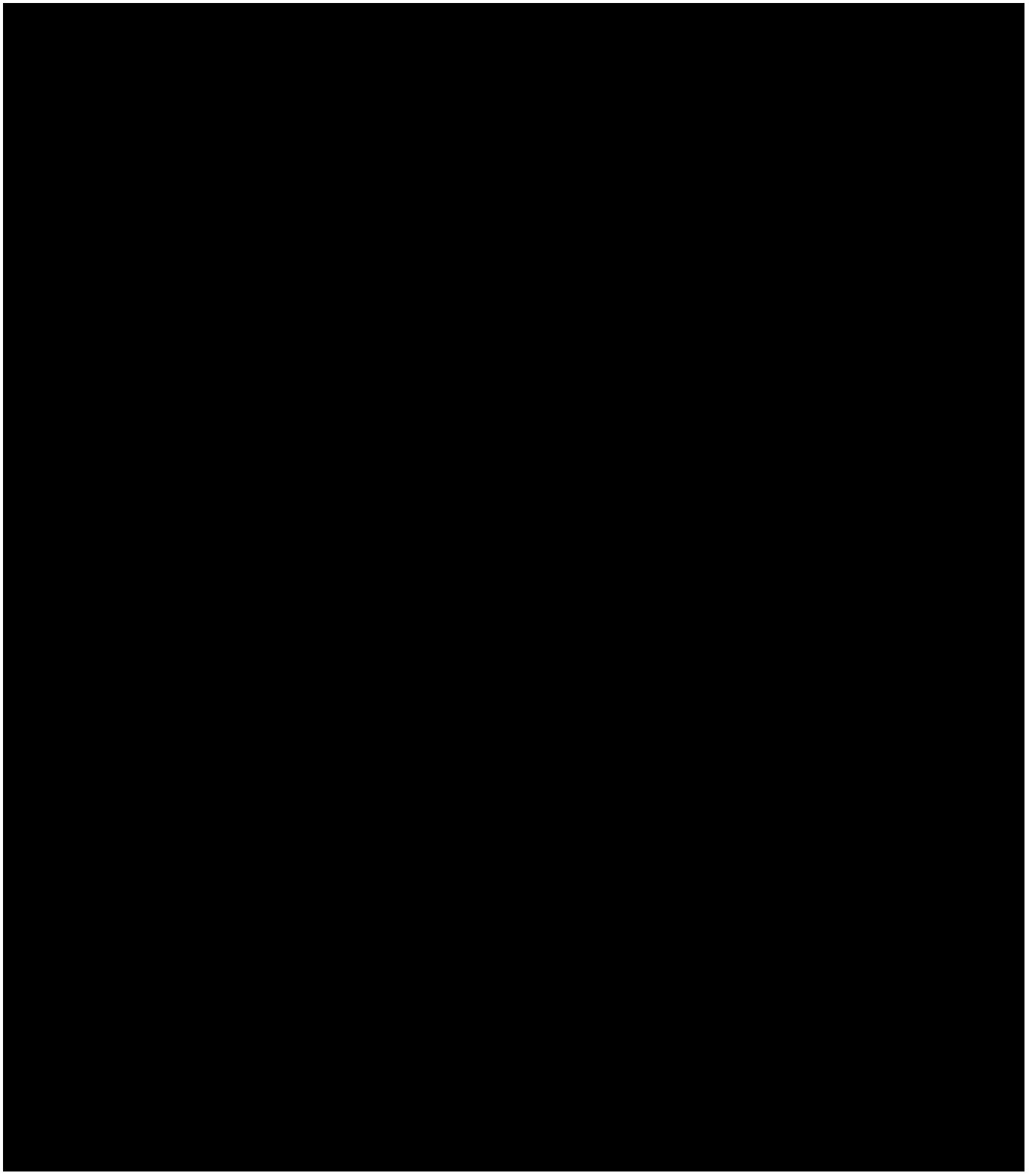
d) Clinical management, including demonstration of outcomes improvement

[redacted]

[redacted]

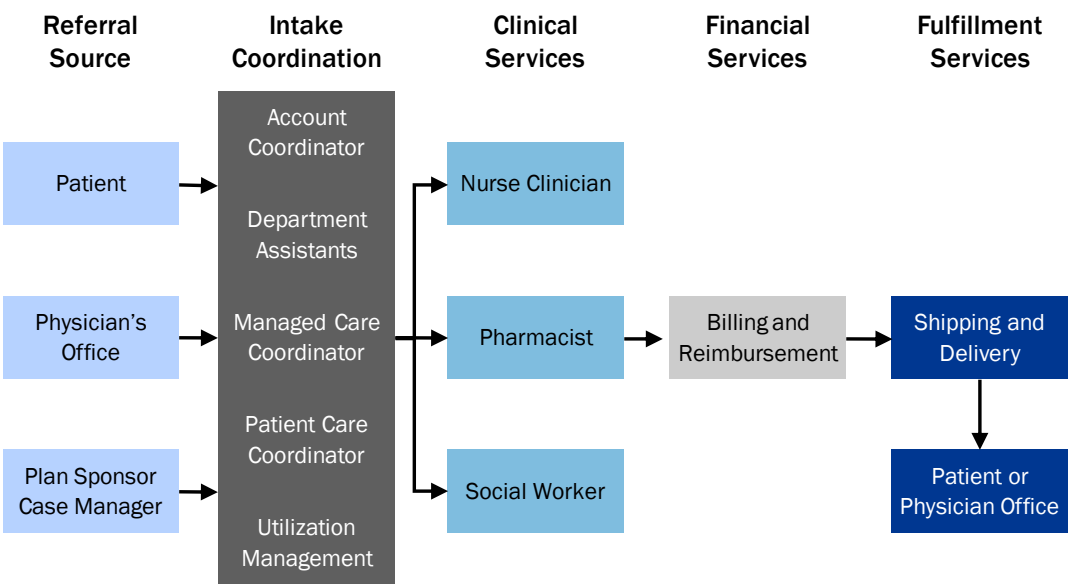
[redacted]





(e) Fulfillment process, including cold-chain supply and shipping logistics

CuraScript's streamlined dispensing process is accurate from the initial patient referral to the delivery of the patient's medications. We work with physicians to obtain patient prescriptions from the time we receive the initial referral. Based on the need-by date, our scheduled delivery turnaround time averages less than 24 hours on "clean" prescriptions — those that are legible and do not require further information — and approximately 48 hours on prescriptions needing further clarification. The illustration below depicts the dispensing process:



Referral Source

CuraScript receives patient referrals from physicians, clinics, patients, plan sponsors, and case managers. Once we receive a referral, we handle all coordination and benefit verification responsibilities for patients and their treating physicians. Physicians may phone or fax referrals via dedicated, toll-free numbers.

Intake Coordination

After referral information is entered, admissions coordinators perform the following tasks:

- Obtain each patient's demographic information
- Verify eligibility and obtain required Prior Authorizations and medical necessity documentation
- Research third-party reimbursement and communicate the findings to the appropriate parties
- Coordinate the initial delivery of the specialty medication with the patient
- Contact the patient to explain CuraScript's services, collect medication history, and assess the patient's knowledge regarding the proper use of the specialty medication.

After the patient has been introduced to the specialty program, patient care advocates support them throughout the course of treatment, coordinating delivery and monitoring adherence. Our patient care advocates' assistance leads to successful therapy results.

Clinical Services

Patient care advocates link injured workers to our experienced clinical intervention team, which is composed of nurses, social workers, and pharmacists. The clinical intervention team provides comprehensive assessments and adherence support to all patients while paying special attention to patients enrolled in our Specialty Care Management programs.

Financial Services

If necessary, CuraScript assists patients in researching and obtaining additional funding for their specialty prescriptions. When patients are unable to locate and obtain financial assistance, they often become non-adherent, resulting in increased use of inpatient and outpatient healthcare services. To avoid this, we provide value-added services designed to assist patients with their insurance coverage and financial liability concerns. Our specialized financial services team investigates insurance issues, manages Prior Authorization, researches secondary coverage, and provides billing services.

Fulfillment Services

After the intake process is complete and a pharmacist has approved the patient's specialty medication prescription, the order is electronically sent to CuraScript's pharmacy for fulfillment and a final check. Once the specialty medication order has been fulfilled, it is packaged, labeled, manifested, and shipped to the patient's address or the physician's office, as specified by the patient or the treating physician.

Specialty Shipping

CuraScript primarily uses UPS and FedEx for shipments from our main distributions centers in Orlando and New Castle. CuraScript's order processing system pulls and stores tracking information into each order's record. Our system also allows employees access to the shipping website for real-time shipment data. All deliveries require a verification receipt unless the patient approves otherwise.

Temperature-Sensitive Products

Each medication is categorized in our information system as "refrigerated" or "not refrigerated" based upon scientific literature, manufacturer recommendations, and product labeling. We ship temperature-controlled medications in insulated mailers with frozen or refrigerated ice packs to protect the medication throughout the delivery process. Orders are shipped using next-day or second-day delivery, taking into consideration the travel time and delivery date of the medication and the forecasted temperatures at both our pharmacy and at the delivery address.

Shipping Containers

CuraScript carefully packages and ships every medication with the utmost consideration for maintaining product integrity. We ship temperature-controlled

medications in sealed Styrofoam coolers that are specifically designed to maintain controlled, refrigerated temperature ranges. Frozen or refrigerated ice packs are included with specialty medication orders to ensure protection throughout the delivery process.

(f) Transition process from First Fill at Retail or Mail

One a prescription is filled at First Fill, we hold it in a pending status until we verify the eligibility record. Then, we can change the status to "approved" or "denied," depending on the record. When the injured worker goes back to the pharmacy, their record is either in "approved" or "denied" status.

Typically, we do not transition from First Fill to home delivery, because home delivery is for maintenance medications for which there have been three or more fills within the previous 90 days.

(3) Do you propose to use one dedicated Specialty Pharmacy or several different Specialty Pharmacies? What are the advantages to this approach? Indicate which of the licensed Pharmacy(ies) in Exhibit II.E.3 will participate in the Specialty Pharmacy Program.

Given the complex disease states and detailed clinical protocols necessary for quality care, our preferred method of distribution is through CuraScript, a wholly owned subsidiary of Express Scripts. Express Scripts recommends the Exclusive specialty program as a standard benefit. Through Exclusive, patients obtain their specialty medications solely through our specialty pharmacy, which provides many vital services not available through retail pharmacies.

Our patient care advocates, nurses, and pharmacists are experts in specialty pharmacy. They interact directly with patients to educate them about their disease, treatment platform, and potential side effects. They also coordinate physician visits, lab results, and drug fulfillment to ensure correct dosing and timing of treatment administration. Additionally, social workers provide patients with access to disease-specific patient groups and financial assistance options when necessary.

We also offer a condition-focused approach, an option where we serve as the exclusive specialty pharmacy for targeted CareLogic® disease states. This approach results in cost savings and maximum patient care for targeted conditions. It may be used for certain high-utilization and high-cost specialty conditions for which we have a Specialty Care Management program, as detailed in the following table:

Condition	Specialty Care Management Program
Bleeding disorders*	Bleeding Disorders Logic™
Hepatitis C*	HEPLogic™
Multiple sclerosis	MSLogic™
Oral oncology	Oncology Care
Psoriasis	PsoriasisLogic™
Pulmonary arterial hypertension*	PAHLogic™
Rheumatoid arthritis	RALogic™
Respiratory syncytial virus	RSVLogic™

*Indicates recommended conditions to implement

Advantages of this approach include:

- Better pricing for implemented disease states
- Ability to target disease states with the highest amount of specialty spend
- Better management of patients in targeted disease states due to clinical management programs, counseling, around-the-clock access to disease-specific specialists, and our specialty standard drug list with automated updates
- Around-the-clock patient access to clinical staff, disease education, and therapy adherence counseling

(4) Detail the mechanisms in place to ensure the prompt, safe, and effective delivery of all Specialty Drugs/Medications in the Specialty Pharmacy Program to Enrollees. Describe the mechanisms the Offeror proposes to facilitate delivery of Limited Distribution Drugs to Enrollees. Describe override procedures the Offeror proposes to facilitate urgent or same-day delivery of Specialty Drugs/Medications in the Specialty Pharmacy Program as well as override procedures proposed when the Designated Specialty Pharmacy is precluded from shipping the medications, i.e. to an Enrollee residing in a skilled nursing facility or foreign country.

[redacted]

[redacted]

[redacted]

[redacted]

(5) (Exclusive to DCS) Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical insurer in providing HCAP services. For those HCAP providers that do not provide medications, how do you propose supplying the medication?

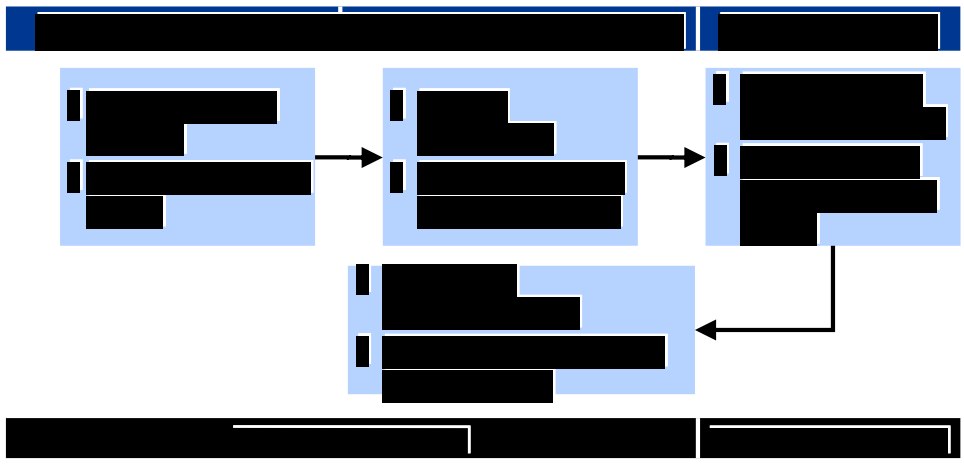
Please see our DCS-specific Technical Proposal binder.

(6) How does your system provide the ancillary supplies that accompany some of the Specialty Drugs/Medications?

Ancillary supplies including syringes, alcohol pads, needles, tubing, and solutions, are provided at no cost. Sharps containers are available at no cost upon request. For the majority of specialty drugs, Express Scripts' specialty pharmacy has developed supply kits that are included with the medication. When the prescription line for the drug is entered into the adjudication system, an additional line is added for the supply kit. Express Scripts contacts the patient prior to delivery and discusses any patient needs for an additional sharps container or other supplies. Express Scripts ships needles in the manufacturer's package with caps; they would be included with the Styrofoam cooler for refrigerated products or the cardboard shipper for non-refrigerated drugs.

(7) Describe the criteria you will use to evaluate new Specialty Drugs/Medications that enter the market and whether they should be included in the Specialty Pharmacy Process.

[redacted]



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12. Claims Processing

The Offeror is required to process all claims submitted under the Programs. The selected Offeror must be capable of processing, as applicable to the respective Programs, Network Pharmacy claims and claims for scripts filled through the Mail Service Pharmacy Process and/or the Specialty Pharmacy(ies) for all Covered Drugs including Specialty Drug/Medication Claims. The Offeror must also process manual submit claims including but not limited to Medicaid , VA , Skilled Nursing Facility claims, out-of-network claims, foreign claims, in network manual claims and COB including Medicare B primary claims and Student Health Center claims. Claims for all Covered Drugs adjudicated at a chain and independent Retail Pharmacy Network Pharmacies and through the Mail Service Pharmacy Process and Specialty Pharmacy(ies) must be processed according to the applicable benefit design and contracted arrangements in place.

The claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the applicable benefit design, Programs' provisions and negotiated agreements with pharmacies. All Program provisions for drug utilization review, benefit design and other utilization or clinical management programs must be adhered to for all prescriptions.

Enrollee Submitted Claims (DCS Only) are required to be submitted to the Offeror no later than one hundred twenty (120) Days after the end of the Calendar Year in which the drugs were dispensed, or one hundred twenty (120) Days after another plan processes the claim, unless it was not reasonably possible for the Enrollee to meet this deadline. The DCS Program count of Enrollee Submitted Claims can be found in Exhibit III.B of this RFP.

a. Duties and Responsibilities

(1) The Offeror must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

(a) Verifying that the Programs benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

(b) Accurate and timely processing of all claims submitted under the Programs in accordance with the benefit design applicable to the Enrollee at the time the claim was incurred as specified to the Offeror by the Procuring Agencies;

(c) Charging the Programs consistent with the Offeror's proposed pricing quotes;

(d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the Procuring Agencies. The Offeror shall utilize refill too soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the Procuring Agencies. The Offeror's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Days supply does not result in over dispensing;

(e) Managing Flexible Formulary (two Flexible Formularies – Original and Enhanced) and Preferred Drug List placement of drugs consistent with the Programs' design and ensuring application of appropriate Copayments based on level assignment (Copayments do not apply NYSIF's Program);

(f) Maintaining claims histories for 24 months online and archiving older claim histories for 6 years and the balance of the calendar year in which they were made with procedures to easily retrieve and load claim records;

(g) Maintaining the security of the claim files and ensuring HIPAA compliance;

(h) Reversing all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error including the reversal of any Claims Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error including but not limited to the Claims Administration Fee; and

(i) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Offeror shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's DSS vendor (DCS only). The Offeror cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Procuring Agencies. The Procuring Agencies understand that the selected Offeror will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Programs all Pharma Revenue due it under the Agreements resulting from this RFP. The Offeror shall inform the Procuring Agencies of the types of data being shared for these specific authorized purposes.

(j Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

(k) Maintaining a claims processing system capable of integrating and enforcing the various utilization review components of the Programs, including, but not limited to: Mandatory Generic Substitution, Prior Authorization, messaging capability in the current NCPDP format, and a concurrent DUR program to aid the Pharmacist at the point of sale.

(l) Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the generic at the Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Retail Pharmacy Network, the Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized generic in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable generic Copayment (DCS only) and the Program charged based on generic pricing. The claims processing system shall reject claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code with appropriate messaging and requires resubmission of the claim since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy. The Programs' logic for the Pharmacy Submitted DAW codes is listed below:

Pharmacy Submitted DAW	Enrollee Copay	Ancillary Charge	Pricing
0	Brand	No	Brand
1	Brand	Yes	Generic
2	Brand	Yes	Generic
3	Generic	No	Generic
4	Generic	No	Generic
5	Generic	No	Generic
6	Generic	No	Generic
7	Brand	No	Brand
8	Generic	No	Generic
9	Generic	No	Generic

(m) Maintaining a claims processing system capable of ensuring that claims are consistently processed with the appropriate brand

name/generic/compound classification in accordance with the requirements set forth in Section V.C.3.a.(6);

(n) Maintaining a Programs' MAC List for Pharmacies;

(o) (Exclusive to DCS) Processing Enrollee Submitted Claims in accordance with the following:

(i) For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Offeror's Minimum overall guaranteed Discounted Ingredient Cost for the Retail Pharmacy Network and dispensing fee for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;

(ii) For Prescriptions filled with a Brand Drug that has a generic equivalent, the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for filling the Prescription with that drug's generic equivalent; not to exceed the submitted charges, less the applicable Copayment;

(iii) For Prescriptions filled with a Generic Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment;

(iv) For Prescriptions filled with a Compound Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment; and

(v) If the Enrollee has two Empire Plan coverages, the DCS Program will reimburse 100% of the copay upon submission of a paper claim form prepared by the Enrollee. For specific methodology on how the DCS Program must be charged for Enrollee Submitted Claims, see Section V.C.7. of this RFP entitled "Enrollee Submitted Claims."

(p) (Exclusive to NYSIF) Processing Non-Network Pharmacy claims submitted to the Offeror in accordance with Chapter V of title 12 NYCRR.

(q) (Exclusive to DCS) Processing claims for Employees enrolled in the SEHP who fill Prescriptions at the SUNY Stony Brook Student Health Service Pharmacy, and other SUNY pharmacies as may be requested by the Department during the term of the Agreement resulting from this RFP. Prescriptions under this

arrangement must be dispensed according to the Plan design for the SEHP (see Exhibit II.C), including required prior authorizations and, where applicable, Days supply limits. The Offeror must monitor the submission of SEHP claims and inform the Department if the SUNY Pharmacies submit charges in excess of the amounts that are paid to the Program's Retail Network Pharmacies for the same NDC's;

(r) Processing all manually submitted claims including but not limited to Medicaid, VA, Skilled Nursing Facility claims, out-of-network claims (DCS and NYSIF), foreign claims, in-network manual claims, COB claims, and Medicare B primary claims in accordance to the Offeror's proposed Claims Adjudication Guarantee;

(s) Analyzing and monitoring claim submissions to promptly identify errors, fraud and abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. The Programs will be charged a Claims Administration Fee only for Final Paid Claims. The Offeror will credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse, without additional administrative charge to the Programs. The Offeror shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however, the Offeror is not responsible to credit amounts that are not recovered.

(t) Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours;

(u) Requiring network pharmacies to submit to the Offeror for each drug dispensed the Pharmacy's Submitted Cost to ensure that the Programs are charged according to the Programs' Lesser of Logic. Further, if an Ancillary Charge (applicable only to DCS) is applied, it will be deducted from the total claim cost;

(v) (Exclusive to DCS) Identifying Enrollees enrolled in Medicare Part D. The Offeror's claims processing system must decline claims at the point of service for Enrollees who are enrolled in a Medicare Part D Plan other than the DCS Program EGWP. Messaging to the Pharmacy must instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

(w) (Exclusive to DCS) Establishing a process to support, and respond, to Federal Medicare Part D audits.

(x) Having a process in place (fully staffed with ample telephone trunks) available 24 hours a Day, seven Days a week where a Pharmacist can call to quickly resolve point of service issues.

(y) (Exclusive to DCS) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. DCS agrees to reimburse the selected Offeror for claims processed under the Disabled Lives Benefit in accordance with Section V.13 of this RFP.

(2) Program Claims Processing System Availability Guarantee: The Offeror must propose separate performance guarantees for the respective Programs. The Programs service level standard requires that the claims processing system will be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time, which shall be reported to the Department in advance and kept to a minimum, based on a 24 hours a day, 7 Days a week availability, calculated on a quarterly basis.

(3) (Exclusive to DCS) Turnaround Time for Claims Adjudication Guarantee: The Offeror must propose a performance guarantee. The Programs service level standard requires that ninety-nine and five-tenths percent (99.5%) of Enrollee Submitted Claims that require no additional information in order to be properly adjudicated that are received by the contractor will be turned around within ten (10) Business Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Offeror's Program designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent.

(4) (Exclusive to NYSIF) Turnaround Time for Claims Adjudication Guarantee: The Offeror must propose a performance guarantee. The NYSIF Program's service level standard requires that ninety-nine and five-tenths percent (99.5%) of Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the contractor will be turned around within thirty (30) Calendar Days of receipt. Turnaround time is measured from the date the Non-Network Pharmacy submitted claim is received in the Offeror's Program designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.4 with the exception of a.1.p and a.4. We have provided clarifications to our approach to a.1.i as shown below and in our response to b.1 and clarifications to our approach to a.1r and a.1.s in our response to b.15 in the DCS Technical Proposal binder. Please see our DCS-specific Technical Proposal binder for our response to items a.1.o,q,v,w and a.3.

i) . Upon the request of the Department, the Offeror shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's DSS vendor (DCS only). The Procuring Agencies understand that the selected Offeror will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Programs Rebates due it under the Agreements resulting from this RFP. The Offeror shall inform the Procuring Agencies of the types of data being shared for these specific and other authorized purposes in accordance with the terms of the Financial Disclosure to Express Scripts' PBM clients.

b. Required Submission

(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating each of the following claim types: Mail Order, Specialty Pharmacy, Network Pharmacy, Enrollee-submitted claims, and Non- Network Pharmacy claims for the NYSIF Program. Provide a description of the comprehensive edits you propose at the point of service to ensure proper claim adjudication, including a detailed description and example of how your proposed refill-too-soon (RTS) edit will operate to ensure cost effective dispensing of Drugs under the Programs. Confirm that you will implement your proposed full RTS edit on January 1, 2014.

Each Express Scripts network pharmacy utilizes our electronic claims adjudication system, including our home delivery pharmacies. Within three seconds, our adjudication system reviews a prescription request for eligibility, plan design, formulary compliance, and Concurrent DUR, messaging approval or rejection back to the dispensing pharmacy. If a network pharmacy submits a paper bill, it receives all clinical edits and is billed like any online claim. Express Scripts then contacts the pharmacy and requests the next fill to be submitted online. Express Scripts has 100% capability to receive and adjudicate bills in NCPDP 5.1 format. We pay the pharmacy and then electronically bill NYSIF.

Electronic Claims Process

1. The injured worker submits the pharmacy ID card/Temporary Prescription Services ID form to a network pharmacy, which is connected to Express Scripts' adjudication processing system either directly or through a switching company.

2. The pharmacist enters information from the ID card/Temporary Prescription Services ID form into the pharmacy's computer system and submits the injured worker's prescription information to Express Scripts' adjudication system. The prescription processing system verifies that the person is eligible for pharmacy coverage and then applies program design and Express Scripts' CDUR edits to the prescription. At a minimum, pharmacies transmit the following information to Express Scripts:

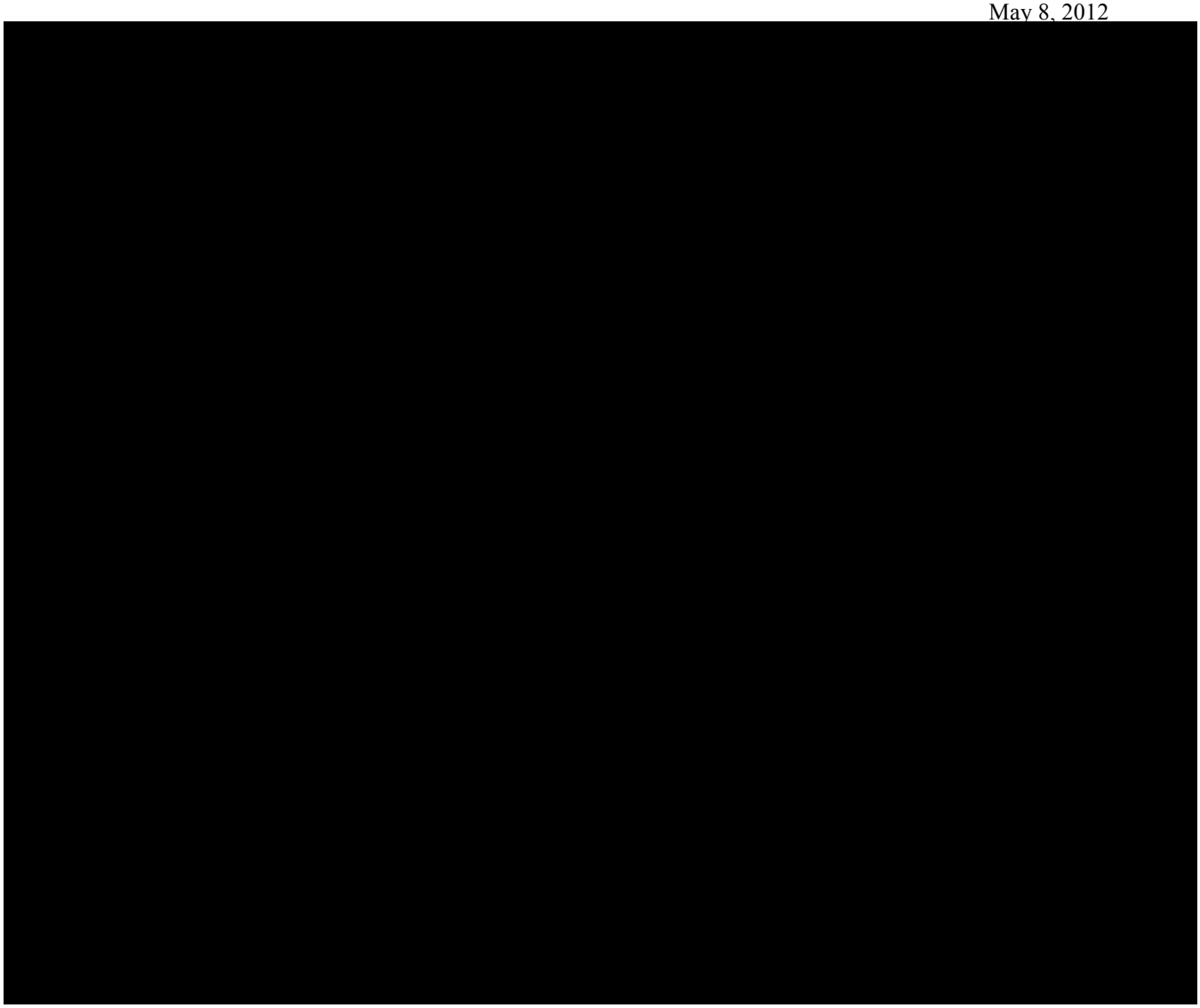
Bin number	NDC number of drug dispensed
Version/release number	Quantity of drug dispensed
Transaction code	Compound code
Group number	Days supply of drug dispensed
Client identification code	Prescription number
Date of injury	New or refill indicator (optional)
Gender code (optional)	U&C cost of drug dispensed
Cardholder ID	Submitted cost of drug dispensed
Date filled	Prescriber ID number
Date of birth of injured worker	Processor Control Number
NPI	Pharmacist License number (dependent upon state regulation)

3. The system checks the prescription against the injured worker's prescription history to identify possible clinical concerns. Prescription histories include those prescriptions submitted to Express Scripts for processing. The prescription processing system contains each injured worker's pharmacy prescription history for the period covered. Information for the new prescription is added to the injured worker's prescription history file. If the client implements the First Fill program, the system will build a pending status eligibility record for injured workers who do not have an eligibility record. This pending status eligibility allows the pharmacy to dispense a first fill based on your program design and can limit the first prescription to a one-time fill of up to 14 days until actual eligibility is submitted.

4. Calculated program information is sent back to the pharmacy. The participating pharmacy receives the following information:

Version/release number	**Total amount payable**
Dispensing fee payable	Ingredient cost payable
Transaction code	Reference number
Sales tax payable	Response status (payable/not payable)
Client ID number	Message
Copayment (if apportionment claim or state mandate applicable)	

If the prescription is rejected, Express Scripts' system provides the pharmacy with the appropriate NCPDP error code number and the reason for the rejection. This information is automatically added to the online prescription history of the injured worker. Our system completes processing within three seconds for 99% of prescriptions. A few additional seconds are needed to transmit prescription information from the pharmacy to our system and back. Once the prescription claim is approved, the pharmacist dispenses the drug to the injured worker along with a receipt. However, if the prescription is rejected, OASIS, our proprietary automated-authorization process, will manage the request in accordance with NYSIF's program design. We will work with NYSIF to offer our expertise insuring the program design aligns with your goals and objectives. This process is the same for prescriptions processed in our home delivery and retail network pharmacies.



Pharmacy and Injured Worker-Submitted Paper Claims

Express Scripts' paper bill workflow and process is as follows for both paper and electronic image or file formats:

1. Processing Bills – Each bill is keyed into Express Scripts' adjudication system and goes through the same Drug Utilization Review process for both paper and electronic bills. Bills are also reviewed for parameters set by the client's program design. If a bill is rejected, the processor notates the appropriate reject code and definition on the imaged paper bill. The system automatically separates and counts the paid and rejected bills. If the rejection requires action by the claims handler to approve the bill for eligibility or formulary, an authorization request is immediately triggered through OASIS, our automated authorization tool. An email is sent to the claims handler with a link to the authorization on the web portal. Once the authorization is received the bill is then processed as if it were

submitted on line at a pharmacy. Any bills we are not able to process are returned to NYSIF with reject code details

2. Batching and Logging of Paper Bills – Each batch is assigned an internal batch number which is logged in Express Scripts' batch log book. The number of claims in the batch is counted and recorded in the batch log, with a batch typically consisting of up to 50 prescriptions. The unpaid claims (defined above in Step 1) are also entered into the batch log for tracking purposes. Then a batch header sheet is printed with the assigned batch number, received date, and due date.

3. Auditing – The auditor proofs the claims for errors and any errors are promptly corrected. Paper bills that are rejected (those that Express Scripts is unable to pay) are returned electronically to the client with a stamp on the image indicating the reason the bills are being returned.

4. Storing of Paper Bills – All paid paper bills are stored onsite for three months and then sent to offsite storage for seven years. All Workers' Compensation bills are imaged upon receipt and can be easily accessed at any time.

Non-network/Third Party Biller Paper Bills

Express Scripts has developed the most comprehensive and effective process for handling out-of-network and third-party bills in the workers' compensation industry. This process helps minimize paper, maximize clinical cost savings and expand network penetration for our clients. The Paper Bill Conversion process promotes point-of-sale success by converting paper claims to electronic claims for future fills.

Express Scripts uses a state-of-the-art imaging and scanning center to process all paper bills. Bills are entered into our system, reviewed for eligibility, and then processed against all formulary and drug utilization review (DUR) edits. Consolidation of all pharmacy bill types through our single adjudication system minimizes waste and abuse caused by duplicate fills from different sources.
The features of the Express Scripts Paper Bill Conversion process include:

- Formulary control — Express Scripts applies the same rigor of formulary control and clinical pharmacy checks to these invoices that we apply to point-of-sale prescriptions filled through our retail network.
- Consolidated authorizations — Express Scripts reaches out to electronic clients for authorization through OASIS, Express Scripts' secure Web portal, on all questionable prescriptions. This makes the OASIS tool the consolidated source for all authorizations associated with pharmacy invoices. Clients without this electronic capability have a fully supported manual prior authorization process available.
- Reduction to Contracted Rate — Express Scripts reduces fills to the contracted rate.

- Consolidated billing — Express Scripts bills clients via the same method as prescriptions that are processed online by the pharmacy.

Express Scripts takes an aggressive and innovative approach to the management of out-of-network pharmacy bills, resulting in maximum savings and increased network penetration. Bills received from pharmacies and third-party billing agencies are reviewed, paid, and then billed to the client. If the processing pharmacy is part of the Express National Network, Express Scripts will contact the pharmacy to communicate proper billing protocols; thereby ensuring future transactions are sent electronically and routed within the network, minimizing cost and administrative burden.

Our comprehensive utilization management program applies the client's unique clinical edits to every out-of-network bill retrospectively. When prescriptions are identified that are not related to the injured worker's injury, or inappropriate prescribing is identified, Express Scripts alerts the claim's handler. Information regarding the reason for the edit is communicated, and the cost of medications not related to the injury can now be eliminated on the back end before the bill is paid, much like they are at the point of sale.

Third-Party Biller Paper Bill Adjudication Process

Express Scripts has established the following process for third-party paper bill adjudication:

1. The client sends all third-party paper bills to Express Scripts. We recommend the client send this information on a weekly, bi-weekly or monthly basis. We will work with the client to determine an appropriate timeline for the submission of paper bills.

2. Express Scripts adjudicates all third-party bills and will pay based on client adjudication logic, if deemed eligible. The bills are paid according to client preference. Following is the recommended process for third-party bill payment; however, Express Scripts will work with the client to customize a program in accordance with their business rules:
   - Express Scripts will process third-party bills at the lesser of the submitted rate and State Fee Schedule for up to 14 days. A letter is sent to inform the third-party biller that they were paid this time, but going forward they will receive the contracted rate.
   - A letter is also sent to the pharmacy and the injured worker. When additional prescriptions come in after 14 days, they are re-priced to the Express Scripts contracted rate. This is Express Scripts' recommended best practice solution.

3. Paper bills are entered into our adjudication system, where the same administrative edits at the point of service are applied to verify eligibility and program design compliance. Concurrent edits are also applied and in the event of a rejection, Express Scripts will contact the claims handler for authorization to

process. Paper bill information is stored in the injured worker's electronic profile for future concurrent review at the point of service. The process continues from here just as it does for the network and non-network paper bills.

Both of the above processes can be administered for retail and Home Delivery programs and are administered by our dedicated Paper Bill team in St. Louis, Missouri.

(2) Please describe your claims processing system platform including any backup system utilized. Describe your disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure. What is the process for Enrollees trying to get a Prescription when the claims payment system is down or is not accessible?

Express Scripts' Workers' Compensation's proprietary computer system is an integrated configuration of several hardware platforms, which were selected for and dedicated to the performance of specific functions:

- Online Adjudication Fault-Tolerant System — The Express Scripts Workers' Compensation adjudication system handles injured worker and provider eligibility, prescription claim processing, network POS systems, state EDI reporting, and ID card billing and generation. The system captures vital information, including the date of injury, claim number, prescription number, physician, and group level. One system performs online adjudication and eligibility, another handles billing and batch processing, and a third is used for development.
- DEC Alpha System — Mail-service activity is processed on DEC system platforms. Express Scripts Workers' Compensation mail-service activity is fully integrated with network prescription adjudication and Drug Utilization Review (DUR).
- IBM AS400 — The primary application on the AS400 is Concurrent DUR, which checks network and mail-service prescriptions for drug interactions and other potential problems. Prescriptions received on our adjudication system are sent to the AS400 for DUR processing and returned to the adjudication system. The AS400 also runs other internal applications.
- Teradata 5800 — This Unix-based system houses the Enterprise Data Warehouse and Trend Central tools.

Express Scripts' comprehensive Business Continuity program responds to risks and threats to business operations. This allows us to sustain and quickly resume operations — ensuring uninterrupted pharmacy benefit services for NYSIF' injured workers.

Express Scripts offers our network pharmacies two means of communication to verify injured worker eligibility during adjudication system downtime: the Pharmacy Help Desk and Express-Scripts.com for Pharmacists.

- Pharmacy Help Desk – Our Pharmacy Help Desk is available 24 hours a day and has real-time access to eligibility, benefits, and claims adjudication data.
- Express-Scripts.com for Pharmacists – Pharmacies can also log into Express-Scripts.com and query on injured worker eligibility based on the information found on an injured worker's prescription drug card.

(3) Describe the capabilities of your claim processing system to perform, at the point of service, for each of the following required Programs' components:

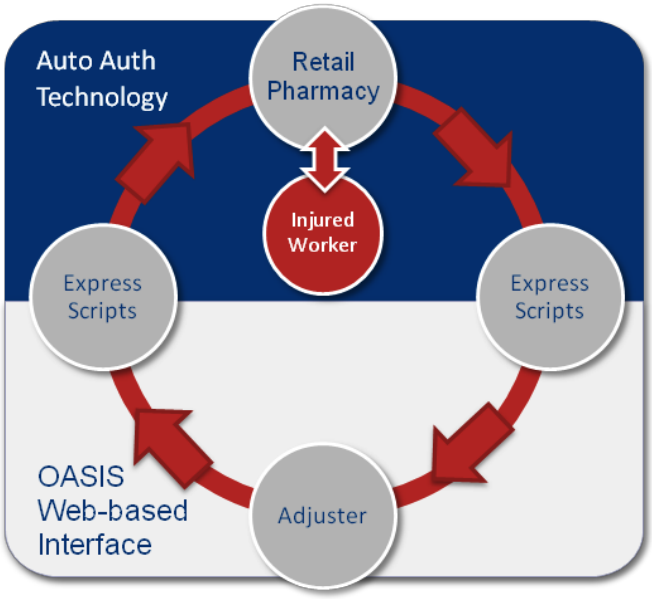
(a) The Programs generic substitution requirements based on the Programs' definition of a Generic Drug as set forth in Section VIII of this RFP;

We contractually require participating retail pharmacies to facilitate generic substitutions whenever possible and permitted by applicable law. The Express Scripts Pharmacy substitutes generic products according to state regulations and NYSIF's plan design.

(b) A Prior Authorization Program for specific drugs that have an increased risk of inappropriate utilization;

We can customize NYSIF's formulary to meet your requirements for increased scrutiny of medications that pose risk for inappropriate utilization. These medications would reject at retail and require NYSIF authorization. For all medications that require authorization, Express Scripts automatically sends the pharmacy an electronic message stating that Express Scripts is in the process of determining whether the medication is authorized (messaging states: "The rejected medication is NOT denied, but requires authorization"). No further action is required on the pharmacy's part.

- Authorization requests automatically populate our authorization system via electronic reject feed. Notification of a pending authorization request is generated and immediately forwarded to the appropriate NYSIF claims staff or decision-maker.
- Claims staff reviews the authorization request and input the approval decision, which is instantly released into the processing system.
- A fax is then auto-generated to the pharmacy, conveying authorization or denial for the medication.



This web-based process can significantly reduce turnaround time. In many cases, prescriptions are processed within five minutes. Through our OASIS authorization process, requests automatically populate our authorization system via electronic reject feed. Notification of a pending authorization request is generated to NYSIF.

Clients have the option of addressing prior authorizations through our OASIS Prior Authorization website, which allows for a more proactive authorization process through our Prior Authorization Notification System. When the prescription rejects at the point of service (even before the pharmacist has called the Contact Center), we automatically send an e-mail notification to the claims staff that an authorization request is waiting on our website. The claims staff has access to approve or reject the authorization request on the website.

(c) A concurrent DUR program identifying Enrollee drug therapy safety edits and Programs' benefit edits;

Express Scripts' Concurrent DUR supports and ensures patient safety at the point of service by identifying potential problems with a patient's prescription that could impact patient care, potentially resulting in an adverse drug event. In addition, it helps to prevent potential fraud and abuse by injured workers or pharmacies before a prescription is dispensed.

Method of Communication

Through an extensive set of edits, Express Scripts' adjudication system reviews each electronically transmitted prescription claim to evaluate pertinent clinical information and identify potential utilization concerns, quickly relaying any safety alerts to the pharmacist processing the claim. If an edit is triggered, an electronic

response is sent to the dispensing pharmacy indicating the potential safety issues and concerns.

Samples of Concurrent DUR Edits

Some examples of concurrent DUR edits include:

- Duplicate Prescriptions (Hard Edit) – Express Scripts checks the injured worker's prescription history for an identical prescription issued by that pharmacy or another pharmacy. If such a prescription is found, the system rejects the prescription and alerts the pharmacist with an online message.
- Therapeutic Duplication (Soft Edit) – Our computer system notifies the pharmacist when a patient is taking two or more medications from the same therapy class, such as anti-inflammatory medications. Pharmacists clarify these orders with the prescriber to preclude filling therapeutically duplicate prescriptions, ensuring patient safety.
- Incorrect Dosage (Hard Edit) – We assess the prescribed dosage using Medi-Span's database of minimum and maximum dosages, which is based upon FDA guidelines. When an incorrect dosage is flagged, the system instructs the dispensing pharmacist to use professional judgment and to consult with the prescribing physician in order to determine the appropriateness of the therapy.
- Refill Too Soon (Hard Edit) – Express Scripts allows refills when a certain percentage of the original prescription is gone. For example, if this percentage is set at 75% of a 32-day supply, the injured worker may not obtain a refill prior to the 24th day, unless the client authorizes an early fill.
- Drug Interactions (Soft Edit) – Express Scripts' computer system checks for severe interactions between medications prescribed to the injured worker. If a concern is flagged, the pharmacist evaluates the nature of the interaction and determines an appropriate course of action. In the case of a potentially dangerous interaction, the pharmacist routinely confers with the prescriber. In less critical cases, the pharmacist may confer with the prescriber or with the injured worker.
- Drug Allergies (Hard Edit) – Express Scripts' database includes data on injured workers' drug allergies. Our system scans new orders against the allergy data and alerts the pharmacist to potential allergic reactions. When an allergy is detected, the pharmacist contacts the prescriber to determine the appropriate course of action.
- Drug-To-Age Conflict (Soft Edit) – Express Scripts' computer system also checks a prescription against an injured worker's age. If a potential drug-age conflict is found, the system sends a message to the pharmacist for appropriate intervention.

- Drug-to-Disease Conflict (Soft Edit) – Express Scripts' system cross-references the Medi-Span Drug-Disease Monitoring System with the injured worker's prescription history to determine whether a potential drug-disease conflict exists. If so, our system alerts the pharmacist and he/she can contact the prescribing physician to determine appropriate action.
- Duration of Therapy (Soft Edit) – Many drugs have an FDA-established guideline for minimum or maximum length of therapy needed for a positive therapeutic effect. If the prescribed drug has a maximum or minimum length of therapy identified in its drug records, and the days of therapy fall below or above the set parameters, the system notifies the pharmacist that consultation with the physician may be appropriate.
- Drug-to-Gender Conflict (Soft Edit) – Certain drug products, by nature of their action or indications, are normally administered to only males or only females. If drug-to-gender conflict is present, the system sends an informational message to the pharmacist.
- High Dose (Hard Edit) – If a prescription has been written for more than 200% of the maximum recommended FDA adult dose, or if the pharmacist enters an inaccurate days supply that would result in a dosage more than double the FDA adult dose recommendations, the system will reject the prescription. The claims staff will have the ability to approve or disapprove this edit. This edit reduces the opportunity for injured workers to abuse controlled substances.

Some soft edits may be overridden by a pharmacist at their discretion. In addition, some hard edits may also be overridden by a pharmacist but require approval from NYSIF first; otherwise, the prescription cannot be dispensed.

Notification of Concurrent DUR Results

Through our OASIS authorization process, requests automatically populate our authorization system via electronic reject feed. Notification of a pending authorization request is generated to NYSIF.

(d) Messaging capabilities to the Network Pharmacy; (e) Eligibility verification;

In addition to the communication programs offered to your injured workers, Express Scripts provides the following education and outreach programs to both physicians and pharmacies:

Pharmacy Communications

- First Fill Letter — Express Scripts provides NYSIF with a temporary eligibility form to be given to the injured worker or pharmacy at the time of injury. This letter includes processing information for the pharmacist to

ensure the prescription is filled through the Express Scripts Worker's Compensation Retail Network.

- Retail Pharmacy Card — Injured workers receive a Retail Pharmacy Card to present to the pharmacy at the time of fill. This card includes Express Scripts' billing information to ensure the prescription is filled through the Express Scripts Worker's Compensation Retail Network.
- Concurrent DUR —Express Scripts' concurrent drug utilization review (DUR) program provides real-time messaging to the pharmacy, relaying any pertinent safety alerts to the pharmacist.
- Step Therapy — Through Step Therapy, messaging directs the pharmacist to contact the prescribing physician to request a generic equivalent before dispensing a higher-cost brand drug.
- Additional Billing Communications — Express Scripts advises dispensing pharmacies of any updates to an injured worker's profile if prescriptions were billed through a third-party biller.

(e) Eligibility verification;

Point-of-service eligibility verification occurs as follows:

- The pharmacist electronically submits the claim.
- The pharmacist immediately receives eligibility information and verification.
- The pharmacist dispenses the drug if the injured worker is listed as eligible.

(f) Customized edits for individual Enrollees;

NYSIF can customize point-of-service edits as described below.

Administrative Edits

Express Scripts' claims adjudication system has many administrative edits that support your benefit design (eligibility, drug coverage, pharmacy contract information, and prescription pricing) and block ineligible persons from accessing your program. Our system's flexibility allows us to combine edits as needed to support the specific provisions of your pharmacy benefit program, while also providing the capability to tailor adjudication messaging at the point of service. Your account team will work with you to determine the best combination of edits to support your needs and overall program goals.

Clinical Edits

Prior Authorization

Express Scripts' formulary is customizable down to the patient level and/or utilizes injury specific drug lists based on NCCI codes to confirm that the medication is related to the injury. We also can customize Prior Authorizations to look at injured workers' profiles and to allow grandfathering of current users.

Step Therapy

Express Scripts can customize our Step Therapy programs so that any combination of drugs can be included as first-line, second-line, or third-line. In addition, Express Scripts can grandfather injured workers using a unique group of drugs that does not necessarily match the first-line or second-line drug groups. Other customizable variables include:

- Lookback period for first-line drugs
- Lookback period for grandfathering
- Number of drugs that must be tried (in the same or different drug groups)
- Override allowed
- Override criteria
- Age restrictions
- Pharmacy messaging

Additional customization is available to account for factors such as days' supply.

Drug Quantity Management

Express Scripts can apply quantity level limits based on a days' supply or per-prescription basis. We can set these limits to apply to individual strengths, dosage forms, package sizes, and other criteria. They can also apply to a group of drugs so that the quantity filled for all included drugs counts toward the limit. This grouping can include any combination of drugs.

Concurrent DUR

Express Scripts offers NYSIF the ability to customize all modules of our Concurrent DUR program, with the exception of the drug-age module.

- Drug-Disease – NYSIF can vary the editing type for the entire module.
- Drug-Drug – NYSIF can add editing for drug interactions not in the Express Scripts standard, remove editing for drug interactions in the Express Scripts standard, or change the alert type.

- Drug-Gender – NYSIF can vary the editing type for the entire module.
- High Dose – NYSIF can modify edit levels for drugs in the Express Scripts standard and remove the high dose edit for products in our standard. Additionally, NYSIF can add the high dose edit for drugs not in the Express Scripts standard or First DataBank module.
- Ingredient Duplication – NYSIF can vary the editing type and other attributes by ingredient or for the entire module.
- Therapy Duplication – NYSIF can vary the editing type and other attributes by therapy class or for the entire module. Clients can also add editing for therapy classes not contained in the Express Scripts standard or remove editing.
- Underutilization – NYSIF can modify editing levels for drugs in the First DataBank Minimum Adult Daily Dose module. Additionally, you can remove the low dose edit for products in the Express Scripts standard or add the low dose edit to products not in First DataBank's Minimum Adult Daily Dose module.

(g) Utilization of some medications intended to treat conditions limited to one sex;

Our point-of-service claims adjudication system ensures all submitted claims meet applicable benefit, formulary, and clinical safety parameters, including drug-gender interactions. Our module for drug-gender interaction is internally developed and maintained based on First DataBank information. Express Scripts clinicians regularly review literature on an ongoing basis for new products and changes to existing products.

(h) Historic claims look up capability to reduce Enrollee disruption at the point of sale; (i) (Exclusive to DCS) Multi-level cost sharing;

With regard to Step Therapy the system looks back to see if a generic had been used previously. If so, then the prescribed brand medication will be process without disruption. If not, then the pharmacist will contact the prescribing physician to see if a generic medication can be dispensed instead. If physician declines the switch the brand is dispensed without further intervention.

(j) Identification and pricing of compounded Prescriptions consistent with the Programs' definitions and requirements set forth in this RFP; and

The following steps describe how retail and mail compound claims are submitted to and priced by Express Scripts:

- The pharmacist flags the claim as a compound.

- The pharmacist submits the NDC number of the most expensive legend (prescription) drug in the compound, combining the quantity of all ingredients, not just the legend drug.
- The pharmacist submits the AWP of the combined compound ingredients and the service fee; these dollar amounts are added together and submitted in a single field.
- The Express Scripts system processes the claim without an AWP discount.
- The pharmacy receives the contracted dispensing fee.

Using specified criteria, the audit team reviews compounded prescriptions on a daily basis. Express Scripts will review all compounds above $150 and audit those claims which are determined to warrant additional scrutiny.

(k) Recognition of Pharmacy submitted cost and ensuring the Programs receive the Lesser of Logic for all Prescriptions filled at a network and Non-Network Pharmacy or through the Mail Service and Specialty Pharmacy Processes.

[redacted]

(4) Please describe how your claims processing system will reject Network Pharmacy claims submitted with a DAW-0 code and send appropriate

messaging to Pharmacists to ensure submission of a code that provides an indication of the Generic Drug's availability in the Pharmacy to facilitate consistent and accurate application of the Programs' mandatory generic substitution provisions.

When the DAW 0 code is submitted to indicate that a drug is not available at the pharmacy. Express Scripts adjudication system will send a message to resubmit with a valid DAW. If the prescription is substitutable and the pharmacy is out of stock, and the pharmacy dispenses the corresponding brand product with the correct DAW code of 4 (Substitution permitted, but generic not in stock), the claim will adjudicate as a generic and the patient will be not be charged an ancillary penalty. If a pharmacy uses that code, the claim will process according to the outline they offered (injured worker pays generic copay, plan is charged based on generic pricing and, by implication, the pharmacy takes a loss because they dispensed a brand medication, but they are being reimbursed for a generic). Express Scripts does not take responsibility for retail pharmacies inventory.

(5) Describe how your adjudication system feeds the reporting and billing systems and any claim update data delays.

Once a claim is adjudicated and has a claim status of paid, the adjudication system feeds the reporting and billing systems. For reporting, key performance indicators, report cards, and data for parametric reports will be available 10 days after the end of a month. Information for reports based on billed date will be available within 10 days of the billing cycle. Information for injured worker profiles will be available 10 days after the claim-processed date.

For billing , claims are passed daily to the billing system. The claim, however, can be delayed from billing due to audit controls that are established on mail order and some retail claims. Until the claim passes audit controls, the claim stays in the billing system until we determine the audits on the claims. If there are no errors, the claim is allowed to bill and is captured by Finance. For a complete description of the reporting package Express Scripts provide to NYSIF, please refer to Reporting section of this proposal.

(6) Do you own the adjudication system, license the software or contract out this service?

Yes. Express Scripts owns the adjudication system, owns and develops the software related to adjudication, licenses business software as needed, and contracts with EDS for system hardware maintenance.

(7) How quickly are your systems brought into compliance when a new version or capability of the standard NCPDP format for claims transmission is released?

We are continually updating and enhancing our systems to provide minimum disruption to our clients and their injured workers. Express Scripts contractually requires the

NCPDP Version D.0 standard, or the most recent industry version, for each claim transmitted, in compliance with HIPAA legislation. If the pharmacy transmits a claim in a format other the standard, Express Scripts has the ability to reject the claim.

Generally, PBMs, NCPDP, and pharmacies collaborate regarding NCPDP releases. Because of this cooperative effort, new NCPDP releases are readily functional in Express Scripts systems and pharmacy systems.

(8) Describe the current Network Pharmacy available overrides to your claims adjudication system. How would overrides from the Retail Pharmacy Network and messaging to the retail Pharmacy network be tracked and reported to the Procuring Agencies? Describe the loading of an override within your claims processing system and confirm whether it over-rides your client's program benefit design? If so, provide the circumstances where you would load an override edit at the point of service. If applicable, describe the circumstances where you would approve the dispensing of quantities in excess of the benefit design amounts within your concurrent DUR program.

[redacted]

[redacted]

(9) Describe how the Mail Service Pharmacy Process, Specialty Pharmacy Program and Network Pharmacy Claims will be subjected to the same prior authorization/quantity limitations, Point of Service and DUR edits and how a common Enrollee profile is maintained for each Enrollee? Is this process on-line for both systems?

Express Scripts uses a single, integrated adjudication platform. The same adjudication system processes both mail and retail scripts, and applies the same edits to these requests. Express Scripts' mail order is fully integrated with retail and paper bills in the adjudication system. As a result, all claims receive the same prior authorization, quantity limitations, and applicable point of service and DUR edits.

The injured worker's prescription history, which is accessed by the adjudication system, contains retail Point of Service as well as mail order. Express Scripts maintains injured worker profiles for those who use mail order services. Each retail pharmacy is required to gather applicable injured worker profile information, such as allergies, as part of their normal business practices.

(10) Describe how any changes to the benefit design would be monitored, verified and tested for the Programs, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Programs.

Express Scripts' Client Benefit Administration (CBA) Testing Unit tests all new implementation plan setups as well as changes that are submitted by the client or account manager. This testing ensures accurate setup prior to the effective date of the change.

To ensure the accuracy of the setup, CBA both visually verifies the setup of benefits in the claims system and also runs claims scenarios using the testing templates in test environments. If errors are identified, the request is returned to the setup analyst for corrections and is then returned to testing. Testing is performed on all new benefit change requests within 10 days if no issues or questions are identified.

There are three testing platforms that are utilized by the CBA testing team:

- P-Mode — Claims processing that takes place in the Anchor Adjudication test environment using production data.
- Q5 — Claims processing that takes place in another test environment using production data that is copied to Q5 on a daily basis. This environment allows the tester to build history to test claim scenarios.
- Compass — Compass is primarily a Contact Center tool that allows a tester to query production data based on claims scenarios.

(11) Identify the resources that are available to a Pharmacist who is having difficulty processing a claim at the point of service. How do you ensure that the Pharmacist is able to get through to a person to resolve the issue?

- Internet access to pharmacy claim reject resolution assistance
- Provider Relations pharmacy network support team (an escalated research team)
- Pharmacy Help Desk manager and supervisors
- Contact Center director
- Express Scripts pharmacists

Additionally, pharmacists can log-on to Express-Scripts.com for Pharmacists for important information that will help them serve injured workers more efficiently. Express-Scripts.com for Pharmacists includes valuable information and features designed to decrease pharmacist response time and to increase injured worker satisfaction:.

- Rejection Resolutions—Pharmacists are able to quickly provide solutions for the most common rejections, such as an invalid cardholder ID or refill-too-soon.

- Patient Search—Pharmacists can access important information about an injured worker's account and resolve rejected claims quickly and easily.
- Pharmacy Notifications—Pharmacists can access helpful hints on processing steps, get key facts about quality-of-care dosing guidelines, view changes in non-covered drug lists, and much more.
- Remittance Request—Pharmacists with questions regarding payments to the pharmacy, the status of a claim, or an explanation of benefits can simply complete the appropriate form and submit their request.
- Frequently Asked Questions—This collection of questions and responses assists pharmacist in helping injured workers by addressing the most common questions about processing a prescription.
- Network Enrollment Form—Pharmacies can complete this form to receive an Express Scripts' provider contract.
- Inquiry Form—Pharmacists needing additional information or help can contact Express Scripts online to get answers to their questions.
- Provider Manual—Pharmacies can view Express Scripts' online pharmacy manual that includes the policy and procedures for pharmacy network providers.

(12) (Exclusive to DCS) Confirm that your claims processing system has the capability to: stop claims at the point of service for Enrollees who are enrolled in a Medicare Part D; plan other than the DCS Program EGWP and send messaging to the Pharmacy to instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

(13) Explain how your claims processing system collects overpayments from your Retail Pharmacy Network.

Due to the specific nature of the Workers' Compensation Audit Compliance Program, pharmacies and prescriptions are generally not tested without a valid reason. Therefore, most audit procedures result in recovery of funds for our clients.

As prescriptions are reviewed and re-adjudicated by our audit staff, any overpayments are identified and corrected. The auditor prepares and corrects the prescription. The reversal and re-adjudication of the prescription may also be completed by the pharmacy during the audit process at the auditor analyst's request.

This corrective process enables the pharmacy's next remittance to show the deducted prescription amount, which will flow through to the client's next regularly scheduled billing. Any audit fees due are typically invoiced the month following the audit recovery. All invoiced recoveries are accompanied by a detailed support document.

(14) Confirm the Offeror will reverse all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error or due to fraud including the reversal of any Claim Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error, including but not limited to the Claim Administration Fee;

In workers' compensation, we would reverse the admin fee as there is no expense to tie it to.

(15) Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged a Claims Administration Fee only for Final Paid Claims. Confirm the Offeror will credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse. In cases of overpayments resulting from errors only found to be the responsibility of the Department, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.

Express Scripts utilizes highly effective techniques to detect and investigate fraud and abuse in our pharmacy networks. We select candidates for investigation based on a number of criteria targeted toward both NYSIF's claims and those submitted across the entire network population. Our investigational techniques depend on the specific allegation. Such techniques include:

- Injured Worker Verification: The standard injured worker verification procedure includes preparation of a "benefit statement," which lists all prescriptions processed by Express Scripts for the injured worker. We ask the injured worker to verify the prescriptions listed on the report and return in a prepaid envelope. We typically perform injured worker verifications in support of an in-depth investigational audit. Information to be verified includes the date the prescription was received, drug received, and quality assurance data.
- Physician Verification: It is sometimes necessary to obtain information from the original prescriber in order to verify the accuracy of the prescription submitted by a pharmacy. In such cases, we send a letter to the physician attributed to the claim. The main components of physician verifications include the validity of the entire prescription (for example, whether the injured worker is a patient and whether the prescriber wrote the prescription); verification of prescription dates, quantities, and strengths; authorization for generic dispensing; dosage instructions; and authorization for refills.
- Desktop Investigations of Pharmacies: The investigator requests the hard-copy prescription, signature logs, and compounding logs from the pharmacy and compares these against the actual prescription submission to ensure accuracy. We educate pharmacies regarding any discrepancies and return overpaid funds to NYSIF.

Express Scripts agrees to credit the programs the amount of the overpayment in cases of ESI error or fraud or abuse; however, overpayments for fraud and abuse by a third party (i.e., pharmacy, member), will be credited to the Department only for those amounts recovered. Express Scripts confirms that, for Department errors, we will use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt.

(16) Can the adjudication system interact with a debit card program for flexible spending accounts?

Not applicable.

(17) What data elements are required by your claims system to process a compound medication claim? How do you guard against inappropriate or inaccurate compound claims? How do you ensure that only those claims that meet the definition of a compound in Section VIII of this RFP are processed as compound claims thereby protecting the Program's financial interest?

Express Scripts has 100% capability to receive and adjudicate bills in NCPDP D.0 format. The recent adoption of D.0 enables full pricing transparency of Compound scripts. Compounds are scrutinized, priced and reported at an individual ingredient level, while dispensing fees are calculated based on the compounding level-of-effort. This methodology helps to contain compound drug costs that formerly were billed at pharmacy submitted rates. We pay the pharmacy and then electronically bill NYSIF.

(18) Programs' Claims Processing System Availability Guarantee: The Programs service level standard requires that the Programs' online claims processing system be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time which shall be reported in advance to the Department and kept to a minimum, based on a 24 hours a day, 7 Days a week availability (or the Offeror's proposed guarantee). The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% below the ninety-nine and five- tenths percent (99.5%) that the Offeror's online claims processing system for the Programs are not available, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, the Offeror may propose higher or lesser amount.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed

guarantee) that the Offeror's online claims processing system for the Programs, based on a 24 hours a day, 7 Days a week availability excluding periods of scheduled down time, which shall be reported in advance to the Department and kept to a minimum, is not available, as calculated on a quarterly basis, the Offeror shall credit against the Program's Claims Administration Fee the amount of $ for DCS and $ for NYSIF.

(19) (Exclusive to DCS) Turnaround Time for Claims Adjudication Guarantee: The DCS Program's service level standard requires that at least ninety-nine and five- tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% of the DCS Program's Enrollee- submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent below the standard of ninety-nine and five-tenths (99.5%) is $5,000 per each quarter for DCS. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%) as calculated on a quarterly basis, is $ for DCS.

[redacted]

(20) (Exclusive to NYSIF) Turnaround Time for Claims Adjudication Guarantee: The NYSIF Program's service level standard requires that at least ninety-nine and five- tenths percent (99.5%) of Non-Network Pharmacy claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in NYSIF's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% of the NYSIF Program's Non- Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are

received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in the FUND's designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent below the standard of ninety-nine and five-tenths (99.5%) is $375 per each quarter for NYSIF. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in NYSIF's designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%) as calculated on a quarterly basis, is $ for NYSIF.

[redacted]

13. Retrospective Coordination of Benefits (Exclusive to DCS)

The selected Offeror must be capable of administering a retrospective coordination of benefits (COB) recovery program. The DCS Program's current COB process is administered on a retrospective basis. A claim is not stopped at the point of service nor is there any current plan to have Prescriptions stopped at the point of service to verify COB coverage unless it is indicated that the Enrollee has enrolled in a Medicare Part D Plan other than the DCS Program EGWP. The DCS Program allows members to receive Prescriptions and have the selected Offeror seek COB recoveries after the Prescription is dispensed.

a. Duties and Responsibilities

(1) **The selected Offeror is required to pursue collection of any money due the DCS Program from other payers or Enrollees who have primary Prescription drug coverage through another carrier and to credit the DCS Program's account one hundred percent (100%) of all recoveries within fifteen (15) Days after the end of the month.**

(2) **The selected Offeror must maintain a system capable of receiving a historical COB data file from the current contractor and benefits information obtained from Enrollee surveys. The Offeror's system must be capable of tracking the date an initial letter is sent to the Enrollee or other carrier until the point money is recovered.**

(3) **The selected Offeror must develop for Department review and approval COB correspondence including, but not limited to; an Enrollee questionnaire to confirm other Prescription drug coverage information, a letter(s) instructing Enrollees to file for reimbursement from the primary plan and advising that the Enrollee must reimburse the DCS Program for the cost of their claims and a collection letter(s) to other carriers who owe the DCS Program reimbursement.**

(4) **The selected Offeror must have a system in place to facilitate collection, without Enrollee intervention, when the primary plan claims adjudicator is the same as the selected Offeror.**

Note: Offerors may choose to enter into a Key Subcontract for the provision of these services; however, the cost of this service must be included in the Offeror's proposed Claims Administration Fee with all gross recoveries credited to the DCS Program (no carve-out of Key Subcontractor fees will be permitted). The Department will not allow any alternative fee arrangement in this regard.

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

Provide a flow chart and step-by-step description of the process you will employ to conduct the DCS Program's retrospective coordination of benefits (COB) requirement. Specifically, please detail how you will collect, store, and investigate COB information for other insurance.

Please see our DCS-specific Technical Proposal binder.

14. Utilization Management

Mandatory Generic Substitution at Retail and Mail

Appropriate utilization of cost-effective clinically equivalent Generic Drugs is an integral component of the Programs benefit design. To promote the use of Generic Drugs, the Programs have a mandatory generic substitution requirement that mandates that FDA approved generic equivalents be substituted for the equivalent Brand Drug or the Enrollee pays the Non-Preferred Brand Drug Copayment plus an Ancillary Charge (DCS only) equal to the difference in the Ingredient Cost of the Brand Drug and the Ingredient Cost of the Generic equivalent, not to exceed the cost of the drug, unless otherwise directed by the Department. Mandatory generic substitution will be applied to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug, as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

Mandatory generic substitution provisions shall apply if a Physician writes a Prescription with a Dispense as Written (DAW) code for a Brand Drug that has an A-rated or authorized Generic Drug available. The Enrollee should be informed that an Ancillary Charge (DCS only) will be applied and the Pharmacist should offer to contact the prescribing Physician for approval to dispense the Generic Drug. Enrollees who receive a multi-source Brand Name drug because of a DAW notation are still required to pay both the applicable Brand Drug Copayment and the Ancillary Charge (DCS only). Mandatory generic substitution does not apply to the strength of a particular drug for which there is no approved Generic Drug.

The Department's Program currently has the following exceptions to the mandatory generic substitution requirement: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. Because the drugs are exceptions to the mandatory generic substitution requirement, no Ancillary Charge can be imposed. The drug placement on the Offeror's proposed PDL will determine the Copayment (DCS only) for these drugs subject to the Program's benefit design which requires that a Brand Drug with a Generic equivalent be placed on the third level of the Preferred Drug List. An appeal cannot change the level status of these drugs on your

proposed PDL.

a. Duties and Responsibilities

To ensure strict adherence to the Program's Mandatory Generic Substitution Requirement and protect the financial interests of the Programs, the Offeror is required to:

(1) Unless otherwise directed by the Procuring Agencies, apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

(2) (Exclusive to DCS) Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the Programs' MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Non-Preferred Brand Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the Programs. The Ancillary Charge shall be assessed even in the event a Physician has specifically directed a Pharmacist to dispense the Brand Drug rather than the A- rated or authorized Generic Drug through DAW notation.

(3) Monitor the pharmaceutical industry on behalf of the Department to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Offeror shall inform the Department of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

(4) (Exclusive to DCS) Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Offeror is required to:

(a) Inform the Department as soon as practicable but in no event later than 14 Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert

Notice" detailed in Section IV.B.8.a. of this RFP, under the subheading "Reports Required at Other Frequencies."

(b) For those drugs that will result in a lower net cost to the Program by enforcing mandatory generic substitution, the Offeror shall provide the "MAC Alert Notice" as described in (a) above. The Offeror shall add the GCN to the Programs' MAC List and begin enforcement as soon as practicable but in no event later than 14 Days after the first date of shipment provided that the majority of Retail Network Pharmacies are able to obtain the Generic Drug. In the case where a GCN is already subject to MAC pricing the Offeror is required to immediately apply the MAC price and mandatory generic substitution to any NDC added to the GCN following the first date of shipment.

(c) For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Offeror shall provide the "MAC Alert Notice" as described in (a) above. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Offeror whether mandatory substitution shall be applied. If the Offeror does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GCN shall be added to the Programs' MAC List effective on the 21st day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the majority of pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Offeror shall apply MAC pricing to the Generic Drug.

(d) To assist the Department in determining when mandatory generic substitution should be enforced based on an adequate supply of Generic drug being available in the market, the Offeror shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new Generic Drug within 21 Days and weekly thereafter until the shortage resolves. The Offeror shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The Department, in its sole discretion, shall determine based on such evidence how the DCS Program's mandatory generic substitution provisions will be applied. The DCS Program will not consider and the Offeror shall not act on availability information provided by 3rd party sources, including but not limited to Medi-Span, Red Book, First Data Bank or wholesalers.

(e) For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to non-preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees who are prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Generic Drug Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are prescribed strengths of the Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Preferred Brand Drug Copayment;

(f) For Non-Preferred Brand Name drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the generic Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Non-Preferred Brand Drug Copayment;

(g) The Offeror shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge will be applied in addition to the applicable Non-Preferred Brand Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Offeror shall require the dispensing Network Pharmacy to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the Programs' Lesser of Logic provisions;

(5) Charge the Programs based on the Programs' MAC List price assigned to the GCN of the dispensed Brand Drug subject to the Programs'

Lesser of Logic plus the applicable dispensing fee as set forth within "Program Claims Reimbursement" of the Contract Provisions, Section VII of this RFP;

(6) Promptly notify and receive the Procuring Agencies prior written approval for any and all exceptions to the Programs' mandatory substitution provisions, other than those resulting the Programs' Mandatory Substitution Appeal Process. Following commencement of mandatory generic substitution, the Offeror must receive the Procuring Agencies written approval prior to suspending enforcement of the Programs' mandatory generic substitution provisions;

(7) Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs' mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the Programs' mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Generic Drug Copayment (DCS only) and the Programs charged based on Generic Drug pricing. The Offeror's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the Programs' mandatory generic substitution requirements;

(8) Immediately notify the Procuring Agencies of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Offeror, subject to the Programs' definitions of Brand and Generic Drugs contained in Section VIII of the RFP.

(9) (Exclusive to DCS) Manage the Narrow Therapeutic Index (NTI) list of multi-source Brand Drugs not subject to Ancillary Charges, and make recommendations to the Department of suggested additions or deletions based on clinical evidence.

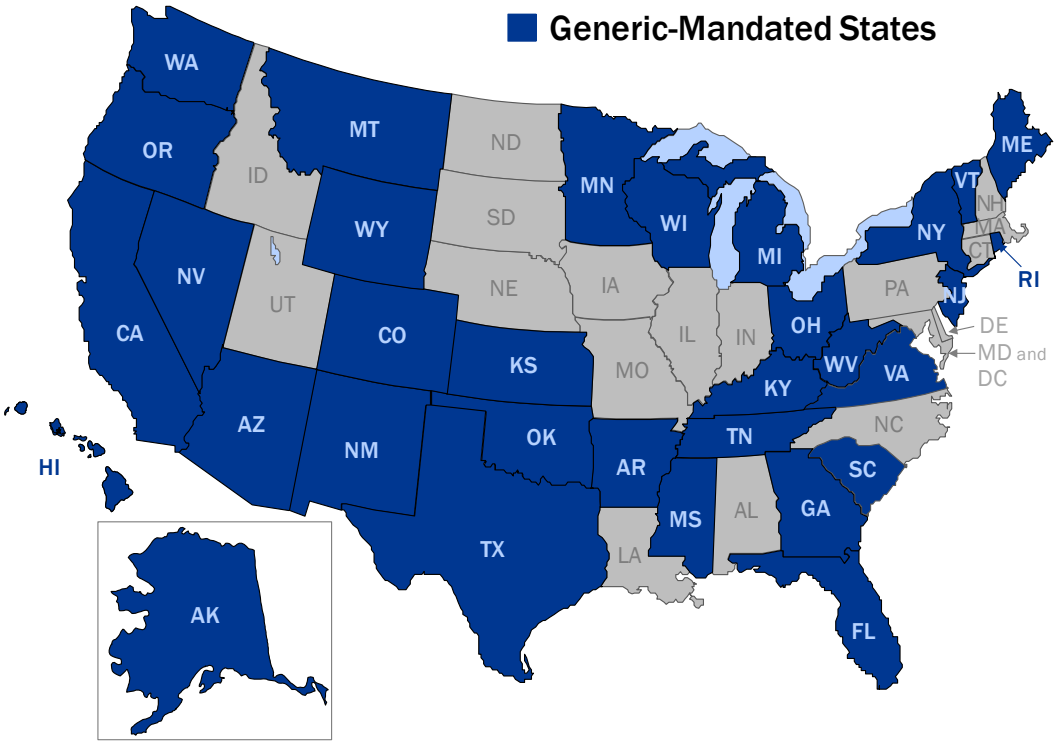
Express Scripts agrees to the duties and responsibilities set forth in item a.1 through a.9, with the exceptions of a.1.2, a.1.4, and a.1.9 which are exclusive to DCS.

b. Required Submission

(1) Please explain in detail the process you will utilize to administer the Programs' mandatory generic substitution provisions in accordance with the requirements set forth in this RFP including, but not limited to, how your claims processing system will enforce the Programs' generic substitution requirement for a Generic Drug within the time limits specified above.

Express Scripts encourages use of generic medications through its formulary system. Individual state requirements are programmed into our adjudication system is programmed to create an automatic trigger to the dispensing pharmacy with no manual intervention required. For generic-mandated states, we request pharmacies dispense a generic drug unless the physician writes a Dispense as Written (DAW1) prescription.
If an attempt is made to process a multi-source brand that has a generic alternative and the physician has allowed substitution, messaging to the dispensing pharmacy indicates that only generics may be dispensed in this instance.

For non-generic mandated states, Concurrent DUR messaging to the pharmacist indicates that a generic is available for this medication and requests substitution. Express Scripts also requires the generic medication to be used in all states with generic substitution laws, outlined in the map below:



Express Scripts also encourages generic substitution through our suite of clinical programs. We have found that enforcing generic substitution can save an average of up to 60% on total claim costs. We are continually expanding and tailoring our services and products to aggressively increase the use of generic medications.

Examples of these programs include:

Step Therapy

With Step Therapy, coverage for higher-cost brand drugs is determined at the pharmacy, as our system checks the injured worker's medication history for the presence or absence of front-line medications. For injured workers whose prescription histories do not include a front-line medication, the brand drug will reject at the point of service with guidance provided to the pharmacist to contact the physician to request a generic alternative. If the physician subsequently prescribes a generic medication, the dispensing process will continue without further interruption (although Concurrent DUR edits will still apply).

However, if the physician chooses not to allow a generic alternative, our OASIS authorization process will be initiated for the prescribed brand drug and NYSIF will decide whether the drug should be dispensed. Many of our clients have chosen to forego the Prior Authorization process if the physician does not change the medication; in this event, the medication processes without delay.

Ultimately, our Step Therapy program enables well-informed decisions and increases the use of therapeutically equivalent generic alternatives. This program generally results in a 25% conversion rate.

Generic Substitution in Home Delivery

Value Solutions, or "Valsol," is a trend management program within Express Scripts' Home Delivery process. When our Home Delivery pharmacy receives a prescription for a multi-source brand drug marked "Dispense as Written," Express Scripts contacts the prescribing physician to request approval to substitute the generic equivalent. The Valsol program demonstrates Express Scripts' ability to help clients control drug costs by managing trend at all channels of distribution.

(2) How do your Retail Pharmacy Network contracts protect the financial interests of the Programs in the event a network Pharmacist does not have a required generic in stock when presented with a Prescription requiring dispensing of the generic under law or pursuant to the provisions of the Programs' mandatory generic substitution program after the maximum twenty-one (21) day period?

Express Scripts does not penalize injured workers or plan sponsors if a pharmacy is out of a mandated generic product. We require a DAW code for each claim transmitted. If the pharmacy is out of the mandated generic product, the pharmacist returns the DAW 4 code (see the table below) and dispenses a brand product. As long as the pharmacist adjudicates the claim as a DAW 4, NYSIF will be charged the generic price.

(3) Explain in detail the process you intend to follow to ensure that drugs meeting the definition of generic as set forth in this RFP are identified in your system as Generic Drugs subjecting them to the generic

pricing requirements set forth in Section V and mandatory generic substitution for A-rated or authorized Generic Drugs.

[redacted]

(4) Please detail how your system will distinguish between A-rated and authorized Generic Drugs requiring generic substitution, A-rated

generics not requiring substitution including, but not limited to Narrow Therapeutic Index (NTI) drugs (DCS only), and non-A-rated Generic Drugs. Please describe the capability of your system to apply MAC pricing but not enforce generic substitution for non-A-rated Generic Drugs, NTI drugs, or for available A-rated Generic Drugs that the Department has directed the Offeror not to enforce the Programs' mandatory generic substitution requirement.

Express Scripts applies a specific MAC price to a specific generic classification. Drugs within a MAC generic classification can be excluded at the NDC level.

(5) Please detail the process for updating your claims processing system upon distribution of a new Generic Drug to ensure prompt application of MAC pricing and/or mandatory generic substitution.

Following the prescribed notification process, the MAC price will be entered into Express Scripts' adjudication system within the agreed timeframe upon the effective date established. MAC pricing will be applied to all products within a generic classification unless specifically excluded by the provisions of the Programs. Typically, updates to our system entail a 24 hour turnaround time. MAC and AWP changes are entered into the system on one day and can be effective the next day, or any future date.

(6) (Exclusive to DCS) Please describe how you will manage the NTI list for the DCS Program including the parties responsible for making NTI recommendations.

Please see our DCS-specific Technical Proposal binder.

Mandatory Generic Substitution Appeal Process (Exclusive to DCS)

An Enrollee may appeal the requirement to pay the Ancillary Charge. Generic appeal review is based upon the demonstrated need for the Brand Drug on an individual Enrollee basis. It is not related to the specific drug as much as it is to the ability of the Enrollee to tolerate the Generic Drug. The criteria may include: previous clinical issues with the Generic Drug, reported allergy to an inert ingredient, co-morbid conditions that require multiple drug therapies, etc. The Offeror is expected to develop a generic appeals process that would allow for exceptions based upon compelling evidence provided by the treating Physician. Each individual case should be decided upon its own merits. For the DCS Program, there must be at least one level of appeal. If an appeal is unsuccessful, an Enrollee may request an external appeal as required by the NYS Insurance Law. Exhibit II.J.1 of this RFP provides the number of generic appeals reviewed for the period of January 1, 2008 through September 17, 2010.

a. Duties and Responsibilities

The Offeror shall administer a Mandatory Generic Substitution Appeal process. The selected Offeror is required to oversee and enforce the DCS Program's generic appeal process including:

(1) Administering a clinically sound generic appeal process at no additional cost to the DCS Program or to the Enrollee. The process must include developing an appeal form and criteria for establishing medical necessity, reviewing appeals for medical necessity, preparing communications to notify Enrollees (subject to Department review and approval) of the outcome of appeals within five (5) Business Days, and integrating the decisions into the claims processing systems including reimbursing the Enrollee for any Ancillary charge paid up to 30 Days prior to receipt of the approved generic appeal; and

(2) Reporting the results of the generic appeal process for the DCS Program to the Department on a drug by drug basis in the format and frequency required in the "Reporting" section of this RFP.

(3) Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge.

(4) Loading into your claims processing system one or more files from the incumbent contractor of the previously approved Generic Appeal requests by the January 1, 2014 implementation date, once an acceptable file is received.

(5) Interfacing with the New York State Department of Financial Services External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or

investigational drug.

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

(1) Describe in detail how you would administer the required generic appeal processes for the DCS Program including:

(a) The turnaround time;

(b) Qualifications of the staff that would conduct the review;

(c) A description of the criteria that would be used to determine whether the brand name medication is medically necessary. Are there any dollar thresholds within your criteria? Do you require generic appeals to be updated after a specific time period? If so, what is the process?

(d) Do you currently administer a generic appeals process? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the Program (for the most recent Calendar Year); and for the following list of drugs:

(a) Prilosec

(b) Fosamax

(c) Topamax

(d) Keppra]

(e) Cellcept

(e) How the Enrollee's claim will be handled during the appeal processing. In the event of a successful appeal, confirm that you will retroactively adjust claims incurred within 30 Days from the date of receipt of a completed appeals form. Describe how member refunds will be handled.

Please see our DCS-specific Technical Proposal binder.

(2) Confirm that you will load previously approved Generic Appeals data into your claims adjudication system.

Please see our DCS-specific Technical Proposal binder.

15. Clinical Management/Drug Utilization Review (DUR)

Clinical management and drug utilization review programs help to control costs and attempt to ensure that Enrollees are receiving safe effective drug treatment. The Procuring Agencies require the selected Offeror to have clinical management/drug utilization programs including a mandatory generic substitution program, a prior authorization program, a concurrent review program and retrospective review programs. The selected Offeror is required to provide these programs; however, an Offeror is not prevented from offering other value oriented programs. No clinical management and drug utilization review programs can be funded by Pharmacy manufacturers. The Procuring Agencies reserves the right to not participate in any program offered by the selected Offeror and the right to opt out of any program at any time.

The Offeror is required to administer and enforce a comprehensive clinical management and DUR program that integrates the various Programs' components, which include at a minimum:

A Prior Authorization Program: to determine the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization;

A Concurrent DUR Program: to aid the dispensing Pharmacist in identifying potential drug therapy problems at the point of sale; and

A Retrospective DUR Program: to look at any long-term effects of drug treatment designed to safeguard Enrollee health and help Physicians make more informed decisions about Prescription drugs. In addition, the Procuring Agencies are interested in receiving information on Physician education/profiling and patient education programs which the Offeror believes would add value to the Programs.

NOTE: THE COST OF ALL THE PROGRAMS LISTED ABOVE IS REQUIRED TO BE IN YOUR CLAIMS ADMINISTRATION FEE.

Prior Authorization

The Programs current Prior Authorization Program determines the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization or a high cost. Drugs currently subject to prior authorization have been recommended by the current contractor and reviewed by the Department. Exhibit II.H provides a current list of the drugs subject to prior authorization. The DCS Program allows Enrollees to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. Exhibit II.H.2 provides the number of Program prior authorizations reviewed and certified for the period January 1, 2008 through September 16, 2011.

The NYSIF Program also prior authorizes certain Prescription drugs. The clinical determination is made by NYSIF and conveyed to the contractor to allow dispensing at a Network Pharmacy.

a. Duties and Responsibilities

To ensure that the resources available to the DCS Program are utilized for appropriate, Medically Necessary Drug therapy, the selected Offeror is required to administer prior authorization programs for the Programs which includes, at a minimum:

(1) A Prior Authorization Program for high cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Offeror as appropriate for Prior Authorization and reviewed by the State shall be included in the Prior Authorization Program. The Prior Authorization Program also subjects specific drugs in certain categories to clinical criteria before benefits are authorized for payment including but not limited to: anti-obesity agents; topical tretinoin; antifungal agents; Hepatitis C agents; Hepatitis B agents for interferon use; select Osteoporosis agents; Respiratory Syncytial Virus (RSV) Therapy agents, select stimulant agent; Multiple Sclerosis agents; Low Molecular Weight Heparin agents; Growth Hormones; Cancer; Pain/Arthritis; Phychosis agents and, Pulmonary Arterial Hypertension agents. Only medications that have been identified as appropriate for the Prior Authorization Program by the Offeror and reviewed by the Procuring Agencies shall be included in the Prior Authorization Program;

(2) (Exclusive to DCS) Informing Medical Professionals who request, by phone, fax, or secure internet portal, a Prior Authorization for a Specialty Drug/Medication about the DCS Program's Specialty Pharmacy Program and providing the information necessary to utilize the Specialty Pharmacy Program to obtain the drug.

(3) Monitoring market changes and recommending deletions or additions

to the list of drugs requiring Prior Authorization on an ongoing basis which must be reviewed by the Procuring Agencies prior to implementation of any changes to the list of medications;

(4) (Exclusive to DCS) Preparing and sending communications (reviewed and approved by the Department) to notify Enrollees and/or their Physicians of the outcome of their prior authorization request and notifying them of the date the Prior Authorization is approved through;

(5) Promptly loading approved prior authorizations determined by the Offeror or received from NYSIF for the NYSIF Program into the claims processing system;

(6) (Exclusive to DCS) Administering an expeditious, HIPAA compliant, internal appeals process which allows Physicians and/or Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. For the Prior Authorization Program, there must be at least one level of appeal, and it must be expeditious and PPACA compliant; and

(7) (Exclusive to DCS) Interfacing with the New York State Department of Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug.

(8) Loading one or more files of Prior Authorization approved-through dates from the incumbent contractors, prior to the January 1, 2014 implementation date, once acceptable files are received.

Express Scripts agrees to the duties and responsibilities set forth in items a.1 through a.8, with the exception of a.1, to which we have provided clarification in our response to b.1. We have provided clarifications to our approach to a.6 and a.7 in our response to b.1.d. Please see our DCS-specific Technical Proposal binder for our response to items a.2, a.4, a.6, and a.7.

b. Required Submission

(1) Referring to the drugs or the drug categories subject to Prior Authorization, describe in detail how you would propose to administer Prior Authorizations including:

(a) The process and criteria you utilize to identify drugs that the Programs should consider for prior authorization;

[redacted]

[redacted]

[redacted]

(b) The qualifications of each level of staff making decisions with regard to the pre- authorization process, denial, and appeal. Based on the DCS Program's number of prior authorizations, what is your projected staffing level for this unit?

[redacted]

(c) A description of any current prior authorization programs you manage including the list of drugs subject to prior authorization and the number of cases reviewed, approved and declined for a client similar to the DCS Program (for the most recent Calendar Year);

Not applicable.

(d) The process you utilize to contract and collect the appropriate information from Physicians in order to make a determination. Provide a timeline for completion of approvals and denials;

Please refer to our response in a above for our process.

(e) The methods you utilize to measure program effectiveness (Do not include any reference to specific monetary savings).

We look at the percentage of prescriptions rejected and never filled. For example, Step Therapy intervention experiences about 26% of medications triggering the edit are never filled. Cost avoidance is one measure of effectiveness because we view this is a measure of driving out waste.

(f) How you will transition Enrollees with current prior authorizations and their Prescriptions into your system. Specifically address whether your system has the flexibility to grandfather benefits for Enrollees currently taking drugs that would require pre-authorization.

As a current client, NYSIF should have no need to grandfather injured worker Prior Authorizations.

Format for Record Layout — Loading Prior Authorizations		
Field Name	**Size**	**Notes**
Plan sponsor-specific injured worker number	Pic X(18)	Plan sponsor-specific injured worker number, including dependent/suffix code
Group number	Pic X(09)	
Fname		Injured worker's first name
Subscriber number	Pic X(09)	The contract number in our system
Dependent code	Pic X(02)	Also referred to as the person code or injured worker suffix code. Values are 00, 01, 02, and on.
Authorization type	Pic X(02)	22, 66, 70B, 70F, 75,96, and 98
NDC number	Pic X(11)	22, 66, 70B, 70F, 75,96, and 98
Number of refills authorized	Pic X(02)	The number of refills authorized by the plan sponsor. If unknown, use 'NN'.
Number of days authorized	Pic X(03)	The number of days the authorization is effective. If unknown, use '365,' then our load program will determine this from the effective and termination dates.
Authorization level	Pic X(01)	Authorizations can be issued by the NDC, generic code, or therapy class
Authorized days per fill	Pic X(03)	Needed for the 19 and 79 series
Authorized quantity per fill	Pic X(03)	Needed for the E7 override
Effective date	Pic X(10)	MM/DD/YYYY
Termination date	Pic X(10)	MM/DD/YYYY
Gender	Pic X(01)	Male or female
Relationship code	Pic X(01)	Relationship to the subscriber: 1 = Subscriber; 2 = Spouse; 3 = Dependent; 4 = Full-time student; 5 = Disabled dependent; 6 = Adult dependent; 7 = Significant other; 8 = Unspecified
Date of birth	Pic X(08)	MM/DD/YYYY

Clients can select the grandfathering process for Prior Authorization, however as NYSIF is a current client, there will be no need for grandfathering Prior Authorizations.

(2) For each of the drugs currently subject to Prior Authorization under the DCS Program, please list the time period of the authorizations that you would apply to each. Also, please confirm what steps the Offeror will perform to re-authorize at the end of the authorization period.

Not applicable.

(3) Confirm that you will send notification letters, subject to the approval of the Department, to the Enrollee and/or Physician to advise of the outcome of the Prior Authorization review and their appeal rights.

Confirmed.

Concurrent Drug Utilization Review (DUR)

The Programs current Concurrent DUR program aids the dispensing Pharmacist in identifying potential drug therapy safety issues at the point of sale, as well as various other point of sale edits that are related to benefit design such as "refill too soon," and Preferred/Non-Preferred Drug designation.

a. Duties and Responsibilities

To safeguard Enrollee health and ensure adherence with the Programs' benefit design, the selected Offeror must administer a concurrent DUR program which includes at a minimum:

(1) A point of service system at all Retail Pharmacy Network locations, Mail Service Pharmacy Process Facilities and Specialty Pharmacies which is continually updated with the latest patient safety edits with the capacity to "message" Pharmacists related to safety issues prior to the dispensing of the Prescription drug; and

(2) A fully integrated point of service system capable of enforcing the Programs' benefit design features.

Express Scripts agrees to the duties and responsibilities set forth in item a.1 and a.2.

b. Required Submission

(1) Please detail the full scope of the Concurrent DUR program that you are proposing to utilize for the Programs. Include the qualifications of the staff responsible for oversight of your Concurrent DUR program.

Concurrent DUR supports and ensures patient safety at the point of service by identifying potential problems with a patient's prescription that could impact patient care, potentially resulting in an adverse drug event. In addition, it helps to prevent potential fraud and abuse by injured workers or pharmacies before a prescription is dispensed.

Through an extensive set of 160 DUR edits, Express Scripts' adjudication system reviews each electronically transmitted prescription claim to evaluate pertinent clinical information and identify potential utilization concerns, quickly relaying any safety alerts to the pharmacist processing the claim. If an edit is triggered, an electronic response is sent to the dispensing pharmacy indicating the potential safety issues and concerns

(2) Describe the software you will utilize to administer the Concurrent DUR program that you will implement for the Programs. Please specify if you have developed this software, purchased it from a third party source, or is it a system you purchased and have adapted for your use.

Express Scripts utilizes both commercially available and internally developed concurrent DUR modules. Express Scripts utilizes an internally developed implementation of First DataBank modules for the drug-drug interaction, high dose, drug-pregnancy and underutilization modules. Express Scripts receives daily, weekly and monthly data feeds from First DataBank. The Express Scripts DUR rules are intended to reduce background noise while increasing the focus on the more critical patient safety concerns.

Express Scripts' modules for drug-age interaction, therapy duplication, ingredient duplication, drug-gender interaction and drug-disease interaction are internally developed and maintained. Express Scripts' clinicians regularly review literature on an ongoing basis for new products and changes to existing products and their findings are presented to committees. Express Scripts' Therapeutic Assessment Committee meets weekly to evaluate the information presented. A workgroup dedicated to concurrent DUR meets regularly to evaluate new information.

(3) Program Safety Edits

(a) Within your Concurrent DUR program describe all safety edits currently enforced through your claims processing system including, but not limited to the safety edits below:

(i) drug-drug interaction including OTC drugs and herbal supplements, if applicable;

[redacted]

(ii) drug-allergy interaction;

The dispensing pharmacy performs drug-to-allergy editing. In the retail network, Express Scripts requires that pharmacies conduct drug allergy editing. At the Express Scripts Pharmacy, we perform editing against injured worker allergies stored in the system. Injured workers report their allergies on the initial injured worker profile and can update the profile as needed.

(iii) drug-medical condition interaction;

Express Scripts developed and maintains our module for drug-disease contraindications. We base our module on First DataBank's drug-disease contraindications and indications data. Our clinicians regularly review additional literature on an ongoing basis for new products and clinical information changes to existing products.

(iv) minimum daily dosage;

We use First DataBank's Minimum Adult Daily Dose module to calculate minimum daily doses for our Under-Utilization Concurrent DUR module. Our minimum daily dose edit sends informational warning messages to the pharmacist for evaluation.

(v) exceeding maximum dosage;

Our system performs standard DUR edits for high dosage. Our high-dose edit is an implementation of First DataBank's Maximum Adult Daily Dose module and focuses on patient safety concerns while avoiding redundancy with the pharmacy's own DUR and minimizing false positive alerts.

Generally, high-dose editing starts at 200% of the First DataBank Maximum Adult Daily Dose. Due to special concerns, high-dose editing for controlled analgesics generally starts at 150% of the First DataBank maximum adult daily dose.

Although Express Scripts recommends our standard high-dose editing configuration, we also support plan sponsor customization for the high-dose edit. Clients can modify, add, or remove high-dose editing levels.

(vi) therapeutic duplication;

The Express Scripts module for therapy duplication is based on First Data Bank's therapy classes. Therapy classes in which duplicate medications are a safety concern are contained within the Therapy Duplication module. Express Scripts clinicians regularly review literature on an ongoing basis for new products and changes to existing products.

(vii) drug-gender interaction;

Drug-pregnancy contraindications, drug-age interaction, and drug-gender interaction also result in concurrent DUR online messaging. Express Scripts utilizes an internally developed implementation of First DataBank pregnancy contraindications for the drug-pregnancy module. Our modules for drug-age interaction and drug-gender interaction are internally developed and maintained based on First DataBank information. Express Scripts clinicians regularly review literature on an ongoing basis for new products and changes to existing products.

(viii) drug-age interaction;

Our modules for drug-age interaction and drug-gender interaction are internally developed and maintained based on First DataBank information. Express Scripts clinicians regularly review literature on an ongoing basis for new products and changes to existing products.

(vix) drug-pregnancy interaction; and

Drug-pregnancy contraindications, drug-age interaction, and drug-gender interaction also result in concurrent DUR online messaging.
Express Scripts utilizes an internally developed implementation of First DataBank pregnancy contraindications for the drug-pregnancy module. Express Scripts clinicians regularly review literature on an ongoing basis for new products and changes to existing products.

(x) compliance with FDA approved drug utilization guidelines.

The Express Scripts Prior Authorization program addresses appropriate drug usage or off-label uses. The program enforces Prior Authorization protocols through concurrent analysis of pharmacy claims. Online messaging instructs the pharmacist to contact our Prior Authorization Services department or the doctor if criteria are not met. The Prior Authorization program employs a hard edit at the point of service when pre-established criteria must be met before a patient can receive a prescription for a particular drug under the regular pharmacy benefit.

Some examples of concurrent DUR edits include:

- Duplicate Prescriptions (Hard Edit) — Express Scripts checks the injured worker's prescription history for an identical prescription issued by that pharmacy or another pharmacy. If such a prescription is found, the system rejects the prescription and alerts the pharmacist with an online message.
- Therapeutic Duplication (Soft Edit) — Our computer system notifies the pharmacist when a patient is taking two or more medications from the same therapy class, such as anti-inflammatory medications. Pharmacists clarify these orders with the prescriber to preclude filling therapeutically duplicate prescriptions, ensuring patient safety.
- Incorrect Dosage (Hard Edit) — We assess the prescribed dosage using Medi-Span's database of minimum and maximum dosages, which is based upon FDA guidelines. When an incorrect dosage is flagged, the system instructs the dispensing pharmacist to use professional judgment and to consult with the prescribing physician in order to determine the appropriateness of the therapy.
- Refill Too Soon (Hard Edit) — Express Scripts allows refills when a certain percentage of the original prescription is gone. For example, if this

percentage is set at 75% of a 32-day supply, the injured worker may not obtain a refill prior to the 24th day, unless the client authorizes an early fill.

- Drug Interactions (Soft Edit) — Express Scripts' computer system checks for severe interactions between medications prescribed to the injured worker. If a concern is flagged, the pharmacist evaluates the nature of the interaction and determines an appropriate course of action. In the case of a potentially dangerous interaction, the pharmacist routinely confers with the prescriber. In less critical cases, the pharmacist may confer with the prescriber or with the injured worker.
- Drug Allergies (Hard Edit) — Express Scripts' database includes data on injured workers' drug allergies. Our system scans new orders against the allergy data and alerts the pharmacist to potential allergic reactions. When an allergy is detected, the pharmacist contacts the prescriber to determine the appropriate course of action.
- Drug-To-Age Conflict (Soft Edit) — Express Scripts' computer system also checks a prescription against an injured worker's age. If a potential drug-age conflict is found, the system sends a message to the pharmacist for appropriate intervention.
- Drug-to-Disease Conflict (Soft Edit) — Express Scripts' system cross-references the Medi-Span Drug-Disease Monitoring System with the injured worker's prescription history to determine whether a potential drug-disease conflict exists. If so, our system alerts the pharmacist and he/she can contact the prescribing physician to determine appropriate action.
- Duration of Therapy (Soft Edit) — Many drugs have an FDA-established guideline for minimum or maximum length of therapy needed for a positive therapeutic effect. If the prescribed drug has a maximum or minimum length of therapy identified in its drug records, and the days of therapy fall below or above the set parameters, the system notifies the pharmacist that consultation with the physician may be appropriate.
- Drug-to-Gender Conflict (Soft Edit) — Certain drug products, by nature of their action or indications, are normally administered to only males or only females. If drug-to-gender conflict is present, the system sends an informational message to the pharmacist.
- High Dose (Hard Edit) — If a prescription has been written for more than 200% of the maximum recommended FDA adult dose, or if the pharmacist enters an inaccurate days supply that would result in a dosage more than double the FDA adult dose recommendations, the system will reject the prescription. The claims staff will have the ability to approve or disapprove this edit. This edit reduces the opportunity for injured workers to abuse controlled substances.

Some soft edits may be overridden by a pharmacist at their discretion. In addition, some hard edits may also be overridden by a pharmacist but require approval from NYSIF first; otherwise, the prescription cannot be dispensed.

(b) Please describe for each edit the messaging sent to the Pharmacist including whether the edit is classified as a soft or hard edit. Describe the type of actions required by the Pharmacist at the point of service following receipt of these alerts. How do you monitor the effectiveness of the safety alerts program?

Please refer to the previous question for hard- or soft-edit classifications and the actions required by the pharmacist at the point of sale.

(4) Program Benefit Edits

(a) Within your Concurrent DUR program describe how your program monitors the following at the point of service, including whether the edits are hard edits or soft edits, and whether the Program monitors overrides at the Pharmacy Level:

A Concurrent DUR program would not be considered complete without the application of administrative edits. Administrative edits support eligibility, drug coverage, pharmacy contract information, and prescription pricing. Specifically, administrative edits are designed to prevent ineligible persons from accessing the Program's benefits and to ensure that prescriptions are processed according to the Programs benefit design. Examples of these types of edits include missing/invalid pharmacy number, missing/invalid days' supply, etc.

[redacted]

[redacted]

(5) Describe the methods you utilize to measure Program effectiveness (Do not include any reference to specific monetary savings).

[redacted]

(6) Describe any other programs the Offeror proposes to provide to administer utilization management on behalf of the Programs.

[redacted]

The Physician Outreach Program targets physicians prescribing multi-source brands [redacted]

[redacted]

Retrospective DUR is an analysis of potential problems or fraud and abuse after a prescription has been filled. These programs provide reports to the client and, with the client's approval, communications to prescribers in an effort to change prescribing patterns.

Our Retrospective DUR program offers the following modules:

- Duplicate Therapy — This program looks at injured workers who have two or more prescriptions in the same therapy class within the last 30 days. The program targets the following therapy classes: non-steroidal anti-inflammatory drugs, COX-2 inhibitors, H2 antagonists, proton pump inhibitors, selective serotonin reuptake inhibitors, and other antidepressants.

- Controlled/Addictive Substances — This module identifies injured workers who have high utilization of controlled substances, muscle relaxants, Ultram, Ultracet, and Stadol. This program looks back 60 days and flags files with seven or more prescriptions; prescriptions greater than or equal to 200% recommended utilization (as determined by First DataBank); prescriptions from two or more physicians; or prescriptions from three or more pharmacies. In addition, the program identifies patients receiving 14 or more prescriptions for controlled substances or greater than 300% recommended utilization from one physician.
- Long-Term Hypnotics (sleep medications) — This program identifies injured workers utilizing prescription hypnotic medications for extended periods. The criteria provide for a look-back period of 120 days for any hypnotic medication with a supply for 90 or more days.

By examining potential substance abuse, identifying long-term hypnotic usage, and identifying duplicate therapies, injured worker safety is increased while potential fraud is reduced. In addition, by checking for proper medication usage, Express Scripts is ensuring NYSIF's drug spend is driven to the lowest net cost.

Narcotics

With narcotic analgesics representing the most utilized and most expensive therapy class of medications in Workers' Compensation, Express Scripts is committed to managing their use through such programs as Concurrent and Retrospective DUR, ScriptAlert, and PDRx. Medications containing fentanyl, such as Actiq and Fentora, represent a small portion of medications within the class (and actually showed a decrease in utilization in 2010), but are extremely costly on a per-prescription basis. At $5,090 per prescription, Actiq can cost up to 10 times as much as OxyContin.

Proactively addressing this challenge, Express Scripts has introduced a new physician communication program that specifically addresses off-label prescribing of fentanyl in brand-name and generic forms.

In addition to those noted above, Express Scripts offers programs to address the use of narcotics both at the point of sale, as well as after the prescriptions have been filled. For example, should NYSIF desire to review/approve narcotics at a given point within an injured workers treatment (i.e., after two or three narcotic fills), we can block these medications and notify the case owner that the medication is pending. (Express Scripts provides adjusters and nurses with extensive resources to assist in their decision-making when these prior authorization requests are presented.)

Conversely, our robust Opioid Report notifies our clients of injured workers who have filled narcotic prescriptions with morphine equivalent dosages that exceed generally accepted treatment guidelines.

Drug Testing

Express Scripts partners with two top national vendors, Ameritox and Dominion, to support client needs for drug testing and monitoring. Drug testing and monitoring programs support adherence, can identify fraud, waste, and abuse, and ultimately provide savings to the client.

In fact, one vendor reported that nearly 69% of test results from more than 250,000 workers' compensation cases were inconsistent with the prescribed medication therapy, costing clients between $3,000 and $5,000 per case.

PDRx

PDRx represents the most in-depth analysis of an individual injured worker's therapy and offers a formal, written report that details drug therapy problems, proposed alternative drug therapies, and desired clinical outcomes. This report is based on our clinical pharmacist's professional review of an injured worker's entire medication file as provided by NYSIF and conformity with established medical practice guidelines. This report also includes a complete financial analysis of all existing drug therapy and potential cost savings associated with any recommended treatment alternatives.

Physician Peer-to-Peer

This program offers consultative outreach to prescribing physicians. This program acts as an escalation for injured worker drug therapy concerns and as an enhancement to existing programs—such as Pharmacist Drug Review (PDRx), ScriptAlert and letter-based programs. The purpose of this program is to promote safety for the injured worker and prevent potential abuse, particularly with narcotics, that increases client costs. Clients will be able to request this physician review and outreach as needed and upon completion will be given a detailed report.

Retrospective DUR Program (Exclusive to DCS)

The DCS Program's current Retrospective DUR Program reviews Enrollee presciption profiles for drug therapy complications. In the event a potential drug complication is identified, alert letters are sent to the prescribing Physician. The DCS Program is designed to safeguard the Enrollee's health and help Physicians make more informed decisions about Prescription drugs.

a. Duties and Responsibilities

To safeguard the Enrollee's health the selected Offeror must administer a Retrospective DUR Program which:

(1) Using the Offeror's standards, evaluates the Enrollee's Prescription drug utilization against the Enrollee's profile using FDA and other evidence based guidelines to identify potential safety related concerns. The Offeror shall alert the prescribing Phyicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of narcotics; and

(2) Identifies potential drug therapy complications for Enrollees, develops Physician alerts (subject to Department review and approval) and sends the alerts to the prescribing Physician; and

(3) Reports the results of its Retrospective DUR Program initiatives, including outcomes, to the Department on a quarterly basis in a mutually agreed upon format.

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

Describe the Retrospective DUR Program that you propose to put in place for the DCS Program including:

(1) The qualifications of the staff that would perform these reviews;

Please see our DCS-specific Technical Proposal binder.

(2) How you identify and select areas for retrospective review and the methods utilized to inform and educate Physicians;

Please see our DCS-specific Technical Proposal binder.

(3) A timeline for these reviews.

Please see our DCS-specific Technical Proposal binder.

(4) What type of follow-up you conduct after communicating the information to the Physician;

Please see our DCS-specific Technical Proposal binder.

(5) How you measure the effectiveness of your Retrospective DUR Program including any statistical measures of the success of your efforts (Do not include any reference to specific monetary savings);

Please see our DCS-specific Technical Proposal binder.

(6) Whether you currently administer a Retrospective DUR Program for other clients; and

Please see our DCS-specific Technical Proposal binder.

(7) The reporting capability for your described program.

Please see our DCS-specific Technical Proposal binder.

Physician Education

a. Duties and Responsibilities

Subject to review and approval by the Procuring Agencies, the Offeror must undertake a Physician education program involving communications with prescribing Physicians which includes at a minimum:

(1) Analysis of Physicians' drug or condition specific prescribing patterns;

(2) Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Enrollees shall make the Physician aware of the distribution channel most cost effective to the Programs and the Enrollee; and

(3) Reporting the results of its Physician Education initiatives to the State on a quarterly basis in a mutually agreed upon format.

(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

Express Scripts agrees to the duties and responsibilities set forth in item a.1 through a.4.

b. Required Submission

Please describe/present the Physician communication/education programs you propose for the Programs. Describe your objectives and approach to Physician profiling and education including:

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

(1) Whether you currently administer a Physician profiling and education program for other clients similar to the Programs;

Confirmed, Express Scripts offers many programs which will be discussed in greater detail below. Express Scripts has a robust approach to physician outreach, and we offer many programs to help achieve our common goals with NYSIF in this regard. A few of these programs are highlighted below.

Our Retrospective DUR program reviews patterns of prescribing and notifies physician by letter when we identify a potential problem such as high number of controlled

substance prescriptions, use of multiple prescribers or pharmacies, therapeutic duplications.

To further strengthen our in-depth review capabilities, we are currently implementing an additional medical review. To augment our clinical programs we will begin to offer Physician outreach calls to the injured worker's prescriber.

This will act as an escalation for injured worker drug therapy concerns and as an enhancement to existing programs — such as Pharmacist Drug Review (PDRx), ScriptAlert and letter-based programs. The purpose of this program is to promote safety for the injured worker and prevent potential abuse, particularly with narcotics, that increase client costs.

The injured worker's case will be referred to the appropriate physician specialist for outreach. Benefits of this program include increased potential for reducing claim costs as physicians migrate prescribing patterns; accommodating options for additional assistance on a claim-level basis, as needed; detailed reports of physician-to-physician review and outreach, including cited references; convenience through ease of administration; and increased safety for injured workers.

ScriptAlert

Express Scripts' ScriptAlert program provides an additional layer of early clinical screening designed to assist NYSIF in identifying potentially inappropriate patterns of medication use. This program manages utilization by monitoring potential drug therapy problems, including narcotic usage, duplication of therapy, excessive duration of therapy, overlapping prescribers, and questionable relevance to injury.

ScriptAlert reports use established criteria to target Workers' Compensation claims that our data predicts a high likelihood to present challenges to NYSIF in the near future. These reports help evaluate the need for such interventions as case management, independent or physician medical examinations, and peer-to-peer conversations.

Pharmacist Drug Review (PDRx)

PDRx represents the most in-depth analysis of an individual injured worker's therapy and offers a formal, written report that details drug therapy problems, proposed alternative drug therapies, and desired clinical outcomes. This report is based on our clinical pharmacist's professional review of an injured worker's entire medication file as provided by NYSIF and conforming with established medical practice guidelines. This report also includes a complete financial analysis of all existing drug therapy and potential cost savings associated with any recommended treatment alternatives. This level of assessment is typically reserved for the most clinically challenging cases such as:

- High-exposure medical case
- Use of multiple medications (polypharmacy)

- Complex/multiple diagnoses (e.g., catastrophic injuries)
- Repeated early refill attempts
- Anticipated treatment greater than six months
- Use of multiple pharmacies or physicians
- Drug therapy of questionable relevance to injury

Prospective reviews are reported real-time, while concurrent reviews are available via e-mail or online reporting. Retrospective reviews are available as written reports sent directly to NYSIF.

With this level of drug utilization review, Express Scripts' clinical pharmacy program facilitates improved quality of patient care, enhanced therapeutic outcomes, and reduced pharmaceutical expenditures for all injured workers, thereby reducing overall healthcare costs.

Physician Outreach Program (POP)

Express Scripts' Physician Outreach Program (POP) capitalizes on proven tactics to help NYSIF increase its generic fill rate and manage pharmacy trend. Through the use of physician communications, which encourage the use of generic medications over brand-name drugs, NYSIF can decrease drug spend without negatively impacting patient care.
The Physician Outreach Program targets physicians prescribing multi-source brands (brands with chemically equivalent generics available) as Dispense as Written and select single-source brands (brands with therapeutic alternatives within the same therapy class). Once identified, we send informational letters to the prescribing physician encouraging the use of generic medications in place of more costly brand-name alternatives.
Results

Express Scripts tracks the success of the Physician Outreach Program, Retrospective DUR, and Step Therapy through quarterly outcomes reporting at the client level. Clients are provided with reporting that identifies the successful conversions due to safety interventions or generic substitution along with the associated savings.
Express Scripts provides the comprehensive Pharmacist Drug Review to clients, who in turn, can opt to utilize the information provided in a variety of ways. Depending upon the manner in which the PDRx recommendations are utilized, the outcomes generated from this report can vary greatly.

(2) A description of the method(s) and analysis you use to select Physicians for profiling and whether your clinical programs involve peer-to-peer Physician discussions;

[redacted]

[redacted]

manner in which the PDRx recommendations are utilized, the outcomes generated from this report can vary greatly.

(3) The frequency of your educational efforts;

[redacted]

(4) The number of Physicians you have contacted as part of a Physician Education Program and the results of those efforts in the areas of increased compliance with recommended protocols and modifying patient Prescription utilization;

[redacted]

(5) How you measure the effectiveness of your Physician profiling program including any statistical measures of the success of your efforts. (Do not include any reference to specific monetary savings); and

[redacted]

(6) Whether you will adapt your Physician Education Program standards to meet the Program's needs as specified by the Department.

We customize our Physician Education programs to each client's specific areas of focus and opportunities.

(7) Confirm that the Physician Education program will not be funded by pharmaceutical manufacturers.

Confirmed. All of our clinical programs are funded solely by Express Scripts and not Pharma manufacturers. The focus of our programs is to drive generic use.

Patient Education (Exclusive to DCS)

The Empire Plan currently includes a Patient Education Program to notify Enrollees of the cost-effective utilization of Prescription drugs through a Half Tablet Program.

a. Duties and Responsibilities

(1) Subject to State review and approval by the Department, the Offeror must develop and implement a patient education program consisting of communications to Enrollees which:

(a) Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Enrollees that have chronic diseases to maximize health benefits of drug treatment;

(b) Analyzes drug utilization to identify and facilitate communication with Enrollees not managing their drug utilization in the most cost effective manner for the Enrollee;

(c) Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and

(d) The Patient Education Program may not be funded by Pharmacy manufacturers.

(2) Offerors may propose a voluntary Half Tablet Program which will allow Enrollees to pay half the regular Copayment at the point of service for half the quantity of double strength, eligible Prescriptions. If such is the case, the Offeror's proposal shall:

(a) Establish a list of drugs that would be appropriate to include in the Half Tablet Program including, but not limited to the drugs listed in Exhibit II.M, if deemed appropriate by the Offeror;

(b) Notify Enrollees of their eligibility to participate in the Half Tablet Program. Monthly, the Offeror must use utilization data to identify Enrollees newly eligible to participate in the Half Tablet Program and mail welcome/announcement letters to those Enrollees. These letters are subject to review and approval by the Department;

(c) Provide each Enrollee newly participating in the Half Tablet Program with one tablet splitter, at no charge to the Enrollee; and

(d) Load a file to transfer current Enrollees with qualifying Prescriptions into the Half Tablet Program as of January 1, 2014.

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

(1) Describe your objectives and approach to patient education including:

(a) Whether you currently administer a patient education program for other clients;

(b) The identification and selection of categories of drugs to apply retrospective review and the method(s) you propose to use to educate and inform patients;

(c) The number of educational interventions and the expected Enrollee response rate; (d) How you measure the effectiveness of your patient education program including any statistical measures of the success of your efforts. (Do not include any reference to specific monetary savings); and

(e) Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

Please see our DCS-specific Technical Proposal binder.

(2) If proposed, describe the Half Tablet Program for the DCS Program, including:

(a) Confirm which drugs listed in Exhibit II.M will be included in the Half Tablet Program.

(b) Detail the criteria that will be used to identify additional drugs for inclusion in the Half Tablet Program. Provide a list of additional drugs you recommend to include in the Half Tablet Program and the basis for the recommendation.

(c) Describe in detail the process to identify newly eligible Enrollees for the Half Tablet Program, including timeframes.

(d) Describe how Enrollees will enroll in the Half Tablet Program. Confirm that a table splitter will be mailed at no additional cost to the Enrollee.

(e) Confirm that if a Half Tablet Program is implemented, a half Copayment would be passed to Enrollees participating in the Programs at the point of service, upon presenting a valid script.

Please see our DCS-specific Technical Proposal binder.

NOTE: THE COST OF ALL THE PROGRAMS LISTED ABOVE ARE REQUIRED TO BE IN THE CLAIMS ADMINISTRATION FEE.

Other Safety Related Programs

The Procuring Agencies are interested in any other clinical management or drug utilization review programs that are intended to promote the health and well being of Enrollees. Offerors may propose other programs of this nature, not already being utilized by the Programs as a requirement of the Contractor under duties and responsibilities set forth in the RFP. The State reserves the right, if allowed by NYS Finance Law, to participate in any such program(s) offered.

For any such program(s), the Offeror must clearly indicate whether or not there is a cost to the State for said program(s) (do not disclose the dollar amount, if any, in the Technical Proposal) and, if there is a cost, whether or not the cost is included in the Offeror's proposed Claims Administration Fee. If there is a cost for a program(s) and that cost is not included in the Offeror's proposed Claims Administrative Fee, Offerors are advised that the Department may be precluded by NYS Finance Law from participating in such program(s).

Should the State choose to participate in such program(s), the State reserves the right to opt out of any such program(s) at any time during the term of the Agreements in such case(s), the Claims Administrative Fee shall be reduced by the cost incurred by the State for that program(s).

a. Duties and Responsibilities

N/A

b. Required Submission

(1) Please describe the purpose of any other clinical management or drug utilization review programs that you are proposing to administer for the Program with the Pharmacy, Physicians, Enrollees, etc. Include a detailed description of how the program operates and its benefit to the Programs and Program's Enrollees.

We have fully described all WC clinical and DUR programs throughout this proposal.

(2) Identify the funding source behind any of the programs you are proposing and confirm whether or not the costs for the Program are included in the Claims Administration Fee.

[redacted]

16. Preferred Drug List Development and Management (Exclusive to DCS)

The selected Offeror is required to efficiently develop, administer and maintain multiple Preferred Drug Lists (PDL) that ensure Enrollee access to appropriate, quality pharmaceutical care based on sound clinical criteria. The DCS Program currently has four (4) formulary benefit designs: Traditional Empire Plan PDL, Flexible Formulary Drug List, Enhanced Flexible Formulary List, and the Excelsior Plan PDL. The DCS Program requires that all Covered Drugs be classified as preferred or non-preferred. PDL management, in particular designation of drugs as preferred (which generally means Level 1 or Level 2), non-preferred, or excluded, is critical to the clinical and financial success of the DCS Program. The Offeror must use sound clinical criteria in any decisions that are made to place or exclude drugs from the PDL's.

The PDLs generally feature Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDLs proposed for the DCS Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the DCS Program's PDLs to Network Pharmacies, medical providers and Enrollees. The design of the DCS Program's Prescription Drug benefit does not require a Brand Drug in every therapeutic category. For the purpose of preparing a response to this RFP, if an Offeror proposes a Preferred drug list which does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section V, Cost Proposal of this RFP.

Note: Do not include any cost information in the technical proposal.

Traditional Empire Plan PDL: Under the traditional Empire Plan PDL, all covered Generics are Level 1 and covered Brand Drugs are on either Level 2 or Level 3. A proposed PDL that includes Generics on Level 2 or Level 3 and/or includes Brand Drugs on Level 1 does not currently meet the Program requirements for the Traditional Empire Plan PDL and would not be acceptable. Drugs may not be excluded from the Traditional Empire Plan PDL. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL. The Traditional Empire Plan PDL is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

Flexible Formularies (two): Under the Flexible Formulary, Generics

may be on Level 1 or excluded. Brand Drugs may be on Level 1, 2, or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 does not meet the Program requirements for the Flexible Formulary Drug List and would not be acceptable. Drugs may be excluded from the Flexible Formulary based on sound clinical and financial criteria. Proposed drug exclusions must meet the following criteria:

Access to one or more drugs in select therapeutic categories may be restricted (not covered) if the drug(s) has no clinical advantage over other generic and brand name medications in the same therapeutic class. Drugs considered to have no clinical advantage that may be excluded include any products that:

a. contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;

b. contain an active ingredient which is a modified version of and therapeutically equivalent to another covered Prescription Drug Product;

c. are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent For the 2012 Flexible Formulary, the following drugs were excluded from coverage: Acuvail, Adoxa, Amrix, Aplenzin, Asacol HD, BenzEFoam, Caduet, Clobex Shampoo, Coreg CR, Detrol LA, Dexilant (formerly Kapidex), Doryx, Edluar, Epdiuo, Extavia, Flector, Genotropin (except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Humatrope (except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age), Iansoprazole, Metozolv ODT, Momexin Kit, Naprelan, Neobenz Micro, Nexium, Norditropin (except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age), Olux/Olux-E Complete Pack, omeprazole/sodium bicarbonate capsule (generic Zegerid), Omnitrope (except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Prevacid Ccapsules, Requip XL, Ryzolt, Soma 250, Terbinex, Testim, Treximet, Triaz, Twynsta, Veramyst, Xopenex Inhalation Solution, Zegerid Capsule, Ziana, Zipsor.

In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL, nor to appeal a drug exclusion. The Flexible Formulary is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

The "Enhanced Flexible Formulary" adds a "Brand for Generic" feature to The Empire Plan's Flexible Formulary. With this feature, a brand-name drug may be placed on Level 1, or excluded, and the generic equivalent placed on Level 3, or excluded. With Department approval, these placements may be revised mid-year when such changes are advantageous to The Empire Plan. Effective January 1, 2013, a "New to You Prescriptions" program will be implemented for enrollees subject to the Enhanced Flexible Formulary. This program will require the enrollee to have two (2) 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

Excelsior Plan PDL: Under the Excelsior Plan PDL, both Brand and Generic Drugs may be placed on Level 1, 2 or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 and/or has Brand Drugs on Level 1 meets Program requirements and would be acceptable for the Excelsior Plan. Drugs may be excluded from the Excelsior Plan PDL based on sound clinical and financial criteria. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL nor to appeal a drug exclusion. The Excelsior Plan PDL may be updated throughout the year. It is currently updated on January 1 and July 1 each year. The goal of the Excelsior Plan PDL is to offer a therapeutically sound formulary that result in a Plan design that costs a minimum of 15% less than The Empire Plan Flexible Formulary.

a. Duties and Responsibilities

The Offeror must provide PDL development and management services for the DCS Program. Such responsibility shall include but not be limited to:

(1) Developing and administering four multi-level formularies, consistent with the Program's four benefit designs. The Offeror's PDL's must be based on sound clinical criteria. The Offeror's Book of Business PDL for the Excelsior Plan PDL must include non-self administered, intravenous and intramuscular injectable drugs covered under the Excelsior benefit plan design. In designating a drug as preferred or non-preferred for the Empire Plan's Traditional PDL and Flexible Formulary drug lists, the Offeror must ensure that drugs recognized in documented medical evidence and studies as clinically superior to similar drugs in a therapeutic class be designated as preferred. In situations where there are multiple drugs in a therapeutic class of similar clinical characteristics, net costs shall be considered in determining a drug's status as preferred or non-preferred. For the

Traditional Empire Plan PDL, generally, one or more single source Brand Drugs in a therapeutic category shall be designated as preferred, unless there is compelling clinical reason for not promoting the use of the Brand Drug(s). The composition of the PDL for the Flexible Formulary and the Traditional PDL will be developed by the Offeror and reviewed annually by the Department;

(2) The Offeror may recommend and the Department may, at its sole discretion, approve a mid–year change in a drug's status from non-preferred to preferred for the Flexible Formularies and Traditional PDL. Any recommended mid-year changes to the PDLs shall be provided to the Department with a summary of the clinical and financial implications to the DCS Program. In the instance when a change to a Preferred Drug List is approved outside of the annual update, the Offeror's communication responsibilities are the same as the annual PDL update. For the Excelsior Plan, the timing of up-tiers and exclusion shall be consistent with the Offeror's Book of Business PDL;

(3) Developing Preferred Drug List's for each of the four benefit designs, subject to the review and approval of the Department, for the purpose of distributing printed copies to Enrollees and medical providers. Additionally, electronic copies will be developed for posting on the Department's website and the Offeror's customized website for the DCS Program in order to inform Enrollees and providers of the placement of the most commonly prescribed medications on each Preferred Drug List. The Department shall be responsible for the distribution of the printed PDL provided by the Offeror on an annual basis to Enrollees. The Offeror shall be responsible for producing and distributing all other copies of the printed PDL, including but not limited to supplies sent to agencies, those sent with Offeror mailings to Enrollees and individual requests by Enrollees or providers. The Offeror is required to promptly mail the Preferred Drug List to Enrollees who call requesting a copy. Printed copies of the Traditional Empire Plan PDL and Flexible Formulary Drug List from 2011 and 2012 are presented in Exhibits II.I through II.I.3. The Excelsior Plan PDL for 2012 is presented in Exhibit II.I.4.

(4) Compiling and organizing the PDLs in two versions, limited to the most commonly prescribed medications for posting and distribution: an alphabetical listing of Preferred Drugs and a listing of Preferred Drugs categorized by therapeutic category. A full listing of the PDL must be available for posting on the website. The Offeror must work with the Department on the format of the PDL. The PDL that is developed for distribution to Enrollees, and providers and posted on the website must provide notice of the pending introduction of a generic equivalent for one or more strengths of a particular Brand Drug that could result in one or more strengths of the drug being

moved to non- preferred status during the year. The PDL shall also list the name of the reference product in parenthesis next to the name of the Generic Drug (i.e. simvastatin (Zocor)) unless the Department otherwise directs. The PDL shall indicate those drugs that require Prior Authorization and those drugs eligible for the Half Tablet Program. The Offeror shall inform the Department of any rebate implications to the DCS Program as a result of including this information on the PDL.

(5) Developing the PDL in a timely manner so that the Department approved, printed PDL is available to be communicated to Enrollees and posted to the website at least forty-five (45) Days before the start of the Calendar Year, to coincide with the DCS Program's option transfer period for Enrollees.

(6) Developing and mailing a Department pre-approved disruption letter, via first class mail, to Enrollees who are affected by a drug's exclusion or a Preferred Brand Drug's reclassification to a non-preferred status unless the reclassification is the result of the introduction of an equivalent generic for the Traditional Empire Plan PDL and Flexible Formulary Drug Lists. Disruption mailings for the Enrollees in the Excelsior Plan will follow the disruption mailing plan employed for the Offeror's Book of Business PDL. Such letters must be sent to Enrollees who have utilized a medication at least once within the latest four month time period, regardless of the Days supply or whether the medication is categorized as maintenance or acute. An additional mailing must be sent to Enrollees who are new users of a medication between the date claims records were selected for the initial disruption mailing and the date that the PDL changes go into effect. Such communications should provide to the Enrollee information concerning clinically appropriate alternatives on the first and second level, when applicable, of the Preferred Drug List as of the effective date of the drug's exclusion or change from preferred to non-preferred status. In situations where Enrollees are affected by a Generic Drug's reclassification to a Brand Drug, the Offeror agrees to send a disruption letter to affected Enrollees;

(7) Notifying the Department in writing when a Class I drug recall or voluntary drug withdrawal occurs. The Offeror must take proper action to help promote patient safety. The Offeror will review with the Department the need to communicate and at the Department's discretion will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the Federal Food and Drug Administration drug or device recalls and manufacturer drug or device withdrawals at no additional cost to the Program. Such notification must be timely and all written materials subject to Department review and prior written approval. The Offeror must assist the Department in collecting monies from recalled products.

(8) Using reasonable efforts to monitor the industry on behalf of the DCS Program and notifying the Department in writing of any class action lawsuits for which a class has been certified and of any proposed orders or settlements that the DCS Program may be entitled to participate in as a member of the class. Unless otherwise notified by the Department, the Offeror shall file claims on behalf of the Program and take all steps necessary to ensure the DCS Program's interests in the class action suit or proposed settlement are protected. Any recoveries collected by the Offeror on behalf of the DCS Program, net of the Offeror's actual costs in securing the DCS Program's participation in the recovery, due the DCS Program must be credited to the DCS Program within fifteen (15) Days upon the Offeror's receipt. The Offeror shall make reasonable efforts to maximize recoveries. Distribution of recoveries, net of the Offeror's actual costs incurred on behalf of the DCS Program, shall be made consistent with the terms of the final settlement order or court decision. The Offeror shall assist the State in its recovery efforts and provide the claims and rebate data required to file a claim on behalf of the DCS Program when requested by the Department.

(9) Holding an annual meeting with the Department to review upcoming Traditional Empire Plan PDL and Flexible Formulary Drug List changes prior to the effective date of any changes. This meeting will include a review of the Offeror's Book of Business PDL strategy. Upon the Department's request the Offeror shall provide a detailed explanation of the clinical and/or financial basis for the decision to change the classification of the drug (s) on the Traditional Empire Plan PDL and Flexible Formulary Drug List as well as a detailed cost analysis of the impact of the changes to the Program.

(10) Assigning a new strength of a drug to the same PDL Level as the pre-existing strengths of the drug in the event a new strength of a drug already on the Traditional Empire Plan PDL or Flexible Formulary Drug List is shipped from the manufacturer or wholesaler;

(11) For the Traditional Empire Plan PDL and the Flexible Formulary Drug Lists, designating as Preferred all FDA approved Covered Drugs without therapeutically equivalent generics prescribed for the treatment of the following diseases; Cancer, Hepatitis, HIV and Diabetes. FDA approved organ transplant anti-rejection drugs shall also be designated as Preferred Brand Drugs. Post award, the Offeror may recommend other disease states where all the Covered Drugs prescribed to treat the illness would be designated as Preferred.

(12) Working with the medical carrier and the mental health and substance abuse carrier to develop communications such as, but not limited to provider newsletters to ensure that participating providers in those networks are fully apprised of the level/status of Covered Drugs.

(13) The Offeror will be responsible for ensuring the Empire Plan Flexible Formularies and the Traditional Empire Plan Preferred Drug List will be electronically available to Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred.

(14) The Offeror will be responsible for protecting the value of the DCS Program's pricing discounts by taking appropriate steps to control Prescription Drug AWP increases.

(15) The Offeror will be responsible for developing, recommending, and implementing Brand for Generic strategies for the Enhanced Flexible Formulary that are financially beneficial to the State. All Brand for Generic placements are subject to Department approval. These placements may be revised mid-year, with Department approval, when such changes are advantageous to The Empire Plan.

(16) The Offeror will be responsible for implementing and administering a "New to You Prescriptions" program. This program requires Enrollees to have two 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

Please see our DCS-specific Technical Proposal binder.

b. Required Submission

Preferred Drug List Management – General

(1) Do you currently develop, maintain and administer plans with three copay level benefit designs utilizing one or more Preferred drug lists? Detail your proposed plan and your capability to administer the Program's three different formulary benefit DCS Program designs.

Please see our DCS-specific Technical Proposal binder.

(2) Describe the various preferred drug lists you have available:

(a) Do you have a standard three copay level preferred drug list used for your Book of Business?

(b) Do you maintain multiple standard and custom preferred drug lists? Provide a description of the differences.

(c) What is the goal of these alternative preferred drug lists?

(d) What role do clients play in the development of your preferred drug lists? (e) How often are changes made for both additions and deletions?

(f) Are there special considerations for biological and specialty Pharmacy products in your preferred drug list and/or process?

Please see our DCS-specific Technical Proposal binder.

(3) What Preferred Drug Lists are you proposing to use in managing the DCS Program? Please provide copies. Are there any therapeutic classes that are composed of only Non-Preferred Drugs due to documented medical evidence of inferior clinical attributes of the Brand Drugs in comparison with competing generics and/or clinically documented safety concerns? What is your clinical rationale for limiting these drugs to Level 3?

Please see our DCS-specific Technical Proposal binder.

(4) Explain how you would work with the medical carrier and the mental health and substance abuse carrier to ensure that participating providers in their networks are fully apprised of the level status of Covered Drugs.

Please see our DCS-specific Technical Proposal binder.

(5) Confirm that the Empire Plan Flexible Formulary and the Traditional Empire Plan Preferred Drug List will be made available on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred. Describe how Rx Hub will be utilized for the benefit of the DCS Program including how it will encourage physicians to prescribe lower cost alternative medications to Enrollees.

Please see our DCS-specific Technical Proposal binder.

(6) Describe the strategy which would be implemented to control Prescription Drug AWP increases.

Please see our DCS-specific Technical Proposal binder.

(7) Describe how you will develop, recommend, and implement Brand for Generic strategies for the Enhanced Flexible Formulary that are financially beneficial to the State.

Please see our DCS-specific Technical Proposal binder.

(8) Do you currently administer a "New to You Prescriptions" program or one similar to this for your book of business? Detail your proposed plan and your capability to administer the "New to You Prescriptions" program.

Please see our DCS-specific Technical Proposal binder.

Preferred/Non-Preferred/Excluded Determination

(1) Describe in detail the process employed to determine whether a drug is designated as preferred, non-preferred or excluded, including:

(a) All standards and criteria used in this determination;

(b) The qualifications of the current participants in the review process, as well as any requirements related to ensuring that the participants in the process are independent, objective, and free of conflict of interest;

(c) The role of net cost in this determination;

(d) Whether the designation of preferred/non-preferred or excluded status is governed by formal corporate policies and procedures detailing standards of review and criteria, is considered in reaching such determination;

(e) Whether the process is governed by formal procedures to ensure sound clinical examination resulting in quality pharmaceutical care;

(f) Whether a record is made of the process leading to preferred/non preferred or excluded designations and whether the Department will have access to either original records and/or summaries detailing the basis for designations;

(g) How often a drug's preferred/non-preferred or excluded status is reviewed and revised and is the review process done on a predetermined scheduled basis? If so, what is the schedule for

the review process and are there exceptions to these scheduled meetings;

(h) Whether the process is different for innovative new therapies than for therapies that already have a competitive alternative; and

(i) The conditions that would cause a drug's preferred, non-preferred, or excluded status to change and several recent examples.

Please see our DCS-specific Technical Proposal binder.

(2) Describe the type of analysis you would perform when a Preferred Brand Drug is being considered for movement to a Non-Preferred Brand Drug list and vice versa.

Please see our DCS-specific Technical Proposal binder.

(3) Provide a diagrammatic illustration of the process from receipt of notification of a new drug entry into the marketplace from the manufacturer, to the Preferred Drug List decision making process, identifying any and all clinical and financial considerations impacting the placement of the product. Please include estimated time frames.

Please see our DCS-specific Technical Proposal binder.

Preferred Drug List Strategy

(1) How are Generic equivalents considered in your assessment of individual therapeutic categories on your Preferred Drug List?

Please see our DCS-specific Technical Proposal binder.

(2) How does your Preferred Drug List development process promote the use of the most cost effective drug within the therapeutically equivalent drugs in the class, including Generics. Provide three examples.

Please see our DCS-specific Technical Proposal binder.

(3) Does your PDL strategy currently allow for drug exclusions? Do your proposed Flexible Formulary and Excelsior PDL's contain Drug exclusions? If so, please list proposed excluded drugs and rationale. Describe how you use exclusion leverage to negotiate rebates with

Pharmacy manufacturers to provide the best value to the DCS Program.

Please see our DCS-specific Technical Proposal binder.

(4) Describe your strategy and process for evaluating and determining the appropriate Preferred Drug List designation for the introduction of "me too" drugs including drugs with OTC equivalents. Please describe your current strategy and its rationale for the proton pump inhibitor class, statin class, and lifestyle drugs (Viagara, Levitra, etc.).

Please see our DCS-specific Technical Proposal binder.

(5) Describe your strategy and process for determining the appropriate Preferred Drug List designation for the introduction of "successor drugs," including extended release products. Provide an example of this strategy.

Please see our DCS-specific Technical Proposal binder.

(6) Please detail your strategy and process for determining the appropriate copay level designation for the introduction of "combination drugs" including, but not limited to any net cost analysis comparing the cost of the new combination drug and the cost of its component drugs. How does this process evaluate comparative cost when the new combination drug does not come in all strengths available in either of the component drugs or if the single combination drug does not meet the usual dosing levels of one of the component drugs? Please provide an example of this strategy.

Please see our DCS-specific Technical Proposal binder.

(7) Explain how your business model ensures that the placement of drugs on the Preferred Drug Lists will result in the best value to the DCS Program and Enrollees. Describe how manufacturer contracting is integrated into this process.

Please see our DCS-specific Technical Proposal binder.

(8) Describe how the anticipated upcoming release of a new Generic drug impacts the placement of its Brand Drug equivalent on the Preferred Drug Lists. Will the rebates available for similar Brand Drugs impact its placement? Does your proposed Preferred Drug List have drugs

anticipated to go generic in 2012 as non-preferred? Please explain the rationale for such classification.

Please see our DCS-specific Technical Proposal binder.

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

(1) Describe your process for complying with the applicable Program requirements in the event of a Class I drug recall or voluntary drug withdrawal including the time notification standards you employ. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?

Please see our DCS-specific Technical Proposal binder.

(2) Describe your process for identifying drug lawsuits and settlements on behalf of the Program. Confirm that the Offeror will notify the Department in a timely manner of class action lawsuits or settlements in which the Program may participate. Confirm that the Offeror will credit the Program for net recoveries within fifteen (15) Days upon receipt by the Offeror. Describe how the Offeror's actual costs incurred in the settlement will be allocated to the Program.

Please see our DCS-specific Technical Proposal binder.

Preferred Drug List Development and Management (Exclusive to NYSIF)

The selected Offeror is required to efficiently develop, administer, and maintain a single Preferred Drug List (PDL) that ensures Claimant access to appropriate, quality pharmaceutical care based on sound clinical criteria. The Program requires that all Covered Drugs be classified as preferred or non-preferred. PDL management, in particular designation of drugs as preferred (which generally means Level 1 or Level 2), non-preferred or excluded, is critical to the clinical and financial success of the Program. The Offeror must use sound clinical criteria in any decisions that are made to place or exclude drugs from the PDL.

The PDL generally features Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDL proposed for the Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the Program's PDL to Network Pharmacies, medical providers, and Enrollees. The design of the NYSIF Program does not require a Brand Drug in every therapeutic category. For the purpose of preparing a response to this RFP if an Offeror proposes a Preferred drug list which does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section V, Cost Proposal of this RFP.

Note: Do not include any cost information in the technical proposal.

a. Duties and Responsibilities

The Offeror must provide PDL composition and management services for the NYSIF Program. Such responsibility shall include but not be limited to:

(1) Creating and maintaining a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g. drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;

(2) Providing NYSIF with a list of therapeutic categories routinely excluded from coverage;

(3) Agreeing that the Offeror does not and will not accept payments from drug companies to promote specific products;

(4) Notifying NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or

not the affected drugs are covered or require prior authorization;

(5) Notifying NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,

(6) Providing NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GCN and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

Express Scripts agrees to the duties and responsibilities set forth in item a.1 through a.6.

b. Required Submission

(1) Describe how you will create and maintain a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g. drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;

Express Scripts' standard and injury-specific formularies are fully customizable by NYSIF and can be adjusted pending the claim handler's approval. The EDI feed of injured worker eligibility information, along with uniform standardization of injury coding, allows Express Scripts' drug formularies to be customized down to individual injury classifications. We use the NCCI Body Part and Nature of Injury code information which can be supplied by NYSIF, combined with the professional expertise of the Express Scripts Clinical Pharmacy Team, to develop a drug formulary that includes only those medications appropriate to the injured worker's specific occupational injury. This flexibility allows for customization of NYSIF's formulary down to the individual injured worker level. There are no additional costs for this customization.

Formulary Options

We have designed a comprehensive formulary management strategy to assist providers and their injured workers in cost containment and safe and effective drug utilization. NYSIF has the option of selecting a detailed set of injury-based formularies or a standard formulary, both of which can be customized to meet client-specific NYSIF needs.

Our formularies are:

- Workers' Compensation-specific and judged to be most appropriate by our Workers' Compensation Clinical Advisory Committee.
- Clinically sound and regularly reviewed and updated
- Fully customizable by NYSIF
- Closed selections of medications reimbursable under the pharmacy benefit

Our injury-specific strategy limits formulary status to those medications that are more appropriate to an injured worker's specific injury. The result is a set of effective formularies that focus on controlling inappropriate prescription costs by eliminating those medications that are not typically used to treat specific occupational injuries.

Additional benefits of our Injury-Specific Formulary include:

- Maximum client savings balanced with appropriate pharmaceutical care — If desired, Express Scripts' Clinical Pharmacy Team is available to work with NYSIF to develop a custom formulary tailored to your specific needs
- The flexibility to adjust the formulary on a case-by-case basis — NYSIF can adjust the formulary depending on the specific needs of each injured worker, allowing for management of drug utilization at the patient, physician, therapy class, or individual drug level.

(2) Provide in electronic format, preferably Excel, a list of therapeutic categories you routinely exclude from coverage;

Please refer to the Attachments Section for a list of therapeutic categories excluded from coverage.

(3) Confirm that you do not and will not accept payments from drug companies to promote specific products;

[redacted]

(4) Confirm you will notify NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected drugs are covered or require prior authorization;

The way the current formulary is set up, First DataBank can move drugs from one GC3 to another, or add a new drug to a GC3 and it would be automatically covered at the same status at the current GC3. However, we would be happy to discuss changing your GC3-based formulary to a GCN-based formulary. By so doing, a drug would be covered as intended even if moved from one GC3 to another. Further, no drugs would be automatically added to the formulary—all would be subject to NYSIF approval.

(5) Confirm you will notify NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,

The way the current formulary is set up, First DataBank can move drugs from one GC3 to another, or add a new drug to a GC3 and it would be automatically covered at the same status at the current GC3. However, we would be happy to discuss changing your GC3-based formulary to a GCN-based formulary. By so doing, a drug would be covered as

intended even if moved from one GC3 to another. Further, no drugs would be automatically added to the formulary—all would be subject to NYSIF approval.

(6) Confirm you will provide NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GCN and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

We are contractually prohibited from providing this information at the detail level requested but will be happy to continue providing NYSIF with a formulary report similar to how we have over the length of our relationship.

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

(1) Describe your process for complying with the applicable Program requirements in the event of a Class I drug recall or voluntary drug withdrawal including the time notification standards you employ. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?

The Emerging Therapeutic Intervention program informs plan sponsors, patients, and providers about newly identified safety concerns for prescription products, and provides rapid response to drug recalls and other issues. Our clinicians monitor information sources to identify clinical issues likely to impact patient safety. We provide information to those impacted by:

- Class I drug recalls
- Market withdrawals
- Labeling changes that affect patient safety and care

To maintain patient safety when Class I drug recalls and voluntary drug withdrawals occur or we identify drug safety concerns, we take the following actions:

- We immediately notify and instruct the Express Scripts Pharmacy and CuraScript, the Express Scripts Specialty Pharmacy, how to handle incoming prescriptions for the drug of concern. The facilities remove affected inventory from stock.
- We establish formal communication lines with the manufacturer of the drug of concern.
- Our Emerging Therapeutic Issues Committee meets. If the committee determines a communication is required, Emerging Therapeutics staff

draft letters to impacted patients, plan sponsors, and physicians as appropriate.

- We notify plan sponsors of the safety issue and give them sample copies of patient letters, physician letters, or both.
- We query plan sponsors' historical claims data to identify which patients are affected by the safety concern and to determine which physicians and patients will receive notification information.
- When appropriate, our claims processing system applies edits and online messaging to prevent network pharmacies from filling prescriptions for the drug of concern.

For Class I drug recalls and market withdrawals, we mail letters to physicians and their patients, alerting them to the safety event. For other significant concerns, such as significant changes to a drug's prescribing information, we send letters to physicians. The letters communicate recommended actions and treatment alternatives as provided by the FDA.

We initiate a communications process to alert patients, physicians and clients, as described below. All of these processes are invoked the moment that we learn of a recall and an Executive Level team, including Our Chief Pharmacist and Chief Medical Officer, are on-call 24 hours a day, 7 days a week, to handle each of these serious situations as they arise.

Communicating the Drug Recall to Patients, Physicians and Clients

All of the following communications processes are invoked the moment that we learn of a recall. Additionally, an Executive Level team, including the Chief Medical Officer, assumes responsibility for responding to all urgent situations such as this as they arise—24 hours a day, seven days a week.

- **Patients –** Our computer systems retain, for immediate retrieval, at least 18 months of patient prescription histories, ensuring that we can most expeditiously identify patients impacted by a recall/product removal, as well as their physicians. Depending on the urgency of the recall, a telephone call may be placed to the patients with active prescriptions to inform them of the recall and appropriate actions to take. If the patient cannot be reached by telephone within 72 hours, we contact the patient by letter or e-mail. This communication process is enacted for patient level recalls only.

  When deemed appropriate, information about drug recalls is also posted on the member website. This information about drug recalls and market withdrawals can be found in our Product Alert section located on the site's home page, as well as the *My Health* area of the home page. The website maintains an archive of relevant past announcements about drug recalls and announcements.

- **Physicians –** We contact physicians by phone upon receipt of incoming prescriptions to request an alternative medication. This communication process is enacted if the product is no longer available (total market withdrawal) no matter what the level of recall.
- **Clients –** We provide our clients' Account Teams with a field alert so that they communicate directly to our clients concerning patient level withdrawal/recalls. This information is forwarded to clients from their Account Management staff as soon as We have received notice and upon review of the process. Our Account Management Teams discuss all recalls and specific drug alerts directly with clients. Information regarding drug recalls and product withdrawals is also posted to Our Client Website. This communication process is enacted for Level 1 recalls only.

Drug manufacturers often handle recalls directly. In these cases, we do not handle returns or issue credit for recalled drugs. If we are involved in the recall, we handle returns or issue credit per manufacturer instructions. Manufacturers generally replace the recalled product at no charge or refund the injured worker's cost.

(2) Describe your process for identifying drug lawsuits and settlements on behalf of the Program. Confirm that the Offeror will notify the Department in a timely manner of class action lawsuits or settlements in which the Program may participate. Confirm that the Offeror will credit the Program for net recoveries within fifteen (15) Days upon receipt by the Offeror. Describe how the Offeror's actual costs incurred in the settlement will be allocated to the Program.

Express Scripts has a detailed process for assisting clients with making claims after settlement of major lawsuits against pharmaceutical manufacturers. When we learn of a settlement, our PharmacoAnalytics team generates reports for all clients detailing claims that may be eligible for compensation under the settlement. Your account team provides applicable reports so that NYSIF may file the required documentation.

Exhibits

EXHIBITS

Exhibit_I.Y.1

Exhibit_I.Y.3

Exhibit_I.Y.4

Exhibit_I.Y.5.W

ATTACHMENTS

Sample Information Packets

Sample Ad Hoc Reporting

Retail Pharmacy Contract and Manual

Limited Distribution Drug Lists With and Without Access

List of Therapeutic Categories Excluded from Coverage

Exhibit I.Y.1

Exhibit I.Y.1

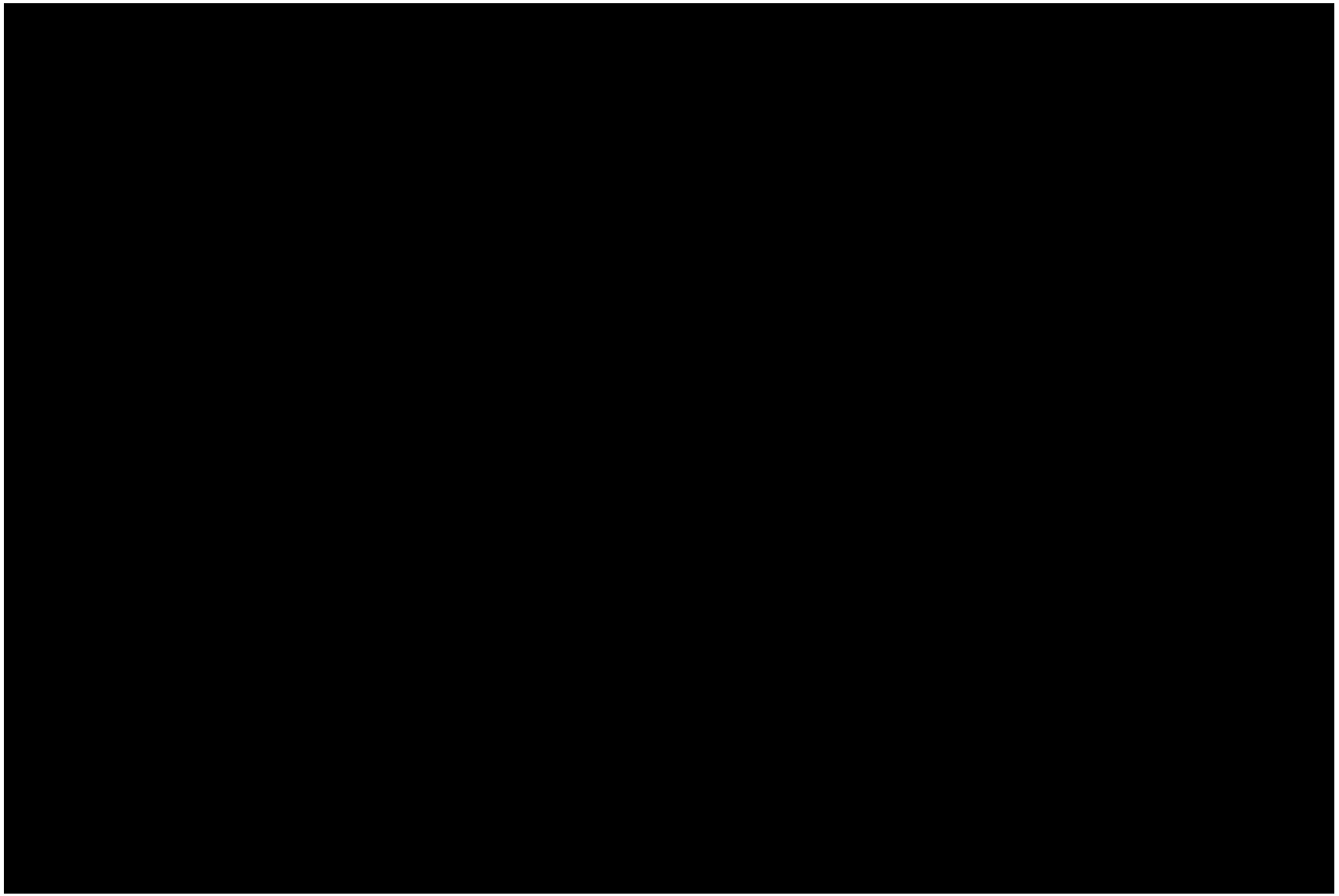


Exhibit I.Y.3

Exhibit I.Y.4

Exhibit I.Y.4

DCS Prescription Drug Program
Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet

Location (2)	Column	# of Empire Plan Enrollees With Access Column (3)	# of Empire Plan Enrollees Without Access Column (4)	Total Empire Plan Enrollees Column (5)	% With Access Column (6)
	Urban	216,919	588	217,507	99.7%
	Suburban	114,198	104	114,302	99.9%
	Rural	195,334	1,393	196,727	99.3%
	Total	526,451	2,085	528,536	99.6%

A. Enter the number of Empire Plan enrollees who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (column 3)

B. Enter the number of Empire Plan enrollees who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries. (column 4)

C. Column (5) equals Column (3) plus Column (4).

D. Column (6) equals Column (3) divided by Column (5).

E. The Offeror's proposed retail pharmacy network access %'s in column (6) must equal, the Program's minimum mandatory access requirements, defined in this RFP, in order for their proposal to be evaluated.

F. The Total Number of Empire Plan Enrollees in the Offeror's Geo Access Accessibility Summaries should equal the totals in Column (5).

Note: All enrollees must be counted in calculating whether the Offeror meets the Retail Pharmacy Network access guarantees. No enrollee may be excluded even if there is no pharmacy located within the minimum mandatory access requirements.

NYSIF Prescription Drug Program
Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet

Location Column (2)	# of NYSIF Enrollees With Access Column (3)	# of NYSIF Enrollees Without Access Column (4)	Total NYSIF Enrollees Column (5)	% With Access Column (6)
Urban	29,364	36	29,400	99.9%
Suburban	6,923	10	6,933	99.9%
Rural	18,865	115	18,980	99.4%
Total	55,152	161	55,313	99.7%

A. Enter the number of NYSIF enrollees who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (column 3)

B. Enter the number of NYSIF enrollees who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries. (column 4)

C. Column (5) equals Column (3) plus Column (4).

D. Column (6) equals Column (3) divided by Column (5).

E. The Offeror's proposed retail pharmacy network access %'s in column (6) must equal, the Program's minimum mandatory access requirements, defined in this RFP, in order for their proposal to be evaluated.

F. The Total Number of NYSIF Enrollees in the Offeror's Geo Access Accessibility Summaries should equal the totals in Column (5).

Note: All enrollees must be counted in calculating whether the Offeror meets the Retail Pharmacy Network access guarantees. No enrollee may be excluded even if there is no pharmacy located within the minimum mandatory access requirements.

Exhibit I.Y.5

Exhibit I.Y.5 (Amended April 4, 2012)

DCS and NYSIF Prescription Drug Programs
Comparison of DCS Current Program Network Pharmacies and the Offeror's Proposed Retail Network

The DCS Program Retail Network Pharmacy File can be obtained by completing and submitting **Exhibit I.Z**, **Confidentiality Agreement and Certificate of Non-Disclosure** with a letter requesting the file ~~and also attesting that the Offeror meets minimum mandatory requirements of Section III.B of this RFP~~. The completed, notarized Confidentiality Agreement and Certificate of Non-Disclosure form and letter must be sent to:

Robert Kennedy, Procurement Manager
Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith State Office Building
Albany, New York 12239

The DCS Program Retail Network Pharmacy File will only be sent to those prospective Offerors that request said file; and complete and submit a properly executed **Exhibit I.Z**~~, and attest that they meet the minimum mandatory requirements of Section III.B of this RFP~~.

Upon receipt of the completed, notarized **Exhibit I.Z** and the Offeror's letter ~~containing~~ requesting the ~~required attestation~~data file, the prospective Offeror's designated Information Technology (IT) contact indicated in **Exhibit I.Z** will be contacted by the Procuring Agencies to arrange secure delivery of the DCS Program Network Pharmacy Data File along with the accompanying record layout

INSTRUCTIONS:

This exhibit will compare the DCS Program network pharmacies that have submitted claims between November 10, 2010 and October 28, 2011 with the Offeror's Proposed Retail Network File provided in Exhibit I.Y.2.

Utilize this file layout to prepare Exhibit I.Y.3 of your Technical Proposal and submit on a CD.

Exhibit I.Y.5 (Amended April 4, 2012)

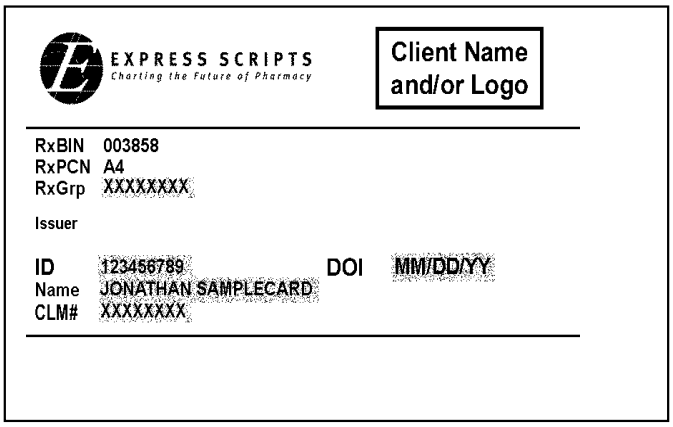
1) The first two columns in the provided file list the National Provider Indicators (NPI) and names of the DCS Program Retail Network Pharmacies.

2) Identify whether each of the DCS Program Retail Network Pharmacies will or will not participate in the Offeror's proposed Retail Network Pharmacy by indicating "YES" or "NO" in the third column.

3) For those pharmacies indicated with a "YES", insert the Pharmacy Corporate ID (number that represents a unique identifier of the contracting or bargaining entity) and Contracting Entity Name (name of the contracting or bargaining entity that corresponds to the pharmacy NPI) in the fourth and fifth columns respectively.

Pharmacy NPI	Pharmacy Name	Network Indicator (Y/N)	Pharmacy Corporate ID	Contracting Entity Name

Sample Information Packets



JOHN DOE SAMPLE
ADDRESS LINE1
CITY, STATE ZIP

Dear Injured Worker:

If you need to fill a prescription for your work-related injury or illness, then [client] has a program that will make getting your prescription a lot easier for you. We have selected Express Scripts to administer this program for you.

Prescription Drug ID Card

Effective immediately, you may take the ***enclosed card*** (above … it's perforated for easy removal) to a participating pharmacy. By using the participating pharmacy, there will be no out of pocket costs for your prescriptions provided they are written for your work-related injury or illness. Express Scripts pays the pharmacy directly. To find a participating pharmacy in your neighborhood, please refer to the list on the other side of this sheet, or call Express Scripts at 1.866.576.3864.

If you have any questions, please call Express Scripts at 1.866.576.3864. A courteous Customer Service representative is available to take your call at any time. Thank you for choosing to use Express Scripts.

Sincerely,

[client]

please continue reading →→→

Client Letterhead

Dear Workers' Compensation Program Administrator:

[Client Name] has teamed up with Express Scripts, Inc. (ESI), a pharmacy benefit management company, to provide your company with a new prescription drug program for work-related injuries. Some features of this pharmacy program include:

- Availability for all compensable work-related injuries.
- Access to over 52,000 pharmacies nationwide.
- Significant savings beyond fee schedules and usual and customary charges of 20-25% and immediate claim adjudication.
- Availability of a registered pharmacist 24 hours per day via a toll-free line.

Enclosed please find a supply of injured worker Temporary Prescription Services ID forms with important benefit information and Prescription Benefits Questions and Answers sheets. Also enclosed is a sample of the Pharmacy Benefit Program packet that will be mailed directly to the injured worker. **When an employee requires treatment for a compensable workers' compensation claim, provide them with the following:**

- **Temporary Prescription Services ID form.**
- **Prescription Benefits Questions and Answers sheet.**

Injured workers will not incur out-of-pocket prescription expenses when they use the enclosed form. The Temporary Prescription Services ID is only valid for work-related prescriptions and may be used at any participating pharmacy. For a complete list of participating pharmacies, call the toll-free number 1-877-XXX-XXXX or access Express Scripts' website at www.express-scripts.com. Shortly after claim approvals the injured worker will automatically be issued a Pharmacy Benefit Program packet from Express Scripts that includes a permanent card and background information. **Prompt reporting of workers' compensation injury is extremely important to facilitate claim approval and issuance of the permanent prescription ID card.**

In addition, Express Scripts can fill injured workers' maintenance (long-term) prescriptions through their mail service pharmacy program. With this program, most prescriptions are filled within 72 hours of receipt and mailed directly to the injured worker's home.

Please familiarize yourself with all the material. If your company has multiple locations, distribute the Temporary Prescription Services ID forms and Prescription Benefits Questions and Answers sheet to the personnel who most often assist injured workers. You may duplicate the material or call an Express Scripts Customer Service Representative toll-free at 1-877-XXX-XXXX for additional Temporary Prescription Services ID forms or Prescription Benefits Questions and Answers sheets. If you have any questions, Express Scripts Customer Service is available 24 hours a day, 7 days a week.

Additional Information May Be Placed Here

Sincerely,
[Client Name]

EXPRESS SCRIPTS
Charting the Future of Pharmacy

Prescription Program Questions and Answers

What is Express Scripts?
Express Scripts is a pharmacy benefit management company experienced with workers' compensation prescriptions. Express Scripts allows you to take a compensable work-related injury prescription to a participating pharmacy location. You may use the pre-authorized Temporary Prescription Services ID form until you receive a permanent card. A Pharmacy Program packet and a permanent card will be sent to you.

How much does the card cost?
The card is free and covers all work-related injury prescriptions.

Can I use the Temporary Prescription Services ID right away?
Yes, you may use it at any participating pharmacy. Just take your prescription and Temporary Prescription Services ID to the pharmacy you select to obtain your medication. (To locate a pharmacy in your neighborhood, call Express Scripts at 1-877-XXX-XXXX or access Express Script's website at http://www.express-scripts.com.)

What if I have already filled and paid for a prescription?
Send the receipt and a copy of the prescription to your [Client Name] claim representative.

When does the Temporary Prescription Services ID expire?
You may use the pre-authorized Temporary Prescription Services ID form until you receive a permanent card. A Pharmacy Benefit Program packet and a permanent card will be sent to you. The permanent card expires when the [Client Name] claim representative notifies Express Scripts to discontinue the pharmacy service.

Can I get additional prescriptions after the permanent card expires?
If the card expires and your treating physician provides a new prescription, contact your [Client Name] claim representative to reactivate the card or your physician can call Express Scripts or fax the prescription to your participating pharmacy location.

What if I run out of medication before the refill date?
Call your treating physician.

Do I have to stay with the same pharmacy location?
No, you may go to any participating Express Scripts pharmacy.

Will this program limit the pharmacies I can use?
As long as you use a pharmacy that participates in the Express Scripts network, you will experience the benefits of this program and have not out of pocket expense. At this time, 75% of all pharmacies in the United States participate in the network.

What if I lose my Temporary Prescription Services ID?
If you have already had a prescription filled using your Temporary Prescription Services ID, and you are using the same pharmacy, you will not need another Temporary Prescription Services ID. Once your compensable injury is reported, a permanent card will be automatically sent to you.

Who can provide me with more information and the name of a participating pharmacy?
Express Scripts Customer Service toll-free at 877-XXX-XXXX will assist with any additional questions or concerns regarding this program.

Temporary Prescription Services ID

Attention Injured Worker

- On your first visit, please give this notice to any pharmacy listed below to expedite the processing of your approved workers' compensation prescriptions. (Based on the established parameters by your employer.)
- Questions or need assistance locating a participating pharmacy: Call the Express Scripts Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

- Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).
- Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

Attention Supervisor: Please complete the following information for the injured worker.

Express Scripts

ID #: SSN to be presented to the pharmacy at the time prescription is filled

Date of Injury: __/__/____
MM/DD/CCYY

Group #: _____

Employee Date of Birth: __/__/____
MM/DD/CCYY

Employee Information

_____ _____ _____
First M Last

Mailing Address

_____
Street Address or PO Box

_____ _____ _____
City State Zip

Employer's Name

_____

Attention Pharmacist

- Express Scripts administers this workers' compensation prescription program. Follow the steps below to submit a claim.
- For assistance, call the Express Scripts Contact Center at 800.945.5951.

Pharmacy Processing Steps	
Step 1	Enter bin number 003858
Step 2	Enter processor control A4
Step 3	Enter the group number as it appears above
Step 4	Enter the injured worker's 9 digit ID#
Step 5	Enter first name & last name
Step 6	Enter the injured worker's date of injury (enter in PA field in the format ccyymmdd)

Participating Pharmacy Chains

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
AmerisourceBergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Duane Reade
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Happy Harry's
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Star Markets
Stop & Shop
Sun Mart
Super Fresh
Target
Texas Oncology Services
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

Sample Ad Hoc Reporting

Status Report
Client ABC

Description	01/07 - 12/07 Total	01/07 - 12/07 Retail	01/07 - 12/07 Home Delivery	01/06 - 12/06 Total	01/06 - 12/06 Retail	01/06 - 12/06 Home Delivery	% Change
Avg Nbr Eligible Members	51,783	51,783	51,783	49,534	49,534	49,534	4.5%
Avg Nbr Eligible Contracts	21,747	21,747	21,747	20,461	20,461	20,461	6.3%
Nbr Patients	38,359	34,870	12,739	36,231	32,312	12,982	5.9%
Pct of Utilizing Members	74.1%	67.3%	24.6%	73.1%	65.2%	26.2%	1.3%
Total Rxs	543,329	361,547	181,782	493,536	316,401	177,135	10.1%
Total AWP Amt	$81,441,181.69	$33,227,315.49	$48,213,866.20	$71,514,694.79	$27,262,773.69	$44,251,921.10	13.9%
Total Ing Cost	$54,398,525.89	$23,108,447.98	$31,290,077.91	$48,782,184.73	$19,324,943.05	$29,457,241.68	11.5%
Total Disp Fee	$641,410.25	$641,410.25	$0.00	$598,899.10	$598,899.10	$0.00	7.1%
Total Copay	$11,598,225	$6,529,776	$5,068,449	$11,166,024	$5,842,488	$5,323,537	3.9%
Total Plan Cost	$43,524,378	$17,271,520	$26,252,858	$38,291,418	$14,127,297	$24,164,121	13.7%
Plan Cost per Rx	$80.11	$47.77	$144.42	$77.59	$44.65	$136.42	3.2%
AWP per Member	$1,572.74	$641.66	$931.08	$1,443.75	$550.39	$893.36	8.9%
Plan Cost per Member	$840.51	$333.54	$506.98	$773.03	$285.20	$487.83	8.7%
Plan Cost PMPM	$70.04	$27.79	$42.25	$64.42	$23.77	$40.65	8.7%
Nbr Rxs per Member	10.5	7.0	3.5	10.0	6.4	3.6	5.3%
AWP per Contract	$3,744.94	$1,527.90	$2,217.04	$3,495.17	$1,332.43	$2,162.74	7.1%
Plan Cost per Contract	$2,001.40	$794.20	$1,207.19	$1,871.43	$690.45	$1,180.98	6.9%
Plan Cost PCPM	$166.78	$66.18	$100.60	$155.95	$57.54	$98.41	6.9%
Nbr Rxs per Contract	25.0	16.6	8.4	24.1	15.5	8.7	3.6%
AWP per Patient	$2,123.13	$952.89	$3,784.74	$1,973.85	$843.74	$3,408.71	7.6%
Plan Cost per Patient	$1,134.66	$495.31	$2,060.83	$1,056.87	$437.22	$1,861.36	7.4%
Nbr Rxs per Patient	$14.16	$10.37	$14.27	$13.62	$9.79	$13.64	4.0%
Average Quantity	77.1	54.8	121.6	78.1	53.9	121.2	-1.2%
Average Days Supply	42.9	21.3	85.9	44.4	20.9	86.4	-3.4%
AWP per Rx	$149.89	$91.90	$265.23	$144.90	$86.17	$249.82	3.4%
Ingredient Cost per Rx	$100.12	$63.92	$172.13	$98.84	$61.08	$166.30	1.3%
Dispensing Fee per Rx	$1.18	$1.77	$0.00	$1.21	$1.89	$0.00	-2.7%
Copay per Rx	$21.35	$18.06	$27.88	$22.62	$18.47	$30.05	-5.6%
Home Delivery Utilization	33.5%			35.9%			-6.8%
Member Cost Share	21.0%	27.4%	16.2%	22.6%	29.3%	18.1%	-6.8%
Preferred Brand Drugs							
Nbr of Rxs	140,727	76,727	64,000	136,530	71,718	64,812	3.1%
Pct of Rxs	25.9%	21.2%	35.2%	27.7%	22.7%	36.6%	-6.4%
Plan Cost	$27,302,550	$11,376,460	$15,926,089	$23,578,871	$9,052,008	$14,526,863	15.8%
Pct of Plan Cost	62.7%	65.9%	60.7%	61.6%	64.1%	60.1%	1.9%
Member Cost Share	16.4%	18.5%	14.8%	18.1%	20.7%	16.4%	-9.5%
Plan Cost per Rx	$194.01	$148.27	$248.85	$172.70	$126.22	$224.14	12.3%
Copay per Rx	$38.03	$33.59	$43.36	$38.18	$32.93	$44.00	-0.4%
Non-Preferred Brand Drugs							
Nbr of Rxs	51,349	31,442	19,907	59,518	33,450	26,068	-13.7%
Pct of Rxs	9.5%	8.7%	11.0%	12.1%	10.6%	14.7%	-21.6%
Plan Cost	$5,948,459	$2,105,718	$3,842,741	$6,885,786	$2,183,452	$4,702,334	-13.6%
Pct of Plan Cost	13.7%	12.2%	14.6%	18.0%	15.5%	19.5%	-24.0%
Member Cost Share	27.7%	38.8%	19.6%	28.0%	39.1%	21.3%	-1.0%
Plan Cost per Rx	$115.84	$66.97	$193.03	$115.69	$65.28	$180.39	0.1%
Copay per Rx	$44.32	$42.54	$47.13	$44.89	$41.86	$48.79	-1.3%
Generic Drugs							
Nbr of Rxs	351,253	253,378	97,875	297,488	211,233	86,255	18.1%
Pct of Rxs	64.6%	70.1%	53.8%	60.3%	66.8%	48.7%	7.3%
Plan Cost	$10,273,370	$3,789,342	$6,484,028	$7,826,761	$2,891,837	$4,934,923	31.3%
Pct of Plan Cost	23.6%	21.9%	24.7%	20.4%	20.5%	20.4%	15.5%
Member Cost Share	27.9%	40.8%	17.3%	29.5%	41.8%	19.6%	-5.6%
Plan Cost per Rx	$29.25	$14.96	$66.25	$26.31	$13.69	$57.21	11.2%
Copay per Rx	$11.30	$10.32	$13.85	$11.03	$9.85	$13.91	2.5%

Top 25 Indications by Ingredient Cost

Client ABC

			01/07 - 12/07					01/06 - 12/06					
Rank	BoB Rank	Indication	Rxs	Patients	Ing Cost	Ing Cost / Rx	Generic Utilization	Rank	Rxs	Patients	Ing Cost	Ing Cost / Rx	Generic Utilization	% Change Ing Cost
1	1	HIGH BLOOD CHOLESTEROL	261,858	44,460	$22,352,591	$85.36	55%	1	226,332	39,946	$29,298,390	$129.45	34%	-23.7%
2	2	HIGH BLOOD PRESS/HEART DISEASE	506,670	55,520	$20,309,609	$40.08	82%	2	461,516	51,289	$17,217,729	$37.31	73%	18.0%
3	4	DIABETES	155,847	14,467	$14,809,861	$95.03	47%	3	141,424	13,166	$11,656,450	$82.42	48%	27.1%
4	6	ASTHMA	86,713	16,967	$12,722,779	$146.72	25%	5	80,089	15,929	$10,477,422	$130.82	31%	21.4%
5	3	ULCER DISEASE	108,485	23,583	$11,433,527	$105.39	50%	4	95,261	20,945	$10,648,542	$111.78	42%	7.4%
6	5	DEPRESSION	167,190	25,034	$9,249,596	$55.32	83%	6	150,869	23,185	$9,230,000	$61.18	75%	0.2%
7	11	BONE CONDITIONS	62,623	12,614	$9,084,458	$145.07	2%	7	63,579	12,719	$8,606,146	$135.36	1%	5.6%
8	12	CANCER	18,753	3,519	$9,084,437	$484.43	55%	8	17,265	3,269	$7,624,153	$441.60	56%	19.2%
9	10	INFLAMMATORY CONDITIONS	8,089	1,493	$7,086,306	$876.04	23%	9	6,759	1,349	$5,950,772	$880.42	26%	19.1%
10	8	SEIZURES	62,948	10,281	$6,785,241	$107.79	66%	10	56,037	9,136	$5,440,411	$97.09	67%	24.7%
11	14	URINARY DISORDERS	50,939	10,394	$6,199,128	$121.70	33%	11	43,274	9,192	$5,219,507	$120.62	18%	18.8%
12	16	MENTAL DISORDERS	24,256	4,783	$5,087,899	$209.76	29%	14	21,770	4,423	$4,232,703	$194.43	30%	20.2%
13	9	INFECTIONS	150,162	65,162	$4,995,621	$33.27	89%	13	142,347	61,495	$4,458,570	$31.32	87%	12.0%
14	18	BLOOD MODIFYING	26,037	4,906	$4,496,465	$172.70	23%	15	23,032	4,517	$3,844,267	$166.91	40%	17.0%
15	23	MENTAL/NEURO DISORDERS	21,463	2,930	$4,249,762	$198.00	1%	16	18,155	2,622	$3,358,611	$185.00	1%	26.5%
16	7	ALLERGIES	57,902	18,644	$4,155,509	$71.77	72%	12	55,118	17,718	$4,613,255	$83.70	54%	-9.9%
17	13	SEVERE PAIN	106,109	31,940	$3,957,069	$37.29	98%	17	95,893	29,242	$3,252,700	$33.92	99%	21.7%
18	20	SKIN DISORDERS	41,490	20,306	$3,558,925	$85.78	69%	18	37,609	18,604	$2,962,850	$78.78	67%	20.1%
19	29	GLAUCOMA	36,980	6,442	$3,339,756	$90.31	23%	19	34,504	5,879	$2,831,065	$82.05	25%	18.0%
20	31	BLOOD CELL DEFICIENCY	1,775	406	$2,880,871	$1,623.03	0%	22	1,700	415	$2,576,919	$1,515.83	0%	11.8%
21	30	ANTICOAGULANT	43,253	7,554	$2,812,096	$65.02	95%	25	38,184	6,865	$2,017,074	$52.83	96%	39.4%
22	17	MULTIPLE SCLEROSIS	1,274	183	$2,796,387	$2,194.97	0%	20	1,187	187	$2,820,785	$2,376.40	0%	-0.9%
23	15	VIRAL INFECTIONS	10,435	3,914	$2,743,027	$262.87	32%	23	9,621	3,673	$2,306,335	$239.72	28%	18.9%
24	19	PAIN AND INFLAMMATION	46,847	18,912	$2,133,078	$45.53	86%	24	44,666	17,708	$2,166,332	$48.50	83%	-1.5%
25	24	SLEEP DISORDERS	32,791	7,680	$2,094,711	$63.88	60%	21	29,170	7,234	$2,758,194	$94.56	22%	-24.1%
		Total Top 25	**2,090,889**		**$178,418,710**	**$85.33**			**1,895,361**		**$165,569,182**	**$87.35**		**7.8%**
		Total All Drugs	**2,880,836**	**123,690**	**$213,604,879**	**$74.15**			**2,632,222**	**116,078**	**$194,967,684**	**$74.07**		**9.6%**

BoB = Book of Business

<==Increase in PMPM on Specialty

Top 50 Drugs by Ingredient Cost
Client ABC

				01/07 - 12/07					01/06 - 12/06				
Rank	BoB Rank	Brand Name	Indication	Rxs	Patients	Ing Cost	Ing Cost / Rx	Rank	Rxs	Patients	Ing Cost	Ing Cost / Rx	% Change Ing Cost
1	2	LIPITOR	HIGH BLOOD CHOLESTEROL	46,005	8,219	$6,759,572	$146.93	1	63,133	13,281	$8,306,665	$131.57	-18.6%
2	4	ADVAIR DISKUS	ASTHMA	18,120	5,238	$4,972,840	$274.44	4	17,261	4,986	$4,275,861	$247.72	16.3%
3	16	FOSAMAX	BONE CONDITIONS	31,943	6,628	$4,179,111	$130.83	3	35,195	7,343	$4,293,676	$122.00	-2.7%
4	5	ENBREL	INFLAMMATORY CONDITIONS	2,015	310	$3,797,539	$1,884.63	6	1,417	270	$3,289,707	$2,321.60	15.4%
5	9	CRESTOR	HIGH BLOOD CHOLESTEROL	22,569	4,751	$3,614,726	$160.16	7	19,037	4,651	$2,891,249	$151.88	25.0%
6	8	PLAVIX	BLOOD MODIFYING	17,838	3,818	$3,354,832	$188.07	10	12,156	3,323	$2,291,553	$188.51	46.4%
7	1	NEXIUM	ULCER DISEASE	10,878	2,423	$3,056,952	$281.02	8	10,469	2,303	$2,795,804	$267.06	9.3%
8	12	SIMVASTATIN	HIGH BLOOD CHOLESTEROL	92,459	19,308	$2,683,494	$29.02	5	34,260	13,204	$3,994,681	$116.60	-32.8%
9	7	VYTORIN	HIGH BLOOD CHOLESTEROL	16,562	3,550	$2,634,224	$159.05	14	12,670	3,060	$1,934,593	$152.69	36.2%
10	26	DIOVAN	HIGH BLOOD PRESS/HEART DISEASE	22,611	4,257	$2,535,878	$112.15	11	19,702	3,747	$2,038,604	$103.47	24.4%
11	15	ZETIA	HIGH BLOOD CHOLESTEROL	17,009	3,628	$2,474,497	$145.48	18	13,775	3,032	$1,855,635	$134.71	33.4%
12	39	ARICEPT	MENTAL/NEURO DISORDERS	11,716	2,055	$2,421,654	$206.70	15	9,864	1,789	$1,910,895	$193.72	26.7%
13	30	FLOMAX	URINARY DISORDERS	17,559	3,901	$2,269,148	$129.23	21	14,826	3,389	$1,713,838	$115.60	32.4%
14	11	ACTOS	DIABETES	8,546	1,895	$2,251,607	$263.47	25	5,943	1,270	$1,495,155	$251.58	50.6%
15	14	PROTONIX	ULCER DISEASE	10,634	2,328	$2,200,533	$206.93	13	10,343	2,300	$1,958,688	$189.37	12.3%
16	10	EFFEXOR XR	DEPRESSION	9,722	1,593	$2,085,128	$214.48	19	9,387	1,563	$1,844,878	$196.54	13.0%
17	6	SINGULAIR	ASTHMA	13,799	3,040	$2,036,341	$147.57	22	12,038	2,653	$1,677,570	$139.36	21.4%
18	20	OMEPRAZOLE	ULCER DISEASE	41,018	11,305	$1,923,395	$46.89	23	26,966	8,420	$1,673,456	$62.06	14.9%
19	3	PREVACID	ULCER DISEASE	6,219	1,335	$1,766,384	$284.03	20	6,682	1,434	$1,802,895	$269.81	-2.0%
20	38	LISINOPRIL	HIGH BLOOD PRESS/HEART DISEASE	117,980	20,682	$1,758,574	$14.91	41	106,151	18,699	$1,059,760	$9.98	65.9%
21	23	AVANDIA	DIABETES	7,850	2,030	$1,749,390	$222.85	9	11,386	2,170	$2,334,788	$205.06	-25.1%
22	25	LAMICTAL	SEIZURES	5,108	821	$1,717,886	$336.31	30	3,949	664	$1,238,143	$313.53	38.7%
23	35	ACTONEL	BONE CONDITIONS	13,024	2,675	$1,712,221	$131.47	24	13,001	2,728	$1,544,534	$118.80	10.9%
24	18	HUMIRA	INFLAMMATORY CONDITIONS	843	129	$1,661,147	$1,970.52	27	580	112	$1,350,952	$2,329.23	23.0%
25	46	SPIRIVA	ASTHMA	7,882	2,002	$1,552,964	$197.03	38	6,011	1,557	$1,090,036	$181.34	42.5%
26	73	REVLIMID	CANCER	236	47	$1,521,815	$6,448.37	71	114	29	$710,869	$6,235.69	114.1%
27	37	SEROQUEL	MENTAL DISORDERS	7,000	1,309	$1,506,358	$215.19	35	5,835	1,153	$1,130,765	$193.79	33.2%
28	49	LOVENOX	ANTICOAGULANT	1,662	929	$1,427,406	$858.85	43	1,330	736	$1,046,184	$786.60	36.4%
29	27	LANTUS	DIABETES	8,550	1,769	$1,409,603	$164.87	37	7,203	1,531	$1,090,348	$151.37	29.3%
30	92	PROCRIT	BLOOD CELL DEFICIENCY	1,163	261	$1,346,791	$1,158.03	28	1,130	263	$1,294,205	$1,145.31	4.1%
31	13	LEXAPRO	DEPRESSION	11,023	2,084	$1,343,265	$121.86	33	10,453	1,980	$1,185,950	$113.46	13.3%
32	61	ARIMIDEX	CANCER	3,188	604	$1,306,340	$409.77	42	2,815	510	$1,047,261	$372.03	24.7%
33	17	CELEBREX	PAIN AND INFLAMMATION	6,367	1,778	$1,291,872	$202.90	32	6,363	1,750	$1,196,336	$188.01	8.0%
34	47	EVISTA	BONE CONDITIONS	7,999	1,658	$1,291,822	$161.50	31	8,053	1,626	$1,226,189	$152.26	5.4%
35	29	COPAXONE	MULTIPLE SCLEROSIS	568	89	$1,266,524	$2,229.80	40	425	75	$1,077,472	$2,535.23	17.5%
36	22	TOPAMAX	SEIZURES	3,738	677	$1,258,986	$336.81	49	3,243	606	$973,090	$300.06	29.4%
37	24	FEXOFENADINE HC	ALLERGIES	17,732	5,474	$1,222,836	$68.96	34	15,268	4,820	$1,170,474	$76.66	4.5%
38	88	XALATAN	GLAUCOMA	13,409	2,885	$1,206,277	$89.96	46	12,060	2,651	$992,642	$82.31	21.5%
39	96	NAMENDA	MENTAL/NEURO DISORDERS	6,697	1,193	$1,201,695	$179.44	54	5,273	967	$892,337	$169.23	34.7%
40	21	CYMBALTA	DEPRESSION	5,755	1,206	$1,182,770	$205.52	77	3,470	802	$651,627	$187.79	81.5%
41	64	ONE TOUCH ULTRA	DIABETES	8,116	2,878	$1,153,099	$142.08	53	6,842	2,383	$920,720	$134.57	25.2%
42	41	OXYCODONE HCL	SEVERE PAIN	9,749	2,433	$1,142,180	$117.16	58	8,348	1,983	$807,535	$96.73	41.4%
43	28	TRICOR	HIGH BLOOD CHOLESTEROL	7,706	1,557	$1,117,227	$144.98	56	5,951	1,262	$815,116	$136.97	37.1%
44	56	ABILIFY	MENTAL DISORDERS	2,193	427	$1,099,722	$501.47	61	1,639	336	$790,073	$482.05	39.2%
45	40	TOPROL XL	HIGH BLOOD PRESS/HEART DISEASE	18,623	4,894	$1,094,142	$58.75	17	35,150	6,612	$1,871,912	$53.25	-41.5%
46	80	GLEEVEC	CANCER	274	39	$1,092,979	$3,988.98	52	207	35	$923,022	$4,459.04	18.4%
47	31	DIOVAN HCT	HIGH BLOOD PRESS/HEART DISEASE	8,352	1,626	$1,081,066	$129.44	60	6,883	1,362	$802,492	$116.59	34.7%
48	68	METOPROLOL SUC	HIGH BLOOD PRESS/HEART DISEASE	23,678	7,022	$1,064,329	$44.95	564	803	748	$31,076	$38.70	3,324.9%
49	34	LEVAQUIN	INFECTIONS	10,179	7,281	$1,061,086	$104.24	36	11,205	8,151	$1,108,480	$98.93	-4.3%
50	48	PROVIGIL	ATTENTION DISORDERS	2,436	537	$1,041,253	$427.44	51	2,214	510	$933,826	$421.78	11.5%
				756,302		**$97,901,481**	**$129.45**		**638,479**		**$85,353,617**	**$133.68**	**14.7%**
		Total All Drugs		**2,880,836**	**123,690**	**$213,604,879**	**$74.15**		**#######**	**116,078**	**$194,967,684**	**$74.07**	**9.6%**

BoB = Book of Business

Client ABC (01/07 - 12/07)									
	TOTAL			NON-SPECIALTY			SPECIALTY		
Description	01/07 - 12/07	01/06 - 12/06	% Change	01/07 - 12/07	01/06 - 12/06	% Change	01/07 - 12/07	01/06 - 12/06	% Change
Avg Employees per Month	21,747	20,461	6.3%	21,747	20,461	6.3%	21,747	20,461	6.3%
Nbr Unique Patients	38,359	36,231	5.9%	0	0	0.0%	0	0	0.0%
Total Plan Cost	$43,524,378	$38,291,418	13.7%	$37,915,382	$33,771,537	12.3%	$5,608,996	$4,519,881	24.1%
Percent of Total Plan Cost				87.1%	88.2%	-1.2%	12.9%	11.8%	9.2%
Total Rxs	543,329	493,536	10.1%	540,010	490,644	10.1%	3,319	2,892	14.8%
Percent of Total Rxs				99.4%	99.4%	0.0%	0.6%	0.6%	4.2%
Plan Cost PEPM	$166.78	$155.95	6.9%	$145.28	$137.54	5.6%	$21.49	$18.41	16.8%
Plan Cost per Rx	$80.11	$77.59	3.2%	$70.21	$68.83	2.0%	$1,689.97	$1,562.89	8.1%
Nbr Rxs PEPM	2.08	2.01	3.6%	2.07	2.00	3.6%	0.013	0.012	8.0%
Generic Fill Rate	64.6%	60.3%	7.3%	65.0%	60.6%	7.3%	6.0%	6.3%	-4.8%
Member Cost Share	21.0%	22.6%	-6.8%	23.3%	24.7%	-5.7%	1.2%	1.5%	-17.3%

Retail Pharmacy Contract and Manual

Limited Distribution Drug Lists With and Without Access

CURASCRIPT AND ACCREDO EXCLUSIVE OR PREFERRED DISTRIBUTION DRUGS					
PRODUCT	MANUFACTURER	DISEASE STATE	SPECIALTY CHANNEL	NUMBER OF OTHER SPECIALTY PROVIDERS	SPECIALTY CHANNEL PROVIDERS
ABRAXANE	CELGENE	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ACTEMRA	GENENTECH	INFLAMMATORY CONDITIONS	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ACTHAR	QUESTCOR	MISCELLANEOUS CNS DISORDERS	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ACTIMMUNE	INTERMUNE	MISCELLANEOUS SPECIALTY CONDITIONS	LIMITED	5	(ACCREDO/CSP), CVS/CAREMARK; WALLGREENS, AETNA, ANTHEM, TELDRUG [CIGNA]
ADAGEN	ENZON	ENZYME DEFICIENCIES	EXCLUSIVE	0	(ACCREDO/CSP)
ADCETRIS	SEATTLE GENETICS	CANCER	LIMITED	ALL SPECIALTY	ASD DROP SHIP ONLY
ADVATE	BAXTER	HEMOPHILIA	LIMITED	10	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ALDURAZYME	GENZYME	ENZYME DEFICIENCIES	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
AMEVIVE	ASTELLAS	INFLAMMATORY CONDITIONS	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
AMPYRA	ACCORDA	MULTIPLE SCLEROSIS	LIMITED	10	(ACCREDO/CSP), AETNA, BIOSCRIP, CVS/CAREMARK, DIPLOMAT, PRESCRIPTION SOLUTIONS, SPECIAL CARE (PR), CIGNA TELDRUG, US BIO, WALGREENS
ANASCORP	RARE DISEASE THERAPEUTICS	SCORPION ENVENOMATION	EXCLUSIVE	0	(ACCREDO/CSP)
APOKYN	USWM	MISCELLANEOUS CNS DISORDERS	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
ARALAST	BAXTER	RESPIRATORY CONDITIONS	LIMITED	5	(ACCREDO/CSP), CVS CAREMARK, CORAM, WALGREENS, US BIO, BIORX
ARCALYST	REGENERON	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
ARESTIN	ORAPHARMA	MISCELLANEOUS SPECIALTY CONDITIONS	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
ARZERRA	GSK	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
AVANDIA AVANDAMET AVANDARYL	GSK	DIABETES	EXCLUSIVE	0	LIBERTY PHARMACY (VIA ACCREDO/CSP COMBINED ORGANIZATION)
AVASTIN	GENENTECH	CANCER	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
BEBULIN	BAXTER	HEMOPHILIA	LIMITED	10	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
BERINERT-P	CSL BEHRING	HEREDITARY ANGIOEDEMA	LIMITED	6	(ACCREDO/CSP), BIORX, CVS CAREMARK, CORAM, IGG AMERICA, WALGREENS, OPTIONCARE

CURASCRIPT AND ACCREDO EXCLUSIVE OR PREFERRED DISTRIBUTION DRUGS					
PRODUCT	MANUFACTURER	DISEASE STATE	SPECIALTY CHANNEL	NUMBER OF OTHER SPECIALTY PROVIDERS	SPECIALTY CHANNEL PROVIDERS
CARBAGLU	ORPHAN EU	ENZYME DEFICIENCIES	EXCLUSIVE	0	(ACCREDO/CSP)
CEPROTIN	BAXTER	MISCELLANEOUS SPECIALTY CONDITIONS	LIMITED	0	HOME HEALTH PHARMACY PRODUCT
CEREDASE	GENZYME	ENZYME DEFICIENCIES	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
CEREZYME	GENZYME	ENZYME DEFICIENCIES	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
CIMZIA	UCB	INFLAMMATORY CONDITIONS	LIMITED	6	(ACCREDO/CSP), BIOSCRIP, CVS/CAREMARK, WALGREENS/MEDMARK; WELLPOINT, AETNA, CIGNA
CINRYZE	VIROPHARMA	HEREDITARY ANGIOEDEMA	LIMITED	2	(ACCREDO/CSP), CVS/CAREMARK, CENTRIC
CORIFACT	CSL BEHRING	HEMOPHILIA	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
CYSTADANE	RARE DISEASE THERAPEUTICS	ENZYME DEFICIENCIES	EXCLUSIVE	0	(ACCREDO/CSP)
CYTOGAM	CSL BEHRING	IMMUNE DEFICIENCY	LIMITED	6	4 NATL [INCL(ACCREDO/CSP)] AND 2 LARGE PAYER SPS HAVE ACCESS. MANUFACTURER WILL NOT RELEASE NAMES OF SPPS
DACOGEN	MGI	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
DYSPORT	TERCICA	NEUROMUSCULAR CONDITIONS/COSMETIC	LIMITED	3	(ACCREDO/CSP), MCKESSON, PRECISION RX SOLUTIONS, OCEAN BREEZE
EGRIFTA	EMD SERONO	MISCELLANEOUS SPECIALTY CONDITIONS	LIMITED	7	(ACCREDO/CSP), AETNA, BIOSCRIP, CIGNA, CVS/CAREMARK, PRESCRIPTION SOLUTIONS, HUMANA RIGHT SOURCE, WALGREENS
ELAPRASE	SHIRE	ENZYME DEFICIENCIES	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
EPOPROSTENOL	TEVA	PULMONARY HYPERTENSION	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
ERBITUX	BMS	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ERIVEDGE	GENENTECH	CANCER	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ERWINAZE	EUSA PHARMA	CANCER	EXCLUSIVE	0	(ACCREDO/CSP)
EXJADE	NOVARTIS	IRON TOXICITY	LIMITED	4	(ACCREDO/CSP), US BIOSERVICES, BIOSCRIP, CAREMARK, PRESCRIPTION SOLUTIONS/OPTUM RX
EYLEA	REGENERON	OPHTHALMIC CONDITIONS	LIMITED	7	AETNA, (ACCREDO/CSP), APOTHECARY SHOPPE, CAREMARK, DIPLOMAT, OPTUM HEALTH (UHC), US BIOSERVICES, WALGREENS
FABRYZYME	GENZYME	ENZYME DEFICIENCIES	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
FEIBA	BAXTER	HEMOPHILIA	LIMITED	10	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
FLOLAN	GILEAD	PULMONARY HYPERTENSION	EXCLUSIVE	0	(ACCREDO/CSP)

CURASCRIPT AND ACCREDO EXCLUSIVE OR PREFERRED DISTRIBUTION DRUGS					
PRODUCT	MANUFACTURER	DISEASE STATE	SPECIALTY CHANNEL	NUMBER OF OTHER SPECIALTY PROVIDERS	SPECIALTY CHANNEL PROVIDERS
FOLOTYN	ALLOS	CANCER	LIMITED	N/A	DROP SHIP FROM CARDINALTO INPATIENT CLINIC ONLY
GAMMAGARD	BAXTER	IMMUNE DEFICIENCY	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
GAMUNEX	TALECRIS	IMMUNE DEFICIENCY	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
GILENYA	NOVARTIS	MULTIPLE SCLEROSIS	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
GLASSIA	BAXTER	RESPIRATORY CONDITIONS	LIMITED	5	(ACCREDO/CSP), CVS CAREMARK, CORAM, WALGREENS, US BIO, BIORX
GLEEVEC	NOVARTIS	CANCER	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
HELIXATE	CSL BEHRING	HEMOPHILIA	LIMITED	7	(ACCREDO/CSP), CVS CAREMARK, BIORX, CORUM, AETNA, CIGNA
HEMOFIL	BAXTER	HEMOPHILIA	PREFERRED	10	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
HERCEPTIN	GENENTECH	CANCER	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
HIZENTRA	CSL BEHRING	IMMUNE DEFICIENCY	LIMITED	5	(ACCREDO/CSP), BIORX, CVS CAREMARK, CORUM, AETNA, CIGNA
HYCAMTIN	GSK	CANCER	PREFERRED	15	(ACCREDO/CSP), AETNA, BIOLOGICS INC, BIOSCRIP, CVS CAREMARK, CAREPLUS, COMMCARE, DIPLOMAT, ICORE, MEDMARK, ONCOLOGYRX CARE ADV, PHARMACARE, OPTIONCARE, SPECIALTY SCRIPS, IVPCARE, US BIO, WALGREENS
ILARIS	NOVARTIS	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
IMPLANON	SCHERING	CONTRACEPTIVE	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
INCRELEX	TERCICA	GROWTH DEFICIENCY	LIMITED	11	(ACCREDO/CSP), CVS/CAREMARK, CIGNA, AETNA, MEDMARK, INFUSION TECHNOLOGIES, OCEAN BREEZES, OPTION CARE, AXIOM, DIPLOMAT, COMPRECARE
INLYTA	PFIZER	CANCER	LIMITED	16	(ACCREDO/CSP), ACS, APOTHECARY SHOPPES, BIOLOGICS, BIOPLUS, BIOSCRIP, CVS CAREMARK, CAREMED, CIGNA/TELDRUG, DIPLOMAT, FL CANCER CENTER, ONCOSOURCE RX, OPTUMRX
IXEMPRA	BMS	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
JAKAFI	INCYTE	CANCER	LIMITED	3	(ACCREDO/CSP), CVS CAREMARK, BIOSCRIP, ONCOLOGY RX CARE ADVANTAGE

CURASCRIPT AND ACCREDO EXCLUSIVE OR PREFERRED DISTRIBUTION DRUGS					
PRODUCT	**MANUFACTURER**	**DISEASE STATE**	**SPECIALTY CHANNEL**	**NUMBER OF OTHER SPECIALTY PROVIDERS**	**SPECIALTY CHANNEL PROVIDERS**
KALYDECO	VERTEX	CYSTIC FIBROSIS	LIMITED	3	(ACCREDO/CSP), CF SERVICES (PART OF CF FOUNDATION 3 PHARMACIES; CA, TX, AL), FOUNDATION CARE (ST LOUIS), ACARIA, AND AMED (CA)
KENALOG	BMS	INFLAMMATORY CONDITIONS	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
KEPIVANCE	BIOVITRUM	INFLAMMATORY CONDITIONS	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
KOATE	TALECRIS	HEMOPHILIA	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
KOGENATE	BAYER	HEMOPHILIA	LIMITED	10	ASD, BDI PHARMA, CARDINAL, CSP, NOVIS, FFF, UBS, BIOCARE RX, HD SMITH, NATIONAL HOSPITAL SPECIALITY, MCKESSON, HEALTH COALITION
KORLYM	CORCEPT	ENDOCRINE DISORDERS	EXCLUSIVE	0	(ACCREDO/CSP)
KRYSTEXXA	SAVIENT	INFLAMMATORY CONDITIONS	LIMITED	3	CSD, BESSE, ICS, MCKESSON
KUVAN	BIOMARIN	ENDOCRINE DISORDERS	PREFERRED	10	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
LETAIRIS	GILEAD	PULMONARY HYPERTENSION	LIMITED	7	(ACCREDO/CSP), AETNA, CIGNA, CVS/CAREMARK, FAIRVIEW, KAISER, WALGREENS/MEDMARK, WELLCARE
LUCENTIS	GENENTECH	OPHTHALMIC CONDITIONS	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
LUMIZYME	GENZYME	ENZYME DEFICIENCIES	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
MACUGEN	EYETECH	OPHTHALMIC CONDITIONS	LIMITED	3	(ACCREDO/CSP), BIOSCRIP, MEDMARK, WALGREENS
MAKENA	THER-RX	MISCELLANEOUS SPECIALTY CONDITIONS	LIMITED	5	AETNA, (ACCREDO/CSP), BIOSCRIP, CIGNA, CVS CAREMARK, WALGREENS
MATULANE	SIGMA-TAU	CANCER	EXCLUSIVE	0	(ACCREDO/CSP)
MONOCLATE	CSL BEHRING	HEMOPHILIA	LIMITED	5	(ACCREDO/CSP), AETNA, BIORX, CVS CAREMARK, CORUM, CIGNA
MONONINE	CSL BEHRING	HEMOPHILIA	LIMITED	5	(ACCREDO/CSP), AETNA, CIGNA, CVS CAREMARK,
MUGARD	ACCESS	CANCER	LIMITED	2	(ACCREDO/CSP), BIOSCRIP, CVS CAREMARK
MYOZYME	GENZYME	ENZYME DEFICIENCIES	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
NAGLAZYME	BIOMARIN	ENZYME DEFICIENCIES	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
NEXAVAR	BAYER	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
NEXPLANON	SCHERING	CONTRACEPTIVE	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
NOVOSEVEN	NOVO NORDISK	HEMOPHILIA	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
NPLATE	AMGEN	BLOOD CELL DEFICIENCY	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS

CURASCRIPT AND ACCREDO EXCLUSIVE OR PREFERRED DISTRIBUTION DRUGS					
PRODUCT	**MANUFACTURER**	**DISEASE STATE**	**SPECIALTY CHANNEL**	**NUMBER OF OTHER SPECIALTY PROVIDERS**	**SPECIALTY CHANNEL PROVIDERS**
ORENCIA SQ	BMS	INFLAMMATORY CONDITIONS	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ORFADIN	RARE DISEASE THERAPEUTICS	ENZYME DEFICIENCIES	EXCLUSIVE	0	(ACCREDO/CSP)
PRIALT	ELAN	PAIN MANAGEMENT	LIMITED	ALL SPECIALTY	AVAILABLE VIA DROP SHIP. THERACOM IS SINGLE SOURCE WHOLESALE DISTRIBUTOR.
PRIVIGEN	CSL BEHRING	IMMUNE DEFICIENCY	LIMITED	5	(ACCREDO/CSP), AETNA, CIGNA, CORUM, BIORX, CVS CAREMARK,
PROMACTA	GSK	BLOOD CELL DEFICIENCY	LIMITED	15	(ACCREDO/CSP), ACS, AETNA, BIOLOGICS INC, BIOSCRIP, CVS CAREMARK, CAREPLUS, COMMCARE, DIPLOMAT, ICORE, MEDMARK, ONCOLOGYRX CARE ADV, OPTIONCARE, SPECIALTY SCRIPS, IVPCARE, US BIO, WALGREENS
QUTENZA	NEUROGESX	INFLAMMATORY CONDITIONS	LIMITED	3	BESSE/ASD HEALTH FOR WHOLESALE, CVS/CAREMARK AND CSP FOR PHARMACY
RECOMBINATE	BAXTER	HEMOPHILIA	LIMITED	10	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
REMODULIN	UNITED THERAPUETICS	PULMONARY HYPERTENSION	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
REVLIMID	CELGENE	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
RIASTAP	CSL BEHRING	ENZYME DEFICIENCIES	LIMITED	>5	NETWORK UNKNOWN, CSL WILL NOT DISCLOSE
RITUXAN	GENENTECH	CANCER	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
SABRIL	LUNDBECK	MISCELLANEOUS CNS DISORDERS	LIMITED	2	(ACCREDO/CSP), CVS/CAREMARK, MCKESSON
SEROSTIM	EMD SERONO	IMMUNE DEFICIENCY	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
SOLESTA	OCEANA	MISCELLANEOUS SPECIALTY CONDITIONS	EXCLUSIVE	0	(ACCREDO/CSP)
SOLIRIS	ALEXION	BLOOD CELL DEFICIENCY	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS

CURASCRIPT AND ACCREDO EXCLUSIVE OR PREFERRED DISTRIBUTION DRUGS					
PRODUCT	**MANUFACTURER**	**DISEASE STATE**	**SPECIALTY CHANNEL**	**NUMBER OF OTHER SPECIALTY PROVIDERS**	**SPECIALTY CHANNEL PROVIDERS**
SOMATULINE DEPOT	TERCICA	ENDOCRINE DISORDERS	LIMITED	10	AETNA, (ACCREDO/CSP), AXIOM, CIGNA, COMPRECARE, CVS, CAREMARK, DIPLOMAT, INFUSION TECHNOLOGIES, MEDMARK/WALGREENS, OCEAN BREEZES, OPTION CARE
SOMAVERT	PFIZER	ENDOCRINE DISORDERS	LIMITED	3	(ACCREDO/CSP), AETNA SPECIALTY, US BIOSERVICES, WALGREENS
SUCRAID	QOL	ENZYME DEFICIENCIES	EXCLUSIVE	0	(ACCREDO/CSP)
SUPPRELIN LA	ENDO	ENDOCRINE DISORDERS	LIMITED	10	(ACCREDO/CSP), AETNA, ARMADA, CIGNA, CVS CAREMARK, DIPLOMAT, ITSRX, PRIMERE, US BIOSERVICES, WALGREENS/MEDMARK
SYLATRON	MERCK	CANCER	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
SYNAGIS	MEDIMMUNE	RSV PREVENTION	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
THALOMID	CELGENE	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
THYROGEN	GENZYME	CANCER	LIMITED	5	AETNA, (ACCREDO/CSP), CVS CAREMARK, CHRONIMED, THERACOM, BIOSCRIP
TICE BCG	SCHERING	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
TRACLEER	ACTELION	PULMONARY HYPERTENSION	LIMITED	2	(ACCREDO/CSP), CVS/CAREMARK, HUMANA RIGHT SOURCE
TYKERB	GSK	CANCER	LIMITED	15	(ACCREDO/CSP), ACS, AETNA, BIOLOGICS INC, BIOSCRIP, CVS CAREMARK, CAREPLUS, COMMCARE, DIPLOMAT, ICORE, MEDMARK, ONCOLOGYRX CARE ADV, OPTIONCARE, SPECIALTY SCRIPS, IVPCARE, US BIO, WALGREENS
TYSABRI	BIOGEN	MULTIPLE SCLEROSIS	LIMITED	8	(ACCREDO/CSP), AETNA, BIOSCRIP, CAREPLUS, CIGNA, CVS CAREMARK, MEDMARK, OPTIONCARE, PRESCRIPTION SOLUTIONS
TYVASO	UNITED THERAPUETICS	PULMONARY HYPERTENSION	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
VALSTAR	ENDO	CANCER	LIMITED	10	(ACCREDO/CSP), AETNA, ARMADA, DIPLOMAT, US BIOSERVICES, CVS CAREMARK, WALGREENS, ITSRX, PRIMERE, AETNA, CIGNA
VANTAS	ENDO	CANCER	LIMITED	9	(ACCREDO/CSP), DIPLOMAT, US BIOSERVICES, CVS CAREMARK, WALGREENS, ARMADA, ITSRX, PRIMERE, AETNA, CIGNA

CURASCRIPT AND ACCREDO EXCLUSIVE OR PREFERRED DISTRIBUTION DRUGS					
PRODUCT	MANUFACTURER	DISEASE STATE	SPECIALTY CHANNEL	NUMBER OF OTHER SPECIALTY PROVIDERS	SPECIALTY CHANNEL PROVIDERS
VELETRI	ACTELION	PULMONARY HYPERTENSION	EXCLUSIVE	0	(ACCREDO/CSP)
VENTAVIS	ACTELION	PULMONARY HYPERTENSION	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
VIDAZA	CELGENE	CANCER	LIMITED	ALL SPECIALTY	PREFERRED PHARMACY NETWORK. ALL NATL AND LARGE PAYER SPS HAVE ACCESS
VISUDYNE	QLT	OPHTHALMIC CONDITIONS	LIMITED	ALL SPECIALTY	PREFERRED PHARMACY NETWORK. ALL NATL AND LARGE PAYER SPS HAVE ACCESS
VOTRIENT	GSK	CANCER	LIMITED	15	(ACCREDO/CSP), ACS, AETNA, BIOLOGICS INC, BIOSCRIP, CVS CAREMARK, CAREPLUS,
VPRIV	SHIRE	ENZYME DEFICIENCIES	LIMITED	ALL SPECIALTY	AVAILABLE VIA DROP SHIP THROUGH CARDINAL.
WINRHO	BAXTER	HEMOPHILIA	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
XALKORI	PFIZER	CANCER	LIMITED	3	(ACCREDO/CSP), CVS CAREMARK, US BIOSERVICES, WALGREENS
XENAZINE	LUNDBECK	MISCELLANEOUS CNS DISORDERS	LIMITED	1	(ACCREDO/CSP), CVS/CAREMARK
XEOMIN	MERZ	NEUROMUSCULAR CONDITIONS/COSMETIC	PREFERRED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
XIAFLEX	AUXILIUM	MISCELLANEOUS SPECIALTY CONDITIONS	LIMITED	10	(ACCREDO/CSP), BIOSCRIP, CVS CAREMARK, CIGNA, WALGREENS, PRESCRIPTION SOLUTIONS, CORUM + 4 OTHERS.
XOLAIR	GENENTECH	RESPIRATORY CONDITIONS	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
XYNTHA	PFIZER	HEMOPHILIA	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
XYREM	JAZZ	MISCELLANEOUS CNS DISORDERS	EXCLUSIVE	0	(ACCREDO/CSP) (VIA SDS)
YERVOY	BMS	CANCER	LIMITED	2	(ACCREDO/CSP), MCKESSON, ONCOLOGY SUPPLY
ZAVESCA	ACTELION	ENZYME DEFICIENCIES	EXCLUSIVE	0	(ACCREDO/CSP)
ZELBORAF	GENENTECH	CANCER	LIMITED	12	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ZEMAIRA	CSL BEHRING	RESPIRATORY CONDITIONS	LIMITED	1	(ACCREDO/CSP), CORUM
ZOLINZA	MERCK	CANCER	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ZORBITIVE	EMD SERONO	GROWTH DEFICIENCY	LIMITED	ALL SPECIALTY	ALL NATL AND LARGE PAYER SPS HAVE ACCESS
ZYTIGA	CENTOCOR	CANCER	LIMITED	11	(ACCREDO/CSP), BIOSCRIP, BIOLOGICS, CVS CAREMARK, DIPLOMAT, ICORE, ONCOLOGY RX, RX SOLUTIONS, RIGHT SOURCE, CIGNA/TELDRUG, WALGREENS, US BIOSERVICES

PRODUCTS NOT AVAILABLE THROUGH CURASCRIPT OR ACCREDO					
PRODUCT	MANUFACTURER	DISEASE STATE	SPECIALTY CHANNEL	NUMBER OF OTHER SPECIALTY PROVIDERS	SPECIALTY CHANNEL PROVIDERS
BEXXAR	GSK	CANCER	OTHER	15+	NUCLEAR MEDICINE AND HOSPITAL CLINICS
CAPRELSA (VANDETANIB)	ASTRAZENECA	CANCER	EXCLUSIVE	1	BIOLOGICS EXCLUSIVE
CAYSTON	GILEAD	RESPIRATORY CONDITIONS	LIMITED	4	CF SERVICES INC, FOUNDATION CARE, IV SOLUTIONS, PHARMACEUTICAL SPEC. INC.
CHENIX (CHENODIOL)	MANCHESTER	MISCELLANEOUS SPECIALTY CONDITIONS	EXCLUSIVE	1	CENTRIC EXCLUSIVE
CUVPOSA	SHIONOGI	MISCELLANEOUS SPECIALTY CONDITIONS	EXCLUSIVE	1	DIPLOMAT
CYSTAGON	MYLAN	MISCELLANEOUS SPECIALTY CONDITIONS	EXCLUSIVE	1	CVS/CAREMARK
FERRIPROX (DEFERIPRONE)	APOPHARMA	MISCELLANEOUS SPECIALTY CONDITIONS	EXCLUSIVE	1	CENTRIC EXCLUSIVE
ELELYSO	PFIZER	ENZYME DEFICIENCIES	EXCLUSIVE	1	CENTRIC EXCLUSIVE
IPLEX	INSMED	GROWTH DEFICIENCY	LIMITED	1	RX CROSSROADS
KALBITOR	DYAX	HEREDITARY ANGIOEDEMA	LIMITED	2	US BIO (AMERISOURCE BERGEN), WALGREEN
METOPIRONE	HRA-PHARMA	ENDOCRINE DISORDERS	EXCLUSIVE	1	DIRECT SUCCESS PHARMACY
MIRENA	BAYER	CONTRACEPTIVE	EXCLUSIVE	1	CVS/CAREMARK
ORTHOCLONE OKT-3	CENTOCOR	MISCELLANEOUS SPECIALTY CONDITIONS	LIMITED	0	TRANSPLANT CLINICS / HOSPITALS ONLY
PHOTOFRIN	AXCAN	CANCER	EXCLUSIVE	0	WHOLESALE CHANNEL ONLY. THIS IS A CSD EXCLUSIVE
PROLASTIN-C	TALECRIS	RESPIRATORY CONDITIONS	EXCLUSIVE	1	CENTRIC EXCLUSIVE
PROVENGE	DENDREON	CANCER	OTHER	0	DIRECT DISTRIBUTION
TESTOPEL	SLATE	ENDOCRINE DISORDERS	LIMITED	4	BIOSCRIP, CVS CAREMARK, MEDICINE SHOPPE, WALGREENS
ZEVALIN	SPECTRUM	CANCER	LIMITED	15+	NUCLEAR MEDICINE AND HOSPITAL CLINICS ONLY

List of Therapeutic Categories Excluded From Coverage

THERAPY CLASS
1ST GEN ANTIHISTAMINE & DECONGESTANT COMBINATIONS
1ST GEN ANTIHISTAMINE-DECONGESTANT-ANALGESIC COMB
1ST GEN ANTIHISTAMINE-DECONGESTANT-EXPECTORANT CMB
1ST GEN ANTIHIST-DECON-ANALGESIC, SALICYLATE
1ST GEN ANTIHIST-DECON-ANALGESIC,SALICYL-XANTHINE
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB
1ST GEN ANTIHIST-DECON-NSAID,COX NONSPEC
1ST GENERATION ANTIHISTAMINE-ANTICHOLINERGIC COMB.
2ND GEN ANTIHISTAMINE & DECONGESTANT COMBINATIONS
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL
5-LIPOXYGENASE INHIBITORS
ABRASIVES
ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION
ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC
ACID AND ALKALI POISON ANTIDOTES
ACID REPLACEMENT
ACNE AGENTS,SYSTEMIC
ACNE AGENTS,TOPICAL
ADRENAL RADIOACTIVE DIAGNOSTICS
ADRENERGIC AGENTS,CATECHOLAMINES
ADRENERGIC VASOPRESSOR AGENTS
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE
ADRENOCORTICOTROPHIC HORMONES
AGENTS FOR STOMATOLOGICAL USE
AGENTS TO TREAT MULTIPLE SCLEROSIS
AGTS TX NEUROMUSC TRANSMISSION DIS,POT-CHAN BLKR
ALCOHOL,SYSTEMIC USE
ALKYLATING AGENTS
ALLERGENIC EXTRACTS, THERAPEUTICS

ALPHA/BETA-ADRENERGIC BLOCKING AGENTS

ALPHA-ADRENERGIC BLOCKING AGENTS

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS

AMEBICIDES

AMINOGLYCOSIDES

AMYOTROPHIC LATERAL SCLEROSIS AGENTS

ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS

ANALGESIC, NON-SAL.- 1ST GENERATION ANTIHISTAMINE

ANALGESIC, NON-SALICYLATE-EXPECTORANT COMBINATION

ANALGESIC,NON-SALICYLATE-1ST GEN ANTIHIST-XANTHINE

ANALGESIC,NSAID-1ST GEN.ANTIHISTAMINE,SEDATIVE CMB

ANALGESICS NARCOTIC, ANESTHETIC ADJUNCT AGENTS

ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS

ANALGESICS, NON-NARCOTICS

ANALGESICS,SALICYLATE & NON-SALICYLATE COMBINATION

ANAPHYLAXIS THERAPY AGENTS

ANDROGENIC AGENTS

ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB

ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB

ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR

ANIMAL/HUMAN DERIVED AGENTS

ANOREXIC AGENTS

ANTHELMINTICS

ANTI-ALCOHOLIC PREPARATIONS

ANTIANDROGENIC AGENTS

ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC

ANTI-ANXIETY DRUGS

ANTIARRHYTHMICS

ANTI-ARTHRITIC AND CHELATING AGENTS

ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS

ANTIBACTERIAL AGENTS,MISCELLANEOUS

ANTIBIOTIC ANTINEOPLASTICS

ANTIBIOTICS, MISCELLANEOUS, OTHER

ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY

ANTICHOLINERGICS,QUATERNARY AMMONIUM

ANTICHOLINERGICS/ANTISPASMODICS

ANTICHOLINERGICS/MICROORGANISMS COMBINATIONS

ANTICOAGULANTS,COUMARIN TYPE

ANTICORROSIVE AGENTS

ANTIDEPRESSANT COMBINATIONS O.U.

ANTIDIARRHEAL MICROORGANISMS AGENTS

ANTIDIARRHEALS

ANTIDIURETIC AND VASOPRESSOR HORMONES

ANTIDOTES,MISCELLANEOUS

ANTIEMETIC/ANTIVERTIGO AGENTS

ANTIFIBRINOLYTIC AGENTS

ANTIFLATULENTS

ANTIFUNGAL AGENTS

ANTIFUNGAL AGENTS (CONTINUED 1)

ANTIFUNGAL ANTIBIOTICS

ANTIFUNGAL-ANTIBIOTIC-STEROID-ANTIHISTAMINE COMB

ANTIFUNGAL-ANTI-INFLAMMATORY STEROID-ANTIHISTAMINE

ANTIFUNGAL-LOCAL ANESTHETIC-ANTIHISTAMINE COMB

ANTIGENIC SKIN TESTS

ANTIHEMOPHILIC FACTORS

ANTIHISTAMINES

ANTIHYPERGLY, (DPP-4) INHIBITOR & BIGUANIDE COMB.

ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)

ANTIHYPERGLY.DPP-4 INHIBITORS &HMG COA RI(STATINS)

ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS

ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIB (N-S)

ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE

ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS

ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE

ANTIHYPERGLYCEMIC, INSULIN-RESPONSE ENHANCER (N-S)

ANTIHYPERGLYCEMIC,BIGUANIDE TYPE(NON-SULFONYLUREA)

ANTIHYPERGLYCEMIC,INSULIN-REL STIM.& BIGUANIDE CMB

ANTIHYPERGLYCEMIC,INSULIN-RESPONSE & RELEASE COMB.

ANTIHYPERGLYCM,INSUL-RESP.ENHANCER & BIGUANIDE CMB

ANTIHYPERLIP - HMG-COA&CALCIUM CHANNEL BLOCKER CB

ANTIHYPERLIP.HMG COA REDUCT INHIB&CHOLEST.AB.INHIB

ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS

ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.&NIACIN

ANTIHYPERTENSIVES, ACE INHIBITORS

ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST

ANTIHYPERTENSIVES, MISCELLANEOUS

ANTIHYPERTENSIVES, SYMPATHOLYTIC

ANTIHYPERTENSIVES, VASODILATORS

ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR

ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR

ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.

ANTILEPROTICS

ANTIMALARIAL DRUGS

ANTIMETABOLITES

ANTIMIGRAINE PREPARATIONS

ANTI-NARCOLEPSY & ANTI-CATAPLEXY,SEDATIVE-TYPE AGT

ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY

ANTINEOPLAST,HISTONE DEACETYLASE (HDAC) INHIBITORS

ANTINEOPLASTIC - AROMATASE INHIBITORS

ANTINEOPLASTIC - EPOTHILONES AND ANALOGS

ANTINEOPLASTIC - HALICHONDRIN B ANALOGS

ANTINEOPLASTIC - IMMUNOTHERAPY, THERAPEUTIC VAC

ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS

ANTINEOPLASTIC - MTOR KINASE INHIBITORS

ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS

ANTINEOPLASTIC ANTIBODY/RADIOACTIVE-DRUG COMPLEXES

ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY

ANTINEOPLASTIC IMMUNOMODULATOR AGENTS

ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.

ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS

ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS

ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES

ANTINEOPLASTICS,MISCELLANEOUS

ANTINFLAMMATORY, SEL.COSTIM.MOD.,T-CELL INHIBITOR

ANTIOXIDANT AGENTS

ANTIOXIDANT MULTIVITAMIN COMBINATIONS

ANTIPARASITICS

ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC

ANTIPARKINSONISM DRUGS,OTHER

ANTIPERSPIRANTS

ANTIPORPHYRIA FACTORS

ANTIPROTOZOAL DRUGS,MISCELLANEOUS

ANTIPSORIATIC AGENTS,SYSTEMIC

ANTIPSORIATICS AGENTS

ANTIPSYCH,DOPAMINE ANTAG.,DIPHENYLBUTYLPIPERIDINES

ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED

ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS

ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG

ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES

ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES

ANTI-PSYCHOTICS,NON-PHENOTHIAZINES

ANTI-PSYCHOTICS,PHENOTHIAZINES

ANTISEBORRHEIC AGENTS

ANTISEPTICS,GENERAL

ANTISEPTICS,MISCELLANEOUS

ANTISERA

ANTITHYROID PREPARATIONS

ANTITUSSIVE-1ST GEN ANTST-ANALGESIC-EXPECT COMB

ANTITUSSIVES,NON-NARCOTIC

ANTI-ULCER PREPARATIONS

ANTI-ULCER-H.PYLORI AGENTS

ANTIVENINS

ANTIVIRAL MONOCLONAL ANTIBODIES

ANTIVIRALS, GENERAL

APPETITE STIM. FOR ANOREXIA,CACHEXIA,WASTING SYND.

ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS

ARTIFICIAL TEARS

ASTRINGENTS

BARBITURATES

BELLADONNA ALKALOIDS

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS

BENZODIAZEPINE ANTAGONISTS

BETA-ADRENERGIC AGENTS

BETA-ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS

BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS

BETA-ADRENERGIC BLOCKING AGENTS

BETA-ADRENERGIC BLOCKING AGENTS/THIAZIDE & RELATED

BETALACTAMS

BICARBONATE PRODUCING/CONTAINING AGENTS

BILE SALT SEQUESTRANTS

BILE SALTS

BILIARY DIAGNOSTICS,RADIOPAQUE

BIOFLAVONOIDS

BIPOLAR DISORDER DRUGS

BLOOD ADMINISTRATION SETS

BLOOD FACTORS,MISCELLANEOUS

BLOOD SUGAR DIAGNOSTICS

BLOOD TESTING PREPARATIONS,IN-VITRO

BLOOD UREA NITROGEN TESTS

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE

BONE RESORPTION INHIBITOR & VITAMIN D COMBINATIONS

BONE RESORPTION INHIBITORS

BPH AGENTS,5-ALPHA-RED INH & ALPHA-1-ADR ANTG CMB

BRACES AND RELATED DEVICES

BULK CHEMICALS

C1 ESTERASE INHIBITORS

CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER

CALCIUM CHANNEL BLOCKING AGENTS

CALCIUM REPLACEMENT

CARBAPENEMS (THIENAMYCINS)

CARBOHYDRATES

CARBONIC ANHYDRASE INHIBITORS

CARDIOPLEGIC SOLUTIONS

CARDIOVASCULAR DIAGNOSTICS,NON-RADIOPAQUE AGENTS

CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE

CATHETERS AND RELATED DEVICES

CENTRAL NERVOUS SYSTEM STIMULANTS

CEPHALOSPORINS - 4TH GENERATION

CEPHALOSPORINS - 5TH GENERATION

CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS

CEREBRAL SPINAL RADIOPAQUE DIAGNOSTICS

CHELATING AGENTS

CHEMOTHERAPEUTICS, ANTIBACTERIAL, MISC.

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

CHLORAMPHENICOL AND DERIVATIVES

CHOLERETICS

CHOLINESTERASE INHIBITORS

CHOLINESTERASE REACTIVAT.&MUSCARINIC ANTG.ANTIDOTE

CHOLINESTERASE REACTIVATING,ORGANOPHOS. ANTIDOTES

CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT,RECTAL TX

CITRATES AS ANTICOAGULANTS

CLEAN AIR CENTERS

COAGULANTS

COLCHICINE

COLORING AGENTS AND DYES

CONCEPTION ASSISTANCE SUPPLIES

CONDOMS

CONTACT LENS PREPARATIONS(GAS,HARD,SOFT)

CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC

CONTRACEPTIVES,IMPLANTABLE

CONTRACEPTIVES,INJECTABLE

CONTRACEPTIVES,INTRAVAGINAL

CONTRACEPTIVES,ORAL

CONTRACEPTIVES,TRANSDERMAL

COSMETIC/SKIN COLORING/DYE AGENTS,TOPICAL

COUGH AND/OR COLD PREPARATIONS

CRYOPRESERVATIVE AGENTS

CXCR4 CHEMOKINE RECEPTOR ANTAGONIST

CYCLIC LIPOPEPTIDES

CYTOTOXIC T-LYMPHOCYTE ANTIGEN(CTLA-4)RMC ANTIBODY

DECARBOXYLASE INHIBITORS

DECON-ANALGESIC,NON-SALICYLATE-XANTHINE

DECONGEST-ANALGESIC,NON-SALICYLATE COMB.

DECONGESTANT-ANALGESIC-EXPECTORANT COMBINATION

DECONGESTANT-EXPECTORANT COMBINATIONS

DECONGESTANT-NSAID, COX NON-SPEC COMB.

DENTAL AIDS AND PREPARATIONS

DENTAL SUPPLIES

DEODORANTS

DIABETIC SUPPLIES

DIABETIC ULCER PREPARATIONS,TOPICAL

DIAGNOSTIC PREPARATIONS,MISCELLANEOUS

DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)

DIALYSIS SOLUTIONS

DIAPHRAGMS/CERVICAL CAP

DIETARY SUPPLEMENT, MISCELLANEOUS

DIETARY SUPPLEMENT, MISCELLANEOUS (CONTINUED 1)

DIGESTIVE AGENTS, OTHER

DIGITALIS GLYCOSIDES

DILUENT SOLUTIONS

DIRECT FACTOR XA INHIBITORS

DIURETICS,MISCELLANEOUS

DRUG TX-CHRONIC INFLAM. COLON DX,5-AMINOSALICYLAT

DRUGS TO TREAT HEREDITARY TYROSINEMIA

DRUGS TO TREAT IMPOTENCY

DRUGS TO TX CHRONIC INFLAMMATORY DISEASE OF COLON

DRUGS TO TX GAUCHER DX-TYPE 1, SUBSTRATE REDUCING

DRUGS USED TO TREAT ACIDOSIS

DURABLE MEDICAL EQUIPMENT,MISC(GROUP 1)

DURABLE MEDICAL EQUIPMENT,MISC(GROUP 2)

DURABLE MEDICAL EQUIPMENT,MISCELLANEOUS

EAR PREPARATIONS, MISCELLANEOUS (OTC)

EAR PREPARATIONS,EAR WAX REMOVERS

ELECTROLYTE DEPLETERS

ELECTROLYTE MAINTENANCE

ELECTROLYTE MAINTENANCE (CONTINUED 1)

EMETICS

ENTERIC VIRUS VACCINES

ESTROGEN & PROGESTIN WITH ANTIMINERALOCORTICOID CB

ESTROGEN/ANDROGEN COMBINATIONS

ESTROGENIC AGENTS

EXPECTORANTS

EYE ANTIHISTAMINES

EYE ANTI-INFECTIVES (RX ONLY)

EYE ANTIVIRALS

EYE DIAGNOSTIC AGENTS

EYE IRRIGATIONS

EYE PREPARATIONS, MISCELLANEOUS (OTC)

EYE VASOCONSTRICTORS (OTC ONLY)

EYE VASOCONSTRICTORS (RX ONLY)

FACTOR IX PREPARATIONS

FAT ABSORPTION DECREASING AGENTS

FEEDING DEVICES

FERTILITY STIMULATING PREPARATIONS,NON-FSH

FIBROMYALGIA AGENTS,SEROTONIN-NOREPINEPH RU INHIB

FLAVORING AGENTS

FLAVORING AGENTS (CONTINUED 1)

FLAVORING AGENTS (CONTINUED 5)

FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS

FLUORIDE PREPARATIONS

FOLIC ACID PREPARATIONS

FOLLICLE-STIMULATING & LUTEINIZING HORMONES

FOLLICLE-STIMULATING HORMONE (FSH)

FOOD OILS

GASTRIC ENZYMES

GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS

GENERAL ANESTHETICS,INHALANT

GENERAL ANESTHETICS,INJECTABLE

GENERAL BRONCHODILATOR AGENTS

GENERAL INHALATION AGENTS

GERIATRIC VITAMIN PREPARATIONS

GLYCYLCYCLINES

GOLD SALTS

GRAM (-) BACILLI (NON-ENTERIC) VACCINES

GRAM NEGATIVE COCCI VACCINES

GRAM POSITIVE COCCI VACCINES

GROWTH HORMONE RECEPTOR ANTAGONISTS

GROWTH HORMONE RELEASING HORMONE (GHRH) & ANALOGS

GROWTH HORMONES

HAIR GROWTH REDUCTION AGENTS

HEARING AIDS AND RELATED DEVICES

HEMATINICS,OTHER

HEMORRHEOLOGIC AGENTS

HEMORRHOIDAL PREP,ANTI-INFLAM STEROID/LOCAL ANESTH

HEMORRHOIDAL PREPARATIONS

HEMORRHOIDALS, LOCAL RECTAL ANESTHETICS

HEPARIN AND RELATED PREPARATIONS

HEPATIC DIAGNOSTICS

HEPATITIS C TREATMENT AGENTS

HEPATITIS C VIRUS NS3/4A SERINE PROTEASE INHIB.

HERBAL DRUGS

HERBAL DRUGS (CONTINUED 1)

HERBAL DRUGS (CONTINUED 11)

HERBAL DRUGS (CONTINUED 3)

HERBAL DRUGS (CONTINUED 5)

HERBAL DRUGS (CONTINUED 7)

HISTAMINE H2-RECEPTOR INHIBITORS

HISTAMINE PREPARATIONS

HOMEOPATHIC DRUGS

HOT WATER BOTTLE AND RELATED DEVICES

HUMAN CHORIONIC GONADOTROPIN (HCG)

HUMAN MONOCLONAL ANTIBODY COMPLEMENT(C5) INHIBITOR

HYDROPHILIC CREAM/OINTMENT BASES

HYMENOPTERA-DERIVED AGENTS

HYPERCALCEMIA, AGENTS TO TREAT (CHELATING-TYPE)

HYPERGLYCEMICS

HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE

HYPERTRICHOTIC AGENTS, SYSTEMIC/INCL. COMBINATIONS

HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE

HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS

HYPNOTICS, MELATONIN AND HERBAL COMBINATIONS

HYPOPIGMENTATION AGENTS

IMMUNOMODULATOR,B-LYMPHOCYTE STIM(BLYS)-SPEC INHIB

IMMUNOMODULATORS

IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN

IMMUNOSUPPRESSIVES

INCONTINENCE SUPPLIES

INFANT FORMULAS

INFLUENZA VIRUS VACCINES

INORGANIC SALT DIURETICS

INOTROPIC DRUGS

INSECTICIDES

INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) HORMONES

INSULINS

INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS

INTESTINAL ADSORBENTS AND PROTECTIVES

INTESTINAL MOTILITY STIMULANTS

INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.

INTRA-UTERINE DEVICES (IUDS)

IODINE CONTAINING AGENTS

IRON REPLACEMENT

IRRIGANTS

IRRIGATION ADMINISTRATION SETS

IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST

IV FAT EMULSIONS

IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS

IV SOLUTIONS: DEXTROSE AND RINGERS

IV SOLUTIONS: DEXTROSE-SALINE

IV SOLUTIONS: DEXTROSE-WATER

JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME

KERATINOCYTE GROWTH FACTOR (KGF)

KERATOLYTICS

KETOLIDES

KIDNEY STONE AGENTS

LEUKOCYTE (WBC) STIMULANTS

LEUKOCYTE ADHESION INHIB,ALPHA4-MEDIAT IGG4K MC AB

LEUKOTRIENE RECEPTOR ANTAGONISTS

LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS

LHRH(GNRH) ANTAGONIST,PITUITARY SUPPRESSANT AGENTS

LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY

LIPOTROPICS

LOCAL ANESTHETICS

LOCAL ANESTHETICS (CONTINUED 1)

LOOP DIURETICS

LUNG SURFACTANTS

LUTEINIZING HORMONES

MAGNESIUM SALTS REPLACEMENT

MAOIS - NON-SELECTIVE & IRREVERSIBLE

MAST CELL STABILIZERS

MEDICAL PROCEDURAL AIDS

MEDICAL SUPPLIES,MISCELLANEOUS

MEDICAL SUPPLIES,MISCELLANEOUS(GROUP 1)

MEDICAL SUPPLIES,MISCELLANEOUS(GROUP 3)

METABOLIC DEFICIENCY AGENTS

METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX

METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX

METABOLIC DISEASE ENZYME REPLACEMENT,POMPE DISEASE

METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS

METABOLIC DX ENZYME REPLACEMT,SEV.COMB.IMMUNE DEF.

METABOLIC FUNCTION DIAGNOSTICS

METALLIC POISON,AGENTS TO TREAT

MINERAL REPLACEMENT,MISCELLANEOUS

MINERALOCORTICOIDS

MIOTICS/OTHER INTRAOC. PRESSURE REDUCERS

MISCELLANEOUS AGENTS

MONOAMINE OXIDASE(MAO) INHIBITORS

MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E(IGE)

MOUTHWASHES

MOVEMENT DISORDERS (DRUG THERAPY)

MUCOLYTICS

MULTIPLE HERBAL INGREDIENT COMBINATIONS

MULTIVITAMIN PREPARATIONS

MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING

MUSCARINIC RECEPTOR ANTAGONISTS

MYDRIATICS

NARC ANTITUSS-1ST GEN ANTIHISTAMINE-ANALG,N-SAL CB

NARCOTIC ANTAGONISTS

NARCOTIC ANTITUSS-1ST GEN ANTIHIST-EXPECT COMB.

NARCOTIC ANTITUSS-1ST GEN. ANTIHISTAMINE-DECONGEST

NARCOTIC ANTITUSS-DECONGESTANT-ANALGESIC-EXPECT CB

NARCOTIC ANTITUSS-DECONGESTANT-EXPECTORANT COMB

NARCOTIC ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE

NARCOTIC ANTITUSSIVE-ANTICHOLINERGIC COMB.

NARCOTIC ANTITUSSIVE-DECONGESTANT COMBINATIONS

NARCOTIC ANTITUSSIVE-EXPECTORANT COMBINATION

NARCOTIC WITHDRAWAL THERAPY AGENTS

NASAL ANTIHISTAMINE

NASAL ANTI-INFLAMMATORY STEROIDS

NASAL MAST CELL STABILIZERS AGENTS

NASAL MOISTURIZER

NASAL NSAIDS, COX NON-SELECTIVE,SYSTEMIC ANALGESIC

NASAL PREPARATIONS,IRRITANTS/COUNTER-IRRITANTS

NASAL WASHES

NEEDLES/NEEDLELESS DEVICES

NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS

NEUROMUSCULAR BLOCKING AGENTS

NEUROTOXIC VIRUS VACCINES

NIACIN PREPARATIONS

NITROFURAN DERIVATIVES

NON-NARC ANTITUS-1ST GEN ANTIHIST-DECON-ANALGES CB

NON-NARC ANTITUS-1ST GEN ANTIHIST-DECONGEST-EXPECT

NON-NARC ANTITUSS-1ST ANTIHIST-DECONG-ANALG-EXPECT

NON-NARC ANTITUSS-1ST GEN ANTIHIST-ANALGESIC COMB.

NON-NARC ANTITUSS-1ST GEN. ANTIHISTAMINE-DECONGEST

NON-NARC ANTITUSS-DECONGESTANT-ANALGESIC-EXPECT CB

NON-NARC ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.

NON-NARC ANTITUSSIVE-1ST GEN ANTIHIST-EXPECT COMB.

NON-NARCOTIC ANTITUSS-DECONGESTANT-EXPECTORANT CMB

NON-NARCOTIC ANTITUSSIVE AND EXPECTORANT COMB.

NON-NARCOTIC ANTITUSSIVE-ANALGESIC COMBINATIONS

NON-NARCOTIC ANTITUSSIVE-DECONGESTANT COMBINATIONS

NON-NARCOTIC ANTITUSSIVE-DECONGESTANT-ANALGESIC CB

NOSE PREPARATIONS ANTIBIOTICS

NOSE PREPARATIONS, MISCELLANEOUS (OTC)

NOSE PREPARATIONS, MISCELLANEOUS (RX)

NOSE PREPARATIONS, VASOCONSTRICTORS (RX)

NOSE PREPARATIONS, VASOCONSTRICTORS(OTC)

NSAID & HISTAMINE H2 RECEPTOR ANTAGONIST COMB.

NSAID & TOPICAL IRRITANT COUNTER-IRRITANT COMB.

NSAID, COX INHIBITOR-TYPE & PROTON PUMP INHIB COMB

NSAIDS/DIETARY SUPPLEMENT COMBINATIONS

NUTRITIONAL THERAPY, MED COND SPECIAL FORMULATION

NUTRITIONAL TX, PHENYLKETONURIA (PKU) FORMULATIONS

OCCULT BLOOD TESTS

OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS

OINTMENT/CREAM BASES

OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY

OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE

OPHTHALMIC MAST CELL STABILIZERS

OPHTHALMIC PREPARATIONS, MISCELLANEOUS

OPHTHALMIC SURGICAL AIDS

ORAL LIPID SUPPLEMENTS

ORAL MUCOSITIS/STOMATITIS AGENTS

ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT

OSMOTIC DIURETICS

OSTOMY SUPPLIES

OTIC,ANTIINFECTIVE-LOCAL ANESTHETIC COMBINATIONS

OTIC-ANTIINFECTIVE, LOCAL ANESTH & ANTI-INFLAM CMB

OVULATION TESTS

OXAZOLIDINONES

OXYTOCICS

PANCREATIC ENZYMES

PANTHENOL PREPARATIONS

PARASYMPATHETIC AGENTS

PARENTERAL ADMINISTRATION SETS

PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS

PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE

PEDIATRIC VITAMIN PREPARATIONS

PERFUMES

PERIODONTAL COLLAGENASE INHIBITORS

PERIODONTAL TETRACYCLINE ANTIINFECTIVE, LOCAL

PHARMACEUTICAL ADJUVANTS, TABLET & CAPSULE MANF.

PHOSPHATE REPLACEMENT

PHOSPHODIESTERASE-4 (PDE4) INHIBITORS

PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)

PHOTOACTIVATED, ANTINEOPLS. & PREMALIGNANT LESIONS

PINEAL HORMONE AGENTS

PITUITARY SUPPRESSIVE AGENTS

PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE

PLASMA EXPANDERS

PLASMA KALLIKREIN INHIBITORS

PLASMA PROTEINS

PLATELET AGGREGATION INHIBITORS

PLATELET PROLIFERATION STIMULANTS

PLATELET REDUCING AGENTS

POLYMYXIN AND DERIVATIVES

POSTHERPETIC NEURALGIA AGENTS

POTASSIUM REPLACEMENT

POTASSIUM SPARING DIURETICS

POTASSIUM SPARING DIURETICS IN COMBINATION

PREGNANCY FACILITATING/MAINTAINING AGENT,HORMONAL

PREGNANCY TESTS

PRENATAL VITAMIN PREPARATIONS

PRENATAL VITAMIN PREPARATIONS (CONTINUED 1)

PRESERVATIVES

PROGESTATIONAL AGENTS

PROTEIN C PREPARATIONS

PROTEIN REPLACEMENT

PROTON-PUMP INHIBITORS

PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS

PULM.ANTI-HTN,SEL.C-GMP PHOSPHODIESTERASE T5 INHIB

PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST

PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE

RADIOACTIVE DIAGNOSTICS, GENERAL

RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES

RADIOACTIVE THERAPEUTIC AGENTS

RECTAL PREPARATIONS

RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)

RENAL FUNCTION DIAGNOSTICS AGENTS

RENIN INHIB, DIRECT/CALC. CHANNEL BLKR/THIAZIDE CB

RENIN INHIBITOR, DIRECT

RENIN INHIBITOR, DIRECT & CALCIUM CHANNEL BLOCKER

RENIN INHIBITOR,DIRECT & ANGIOTENSIN RECEPT ANTAG.

RENIN INHIBITOR,DIRECT AND THIAZIDE DIURETIC COMB

RESPIRATORY AIDS,DEVICES,EQUIPMENT

RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS

ROSACEA AGENTS, TOPICAL

RUBBER SYRINGES

SALIVA STIMULANT AGENTS

SALIVA SUBSTITUTE AGENTS

SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERM)

SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)

SEXUAL DYSFUNCTION DEVICES

SHAMPOOS/LOTION

SICKLE CELL ANEMIA AGENTS

SKELETAL MUSCLE RELAX.& TOP.IRRITANT COUNTER-IRRIT

SKIN TISSUE REPLACEMENT

SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)

SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST

SMOKING DETERRENTS, OTHER

SODIUM/SALINE PREPARATIONS

SOLVENTS

SOLVENTS (CONTINUED 1)

SOLVENTS (CONTINUED 2)

SOMATOSTATIC AGENTS

SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT

SSRI & ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG CMB

STEROID ANTINEOPLASTICS

STREPTOGRAMINS

SUNSCREENS

SUPPORT HOSIERY

SURFACE ACTIVE AGENTS

SURFACTANTS

SURFACTANTS (CONTINUED 1)

SUSPENDING AGENTS

SWEETENERS

SYMPATHOMIMETIC AGENTS

SYRINGES AND ACCESSORIES

SYSTEMIC ENZYME INHIBITORS

THERMOMETERS

THIAZIDE AND RELATED DIURETICS

THICKENING AGENTS, ORAL

THROMBIN INHIBITORS,SEL.,DIRECT,&REV.-HIRUDIN TYPE

THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE

THROMBOLYTIC ENZYMES

THROMBOPOIETIN RECEPTOR AGONISTS

THYROID FUNCTION DIAGNOSTIC AGENTS

THYROID HORMONES

TISSUE BULKING IMPLANTS

TISSUE/WOUND ADHESIVES

TOOTH ACHE PREPARATIONS

TOPICAL AGENTS,MISCELLANEOUS

TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY,STEROID AGENT

TOPICAL ANTIFUNGALS

TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC

TOPICAL ANTI-INFLAMMATORY, NSAIDS

TOPICAL ANTI-INFLAMMATORY, OTHER

TOPICAL ANTINEOPLASTIC & PREMALIGNANT LESION AGNTS

TOPICAL ANTISEPTIC DRYING AGENTS

TOPICAL ANTIVIRAL & ANTI-INFLAMMATORY STEROID CMB

TOPICAL ANTIVIRALS

TOPICAL GENITAL WART-HPV TREATMENT AGENTS

TOPICAL HEMOSTATICS

TOPICAL HYPERPIGMENTATION AGENTS

TOPICAL HYPERTRICHOTIC AGENTS, EYELASHES

TOPICAL IMMUNOSUPPRESSIVE AGENTS

TOPICAL LOCAL ANESTHETICS

TOPICAL PLEUROMUTILIN DERIVATIVES

TOPICAL PREPARATIONS,MISCELLANEOUS

TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID

TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES

TOPICALS, HYPERTRICHOTIC AGENTS

TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS

TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS

TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS

TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST

TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY

TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE

URICOSURIC AGENTS

URINARY PH MODIFIERS

URINARY TRACT ANALGESIC AGENTS

URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)

URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAG.

URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT

URINARY TRACT RADIOPAQUE DIAGNOSTICS

URINE ACETONE TEST AIDS

URINE GLUCOSE TEST AIDS

URINE GLUCOSE/ACETONE TEST AIDS,STRIPS

URINE MULTIPLE TEST AIDS

URINE TEST AIDS,MISCELLANEOUS

VACCINE/TOXOID PREPARATIONS,COMBINATIONS

VAGINAL ANTIBIOTICS

VAGINAL ANTIFUNGALS

VAGINAL ANTISEPTICS

VAGINAL DEODORANTS

VAGINAL ESTROGEN PREPARATIONS

VAGINAL LUBRICANTS PREPARATIONS

VAGINAL PREPARATIONS

VAGINAL SULFONAMIDES

VANCOMYCIN AND DERIVATIVES

VASOACTIVE NATRIURETIC PEPTIDES

VASODILATORS, COMBINATION

VASODILATORS,CORONARY

VASODILATORS,MISCELLANEOUS

VASODILATORS,PERIPHERAL

VEHICLES

VENOSCLEROSING AGENTS

VINCA ALKALOIDS

VIRAL/TUMORIGENIC VACCINES

VITAMIN A & D PREPARATIONS

VITAMIN A DERIVATIVES

VITAMIN A DERIVATIVES, TOPICAL COSMETIC AGENTS

VITAMIN A PREPARATIONS

VITAMIN B PREPARATIONS

VITAMIN B1 PREPARATIONS

VITAMIN B12 PREPARATIONS

VITAMIN B2 PREPARATIONS

VITAMIN B6 PREPARATIONS

VITAMIN C PREPARATIONS

VITAMIN D PREPARATIONS

VITAMIN E PREPARATIONS

VITAMIN K PREPARATIONS

WATER

WEIGHT LOSS PLANNING AIDS WITH A DIETARY SUPPLEMNT

WOUND HEALING AGENTS, LOCAL

XANTHINES

XANTHINES/DIETARY SUPPLEMENT COMBINATIONS

ZINC REPLACEMENT