MedImpact
Response to PBM Services
Request for Proposal

Technical Proposal

Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan, and NYS Insurance Fund Worker's Compensation Prescription Drug Programs

JULY 2, 2024

MedImpact

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5.1 Executive Summary

MedImpact (MedImpact Healthcare Systems, Inc.), is pleased to present our response to the New York State Department of Civil Service (DCS) RFP (Request for Proposals) for "Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs." Our proposal conveys a comprehensive and thoughtful approach to meeting and exceeding the RFP requirements, all State and Federal regulations, and the objectives of DCS.

Who We Are

MedImpact is a privately held California corporation, founded by pharmacists in 1989 to provide clinically innovative and client-oriented payer solutions. Headquartered in San Diego, California, we **employ over 1,300 colleagues across the nation** and provides pharmacy benefit management services for approximately 15 million lives, including direct contracts with state agencies (employee benefits, Medicaid).

MedImpact is a health services technology company that has met every regulatory and technical challenge along our journey including implementing Medicaid managed care programs in the 90s, Medicare in 2006, Health Insurance Marketplace programs in 2014, and fee-for-service Medicaid in 2021. As our clients' businesses have evolved, we have been there to provide new solutions for these regulated markets.

Since the beginning, MedImpact has not waivered on our core differentiating principles of:

- Independence (we are privately held)
- Freedom from conflict (not owned by a health plan or own pharmacies)
- Transparency (since the beginning)

We offer DCS nearly **35 years of independent PBM (pharmacy benefits management) expertise** which translates into greater depth and sophistication in how we collaborate with clients to solve complex problems. We are among **the top 6 largest PBM organizations in the country and serve roughly 15 million** enrollees across all lines of business including public sector, government, employers, unions, hospitals, health systems, Medicare, Medicaid, and the Health Insurance Marketplace.

MedImpact has a unique business model. We are not owned by a health plan, drug manufacturer, drug wholesaler, or a chain drug stores, and we are among the only truly independent PBMs on a national scale, providing a full spectrum of sophisticated services focused on optimizing health outcomes with a transparent business model and client service culture. We are not vertically integrated and have **no conflict of interest.** Our clients can freely run their program with the confidence that their PBM is not driving utilization to specific pharmacies or implementing specific programs that may not be in their best interest.

We continue to maintain a strong organizational history and structure, with the same chief executive officer throughout our history and in-depth PBM experience at the executive and staff levels. We are a financially stable and strong organization. **MedImpact's central administrative and district office addresses are as follows**:

- Headquarters: 10181 Scripps Gateway Court; San Diego, California 92131

- Southwest regional office: 8150 South Kyrene Road; Tempe, Arizona 85282
- Corporate services: 350 S. Williams Blvd; Tucson, Arizona 85711

Understanding Of Requirements

MedImpact recognizes DCS will be entrusting us with your most important assets, your people: employees, retirees, and their dependents. We do not take this lightly. We are pleased to present the **senior officer responsible for this account as Lisa Varrato, our Chief Client Experience Officer**.

Ms. Varrato is an integral part of MedImpact's senior leadership team. She will serve as the executive voice of MedImpact and liaise with DCS and NYSIF to:

- Collaborate in development of strategic roadmaps
- Eliminate internal barriers and advocate for initiatives that promote new opportunities
- Stay informed on the account through an established strategic account review process
- Attend quarterly internal strategy meetings and DCS and NYSIF annual leadership meetings

MedImpact commits to **prioritization of DCS and NYSIF as a key MedImpact customer with high visibility** within the organization. Ms. Varrato will ensure DCS, NYSIF and its enrollees receive the appropriate service required to meet the unique needs of its enrollees.

MedImpact's experienced senior leadership team is responsible for the overall strategy, direction, and success of the organization. This team is dedicated to achieving the company's primary objective—client and enrollee satisfaction through flexible solutions and enrollee-centric products with a keen focus on innovation and quality outcomes.

MedImpact understands that public sector clients have unique and dynamic needs. We are cognizant of your legislative demands and cycles and provide an experienced team to help you navigate these complex requirements. MedImpact takes a proactive approach to monitoring legislative initiatives to provide input to policymakers and learn about the changing industry regulations critical for our clients. We work with policymakers, regulators, healthcare media, and other key individuals who determine the role of PBMs in the marketplace and their plan sponsors in the public policy arena. We maintain a structured process to review, communicate, and implement regulations that will impact our clients' pharmacy benefit.

MedImpact recognizes DCS has **issued one procurement to secure the services with one single offeror to enter separate contracts to administer its Prescription Drug Programs**. MedImpact will contract with DCS to administer the prescription drug program for The Empire Plan, Student Employee Health Plan and will contract with the NYSIF (New York State Insurance Fund) to administer the workers compensation prescription drug program inclusive of disability benefits for off-the-job injuries. Though we are proposing a Key Subcontractor to assist with the NYSIF scope of work, we understand that we have ultimate responsibility for the fulfillment of all the responsibilities under the Agreements. We acknowledge that the Department and/or NYSIF must reserve the right to approve/disapprove all Key Subcontractors.

MedImpact has a proven track record of successfully implementing intricate benefit designs. We have successfully transitioned PBM services for government programs with 1.5 million lives in six months and are confident our implementation teams will do the same for DCS and NYSIF pharmacy programs acknowledging a shorter implementation timeline is needed.

MedImpact has structured our proposal to identify responses specific to DCS and NYSIF for ease of evaluation and in accordance with Attachment 97 – Programs Services Matrix.

What We Do

MedImpact has provided services for public sector systems for 31 years. We have provided PBA and/or PBM software and services for 35 years. This includes clinical, operational, and analytical guidance and support to Medicaid programs, Medicare Advantage plans, Marketplace/Exchange, commercial and government employers, health plans, and other organizations as a third party-administrator. Our core services include (but are not limited to):

- Claims processing
- Network administration/management (including payment and audits)
- Utilization management/clinical consultation
- Development and Implementation of Preferred Drug Lists and benefit designs
- PT/DUR Board support
- Adjudication of PA (prior authorization) requests, including appeals and grievances
- ProDUR/RetroDUR activities
- Provider and enrollee support
- Reporting and analytics
- Rebate management/administration

MedImpact has a **long history of managing state and local government pharmacy benefits** as we value working in a transparent environment. **Table 1** outlines recent and current state government clients over the last three years.

Client	Lives
Commonwealth of Kentucky (Medicaid)	1,488,274
State of Mississippi (Medicaid)	750,000
Alabama Public Education Employees' Health Insurance Plan (State Employee)	167,289
State of Arkansas (State Employee)	158,783
State of Arizona (State Employee)	132,269
State of Colorado (State Employee)	43,503
State of Wyoming (State Employee)	33,568
State of Maine (State Employee)	26,413
Arkansas Municipal League (State Employee)	17,526
Louisiana State University (State Employee)	16,288
Arkansas State University (State Employee)	4,533
Arkansas State Police (State Employee)	3,216

Table 1: MedImpact State Government Clients in Past 3 years

Key Subcontractor Partnerships

To optimally fulfill all RFP requirements, MedImpact sought a **highly experienced workers' compensation URAC accredited PBM for NYSIF**. MedImpact complements the experience and talents of our team with Healthesystems as a proposed subcontractor to assist with PBM services for NYSIF. Healthesystems, like MedImpact, can offer independence as one of the few remaining privately owned workers' compensation PBMs.

MedImpact understands it will be the sole contact regarding all provisions of the Agreements of this contract. We will work side-by-side with our partner to ensure we meet or exceed all requirements of this RFP and provide a seamless experience for the NYSIF agency and their enrollees. MedImpact will provide oversight, strategic direction, and program continuity.

Healthesystems has been providing PBM services to workers' compensation clients since 2002. Their experience includes direct service contract arrangements with municipal government entities, monopolistic and competitive market state insurance funds, as well as numerous government employers both directly and through various TPA partner relationships. Within their insurance carrier and workers' compensation state insurance fund customer base, 5 are ranked within the top 15 largest workers' compensation/specialty insurance companies. Their customer base services over 300,000 policy holders and employers nationally, which includes **over 1.2 million eligible injured worker patient lives**.

Healthesystems is staffed by over 350 full-time employees. Today, their business model includes two independent service lines: PBM and ancillary benefits management (ABM). PBM was initially the core focus of their business which began in 2002 when they implemented the nation's largest property & casualty insurance company in the United States. Subsequently, their ABM program started in 2006 and currently **services the second largest workers' compensation state insurance fund in the country.**

Healthesystems co-authored the ACOEM workers compensation formulary which is now used as the foundation for state specific formularies in jurisdictions such as New York and California. This level of insight and understanding has helped the Healthesystems customer base maintain a competitive advantage and remain at the forefront of the industry when deploying these program strategies. The Healthesystems team acutely understands the significant cost and clinical impacts of problematic drug therapies commonly seen in workers' comp. Because of this powerful industry expertise, they have been able craft the best solutions to solve pain points for their customers, identify new opportunities to benefit their patients, and increase cost savings. Based on our understanding of the NYSIF's book of business, we are certain our environment can scale to meet NYSIF's needs without any degradation and that our entire organization is well equipped to support NYSIF's staff and injured worker patients.

Collectively, MedImpact and Healthesystems, are highly qualified to assume the functions and activities required by this RFP. Our experience managing self-funded pharmacy benefits and worker's compensation is extensive and aligns well with the objectives and requirements outlined by the Department. We have implemented and managed multiple complex pharmacy programs with great success. Our understanding of the scope of work is reinforced by our success in managing multiple state employee and worker's compensation pharmacy benefit contracts.

Our Approach

MedImpact's PBM structure allows DCS and NYSIF to be in control during these unprecedented times of PBM vertical integration and transparency regulations. What and how PBMs operate today may not be what is done tomorrow; and MedImpact's independence proves the best partner choice to navigate the uncertainty of the PBM market in the coming years. We have the flexibility to adjust to any unforeseen regulation and market changes.

Organizational Structure

MedImpact's Key Executive Leadership organizational chart is presented in **Figure 1** and an organizational chart of Healthesystems' leadership team is represented in **Figure 2**. All administrative and operational components of this RFP will roll into their respective teams. Following the organizational chart, **Table 2** explains MedImpact's capacity and approach to the identified administrative and operational components of our PBM offerings.

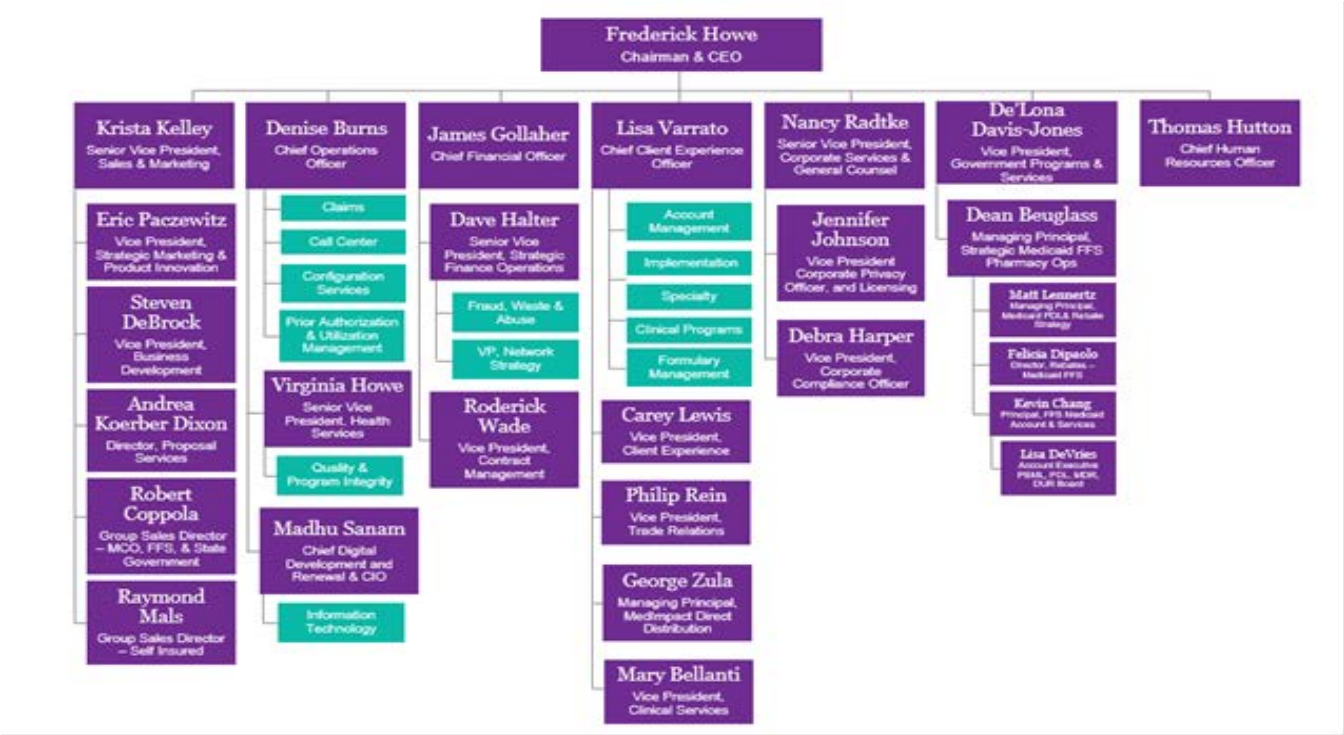


Figure 1: MedImpact's Key Executive Leadership

Figure 2: Healthesystems Organizational Chart

The following administrative and operational components will be performed by MedImpact:

Function	Approach
a. Network Management	MedImpact offers a broad comprehensive network inclusive of independent and all major chain pharmacies. This equates to a network that exceeds access standards inclusive of over 60,000 retail pharmacies nationwide and greater than 5,100 pharmacies located within New York. MedImpact will utilize our existing network with a pass-through pricing arrangement. Our networks are fully credentialed to ensure all insurance, licensure, and quality measures are compliant with MC-Rx standards. We understand the significant role of independent network pharmacies. Our independent pharmacy network maintains the composition of the independent Network Pharmacies in the program's current Retail Pharmacy Network. Our approach to enrollee disruption includes an evaluation of the prescription history provided by DCS and NYSIF to compare the pharmacy utilization and to include additional network opportunities. We will recruit pharmacies identified as not participating in the network for inclusion. We also enroll any out-of-network pharmacies that meet eligibility requirements. To maintain the integrity of our network, our pharmacy audit and fraud, waste, and abuse (FWA) team also monitors pharmacy activity and performs both desktop and on-site audits.
b. Specialty Pharmacy Program	MedImpact Direct Specialty® offers an exclusive or preferred network of specialty pharmacies to provide clients access to 100% of open, limited, and exclusive specialty drugs. 100% of LDDs (limited distribution drugs) are accessible through our specialty pharmacy program.

Function	Approach

MedImpact Direct Specialty follows 7 steps for a prescription order fulfillment process:

1. Prescription intake
2. Prescription verification (pharmacist reviews for risk evaluation and mitigation strategy)
3. Enrollee contact
4. Enrollee counseling
5. Dispensing
6. Order verification
7. Shipping

MedImpact Direct Specialty provides clinical care for every enrollee from the first fill of a specialty medication to the conclusion of their medication therapy regimen. A patient care coordinator (PCC) calls each enrollee and records information related to current medications (including any vitamins or OTCs), allergies, list of current prescribers and specialist, current health condition and disease-state impact, and side-effects of any prior or current medication. The PCC also tracks enrollee attitude towards their disease, form of payment, and the enrollee or prescriber address for overnight delivery of specialty medication. The PCC stresses medication adherence and educates enrollees on their diseases, medication treatment expectations, and refill processes. The PCC also reminds them that they have 24/7 access and access to a specialty pharmacist or clinician.

The specialty fulfillment pharmacy receives the prescription referral from MedImpact Direct Specialty, contacts the enrollee and prescriber to gather additional information, and processes the specialty prescription for fulfillment. The specialty fulfillment pharmacy dispenses and ships the medication to the enrollee via free overnight delivery, according to manufacturer guidelines.

Transitioning new enrollees to MedImpact Direct Specialty with open specialty medication refills includes:

- Enrollee welcome call from specialty pharmacy
- Welcome letter with a list of services
- Toll free number
- Letters to prescribers

If an enrollee needs an emergency specialty prescription or replacement dispensed, the MedImpact Direct Specialty network pharmacy arranges for weekend or holiday shipping through FedEx or UPS.

Function	Approach
c. Mail Service Pharmacy Process	The MedImpact Direct Mail® Program (MID Mail) comprises our PBM services *and* Birdi patient care/dispensing. The program is an end-to-end solution for managing maintenance drug therapies. When clients move to MID Mail, they will receive drug cost savings because of market-competitive rates, waste mitigation, and pharmacy oversight. Clients moving to MedImpact Direct Mail generally experience maintenance drug cost savings of 3% to 5% in the first year. Savings are a result of market-competitive pricing, reduced medication waste and pharmacy oversight. MID Mail functionality is built to help improve adherence and reduce waste. • AutoFill: When a new or renewal prescription is received from a prescriber, the pharmacy automatically fills and ships the prescription if it has filled a medication for the enrollee in the last 6 months. This decreases the turnaround time for the enrollee to get prescription promoting medication adherence and enrollee health. • Auto Refill: Auto refill logic minimizes drug waste for an enrollee and plan by reducing 1 maintenance medication (90-day) prescription per year. The mail-order pharmacy fills the enrollee's eligible auto-refill prescription 14 days before the prescription runs out and sends subsequent refills about 90 days after each refill. • Manufacturer coupons are accepted to help improve medication affordability for enrollees. • Automated notifications and alerts including interactive technology (outbound email refill reminder for easy refill via email request) to promote adherence Through Birdi, enrollees benefit from the convenience of home delivery. Birdi has been serving MedImpact clients since 2015. The mail pharmacy's facility expansion is underway, which will increase mail order prescription capacity to 6 million prescriptions. **Ordering Process** The mail pharmacy can receive new maintenance medication prescriptions as follows: ➢ Prescriber sends prescription to the mail pharmacy through e-prescribe or fax ➢ The enrollee signs into the Consumer Portal to request prescriptions

Function	Approach
	➢ The enrollees mail the prescription to the mail pharmacy Prescription intake includes prescription scanning and a pharmacist compliance review according to the client-specific formulary. The mail pharmacy calls enrollees to collect information on chronic conditions, allergies, preferred payment method, and to verify their shipping address. The mail pharmacy accepts credit cards, checks, and money orders as payment. **Refills** Enrollees can sign into the Consumer Portal to request a new prescription, order a refill, or transfer prescriptions from a retail pharmacy by clicking 'Request a Prescription' and following the instructions. They can also download the medication order form by clicking 'Documents,' filling out the form, and sending it to Birdi directly. Once the refill is processed, enrollees can track orders within the Consumer Portal. Enrollees can also order refills by calling the toll-free number listed in the welcome kit, prescription insert, or ID card. They can speak to a live CSR (customer service representative) or use the IVR to refill their prescription. The mail pharmacy proactively sends outbound refill reminder messages by email, text, and automated telephone calls. When an enrollee alerts the mail pharmacy that an additional refill is needed or a new prescription, a pharmacist assists the enrollee by contacting the prescriber on their behalf for authorization. The mail pharmacy drives high enrollee adherence while minimizing waste through a unique approach to autofill and auto-refill logic. The mail pharmacy refills eligible prescriptions in the auto-refill program 14 days before the prescribed quantity is set to run out. So that enrollees always have at least a 2 weeks' supply of medication on hand, subsequent refills arrive about 90 days after the initial prescription delivery. They receive at least 1 fewer 90-day prescription per year through this approach, which delivers savings of drug ingredient costs and reduces the cost of care for the client and the enrollee. When the mail pharmacy receives a renewal prescription for a medication filled in the past 6 months, the pharmacy automatically fills and ships the medication. This promotes greater adherence to the drug therapy and improves the continuity of care.
d. Claims Processing	Our PBM solution delivers a proprietary claims processing solution in a single, integrated platform, offering robust flexibility and configurability. Our

Function	Approach
	single platform delivers a high degree of claims processing accuracy and efficiency including the ability to check validity, enrollee and provider eligibility, benefit plans, edits/business rules, and claims disposition. It is available 24 hours a day, 7 days a week, 365 days a year. Our adjudication architecture has unlimited capacity as we can expand our processing and storage capabilities to satisfy any performance requirement. As we own the system and control all priorities, as one of our largest clients DCS and NYSIF will benefit from being the highest priority for any benefit change. Foundational to our unified technology platform is a combination of industry standard COTS products, such as Oracle RDBM (Relational Data Base Management) and enterprise-class, open-source software, such as Gravitee (API Management Software). We maintain concurrency with current releases, or at times current release level minus one. Our development platform is based on C++ and Java, while the database platform utilizes Oracle.
e. Retrospective Coordination of Benefits	MedImpact offers both online and manual paper process COB (coordination of benefits) options. These require the submission of primary payer information on the claim when the eligibility file flags the enrollee as having primary coverage with another carrier. We provide online COB claims processing services to our clients using standard NCPDP (National Council for Prescription Drug Program) COB logic that conforms to CMS (Centers for Medicare and Medicaid Services) regulations. MedImpact accepts other coverage codes that the pharmacy submits on the claim transaction, and we adjudicate the COB claim based on the plan and enrollee payer amounts provided and plan specific configuration. The accepted other coverage codes indicating presence of a primary payer are as follows: ➢ **02 Other Coverage Exists**: Payment is collected. We bill the claim as a secondary claim, and the primary insurer has approved and paid the claim. When the pharmacy submits OCC (other coverage code) 2, they must also submit the amount that the other payer has paid. (NCPDP field 431-DV). ➢ **03 Other Coverage Exists**: This claim is not covered. The primary insurer has rejected the claim. When submitting OCC 3, we require the pharmacy to submit the NCPDP rejection code from the primary claim, which we validate to determine if it is an accepted reject code. ➢ **04 Other Coverage Exists**: Payment is not collected. The claim is secondary, and the primary payer has approved the claim and has paid nothing (e.g., the enrollee has a 100% copay benefit or is still in deductible coverage range). When

Function	Approach
	the pharmacy submits OCC 4, they must also submit the amount that the other payer(s) has paid as 0. ➢ **08 Other Coverage Exists**: Claim is billed for a copay. The claim is secondary, and the primary payer has approved and paid the claim. When the pharmacy submits OCC 8, they must also submit the enrollee's total OOP (out-of-pocket) expense from the primary claim. The MedImpact eCOB program is fully compliant with NCPDP D.0 standards for claim submission The pharmacy generally submits COB claims electronically. In limited scenarios today, pharmacies may submit paper COB claims; however, paper COB claims follow the same logic as eCOB MedImpact partners with highly trained specialists to investigate, outreach, and retroactively update COB.
f. Customer Service	MedImpact will maintain separate call centers located in the United States for DCS. Customer service representatives (CSRs) will be available from 7:00 am to 7:00 pm ET to support DCS enrollees, and our entire call center is available 24 hours a day, 7 days a week, 365 days per year. All CSRs will receive training on DCSs benefit plan to accurately answer calls by the go-live date. The client administrator will work with DCS during implementation to set up processes on how to handle calls, override criteria, and provide information to CSRs on benefit setups. Throughout the relationship term, the client administrator will provide CSRs with up-to-date information on procedural changes, run reports for DCS, and educate CSRs on DCS-specific information. CSRs can easily access system notes with all specific plan details including any DCS-approved CSR responsibilities (vacation override, administrative prior authorizations, emergency medication fill, etc.) and enrollee population nuances (e.g., the majority of enrollee speak English as second language, elder population, rural pharmacy access challenge). CSRs can transfer enrollees requiring assistance from a pharmacist to MedImpact's PA (prior authorization) department, which provides a dedicated clinical line for the administration of grievances, coverage determinations, and appeals. Providers can leave a message indicating the best date, time, and phone number. Pharmacists are available to return calls. MedImpact records and stores 100% of customer service center call interactions for performance monitoring, quality standards, and customer service metrics. If CSRs need to escalate phone calls, they have access to additional research for calls requiring direction to higher levels. We log

Function	Approach
	escalated calls in our system for tracking and reporting purposes, which are then reviewed by a senior representative for follow-up and resolution. The client administrator notifies DCS and the account management team of the concern. The caller receives a follow-up call within 1 business day. Our call centers are in Tempe, Arizona, and San Diego, California. There are typically around 150 CSRs and 10 supervisors employed in MedImpact's call centers. The 2023 CSR turnover rate is 1.6% with 0% turnover in supervisors over the past 2 years. In addition, some CSRs work remotely. For NYSIF, clinical questions related to prescriptions can be directed to the Clinical Consultation Line (Drug Information Line), which is staffed by clinical pharmacist team. Claims professionals or other client stakeholders can contact a clinical pharmacist via phone or via email. The clinical pharmacist will answer calls and emails during regular business hours. 100% of calls are recorded and a formal escalation process is available.
g. Enrollee Communication Support	When enrollees are not informed, we fail. That is why MedImpact maintains a robust legal and regulatory department that works with our clients to ensure all enrollee communications are appropriately compliant. Our general counsel and compliance officer provides regulatory, legal, and compliance support as needed. Regarding communications, our team sends timely communications to clients that summarize key regulatory activity, as well as bills that have potential to affect our clients' business. MedImpact understands DCS and NYSIF know their enrollees better than anyone else. We will provide the programs with the ability to customize forms and letters and always with an opportunity to issue final approval before communicating to enrollees. Due to the large membership of DCS, MedImpact understands having information at enrollee's fingertips. We will support DCS by having a customized website where enrollees can click that serves as a central repository of all pharmacy benefit information. Additionally, we will attend in person Health benefit fairs and related conferences to educate enrollees on their benefits, show them the website and the resources and support they have available. Communications for the Empire Plan will follow all CMS guidance regarding marketing and beneficiary communication requirements. CMS allows cobranding on ID cards, booklets, and many letters. During implementation and annually, we will collaborate with DCS to determine any further customizations. There is flexibility with the pre-enrollment communications. If DCS prefers to send the EGWP pre-enrollment materials with their other retiree

Function	Approach
	communications, we will provide the required CMS elements, so DCS can include them in the mailings. However, if DCS elects us to manage these mailings, DCS will need to send us the pre-enrollment enrollee file monthly to include any enrollees aging into Medicare within the next 60 to 90 days. Alternatively, our standard AppIntake enrollment file that DCS will provide daily or weekly for both pre-enrollment mailings and submission to CMS to enroll each enrollee into the plan can be utilized. Specific to NYSIF, due to the circumstances of enrollment in the NYSIF program, we understand the importance of timely and information to enrollees. We will develop a customized information packet, including ID cards and other prescription information.
h. Enrollment Management	MedImpact accepts the ANSI X12 834 - Benefit Enrollment and Maintenance transaction and our proprietary standard eligibility file formats including Type 12 - Group and Type 23 - Enrollee Record Layouts. We can also accommodate custom DCS-specified eligibility formats and load frequency. At implementation, DCS can present the specific eligibility format to the implementation team for documentation of requirements and custom conversion program creation, converting DCS' eligibility file format to MedImpact's standard eligibility file layout for processing. DCS and MedImpact will coordinate to ensure the timely receipt of accurate and complete eligibility and claims data, including: ➢ Claims history files ➢ Prior authorization history files ➢ Accumulator files ➢ Eligibility files ➢ Benefit design criteria provided in a format compatible for loading into the system As part of regression testing, we work with DCS to load actual historical prior approvals into the end-to-end integration test environment against a preproduction test eligibility file containing DCS' live enrollee information allowing MedImpact to validate the historical prior approval load by mirroring the process we will use later to load the historical PAs into production.
i. Reporting	**DCS** MedImpact's MedOptimize® reporting system provides clients with flexible reporting, business intelligence, and decision-support options offers real-time access to data with powerful user-friendly standard reporting and ad hoc query capabilities. We provide MedOptimize through a secure website with 24-hour, 7-day a week availability and direct access to data for efficient and effective analysis of DCS' prescription drug program enabling DCS to make informed decisions. We have hundreds of standard reports available. These include management reports around prescription drug claim key statistics such as

Function	Approach
	number of claims, costs per enrollee per month, brand/generic usage, formulary product utilization, utilization by fulfillment channel, and more. Report examples in this category include Key Performance Indicators and Trends, Utilization Summary by Month, and PMPM Trend Analysis. The reports can be generated by your team or your account team. Reports can even be scheduled to automatically run and delivered to your email address on any specified frequency. MedOptimize enables users to create ad hoc queries and reports quickly and easily by choosing data points from numerous subject areas and hundreds of data elements to produce required reports. The data required to produce the required reports is pulled into MedOptimize from our claim processing system nightly. MedOptimize reports export in various file formats including PDF, HTML, Excel, and CSV. DCS can save, download, and share reporting via email. **NYSIF** The majority of reports requested are parameter based and can be created "on demand" via the Verticē web portal tool. In addition to standard reports, NYSIF has access to our interactive data visualization reporting suite which leverages interactive, intuitive, and visually friendly data dashboards to increase the accessibility and usability of data. These self-service dashboard capabilities are accessible within our Verticē portal. Reports can be exported and saved to other desktop applications such as Word, Excel, PDF and more. Reports can be scheduled for automatic distribution on a predetermined basis. Custom reports are also available.
j. Clinical Management/ Prior Authorization	DCS and NYSIF incorporate a concierge-style approach to clinical management that puts the enrollee first, beginning at the point of care through formulary development designed to guide safe, appropriate, cost-effective prescribing. It continues at the pharmacy counter and throughout the entirety of the claim lifecycle through the integration of clinical intelligence into our automated rules, edits and workflow decision support, medical management, and more. Overall, our approach to clinical management is two-fold. First, we take a population health approach to developing our formularies and clinical management protocols. We have an interdisciplinary effort, calling for the collaboration of physicians, pharmacists, and nurses. Secondly, we take a holistic approach to individual enrollee prior authorization. Our PA team uses all information available to determine if the patient has met the medical necessity established for the medication.

Function	Approach
	MedResponse PA, a fully integrated PA case management system, facilitates end-to-end process management, will be utilized for DCS PAs. We manage and staff MedResponse's capacity to be able to double the volume of current PAs. MedImpact was recently awarded large state client with 1.5 million lives, and MedResponse was able to successfully handle the increased capacity ensuring MedImpact provides the best service possible. MedImpact's PA review platform tightly integrates with our claims platform to provide users with a robust workflow and a one-stop information source to prevent duplication of work. Our PA platform is a real-time, intuitive, web-based solution that simplifies and streamlines decisions by immediately updating our claims platform to allow real-time claims adjudication. The PA platform is an effective tool to help our team ensure Agency enrollees receive appropriate access to medications. MedImpact's clinical management offerings include: ➢ Opioid overutilization and safety controls ➢ Opioid case management ➢ HCG X™ (High-Cost Generic Exclusion) ➢ MedIntegrate (manage specialty drug costs and improve care across the medical and pharmacy benefits) ➢ Medical rebates These programs are described within our proposal response. Specific for NYSIF, the Verticē web portal provides a single platform for all pharmacy and ancillary claims management activity. The electronic prior authorization tools incorporate NYSIF defined automated messaging (alerts) and advanced workflow and routing to help facilitate more effective prior authorization decisions. In addition, the Customer Service Center provides a proactive servicing role for all prior authorization activity. Rather than waiting for pharmacies to rectify prior authorizations, we proactively engage pharmacies in real time to ensure an expedited and accurate PA resolution.
k. Drug Utilization Review (concurrent, retrospective and narcotics)	MedImpact has a comprehensive DUR (drug utilization review) program that leverages technology to identify and manage drug problems through prospective DUR and concurrent DUR edits. Both types of edits identify potential problems at POS (point of sale) and allow the pharmacist to resolve issues before the enrollee receives the medication. Our business processes apply prospective DUR and concurrent DUR drug reviews to all claims as follows: **Prospective DUR:** Predetermined criteria from industry standard drug information databases trigger prospective DUR. Clients can select from First Databank or Medi-Span. Prospective DUR edits have various customizable

Function	Approach
	parameters including severity levels and clinical significance for each drug language. Additionally, MedImpact prospective DUR edits meet CMS requirements for regulated markets. **Concurrent DUR:** Concurrent DUR performs drug-problem identification and drug problem prevention through point-of-sale clinical edits, step therapy, lock in programs, and medication therapy management that provide technology-based guardrails to ensure positive enrollee outcomes. These clinical edits use drug information databases and other data sources such as history drug lists, prescriber counts, enrollee attributes, and diagnosis codes. Concurrent DUR edits allow therapy for an enrollee to be altered if necessary. Custom edit development is also available. **Narcotics**: MedImpact's Opioid Overutilization and Safety Controls Program prevents the overutilization of prescribed medications by placing drug utilization controls to increase enrollee safety. The program focuses on improving drug utilization management for medications known to be prone to misuse, addiction, and overdose. The Overutilization and Safety Controls Program includes programs focused on APAP (acetaminophen) and opioids. These programs can curtail misuse and increase enrollee safety with a series of edits designed to block the fulfillment of excess opioid and APAP prescriptions. **Retrospective:** MedImpact designed the Retrospective DUE (Drug Utilization Evaluation) program to identify potentially inappropriate enrollee drug utilization patterns and provide a mechanism to notify prescribers. We provide targeted information to prescribers to assist them in re-evaluating therapy and making modifications, where appropriate, to enhance the quality of an enrollee's prescription drug therapy.
l. Flexible and Advanced Flexible Formulary Development and Management	MedImpact determines cost-effectiveness by reviewing drug cost, net cost after discounts, and actual outcome of treatment under real life conditions including considerations of total healthcare costs through utilization of pharmacoeconomic principles. We base formulary decisions and therapeutic designations on the objective evaluation of the products' relative therapeutic efficacy, safety, enrollee outcome, and cost-effectiveness. The P&T (pharmacy and therapeutic) committee uses clinical reviews, plus the clinical considerations listed as follows to determine formulary drug coverage, tier placement, and clinical criteria: ➢ Efficacy ➢ Clinical appropriateness, including genomic testing ➢ Safety ➢ Cost ➢ Ongoing treatment criteria

Function	Approach
	The MedImpact clinical department proactively monitors new specialty drugs in the FDA pipeline nearing approval and market launch. MedImpact applies the same clinical process as with non-specialty drugs including the P&T committee recommendations for utilization management coverage as well as formulary inclusion and tiering. The list of individuals involved includes 11 to 13 practicing clinicians (prescribers and pharmacists). The P&T committee includes enrollees who specialize in internal and family medicine, cardiology, obstetrics, gynecology, endocrinology, and geriatrics. Representatives from pharmaceutical companies do not sit on or participate with the P&T committee. MedImpact considers specific information regarding P&T committee enrollees confidential. We adopted this policy to avoid undue influence from outside entities. The FBRC (Formulary Business Review Committee) serves in an advisory capacity to MedImpact's clinical management and medical and clinical professionals of MedImpact's clients on matters pertaining to clinical and financial management of rebateable drug initiatives. They abide by all recommended therapeutic designations and prescribing guidelines of the P&T committee in identifying, evaluating, and initiating implementation of clinically appropriate strategies that are cost effectively sound.
m. Rebate Administration	**DCS** MedImpact works with our rebate services vendor to determine the low net cost solution at a therapy class level. On a monthly basis, we monitor the brand for generic strategy to ensure it is generating the lowest net cost. When the brand for generic strategy no longer delivers the lowest net cost solution, we will cancel the strategy. MedImpact's rebate strategy optimizes rebates by not locking rebates into a single source as it would if we contracted directly with pharmaceutical manufacturers. Instead, we use a rebate services vendor that forces multiple sources (aggregators) to bid against each other by therapeutic class providing the best overall low net cost. **Because MedImpact does not focus on maximizing rebates, DCS can expect a decline in ingredient costs, greater value, and more flexibility with MedImpact's rebate strategy.** MedImpact submits claims data to our rebate services vendor who submits invoices to pharmaceutical manufacturers and rebate aggregators 60 days after the end of the quarter. Pharmaceutical manufacturer's invoice payment terms average 60 to 90 days. We provide estimated rebate payment reports to clients approximately 100 days after the end of the quarter. We provide payments to clients approximately 150 days after the end of the quarter, and we provide annual true-up rebate reporting and payment within 180 days after the end of the year.

Function	Approach
	As market dynamics change, MedImpact is engaging with pharmaceutical manufacturers surrounding biosimilar, diabetes, and GLP-1 launches to assist in securing best pricing and rebates on all products. MedImpact's medical rebate program optimizes rebate yield available for certain specialty drugs billed under the medical benefit. Medical rebate services include: ➢ Consultation to maximize rebate yield ➢ Provision of administrative services to support billing and collections with pharmaceutical manufacturers ➢ Delivery of quarterly medical rebate summary reports ➢ Analysis of historical medical claims to identify additional savings opportunities ➢ Assessment and determination of optimal rebate strategy for select high-impact drugs ➢ Provision of administrative services to facilitate billing and collections with pharmaceutical manufacturers **NYSIF** Our rebate processor provides detailed reports to our secure FTP site monthly. These reports include all rebates and manufacturer administrative fees broken out by enrollee ID and customer. These details are stored in our system and used to disclose and pay rebate amounts to our clients and to respond to any rebate reporting requirements. Rebates and manufacturer administrative fees related to claims submitted, processed, and reimbursed to NYSIF during each quarter will be included in each quarterly rebate file. Payment will be made to NYSIF within 30 days of the quarter end. 90 days after the contract year's end, an annual true-up file will be created to include all rebates submitted, processed, and reimbursed during the year. Any rebates related to the contract year that remain unpaid will be reconciled and paid then.
n. Account Management	Our account management team model features executive-level team leadership and an interdisciplinary account management team with clearly defined escalation and resolution points. Enrollees of DCS' and NYSIF account management team are involved during the implementation phase. Typically, after a 90-day post-implementation period the implementation manager passes responsibility for the account to the account executive to lead the strategic management of DCS' and NYSIF plan. MedImpact will coordinate with our Key Subcontractor, Healthesystems to oversee all implementation and account management activities.

Function	Approach
	A comprehensive account management team will be provided to DCS and NYSIF, supported by an expansive internal network of subject matter experts. MedImpact will collaborate with DCS on any account management staffing changes (anticipated or otherwise). DCS' account management team will include (at a minimum) an account executive (director), account manager, implementation manager, client services business analyst, clinical program manager, Medicare Part D specialist, and PDE analyst. The NYSIF account management team will include an account management director, account manager, implementation manager, and operational manager. MedImpact's account executive will be responsible for coordinating all activities including those of our Key Subcontractor. This position also reports directly to Lisa Varrato, our executive sponsor on this account. Lisa will provide direct line of sight for our corporate leadership into the status of the program.
o. Mandatory Generic Substitution and Generic Appeals Process	MedImpact's mandatory generic program provides the following options: ➢ Charge the member the difference between the cost of the generic and brand (DAW difference) ➢ Deny the multisource brand claims with a point-of-sale message that the pharmacy must dispense the generic. MedImpact treats this process the same as we do our prior authorizations. They will be vetted by a clinician in an effort to ensure any criteria is met and to improve access to these medications whenever necessary. MedImpact has developed an ERISA and Patient Protection and Affordable Care Act compliant standard appeals program for clients that delegate this function. We will work with the Department during the implementation phase to determine the level of MedImpact involvement in the member appeals process. The MedImpact appeals coordinator manages all appeal requests, and a clinical pharmacist reviews them. A physician review is available at the internal (first level) clinical appeals when required. For external (second level) clinical appeals, we send the request to an IRO (independent review organization) that we contract for availability of a physician specialist review panel. For external (second level) clinical appeals received, we forward the request to the Department.
p. Pharmacy Audit and Responses to NYS Audits	MedImpact's claims adjudication system provides numerous built-in edits to automatically detect inappropriate pharmacist dispensing or utilization. Upfront edits at the POS (point of sale) assist our clients by stopping inaccurate and fraudulent claims before they process, which requires less time than a pay-and-chase methodology. Our soft and hard system edits serve as the first line of defense against pharmacy FWA (fraud, waste, and

Function	Approach
	abuse). Designed to address our client's varying business needs, the MedImpact portfolio of system edits can significantly reduce wasteful pharmacy errors at POS, which results in reduced costs, improved service, and enhanced quality of care. Despite best efforts at catching inappropriate claims at the POS, evolving fraud schemes require more of a defense post adjudication. MedImpact offers the following solutions to identify, stop, and prevent FWA: ➢ Standard and Enhanced FWA Program ➢ Dynamic Refill Too Soon POS Edit MedImpact utilizes Isolated Behavior Outlier Detection, Entity Profiling Outlier Detection, Enrollee Suspicious Activity Report, and Prescriber Opioid Scoring Report to share with our clients to identify abhorrent behavior. MedImpact conducts desk audits and onsite audits based on established criteria and compliance with federal and state laws and regulations. Pharmacies that fail an audit are placed on a corrective action plan. Under the corrective action plan, MedImpact continues to closely monitor the pharmacy's claims submissions to ensure compliance with the pharmacy agreement, provider manual, and applicable federal and state laws and regulations. MedImpact will remit 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within30 days upon final audit determination. MedImpact will assign a designated audit manager and team to respond to NYS Audits. The audit manager will manage all aspects of the audit process, including notification, data requests, data transfers, audit reports and findings.
q. Drug Lawsuits/Settlements	MedImpact supports clients with customized solutions for class action engagement. We can provide timely notice of potentially relevant class actions and file a Proof of Claim including DCS' precise drug data. If DCS prefers that MedImpact handle the class action(s), then MedImpact will do so, including regular reporting of its filing, collection, and redistribution efforts. If DCS prefers to self-file, MedImpact will provide a file-ready drug report to facilitate DCS' own submission. If DCS is involved in a financial settlement associated with a pharmaceutical-related class action litigation, MedImpact will support DCS' claim by providing specific cost related data, as defined by the settlement, to validate and substantiate DCS' claim to be included in the settlement.

Function	Approach
	MedImpact can take the lead with negotiating post-filing actions with the parties to the class action.
r. Medicare Part D Prescription Drug Program Administration	MedImpact has supported Medicare Part D since 2006 when CMS introduced the program. Today we serve 103 Medicare clients with nearly 873,000 members. We support clients who offer Medicare Part D, PDP (prescription drug plan), EGWP (employer group waiver plan), Medicare-Medicaid plan, special needs plan, and RDS benefits. MedImpact reviews all forms of CMS guidance including the annual call letter, daily HPMS memos, CMS manual chapters, and other memoranda. We participate in the PCMA (Pharmaceutical Care Management Association) and NCPDP forums and committees to ensure that all MedImpact Medicare Part D programs meet regulatory requirements. MedImpact's Government Programs and Services (GPS) department tracks and monitors CMS requirement changes helping every client stay compliant in the ever-changing CMS regulatory environment. On an annual basis, our GPS department updates the Medicare.gov plan finder file submission, model enrollee communications, CMS-required reporting, and other CMS-required changes. Monthly webinars share regulatory CMS updates along with MedImpact's plan to implement them for the upcoming plan year. MedImpact assigns a Medicare Part D specialist to every client. We also assign a PDE (prescription drug event) analyst if MedImpact performs PDE (prescription drug event) submission. These 2 Medicare Part D specialists work with the account management team providing competitive overall cost management, flexible plan design, clinical pharmacy management, and comprehensive statewide pharmacy networks. MedImpact generates and quality checks CMS-required reports before giving them to clients 2 weeks before submission to CMS. EGWP: MedImpact understands the requirements and has the experience to support the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap for The Empire Plan. MedImpact's underwriting team will work closely with the State of NY in conjunction with your actuarial consultants to assist with the development of your EGWP premiums. The EGWP enrollment and disenrollment process includes the following steps: ➢ The client provides an enrollment file with all applicable elections, terminations, and changes. Clients have the option of sending enrollment records in our proprietary file format or we can also accept an x834 file.

Function	Approach
	➢ MedImpact will pick up the file and review the file ensuring client uploaded compliant and clean records. The EGWP team manages any records requiring clarification or compliance approval in coordination with the client and loads the records into the enrollment system once approved. ➢ Enrollment and disenrollment records are sent to CMS for approval and eligibility data is sent to MedImpact daily, so PBM and enrollment databases align. ➢ Once CMS processes the record, CMS returns TRC (transaction reply codes) that trigger CMS required enrollee notifications and update eligibility data. CMS approval generally occurs within 24 to 48 hours. Clients receive a copy of the CMS TRR file containing all TRC activity. ➢ We generally process enrollment transactions including new enrollment and disenrollment within 24 to 48 hours from receipt, mailing proper enrollee notification within CMS timeframes. ➢ CMS processes enrollments with effective dates beginning on the first of the month and processes terminations effective on the last day of the month. MedImpact has experience with process in place that will support DCS EGWP eligibility reconciliation, MBI Administration, Formulary Management, ID Card, Enrollee Communications, Claims Processing, Supplemental Wrap Administration, override process, catastrophic Reinsurance Claims, and Low-Income Subsidy.
s. Medical Exception Program	MedImpact utilizes our PA process to administer its medical exception requests. Our therapeutic PA request process includes formulary exception, step therapy, quantity limit, and tier exception requests. Pharmacy staff initially perform these reviews for possible approval. Our formulary exceptions guidelines and formulary analyzer systems provide a unique and accurate tool for our pharmacy staff to adequately review formulary exceptions. A licensed pharmacist within the PA department or a physician, if required by accrediting body or state utilization management regulations, subsequently reviews. This immediate pharmacist intervention offers a high level of accuracy by providing an efficient PA review. The individual PA guidelines dictate the required number of trials of formulary alternatives and criteria required for the medical exception to be approved. MedImpact has reviewed attachment 80 that identifies volume of historical medical exception request and has appropriate PA, appeals and grievance team staffing to support the DCS program.

Function	Approach
t. Drug Recall and Withdrawal Notification	In the event of a safety-related FDA drug recall or voluntary manufacturer drug withdrawal, MedImpact will notify DCS within 48 hours of receiving the information from the FDA. Communication includes: ➢ Description of the recall ➢ MedImpact's action plan ➢ Affected enrollee reports ➢ Template enrollee notification letters ➢ Template provider notification letters MedImpact can notify DCS of recalls that affect select lots (partial lots) of a product that pose a significant safety risk (high likeliness of serious harm or death). Additional actions related to drug recalls can include the following: ➢ Placing edits in the claims adjudication system that either blocks the drug (hard edit) or warns the pharmacist and enrollee of the drug's recall (soft edit) ➢ Providing recommendations for drug substitutions, prior authorizations, or benefit changes as appropriate ➢ Implementing a withdrawal notice in the call center
u. Financial Support Services	MedImpact will support the Department by providing comprehensive financial support services. In addition to the routine aspects of PBM administration including claims payment, providing supporting documentation, etc. MedImpact's underwriters will be available to the Department for budgetary assistance, as requested. For financial guarantees, MedImpact will work to ensure timely and accurate information is provided to NYS so that there is assurance that all obligations have been met. For continuity, we will assign a designated resource to the Department.
v. Transition and Termination of Contract	MedImpact commits to full cooperation with the successor contractor inclusive of timely receipt of information. MedImpact will collaborate with DCS and NYSIF to complete a mutually agreed upon termination transition plan. The account executive will meet with DCS and NYSIF to document requested run-out services including file transfers to the new vendor in an executed, post-termination services letter. Additionally, the account manager identifies and documents all post-termination requirements in a termination questionnaire, which we distribute internally to notify impacted departments of the terminated services and those services that will continue per the letter. The account manager tracks the progress of the termination using a Termination Process Project Plan. Through the end of the contract term, DCS and NYSIF will continue to work with the account manager to coordinate services that we will provide during the transition period.

Function	Approach
	MedImpact will provide run-out support as mutually agreed upon, typically for up to 90 days post-contract termination, as outlined in the agreement.
w. Information Technology Support Services	The MedImpact IT support organization operates on a 24/7 basis, utilizing a customer facing call center and a dedicated Network Operations Center (NOC) so that any arising issues can be addressed promptly, no matter the hour. Our technical service desk initially handles issues and requests through a tiered system, where Tier 1 resources resolve immediate and common problems while Tier 2 & 3 resources address more complex issues. The representatives in the NOC are empowered to initiate the incident management process. Through the incident process, the NOC will initiate a Command Center Call and engage resources from the Systems, Network, DBA and Application Support teams to triage and mitigate the issue. After resolution, a thorough review is conducted to ensure complete resolution and to provide continuous improvement. The combination of these elements within our IT support system provides a rapid response to any technical issues, resulting in reduced downtime.
x. Vaccine Program	MedImpact's vaccine network, MedNetwork® vaccine, provides coverage for Covid and non-flu vaccinations to help improve enrollee health and reduce overall health costs for both clients and enrollees. MedNetwork vaccine includes over 50,000 locations with point-of-sale adjudication improving data access to immunization rates. MedNetwork vaccine will benefit DCS by: ➢ Decreasing total healthcare costs such as emergency room visits and hospitalizations ➢ Generating site-of-care savings from medical to lower-cost pharmacy visits ➢ Improving workplace productivity ➢ Reducing absenteeism ➢ Optimizing plan wellness initiatives ➢ Improving quality performance for all plans including Star ratings for Medicare ➢ Coordinating with pharmacies to provide worksite immunization clinics ➢ Providing access to enrollee outreach and awareness programs including letter campaigns, outbound messages, and website engagement We expect minimal to no disruption to the pharmacies DCS enrollees use today.

Table 2: Approach to the Identified Administrative and Operational Components

Our Commitment to You

MedImpact looks forward to the opportunity to help strengthen DCS and NYSIF PBM offerings. **We commit to collaboration, a smooth transition with minimal disruption, and partnering with DCS and NYSIF to achieve its pharmacy program objectives and goals.**

We look forward to welcoming you to MedImpact.

5.1 Exhibits

There are no referenced exhibits in Section 5.1

5.2 Account Team

1. The Offeror must provide an organizational chart and narrative description illustrating how the Offeror proposes to administer, manage, and oversee all aspects of the Programs. Include the following:

a. Names, qualifications, and job descriptions of the key individuals proposed to comprise the implementation, operational, clinical, and account management team(s) for the Offeror and its Key Subcontractor(s) (if applicable). Description of how, if there are separate Commercial and EGWP Teams for the DCS Program, those teams will work together to jointly support the Department. A dedicated Account Executive must be listed. Complete Attachment 14, Biographical Sketch Form, of this RFP for all key members of the proposed account management team(s). Where key individuals are not named, include qualifications of the individuals that the Offeror would seek to fill the positions; and

b. Reporting relationships and the responsibilities of each key position of the account management team(s); and how the team will interact with other business units or functional areas within the Offeror's organization, including, but not limited to, customer service, clinical services, reporting, auditing, and network management. The Offeror must include the percentage of time (by position) dedicated to the Program and reporting relationships. Describe how the account management team interfaces with senior management and ultimate decision makers within the Offeror's organization.

MedImpact and Healthesystems will team to provide a complete account management team in support of all aspects of the Programs.

DCS

DCS' account manager will manage the commercial and EGWP programs ensuring consistency between commercial and EGWP strategies and formulary changes, as Medicare permits.

Our account management team model features executive-level team leadership and an interdisciplinary account management team with clearly defined escalation and resolution points. Members of MedImpact's account management team are involved during the implementation phase, while the implementation manager leads the implementation. Typically, after a 90-day post-implementation period the implementation manager passes responsibility for the account to the account executive to lead the strategic management of DCS' plan.

Table 3 details DCS' designated account management team, roles, and responsibilities.

Account Management Team	Role/Responsibility
Director, Account Management	The director of account management leads the strategic business direction of the client and account management team. They execute the strategy of their team to support the goals of the client and act as the liaison between the client's leadership and MedImpact's senior leadership team. They keep a watchful eye on market trends and solutions.
AE (Account Executive)	The AE works in partnership with the CPM (clinical program manager) to implement and maintain an effective and efficient benefit management program tracking metrics and prioritizing team activities to meet or exceed established goals, standards, and contract terms and conditions. The AE also provides consultative leadership and proactively seeks solutions

	to reduce the overall net cost and improve the quality of healthcare. The AE is responsible for service excellence and full compliance with contract terms and conditions. They support efforts to win new business and retain clients. The AE reports directly to the Director, Account Management.
AM (Account Manager)	The AM will derive a complete understanding of 's objectives, expectations, and desired outcomes and will serve as the single point of contact for day-to-day issues. The AM interacts with internal departments as needed to coordinate actions and gather information to ensure we resolve questions, issues, and projects timely and completely. The AM strictly adheres to procedural and quality standards including thorough and accurate documentation, testing protocols, and claims analysis. The AM reports to the Director, Account Services
Implementation Manager	The implementation manager provides end-to-end oversight for all implementation projects. Efforts include coordinating with various operational business units to implement benefits, programs, formularies, etc.; scheduling recurring client conference calls and meetings as needed, managing timelines to help ensure implementation projects are successfully completed. In addition, the implementation manager ensures we complete thorough client plan testing timely and accurately within the operational business units prior to implementation date, documenting all required forms for client approval.
CS BSA (Client Services, Business Systems Analyst)	The CS BSA is the technical lead of the account management team. During the implementation phase and throughout the account management phase, the CS BSA will work with on any IT related processes and requirements to ensure timely and accurate flow of information. The responsibilities include a variety of IT subject areas. The CS BSA obtains detailed knowledge of the requirements and documents these for internal IT reference and business maintenance.
CPM (Clinical Program Manager)	The CPM is the clinical lead of the account management team. The CPM routinely identifies and analyzes key trends and, along with the AE, recommends action plans to improve plan performance. When clients purchase clinical services, a CPM assists with the implementation and maintenance of the clinical programs. Our CPMs hold degrees from accredited schools and have completed a pharmacy residency or equivalent experience. We require them to maintain a valid registered pharmacist's license. The CPM can also provide support to meet HEDIS, NCQA, and URAC guidelines.

Table 3: Account Management Team

NYSIF

Key individual for the NYSIF Workers' Compensation PBM program includes:

Please see **Exhibit B**: NYSIF Account Team Biographical Sketch Forms.

We will assign and maintain a Customer Success Team which is comprised of the Account Manager, Account Representative, Clinical Pharmacist, and Customer Service Center liaison who together will be responsible for managing the day to day and strategic oversight of all aspects of the NYSIF program.

These individuals are knowledgeable of operational processes, state rules, and legislative changes which allow us to be responsive and quick to resolve issues. In addition to the Account Manager, other team members on the Account Management team will assist with providing day to day operational support as well as overall strategic oversight of the program. The includes a designated clinical pharmacist who will regularly highlight trends and make program recommendations, reporting, and more.

The team will also attend and conduct quarterly meetings at mutually agreed upon times and dates to:

- Review program analytics, trends and results
- Monitor program effectiveness
- Monitor client satisfaction
- Suggest program enhancements

Additionally, during the implementation process, there will be an assigned implementation team led by an implementation manager and supported by representatives from IT, Operations, Clinical Services and Account Management. Generally, there are 4-5 people on the Implementation Team who are responsible for project design and execution.

Our workers' compensation customers are supported by a staff of over 350 full-time employees. This includes an unparalleled customer service infrastructure of Account Management teams, Clinical staff, IT software development and support teams, and a highly responsive CSR (Customer Service Representative). We will assign Client an Account Management services team to provide day to day and overall program oversight including designated team members such as an Account Manager, a Clinical Pharmacist and Account Representative, as well as other team resources from Regulatory Compliance, Information Technology Services, Data Analytics and others.

Our leadership team establishes customer focus by engaging with all levels of our client's business. This is accomplished with weekly calls, automated and manual reporting and analytics, monthly meetings, and quarterly business reviews. Our executive leadership is also active in weekly customer management meetings, which focus on our customers' most critical issues, and what solutions we can implement to solve them.

Our leadership team is also involved in ongoing monthly meetings that monitor overall customer progress and program performance. And this level of communication is not just limited to the executive level. 98% of calls to our 24/7/365 customer service center are answered within 30 seconds by a live person.

Below is a high-level breakdown of the departments serving customers:

- Account Management
- Accounting & Finance
- Advocacy & Compliance
- Clinical Services
- IT
- Analytics
- Operations
- Product & Client Solution

The Implementation team is led by [redacted], AVP Enterprise Portfolio Management. She will be supported by representatives from IT, Operations, Clinical Services and Account Management. Generally, there are 4-5 people on the Implementation Team who are responsible for project design and execution.

The CSR team members are available to pharmacies, ancillary benefit vendors, claims professionals, and patients, 24/7/365. In cases when it is needed, a Customer Service Center team liaison will be designated to the NYSIF account to escalate transactional related items from the CSR to the Account Management team members.

The leadership team establishes customer focus by engaging with all levels of our client's business and remaining accessible to all staff members. Our account management, customer service, operations, and clinical management teams engage with senior leadership on a daily basis. Our executive leadership is also active in weekly customer management meetings, which focus on our customers' most critical issues, and what solutions we can implement to solve them. Our leadership team is also involved in ongoing monthly meetings that monitor overall customer progress and program performance.

- [redacted]

We are customer focused and we make it our business to stay aware of our clients' needs. Our support model allows for flexibility and customization of client-specific processes, and we pride ourselves on being able to deliver this customization while still exceeding service level commitments.

2. Describe the experience of the individual(s) who will assume the role of account leader for the Programs. Include a description of the individual's experience with clients whose needs were of similar size and scope as those of the Procuring Agencies.

The director of account management leads the strategic business direction of the client and account management team. They execute the strategy of their team to support the goals of the client and act as the liaison between the client's leadership and MedImpact's senior leadership team. They keep a watchful eye on market trends and solutions.

[redacted] will assume this role for the DCS Programs. As director of account management, [redacted] works with a team of account executives to ensure service excellence is provided to each client. Prior to her promotion, [redacted] served as an account executive. In that role [redacted] owned the client relationship including development and execution of consultative and strategic planning, business development with the client, renewal process, client retention and overall client satisfaction in line with corporate goals.

Kristen has more than 30 years of pharmacy related experience and has been in the pharmacy benefits management (PBM) industry for more than 25 years. Before joining MedImpact, [redacted] worked for Walgreens Health Initiatives

as an account executive and director of strategic accounts. In her prior roles, she was accountable for her region's successful client retention and satisfaction as well as individual client development and planning.

[redacted] attended Anna Maria College and was a certified pharmacy technician for more than 10 years.

For NYSIF, [redacted] will assume the role of account leader.

As an Account Manager, Senior with Healthesystems, [redacted] fosters the client relationship by managing various aspects of client related projects including new account implementations, program training, business reviews, data exchange maintenance, billing and payment reconciliation, legislative issues in addition to monitoring client reporting and program enhancement projects. [redacted] focuses on understanding each client's claims operational and systems environments as well as remaining current with the latest workers' compensation industry cost containment practices. He also assists clients with monitoring the pharmacy program performance, formulary design and the effectiveness of the clinical program tools.

With more than 10 years of experience in the medical expenses software industry, [redacted] has an expertise in workflow management software and utilization review. [redacted] holds professional affiliations with AWCO, ASIA, WCAWA, GSIA, SBWC, IWCF, SCWCEA, Risk & Insurance Management Society, TNSIA, MCA and Workers Comp Cost Containment Professionals.

3. Confirm that the Account Team will be readily accessible to the Programs. Describe where the Account Team(s) will be based. The Offeror must:

a. Describe how the Offeror proposes to ensure that timely responses (one to two (2) Business Days) are provided to administrative concerns and inquiries; and

b. Describe what actions will be taken if the Procuring Agencies express concern that the Account Team is not adequately staffed; and

c. Describe the protocols that will be put into 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.

MedImpact confirms our account team will be readily accessible to the Programs.

Responsiveness

MedImpact account team personnel will respond to client inquiries by email within an average of 2 business days.

Actions Taken

We will collaborate with DCS on account management staffing changes (defined as account executive, account manager, and clinical program manager). We value continuity and will do our best to ensure we meet DCS's expectations without disruption. We will work with DCS to correct or improve any personnel issues before replacing or adding an account management team member.

Protocols

The account management team works with us to stay informed of all updates to client procedures. The client administrator sends a monthly email to the account management team throughout the plan year, starting in October, to ensure we address all client changes for January 1 plan year start. The email requires a response for every plan element as follows:

- Increase or decrease in number of lives
- Formulary changes
- Benefit changes and new programs added
- Migrations to new plans
- Identification card changes
- Claims processing changes
- Pending member, pharmacy, provider letters
- Any changes that may cause a negative impact to the member that may generate a member call to customer service

4. Describe the Corporate resources that will be available to the Account Team to ensure compliance with all legislative and statutory requirements. Confirm the Offeror's commitment to notify the Procuring Agencies immediately if the Offeror were 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 the Offerors commitment to work with the Department to develop accurate Certificates and/or Program material.

DCS

Our compliance team maintains a system (PBMSource) that provides the ability to receive, track, and respond to updated or recently passed state and federal regulations and rules that impact the PBM and pharmacy network. We also use PBMSource through implementation steps of a regulation to determine necessary changes in process, as applicable. These reviews and implementation steps include utilization management (prior authorization). In addition, we review Medicaid and Medicare enacted laws on a weekly basis with cross functional representation. These new laws may impact the client we communicate through the assigned account teams to ensure visibility to the client and that we take necessary steps to align requirements with regulatory requirements.

MedImpact's Medicare regulatory compliance teams monitor policy and regulation changes for Medicare and reviews new regulatory requirements with the requirements with key functional areas to ensure we notify impacted areas and fully implement necessary changes. MedImpact will summarize and communicate our actions as a result of the changes and 's responsibilities.

A strong partnership between DCS and MedImpact is essential to stay in front of regulatory changes. We have proven success in monitoring such changes and providing our clients with recommendations and solutions that result in CMS, federal, and state regulatory compliance.

MedImpact confirms our commitment to notify the Procuring Agencies immediately if we are unable to comply with any legislative or statutory requirements and we will work with DCS to take the appropriate remedial action. We

also confirm our commitment to work with the Procuring Agencies to develop accurate certificates and/or program material.

NYSIF

We maintain a dedicated Advocacy & Compliance team that monitors and reviews statutory and regulatory changes via various channels such as State Work Comp Websites, regulatory email subscription services, Lexis-Nexis®, industry news and blogs, as well as a paid subscription service for State Fee Schedule updates.

The team is comprised of three analysts and one manager who focus on regulatory compliance. The team members average 15 years of experience in workers' compensation/property & casualty claims, medical bill review, state reporting, healthcare compliance and PBM operations. The leader of the team, [redacted], has 30 years of experience in compliance, claim regulations, claim adjusting, medical bill review and state reporting.

The analysts are dedicated to monitoring and reporting on emerging and newly adopted regulation changes, and they work closely with our Account Managers and our Operations teams to ensure broad visibility into upcoming regulation changes which will impact customers or require changes to our business process. Our analysts and managers work closely with our bill review and real time adjudication teams to ensure ongoing compliance with regulatory requirements. All new and proposed guidelines are evaluated to determine applicability to PBM and Clinical program, and these requirements are incorporated into our technical and customer-facing platform. This allows all necessary state mandated rules, payment policies, formulary changes, coding and appropriate pricing to be applied prospectively.

Our Advocacy and Compliance Department also actively engages law makers and regulators regarding existing and pending laws, rules and regulations. We provide written comments and industry statistics, to help assist and offer a broader perspective on the rule-making process, as well as appearing in person at scheduled public hearings where appropriate.

We also have a full-time General Legal Counsel who serves as our expert on all legal interpretations of the law and supports all compliance functions as needed.

Our process of prospective regulatory monitoring has enabled us to ensure compliance with all regulatory changes on or before the effective date since our inception.

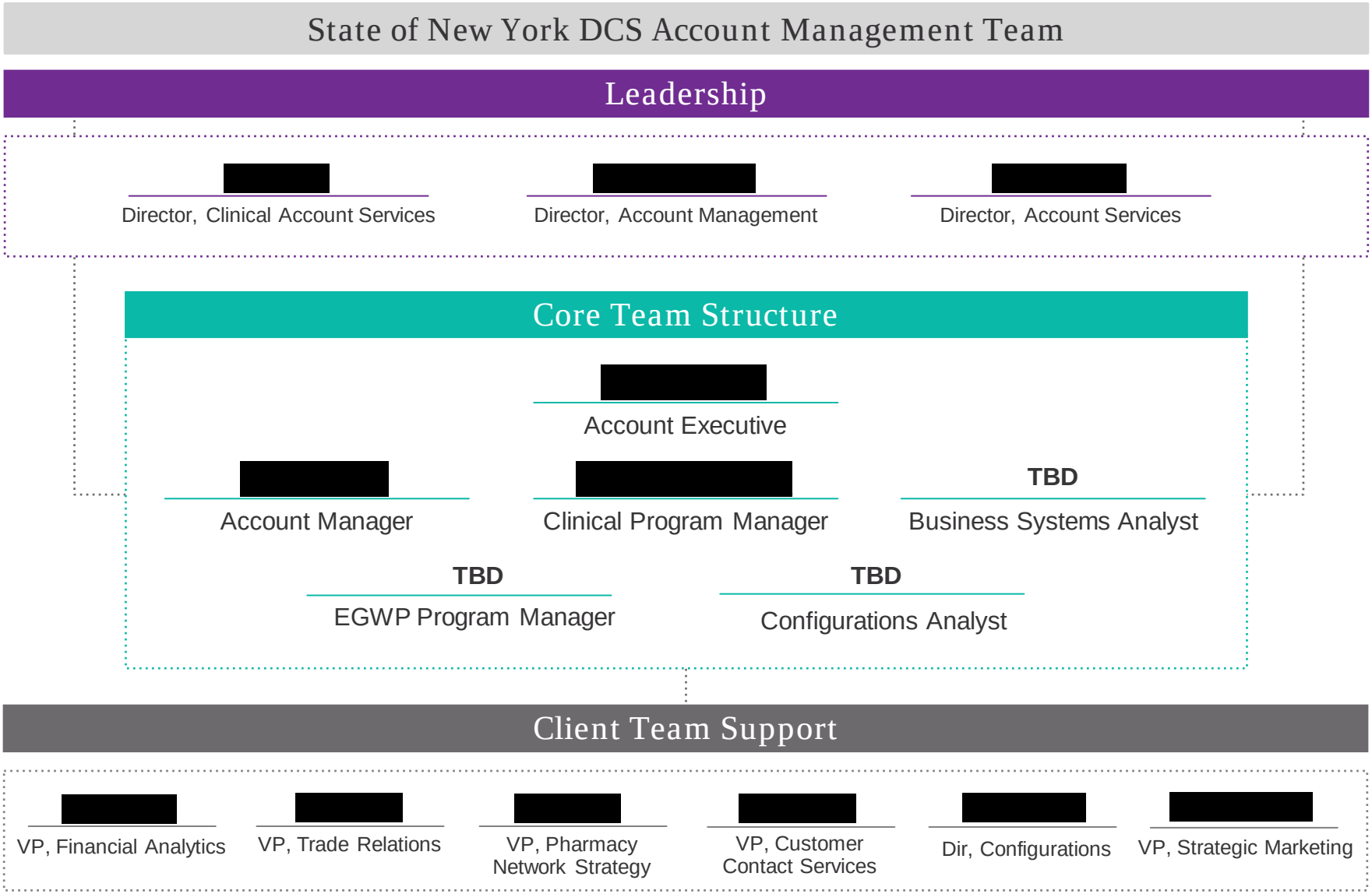
If for any reason we are unable to come into compliance on or before prior a regulation effective date, the dedicated Account Manager will notify NYSIF and provide details on our efforts to come into compliance. However, it is important to note that in the State of NY this has never historically occurred due to remaining actively engaged on all legislative matters whereby we maintain ample notice and lead time to implement technical and operational changes.

5.2 Exhibits

The following exhibits are referenced in Section 5.2 and have been provided here per RFP instructions.

Exhibit	Description
5.2 Exhibit A	Account Management Organizational Chart
5.2 Exhibit B	Biographical Sketch Forms

State of New York DCS Account Management Team



ATTACHMENT 14

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form - RFP entitled: "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and NYS Insurance Fund Workers'**

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: MedImpact Healthcare Systems, Inc.

Individual's Name: [redacted]

Job Title: Account Executive

Relationship to Project: dedicated account executive assigned to DCS

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
The University of Chicago Booth School of Business - MBA			

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
April 2020 - Present	MedImpact	Account Executive

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Additional healthcare experience includes product management and hospital consultation at Baxter Diagnostics, Inc., pharmaceutical sales with Allergan, Inc., and Vice President for a 501c3 foundation dedicated to both funding cancer research at Cardinal Bernardin Cancer Center in Chicago and housing patients and their families at MD Anderson in Houston, Texas: The Jimmy Burns Foundation.

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Offeror Name: MedImpact Healthcare Systems, Inc.

Individual's Name: [redacted]

Job Title: Account Manager

Relationship to Project: account manager assigned to DCS

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Central Florida -	BS in Business Administration		

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
2020 - Present	MedImpact	Account Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Prior to joining MedImpact, Lynn managed offices for physicians and dentists, and assisted in the onboarding and coordination of physicians for a major hospital in South Florida. She also contracted as an enrollment vendor for Cigna, Delta Dental, and Gehring Group Consulting during annual enrollment periods to present plan benefits to members and assist with enrollment into the plan. Her work with Gehring Group consisted mainly of assisting local, self-insured municipalities with benefit education and enrollment.

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Offeror Name: MedImpact Healthcare Systems, Inc.

Individual's Name: [redacted]

Job Title: Clinical Program Manager

Relationship to Project: clinical program manager assigned to DCS

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Massachusetts College of Pharmacy	Doctor of Pharmacy		

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
2020 - Present	MedImpact	Account Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Aja has over 23 years of experience in the healthcare industry. She was the manager of the prior authorization audit support and quality assurance teams until she transitioned into the clinical program manager role in 2017. Prior to MedImpact, Aja held leadership positions in hospital, long term care, and retail pharmacy operations.

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Offeror Name: Healthesystems

Individual's Name: [redacted]

Job Title: Account Manager, Senior

Relationship to Project: Account Manager

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Georgia State University Perimeter College		1992 – 1996	Business / Marketing

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
2012 – Current	Healthesystems	Account Manager, Senior
2010 – 2011	UniMed Direct	Regional Business Development Director
2008 – 2010	Network Synergy Group	Regional Sales Executive
2002 – 2008	Medical Services Company	Senior Account Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

With over 20 years of experience in the PBM industry I have additional expertise in medical expenses software industry, workflow management software and utilization review. I foster the client relationship by managing various aspects of client related projects including new account implementations, program training, business reviews, data exchange maintenance, billing and payment reconciliation, legislative issues in addition to monitoring client reporting and program enhancement projects. I focus on understanding each client's claims operational and systems environments as well as remaining current with the latest workers' compensation industry cost containment practices. I also assist clients with monitoring the Healthesystems pharmacy program performance, formulary design and the effectiveness of the clinical program tools and consulting clients with process improvements to remain in line with their ever-changing environments.

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Offeror Name: Healthesystems

Individual's Name: [redacted]

Job Title: AVP, Enterprise Portfolio Management

Relationship to Project: Implementation Manager

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Florida Gulf Coast University, Fort Myers, FL.	BS, Computer Information Systems	2000	
Project Management Institute	Project Management Professional	2008	

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
April 2015 – Present	Healthesystems	AVP, Enterprise Portfolio Management
February 2013 – March 2015	Lakeland Regional Medical	Project Manager
October 2011 – February 2013	Health Plan Services	Project Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] has been with Healthesystems for over 8 years. During that time, she has successfully led a team of implementation managers, as well as implemented several customers directly.

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Offeror Name: Healthesystems

Individual's Name: [redacted]

Job Title: Manager, Clinical Services

Relationship to Project: Assigned Clinical Pharmacist

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Florida, Gainesville, FL	PharmD	2012	Pharmacist
University of South Florida, Tampa, FL	B.S.	2004	Business Management

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
August 2013 – Present	Healthesystems	Manager, Clinical Services (current title)
August 2012- August 2013	Target Pharmacy	Executive Pharmacist
November 2012 – March 2013	Northside Hospital & Heart Institute	Clinical Pharmacist, PRN

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Currently oversee our Formulary Management team with expertise in state rules and regulations and the application of state-mandated closed formularies. Pharmacy & Therapeutic (P&T) Committee member and past speaker. Provide ongoing clinical support to customers such as strategies for formulary design, trend monitoring and data analysis, provide training and education to various stakeholders, and the development of interventional strategies to enhance overall program results, etc.

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Offeror Name: Healthesystems

Individual's Name: [redacted]

Job Title: Account Representative

Relationship to Project: Account Representative for NYSIF

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Chamberlain High School	HS	1997	

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
2007 – Present	Healthesystems	Account Representative
2006 – 2007	Verizon	Customer service Representative
2005 – 2006	Quest Diagnostics	Customer service Representative
2000 – 2005	Lab Corp	Supervisor

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Manage ongoing relationships and service delivery to multiple clients with multiple accounts. Act as outward facing, dedicated resource for assigned accounts. Assist with direct adjuster inquiries and provide verbal or written instructions for effective use of program applications. Perform research and evaluation of system issues to minimalize impacts to client processes.

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Offeror Name: Healthesystems

Individual's Name: [redacted]

Job Title: AVP, Operations

Relationship to Project: PBM Operations AVP

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Georgia, Athens, GA	BA	1982	Communications

PROFESSIONAL EMPLOYMENT (Start with most recent)

Dates From - To	Employer	Title
6/2012-current	Healthesystems	AVP, Operations

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Extensive experience leading call center teams in diverse locations; delivering exceptional performance for clients, managing multiple operational functional areas and maintaining high levels of quality and productivity, driving efficiency throughout the teams.

5.3 Implementation Plan

The Offeror must provide a detailed Implementation Plan in narrative, diagram, and timeline formats, designed to meet the implementation by the specified completion dates for the respective Procuring Agencies Contracts.

1. Provide separate detailed implementation plans (narrative, diagram, and timeline) at least six months prior to the respective Procuring Agencies Project Services Start Date, that results in the implementation of all Program Services by the required Project Service Start Date, 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, Formulary development, mail service and specialty Pharmacy transition, customized website design, eligibility feeds, claims testing and EGWP approval and transition.

We have provided detailed sample implementation plans that reflect a 6-month timeline within the **5.3 Exhibits** tab as requested. We have thoroughly reviewed the RFP requirements and we acknowledge and understand that the implementation timeline anticipates a DCS go-live date of January 1, 2025, or 90-Days after OSC approves the Contract, whichever is later and a NYSIF go-live date of April 1, 2025, or 90-Days after OSC approves the Contract, whichever is later.

The delivery of all implementation plans will be adjusted to accommodate the timelines required by the Department to accomplish the respective procuring agencies' project services start dates.

Based on MedImpact's more than 30 years of implementing and administering pharmacy benefit manager service programs, we consider the following the most typical implementation challenges:

- Target creep
- Meeting deadlines
- Ensuring quality
- Cross-department collaboration
- Miscommunication

Our project plan(s) takes these challenges into consideration and our teams proactively address these challenges to help avoid complications.

2. The Implementation Plan must include estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. It must include key activities such as:

a. Training of call center staff;

b. Website development;

c. Network development;

d. Transition of benefits; and

e. Eligibility feeds and testing claims processing.

Thorough and accurate implementation planning is essential for successful implementations. We have a strong history of implementing state and local government pharmacy benefits. We have implemented and currently mange the unique clients listed in **Table 4**:

Client	Lives
Commonwealth of Kentucky	1,488,274
State of Mississippi	750,000
Alabama Public Education Employees' Health Insurance Plan	167,289
State of Arkansas	158,783
State of Arizona	132,269

Table 4: Unique Client Implementations

Due to the uniqueness of this proposal, we will implement the project diligently using parallel project plans.

DCS Implementation Plan Overview

We practice a multiphase implementation approach dividing DCS's implementation project into separate stages for both MedImpact's and DCS's complete understanding of crucial deliverable deadlines for a successful launch on the go-live date. We have a comprehensive implementation plan in place with established timeframes and objectives for the DCS portion of the business that includes:

- **System Analysis and General Design Phase**: Through in-depth, multi-departmental interviews with DCS, our implementation team gathers all technical and functional requirements for the implementation. The implementation manager works with the various business unit representatives to develop a comprehensive project plan encompassing all aspects of the implementation, including timelines and accountabilities from both MedImpact and DCS. We will work with the client to develop this project plan. Once DCS approves it, we move into the technical design phase of the implementation process.
- **Technical Design Phase**: During the technical design phase of implementation, our implementation team members will develop a comprehensive design plan for DCS's specific needs using the project plan to direct the design plan. We copy DCS on all design documents (e.g., service requests), and DCS must approve them before work begins ensuring mutual agreement on how we will implement DCS's specific requirements into the system.
- **Development Phase**: During the development phase, we code DCS's specific requirements into our system coding the benefits and pharmacy network information and developing the necessary technical customizations to complete the implementation. We will test all work to make sure it is consistent with DCS's specifications using the project plan to document regular updates from the implementation team, standing meeting schedules, and ad hoc communications.
- **Implementation and Operations Phase**: After we code and test DCS's requirements, we will place them into production so that claims processing begins on DCS's start date. We will monitor closely DCS's activity during the first weeks of production to confirm everything functions properly to address and correct any observed issues in a timely manner. We provide DCS with frequent updates during the implementation phase to make all parties aware of progress, issues, and resolutions.

NYSIF Implementation Plan Overview

A typical implementation plan covers the migration of all aspects of the existing pharmacy program history in addition to integrating the necessary data interface components for exchanging eligibility, billing/payment and remitting data. In addition to the technology set up and integration, the implementation team will perform all training and program design including consultation regarding formulary set up and overall pharmacy program workflow. Our implementation process begins with a discovery phase where we will conduct an onsite meeting to determine workflow, integration points and high-level setup requirements. This session provides the scope necessary to determine an implementation date.

Prior to the initial onsite implementation meeting with NYSIF, we will complete the initial draft of the Implementation Project Plan, which details the various tasks, timelines and resource name(s). The NYSIF's Implementation Project Plan is categorized in 5 different phases as follows:

- **Phase 1**: Implementation Discovery
- **Phase 2**: Requirements/Development/Quality Assurance
- **Phase 3**: Communications and Training
- **Phase 4**: Production/Go Live
- **Phase 5**: Post-Implementation Validation

All implementations, including timelines, are customized to the needs and requests of each customer. Implementation timelines highly depend upon client readiness. In many cases, we can accelerate program implementation timelines when necessary; however, our standard implementation process accommodates for a thorough QA review process prior to going live, while also incorporating as much automation as possible to ensure long-term program efficiency.

Our goal is to minimize the amount of work required from NYSIF and its partners and leverage as much of its existing infrastructure as possible (e.g., file exchange formats).

Training

DCS

Our robust training program promotes quality and accuracy for an enhanced customer experience. We train all CSRs (customer service representatives) to address benefit, eligibility, and mail service inquiries quickly and efficiently. Our flexible and clearly defined policies permit modifications to meet specific requests. We invest a lot of time educating CSRs, developing their career paths, and encouraging them to continually grow and learn. New CSRs undergo more than 80 hours of total training. CSRs spend 20 hours in initial classroom training, 20 hours taking calls, 20 hours of ongoing classroom training, and 20 or more hours of ongoing training taking monitored calls (as needed, with no set number of hours).

All new CSRs must complete 2 weeks of class and 2 weeks of on-the-job training with a seasoned MedImpact representative. We then continue to build the CSRs' knowledge and skills through knowledge checks (given monthly, consisting of 5 to 10 questions based on topics supervisors identify via quality reviews), job aids, and individual training. In addition, all new hires and ongoing CSR's receive cultural sensitivity and customer service excellence

training. We require this training to ensure all staff understand our deep commitment to excellent customer service, diversity, and respect for other cultures, ages, and personal challenges.

NYSIF

CSR's will be trained in NYSIF workers' compensation program requirements during the implementation process. They are trained in-house using a formal certification process and an ongoing training program is provided for all CSR's.

Website Development

DCS

As part of the Implementation Plan, we will work closely with DCS within the scheduled timeframes to customize the Consumer Portal and meet implementation tasks, testing dates, and objectives.

NYSIF

Website development is not applicable to NYSIF.

Network Development

We have a high quality, comprehensive network that exceeds most access standards. We will solicit retail pharmacies that have previously served DCS's members but are not in our retail network provided they meet our quality and credentialing standards. We have been successful in new pharmacy solicitation efforts by:

- Assisting in the transition to a network pharmacy
- Adding the member's existing pharmacy to the MedImpact network
- Securing home delivery service for the member through our mail order or specialty pharmacy partner

The pharmacy network exceeds 56,000 retail pharmacies nationwide and approximately 4,139 pharmacies in New York. utilization and any additional network opportunities. Pharmacies identified as not participating in the network are recruited for inclusion in our network. Out of network pharmacies that meet eligibility requirements are enrolled. Ongoing transactions are reviewed monthly for network participation and candidates for recruitment are targeted from those submitting transactions out of network.

Consistent assessment of paper bill prescription transactions and non-network pharmacies are identified. When non-network pharmacy identification occurs, this information is used for contracting efforts with those pharmacies that can bill electronically and prepare them to enroll/convert existing out-of-network claims to in network. This process continues after going live and is part of our retrospective bill review process.

Transition of Benefits

DCS

We transition clients to MedImpact using a proven consistent, successful implementation process identifying all prior vendors and claim file parameters. We will transfer at least 12 months of claim history into our claims system including all open and active PAs (prior authorizations), step therapy, mail order, and specialty prescriptions from the client's incumbent vendors. Our claims processing system conducts a step therapy look back of 180 days to confirm member has a prescription history without a break in coverage for prescription approval.

In support of member information, members receive welcome materials aligned with the specific line of business in accordance with client and CMS designated timelines, as applicable. Standard welcome kits include a welcome letter and ID cards. ID cards will include member and group numbers, plan copays, DCS-specific toll-free number, MedImpact website address, and DCS-specific logo. In addition, we can include a variety of standard, and CMS-required brochures such as fliers for flu vaccinations, member website overview, our mail order pharmacy overview, and a FAQ (frequently asked question) brochure.

Specific to EGWP, our subsidiary VibrantRx, follows all CMS marketing guidance regarding marketing and beneficiary communication requirements. CMS allows cobranding on ID cards, booklets, and many letters. During implementation and annually, VibrantRx will collaborate with DCS to determine any further customizations.

VibrantRx allows flexibility with the pre-enrollment communications. If DCS prefers to send the EGWP pre-enrollment materials with their other retiree communications, VibrantRx will provide the required CMS elements, so DCS can include them in the mailings. However, if DCS elects VibrantRx to manage these mailings, DCS will need to send us the pre-enrollment member file monthly to include any members aging into Medicare within the next 60 to 90 days. Alternatively, VibrantRx can use our standard AppIntake enrollment file that DCS will provide daily or weekly for both pre-enrollment mailings and submission to CMS to enroll each member into the plan.

NYSIF

When transitioning claimants from a previous PBM, the crucial element needed to make the conversion as effective as possible is to obtain the pharmacy history data for all injured workers. It is our goal to load/convert as much historical data as possible from the incumbent pharmacy provider. Using this information, prior to going live, the implementation team will target all claimants receiving medications and begin an outbound call and mail campaign. As part of the implementation/transition process, our CSRs contact the pharmacies currently dispensing medications for injured workers and alert them of the pending change and ensure that future scripts will be processed as a network transaction. If necessary, we forward documentation for the injured worker's benefit.

In addition, we send the injured worker a letter notifying them of the change with instructions relative to any actions they need to take to ensure their medication continues to process appropriately and they do not experience a gap in therapy. We enclose a new prescription card for each injured worker for them to provide to the pharmacy and all documentation has the Customer Service Center contact information, including billing information.

Eligibility

DCS

We accept the ANSI X12 834 - Benefit Enrollment and Maintenance transaction and our proprietary standard eligibility file formats including Type 12 - Group and Type 23 - Member Record Layouts. We can also accommodate custom DCS-specified eligibility formats. At implementation, DCS can present the specific eligibility format to the implementation team for documentation of requirements and custom conversion program creation, converting DCS's eligibility file format to our standard eligibility file layout for processing. DCS and MedImpact will coordinate to ensure the timely receipt of accurate and complete eligibility and claims data, including:

- Claims history files
- Prior authorization history files
- Accumulator files
- Eligibility files
- Benefit design criteria provided in a format compatible for loading into the system

As part of regression testing, we will work with DCS to load actual historical prior approvals into the end-to-end integration test environment against a preproduction test eligibility file containing DCS's live member information allowing us to validate the historical prior approval load by mirroring the process we will use later to load the historical PAs into production. DCS's implementation business systems analyst reviews the load process and analyzes the results to the implementation team and DCS. This process offers transparency into the total volume of PAs received, successfully loaded, and loaded with errors. The start of the new plan includes automatic claims history review by our claims processing system to acknowledge approved and open PAs and step therapy requirements to immediately approve the prescription for member at POS (point of sale).

For the EGWP, during implementation, VibrantRx, discusses enrollment file options and custom requests with DCS. The standard enrollment file includes required and optional fields. The file format is .txt. The employer group can send the file daily or weekly depending upon volume and preference. Employer groups can use optional fields or filler fields to capture custom data. VibrantRx, processes enrollment and sends the member record to us using our eligibility format.

The eligibility process includes:

- The employer group provides an enrollment file with all applicable elections, terminations, and changes. The employer group can send a change-only file or full file as often as daily and multiple times a day if needed.
- Upon receipt of the eligibility file from the employer group, VibrantRx loads the file into our enrollment system validating the enrollment against MARx (Medicare Advantage Prescription Drug system), submitting clean records to CMS. The enrollment team works on eligibility outliers like records retroactive or missing information.
- The system generates enrollment output files from the system daily and loads them to MedImpact's system.
- The enrollment process includes continual monitoring of enrollment records.

NYSIF

The implementation staff utilize as many existing data integration components (e.g., existing file layouts supported by NYSIF, frequently these may be used from the existing PBM program, etc.) or, if necessary, assist with developing new file exchange formats and processes to establish electronic data feeds. This includes multiple interfaces that support the various claims systems.

Eligibility status and rules are established with each customer based upon the process followed within their claim system and how the data is received via the electronic file. In most cases, we establish different rules and crosswalk routines during the implementation process to ensure we capture and reflect the appropriate process for how the customer tracks and records eligibility.

3. Implementation and Start-Up Guarantee: The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section 5.3(2) of this RFP is fully operational on or before the respective Project Services Start Date, with the exception of opening the Dedicated Call Center and completing work on the customized website. The Dedicated Call Center must be opened at least 30 Days prior to the DCS Project Services Start Date. The customized website must be live and operational at least 30 Days prior to the DCS Project Services Start Date. This guarantee is not subject to the limitation of liability provisions of the Contract.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror shall propose, separately for each Program, the forfeiture of a percentage of the 2025 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 2025 Claims Administration Fees (prorated on a daily basis). However, Offerors may propose higher or lower percentages.

We commit to having the required dedicated call center team and custom website available 30 days prior to the DCS project services date, as required. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

5.3 Exhibits

The following exhibits were referenced in Section 5.3 and have been provided here per RFP instructions.

Exhibit	Description
5.3 Exhibit A	Implementation Plans for Commercial, EGWP, and NYSIF Programs
Attachment 6	Performance Guarantees (included at the end of the technical proposal)

Task Name	Start	Finish
RFP Sample - Commercial 6 Month 1.1.25	07/01/24	02/20/25
Client Engagement	07/01/24	12/31/24
Request General Information Questionnaire Completion	07/01/24	07/11/24
Obtain Contact Info from SE	07/01/24	07/02/24
Send General IQ To Consultant/Client to Complete	07/03/24	07/03/24
Receive updated General IQ	07/05/24	07/11/24
Conduct Introduction Call with Consultant (if applicable)	07/11/24	07/11/24
Schedule Kick-Off Meeting Date and Location	07/12/24	07/16/24
Complete Internal Kick Off Prep Meeting	07/12/24	07/16/24
Pre-Populate IQ Sections Prior to Kick Off	07/17/24	07/17/24
Facilitate Kickoff Meeting with Client	07/17/24	07/17/24
Finalize Service Contract	11/08/24	12/31/24
Project Planning	07/18/24	08/07/24
Finalize Project Schedule to Include New Requirements	07/18/24	07/31/24
Review Final Project Schedule and Milestones Dates with Client	08/01/24	08/07/24
Lock Down Project Plan upon Client Approval	08/07/24	08/07/24
Information Technology - Requirements and Set-Up	07/01/24	01/29/25
Connectivity	07/18/24	10/01/24
Review and Complete Connectivity IQ Section	07/18/24	07/31/24
Initiate NDA Process - Complete All Applicable NDAs	07/18/24	08/28/24
Approve and Sign Connectivity Form	08/01/24	08/14/24
Establish Connectivity (MFTP Site, Folders, Product Applications)	08/15/24	09/26/24
Test Connectivity and User Log on Access	09/27/24	10/01/24
Hierarchy Review	07/18/24	08/15/24
Review MedImpact Data Hierarchy with Client	07/18/24	07/24/24
Obtain Agreement on Proposed Data Hierarchy	07/25/24	08/07/24
Complete Hierarchy IQ Section	08/09/24	08/15/24
Group Record Layout	07/01/24	12/16/24
Review and Complete Group Layout IQ Section	07/18/24	08/14/24
Complete Group File Mapping Process - QC and Confirm Accuracy of File	08/15/24	09/05/24
Send or create Group Test File	09/05/24	09/05/24
Load Group Test File in E2E	09/30/24	10/01/24
Send or create Production Group File (If necessary)	07/01/24	07/01/24
Load Group File in Production	12/13/24	12/16/24
Group Attribute Record Layout	07/01/24	09/09/24
Review and Complete Group Attribute IQ Section	07/18/24	08/14/24
Complete Group Attribute File Mapping Process - QC and Confirm Accuracy of File	08/15/24	09/05/24
Send 1st Group Attribute Test File	09/05/24	09/05/24
Load Group Attribute Test File in E2E	09/06/24	09/09/24
Send Production Group Attribute File	07/01/24	07/01/24
Load Group Attribute File in Production	07/01/24	07/02/24
Eligibility/Member Record Layout	07/18/24	01/01/25
Review and Complete Eligibility IQ Section	07/18/24	08/14/24
Complete Custom Eligibility file mapping process (If necessary)	08/15/24	09/05/24
Send Eligibility Test File	09/06/24	09/06/24
Load Eligibility Test File in E2E	10/02/24	10/08/24
Send Updated Eligibility Test File (If appropriate)	09/13/24	09/13/24
Load Updated Eligibility Test File (If appropriate)	09/13/24	09/19/24
Send Production Eligibility File (ID Card Production)	11/18/24	11/18/24
Load Eligibility File in Production	11/18/24	11/22/24
Confirm Automated File Load Process is Working Correctly	01/01/25	01/01/25
Member Attribute File	07/18/24	11/22/24
Review and Complete Member Attribute IQ Section	07/18/24	08/14/24
Complete Member Attribute File Mapping Process - QC and Confirm Accuracy	08/15/24	09/05/24
Send Member Attribute Test File	09/06/24	09/06/24
Load Member Attribute Test File in E2E	09/06/24	09/12/24
Send Updated Member Attribute File (If necessary)	09/13/24	09/13/24
Load Updated Member Attribute File (If necessary)	09/13/24	09/19/24
Send Final Production Member Attribute File	11/18/24	11/18/24
Load Final Member Attribute File in Production	11/18/24	11/22/24
Claims History Files	07/18/24	01/15/25
Review and Complete Claims History IQ Section	07/18/24	08/14/24
Send First Claims History File	08/29/24	08/29/24
Convert Claims History to Excel and Add Member Demographics	09/06/24	09/12/24
Load Claims History Test File in E2E	10/09/24	10/15/24

Task Name	Start	Finish
Send Second Claims History File	12/13/24	12/13/24
Load 1st Claims History File in Production	11/25/24	11/25/24
Load 2nd Claims History File in Production	12/16/24	12/18/24
Send Claims History Lag File	01/10/25	01/10/25
Load Claims History Lag File into Production	01/13/25	01/15/25
Prior Authorization History Files	07/18/24	01/29/25
Review and Complete PA File IQ Section	07/18/24	08/14/24
1st PA File	08/29/24	11/25/24
Send PA File for Load to Test	08/29/24	08/29/24
Format PA File for Review	08/29/24	09/05/24
Internal review of PA file (if incumbent has provided PA reasons)	09/06/24	09/12/24
Formulary Disruption Analysis to Identify PA's with UM's (No PA reasons received)	09/06/24	09/19/24
Discuss Open PA's with Client for Cutoff Dates	09/20/24	09/24/24
Load PA File into E2E	09/25/24	10/01/24
Load PA File into Production	11/25/24	11/25/24
Production PA File (New and Updated PA's)	11/26/24	01/14/25
Send Production PA File (New and Updated PAs)	01/01/25	01/01/25
Format Production PA File for review	01/01/25	01/07/25
Internal review of Production PA file (if incumbent has provided PA reasons)	01/08/25	01/14/25
Formulary Disruption Analysis to Identify Production PA's with UM's (No PA Reasons Received)	01/08/25	01/08/25
Internal Review and Application of 1st PA File Business Rules	01/09/25	01/10/25
Load Production PA File into E2E and then Production	11/26/24	12/03/24
PA Lag File	01/08/25	01/29/25
Send PA Lag File (New and Updated PAs)	01/08/25	01/08/25
Format PA Lag File for Review	01/09/25	01/15/25
Internal review of Production PA file (if incumbent has provided PA reasons)	01/16/25	01/22/25
Formulary Disruption Analysis to Identify Production PA's with UM's (No PA Reasons Received)	01/16/25	01/22/25
Load PA Lag File in E2E [illegible] oduction	01/23/25	01/29/25
Accumulator Files	07/18/24	01/01/25
Review and Complete Ac[illegible] File IQ Sect[illegible]	07/18/24	08/14/24
Complete Accum File Mapping P[illegible]ess - QC an[illegible] Confi[illegible] A[illegible]ura[illegible]y o[illegible] File	08/15/24	09/05/24
Accum File - Non Hist[illegible]ical DED[illegible]nd [illegible]OP	09/06/24	01/01/25
Send 1st Test Accum F[illegible]	09/06/24	09/06/24
Load Accum Test File in E2E	10/09/24	10/15/24
Provide 1st Accum Extract File (Type 28) for Client/Vendor Validation	10/16/24	10/22/24
Send Production Accum File	01/01/25	01/01/25
Load Production Accum File	01/01/25	01/01/25
Accum File - Historical (Mid-Year Plan Starts)	09/06/24	12/31/24
Send 1st Historical Test Accum File	09/06/24	09/06/24
Load Historical Test Accum File to E2E	10/09/24	10/15/24
Send Production Accum History File	12/23/24	12/23/24
Load Production Accum History File to E2E then Production	12/24/24	12/31/24
Claims Detail Extract	07/18/24	11/07/24
Review and Complete Claims Detail Extract IQ Section	07/18/24	08/14/24
Custom Claims Detail	08/15/24	10/31/24
Obtain HLOE and SR Approval (for Custom Claims Detail)	08/15/24	09/05/24
Complete Custom Claims Detail Extract File Mapping (If needed)	09/06/24	10/31/24
Provide 1st Claims Detail Extract File for Client Validation	11/01/24	11/07/24
Benefits - Requirements and Configuration	07/12/24	08/14/24
Provide Benefit Information (SPD, EOC, Plan Summary, Grids, etc)	07/12/24	07/16/24
Complete Benefits IQ Sections and Document Test Scenarios	07/18/24	08/14/24
Specialty Programs	08/01/24	10/11/24
Complete Specialty Copay Assistance IQ	08/01/24	08/14/24
Design Review(s)	08/27/24	08/29/24
Complete Benefit Coding, QC, and Move to End to End Testing	08/30/24	09/27/24
Update Carrier Flow Worksheet (CFW) - Benefits	09/27/24	09/27/24
T&V QC Task - Benefits	09/30/24	10/11/24
Formulary - Requirements and Configuration	07/03/24	09/12/24
Determine Formulary	07/03/24	07/17/24
Complete Formulary IQ Sections and Document Test Scenarios	07/18/24	08/14/24
Complete Formulary Coding, QC, and Move to End to End Testing	08/15/24	09/12/24
Carrier Configuration - Requirements and Configuration	07/18/24	10/11/24
Review, Complete Carrier Configuration IQ Sections and Document Test Scenarios	07/18/24	08/14/24
Complete and Submit Network Rate Form (NRF)	07/18/24	08/14/24
Code Pharmacy Carriers and Move to End to End Testing	08/30/24	09/27/24

Task Name	Start	Finish
Create Carrier Flow Worksheet (CFW) - Carrier Configuration	09/23/24	09/27/24
T&V QC Task - Carrier Build	09/30/24	10/11/24
Direct Member Reimbursement - Requirements and Configuration	01/24/25	02/20/25
Complete DMR IQ Section and Document Test Scenarios	01/24/25	02/20/25
iRX Program - Requirements and Configuration	07/18/24	08/14/24
Review and Complete iRX IQ Section with Client	07/18/24	08/14/24
Configuration Requirements Finalized (IT, Benefits, Formulary, Pharmacy, DMR, iRX)	08/15/24	08/15/24
Internal Configuration IQ Review (IM Leadership)	08/16/24	08/19/24
Send Configuration IQ for Client Approval	08/20/24	08/20/24
Sign Configuration Requirements IQs (IT, Benefits, Formulary, Pharmacy, DMR)	08/26/24	08/26/24
MedImpact Testing Preparation Period	10/09/24	10/18/24
Present Configuration Test Plan to Client	10/11/24	10/15/24
Approve Test Plan	10/16/24	10/18/24
Validate the Final Configuration and Complete Readiness Checklist	10/09/24	10/10/24
30 Minute Testing Prep Meeting with BQA	10/11/24	10/11/24
Go-Ready Date - Phase 1	10/10/24	10/10/24
Validation and Testing (Phase 1)	10/11/24	11/20/24
Validation Review & Corrections (Phase 1)	10/11/24	10/17/24
Test and Generate Test Claims (Phase 1)	10/18/24	10/31/24
Conduct Internal Test Claims Review (Phase 1)	11/01/24	11/05/24
Complete Presentation for Test Claims Review with Client (Phase 1)	11/06/24	11/07/24
External Test Claims Review (Phase 1)	11/08/24	11/15/24
Send Test Claim Acceptance Form for Approval (Phase 1)	11/18/24	11/18/24
Client Approves 1st Level Test Claims	11/19/24	11/20/24
Open Enrollment Services	08/27/24	11/07/24
Review CS Pre-Go Live Services IQ	08/27/24	09/03/24
Conduct Open Enrollment Site demo and complete IQ	08/27/24	09/03/24
Receive Client Approval of C	09/04/24	09/06/24
Move Configuration and Fil to Prod ction (O Enrolln	10/18/24	10/18/24
Complete Group Linking in P duction	10/21/24	10/22/24
Create Guest Members for OE	10/23/24	10/24/24
Open Enrollment Site setu	10/25/24	11/07/24
Begin Open Enrollment Servic	11/07/24	11/07/24
Test and Generate Test Claims (Phase 2)	11/01/24	11/15/24
Conduct Internal Test Claims Review (Phase 2)	11/18/24	11/22/24
Complete Presentation for Test Claims Review with Client (Phase 2)	11/25/24	11/27/24
External Claims Review (Part 2)	11/29/24	12/05/24
Send Test Claim Acceptance Form for Approval (Phase 2)	12/06/24	12/06/24
Test Claim Sign Off - Final	12/11/24	12/11/24
Additional Operational Services	07/01/24	02/20/25
Standard Consumer Portal	07/03/24	09/18/24
Review and Complete Consumer Portal IQ and Demo	08/21/24	09/11/24
Approve and Sign Consumer Portal IQ - Standard	09/12/24	09/16/24
Send Consumer Portal FAQ's and Supporting User Guides	09/17/24	09/18/24
Configure Standard Consumer Portal	07/03/24	07/17/24
Create Guest Members for Consumer Portal Testing	07/18/24	07/24/24
Test Consumer Portal	07/25/24	07/29/24
Custom Consumer Portal	08/27/24	01/03/25
Review and Complete Member Portal IQ - Custom	08/27/24	09/17/24
Approve and Sign Member Portal IQ - Custom	09/18/24	09/24/24
Provide Custom URL to client for member communications	09/25/24	09/25/24
Document Custom Portal Requirements on Service Request	09/25/24	09/27/24
Review, Approve and Sign Service Request	09/30/24	10/02/24
Configure Custom Member Portal	10/03/24	10/30/24
Create Guest Members for Custom CP Testing	12/17/24	12/23/24
QC Portal Customizations Internally and Provide Approval to Web Team	12/24/24	12/27/24
Review Portal Customizations with Client and Receive Approval	12/30/24	01/03/25
Member Communications	08/09/24	01/07/25
Welcome Letters	08/09/24	10/11/24
Update Sample Welcome Letter Templates with Client info	08/09/24	08/15/24
Provide Client with Sample Welcome Letters	08/16/24	08/19/24
Develop Initial Welcome Letter Draft with Client	08/20/24	09/10/24
Finalize Welcome Letter	09/11/24	09/13/24
Determine with Client What Members Will Receive Welcome Letters	09/16/24	09/20/24
Create Welcome Letter Mailing List (fr. Eligibility or Mailing Roster)	09/23/24	09/27/24

Task Name	Start	Finish
Prepare and Mail Welcome Letters	09/30/24	10/11/24
POS Disruption Lettering	08/16/24	01/07/25
Provide Client with Sample POS Disruption Letters	08/16/24	08/20/24
Finalize POS Disruption Letters with Client	08/21/24	09/18/24
Obtain Applicable Logo and LANN Information from Client	08/21/24	09/18/24
Client Approval of POS Disruption Letters	09/19/24	09/25/24
Update Survey and Submit to Clarity	09/26/24	09/30/24
Send SFC to Ops Scheduler to have Test Files from E2E Sent to Clarity	10/01/24	10/07/24
Validate Letter Templates in Clarity	10/08/24	10/14/24
Send Ops Scheduler SFC for Production Files to Clarity	10/15/24	10/21/24
Review Production POS Letters for Accuracy	01/01/25	01/07/25
Customer Service Help Desk	07/11/24	09/20/24
Assign New Toll Free Number	07/11/24	07/24/24
Obtain Call Volume	07/18/24	07/31/24
Review and Complete IQ and CS Helpdesk Procedures	08/30/24	09/13/24
Client Approves CS Helpdesk Procedures	09/16/24	09/20/24
Prior Authorization (Coverage Determinations)	08/16/24	11/01/24
Review and Complete PA IQ Sections	08/16/24	08/29/24
Provide Client Custom Guidelines (if applicable)	08/30/24	09/13/24
Develop Prior Auth Procedures (PACIP)	09/16/24	10/04/24
Provide Client with Copies of Standard PA Letters and Forms	08/30/24	09/06/24
Client Modifications and Approval of PA and Appeals Letters	09/09/24	09/27/24
Configure PA Guidelines into MedResponse	10/07/24	11/01/24
Manual Claims Processing Services (DMR)	09/09/24	02/20/25
Provide Standard Part D DMR and Subrogation Letter Templates (if applicable)	09/09/24	09/13/24
Review and Approve DMR and Subrogation Letter Templates	09/16/24	10/04/24
Create/Update Claims Internal Process document (CIP)	02/07/25	02/20/25
Specialty	08/16/24	01/10/25
Specialty Member Communications - Non MIDS	08/16/24	08/29/24
Conduct Introduction Call with Specialty Vendors and Client (non MIDS)	08/16/24	08/22/24
Develop Communication Plan with Specialty Vendor and Client	08/23/24	08/29/24
Specialty Member Communications - (MIDS)	08/16/24	10/15/24
Conduct Specialty Process Overview (MIDS)	08/16/24	08/29/24
Provide MIDS Specialty Letter Templates and Brochures	08/30/24	09/06/24
Complete Specialty & LDD Utilization Analysis to Determine Members	09/13/24	09/19/24
Finalize MIDS Specialty Member Letters (If not combined in welcome letter)	09/09/24	09/27/24
Client Approves MIDS Specialty Member Letter	09/30/24	10/04/24
Mail the MIDS Specialty Member Letters	10/07/24	10/15/24
Specialty Open Refill Transfer (ORT) Files	08/23/24	01/10/25
Schedule and Facilitate Meeting with Specialty Vendors to determine file type, method and dates	08/23/24	08/26/24
Facilitate the Exchange of PIC information between Specialty Vendors	08/27/24	09/03/24
Vendor Send First (Test) Specialty ORT File	12/03/24	12/03/24
Vendor Send Second (Production) Specialty ORT File	01/01/25	01/01/25
Vendor Send Lag Specialty ORT File	01/10/25	01/10/25
Mail Order	08/16/24	01/13/25
Mail Order Communications - (Non MID)	08/16/24	09/13/24
Conduct Introduction Call with Mail Order Vendors and Client	08/16/24	08/29/24
Determine Mail Order Communication Plan	08/30/24	09/13/24
Mail Order Member Communications - (Birdi)	08/16/24	12/04/24
Conduct Mail Order Process Overview - (Birdi)	08/16/24	08/22/24
Provide Mail Order Letter Templates and Brochures to client	08/23/24	08/29/24
Complete Mail Order Utilization Analysis to Determine Members	09/13/24	09/19/24
Finalize Mail Order Member Letters (If not combined in welcome letter)	08/30/24	09/13/24
Client Approves Mail Order Member Letter	09/16/24	09/20/24
Develop Mail Order Mailing LIst	09/20/24	09/20/24
Mail the Mail Order Member Letters	11/25/24	12/04/24
Mail Order Open Refill Transfer (ORT) Files	08/30/24	01/13/25
Schedule and Facilitate Meeting with Mail Order Vendors to determine file type, method and dates	08/30/24	09/03/24
Facilitate the Exchange of PIC information between Mail Order Vendors	09/04/24	09/10/24
Vendor Send First (Test) Mail Order ORT File	12/03/24	12/03/24
Vendor Send Second (Production) Mail Order ORT File	01/02/25	01/02/25
Vendor Send Lag Mail Order ORT File	01/13/25	01/13/25
Member ID Cards - Plan Print	07/18/24	10/24/24
Provide 4RX Processing Information for ID Card	07/18/24	07/24/24
Client/Vendor Provide Mailing Timelines to MI	07/25/24	07/31/24

Task Name	Start	Finish
Develop and Provide Draft ID Card for MI Review & Approval	07/25/24	08/21/24
Provide Final Mail Out Ready Copy	08/22/24	09/19/24
Receive MedImpact Approval	09/20/24	09/26/24
Mail ID Cards and Confirm with MedImpact	09/27/24	10/24/24
Member ID Cards - MedImpact Print	08/16/24	01/07/25
Review and Complete ID Card IQ Section (Print Vendor Services IQ)	08/16/24	08/29/24
Provide ID Card Samples to Client for Review	08/16/24	08/22/24
Select and Confirm ID Card Format	08/16/24	08/29/24
Provide Plan Logos (if applicable)	08/30/24	09/06/24
Create ID Card Mock Up	12/17/24	12/31/24
Client Approval of ID Card Mock-up	01/01/25	01/07/25
Ensure Eligibility is loaded to Production and Inform Production Team	11/25/24	11/25/24
Create ID Card Production Proofs	11/26/24	12/03/24
Client Approval of ID Card Production Proofs	12/04/24	12/06/24
Mail Out ID Cards	12/09/24	12/17/24
Complete ID Card Run-out and Activate Ongoing Production	12/24/24	12/31/24
Software Choices	07/01/24	01/03/25
Complete Software Choices IQ Section (MedAccess/MedOptimize/Portal)	08/30/24	09/06/24
Request Client Specific Enterprise Security IQ	09/09/24	09/20/24
Request TPA/Consultant Specific Enterprise Security IQ	09/09/24	09/20/24
Present Enterprise Security Form to Client	09/23/24	09/27/24
Review the Applications IQ Guide and Data Roles with Client	09/23/24	09/27/24
Complete Enterprise Web IQ - Identify Users and Access	09/30/24	10/11/24
Review, Approve, and Sign Enterprise Web IQ	10/14/24	10/18/24
MedAccess	07/01/24	10/25/24
Conduct the MedAccess Demo/Client Portal Overview	08/30/24	09/13/24
Set Up MedAccess Accounts	10/14/24	10/25/24
Provide MedAccess Usernames and Passwords	07/01/24	07/02/24
Test Client Portal Connectivity and User Login Access	07/01/24	07/29/24
Complete MedAccess Instructor Lead Training	07/01/24	07/22/24
MedOptimize	10/21/24	01/03/25
Send Online Training Information to client	10/21/24	10/22/24
Complete Self Paced MedOptimize Training	10/23/24	12/27/24
Setup MedOptimize Accounts	12/30/24	12/31/24
Provide MedOptimize Usernames and Passwords	12/30/24	12/31/24
Schedule MedOptimize Instructor Led Training Post Go Live (If Client Requests)	01/01/25	01/03/25
MOR	08/30/24	12/27/24
Identify List of MOR Users via Accounting IQ	08/30/24	09/06/24
Setup MOR Accounts	09/09/24	09/20/24
Provide MOR Username/Password and the MOR Reference Guide	12/24/24	12/27/24
MedResponse	08/30/24	10/14/24
Provide MedResponse Demo	08/30/24	09/13/24
Complete MedResponse Enterprise Web IQ	09/16/24	09/19/24
Set up MedResponse Access	09/20/24	10/10/24
Send MedResponse Training Documents	10/11/24	10/14/24
E-Prescribing	08/30/24	10/21/24
Review and Complete E-Prescribing IQ Section	08/30/24	09/30/24
Setup E-Prescribing	10/01/24	10/21/24
Complete Pharmacy Solicitation Activities (If applicable)	07/01/24	09/24/24
Accounting	08/16/24	01/21/25
Send Accounting Documents to Client	08/16/24	08/22/24
Review and Complete Accounting IQ Section	08/23/24	08/29/24
Set-up Wire Transfer	12/10/24	01/07/25
Confirm Client has Logged into to MOR and MedOptimize	01/15/25	01/21/25
Rebates	08/23/24	10/16/24
Review and Complete Rebates IQ Section	08/23/24	08/29/24
Set up Rebates	08/30/24	10/16/24
Clinical Services	09/27/24	12/31/24
Pre-Populate Clinical IQ Section	09/27/24	10/17/24
Review and Complete Clinical IQ Section with Client	10/18/24	10/31/24
Set up Clincal Services	11/01/24	12/31/24
Provider Auditing	09/12/24	10/16/24
Review and Complete Provider Auditing IQ Section	09/12/24	09/25/24
Setup Provider Auditing Services	09/26/24	10/16/24
Pharmacy Broadcast	12/03/24	01/22/25

Task Name	Start	Finish
Receive Copy of Client's ID Card	01/08/25	01/08/25
Create Pharmacy Broadcast Communication and Payor Sheet	01/09/25	01/10/25
Internal Review and Approval of Pharmacy Broadcast	01/13/25	01/14/25
Present Pharmacy Broadcast to Client	01/15/25	01/21/25
Send Pharmacy Broadcast 1	01/22/25	01/22/25
Send Pharmacy Broadcast 2 (30 days prior to go live)	12/03/24	12/03/24
Send Pharmacy Broadcast 3 (15 days prior to go live)	12/10/24	12/10/24
Send Pharmacy Broadcast 4 (7 days prior to go live)	12/24/24	12/24/24
All Implementation Questionnaires Completed	12/13/24	12/13/24
Final IQ Sign Off	12/20/24	12/20/24
Production Deployment	12/12/24	12/18/24
Load IT Files into Production	12/12/24	12/18/24
Move Benefits Projects into Production	12/12/24	12/12/24
Move Formularies into Production	12/12/24	12/12/24
Move Pharmacy Projects into Production	12/12/24	12/12/24
GO LIVE: 1/1/2025	01/01/25	01/01/25
Monitoring GO LIVE	01/01/25	01/31/25
Run Claim Status Reports	01/01/25	01/14/25
Review Invoices/Reports with Client	01/29/25	02/04/25
Create Plan Standards Document	01/01/25	01/01/25
Transition Process	02/12/25	02/20/25
Present Tranisition Plan and Presentation to client	02/12/25	02/18/25
Send Transition Letter to Client	02/19/25	02/20/25

Task Name	Start	Finish
RFP Sample EGWP 1/1/25	**Mon 2/5/24**	**Thu 1/30/25**
Initial Client Engagement	Mon 2/5/24	Tue 2/13/24
Conduct Introduction Call	Mon 2/5/24	Mon 2/5/24
Schedule Kick-Off Meeting Date and Location	Wed 2/14/24	Fri 2/16/24
Complete Internal Kick Off Prep Meeting	Mon 2/19/24	Mon 2/19/24
Initiate NDA Process - Complete All Applicable NDAs	Mon 2/19/24	Fri 3/29/24
Pre-Populate Applicable IQ Sections Prior to Kick Off	Tue 2/20/24	Wed 2/21/24
Facilitate Kickoff Meeting with Client	Thu 2/22/24	Thu 2/22/24
CMS Call Letter and Submission Requirements	**Mon 2/5/24**	**Thu 9/19/24**
Submission of Plan Bids	**Tue 6/4/24**	**Thu 8/29/24**
CMS Deadline for Submission Plan Bids (including Service Area Verification)	Tue 6/4/24	Tue 6/4/24
Plan to Provide Submitted Plan Bids and Service Area Report	Tue 6/4/24	Thu 6/6/24
Inform Internal Team of Receipt and Location of Plan Bids	Fri 6/7/24	Fri 6/7/24
Plan to Provide CMS Approved (Corrected) Plan Bids and Service Area Report	Fri 6/7/24	Thu 8/29/24
Medication Therapy Management (MTM) Program	**Tue 4/30/24**	**Mon 7/1/24**
CMS Release of MTM Program Submission in HPMS	Tue 4/30/24	Tue 4/30/24
Complete MTM Program Application	Tue 4/30/24	Mon 5/13/24
Deadline to Submit MTM Program Application to CMS via HPMS	Mon 5/13/24	Mon 5/13/24
Provide Full MTM Approval Report to MedImpact	Tue 5/14/24	Mon 7/1/24
Formulary Submission	**Wed 5/8/24**	**Mon 10/7/24**
CMS Opens Formulary Submission Window in HPMS	Tue 5/21/24	Mon 6/3/24
Submit Initial Formulary and PA/Step Therapy Files via HPMS	Wed 5/8/24	Tue 5/21/24
CMS Deadline for Submission of Formularies	Mon 6/3/24	Mon 6/3/24
Submit Supplemental Formulary Files, and ADD Files to CMS	Tue 6/4/24	Mon 6/10/24
CMS Deadline for Submission of Supplemental Formulary Files	Mon 6/3/24	Mon 6/3/24
CMS Approval of Formulary (Estimated to be September 2024)	Tue 6/4/24	Mon 10/7/24
Formulary Print Files	**Wed 5/8/24**	**Tue 6/11/24**
Provide Sample Formulary Document to Client	Wed 5/8/24	Tue 5/14/24
Review and Finalize Formulary Print Requirements with Client	Wed 5/15/24	Mon 6/10/24
Provide Formulary Print to [illegible] for Posting to Website	Tue 6/11/24	Tue 6/11/24
Marketing	**Thu 6/6/24**	**Fri 10/4/24**
Create and Provide First Pharmacy Listing to Client (To be Provided Monthly)	Mon 9/30/24	Fri 10/4/24
CMS Deadline to Send ANOC and EOC Documents to Members	Mon 9/30/24	Mon 9/30/24
Send Client the PA and Step Therapy PDFs for Website	Mon 9/30/24	Mon 9/30/24
Post PA and Step Criteria on Website	Fri 9/27/24	Fri 9/27/24
CMS Part D Maintenance screens in MedAccess	**Thu 6/6/24**	**Tue 8/13/24**
Update all CMS Part D Maintenance screens for all CMS Contract IDs per PBP plan bids (Requires Formulary IDs, PBP IDs, Rep Formulary Benefit Code)	Thu 6/6/24	Thu 6/6/24
Notify PDE Ops Analyst upon completion of updates to the CMS Maintenance screens	Fri 6/7/24	Mon 6/17/24
QCs the CMS Maintenance screens in MedAccess and works with GPS Specialist to correct if needed	Tue 6/18/24	Tue 7/16/24
New clients and New contracts to start their setup with Destination Rx and notify MedImpact (IM/CSS) when complete	Wed 7/17/24	Tue 8/13/24
Project Planning	**Fri 2/23/24**	**Tue 3/19/24**
Finalize Project Schedule to Include New Requirements	Fri 2/23/24	Tue 3/5/24
Review Final Project Schedule and Milestones Dates with Client	Wed 3/6/24	Tue 3/19/24
Lock Down Project Plan upon Client Approval	**Mon 2/5/24**	**Mon 2/5/24**
Information Technology - Requirements and Set-Up	**Mon 2/5/24**	**Fri 4/19/24**
Connectivity	**Mon 2/5/24**	**Fri 3/15/24**
Review and Complete Connectivity IQ Section	Mon 2/5/24	Fri 3/1/24
Approve and Sign Connectivity Form	Mon 2/5/24	Fri 2/16/24
Establish Connectivity (MFTP Site, Folders, Product Applications)	Mon 2/5/24	Fri 3/15/24
Test Connectivity and User Log on Access	Mon 2/5/24	Wed 2/7/24
Hierarchy Review	**Mon 2/5/24**	**Fri 2/16/24**
Review MedImpact Data Hierarchy with Client	Mon 2/5/24	Fri 2/9/24
Obtain Agreement on Proposed Data Hierarchy	Mon 2/5/24	Fri 2/16/24
Complete Hierarchy IQ Section	Mon 2/5/24	Fri 2/9/24
Group Record Layout	**Mon 2/5/24**	**Fri 2/23/24**
Review and Complete Group Layout IQ Section	Mon 2/5/24	Fri 2/23/24
Provide Carrier Flow Worksheet (CFW) to Client	Mon 2/5/24	Mon 2/5/24
Complete Group File Mapping Process - QC and Confirm Accuracy of File	Mon 2/5/24	Fri 2/23/24
Send 1st Group Test File	Mon 2/5/24	Mon 2/5/24
Load Group Test File in E2E	Mon 2/5/24	Fri 2/9/24
Send Production Group File	Mon 2/5/24	Mon 2/5/24
Load Group File in Production	Mon 2/5/24	Fri 2/9/24
Group Attribute Record Layout	**Mon 2/5/24**	**Fri 2/23/24**

Task Name	Start	Finish
Review and Complete Group Attribute IQ Section	Mon 2/5/24	Fri 2/23/24
Complete Group Attribute File Mapping Process - QC and Confirm Accuracy of File	Mon 2/5/24	Fri 2/23/24
Send 1st Group Attribute Test File	Mon 2/5/24	Mon 2/5/24
Load Group Attribute Test File in E2E	Mon 2/5/24	Fri 2/9/24
Send Production Group Attribute File	Mon 2/5/24	Mon 2/5/24
Load Group Attribute File in Production	Mon 2/5/24	Tue 2/6/24
Eligibility/Member Record Layout	**Mon 2/5/24**	**Fri 4/5/24**
Review and Complete Eligibility IQ Section	Mon 2/5/24	Fri 2/23/24
Complete Eligibility File Mapping Process - QC and Confirm Accuracy of File	Mon 2/5/24	Fri 4/5/24
Send Eligibility Test File	Mon 2/5/24	Mon 2/5/24
Load Eligibility Test File in E2E	Mon 2/5/24	Fri 2/9/24
Send Updated Eligibility File (Pre Open Enrollment)	Mon 2/5/24	Mon 2/5/24
Load Updated Eligibility File (Pre-Open Enrollment) in Production	Mon 2/5/24	Fri 2/9/24
Send Production Eligibility File (ID Card Production)	Mon 2/5/24	Mon 2/5/24
Load Eligibility File in Production	Mon 2/5/24	Fri 2/9/24
Send Final Eligibility File (After End of Annual Election Period)	Mon 2/5/24	Fri 2/16/24
Load Final Eligibility File to Production	Mon 2/5/24	Fri 2/9/24
Confirm Automated File Load Process is Working Correctly	Mon 2/5/24	Mon 2/5/24
Member Attribute File	**Mon 2/5/24**	**Fri 4/5/24**
Review and Complete Member Attribute IQ Section	Mon 2/5/24	Fri 2/23/24
Complete Member Attribute File Mapping Process - QC and Confirm Accuracy	Mon 2/5/24	Fri 4/5/24
Send Member Attribute Test File	Mon 2/5/24	Mon 2/5/24
Load Member Attribute Test File in E2E	Mon 2/5/24	Fri 2/9/24
Send Production Member Attribute File (Pre-Open Enrollment)	Mon 2/5/24	Mon 2/5/24
Load Member Attribute File (Pre Open Enrollment) in Production	Mon 2/5/24	Fri 2/9/24
Send Final Production Member Attribute File	Mon 2/5/24	Mon 2/5/24
Load Final Member Attribute File in Production	Mon 2/5/24	Fri 2/9/24
Claims History Files	**Mon 2/5/24**	**Fri 2/23/24**
Review and Complete Cla ns Histo IQ Sec	Mon 2/5/24	Fri 2/23/24
Send Claims History Test	Mon 2/5/24	Mon 2/5/24
Convert Claims History to Exce	**Mon 2/5/24**	**Tue 2/13/24**
Add Member Demograp ics to Cla ns History	Mon 2/5/24	Tue 2/13/24
Load Claims History Test	Mon 2/5/24	Fri 2/9/24
Send 2nd Claims History File - Production	Mon 2/5/24	Mon 2/5/24
Load 2nd Claims History File in Production	Mon 2/5/24	Wed 2/7/24
Send Claims History Lag File	Mon 2/5/24	Mon 2/5/24
Load Claims History Lag File into Production	Mon 2/5/24	Fri 2/9/24
Prior Authorization History Files	**Mon 2/5/24**	**Fri 2/23/24**
Review and Complete PA File IQ Section	Mon 2/5/24	Fri 2/23/24
Request and Receive Incumbent PA File Definition Companion Guide	Mon 2/5/24	Fri 2/9/24
Send PA File for Load to Test	Mon 2/5/24	Mon 2/5/24
Format PA File for Review	Mon 2/5/24	Fri 2/9/24
Determine Business Rules and Override Types for Loading PAs	Mon 2/5/24	Fri 2/16/24
Load PA File into E2E	Mon 2/5/24	Fri 2/9/24
Send 2nd PA File (New and Updated PAs)	Mon 2/5/24	Mon 2/5/24
Format 2nd PA File for review	Mon 2/5/24	Fri 2/9/24
Apply 1st PA File Business Rules and Prep File for Load	Mon 2/5/24	Fri 2/9/24
Load 2nd PA File into Production	Mon 2/5/24	Fri 2/9/24
Send PA Lag File (New and Updated PAs)	Mon 2/5/24	Mon 2/5/24
Format PA Lag File for Review	Mon 2/5/24	Mon 2/5/24
Apply 1st PA File Business Rules and Prep File for Load	Mon 2/5/24	Fri 2/9/24
Load PA Lag File in Production	Mon 2/5/24	Fri 2/9/24
Accumulator Files	**Mon 2/5/24**	**Fri 4/19/24**
Review and Complete Accum File IQ Section	Mon 2/5/24	Fri 2/23/24
Complete Accum File Mapping Process - QC and Confirm Accuracy of File	Mon 2/5/24	Fri 4/19/24
Send 1st Test Accum File	Mon 2/5/24	Mon 2/5/24
Load Accum Test File in E2E	Mon 2/5/24	Fri 2/9/24
Provide 1st Accum Extract File (Type 28) for Client Validation	Mon 2/5/24	Mon 2/5/24
Send Production Accum File	Mon 2/5/24	Mon 2/5/24
Load Production Accum File	Mon 2/5/24	Mon 2/5/24
Member Restriciton File (Type 26)	**Mon 2/5/24**	**Fri 3/1/24**
Determine and Document Member Restriction Override/Approval Types	Mon 2/5/24	Fri 2/23/24
Send Override Codes and File Mapping Information to Client	Mon 2/5/24	Tue 2/6/24
Complete Member Restriction File Mapping - QC File	Mon 2/5/24	Fri 3/1/24
Send Member Restriction Test File	Mon 2/5/24	Mon 2/5/24

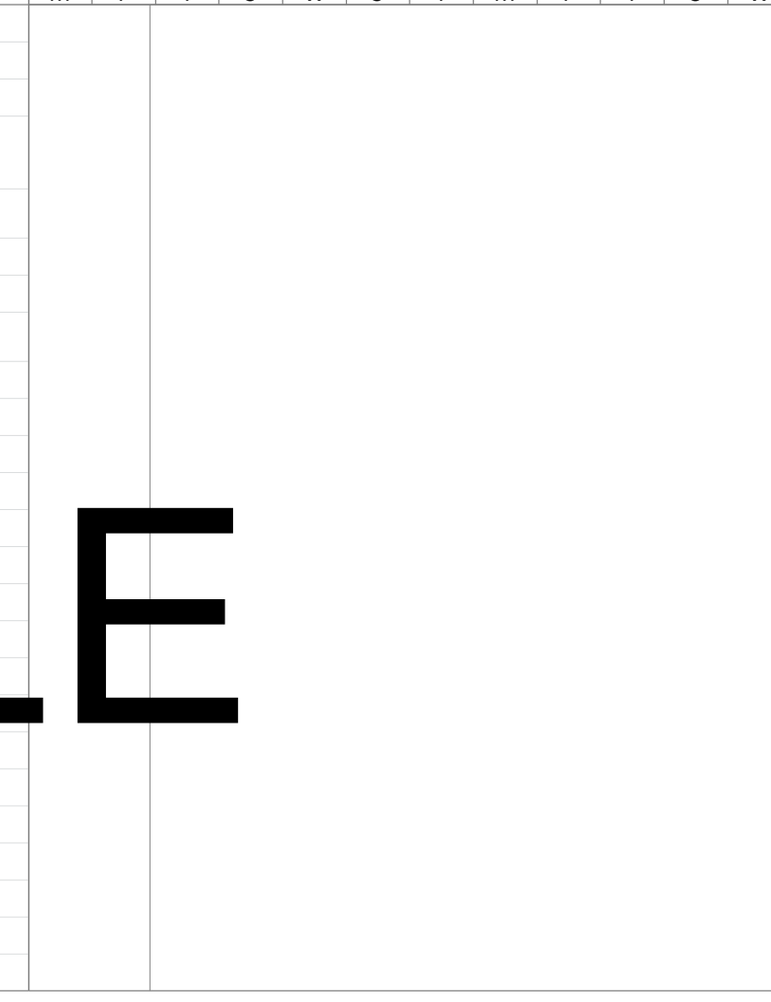
Task Name	Start	Finish
Load Member Restriction Test File into E2E	Mon 2/5/24	Fri 2/9/24
Send 2nd Member Restriction File (New and Updated Overrides)	Mon 2/5/24	Mon 2/5/24
Load Member Restriction File in Production	Mon 2/5/24	Fri 2/9/24
Send Member Restriction Lag File, if applicable	Mon 2/5/24	Mon 2/5/24
Load Member Restriction Lag File in Production	Mon 2/5/24	Mon 2/5/24
Claims Detail Extract	**Mon 2/5/24**	**Fri 3/29/24**
Review and Complete Claims Detail Extract IQ Section	Mon 2/5/24	Fri 2/23/24
Complete Claims Detail Extract File Mapping	Mon 2/5/24	Fri 3/29/24
Provide 1st Claims Detail Extract File for Client Validation	Mon 2/5/24	Fri 2/9/24
Benefits - Requirements and Configuration	**Fri 6/7/24**	**Tue 10/1/24**
Complete Benefits IQ Sections and Document Test Scenarios	Fri 6/7/24	Thu 6/27/24
Complete Specialty IQ Sections and Document Test Scenarios	Fri 6/7/24	Thu 6/27/24
Build Representative Benefit Codes for Plan Finder	Mon 6/10/24	Fri 6/14/24
Provide Representative Benefit Codes to GPS	Mon 6/17/24	Mon 6/17/24
Design Review(s)	Fri 6/28/24	Fri 7/5/24
Complete Benefit Coding, QC, and Move to End to End Testing	Mon 7/8/24	Fri 8/2/24
Update Carrier Flow Worksheet (CFW) - Benefits	Mon 7/8/24	Fri 7/12/24
Move Benefit Projects to Production	Mon 9/30/24	Tue 10/1/24
Formulary - Requirements and Configuration	**Fri 2/23/24**	**Mon 9/30/24**
Determine Formulary	Fri 2/23/24	Wed 3/6/24
Pre-populate Formulary IQ Sections	Thu 3/7/24	Wed 3/13/24
Send Formulary IQ Section to Standard Formulary Clients	Thu 3/14/24	Thu 3/14/24
Complete Formulary IQ Section with Client	Fri 3/15/24	Thu 3/28/24
Client Sign Off on Formulary IQ Section	Fri 3/29/24	Tue 4/2/24
Submit Formulary Modifications (if applicable)	Fri 3/29/24	Thu 4/18/24
Update Formulary IQ (if modification is required)	Fri 3/29/24	Tue 4/2/24
Complete Formulary Coding, QC, and Move to End to End Testing	Wed 4/3/24	Tue 5/7/24
Move Formulary Projects to P[illegible]n	Mon 9/30/24	Mon 9/30/24
Carrier Configuration - Requirements and Configuration	**Fri 6/7/24**	**Tue 10/1/24**
Review, Complete CCS IQ S[illegible]ions and Document Test S[illegible]rios	Fri 6/7/24	Mon 6/10/24
Complete and Approve Network Rate Form (NRF)	Fri 6/7/24	Thu 6/27/24
Build Carrier Shells/Network Rates for Plan Finder	Mon 6/10/24	Fri 6/14/24
Code Pharmacy Carriers and Move to End to End Testing	Mon 7/8/24	Fri 8/2/24
Create Carrier Flow Worksheet (CFW) - Carrier Config.	Mon 7/8/24	Fri 7/12/24
Move Carrier Projects into Production	Mon 9/30/24	Tue 10/1/24
Provider Enrollment Requirements and Configuration	**Mon 2/5/24**	**Mon 9/30/24**
Complete Provider Enrollment Requirements	Mon 2/5/24	Fri 6/7/24
Complete Provider Enrollment Coding and Move to E2E	Mon 7/8/24	Fri 8/2/24
Move Provider Enrollment Configuration to Production	Mon 9/30/24	Mon 9/30/24
Direct Member Reimbursement - Requirements and Configuration	**Fri 6/7/24**	**Fri 8/2/24**
Complete DMR IQ Section and Document Test Scenarios	Fri 6/7/24	Thu 6/27/24
Configure DMR Carriers and Load to E2E	Mon 7/8/24	Fri 8/2/24
iRX Program - Requirements and Configuration	**Fri 6/7/24**	**Fri 8/2/24**
Configuration Requirements Finalized (IT, Benefits, Formulary, Pharmacy, DMR, iRX)	Mon 8/5/24	Mon 8/5/24
Implementation Leadership Config. IQ Review	Fri 6/28/24	Mon 7/1/24
Sign Configuration Requirements IQs (IT, Benefits, Formulary, Pharmacy, DMR)	**Thu 6/27/24**	**Thu 6/27/24**
MedImpact Preparation Period	**Mon 7/8/24**	**Fri 7/19/24**
Present Configuration Test Plan to Client	Mon 7/8/24	Fri 7/12/24
Approve Test Plan	Mon 7/15/24	Fri 7/19/24
Validate the Final Configuration and Complete Readiness Checklist	Mon 7/8/24	Tue 7/9/24
1st Go-Ready Date	**Wed 8/28/24**	**Wed 8/28/24**
Validation and Testing (Phase 1)	**Mon 7/8/24**	**Fri 9/27/24**
Validation Review & Corrections (Phase 1)	Mon 7/8/24	Fri 7/26/24
Test and Generate Test Claims (Phase 1)	Mon 7/29/24	Fri 8/23/24
Conduct Internal Test Claims Review (Phase 1)	Mon 8/26/24	Fri 9/6/24
Complete Presentation for Test Claims Review with Client (Phase 1)	Mon 9/9/24	Tue 9/10/24
External Test Claims Review (Phase 1)	Wed 9/11/24	Tue 9/24/24
Send Test Claim Acceptance Form for Approval (Phase 1)	Wed 9/25/24	Wed 9/25/24
Client Approves 1st Level Test Claims	Thu 9/26/24	Fri 9/27/24
Confirm CS Pre Go Live Services Support Setup Is Complete	Mon 9/30/24	Mon 9/30/24
Confirm Portal Setup is Complete	Tue 10/1/24	Tue 10/1/24
Begin Open Enrollment Services - Medicare Part D	**Tue 10/15/24**	**Tue 10/15/24**
Review Claims Processing Set-up Based on Final Plan Bids	**Fri 8/30/24**	**Mon 9/23/24**
Complete Change Order (if applicable, based on final plan bids)	Fri 8/30/24	Tue 9/3/24
Review, Sign and Return Change Order Request	Wed 9/4/24	Thu 9/5/24

Task Name	Start	Finish
Update Benefit Configuration (if applicable, based on final plan bids)	Fri 9/6/24	Thu 9/19/24
Submit Request to T&V to Complete Additional Testing (if applicable)	Fri 9/20/24	Mon 9/23/24
Testing Preparation (Phase 2)	**Tue 9/24/24**	**Wed 10/2/24**
Conduct Test Strategy Meeting (Phase 2)	Tue 9/24/24	Thu 9/26/24
Validation Review & Corrections, Complete Readiness Checklist (Phase 2)	Fri 9/27/24	Wed 10/2/24
2nd Go-Ready Date	**Mon 2/5/24**	**Mon 2/5/24**
Test and Generate Test Claims (Phase 2)	Thu 10/3/24	Wed 10/23/24
Conduct Internal Test Claims Review (Phase 2)	Thu 10/24/24	Wed 10/30/24
Complete Presentation for Test Claims Review with Client (Phase 2)	Thu 10/31/24	Wed 11/6/24
External Test Claim Review (Phase 2)	Thu 11/7/24	Wed 11/13/24
Send Test Claim Acceptance Form for Approval (Phase 2)	Thu 11/14/24	Thu 11/14/24
Test Claim Sign Off - Final	**Thu 11/14/24**	**Thu 11/14/24**
Complete IQ Sections 1 (Health Plan Info.) and 2 (Contacts)	Tue 2/20/24	Mon 3/11/24
CP Open Enrollment Site	**Mon 7/8/24**	**Thu 9/12/24**
Complete OE Demo with Client	Mon 7/8/24	Fri 8/16/24
Complete OE IQ	Mon 8/19/24	Fri 8/23/24
Create Guest Member(s) using PRC Code	Mon 8/26/24	Tue 8/27/24
Configure OE Site	Wed 8/28/24	Tue 9/10/24
Test and Validate OE Configuration and PRC Functions Against IQ	Wed 9/11/24	Thu 9/12/24
Option: Standard Consumer Portal	**Mon 7/8/24**	**Fri 10/4/24**
Complete Consumer Portal Demo	Mon 7/8/24	Fri 8/2/24
Complete Consumer Portal IQ	Mon 8/5/24	Tue 8/6/24
Approve and Sign Member Portal IQ - Standard	Wed 8/7/24	Thu 8/8/24
Complete Configuration of Standard Consumer Portal	Fri 8/9/24	Thu 8/22/24
Test Consumer Portal using Guest Members	Wed 10/2/24	Fri 10/4/24
Option: Custom Consumer Portal	**Mon 7/8/24**	**Fri 10/11/24**
Review and Complete Custom Consumer Portal IQ - Custom	Mon 7/8/24	Fri 8/2/24
Approve and Sign Member P[illegible] Custom	Mon 8/5/24	Fri 8/9/24
Document Custom Portal R[illegible]uiremen[illegible]s on Se[illegible]ic Reque[illegible]	Mon 8/12/24	Fri 8/16/24
Review, Approve and Sign S[illegible]ice Request	Mon 8/19/24	Fri 8/23/24
Configure Custom Consumer Porta[illegible]	Mon 8/26/24	Fri 9/20/24
QC Portal Customizations I[illegible]ernally a[illegible] Pr[illegible]ide App[illegible]val [illegible] We[illegible] Team[illegible]	Mon 9/23/24	Fri 9/27/24
Review Portal Customizations[illegible]ith C[illegible]ent a[illegible]d Receive[illegible] pp[illegible]val	Mon 9/30/24	Fri 10/4/24
Deploy Portal Customizations to Production	Mon 10/7/24	Fri 10/11/24
Customer Service Help Desk	**Mon 7/8/24**	**Thu 12/12/24**
Review, Complete and Sign Pre-Go Live IQ for Open Enrollment	Mon 7/8/24	Fri 7/19/24
Assign MedImpact Toll Free Number	Mon 7/22/24	Fri 8/2/24
Review and Complete IQ and CS Helpdesk Procedures	Mon 7/22/24	Fri 8/16/24
Client Approves CS Helpdesk Procedures	Mon 8/19/24	Fri 8/23/24
Provide HPMS Screen Shots of Toll Free Number and Provide to CS Admin	Mon 8/26/24	Thu 12/12/24
Prior Authorization (Coverage Determinations)	**Fri 6/7/24**	**Fri 12/6/24**
Review and Complete PA IQ Sections	Fri 6/7/24	Thu 7/4/24
Provide Client Custom Guidelines (if applicable)	Fri 7/5/24	Thu 7/18/24
Develop, Review and Approve Prior Auth Procedures (PACIP)	Fri 7/19/24	Thu 8/8/24
Provide Client with Copies of Standard PA Letters and Forms	Fri 8/9/24	Thu 8/15/24
Client Approval of PA and Appeals Letters	Fri 8/16/24	Thu 9/12/24
Provide PA & Appeals Letters to CMS for Approval	Fri 9/13/24	Fri 9/13/24
Configure PA Guidelines into MedResponse	Mon 9/16/24	Fri 12/6/24
Manual Claims Processing Services (DMR)	**Mon 8/26/24**	**Fri 10/11/24**
Create/Update Claims Internal Process document (CIP)	Mon 8/26/24	Fri 9/6/24
Provide Standard Part D DMR and Subrogation Letter Templates (if applicable)	Mon 9/9/24	Fri 9/13/24
Review and Approve DMR and Subrogation Letter Templates	Mon 9/16/24	Fri 10/11/24
Specialty	**Mon 7/8/24**	**Wed 11/20/24**
Specialty Member Communications - Part D	**Mon 7/8/24**	**Wed 11/20/24**
Conduct Introduction Call with Specialty Vendors and Client	Mon 7/8/24	Fri 7/19/24
Complete Specialty & LDD Utilization Analysis to Determine Members	Mon 7/22/24	Tue 7/30/24
Develop and Finalize Specialty Member Letters	Tue 10/1/24	Mon 10/28/24
Client Approves Specialty Member Letter	Tue 10/29/24	Mon 11/11/24
Mail the Specialty Member Letters	Tue 11/12/24	Wed 11/20/24
Specialty Open Refill Transfer (ORT) Files	**Mon 7/8/24**	**Mon 7/29/24**
Schedule and Facilitate Meeting with Specialty Vendors to determine file type, method and dates	Mon 7/8/24	Fri 7/19/24
Document Specialty Transfer Agreements	Mon 7/22/24	Fri 7/26/24
Vendor Send Test Specialty ORT File	Fri 7/26/24	Fri 7/26/24
Vendor Send Production Specialty ORT File	Mon 7/29/24	Mon 7/29/24
Vendor Send Lag Specialty ORT File	Mon 7/29/24	Mon 7/29/24

Task Name	Start	Finish
Mail Order	**Mon 7/8/24**	**Wed 1/8/25**
Mail Order Member Communications	**Mon 7/8/24**	**Thu 11/28/24**
Conduct Introduction Call with Mail Order Vendors and Client	Mon 7/8/24	Tue 7/16/24
Complete Mail Order Utilization Analysis to Determine Members	Tue 10/1/24	Wed 10/9/24
Develop and Finalize Mail Order Member Letters (If not combined in welcome letter)	Thu 10/10/24	Wed 11/6/24
Client Approves Mail Order Member Letter	Thu 11/7/24	Tue 11/19/24
Mail the Mail Order Member Letters	Wed 11/20/24	Thu 11/28/24
Mail Order Open Refill Transfer (ORT) Files	**Wed 7/17/24**	**Wed 1/8/25**
Schedule and Facilitate Meeting with Mail Order Vendors to determine file type, method and dates	Wed 7/17/24	Tue 7/30/24
Document Mail Order Transfer Agreements	Wed 7/31/24	Tue 8/6/24
Vendor Send Test Mail Order ORT File	Wed 1/1/25	Thu 1/2/25
Vendor Send Production Mail Order ORT File	Fri 1/3/25	Tue 1/7/25
Vendor Send Lag Mail Order ORT File	Wed 1/8/25	Wed 1/8/25
Medication Therapy Management (MTM) Program	**Mon 8/5/24**	**Tue 10/22/24**
Review and Complete MTM IQ Section	Mon 8/5/24	Fri 8/23/24
Obtain Client Logo, E-signature and Formulary URL - Document on MTM IQ	Mon 8/26/24	Tue 9/3/24
Complete MTM Program Set Up	Wed 9/4/24	Tue 9/24/24
Send MTM Letter and fax templates to client for review and approval	Wed 9/25/24	Thu 9/26/24
Client Approval of MTM Letter and Fax Templates	Fri 9/27/24	Thu 10/10/24
Forward approved MTM letter and fax templates to MTMP Team (MTMP@MedImpact.com)	Fri 10/11/24	Tue 10/15/24
Set client up for MTM_EXTRACT and MTM_LOAD_VALIDATION in client process parameters table	Wed 10/16/24	Tue 10/22/24
Print Vendor Services	**Mon 7/15/24**	**Fri 12/6/24**
Review and Complete Print Vendor Services IQ Section	Mon 7/15/24	Fri 7/26/24
Complete Print Vendor Services Setup	Mon 7/29/24	Fri 8/16/24
Provide Demo of Clarity Tool	Mon 8/19/24	Mon 9/9/24
Plan and Clarity Work to Enter Plan Data into Tool	Tue 9/10/24	Mon 10/7/24
Populate Templates Proofs for Plan Review	Mon 10/7/24	Mon 10/7/24
Client Approval of CMS Requ[illegible]ters (MEOB & TOC)	Tue 10/8/24	Mon 10/14/24
Submit MEOB & TOC Lette[illegible] to CMS for Appr[illegible]a	Tue 10/15/24	Fri 10/18/24
CMS Approves MEOB & TO[illegible]letters	Mon 10/21/24	Fri 11/29/24
Provide CMS approved MEOB & TO[illegible]letters to Cla[illegible]y, if c[illegible]ntracted	Mon 12/2/24	Fri 12/6/24
Member ID Cards - Plan Pri[illegible]	**Mon 7/8/24**	**Wed 12/4/24**
Provide 4RX Processing Info[illegible]ation for ID Card	Mon 7/8/24	Wed 7/24/24
Provide Mailing Timelines to MI	Thu 7/25/24	Wed 8/7/24
Provide Draft ID Card for MI Review & Approval	Thu 8/8/24	Wed 9/4/24
Provide Final Mail Out Ready Copy	Thu 9/5/24	Wed 10/16/24
Receive MedImpact Approval	Thu 10/17/24	Wed 10/23/24
Mail ID Cards and Confirm with MedImpact	Thu 10/24/24	Wed 12/4/24
Software Choices	**Mon 7/15/24**	**Tue 12/24/24**
Review the Applications IQ Guide and Data Roles with Client	Mon 7/29/24	Fri 8/9/24
Create Client Specific Enterprise Web IQ	Mon 8/12/24	Fri 8/23/24
Present Enterprise Security Form to Client	Mon 8/26/24	Fri 8/30/24
Complete Enterprise Web IQ - Identify Users and Access	Mon 9/2/24	Fri 9/13/24
Review, Approve, and Sign Enterprise Web IQ	Mon 9/16/24	Fri 9/20/24
Complete Software Choices IQ Section (MedAccess/MedOptimize/Portal)	Mon 9/16/24	Fri 9/20/24
MedAccess	Mon 9/23/24	Tue 12/24/24
MedOptimize	Mon 9/23/24	Thu 12/5/24
MOR	Mon 7/22/24	Wed 8/14/24
MedResponse	Mon 9/23/24	Mon 11/4/24
E-Prescribing	**Mon 7/15/24**	**Tue 10/22/24**
Review and Complete E-Prescribing IQ Section	Mon 7/15/24	Mon 8/12/24
Setup E-Prescribing	Wed 10/2/24	Tue 10/22/24
Member Communications	**Thu 8/8/24**	**Wed 12/25/24**
Welcome Letters	**Thu 8/8/24**	**Wed 12/25/24**
Provide Client with Sample Welcome Letters	Thu 8/8/24	Wed 8/21/24
Develop Initial Welcome Letter Draft with Client	Thu 8/22/24	Wed 9/11/24
Finalize Welcome Letter	Thu 9/12/24	Wed 10/2/24
Prepare and Mail Welcome Letters	Thu 12/5/24	Wed 12/25/24
Formulary Disruption Mailings (If Applicable)	**Thu 8/22/24**	**Mon 11/11/24**
Provide Client with Sample Formulary Disruption Letters	Thu 8/22/24	Mon 8/26/24
Develop Initial Formulary Disruption Letter Drafts with Client	Tue 8/27/24	Mon 9/23/24
Finalize Formulary Disruption Letters	Tue 9/24/24	Mon 10/7/24
Review and Approve Formulary Disruption Letters	Tue 10/8/24	Mon 10/14/24
Prepare and Mail Formulary Disruption Letters	Tue 10/15/24	Mon 11/11/24
Complete Pharmacy Solicitation Activities (If applicable)	Fri 6/28/24	Thu 10/31/24

Task Name	Start	Finish
PDE	**Wed 8/7/24**	**Tue 10/29/24**
Submit SF Case to PDE Ops queue to pre-populate PDE IQ section	Wed 8/7/24	Tue 8/13/24
Review and Complete PDE IQ Section with Client	Wed 8/14/24	Tue 9/10/24
Complete PDE Setup	Wed 9/11/24	Tue 9/17/24
PDE Team manages application, testing and certification	Wed 9/18/24	Tue 10/29/24
Part D Deliverables	**Wed 9/11/24**	**Fri 12/6/24**
Schedule Meeting with GPS & AE to Review and Populate IQ Section - Refer to New CY Part D Deliverables Schedule	Wed 9/11/24	Fri 9/13/24
Pre-Populate Part D Deliverables IQ Section	Mon 9/16/24	Fri 9/20/24
Review and Complete Part D Deliverables IQ Section with Client	Mon 9/23/24	Wed 9/25/24
Set-up Part D Deliverables	Thu 9/26/24	Fri 9/27/24
Contact TrOOP Facilitator to set up FIR (For new CMS Contract Numbers)	Mon 9/30/24	Fri 11/8/24
Set up client with new CMS Contract IDs to receive Financial Information Reporting (FIR)	Mon 11/11/24	Fri 12/6/24
Accounting	**Mon 7/8/24**	**Thu 12/12/24**
Send Accounting Documents to Client	Mon 7/8/24	Fri 7/12/24
Review and Complete Accounting IQ Section	Mon 7/15/24	Fri 7/19/24
Set-up Wire Transfer	Mon 7/22/24	Fri 8/30/24
Confirm Client has Logged into to MOR and MedOptimize	Fri 12/6/24	Thu 12/12/24
Rebates	**Mon 7/22/24**	**Fri 10/4/24**
Review and Complete Rebates IQ Section	Mon 7/22/24	Fri 8/2/24
Set up Rebates	Mon 8/5/24	Fri 10/4/24
Clinical Services	**Mon 7/8/24**	**Fri 8/30/24**
Pre-Populate Clinical IQ Section	Mon 7/8/24	Fri 7/26/24
Review and Complete Clinical IQ Section with Client	Mon 7/29/24	Fri 8/9/24
Set up Clincal Services	Mon 8/12/24	Fri 8/30/24
Provider Auditing	**Mon 8/12/24**	**Fri 9/13/24**
Review and Complete Provider Auditing IQ Section	Mon 8/12/24	Fri 8/23/24
Setup Provider Auditing Services	Mon 8/26/24	Fri 9/13/24
Pharmacy Broadcast	**Thu 10/17/24**	**Fri 11/22/24**
Receive Copy of Client's ID Card	Thu 10/17/24	Wed 10/23/24
Create Pharmacy Broadcast Communication and Flavor Sheet	Thu 10/24/24	Mon 10/28/24
Internal Review and Approval of Pharmacy Broadcast	Tue 10/29/24	Wed 10/30/24
Present Pharmacy Broadcast to Client	Thu 10/31/24	Fri 11/1/24
Send Pharmacy Broadcasts (ideally 5 days prior to go live)	Mon 11/4/24	Fri 11/22/24
All Implementation Questionnaires Completed	Tue 10/29/24	Tue 10/29/24
Final IQ Sign Off	**Wed 10/30/24**	**Tue 11/12/24**
Complete Go Live Checklist	Fri 12/27/24	Fri 12/27/24
GO LIVE: 1/1/2025	**Wed 1/1/25**	**Wed 1/1/25**
Monitoring GO LIVE	**Wed 1/1/25**	**Tue 1/28/25**
Run Claim Status Reports to monitor activity	Wed 1/1/25	Tue 1/21/25
Review Invoices/Reports with Client	Wed 1/22/25	Tue 1/28/25
Transition Process	**Wed 1/22/25**	**Thu 1/30/25**
Present Tranisition Plan and Presentation to client	Wed 1/22/25	Tue 1/28/25
Send Transition Letter to Client	Wed 1/29/25	Thu 1/30/25

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1	**Implementation Timeline**	**152 days**	**Wed 11/1/23**	**Thu 5/30/24**		
2	**Phase 1: Implementation Discovery**	**124 days**	**Wed 11/1/23**	**Mon 4/22/24**		
3	Contract Negotiation	40 days	Wed 11/1/23	Tue 12/26/23		
4	Sales/Implementation/Account Management transition discussions (Client's expectations & preliminary	5 days	Tue 1/2/24	Mon 1/8/24		Sales,Implementation,Account Management
5	**Implementation Strategy - Client Meetings**	**11 days**	**Tue 1/9/24**	**Tue 1/23/24**		**Sales,Implementation,Account**
6	Implementation Strategy - Client Meeti	5 days	Tue 1/9/24	Mon 1/15/24		
7	Customer workflow and design	10 days	Wed 1/10/24	Tue 1/23/24		Implementation,Client
8	Weekly Fact Finding Meetings with Client - Post Meeting	70 days	Tue 1/16/24	Mon 4/22/24	6	Implementation,Client,Account
9	Determine Go Live Date	2 days	Wed 1/24/24	Thu 1/25/24	7	Implementation,Client
10	**Phase 2: Req/Dev/QA**	**60 days**	**Tue 1/16/24**	**Mon 4/8/24**		
11	**Sprint 1**	**10 days**	**Tue 1/16/24**	**Mon 1/29/24**		
12	Eligibility	10 days	Tue 1/16/24	Mon 1/29/24	6	Implementation,Client,HES IT
13	**Sprint 2**	**10 days**	**Tue 1/30/24**	**Mon 2/12/24**	**11**	
14	Eligibility	10 days	Tue 1/30/24	Mon 2/12/24		Implementation,Client,HES IT
15	Pharmacy system setup	10 days	Tue 1/30/24	Mon 2/12/24		Implementation,Client
16	Billing	10 days	Tue 1/30/24	Mon 2/12/24		Implementation,Client,HES IT
17	Paper	10 days	Tue 1/30/24	Mon 2/12/24		Implementation,Client,HES IT
18	**Sprint 3**	**10 days**	**Tue 2/13/24**	**Mon 2/26/24**	**15**	
19	Pharmacy system setup	10 days	Tue 2/13/24	Mon 2/26/24		Implementation,Client
20	Billing	10 days	Tue 2/13/24	Mon 2/26/24		Implementation,Client,HES IT
21	Paper	10 days	Tue 2/13/24	Mon 2/26/24		Client,Implementation,HES IT
22	History	10 days	Tue 2/13/24	Mon 2/26/24		Client,Implementation,HES IT
23	**Sprint 4**	**10 days**	**Tue 2/27/24**	**Mon 3/11/24**	**18**	
24	Billing	10 days	Tue 2/27/24	Mon 3/11/24		Implementation,Client,HES IT
25	Paper	10 days	Tue 2/27/24	Mon 3/11/24		Client,Implementation,HES IT



Project: Gray Insurance PBM Imp
Date: Tue 10/17/23

Task	External Tasks	Manual Task	Finish-only		
Split	External Milestone	Duration-only	Deadline		
Milestone	Inactive Task	Manual Summary Rollup	Progress		
Summary	Inactive Milestone	Manual Summary			
Project Summary	Inactive Summary	Start-only			

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
26	Reports	10 days	Tue 2/27/24	Mon 3/11/24		Client,Implementation,HES IT
27	History	10 days	Tue 2/27/24	Mon 3/11/24		Client,Implementation,HES IT
28	Reconciliation	10 days	Tue 2/27/24	Mon 3/11/24		Client,Implementation,HES IT
29	UAT	20 days	Tue 3/12/24	Mon 4/8/24	23	Client
30	**Development release to production**	5 days	Tue 4/9/24	Mon 4/15/24	29	HES IT,Client
31	**Phase 3: Communications and Training**	**26 days**	**Tue 3/19/24**	**Tue 4/23/24**		
32	**Communications**	**26 days**	**Tue 3/19/24**	**Tue 4/23/24**		
33	Communication to Claimant (RX Card	10 days	Wed 4/10/24	Tue 4/23/24	40FS-5 days	Implementation,Client
34	Policy Holder	10 days	Tue 3/19/24	Mon 4/1/24	39FS-30 days	Implementation,Client
35	**Training**	**15 days**	**Wed 3/27/24**	**Tue 4/16/24**		
36	Client Introductory Training	1 day	Wed 3/27/24	Wed 3/27/24	40FS-15 days	Implementation,Client
37	Client Go Live Training	1 day	Tue 4/16/24	Tue 4/16/24	40FS-1 day	Implementation,Client
38	HES Internal Training	1 day	Thu 4/11/24	Thu 4/11/24	40FS-4 days	Implementation
39	**Phase 4: Production/Go Live**	**10 days**	**Tue 4/16/24**	**Mon 4/29/24**		
40	Transactions processing in Healthesyster	1 day	ue 4/16/	Tue 4/	30	ent
41	Pharmacy conversion efforts	10 days	ue 4/16/24	Mon 4/29/	40FS-1 ay	mplementation
42	**Phase 5: Post Implementation Validation**	**32 days**	**Wed /24**	**Thu 30/24**		
43	Verify Client's production data	30 days	Wed 4/17/	Tue /28/24	0	mplementation,HES IT
44	Conduct Client Review Meetings	30 days	4/19/2	Th 5/30/24	4 S+2 ays	mplementation,Client

Dec 13, '20 | Jan 10, '21 | Feb 7, '21 | Mar 7, '21 | Apr 4, '21

M F T S W S T M F T S W

Project: Gray Insurance PBM Imp
Date: Tue 10/17/23

Task	External Tasks	Manual Task	Finish-only		
Split	External Milestone	Duration-only	Deadline		
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Project: Gray Insurance PBM Imp
Date: Tue 10/17/23

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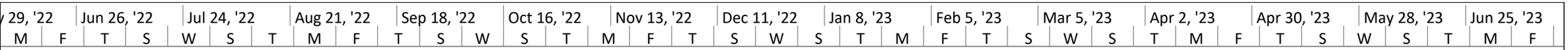
Project Summary	Inactive Summary	Start-only			

Project: Gray Insurance PBM Imp
Date: Tue 10/17/23

Task		External Tasks		Manual Task		Finish-only	
Split		External Milestone		Duration-only		Deadline	
Milestone		Inactive Task		Manual Summary Rollup		Progress	
Summary		Inactive Milestone		Manual Summary			
Project Summary		Inactive Summary		Start-only			

Project: Gray Insurance PBM Imp
Date: Tue 10/17/23

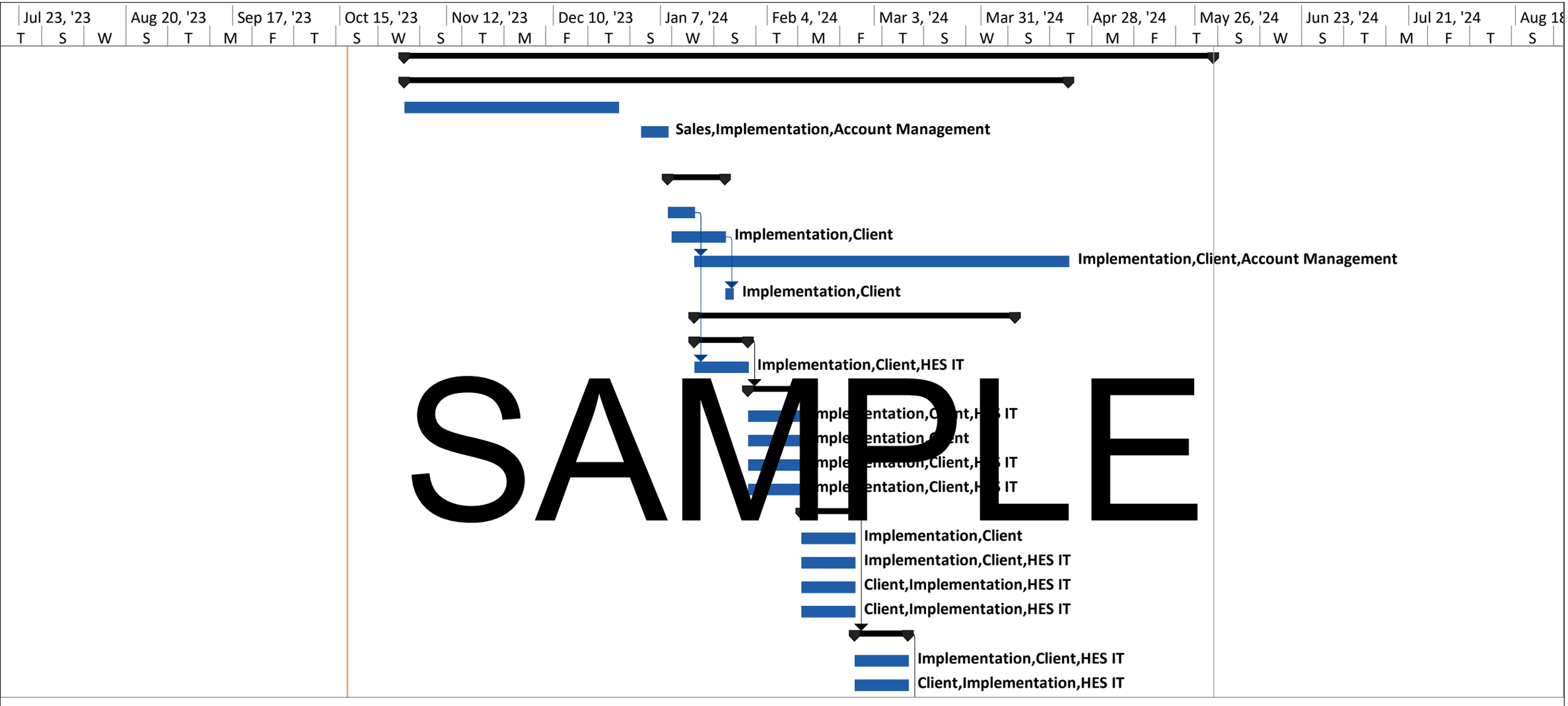
Task		External Tasks		Manual Task		Finish-only	
Split		External Milestone		Duration-only		Deadline	
Milestone		Inactive Task		Manual Summary Rollup		Progress	
Summary		Inactive Milestone		Manual Summary			
Project Summary		Inactive Summary		Start-only			



SAMPLE

Project: Gray Insurance PBM Imp
Date: Tue 10/17/23

Task		External Tasks		Manual Task		Finish-only	
Split		External Milestone		Duration-only		Deadline	
Milestone		Inactive Task		Manual Summary Rollup		Progress	
Summary		Inactive Milestone		Manual Summary			
Project Summary		Inactive Summary		Start-only			



Task	External Tasks	Manual Task	Finish-only
Split	External Milestone	Duration-only	Deadline
Milestone	Inactive Task	Manual Summary Rollup	Progress
Summary	Inactive Milestone	Manual Summary	
Project Summary	Inactive Summary	Start-only	

Project: Gray Insurance PBM Imp
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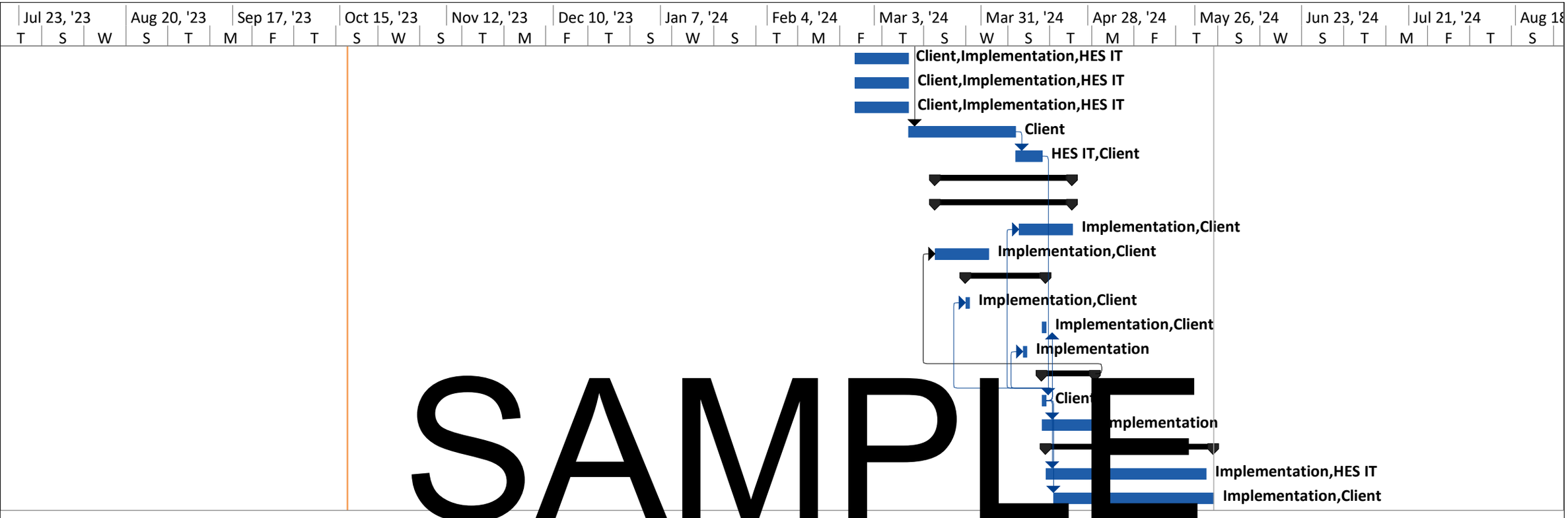


Project: Gray Insurance PBM Imp
Date: Tue 10/17/23

Task	External Tasks	Manual Task	Finish-only
Split	External Milestone	Duration-only	Deadline
Milestone	Inactive Task	Manual Summary Rollup	Progress
Summary	Inactive Milestone	Manual Summary	
Project Summary	Inactive Summary	Start-only	

5.4 Customer Service

1. Confirm the Offeror will provide Enrollees access to Program information on Claimants through separate consolidated toll-free numbers twenty-four (24) hours a day, 365 Days a year.

Medimpact confirms that enrollees will be provided separate toll-free customer service numbers that are available 24 hours a day, 365 days a year.

2. (Exclusive to DCS) Confirm the Offeror will work with The Empire Plan Medical Program, or other party designated by the Department, and AT&T to set up a connection. Confirm the Offeror will provide twenty-four (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.

Medimpact confirms that our customer service center offers TTY/TDD formats for deaf and hard of hearing individuals 24 hours a day, 365 days a year.

3. Confirm the Offeror will maintain separate call centers, located in the United States, for each Program employing a staff of fully trained Customer Service Representatives (CSRs) and supervisors available 24 hours a Day, 365 Days a year. Indicate if any call centers are located in New York State. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00 a.m. and 7:00 p.m. 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 (either through warm transfers or call-back within four (4) hours) to Pharmacist(s) 24 hours a Day, 365 Days a year.

Medimpact confirms that separate call centers located in the United States, are available for each program.

Our call centers are in Tempe, Arizona, and San Diego, California; there are no call centers located in New York state. Dedicated CSRs will be available from 7:00 am to 7:00 pm ET to support DCS members and our entire call center is available 24 hours a day, 7 days a week, 365 days per year.

All CSRs will receive training on DCS' specific benefit plan to accurately answer calls by the go-live date. The client administrator will work with DCS during implementation to set up processes on how to handle calls, override criteria, and provide information to CSRs on benefit setups. Throughout the relationship term, the client administrator will provide CSRs with up-to-date information on procedural changes, run reports for DCS, and educate CSRs on DCS-specific information.

CSRs can easily access system notes with all specific plan details including any DCS-approved CSR responsibilities (vacation override, administrative prior authorizations, emergency medication fill, etc.) and member population nuances (majority of members speak English as second language, elder population, rural pharmacy access challenge, etc.).

CSRs can transfer members requiring assistance from a pharmacist to our PA (prior authorization) department, which provides a dedicated clinical line for the administration of grievances, coverage determinations, and appeals. Providers can leave a message indicating the best date, time, and phone number. On-call pharmacists are available to manage calls within the call-back timeframe required by the Department. MedImpact pharmacist standard business hours to return calls are:

- Monday through Friday: 9 am to 9 pm ET
- Saturday and Sunday: 9 am to 4:30 pm ET

We will maintain a call center for the NYSIF Workers' Compensation program, which is available 24 hours a day, 365 days a year. The call center is geographically diverse with concentrations of agents in FL and AZ as well as several other states to ensure coverage across all time zones. Clinical questions related to prescriptions can be directed to the Clinical Consultation Line (Drug Information Line), which is staffed by the clinical pharmacist team. Claims professionals or other client stakeholders can contact a clinical pharmacist via phone or via email. The clinical pharmacist will answer calls and emails during regular business hours.

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;

b. A sample of the IVR script and a description of customizable options, if any, the Offeror proposes for the Programs;

c. A description of the management reports and information available from the system including the key statistics the Offeror proposes to report; and

d. A description of the capabilities of the Offeror's phone system to record calls, track call types, reasons, and resolutions.

We have information, resources, and system capabilities available for CSRs to address and resolve member inquiries promptly and accurately.

IVR System

DCS

We will provide access to an IVR (interactive voice response) system with advanced speech recognition. Our automated user-friendly IVR system enhances the services and functionality available to our callers, ensuring efficiency, accuracy, and reliability. With a combination of touchtone telephone keypad entry and voice input, the IVR can handle services such as the following:

- Check eligibility
- Check PA (prior authorization) status
- Locate a participating pharmacy

NYSIF

We will not utilize an IVR for NYSIF.

IVR Script

DCS

The IVR menu includes the following prompts to determine if the caller is a pharmacy, member, prescriber, or client:

- If you're a pharmacy, press or say 1.
- If you're a member, press or say 2.
- If you're a physician, press or say 3.
- If you're a health plan or employer group, press or say 4.

If the system cannot complete a voice command, the system routes the call to a customer service representative.

NYSIF

All NYSIF calls are answered by a live person and the use of IVR is not anticipated.

Management Reports

DCS

MedImpact uses MedOptimize®, driven by IBM Cognos®, as our proprietary online reporting tool. Our MedOptimize application includes standard predefined reports and dashboards as well as the ability perform ad-hoc queries and design custom reporting. We will provide call center reporting through our reporting tool. The call log detail report provides detailed information regarding each call reason logged. The client call tracking report provides a summary of inbound calls logged. The report captures the number of calls logged and the number and reasons for calls received broken out by the caller source (participant, client, pharmacy, or prescriber). We will track all calls through an innovative Cisco telephone accounting system. This automated process lets management study the quantity, length of all calls, average speed of answer, and abandonment rate. We will use the data generated from these reports to monitor call activity and staff appropriately during peak periods. We also use scheduling software to further assist in forecasting staffing needs.

NYSIF

We will measure satisfaction with the call center in several key areas, including monitoring of customer service phone calls, data entry accuracy, and process adherence. Call center supervisors perform phone monitoring of their team, as part of the CSRs' performance score and to ensure quality standards are met. Results and available reports include:

- Calls are answered by a live person (100%)
- Pharmacy calls answered within 30 seconds (More than 90%)
- Outbound calls (more than 50%), illustrating our proactive approach to resolving pharmacy processing issues; this equates to a greater % of in-network transactions
- Call abandonment rate (approximately 1.5% – 2%)

Call Recording, Tracking and Resolution

We will record and store 100% customer service center call interactions for performance monitoring, quality standards, and customer service metrics. MedImpact uses a web-based call recording and monitoring system to capture voice recordings and CSR screen input storing CSR call notes in MedAccess® and adhering to our documented guidelines while monitoring calls. MedAccess is a real-time interactive web-based application, which allows authorized users to immediately access and view pharmacy claims data and member/patient information online.

CSRs can review claim and member information directly through their online terminals. In most cases, 99% of inquiries and problems can be handled while the member is on the phone. If CSRs need to escalate phone calls, they have access to an additional research screen for calls that require direction to higher levels, shown in **Figure 3.** Through this screen, questions are transferred to a senior representative and to any appropriate departments. If the situation cannot be resolved, a supervisor provides immediate assistance. CSRs escalate calls for resolution or referral when necessary. Escalated calls are logged in our system as a concern for tracking and reporting purposes and are followed-up by a senior representative who conducts research and follow-up for resolution. The client administrator notifies DCS and the account management team of the concern. The caller receives a follow up call within 1 business day.

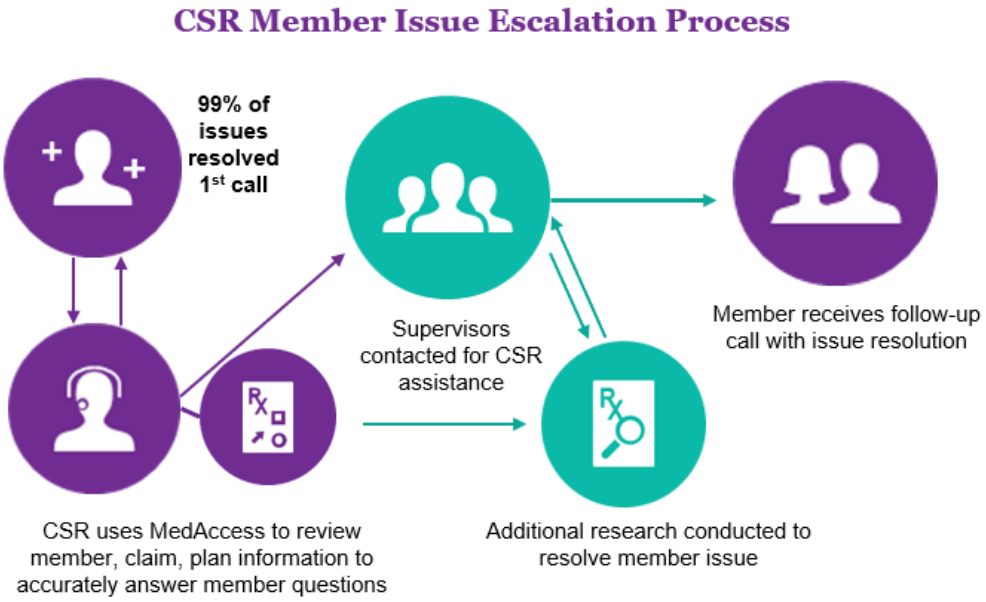


Figure 3: CSR Escalation Process

To achieve a high level of caller satisfaction, our call quality rubric places concentrated emphasis on CSR's performance. Our PICs (performance improvement coordinators) and supervisors review and grade performance using a web-based call recording and monitoring system. We identify and compile improvement points (trending plan issues, growth opportunities for CSRs, etc.) during call monitoring to use as training opportunities.

All (100%) customer service center calls are recorded. Call center supervisors perform phone monitoring of their team to help determine the agents' performance score and ensure quality standards are met.

In addition, a dedicated help desk has a formal escalation process in place to handle disputes or complaints. These escalated items are managed through a consolidated internal database with built-in escalation protocols to disseminate the inquiry to the appropriate department for research and response. The escalation process is tracked and monitored by management to ensure items are responded to promptly. This process also allows for all items to be summarized and reviewed at a higher level to identify trends and opportunities for improvement. These are reported to and reviewed within the quality committee.

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;

b. The first call resolution rate for the proposed call centers;

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

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

DCS's client administrator is charged with providing MedImpact CSR training on DCS's specific benefit plan to accurately answer calls by the go-live date. The client administrator will work with DCS during implementation to set up processes on how to handle calls, override criteria, and provide information to CSRs on benefit setups. Throughout the relationship term, the client administrator will provide CSRs with up-to-date information on procedural changes, run reports for DCS, and educate CSRs on DCS-specific information.

Our CSRs are trained in-house using a formal certification process, and an ongoing training program is provided for all CSRs. All CSR staff and the clinical pharmacist teams will be trained on NYSIF's program and requirements as part of the implementation process. A dedicated clinical pharmacist will be assigned to NYSIF that will serve within NYSIF's cross-functional account team. This person will work with NYSIF on all clinical management and interventional aspects of the PBM program and with additional clinical pharmacist resources to execute NYSIF clinical strategies.

Internal Reviews

DCS

To achieve the highest level of caller satisfaction, we emphasize CSR performance. Our performance improvement coordinators and supervisors review and grade performance using a web-based call recording and monitoring system. We will compile issues identified during call monitoring to use as training opportunities. We will conduct mock calls, provide mandatory knowledge checks, and continually coach on improvement opportunities 1-on-1 and in staff meetings. We will continue to build the CSRs' knowledge and skills through monthly knowledge checks that we provide 5 to 10 questions based on topics identified via quality reviews, job aids, and individual training.

Our CSRs will have at least 15 calls reviewed for quality per month. A CSR supervisor will review 5 calls, and the quality assurance team will review 10 calls. The number of calls reviewed may vary based on business needs.

NYSIF

Quality is measured across our entire organization including all aspects of customer service, transaction adjudication, billing, technology development, etc. Key areas of quality include monitoring of customer service phone calls, data entry accuracy, and process adherence. As part of their job responsibilities, call center supervisors perform phone monitoring of their team as part of the agents' performance score, and to ensure quality standards are met. Additionally, as an ongoing exercise and to meet URAC standards, Healthesystems initiates regular QIPs (Quality Improvement Processes) and reports the results on a regular schedule. Related to the quality team, we also have an internal audit team that does ad hoc, quarterly, or annual audits of key operational processes.

The quality team documents quality scores and coaching opportunities at the time of the review. Coaching and feedback may occur in real-time, depending on the urgency of the findings. Urgent issues or concerns are escalated to the quality team and findings are provided to the appropriate manager. Also, the Account Manager receives an escalation from the quality team so items can be followed up with the customer, as needed. All customer service and quality issues are documented and tracked within our system and reported monthly. As part of our customer service agents' monthly performance feedback, quality scores are reviewed, and opportunities for improvement are identified.

First Call Resolution Rate

DCS

We resolve more than 99% of calls during the first call; if the issue needs additional research, we escalate it for follow-up and resolution. Our first call resolution rate is 99.65%. for 2023. Our goal is to respond/acknowledge an issue that has been reported within 24 hours. Depending on the type of issue being reported resolution may vary; however, we stay in constant contact with our customers throughout the resolution process.

NYSIF

All calls will be answered by a live person and more than 90% of calls are answered within 30 seconds or less. Some of the primary functions of the CSR include handling prior authorizations, updating injured worker profiles, locating participating pharmacies for injured workers, and answering general drug-related questions. Our workflow often requires outreach to the client for review and decision; those calls are not able to be resolved within one call, but we resolve all calls as quickly as possible.

Call Center Locations, Staff, and Turnover Rate

DCS

Our call centers are in Tempe, Arizona, and San Diego, California. There are typically around 150 CSRs and 10 supervisors employed in our call centers. The 2023 CSR turnover rate is 4.78% with 0% turnover in supervisors over the past 2 years.

NYSIF

Our call center is geographically diverse; we have concentrations of agents in FL and AZ as well as several other states to ensure coverage across all time zones. Our average staff size is 37, including managers, supervisors, specialists, QA and other support personnel. Our overall turnover rate is 14%.

Ratio of Management and Supervisory Staff

DCS

Our staffing ratio is approximately 1 supervisor for every 12 to 15 CSRs and 1 manager for every 7 supervisors.

NYSIF

Our staffing ratio is 1 team lead and 1 supervisor for every 10-12 customer service specialists. Currently there is 1 manager for the CSC.

Proposed Staffing Levels

DCS

We plan to add 20 CSRs to provide exceptional customer service and meet the needs of the New York Department of Civil Service.

We can increase capacity to 200% of our normal call volume in 90 days or less in preparation for our peak season (typically from January to March). If required, MedImpact can exceed 200% to meet the needs of our clients. Our successful implementation process will use historical data that DCS will provide such as claim data and call volume to forecast factors of current similar clients to generate volume and workload assumptions. We factor in service level targets to ensure adequate staffing is in place to support the new implementations in addition to the overall book of business. We use call center tools such as NICE IEX Totalview, Cisco Unified Intelligence Center, and Calabrio call recording to analyze and adjust the staffing plan accordingly. We use the IEX Workforce Management System to forecast and monitor key performance indicators. IEX enables our customer service management team and individual customer service staff to establish and track their schedules and predict future staffing needs based on customer service utilization data. MedImpact also uses Calabrio, an application that allows us to sample, monitor, and analyze calls and make decisions on resource allocation and training needs. We use algorithms, reports, direct observation, and performance metrics to continuously monitor and adjust staffing in response to seasonal variations, increased call volume in response to outbound call campaigns or program changes, and client's direction.

NYSIF

Based on our experience and historical workload with managing programs of similar/larger size to NYSIF, combined with our understanding of NYSIF's volume, the projected staffing increase would be an additional 10 specialists, 1 team lead, and 1 supervisor. We will also consider additional support in our areas depending on additional scope and/or workflow that may be defined or uncovered during the project rollout.

6. Describe the backup systems of the Offeror's primary telephone system which would be used in the event the primary telephone system fails, is unavailable, or at maximum capacity. If a backup 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 backup system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by the Offeror's Dedicated Call Centers and that the backup call center would only be used in case of system failure or call overflow.

DCS

To ensure continuous support for our clients' enrollees, our call center business structure does not require scheduled closures. Our business continuity processes include redundancies and can immediately start the execution of backup plans.

We confirm that calls will be handled exclusively by our call centers. Backup call centers would only be used in cases of system failure.

NYSIF

For NYSIF, our call system is backed up by a live answer service 24/7/365. If a call holds in the system for more than several minutes, or if a call comes in after operational hours (7am - 11:30 pm ET) the call will route to our live answer service. They provide specific guidance on the information needed for our clients; they gather all the information needed and route it back to us to be handled. If this occurs during the business day, the supervisor will work it as an escalated item. If this occurs during overnight hours, it will be worked at 7am the following morning. Over the past 2 years, approximately 0.6% of our calls have gone to our answer service.

7. (Exclusive to DCS) Describe the information and capabilities your website provides to members and describe the process the Offeror will utilize to develop it. Confirm that the Offeror will develop a customized website for the DCS Program and that it will be operational and available to Enrollees thirty (30) Days prior to the Implementation Date. 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 reimbursement forms, claim status, Prescription drug history for both retail and mail claims and the Drug Lists (Flexible or Advanced Flexible). The Preferred Drug List and the Excluded Drug List must contain 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.

Our Consumer Portal enhances the member experience and is a key component of our multichannel member engagement strategy to help members take control of their health and prescription drug costs. The Consumer Portal expands the member communication and engagement channels with the following:

- Texting between member and MedImpact's mail order pharmacy
- Email engagement (MedImpact's mail order pharmacy)
- Push notifications such as refill reminders (mobile app)
- Reminders to take medication (mobile app)
- Reminders on low refills (mobile app)
- Savings opportunities (mobile app/website)

- PA (prior authorization) approval/denial letters (mobile app/website)

The Consumer Portal allows members to view pharmacy benefits, manage medications, view plan-specific benefit information, manage mail order prescriptions, and more.

- View plan-specific network Pharmacy Locator and GPS (global positioning system) directions
- View plan-specific medication information including PA and UM (utilization management) edits and pharmacy and therapeutic class price shopping
- View plan-specific information based on member's elections
- Submit MedImpact's mail order pharmacy prescriptions electronically (website)
- Transfer prescriptions between network pharmacies (retail to retail, retail to mail, mail to retail) for lowest member price
- View medication and disease-state education
- View utilization
- Track all individual and family accumulators for plan-specific deductibles
- Digital member ID (identification) card for use at any network pharmacy (mobile app)
- Access member help center
- Opt in to receive MedImpact's mail order pharmacy notifications (mobile app)
- Online interactive DMR (direct member reimbursement) form

Custom Website

We can customize the Consumer Portal for DCS. DCS can submit website change requests through its account team to complete the Consumer Portal implementation questionnaire with custom requirements at implementation or throughout the contract. Customization requests are reviewed by MedImpact's solutions team in order to provide an estimate of time needed, any associated costs, etc. back to DCS.

DCS may also cobrand the Consumer Portal. Cobranding opportunities preferred by our clients, at no additional cost, include:

- **Logos**: DCS provides their logo for cobranding
- **Colors**: DCS provides a primary color to apply a theme across the entire site
- **Top banners**: DCS provides images reflecting DCS's internal culture or use banners as redirect links to DCS's external site promoting new programs and services
- **Welcome message**: DCS provides specific messaging about plan, purpose, or member approach to prescription benefits
- **Custom links**: DCS provides client-specific links that send members to a specific site or document(s) hosted by DCS
- **Consumer Portal disclaimers customization**: DCS can customize portal disclaimers

For a fully branded portal that looks and feels just like DCS's website, MedImpact may require an additional fee. Our Consumer Portal works with DCS's website to provide single sign-on with pass-through authentication.

Website Information Availability

MedImpact confirms the following information will be available on the website:

- DCS Program benefits
- Network Pharmacy locations
- Eligibility
- Mail service order status
- Copayment information
- Claim reimbursement forms
- Claim status
- Prescription drug history for both retail and mail claims
- Drug Lists

Website URL

To log in, perform the following:

- **URL**: medimpact.com
- **Username**: Client demo
- **Password**: Abcd123$*

8. Call Center Telephone Guarantees: For each of the four (4) Call Center Telephone Guarantees below, 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 Telephone Response Time Guarantee: 90% of incoming calls to the Offeror's telephone line must be answered by a customer service representative within sixty (60) seconds.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a credit 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. The Standard Credit Amount is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

b. Call Center Availability Guarantee: The Offeror's telephone line must be operational and available to Enrollees, Claimants, Dependents and Pharmacies 99.5% of the Offeror's Call Center Hours.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five- tenths percent (or the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available during the Offeror's Call Center Hours. The Standard Credit Amount is $100,000 per quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

c. Telephone Abandonment Rate Guarantee: No more than 3% of calls to the Offeror's telephone line will disconnect a call prior to the call being answered by a customer service representative.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a credit 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). The Standard Credit Amount is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts.

d. Telephone Blockage Rate Guarantee: No more than 3% of incoming calls to the Offeror's telephone line will be blocked by a busy signal.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a credit 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). The Standard Credit Amount is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lower amounts

We will commit to meeting the call center performance guarantees for DCS and NYSIF, as required. We regularly exceed the requested metrics and are confident in the ability to uphold these standards. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

9. Secure Online Customized Website Guarantees (Exclusive to DCS): The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fees, for failure to meet the Offeror's proposed guarantee.

a. Website Accuracy Guarantee: The Offeror shall take no more than 3 Business Days to correct information appearing on the customized website.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each Business Day in excess of the standard of 3 Business Days (or the Offeror's proposed guarantee) to correct inaccurate information on the customized website. The Standard Credit Amount is $25,000 per each quarter for DCS. However, Offerors may propose higher or lower amounts.

b. Website Update Timeliness Guarantee: The Offeror shall take no more than 5 Business Days to post correct information to the customized website.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a credit against the Claims Administration Fee for each Business Day in excess of the standard of 5 Business Days (or the Offeror's proposed guarantee) to post accurate information on the customized website. The Standard Credit Amount is $25,000 per each quarter for DCS. However, Offerors may propose higher or lower amounts.

We will commit to having the required customized DCS website consistently available with accurate information. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

5.4 Exhibits

There are no referenced exhibits in Section 5.4, however, Attachment 6 includes our customer service performance guarantees as requested. Attachment 6 is included at the end of the Technical Proposal.

5.5 Empire Plan Medicare Rx (Exclusive to DCS)

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.

We have supported Medicare Part D since 2006 when CMS introduced the program. We support clients who offer Medicare Part D, PDP (prescription drug plan), EGWP (employer group waiver plan), Medicare-Medicaid plan, special needs plan, and RDS benefits. MedImpact reviews all forms of CMS guidance including the annual call letter, daily HPMS memos, CMS manual chapters, and other memoranda. We participate in the PCMA (Pharmaceutical Care Management Association) and NCPDP forums and committees to ensure that all MedImpact Medicare Part D programs meet regulatory requirements.

Our GPS department tracks and monitors CMS requirement changes, helping every client stay compliant in the ever-changing CMS regulatory environment. Annually, our GPS department updates the Medicare.gov plan finder file submission, model member communications, CMS-required reporting, and other CMS-required plan sponsor changes. Monthly webinars share regulatory CMS updates with plan sponsors along with our plan to implement them for the upcoming plan year.

We will assign a Medicare Part D specialist to every client. We also assign a PDE (prescription drug event) analyst if we perform PDE (prescription drug event) submission. These 2 Medicare Part D specialists work with plan sponsor's account management team providing competitive overall cost management, flexible plan design, clinical pharmacy management, and comprehensive statewide pharmacy networks. We generate and quality checks CMS-required reports before giving them to plan sponsors 2 weeks before submission to CMS.

We build quality assurance controls, processes, and response loops into each phase of the Medicare Part D business driving successful processing standards and CMS-adherent policies and procedures by identifying key performance indicators, establishing performance goals, and consistently measuring and reporting results to clients. Additionally, MedImpact works with plan sponsors to perform the following:

- Develop and implement clinical, network, and plan changes to maintain high clinical quality while focusing on lowering overall net cost
- Complete annual market checks, adjustments, and maintenance of current market rates and pricing levels to remain competitive
- Track and monitor CMS guidance and exploration of solutions in advance of emerging market developments

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, including providing temporary Commercial Coverage for Enrollees and/or Dependents who are pending enrollment by Medicare

c. Enrollee Opt-Out process

d. Eligibility Reconciliations on a cadence and format determined by the Department

e. Medicare Beneficiary Identifier (MBI) administration

f. Formulary management

g. Issuing of Medicare PDP EGWP member identification cards

h. Member Communications, including required explanation of benefits statements

i. Claims Processing

j. Administration of a Medicare D supplemental wrap with the goal of providing Medicare-primary Enrollees with a prescription drug benefit that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and dependents

k. Ensure an override process for medications covered under the Medicare PDP EGWP when providing temporary Commercial Coverage for Enrollees and/or Dependents who are pending enrollment or re-enrollment by Medicare.

l. Timely administration of catastrophic reinsurance claims

m. Administration of Low-Income Subsidy requirements, including direct reimbursement of Low-Income Subsidies to eligible Enrollees of the Plan

We understand the requirements and have the experience to support the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap for The Empire Plan.

EGWP Premium Development

Our underwriting team will work closely with the State of NY with your actuarial consultants to help develop your EGWP premiums.

Enrollment

The EGWP enrollment and disenrollment process includes the following steps:

- The client provides an enrollment file with all applicable elections, terminations, and changes. Clients have the option of sending enrollment records in our proprietary file format or we can also accept an x834 file.
- We will pick up the file and review the file ensuring client uploaded complaint and clean records. The EGWP team manages any records requiring clarification or compliance approval in coordination with the client and loads the records into the enrollment system once approved.
- Enrollment and disenrollment records are sent to CMS for approval and eligibility data is sent to MedImpact daily, so PBM and enrollment databases align.
- Once CMS processes the record, CMS returns TRC (transaction reply to codes) that trigger CMS required member notifications and update eligibility data. CMS approval generally occurs within 24 to 48 hours. Clients receive a copy of the CMS TRR file containing all TRC activity.

- We generally process enrollment transactions including new enrollment and disenrollment within 24 to 48 hours from receipt mailing proper member notification within CMS timeframes.
- CMS processes enrollments with effective dates beginning on the first of the month and processes terminations effective on the last day of the month.

Eligibility Reconciliation

We will send a file to the client at a mutually agreeable timeframe to assist with eligibility reconciliation.

MBI Administration

In the past, we have assisted employer groups with obtaining the Medicare identifier (HICN); however, with the implementation of the MBI (Medicare beneficiary identifier), employer groups must obtain the MBI and submit it when enrolling the member. Members submitted without the MBI fall into the request for information process where we mail the prospective member a letter requesting the missing information within a given timeframe.

Formulary Management

We update standard Medicare Part D formularies weekly, monthly, quarterly after P&T (pharmacy and therapeutic) meetings, and annually. Negative formulary changes occur between February through September of the current plan year.

ID Cards

VibrantRx provides all CMS-required EGWP communications, including a VibrantRx ID card.

Member Communications

We will mail all CMS communications including all pre-enrollment, Welcome Kit and/or Annual Notice of Change communications, and all standard enrollment-related and Transition of Care notices. We will also explain benefits that include upcoming negative formulary changes for members taking the impacted drug at least 30 days prior to the formulary change effective date. In addition, we provide a future formulary change document to all members showing upcoming negative formulary changes at least 30 days prior to the effective date. We update and post future formulary change documents and comprehensive formularies on group websites.

Claims Processing

Our system provides flexible benefit designs for claims processing for various lines of business, including EGWP. During implementation we will obtain DCS benefit design requirements for EGWP claims processing. For the first 30 days of the new plan year, we perform close monitoring of claims activity to ensure accurate processing.

Supplemental Wrap Administration

We support EGWP benefits providing commercial (non-Medicare Part D) wrap-around coverage that supplements a basic Medicare Part D benefit package, so plans can apply the manufacturer coverage gap discount before the other commercial payer provides any coverage or financial assistance. Most EGWP clients use a commercial wrap to cover

non-Medicare Part D drugs and wrap the Medicare defined standard benefit. The wrap provides real time integration. If the claim is not approved under Medicare Part D, the claim approves under wrap seamlessly with no delays to members.

Override Process

Administrative PA (prior authorization) refers to the process in which we evaluate dispensing of drugs on behalf of our client. Such evaluation does not require professional consultation with a prescriber, prescriber office staff, nurse, clinical pharmacist, and other persons authorized to prescribe medications or other health care professionals. The following are some administrative PAs:

- Vacation overrides
- Lost/stolen/spilled overrides
- Emergency PAs
- School supply
- Facility overrides

Our pharmacy help desk staff manages administrative PAs. We include administrative PAs in the administrative fee.

Catastrophic Reinsurance Claims

CMS pays annually, approximately 1 year after the end of the plan year, 80% of any enrollee claim costs processed in the catastrophic phase of the benefit, which we pass back to the client when received. We pay prospective reinsurance payments monthly that we reconcile against the actual incurred reinsurance costs during the normal annual reconciliation process. If the prospective reinsurance payments exceed the actual incurred reinsurance amount calculated during reconciliation, CMS recoups the difference. If the prospective reinsurance payments are less than the actual incurred reinsurance amount, DCS will receive payment of the difference in accordance with current reconciliation processes.

Low Income Subsidy

We support the following low-income subsidy programs:

- **Low-income cost sharing subsidies**: CMS makes the employer whole annually for the reduced copays paid by low-income members. DCS will receive remittance as part of the year end reconciliation process (for the prior plan year) within 10 business days of receipt from CMS (determined by MARx payment calendar, but generally the first of the month).
- **LIPS (low-income premium subsidies)**: An amount CMS pays for members identified as low income, based on federal poverty guidelines, to subsidize premium payments. We will pass these subsidies to DCS monthly. If the member pays a prescription premium, the employer group must remit these subsidies to the member and/or MedImpact can send any LIPS refunds directly to the member.

3. Confirm that the Offeror 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 Rx Program on behalf of the Department.

MedImpact confirms.

4. Provide a copy of your proposed Medicare Part D formulary in combination with your Medicare Part D supplemental wrap coverage and provide a side-by-side comparison in Excel to your proposed Empire Plan Advanced Flexible Formulary. Comment on reasons for variances. Please note that the Department's goal is to provide benefit s and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and dependents.

Please see the side-by-side comparison in Excel of our formulary to the Empire Plan Advanced Flexible Formulary, which due to file size, has been included on the USB drives as **5.5 Exhibit A**.

5. Provide a sample member communications package, including proposed benefit card, for the Empire Plan Medicare Rx.

Please see **5.5 Exhibits** tab for a sample ID card. Due to file size, sample welcome kit documentation has been included on the USB drives as **5.5 Exhibit B**.

6. Describe in detail the transition services the Offeror 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.

VibrantRx follows the standard transition process or transition of care that meets CMS guidelines providing temporary, unrestricted access to both nonformulary Medicare Part D drugs and Medicare Part D drugs with UM (utilization management) restrictions (prior authorization, step therapy, and quantity limits). The transition process is necessary with respect to the following types of members:

- New enrollees following the annual coordinated election period
- Newly eligible Medicare beneficiaries from other coverage
- Enrollees who switch from 1 group to another after the start of a contract year
- Current enrollees affected by negative formulary changes across contract years
- Enrollees residing in LTC (long-term care) facilities

VibrantRx provides a 120-day transition period beginning on the enrollee's effective date of coverage for new members who take 1 of the following 6-drug classes of clinical concern:

1. Antidepressant
2. Antipsychotic
3. Anticonvulsant
4. Antineoplastic
5. Antiretroviral
6. Immunosuppressant (for prophylaxis of organ transplant rejection)

VibrantRx also places in transition current members who need of a 1-time emergency fill or prescribed a nonformulary drug as a result of a level of care change. For a current member who a negative formulary change will affect in the upcoming year, VibrantRx provides a transition process at the start of the new contract year or prior to the start of the new contract year.

For groups that elect to administer the perpetual grandfathering program, the program allows members to receive continued coverage of a Medicare Part D drug so that enrollees would not go through the transition process.

Retail Pharmacy Setting Transition

For new members in the retail pharmacy setting, the transition process provides for at least a 1-time temporary fill of at least a month's supply of medication (unless the enrollee presents with a prescription written for less than a month's supply in which case VibrantRx allows multiple fills to provide up to a total of a month's supply of medication) anytime during the first 90 days of a member's enrollment in a group, beginning on the enrollee's effective date of coverage.

LTC Pharmacy Setting Transition

For new members in the LTC pharmacy setting the transition process provides for at least a 1-time temporary fill of at least a month's supply of medication (unless the enrollee presents with a prescription written for less than a month's supply), which dispenses incrementally as applicable and with multiple fills provided if needed during the first 90 days of a beneficiary's enrollment in a group, beginning on the enrollee's effective date of coverage. After the transition period's expiration, the transition process provides for a 31-day emergency supply of nonformulary Medicare Part D drugs (unless the enrollee presents with a prescription written for less than 31 days) while requesting an exception or prior authorization. For an enrollee that an LTC facility admits or discharges, VibrantRx removes early refill edits and enrollees can access a refill upon admission or discharge.

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

DCS will provide an enrollment file with all applicable elections, terminations, and changes to VibrantRx. Clients have the option of sending an enrollment change file or full file. The change file contains any differences from the last file including new enrollments, disenrollments, and changes to existing members. The full file contains all member information where VibrantRx derives changes by comparing the current full file to the last full file. The client can send this file daily or weekly, depending upon volume and preference.

VibrantRx processes prospective termination records upon receipt and reviews and submits retroactive termination records for compliance review loading PBM eligibility files (Type 23/24) daily and sending records to CMS up to 3 times a day. CMS processes the request returning TRCs (transaction reply codes) with the termination date as the last day of the month. In addition to client submitted terminations, when a member joins another plan, CMS sends termination TRCs, which update the member's eligibility with a termination end date. VibrantRx sends all CMS TRC activity to clients via the CMS TRR (Transaction Reply Report).

8. Describe your capability to provide the services necessary to support and assist the Department in maximizing DCS Program savings by analyzing its experience with the Empire Plan Medicare Rx and recommending other permitted options under Medicare Part D that may be advantageous to the Department, Participating Agencies, Participating Employers, and Enrollees.

We will work to manage trends by controlling appropriate utilization across channels. The client team oversees commercial and EGWP clients and reviews key performance indicators and trend drivers quarterly for each segment, keeping in mind the clinical pipeline for drugs that are coming off patent or new drugs coming to market. The clinical program manager may suggest different cost savings strategies based on the unique situation and trends to help drive low net cost.

Formulary Strategies

The following formulary strategies are offered to manage trend:

- **Restricted formulary**: Providing a cost saving formulary providing significant cost savings and minimal member disruption.
- **Core formulary**: A cost saving, CMS compliant formulary design we offer where generics are stratified throughout the formulary based on cost. The lower cost generics are placed in the lower generic tiers and the highest cost generics are placed into the highest brand tiers. Generics that meet the CMS defined specialty threshold are placed in the specialty tier.
- **Brand for generic strategy**: Controlling costs during generic exclusivity periods by negotiating rebate agreements with the pharmaceutical manufacturers allowing clients to access a significantly lower net price for the brand drugs compared to the generic product
- **Non-extended days' supply**: Limiting all tier 4 drugs (specialty) to a 30 days' supply
- **Wrap drugs**: Placing more expensive wrap drugs on higher tiers or with more restrictive UM (utilization management)
- **UM**: Including UM (prior authorizations, step therapy and quantity limits) in Medicare Part D standard formularies

Clinical Strategies

The following are clinical strategies offered to manage trend:

- **High-cost generic program for wrap drugs**: Managing spend on wrap drugs
- **Adherence programs**: Using different adherence programs proven to reduce costs on the medical side
- **Specialty programs**: Managing high-cost specialty drugs through formulary and specialty programs

Network Strategy

By establishing a preferred pharmacy network, DCS can obtain network cost savings to help manage trends.

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 payer, upon finalization of the subrogation process by CMS, also known as Medicare Secondary Payer.

MedImpact confirms. VibrantRx is responsible for recovering covered Medicare prescription drug costs for which Medicare is not the primary payer. According to CMS regulations in 42 CFR §422.108 and 423.462, VibrantRx, as a Medicare prescription drug plan sponsor, exercises the same rights of recovery that the secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

COB (coordination of benefits) recovery situations occur when VibrantRx retroactively identifies other primary health information at which time we work with the other insurers seeking reimbursement for claims mistakenly paid as primary. Upon receipt of payment, VibrantRx works with MedImpact on all applicable true-up and subsequent PDE (prescription drug event) adjustments.

10. The Offeror must provide documentation confirming its Medicare D Plan Overall star rating by the Centers for Medicare & Medicaid Services (CMS) Star Quality Rating System for 2022, 2023 and 2024.

a. Please provide the last three (3) years (2022, 2023 and 2024) of CMS Star Rating for the Offeror's Medicare D Plan.

b. Has CMS frozen enrollment any time during the last three (3) years?

Our Star Ratings for VibrantRx have progressively improved since VibrantRx began in 2019. We're pleased to share that we've maintained our 3.5 Star Rating for 2024. This rating is the same or higher than most of our competitors and is a testament to the happiness of our members as well as how we manage our EGWP program along with our high performing EGWP clinical programs. The **5.5 Exhibits** tab includes the CMS Star Rating documents for 2021-2024.

We have never had CMS freeze our enrollment.

5.5 Exhibits

The following exhibits were referenced in Section 5.5 and have been provided here per RFP instructions.

Exhibit	Description
5.5 Exhibit A	Side-by-Side Formulary Comparison (not included in hard copy; included on USB flash drive)
5.5 Exhibit B	Sample Welcome Kit (not included in hard copy; included on USB flash drive)
5.5 Exhibit C	Sample ID Card
5.5 Exhibit D	CMS Star Ratings for 2021-2024

vibrantrx prescription drug plan

Client Logo

PO Box 509097 | San Diego, CA 92150

<MemberFirstName> <MI> <MemberLastName>
<MemberPOAAddressLine1> <MemberPOAAddressLine2>
<City>, <ST> <ZIP>

Member ID: <MemberID>
Effective date: <EffDate>

Welcome to VibrantRx (PDP)!

<Date>

Dear <MemberFirstName> <MemberLastName>,

VibrantRx™ (PDP) is pleased to welcome you as a member of our plan for your Medicare Part D prescription drug coverage. Your prescription drug identification (ID) card attached will allow you to access your prescription drug benefits. You may start using your prescription drug ID card as of the effective date at the top of this letter. Please confirm that the name on your card is correct. If your card has incorrect information, please call us right away at 1-844-826-3451, 24 hours a day, 365 days a week. TTY users dial 711.

Please detach your prescription drug ID card and keep it with you at all times. Always present your prescription drug ID card to your pharmacist every time you purchase your prescriptions. Your ID card will ensure that you pay the correct cost sharing and that the money you spend is correctly tracked.

If you have any questions regarding your coverage, please call VibrantRx Member Services at 1-844-826-3451, 24 hours a day, 365 days a year. TTY users should dial 711.

Sincerely,

VibrantRx

VibrantRx is a Prescription Drug Plan with a Medicare contract offered by MG Insurance Company. Enrollment in VibrantRx depends on contract renewal.

Peel and remove your ID card here

Member Services 24 hours a day/365 days a year

1-844-826-3451 TTY/TDD: 711

www.MyVibrantRx.com/<group>

Submit pharmacy claims to:
ATTN: CLAIMS DEPARTMENT
VibrantRx
PO Box 509097
San Diego, CA 92150

2021 Star Ratings

MG Insurance Company - S3285

2021 Medicare Star Ratings

Every year, Medicare evaluates plans based on a 5-star rating system. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Ratings that focus on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2021, MG Insurance Company received the following Overall Star Rating from Medicare.

★★½
2.5 Stars

We received the following Summary Star Ratings for MG Insurance Company's health/drug plan services:

Health Plan Services:	Not offered
Drug Plan Services:	★★½ 2.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 24 Hours a day Pacific time, 7 days a week at 844-826-3451 (toll-free) or 711 (TTY).

Current members please call 844-826-3451 (toll-free) or 711 (TTY).

Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

vibrantrx prescription drug plan

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2022 Medicare Star Ratings

MG Insurance Company - S3285

For 2022, MG Insurance Company - S3285 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★☆☆
Health Services Rating:	Not offered
Drug Services Rating:	★★★☆☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact MG Insurance Company 24 Hours a day Pacific time, 7 days a week at 844-826-3451 (toll-free) or 711 (TTY). Current members please call 844-826-3451 (toll-free) or 711 (TTY).

vibrantrx prescription drug plan

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2023 Medicare Star Ratings

MG Insurance Company - S3285

For 2023, MG Insurance Company - S3285 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	Service not offered
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact MG Insurance Company 24 Hours a day Pacific time, 7 days a week at 844-826-3451 (toll-free) or 711 (TTY). Current members please call 844-826-3451 (toll-free) or 711 (TTY).

vibrantrx prescription drug plan

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2024 Medicare Star Ratings

MG Insurance Company - S3285

For 2024, MG Insurance Company - S3285 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	Service not offered
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact MG Insurance Company 24 Hours a day Pacific time, 7 days a week at 844-826-3451 (toll-free) or 711 (TTY). Current members please call 844-826-3451 (toll-free) or 711 (TTY).

24STAR

5.6 Member Communication Support

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to develop Member Communication Support specified in Section 3.5 of this RFP, including the following:

1. Describe the role of the Offeror's legal department.

We maintain robust legal and regulatory departments that work with our clients to ensure all member communications are appropriately compliant. Our general counsel and compliance officer provides regulatory, legal, and compliance support as needed.

Regarding communications, our team sends timely communications to clients that summarize key regulatory activity, as well as bills that have potential to affect our clients' business.

2. Provide two examples of communications the Offeror has developed for other clients.

Please see the **5.6 Exhibits** tab for sample customized communications.

3. Confirm the Offeror's 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 the Advanced Flexible and Flexible Formularies communications set forth in Drug List Development and Management within Section 5.15 of this RFP.]

MedImpact confirms.

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

VibrantRx follows all CMS marketing guidance regarding marketing and beneficiary communication requirements. CMS allows cobranding on ID cards, booklets, and many letters. During implementation and annually, VibrantRx will collaborate with DCS to determine any further customizations.

VibrantRx allows flexibility with the pre-enrollment communications. If DCS prefers to send the EGWP pre-enrollment materials with their other retiree communications, VibrantRx will provide the required CMS elements, so DCS can include them in the mailings. However, if DCS elects VibrantRx to manage these mailings, DCS will need to send us the pre-enrollment member file monthly to include any members aging into Medicare within the next 60 to 90 days. Alternatively, VibrantRx can use our standard AppIntake enrollment file that DCS will provide daily or weekly for both pre-enrollment mailings and submission to CMS to enroll each member into the plan.

5. (Exclusive to DCS) Confirm that staff will be available to attend (in-person or virtually) Health Benefit Fairs, select conferences, and benefit design information sessions, etc., in New York State and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events. See Attachment 58, Vendor Attendance, for a summary of DCS Program presentations that took place from 2019-23.

MedImpact confirms. We will work with DCS to determine the appropriate level of representation and support at these events. There are times, in support of DCS we may use TBC (Total Benefit Communications) to support benefit fairs, conferences, benefit design information sessions, etc. This vendor is fully trained to accommodate the various clients MedImpact supports and we have leveraged their services for several years. They consistently receive outstanding reviews from our clients that have utilized their services.

6. Confirm your commitment to work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs. Provide examples of how the Offeror has worked with other large clients to produce customized communications. Provide details on how the Offeror will separate the Programs from other Book of Business clients for enterprise-wide issues such as Global coding errors.

MedImpact confirms. Samples of customized communication have been provided within the **5.6 Exhibits** tab.

We will customize all forms and letters for our customers, including insertion of their logos. Additional customization of existing documents and creation of new documents is available as needed. A version control system separates the codebase between programs to prevent global coding errors with rigorous testing and quality assurance processes in place.

7. (Exclusive to NYSIF) 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.

MedImpact Confirms. Please see the **5.6 Exhibits** tab for a sample communication specific to NYSIF.

8. (Exclusive to DCS) Detail the Offeror's experience in working with large clients who have required customized websites or web portals for benefits information.

We can customize the Consumer Portal for DCS. DCS can submit website change requests through its account team to complete the Consumer Portal implementation questionnaire with custom requirements at implementation or throughout the contract. Customization requests are reviewed by our solutions team to estimate time needed, any associated costs, etc. back to DCS.

DCS may also cobrand the Consumer Portal. Cobranding opportunities preferred by our clients, at no additional cost, include:

- **Logos**: DCS provides their logo for cobranding
- **Colors**: DCS provides a primary color to apply a theme across the entire site
- **Top banners**: DCS provides images reflecting DCS's internal culture or use banners as redirect links to DCS's external site promoting new programs and services
- **Welcome message**: DCS provides specific messaging about plan, purpose, or member approach to prescription benefits
- **Custom links**: DCS provides client-specific links that send members to a specific site or document(s) hosted by DCS
- **Consumer Portal disclaimers customization**: DCS can customize portal disclaimers

For a fully branded portal that looks and feels just like DCS's website, we may require an additional fee. Our Consumer Portal works with DCS's website to provide single sign-on with pass-through authentication.

9. Complete a second Biographical Sketch Form (Attachment 14), for all staff proposed for involvement in Member Communication Support.

Biographical information for each proposed team member is included within the **5.2 Exhibits** tab.

The primary staff members involved in member communication support for NYSIF are Randall Corcoran, Account Manager, Senior; Philip Hayes, Account Representative; and Debbie Hill, Director of Operations.

10. (Exclusive to DCS) Member Communication Support Guarantee. Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each occurrence of a form or letter, including but not limited to notification of drug recalls or withdrawals and notification of mid-year formulary changes, that is not mailed within 30 Calendar Days of DCS' requested effective date (e.g., for a Prior Authorization change that will be effective April 1, letters need to mail by March 1). The forfeited amount (Standard Credit Amount) for each type of form or letter not mailed within 30 Calendar Days is $1,000 per occurrence, calculated quarterly. However, an Offeror may propose higher or lower amounts.

We will commit to meeting the member communication support types and timelines required.

Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

11. (Exclusive to DCS) Formulary Coding Accuracy Guarantee. Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each instance of incorrect coding, such a coding not updating to reflect formulary decisions for the start of the Plan Year, or the Offeror applying Book changes to the Plan without DCS approval. The forfeited amount (Standard Credit Amount) for each occurrence of incorrect coding being applied is $1,000 per occurrence calculated quarterly. However, Offerors may propose higher or lower amounts.

We commit to ensuring formulary information is accurately coded within our system and takes responsibility for instances of incorrect coding. In the event book of business system updates are made, DCS will be informed by your account management team ahead of time. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

5.6 Exhibits

The following exhibits were referenced in Section 5.6 and have been provided here per RFP instructions.

Exhibit	Description
5.6 Exhibit A	Sample Custom Communications
5.6 Exhibit B	NYSIF Sample Custom Communication
Attachment 6	Performance Guarantees (included at the end of the Technical Proposal)

Dollar Tree Pharmacy Plan Top FAQs

1. **Who Is MedImpact?**
MedImpact was founded more than three decades ago by a pharmacist and independent drug store owner who saw firsthand how families struggled with the high cost of prescriptions, and how it impacted their lives. While MedImpact has grown to be one of the nation's leading Pharmacy Benefit Managers, we are as committed to these principles today as we were in 1989. Our vision is to help improve the wellness of communities and individuals by making healthcare understandable and accessible. Our mission is to use world-class clinical expertise, technology, and innovative thinking to engage people to lead healthier lives.

2. **Why do I have to switch my medicine and how do I find an alternative?**
There may be more than one drug that can treat your condition. A drug may be excluded from coverage because other formulary drugs have the same clinical benefit and may cost less. The Dollar Tree plan can "prefer" certain drugs that are just as effective and appropriate. These drugs are called "formulary/preferred drugs" and may be offered at a lower cost. Ask your doctor if a formulary/preferred drug is right for you. You can use the Drug Price Lookup Tool found in your member portal to find covered drugs on your plan. Your doctor also has access to your drug formulary and preferred alternatives.

3. **Can I get a 90-day supply of medicine at my local pharmacy?**
Yes. If you'd like to get a 90-day supply of your maintenance medicine, you may pick it up at your participating local network pharmacy or use Birdi™, formerly known as MedImpact Direct Mail, for free home delivery.

4. **What is the Mandatory 90 Day Maintenance Program?**
After two 30-day fills of a maintenance medication, associates and their dependents are required to fill a maintenance medication for a 90 days' supply. Medications can be filled at either a Choice90 retail pharmacy or by Mail Order. Certain medications, such as controlled substances, are excluded from this program.

5. Can you explain the Prior Authorization (PA) process?
The Dollar Tree plan requires specific drugs to be reviewed against plan criteria to decide if the medicine is being prescribed for the appropriate diagnosis and dosage. The outcome of the review will determine if coverage is accepted or denied. If your request for prior authorization is denied, you will receive a letter explaining your rights to appeal the decision.

To check on the status of a prior authorization, call MedImpact customer center toll-free at 1-888-388-1229 (TTY dial 711), 24/7/365 days.

6. How does the Appeals process work?
If your Prior Authorization (PA) request is denied, you or your doctor can request an Appeal of the decision. The Appeal process is summarized in a letter you will receive notifying you of the decision to deny your PA request.

7. What is Step therapy?
Step therapy is a type of prior authorization that requires you to try a more cost-effective and/or safer drug before a non-preferred drug is covered.

8. What diabetes meters and test strips are on the MedImpact formulary?
Diabetes meters and test strips are listed under Diabetic Supplies within the Preferred Drug List (PDL). Freestyle and Precision test strips made by Abbott are the preferred test strips. Members can get a free meter when they use the Freestyle and Precision test strips.

9. How do I set up my account on the MedImpact website? And why can't I see all my family members?
To set up your MedImpact user account, visit www.MedImpact.com.
Follow the prompts to create a new user ID and password. The information provided by you should match what is on your Medical ID card.

- If you are experiencing issues, please call 1-888-388-1229 (TTY dial 711).
- An alert will appear next to the bell icon on your dashboard if your profile is incomplete.
    - Click on the alert to bring you to the section that needs to be completed.

- You can also click the down arrow by your name (profile drop down section) in the upper right corner of the screen and select "Settings".
- A red dot will appear next to any section that needs to be filled out to complete your profile.

- To view your dependents, select the down arrow by your name (profile drop down section) in the upper right corner on your dashboard.
  - Select the "Add Dependent/Add Other Users" button which will take you to the "View Dependents" section.
  - In this section, dependents under 12 years old will automatically be viewable (listed under "Members I Can View").
  - To view other dependents 12 years old and older, you will need to request access to their accounts due to privacy concerns (e.g. the user must have set up his/her own account and registered to be viewable).
  - Click "Request View Access" and enter member first and last name, date of birth, and member number (make sure the information provided matches what is on his/her ID card).

  Member account will show a pending request. Once the request is accepted, the member will show up in the "Members I Can View" section, click on the member and their account will be available to view.

10. Who do I call at MedImpact?

General Questions:
MedImpact Customer Service (See back of ID card)
1-888-388-1229 (TTY dial 711), 24/7/365 days a year.

Mail-order Questions:
Birdi™, 1-855-873-8739 (TTY dial 711),
Monday – Friday from 8AM-8PM Eastern Time and Saturday from 9AM-5PM Eastern Time. Pharmacists are available 24/7/365 for urgent clinical consultations.

Specialty Questions:
MedImpact Direct Specialty, 1-877-391-1103 (TTY dial 711),
Monday – Friday from 8AM to 8PM Eastern Time.

Learn more at www.medimpact.com or use the QR code below. Apple users can scan QR code with their iPhone, iPad, or iPod if it has a working camera. Smartphones with updated software versions may also be able to scan QR codes by opening the camera and hovering over the attached code:

A 10181 Scripps Gateway Ct, San Diego, CA 92131
P 800.788.2949
MedImpact.com

Kroger
Prescription
Plans

1014 Vine Street
Cincinnati, Ohio 45202

MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

*****BANNER PAGE*****

RECONSIDERATION DECISION

DECISION_DATE

MBR_FIRST_NAME1 MBR_LAST_NAME1
MBR_LINE1_ADDR1
MBR_LINE2_ADDR1
MBR_CITY1, MBR_STATE1 MBR_POSTAL_CODE1

Prior Authorization Reference Number: PA_NUMBER
Member DOB: MBR_BIRTH_DATE
Group Health Plan: CARRIERHQNAME
Plan Name: CARRIERHQNAME1
Plan Code: CARRIERHQCODE

RE: RECONSIDERATION DECISION

Date of Reconsideration request: MRF_RECV_DATE
Date of decision: DECISION_DATE1

Dear Member,

Kroger Prescription Plans is a pharmaceutical benefit management company that provides services to members of Wellfleet Rx. ~~MedImpact is a pharmaceutical benefit management company that provides services to members of CARRIERHQNAME2.~~ Kroger Prescription Plans partners with MedImpact when ~~C~~certain prescription drugs and services require a prior authorization before they can be covered by your benefit plan. When this occurs, your healthcare practitioner will contact MedImpact to request prior authorization.

Based upon the information we received from your healthcare practitioner, PHY_FIRST_NAME PHY_LAST_NAME, we are unable to authorize FN_DRUG_APPR_NAME FN_DRUG_APPR_STR. Listed below is/are the reason(s) for the denial:

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT

This decision is in accordance with your eligibility for coverage and the terms and conditions of your governing plan document's Exclusions & Limitations section in effect at the time services are received. If you need a copy of your governing plan documents, please contact your employer or group health plan.

MedImpact makes prior authorization decisions based upon your benefits as outlined in your plan description in effect at the time services are provided, as well as the information provided by your healthcare practitioner. MedImpact makes those prior authorization decisions within the following timeframes (a) prior to service being provided, fifteen calendar days of receipt for standard requests; (b) prior to service being provided seventy-two hours of receipt for urgent requests; and (c) after service has been provided, thirty calendar days of the receipt of the request for payment.

Copies of information relevant to this reconsideration request, including the rule, guideline, protocol, or criteria that MedImpact relied upon in making this decision, is available to you and your healthcare practitioner upon request and at no charge.

To request, contact us at HELP_PHONE. For hearing or speech impairment assistance please call us at: TTY/TTD use 711. Our customer service center is available 24 hours per day, 7 days per week and 365 days per year. Your healthcare practitioner was also provided the telephone number to call and discuss this decision with a clinical reviewer (pharmacist or physician) if desired.

The ultimate decision to obtain the requested prescription, irrespective of coverage, is between you and your healthcare practitioner.

Sincerely,

AUTHORIZED_BY1 AUTHORIZED_BY2
Standard PA UM Department

cc: Dr. PHY_FIRST_NAME1 PHY_LAST_NAME1
Fax: FN_PHY_FAX

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us **Toll Free at 1-800-788-2949** if you need assistance understanding this notice or our decision to deny you a service or coverage. For hearing or speech impairment assistance please call us at: **TTY/TTD use 711.**

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part). We have denied your request for benefit approval for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.

How do I file an appeal? To file an appeal you can call us at **1-800-788-2949** or write us within **180** days from receipt of this notice to the following address.

Appeals Mail Address Information:
MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131
ATTN: Appeals Coordinator
or
Fax: 858-790-6060

Be sure to include the member's name, ID#, Prior Authorization Reference #, and requestor's name (if different from member). Also, indicate whether the requestor is a Covered member, the member, or an Authorized Representative.

See also the "Other Resources to Help You" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation is urgent, we will notify you of the decision within 72 hours. Generally, an urgent situation is one in which your life, health, or ability to regain maximum function may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you have a medical condition such as that described above, and it is substantiated by your physician either orally or in writing, you or your treating physician or authorized representative may file a request for an expedited appeal by following the instructions under "How do I file an appeal?" In an urgent situation, you may also submit your request for an external appeal by an independent reviewer at the same time. Please call us at the number listed under "Appeals Contact Information" for assistance in requesting the external, independent review. Upon request for an external, independent review, you will be considered to have exhausted the internal appeal process.

Appeals Contact Information:
For questions about your appeal rights, this notice, or for assistance to file an appeal, write to the address above, or call us at:
Toll Free: 1-800-788-2949
TTY/TTD: 711

Who may file an appeal? You or your authorized representative may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. You may contact us at **1-800-788-2949** to learn how you can appoint a representative. If you have hearing or speech impairment, please call **711**.

Can I provide additional information about my claim? Yes, you may submit written comments, documents, or other relevant information. Please include any additional information with the appeal request.

Can I request copies of information relevant to my prior authorization request? Yes, you may request copies (free of charge) by contacting us at the same toll free number or address listed on this page. If a bill or claim is included in your appeal, and you think a coding error may have caused this claim to be denied, you have the right to have billing, treatment and diagnosis codes (and the corresponding meanings, if applicable), and can request this information by contacting either your health provider or your health plan.

What happens next? If you appeal, your appeal will be reviewed by person(s) not involved in the previous decision and provide you with a written determination in no more than 30 days (or 72 hours if your request is urgent). If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your prior authorization request by an independent third party, who will review the denial and issue a final decision. Additional information regarding the external review process will be provided upon request, as well as in the notice if we continue to deny your appeal.

If you are a member of an ACA or ERISA-regulated group health care plan, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency. If you have completed the appeals process without satisfaction, you may have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act.

Other Resources to Help You:
For questions about your appeal rights, this notice, or for assistance you can contact:

Employee Benefits Security Administration at 1-866-444-EBSA (866-444-3272)

Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)
300 Jefferson Blvd, Suite 300
Warwick, RI 02888
(855)-747-3224
RIPIN.org

Office Of The Health Insurance Commissioner
1511 Pontiac Ave
Building #69 First Floor
Cranston, RI 02920
(401) 462-9517
OHIC.Healthinsinq@ohic.ri.gov

SPANISH (Español): Para obtener asistencia en Español, llame al
CHINESE (中文):如果需要中文的帮助，请拨打这个号码
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'
TAGALOG (Tagalog):Kung kailangan niyo ang tulong sa Tagalog tumawag sa

LANG_ASSIST_PHONE

Healthe SYSTEMS

Transforming healthcare.

Healthesystems Exhibit D:
Sample Communications

Prepared for: New York State Insurance Fund

Kristi Klecka
National Sales Director
813-463-1269
kklecka@healthesystems.com
www.healthesystems.com

Healthe SYSTEMS
Transforming healthcare.

Injured Worker Patient Educational Resources

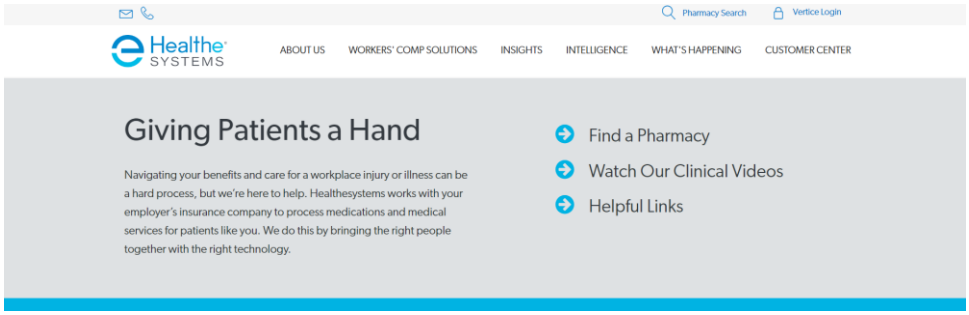
PATIENT PRESCRIPTION BENEFITS RX CARD FLYER

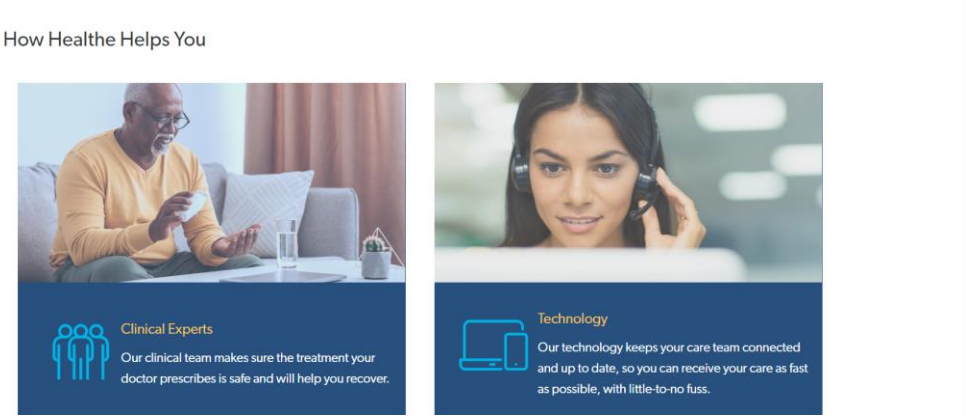
PATIENT

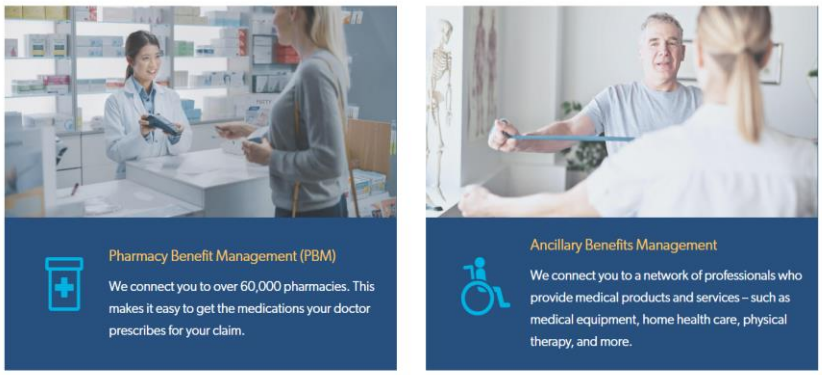
Healthe SYSTEMS

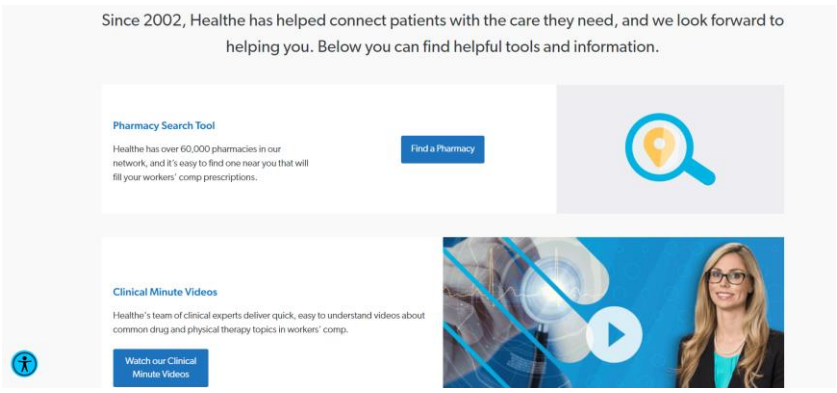
Transforming healthcare.

ONLINE PORTAL









Healthe SYSTEMS

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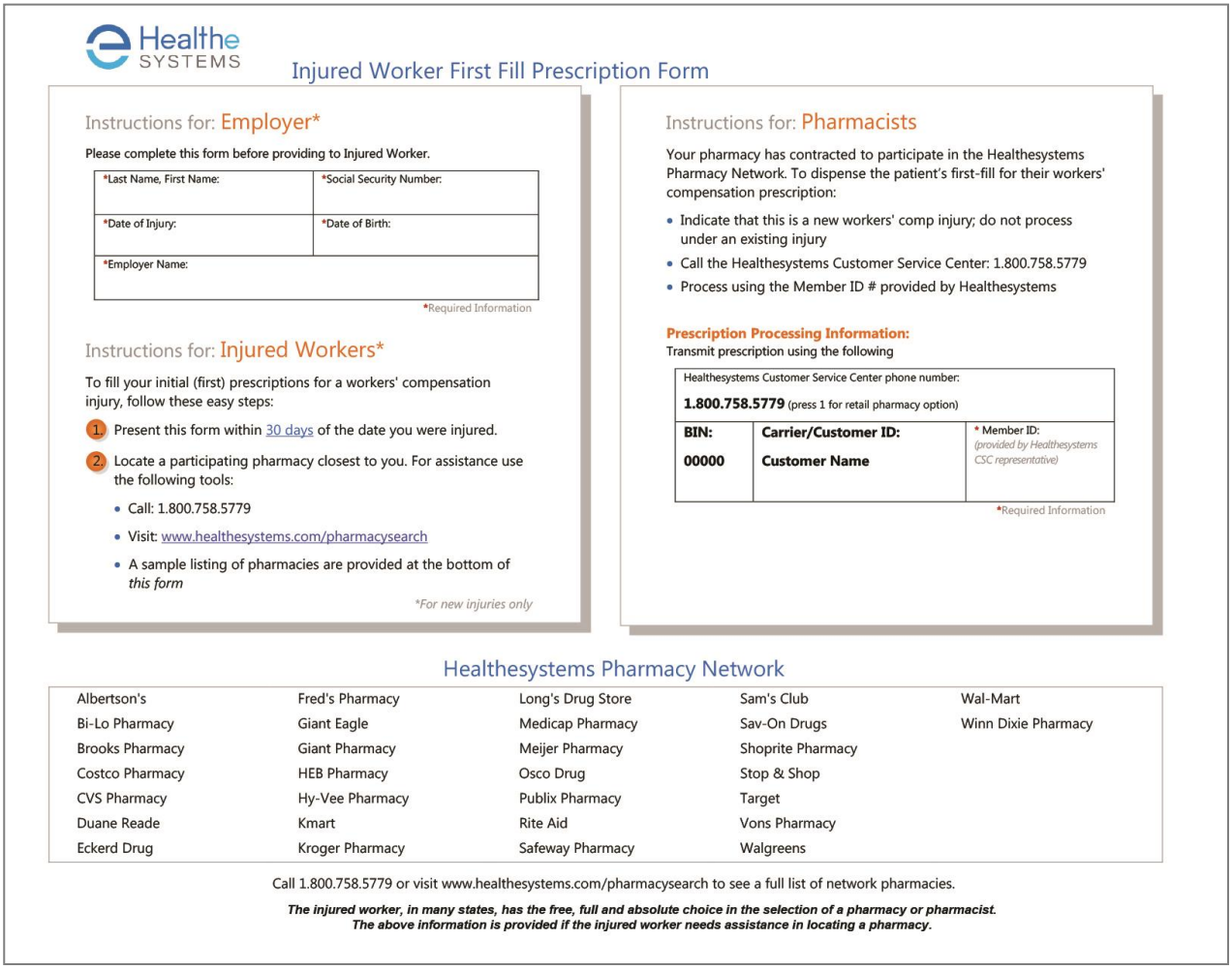
PATIENT FIRST FILL FORM



Healthe SYSTEMS

Injured Worker First Fill Prescription Form

Instructions for: Employer*

Please complete this form before providing to Injured Worker.

*Last Name, First Name:	*Social Security Number:
*Date of Injury:	*Date of Birth:
*Employer Name:	

*Required Information

Instructions for: Injured Workers*

To fill your initial (first) prescriptions for a workers' compensation injury, follow these easy steps:

1. Present this form within 30 days of the date you were injured.
2. Locate a participating pharmacy closest to you. For assistance use the following tools:
   - Call: 1.800.758.5779
   - Visit: www.healthesystems.com/pharmacysearch
   - A sample listing of pharmacies are provided at the bottom of *this form*

*For new injuries only

Instructions for: Pharmacists

Your pharmacy has contracted to participate in the Healthesystems Pharmacy Network. To dispense the patient's first-fill for their workers' compensation prescription:

- Indicate that this is a new workers' comp injury; do not process under an existing injury
- Call the Healthesystems Customer Service Center: 1.800.758.5779
- Process using the Member ID # provided by Healthesystems

Prescription Processing Information:

Transmit prescription using the following

Healthesystems Customer Service Center phone number: **1.800.758.5779** (press 1 for retail pharmacy option)		
BIN: **00000**	**Carrier/Customer ID:** **Customer Name**	* Member ID: *(provided by Healthesystems CSC representative)*

*Required Information

Healthesystems Pharmacy Network

Albertson's	Fred's Pharmacy	Long's Drug Store	Sam's Club	Wal-Mart
Bi-Lo Pharmacy	Giant Eagle	Medicap Pharmacy	Sav-On Drugs	Winn Dixie Pharmacy
Brooks Pharmacy	Giant Pharmacy	Meijer Pharmacy	Shoprite Pharmacy	
Costco Pharmacy	HEB Pharmacy	Osco Drug	Stop & Shop	
CVS Pharmacy	Hy-Vee Pharmacy	Publix Pharmacy	Target	
Duane Reade	Kmart	Rite Aid	Vons Pharmacy	
Eckerd Drug	Kroger Pharmacy	Safeway Pharmacy	Walgreens	

Call 1.800.758.5779 or visit www.healthesystems.com/pharmacysearch to see a full list of network pharmacies.

The injured worker, in many states, has the free, full and absolute choice in the selection of a pharmacy or pharmacist. The above information is provided if the injured worker needs assistance in locating a pharmacy.

5.7 Enrollment Management

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.

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

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?

Our testing process begins with the gathering and review of client configuration requirements. The implementation team provides a comprehensive overview of configuration setup options and works with the client to document and approve those requirements. The build teams (formulary, benefits, and pharmacy network) begin setup based on documented and approved requirements. Each team fully tests their setup at the configuration level (e.g., quality staging platform, enterprise formulary, and configuration systems) before moving those projects into integrated testing.

We will accept the ANSI X12 834 - Benefit Enrollment and Maintenance transaction and our proprietary standard eligibility file formats including Type 12 - Group and Type 23 - Member Record Layouts. We can also accommodate custom DCS-specified eligibility formats. At implementation, DCS can present the specific eligibility format to the implementation team for documentation of requirements and custom conversion program creation, converting DCS's eligibility file format to our standard eligibility file layout for processing. As part of regression testing, we will work with DCS to load actual historical prior approvals into the end-to-end integration test environment against a preproduction test file containing DCS's live member information allowing us to validate the historical prior approval load by mirroring the process we will use later to load the historical PAs into production. DCS's implementation business systems analyst reviews the load process and analyzes the results to the implementation team and DCS. This process offers transparency into the total volume of PAs received, successfully loaded, and loaded with errors. The start of the new plan includes automatic claims history review by MedImpact's claims processing system to acknowledge approved and open PAs and step therapy requirements to immediately approve the prescription for member at POS (point of sale).

For the EGWP, during implementation, VibrantRx discusses enrollment file options and custom requests with DCS. The standard enrollment file includes required and optional fields. The file format is .txt. The employer group can send the file daily or weekly depending upon volume and preference. Employer groups can use optional fields or filler fields to capture custom data. VibrantRx processes enrollment and sends the member record to MedImpact using our eligibility format.

The eligibility process includes:

- The employer group provides an enrollment file with all applicable elections, terminations, and changes. The employer group can send a change-only file or full file as often as daily and multiple times a day if needed.

- Upon receipt of the eligibility file from the employer group, VibrantRx loads the file into our enrollment system validating the enrollment against MARx (Medicare Advantage Prescription Drug system), submitting clean records to CMS. The enrollment team works on eligibility outliers like records retroactive or missing information.
- The system generates enrollment output files from the system daily and loads them to our system.
- The enrollment process includes continual monitoring of enrollment records.

We incorporate 3 levels of eligibility testing:

- Format testing (Format/Character Type/Field length and required field population)
- Load/volume testing to ensure the numbers of claims sent matches the # of claims loaded
- User Acceptance testing to validate the enrollment status is as expected (Active/Inactive/Termed, etc.)

Quality Controls

During implementation, after we complete the testing process, we turn over the project to our QA (quality assurance) department for quality checking. If the quality check involves new plans or restriction tables, the QA department prints each table involved and thoroughly reviews each line to ensure accuracy. Our QA process ensures consistency with CMS requirements for benefit design and plan finder and other public reference materials.

Our ongoing file validation process identifies major issues that can prevent an eligibility file from being processed. We can set a DCS-error threshold to stop the file from processing if the number of errors exceed the error threshold. DCS can place additional checks and balances for TBA (term by absence) processing, such as specifying a custom threshold for maximum terminations that prevent the termination of a large percentage of membership without DCS's approval. Validation checks help avoid the automatic termination that can occur when the file lists a member not included in the prior eligibility upload. We can generate a termination file that DCS can review and modify prior to processing any member terminations. Typically, default error rates of more than 10% automatically reject an entire eligibility file load; however, DCS can configure the error threshold to their preference.

We identify both mandatory and 'nice to have' data elements identified that we will work with NYSIF to obtain for enrollees. Missing or invalid data elements are identified and will error for handling. Examples that cause errors include:

- Missing claim number
- Invalid DOB
- Invalid DOI
- Missing header rows
- Missing trailer rows

Exception Reporting

Each eligibility file load initiates the creation of a load result report that we will send to DCS immediately following the load process. The load result report includes the following elements:

- Total records processed
- New member records added

- Existing member records updated or skipped (that is, no change in any record information)
- Total members terminated
- Total errors encountered (with a detailed listing of the error records)

The eligibility feedback report allows DCS to actively monitor file load accuracy and performance and react immediately to any issues that arise.

We send an eligibility feedback file to DCS that includes all eligible members listed in our eligibility database. DCS can use this file to ensure the MedImpact data matches their data and, if they notice discrepancies, can deploy it to initiate an analysis request to rectify discrepancies in the system.

2. Describe your system capabilities for retrieving and maintaining Commercial enrollment information within twenty-four (24) hours of its release by the Department and within twelve (12) hours of release by the NYSIF as well as:

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 online?

b. How your system handles retroactive changes and corrections to enrollment data.

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.

d. Confirm your enrollment and claims processing system has the capacity to administer 1) a Social Security number; 2) Employee identification number and; 3) 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.

We generally load electronic data interchange batch file transfers received by 7:00 pm ET within 1 business day via batch process. We manage manual updates processed through MedAccess in a real-time environment. We load files in the order we receive them. We can support the following 3 connectivity methods for data exchange:

- Customer-owned private circuits
- Site-to-site VPNs over the internet (encrypted)
- Direct internet connectivity with HIPAA-compliant encrypted communication methods HTTPs

Eligibility should be exchanged electronically at least once per day; however, we can support this more frequently based upon a customer's capability. In some cases, we exchange eligibility real time via web services with clients. All eligibility and claimant information exchange are performed electronically via daily (or more frequent if possible) electronic data feeds from our customers. The eligibility feed includes updates on claimant status or any changes to overall patient demographics. When necessary, eligibility can be updated or received via our Customer Service Center over the phone (typically when a patient is at the pharmacy).

Eligibility status and rules are established with each customer based upon the process followed within their claim system and how the data is received via the electronic file. In most cases, the system establishes different rules and

crosswalk routines during the implementation process to ensure we capture and reflect the appropriate process for how the customer tracks and records eligibility. We will work with the NYSIF team to identify the most optimal path and can accept a proprietary file, or industry standards such as 835, 837, and 997. We support a multitude of integration tools and protocols such as web services via SOAP, flat files, and XML. Active directory, and insurance industry formats such as ACORD. We maintain a flexible integration architecture and can work with each customer to determine the most optimal integration process that will meet our mutual needs.

Enrollment Data History

Historical data is available for real-time claims adjudication system is kept for 4 years and the balance of the current year.

We store information indefinitely and do not have a limit.

Retroactive Changes

We accept future termination and effective dates at the member and group level via eligibility file loads. In addition, we can retroactively implement member and group level effective dates for our clients and retroactively terminate member and group records through MedAccess.

For DCS and NYSIF, we can receive eligibility updates in real time or in batch daily to communicate changes for claims communicated for handling.

Reporting

MedOptimize enables users to create ad hoc queries quickly and easily by choosing data points from numerous subject areas and hundreds of data elements to produce required reports. The data required to produce the required reports is pulled into MedOptimize from our claim processing system nightly.

Claims System Capacity

We confirm we can process eligibility using social security numbers, employee identification number, or an alternate identification number assigned by the Department. The alternate ID must remain unique to the individual member so that the system uses only the appropriate individual's claim and PA history as a crosswalk. We can store multiple member IDs, such as unique identifiers and social security numbers, in our system for use in cross-walking member information.

We can process enrollment using social security number, employee identification number, and an alternate identification number assigned by NYSIF. There are no special requirements to accommodate these identification number options. Since this work is specific to workers' compensation, coverage and claims processed are only applicable for the injured worker.

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

We will accommodate data exchange with its clients in the formats specified in the HIPAA Standardized Transaction Set used to support prescription drug management programs. We can establish SFTP connectivity with DCS and

vendors during implementation. Most of our clients use batch file exchanges on a daily basis. We encrypt all data both at rest and in transit. We currently support numerous data exchange options for sharing pharmacy claim information. We support web service-based APIs along with message queue and traditional batch interfaces. We use file-based integration for most clients but can work with the data exchange method that works best for our clients.

We manage data file transfers for batch membership and eligibility through a secure FTP platform with PGP encryption. We can support alternative methods of enhancing security such as VPN connections. We will support batch-oriented data exchange for large volumes of data including accumulators via SFTP, daily, or more frequently as agreed to mutually.

Our systems currently support the following NCPDP and ANSI (American National Standards Institute) standards:

- NCPDP Telecommunication Standard Version D.0
- NCPDP 1.2 Batch Standard
- NCPDP 2.2 Post-Adjudication Standard
- NCPDP 4.2 Post-Adjudication Standard
- NCPDP Benefit Integration Standard
- NCPDP 3.0 Subrogation Standard
- NCPDP Prior Authorization Standard
- ANSI X12 Version 5010
- ANSI X12 270 Eligibility, Coverage or Benefit Inquiry
- ANSI X12 271 Eligibility, Coverage or Benefit Response
- ANSI X12 834 Benefit Enrollment and Maintenance
- ANSI X12 835 Health Care Claim Remittance/Advice
- ANSI X12 878 Product Authorization/De-Authorization
- ANSI X12 879 Price Information
- Edge Server Pharmacy Claims Submission File

All NYSIF data transmission and transaction adjudication adhere to strict NCPDP format and credentialing, which is HIPAA compliant throughout the messaging process. During file transfers, PGP and secure FTP are used for any file transfers between our systems and our clients. MedImpact uses 128-bit secure sockets layer (SSL) encryption and Healthesystems utilizes Transport Layer Security 1.2 and 128bit AES to ensure secure Data-In-Transit/Motion.

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.

We operate redundant systems so that member information is always available at the point of service. If a member at the pharmacy needs eligibility assistance, eligibility overrides can be placed by our CSRs at DCS's direction. These rules will be established with DCS during implementation.

For NYSIF, eligibility can be updated or received via our CSR over the phone (typically when a patient is at the pharmacy). Eligibility status and rules are established with each customer based upon the process followed within their claim system and how the data is received via the electronic file. In most cases, we establish different rules and crosswalk routines during the implementation process to ensure we capture and reflect the appropriate process for how the customer tracks and records eligibility.

5. (Exclusive to DCS) Confirm that the Offeror will maintain a read-only connection to the NYBEAS enrollment system, and that Offeror's authorized 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 as indicated on the Department's website.

MedImpact confirms.

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

Our claim system meets applicable NMCSO requirements. Our system can accommodate requirements to store information relative to information release. To ensure that information is released only to the appropriate parties, we use a confidentiality flag in our system. Our privacy team manages the application of this information to ensure confidentiality. When this appears within a member profile, it includes instructions for the CSR to follow on who they can or cannot speak to.

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.

We practice the following procedures for entering and updating eligibility at the group, member, and dependent level. Our customer service staff can assist callers with urgent or emergency situations, at the direction of DCS, to ensure members receive their medications while at the pharmacy.

DCS Manual Eligibility Processes

Eligibility can be entered manually through MedAccess and can be provided at the group and member level.

Group Level

Group level eligibility establishes, changes, or terminates a new group. Additionally, the group file can establish or change links between the group and a benefit structure and pharmacy network. We must set up the group in MedAccess prior to the loading of member eligibility. Clients can send group files to MedImpact daily for frequent changes or on an as-needed basis for groups with infrequent changes (e.g., Medicare Part D groups).

We allow clients to load a Type 12 group file manually, while other clients request MedImpact do this on their behalf. If DCS would like to send in the Type 12, they can actively manage the groups and divisions by headquarters code. If not, our team will work with DCS to make the changes on their behalf with a standard turnaround time of 1 to 3 business days.

If a manual group eligibility update does not match the full file load, the eligibility update is rejected. We will send an eligibility error report to DCS for review and correction to ensure we accurately process eligibility updates with the eligibility file uploaded again.

Member and Dependent Level

Member level eligibility establishes, changes, or terminates members as part of a group. It also manages member level information or attributes used for processing and reporting. Clients typically send member change files daily to us and full files on an agreed-upon schedule to conduct a full eligibility refresh. Our system can process full files via regular eligibility rules or via the TBA (term by absence) process. We upload all member eligibility files within 1 business day.

NYSIF Manual Eligibility Process

We incorporate a First Fill program to accommodate the initial fill process when claims have not yet been reported. This is an "at risk" program whereby we provide an initial 10-day supply when eligibility from NYSIF has not been received. NYSIF will not be responsible for prescription charges from First Fills not matched to NYSIF's eligibility. The First Fill program can be set up and customized based on NYSIF's requirements.

Our standard definition for the first fill is as follows: the first prescription presented to a participating network pharmacy by a claimant is within 15 days from date of injury. Typically, the network pharmacy will be restricted to dispensing no more than a 10-day supply of the prescription drug.

One of the critical elements to ensuring we can match First Fills against patient eligibility data and optimize the "in-network" capture of first prescription/initial fills, is ensuring the injured worker has the First Fill Form or Prescription card when visiting the pharmacy. We have had great success with our First Fill Form and assisting customers with strategizing to ensure claimants have this information available for their initial pharmacy visit. We have also recently rolled out digital capabilities via web and text to further enhance our success in this area.

For new injuries, a First Fill sheet can be provided to the employer to facilitate the set-up of the new injury at the pharmacy, prior to the First Report of Injury being reported to the client. We will supply the employer/client with a temporary card or a First Fill information sheet for distribution to the newly injured worker to take to the pharmacy. Additionally, we have Digital First Fill webpages established that our clients and their customers can drive to in their own patient materials via QR code.

Our First Fill program is available 24/7/365. All pharmacy transactions are processed according to consistent DUR edits, formulary rules, and business rules regardless of whether prospectively or retrospectively. Additionally, we are partnered with Health Lift as part of an SMS text-based program that facilitates outreach to patients at the point of first fill who may not yet have their prescription benefit information. This allows Health Lift to match Healthesystems as the PBM, as well as proactively provide the patient with their Rx benefit information to drive penetration at the next opportunity.

Network pharmacies are also notified of the relationship between Healthesystems and NYSIF in addition to our First Fill program and, frequently, our participating pharmacies are familiar with us and will know who the PBM is for a policy holder. In these cases, the pharmacy calls our Customer Service Center and can establish eligibility via the phone.

8. (Exclusive to NYSIF) Confirm that the Offeror 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 in accordance with Attachment 65, NYSIF Short Fill Process, of this RFP.

We will incorporate a First Fill program to accommodate the initial fill process when claims have not yet been reported. This is an "at risk" program whereby we will provide an initial ten-day supply when eligibility from NYSIF has not been received. NYSIF will not be responsible for prescription charges from First Fills not matched to NYSIF's eligibility. The First Fill program can be set up and customized based on NYSIF's requirements.

We will exchange eligibility data with our customers daily (at a minimum), which is critical to capturing newly injured workers on the date of injury. However, in cases where claims have not yet been reported or eligibility information is not yet available, we incorporate a First Fill program to accommodate the initial fill process when claims have not yet been reported. This is an at-risk program whereby we can provide an initial 10 supply of medication when eligibility has not been received.

Our standard definition for the first fill is as follows: the first prescription presented to a participating network pharmacy by a claimant is within 15 days from date of injury. Typically, the network pharmacy will be restricted to dispensing no more than a 10-day supply of the prescription drug.

One of the critical elements to ensuring we can match First Fills against patient eligibility data and optimize the "in-network" capture of first prescription/initial fills, is ensuring the injured worker has the First Fill Form or Prescription card when visiting the pharmacy. We have had great success with our First Fill Form and assisting customers with strategizing to ensure claimants have this information available for their initial pharmacy visit.

For new injuries, a First Fill sheet can be provided to the employer to facilitate the set-up of the new injury at the pharmacy, prior to the First Report of Injury being reported to the client. We will supply the employer/client with a temporary card or a First Fill information sheet for distribution to the newly injured worker to take to the pharmacy.

The First Fill program is available 24/7/365. All pharmacy transactions are processed according to consistent DUR edits, formulary rules, and business rules regardless of whether prospectively or retrospectively.

Network pharmacies are also notified of the relationship between us and NYSIF in addition to our First Fill program. In these cases, the pharmacy calls our Customer Service Center and can establish eligibility via the phone.

9. Enrollment Management Guarantee: The Programs' service level standard requires that one hundred percent (100%) of all Commercial 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 release by the Department that one hundred percent (100%) of the Commercial 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 lower amounts.

The Standard Credit Amount for each 24-hour period beyond twelve (12) hours from 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 lower amounts.

We will commit to meeting the enrollment management guarantees for DCS and to meeting applicable performance guarantees for NYSIF, as required. We regularly exceed the requested metrics and are confident in the ability to

uphold these standards. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

5.7 Exhibits

There are no referenced exhibits in Section 5.7, however, Attachment 6 includes our enrollment performance guarantees as requested. Attachment 6 has been included at the end of the Technical Proposal.

5.8 Reporting Services

1. (Exclusive to DCS)
a. How will reversed, rejected, and adjusted (adjusted claims are exclusive to DCS) 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 Agencies 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.
b. 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 Agencies to be able to analyze and manage the Programs. Provide an overview of your reporting capabilities with the value the Offeror believes this will bring to the Programs.
c. Confirm that the Offeror will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by the Agencies.
d. Confirm that the Offeror will provide direct, secure access to your claims system and any online and web-based reporting tools to the Agencies' offices. Include a copy of the data sharing agreement the Offeror propose for Agencies staff to execute in order to obtain systems access.
e. Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that the Offeror has performed for other clients.
f. Reporting Services and Claim File Guarantees: The DCS Program's service level standard requires that accurate management reports and claims files, including MAC Alert Notices, will be delivered to the Agencies no later than their respective due dates. For the management reports and claim files listed in Attachment 36, Program Reporting, as well as in Section 3.7 of this RFP, the Offeror must propose a performance guarantee. Utilizing the Performance Guarantees form (Attachment 6), 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 accurate or is not received by its respective due date is $1,000 per report per 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. However, Offerors may propose higher or lower amounts.

MedImpact's MedOptimize® reporting system provides clients with flexible reporting, business intelligence, and decision-support options.

Adjusted Claims

All DCS's claims, including approved, denied, and reversed transactions, are available to DCS for reporting and analysis.

Sample Financial and Utilization Reports

We will provide management reports around prescription drug claim key statistics such as number of claims, costs per member per month, brand/generic usage, formulary product utilization, utilization by fulfillment channel, and

more. Report examples in this category include Key Performance Indicators and Trends, Utilization Summary by Month, and PMPM Trend Analysis.

Format

MedOptimize reports export in various file formats including PDF, HTML, Excel, and CSV. DCS can save, download, and share reporting via email. Scheduled reports automatically generate a report completion email.

Access

MedOptimize offers real-time access to data with powerful user-friendly standard reporting and ad hoc query capabilities. We provide MedOptimize through a secure website with 24-hour, 7-day a week availability and direct access to data for efficient and effective analysis of DCS's prescription drug program enabling DCS to make informed decisions.

Ad Hoc Reports

We are willing and able to provide ad hoc reports. MedOptimize enables users to create ad hoc queries quickly and easily by choosing data points from numerous subject areas and hundreds of data elements. Through a simple point-and-click, drag-and-drop user interface, users can design reports that:

- Apply mathematical and statistical calculations
- Modify report and data formats
- Highlight key results with conditional value-driven formatting
- Add sorting
- Define data groupings
- Insert totals and subtotals
- Schedule on any common frequency
- Save and share with others
- Export results to multiple output formats

Guarantees

We agree to comply with the reporting services and claim file guarantees, as required. Please see **Attachment 6** for amounts at risk.

2. (Exclusive to NYSIF)
a. Confirm the Offeror's agreement to generate and submit all daily, weekly, monthly, quarterly, semi-annual, and annual reports per NYSIF specification.
b. Confirm the Offeror will provide NYSIF with electronic file of eligibility and authorization on the GC3, GPI or similar code level. Indicate your capability for capturing drug denials on the NDC code levels. If unable to capture denials on the GC3 or GPI code level, provide a detailed description of your denial coding system.
c. Confirm that the Offeror will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by NYSIF.
d. Confirm that the Offeror will provide NYSIF with an on-line decision support tool with ad-hoc query capability.
e. Confirm the Offeror's ability and willingness to provide Ad Hoc Reports and other data analysis. Provide

examples of Ad Hoc reporting that the Offeror has performed for other clients.
f. Describe how the Offeror's proposed system will accept pharmacy bills from the Offeror's network pharmacies.
g. Describe how the Offeror's proposed system will edit these pharmacy bills in accordance with NYSIF business rules.
h. Describe how the proposed system will reject, with reason, any pharmacy bills that do not adhere to NYSIF business rules.
i. Describe the method for notification of the Offeror's network pharmacy in the event of rejection.
j. Describe how the pharmacy bills submitted will validate against the claim eligibility information provided by NYSIF.
k. Confirm that the weekly billing file will follow the specifications in Attachment 60, NYSIF Billing Process, of this RFP.
l. Describe the encryption and secure transmission protocol for the pharmacy billing files.
m. Describe how the system will be monitored for performance.
n. Describe how NYSIF will be notified in the event of a system and/or transmission failure.
o. Describe how it will be determined into which file Established Claim or Instant Enrollment/Short Fill, the pharmacy bill will be placed.
p. 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.
q. Describe how card issuance information is tracked in your system.
r. Describe the Offeror's encryption and secure transmission protocol for your electronic files.
s. Confirm the Offeror's agreement to create specified electronic files in the form of an ASCII text file.
t. Describe how rebate information is tracked in the Offeror's system.
u. Describe the process that determines when a rebate is included in the quarterly rebate and annual true-up files.
v. Reporting Services and Claim File Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all NYSIF Program management reports and claims files in Section 3.7 and, as applicable, in Attachment 36, Program Reporting, will be accurate and delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the NYSIF Claims Administration Fee for failure to meet this standard.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each calendar day the Department has not received the NYSIF Program management report and claims file by their respective due date. The forfeited amount (Standard Credit Amount) for each management report or claim file that is not received by its respective due date is $100 per Calendar Day per report. However, an Offeror may propose a higher amount.

We are committed to providing comprehensive support for injured workers covered under NYSIF.

Reporting

Most reports requested are parameter based and can be created "on demand" via the Verticē web portal tool. In addition to our standard reports, we provide clients with access to our interactive data visualization reporting suite which leverages interactive, intuitive, and visually friendly data dashboards to increase the accessibility and usability of data. These self-service dashboard capabilities are accessible within our Verticē portal.

Reports can be exported and saved to other desktop applications such as Word, Excel, PDF and more. Reports can be scheduled for automatic distribution on a predetermined basis. Custom reports are also available.

Electronic Files

The workers' compensation specific formulary is based on a hybrid of GPI and NDC. As a starting point, GPI is used to establish the formulary framework, and includes a range of 2-digit to 14-digit GPIs, depending on the level of granularity within a specific medication class. For example, 2-digit and 4-digit GPIs are used to restrict to a medication group or class, and in some cases a 12-digit and 14-digit GPI are used to restrict to a specific dosage form or strength.

Typically, when adjudicating drug transactions, the pharmacy submits an NDC code captured in our system and rolled up to the corresponding GPI to apply the formulary rules. In some cases, we drill down to an NDC-level to include or exclude a certain drug/manufacturer, and our formulary can apply NDC-based parameters when dispensing. Formularies can always be customized at a patient-specific level and can be as detailed as the customer would like. PA determinations, for both authorizations and denials, may be submitted by either GPI (to address all NDCs for a particular drug) or by a specific NDC (for additional specificity).

The Verticē web portal provides a single interface through which claims adjuster can share, receive and exchange critical information around prior authorizations and other aspects of claim's management, dispensing pharmacies, and any other integrated stakeholders documents all prescription activity, including approval and denial dates. Claims professionals can view all prior authorization history (including authorizations and denials with corresponding dates, etc.) as well as the paid transaction history for all paid prescription activity. Routing rules can be set up based on customer, customer's accounts, state, and authorization type. Triggers include:

- Drug cost
- Claim status
- Physician dispensed
- Compounds
- GPIs
- Reject codes

We can also provide NYSIF with a formulary denial feed. However, it is important to note that typically this has not been necessary due to the out-of-network solutions that we provide our customers. We process all in-network and out-of-network transactions on behalf of our customers through our single, consolidated patient profile. Within our core PBM adjudication system, we process all POS and paper transactions. For example, if an in-network POS transaction is denied and subsequently billed on paper, our system will deny it. We believe we have a differentiated solution in the market due to the consolidated POS/Paper solution that utilizes the core PBM adjudication environment, forcing all transactions to be scrutinized against the same formulary, rules, and edits. Regardless of our capabilities that can be used to avoid this, we understand there may be other bill workflow requirements NYSIF may have that we would need to consider as part of the best solution.

Report Formats

Reports can be exported and saved to other desktop applications such as Word, Excel, PDF, and more. Reports can be scheduled for automatic distribution on a predetermined basis. Clients may also request ad-hoc/custom report production to meet their needs.

Online Capabilities

Verticē is the web portal used for NYSIF, which provides a single platform for all pharmacy and ancillary claims management activity.

Verticē provides a better and more efficient claims management experience through a robust suite of real-time, web-based tools to assist claims representatives and nurse case managers in effectively monitoring and managing a claimant's prescription activity. Verticē allows clients to create workflow rules to embed custom alert messages, and present clinical documentation to claims professionals at the time of authorization. Verticē's tools are accessible from a web browser. A few key pharmacy functions included in Verticē are:

- **Electronic Prior Authorization Queue (ePaq)**: Allows claims professionals to perform real-time prior authorizations online rather than receiving phone calls. This electronic process for reviewing and actioning prior authorization decisions helps reduce the time spent on authorization decisions, streamlining the pharmacy experience for both the pharmacists and the injured worker, and reducing out-of-network billing. As part of prospective adjudication, we provide claims professionals with the tools they need to make the best decisions possible regarding prior authorization. Systematic rules will trigger alerts when a drug not in the formulary is prescribed, and claims professionals are provided with educational materials to influence the decisions which claims professionals make. Furthermore, prescribers are sent material from our clinical services team to modify prescribing habits moving forward. Additionally, customized alerts presented to the claim's professional at the time of authorization also support decision-making, improving claims staff adherence to the formulary and ultimately driving better claims outcomes.
- **Paper Bill Roster**: Enables claims professionals to effectively manage out of network bills that require authorization due to the prescription transactions being rejected due to DUR and claim eligibility edits. The retrospective review of out of network prescription activity applies the same level of DUR and plan design edits as a point-of-sale transaction allowing for full clinical and cost containment management of every prescription.
- **Web-based reporting tool**: Assists claims staff in assessing prescription history and activity on a global or claimant-specific basis. Our reporting package contains a wide array of standard and customized pharmacy reports.
- **Mail Order: We developed a proprietary web-based mail order tool used to auto-identify candidates qualifying for mail order.** Claims representatives can approve or deny the claim from mail order transfer via the web tools or manually submit mail order referrals.
- **Clinical Services Referral and Authorization queue**: provides a centralized location for alerting claims professionals about patients receiving questionable or inappropriate drug treatment regimens. Claims professionals can authorize the clinical pharmacist team to perform an Independent Pharmacotherapy Evaluation and physician intervention. All clinical correspondence created and performed is recorded as part of the patient profile within the Verticē web portal.

- **Drug Information Request and Help Desk Resource Center**: These resources allow patients, claims professionals and medical professionals the opportunity to contact a pharmacist and/or submit a question online. This service is available for our customers through Verticē, and through our corporate website for patients, pharmacists and other medical professionals.

In-App Guidance

In-application guidance and tips are provided within Vertice that walk users through workflows with step-by-step how-to guides, offer helpful advice, and generate context-driven alerts. A robust library of informative support documents is also easily accessible, along with right-time clinical guidance and education. Training resources for the Vertice web portal also includes computer- based training modules and help that reside within the portal. These are self-directed training modules which can be accessed at any time.

Reports

Clients receive unlimited access to our entire reports library in addition to developing ad hoc custom reports as needed. The relational database that stores our pharmacy transaction data allows for robust and flexible reporting. Reports also include graph and drill down capability and dashboard capabilities for presenting real-time interactive graphs and charts. Report and data visualization information can include all financial related data (e.g., program savings and results), clinical data, network performance, prior authorization activity and performance, etc.). Most reports are parameter based and can be created "on demand" via the Verticē web portal tool.

In addition to our standard reports, we provide clients with access to our interactive data visualization reporting suite which leverages interactive, intuitive and visually friendly data dashboards to increase the accessibility and usability of data. These self-service dashboard capabilities are accessible within our Verticē portal. The dashboard suite includes a Formulary Adherence dashboard, which allows program managers to view claims staff adherence to upholding formulary recommendations at prior authorization, highlighting areas where there are opportunities to intervene with staff and increase adherence to program rules.

There are currently hundreds of different reports in the reporting library. These reports, along with client requested ad hoc reports, can be created and made available via our Verticē web portal. There is no fee associated with this report feature.

Our most popular standard reports are:

- Executive Savings Summary
- Employer Savings Summary
- Savings Summary
- Retail Generic Performance by State
- Point of Sale Utilization Review Summary
- Polypharmacy
- Top Therapeutic Classes Dispensed Based on Total Number of Rxs
- Drug Utilization Review
- High Utilization of Controlled Substances

All standard reports are parameter-based whereby flexibility regarding reporting time periods and other claim and/or operations demographics can be incorporated. We also have many reports that we build ad-hoc for customers (i.e., Rolling 12-month MED Report, Step Therapy Savings Report).

Clients may also request ad-hoc/custom report production to meet their needs. Please see **5.8 Exhibits** for NYSIF sample pharmacy reports.

Ad Hoc Reports

Clients may request ad-hoc/custom report production to meet their needs. Typically, there is no additional cost to our customers to build ad hoc reports. Depending on the complexity, typical creation time is 1-2 weeks. Custom reports are requested by the customer through their dedicated account manager.

Client requested ad hoc reports can be created and made available via our Verticē web portal. There is no fee associated with this report feature.

Accept Pharmacy Bills

All point-of-sale prescription transactions are processed electronically from the respective pharmacies to our claims system via real-time/online communication.

Integrated technology ensures all pharmacy transactions are fully managed regardless of whether they process through the point-of-sale environment (prospective) or come in retrospectively (on paper, etc.). All pharmacy activity is processed on one system – utilizing a single patient profile in one system, therefore ensuring all pharmacy activity for a single patient is managed using the same clinical rules and edits.

All invoicing is performed electronically and does not require any distribution or exchange of paper generated information (invoices). All customers exchange billing/payment and remit information electronically in addition to eligibility files.

The standard billing cycle to clients is weekly. Depending on the timing (i.e., number of days after receiving the billing file) when client will remit payment, the remittance can be either weekly or every other week. We will remit to pharmacies weekly, 14 days in arrears meaning no prescription gets paid later than 30 days from the date submitted by the pharmacies. Our billings and remittances with clients can be customized to any frequency that fits within the constraints of our pharmacy remittances.

We process and pay 100% of all prescription transactions (POS/retail, mail order and retrospective/paper) on behalf of NYSIF. Following the weekly billing cycle and upon receipt of payment from NYSIF for the respective transactions, we will pay the pharmacy on NYSIF's behalf.

Payments in error such as overpayments or reversals will be credited to NYSIF. These credit transactions generally are submitted in the weekly billing file.

Edit Pharmacy Bills

All pharmacy transactions, including First Fills, will be processed according to consistent DUR edits, formulary rules, and business rules regardless of whether prospectively or retrospectively. Business rules, DUR edits, and the formulary can be customized to NYSIF's needs.

Pharmacy Bill Rejections

All bills, regardless of whether they are from participating or non-participating pharmacies, will be entered and adjudicated into the point-of-sale system - applying the same rules and edits as prescriptions being submitted as POS transactions.

All transactions are then adjudicated, posted for approval and payment is made on behalf of our clients. Our adjudication process will apply all edits as if the respective transactions were POS transactions, applying duplicate checking, medication plan editing, generic rule editing, eligibility editing, state fee schedule, DUR edits and any client specific custom edit. Any transactions with a failed edit will route to our clients for approval (via the Verticē web portal) before we make payment. We also issue all Explanation of Reimbursement (EOR) to the pharmacy (we are in adherence with state specific EOR rules) on behalf of our clients.

After all paper and electronic third-party billings are adjudicated, we electronically route all eligible transactions to the Bill Conversion team at our CSR. The team then begins an outbound phone call process to the respective pharmacies to alert the pharmacy of the network information and ensure any future (follow up) scripts will be processed appropriately.

Rejection Notification

Any transactions with a failed edit will route to our clients for approval (via Verticē web portal) before we make payment. We also issue all Explanation of Reimbursement to the pharmacy and comply with any state specific EOR rules on our clients' behalf.

Pharmacy Bill Validation

It is important to note that our integrated technology ensures all pharmacy transactions are fully managed regardless of whether they process through the point-of-sale environment (prospective) or come in retrospectively (on paper, etc.). All pharmacy activity is processed on one system – utilizing a single patient profile in one system, therefore ensuring all pharmacy activity for a single patient is managed using the same clinical rules and edits.

Updates to eligibility do impact rules associated with how to handle a claim according to its status. We will work with NYSIF to establish an eligibility matrix that uses a combination of pharmacy benefit indicator, claims status, termination date, and close date to determine eligibility of benefits for a claim.

Weekly Billing File

All customers perform the billing and payment/remit process electronically. Each customer may perform the process slightly differently depending on how their banking arrangements and claim system functions perform. We will work

with each customer during the implementation process to determine the most efficient manner to automate this process.

Pharmacy Billing File Transmission

Typically, we will integrate with customers' claims and/or managed care systems (e.g., claims management system, managed care and bill review systems and partners, utilization review, etc.) to optimize the pharmacy authorization process and maximize their ability to proactively manage their patient care needs. File types typically include claim eligibility information, and the ability to send an electronic billing file to NYSIF for all transactions processed, as well as a payment and reconciliation process.

System Monitoring

We deploy a security Information & Event Monitoring system that conducts continuous monitoring of all network activity and is actively monitored by IT Security personnel.

Notification of System Failure

Continuous monitoring is in place to provide real-time awareness of all system activity and is configured to automatically detect any performance issues or abnormal behavior and will immediately initiate alerts to system administrators. Upon notification, system administrators will quickly review/analyze all alerts to determine the root cause of the incident, identify the resources that are impacted and initiate the appropriate mitigation solution to eliminate the issue and restore the network to full operability.

We will employ a compressive Major Incident Management (MIM) process that enables the organization to identify, respond to, and recover from major incidents (service impacting outages) promptly. The MIM process also includes procedures to ensure relevant and timely stakeholder communications. As part of the MIM communication process, the provider will notify the Customer of service impacting event within 4 business hours, during normal business hours of 8:00 am ET to 6:00 pm ET. Additional details regarding the MIM are available upon request.

File Placement of Claims

We will utilize First Fill, a program that will accommodate the initial fill process when claims have not yet been reported. We will exchange eligibility data with our customers daily (at a minimum), which is critical to capturing newly injured workers on the date of injury. The First Fill program can be set up and customized based on NYSIF's requirements. Once eligibility has been received, our system will match the First Fill claim number to the established claim number and future fills will be processed against the established claim.

Aging Bills

Billing is performed weekly based on claims processed. Payments on accounts receivable are due on presentation and are applied to indicated invoices. Outstanding balances, including partial amounts due are placed in the Aging Bill file and categorized based on the number of days they are overdue. Aging categories are 0-30 days, 31-60 days, 61-90 days, and 91+ days past due. Paid invoices move from the aging, while unpaid invoices remain and move into other aging buckets based on the number of days they are overdue. Detailed accounts receivable aging reports will be provided monthly, and Account Management will research discrepancies and follow up on questions.

Card Issuance

Prescription cards are sent based on the customer's parameters and are determined during program set-up. Typically, the customer eligibility file contains key status fields that will be the driver of Rx cards. The system logic for Rx card eligibility can be driven off one specific field or based on meeting conditions of several different fields. Cards can also be manually requested by the claim's professional. Our system retains the date of the Rx card generation, and the card itself is visible in our Vertice UI. In addition to printed Rx cards, we will also work with NYSIF to leverage mobile technology for distribution.

Encryption and Secure Transmission

We can support the SFTP, FTPS and FTP protocols for inbound and outbound file transfers. It is highly recommended that the SFTP or FTPS protocols be used to safeguard against network security risks, if possible. However, we do support FTP if that is the only option for the transmission of files.

An overview of the transfer protocols supported includes:

- **SFTP (Secure File Transfer Protocol)**: a secure replacement for FTP (File Transfer Protocol) based on the Secure Shell protocol. SFTP does not use the FTP protocol as the transport, it is SSH-based. SFTP runs the communication over one port for command and data (whereas FTP uses separate ports or sockets for command vs. data). Please note that this is our preferred and recommended protocol.
- **FTPS (FTP with SSL)**: an extension to the commonly used File Transfer Protocol (FTP) that adds support for the Transport Layer Security (TLS) and the Secure Sockets Layer (SSL) cryptographic protocols. FTPS is an FTP implementation which encrypts communication sockets. Like standard FTP, it uses one port for command communication, and a different port for the actual transport of data. It can be implemented in two different modes:
- **Explicit**: preferred method according to RFC 4217. The customer connects to server port 21 and starts an unencrypted FTP session as normal, but requests that TLS security be used and performs the appropriate handshake before sending any sensitive data. With explicit, you can specify if the data connection is encrypted.
- **Implicit**: the customer connects to a different port (usually 990), and an SSL handshake is performed before any FTP commands are sent. With implicit, the data connection will automatically be encrypted.
- **FTP (File Transfer Protocol)**: does not take any precautions to protect information transmitted during a session. This includes your username, password, and any files transmitted.

Our data transmission and transaction adjudication processes adhere to strict NCPDP format and credentialing which is HIPAA compliant throughout the process of messaging. During file transfers, PGP (Pretty Good Protection) and secure FTP are used for any file transfers between us and our clients. We use 128-bit secure sockets layer (SSL) encryption.

We utilize Transport Layer Security 1.2 and 128bit Advanced Encryption Standard (AES) to ensure secure Data-In-Transit/Motion.

ASCII Agreement

We can utilize ASCII character encoding for specified electronic files. More detail would be needed during design and implementation to better understand if any specific ASCII file standard is required.

Rebate Information

Our rebate processor provides detailed reports to our secure FTP site monthly. These reports include all rebates and manufacturer administrative fees broken out by member ID and customer. These details are stored in our system and used to disclose and pay rebate amounts to our customers and to respond to any rebate state reporting requirements.

Rebate Inclusion

Rebates and manufacturer administrative fees related to claims submitted, processed, and reimbursed during each quarter will be included in each quarterly rebate file. Payment will be made to the Customer within 30 days of the quarter end. 90 days after the contract year's end, an annual true-up file will be created to include all rebates submitted, processed and reimbursed during the year. Any rebates related to the contract year that remain unpaid will be reconciled and paid then.

Reporting Services and Claim File Guarantee

This information has been completed within **Attachment 6** at the end of the Technical Proposal.

5.8 Exhibits

Exhibit	Description
5.8 Exhibit A	NYSIF Sample Pharmacy Reports
Attachment 6	Performance Guarantees (included at the end of the technical proposal)

Healthe SYSTEMS

Transforming healthcare.

Healthesystems Exhibit A:
Sample Pharmacy Reports

Prepared for: New York State Insurance Fund

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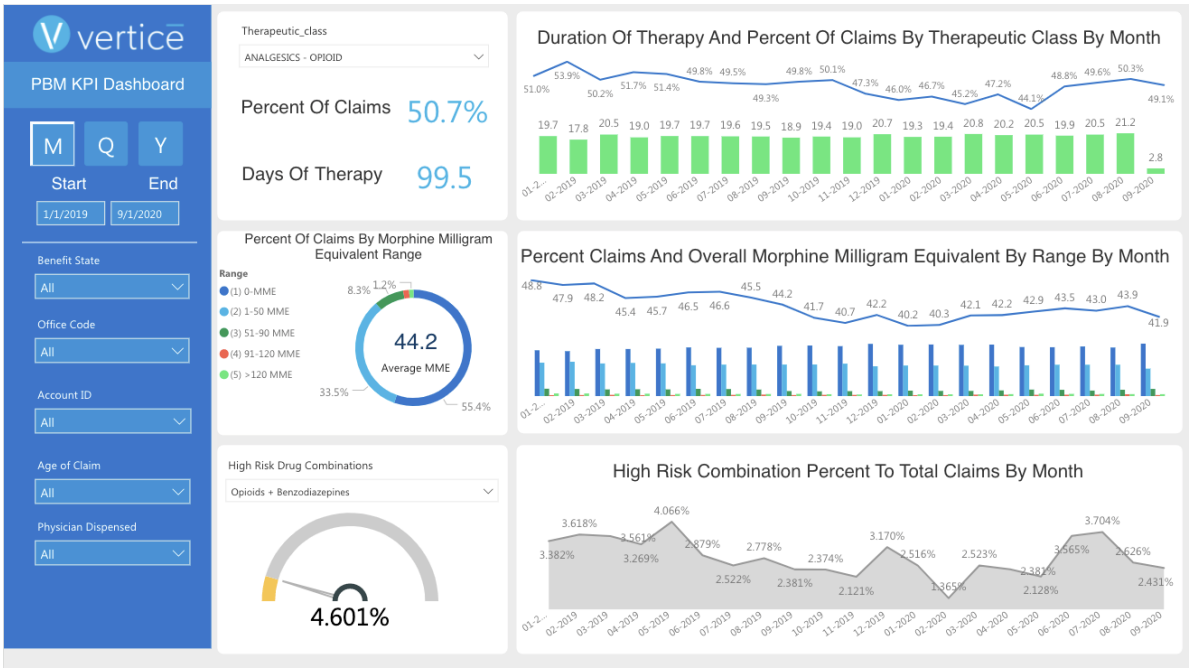
www.healthesystems.com

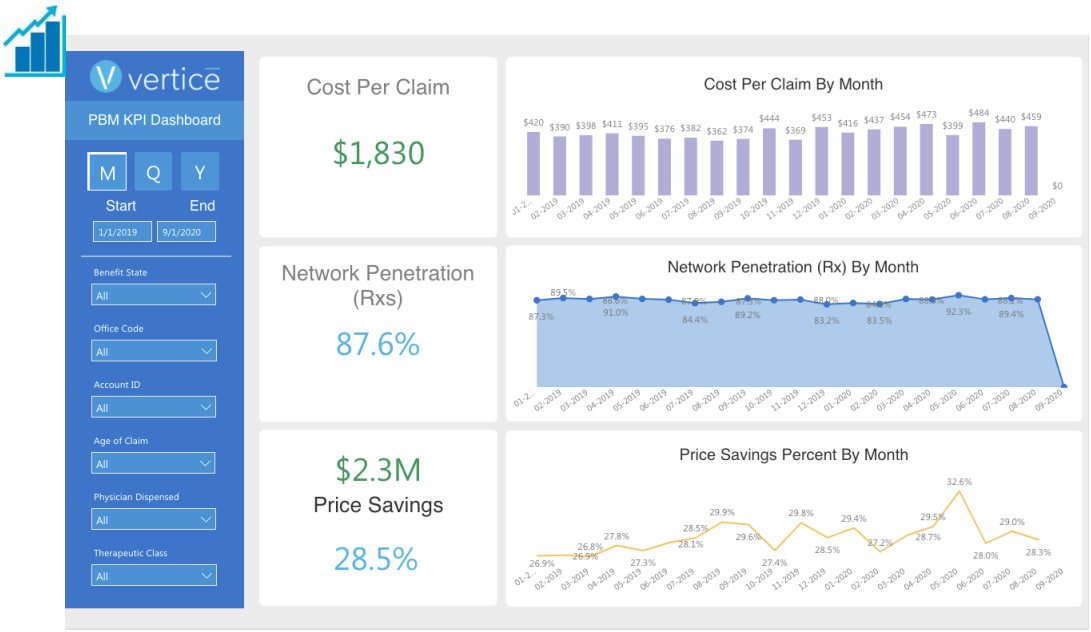
Interactive Reports

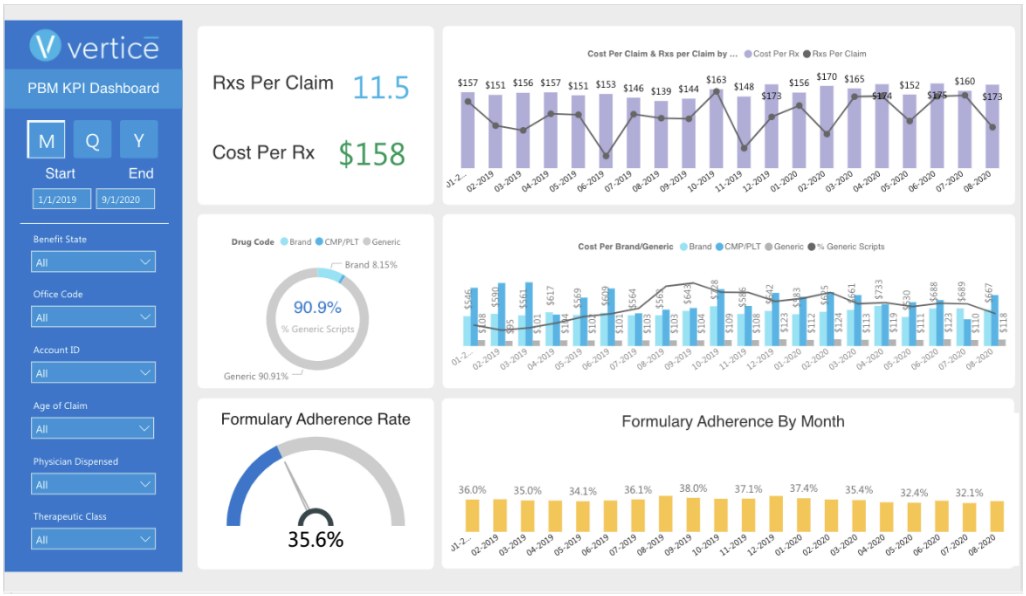
Healthesystems' interactive data visualization reporting suite is available within our Verticē portal allowing clients to access, filter, and configure data in real time, providing key insights into program performance, clinical and operational management functions, and outcomes.

INTERACTIVE REPORT: KEY PERFORMANCE INDICATORS (KPIs)



INTERACTIVE REPORT: KEY PERFORMANCE INDICATORS (KPIs)

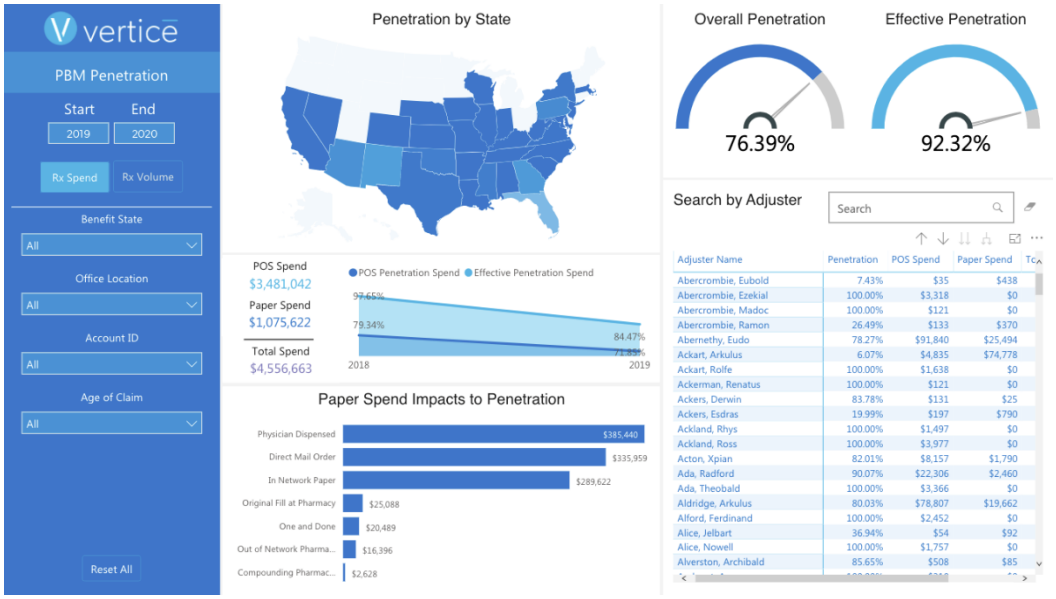




Description: Key performance indicators provide high level program results, operational and clinical performance.

Data Elements: The KPI's include top metrics across varied areas, including: Cost & Savings, Penetration, Utilization, Generic Efficiency, Formulary Adherence, Opioid Usage, Duration of Therapy and prescribing of High-Risk combinations.

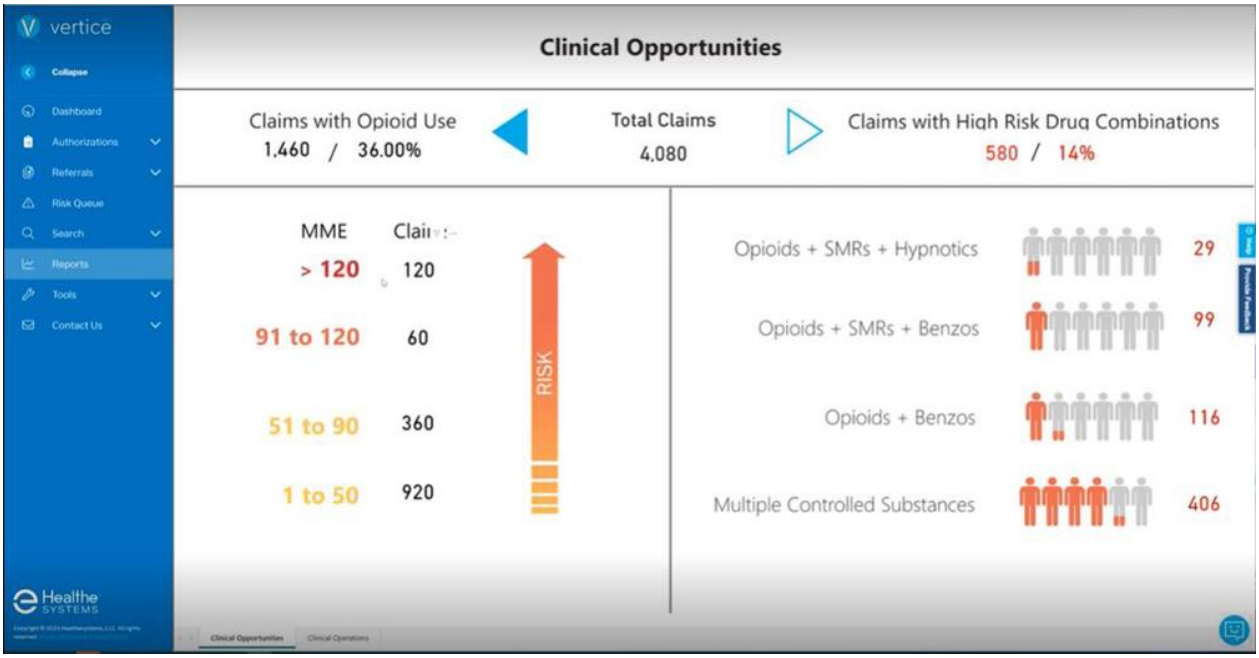
INTERACTIVE REPORT: NETWORK PENETRATION



Description: Network penetration tracks point of sale transactions against paper out of network transactions, providing insight to drive strategies to increase penetration.

Data Elements: Penetration can be sliced by Jurisdiction, Employer, Office Location and Claims Professional. Additional insight provided into the reasons for leakage, such as physician dispensing or 3rd party billers.

INTERACTIVE REPORT: PBM Clinical Opportunities Dashboard



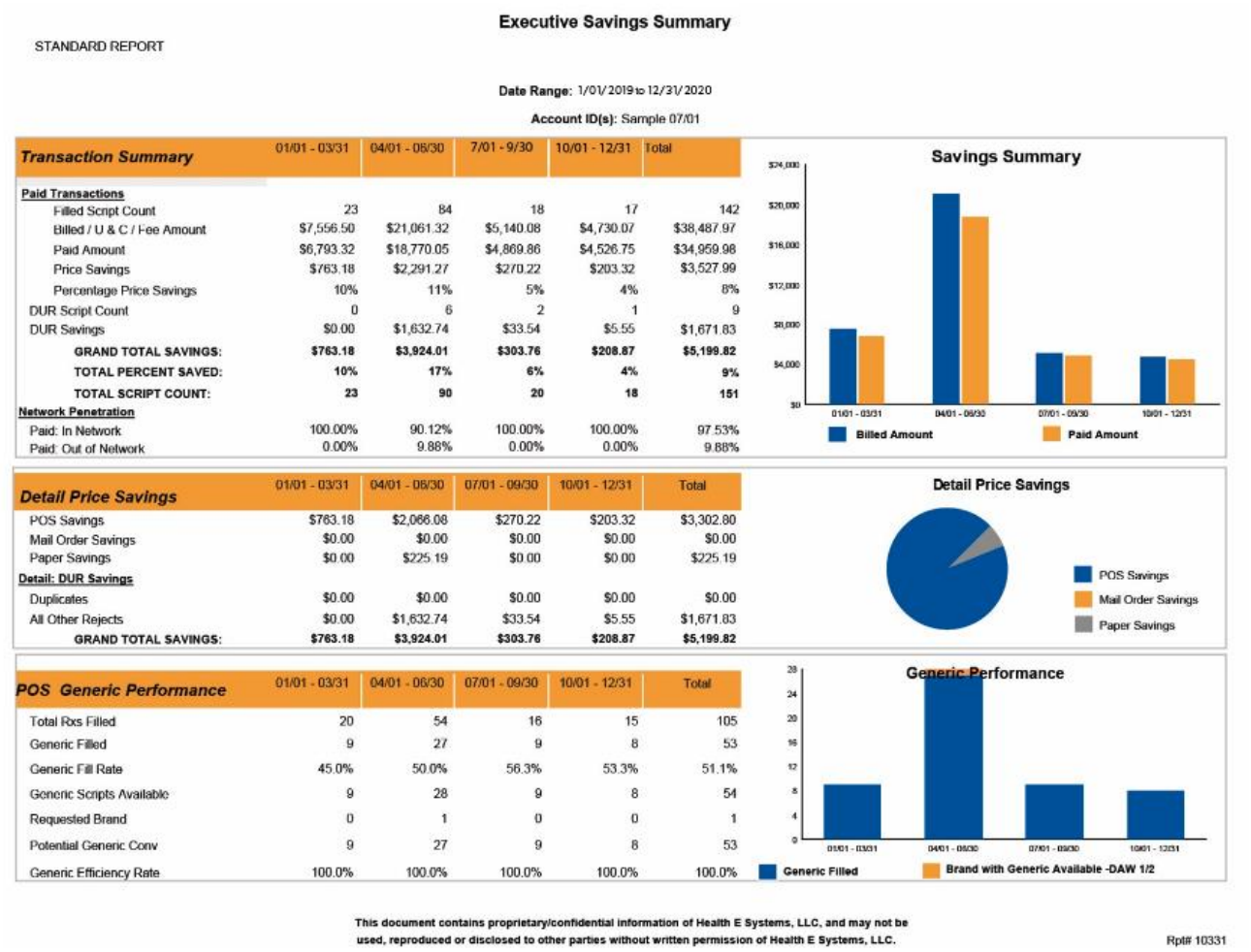
Description: Our PBM Clinical Opportunities Dashboard stratifies your claims populations to identify claims exhibiting therapeutic risk based upon criteria including MME and high-risk drug combinations. Rather than a static report, this dashboard provides real-time population data identifying areas of opportunity for clinical management and/or intervention.

Data Elements: Claims with opioid use, MME, Claims with high-risk drug combinations and those combinations.

Classic Reports

Classic reports are parameter-based and can be created “on demand” via the Verticē web portal tool to return a set of updatable results for review. These reports also include charts, graphs, and drill-down capabilities. Classic reports can be scheduled for updates and delivery at specified intervals and formats.

REPORT: EXECUTIVE SAVINGS SUMMARY



Executive Savings Summary

STANDARD REPORT

Date Range: 1/01/2019 to 12/31/2020

Account ID(s): Sample 07/01

Transaction Summary	01/01 - 03/31	04/01 - 06/30	7/01 - 9/30	10/01 - 12/31	Total
Paid Transactions					
Filled Script Count	23	84	18	17	142
Billed / U & C / Fee Amount	$7,556.50	$21,061.32	$5,140.08	$4,730.07	$38,487.97
Paid Amount	$6,793.32	$18,770.05	$4,869.86	$4,526.75	$34,959.98
Price Savings	$763.18	$2,291.27	$270.22	$203.32	$3,527.99
Percentage Price Savings	10%	11%	5%	4%	8%
DUR Script Count	0	6	2	1	9
DUR Savings	$0.00	$1,632.74	$33.54	$5.55	$1,671.83
GRAND TOTAL SAVINGS:	**$763.18**	**$3,924.01**	**$303.76**	**$208.87**	**$5,199.82**
TOTAL PERCENT SAVED:	**10%**	**17%**	**6%**	**4%**	**9%**
TOTAL SCRIPT COUNT:	**23**	**90**	**20**	**18**	**151**
Network Penetration					
Paid: In Network	100.00%	90.12%	100.00%	100.00%	97.53%
Paid: Out of Network	0.00%	9.88%	0.00%	0.00%	9.88%

Savings Summary

Billed Amount | Paid Amount

Detail Price Savings	01/01 - 03/31	04/01 - 06/30	07/01 - 09/30	10/01 - 12/31	Total
POS Savings	$763.18	$2,066.08	$270.22	$203.32	$3,302.80
Mail Order Savings	$0.00	$0.00	$0.00	$0.00	$0.00
Paper Savings	$0.00	$225.19	$0.00	$0.00	$225.19
Detail: DUR Savings					
Duplicates	$0.00	$0.00	$0.00	$0.00	$0.00
All Other Rejects	$0.00	$1,632.74	$33.54	$5.55	$1,671.83
GRAND TOTAL SAVINGS:	**$763.18**	**$3,924.01**	**$303.76**	**$208.87**	**$5,199.82**

Detail Price Savings

POS Savings | Mail Order Savings | Paper Savings

POS Generic Performance	01/01 - 03/31	04/01 - 06/30	07/01 - 09/30	10/01 - 12/31	Total
Total Rxs Filled	20	54	16	15	105
Generic Filled	9	27	9	8	53
Generic Fill Rate	45.0%	50.0%	56.3%	53.3%	51.1%
Generic Scripts Available	9	28	9	8	54
Requested Brand	0	1	0	0	1
Potential Generic Conv	9	27	9	8	53
Generic Efficiency Rate	100.0%	100.0%	100.0%	100.0%	100.0%

Generic Performance

Generic Filled | Brand with Generic Available -DAW 1/2

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Rpt# 10331

Description: This report provides an executive summary of PBM activity for the specified date range. Results can be restricted by lines of coverage (if applicable), report length (month/quarter/year), summary column (single column vs multiple columns), field offices, account IDs, SOJs and/or employer locations.

REPORT: RETAIL GENERIC PERFORMANCE – STATE BREAKDOWN

STANDARD REPORT

Retail Generic Performance - State Breakdown

Date Range: 1/01/2019 to 12/31/2020

Date Field: Date Submitted

State	Total RXs Filled	Generic Filled	Brand W Generic Available	DAW1	DAW2	DAW 0 & 3-9	Brand w/No Generic Available	Generic Fill Rate	Total Drugs Available Generically	% of Total Available that were DAW1	% of Total Available that were DAW2	Potential Generic Conversion	Generic Efficiency Rate
AL +	993	818	0	0	0	0	175	82.4%	818	0.0%	0.0%	818	100.0%
FL +	11,934	9,401	255	245	1	9	2,278	78.8%	9,656	2.5%	0.0%	9,656	97.4%
GA +	1,567	1,466	0	0	0	0	101	93.6%	1,466	0.0%	0.0%	1,466	100.0%
IL	734	639	25	15	8	2	70	87.1%	664	2.3%	1.2%	664	96.2%
IN	790	735	5	1	4	0	50	93.0%	740	0.1%	0.5%	740	99.3%
KY ++	41	35	0	0	0	0	6	85.4%	35	0.0%	0.0%	35	100.0%
LA +	30	21	0	0	0	0	9	70.0%	21	0.0%	0.0%	21	100.0%
MD	18	15	0	0	0	0	3	83.3%	15	0.0%	0.0%	15	100.0%
MI +	502	384	0	0	0	0	118	76.5%	384	0.0%	0.0%	384	100.0%
MO	160	152	0	0	0	0	8	95.0%	152	0.0%	0.0%	152	100.0%
MS +	469	403	0	0	0	0	66	85.9%	403	0.0%	0.0%	403	100.0%
NC +	1,082	931	0	0	0	0	151	86.0%	931	0.0%	0.0%	931	100.0%
SC +	689	556	3	1	0	2	130	80.7%	559	0.2%	0.0%	559	99.5%
TN ++	1,112	923	2	2	0	0	187	83.0%	925	0.2%	0.0%	925	99.8%
TX ++	17	17	0	0	0	0	0	100.0%	17	0.0%	0.0%	17	100.0%
VA +	31	31	0	0	0	0	0	100.0%	31	0.0%	0.0%	31	100.0%
Generic Mandatory Totals													
	18,466	**14,985**	**260**	**248**	**1**	**11**	**3,221**	**81.1%**	**15,245**	**1.6%**	**0.0%**	**15,245**	**98.3%**
Non Generic Mandatory Totals													
	1,703	**1,542**	**30**	**16**	**12**	**2**	**131**	**90.5%**	**1,572**	**1.0%**	**0.8%**	**1,572**	**98.1%**
Grand Totals													
	20,169	**16,527**	**290**	**264**	**13**	**13**	**3,352**	**81.9%**	**16,817**	**1.6%**	**0.1%**	**16,817**	**98.3%**

+ denotes Generic Mandatory
++ denotes Generic Mandatory & PPD state

Rpt# 10156

Description: This report shows the generic performance of each State of Venue with an overall grand total for the specified date range. Results can be restricted to account IDs, SOJ and/or company names. This report allows the user to select which date type to use when selecting data. This report contains a drill down that will show only results for the selected states and its comparison to the grand total.

Data Elements: State Breakdown: State, Total RXs Filled, Generic Filled, Brand w Generic Avail, DAW 1, DAW 2, DAW 0 & 3-9, Brand w/ No Generic Available, Generic Substitution %, Total Drugs Available Generically, % of Total Available that were DAW 1, % of Total Available that were DAW 2, Total Potential Generic Conversion, Generic Efficiency Rate

REPORT: POINT OF SALE DRUG UTILIZATION REVIEW SUMMARY

Point of Sale Drug Utilization Review - Summary

STANDARD REPORT

Date Range: 1/01/2019 to 12/31/2020

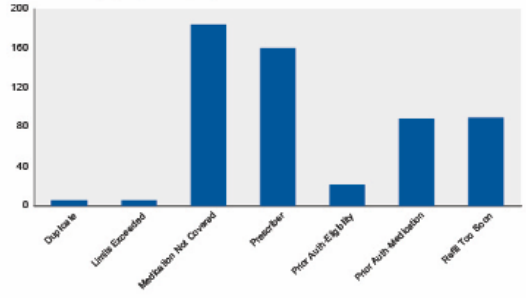
Summary	Totals	% of Totals
Total Injured Workers	942	
Total RXs Filled (#)	2,052	78.62%
Total RXs Filled ($)	$350,390	79.60%
Initial Rejects (#)	824	28.65%
Initial Rejects ($)	$140,199	28.58%
Ultimate Rejects (#)	558	21.38%
Ultimate Rejects ($)	$89,804	20.40%

Detail Ultimate Rejects by Count	Totals	% of Totals
Duplicate	6	0.23%
Limits Exceeded: $'s, Qty	6	0.23%
Medication Not Covered	185	7.09%
Prescriber	161	6.17%
Prior Auth-Eligibility	21	0.80%
Prior Auth-Medication	89	3.41%
Refill Too Soon	90	3.45%

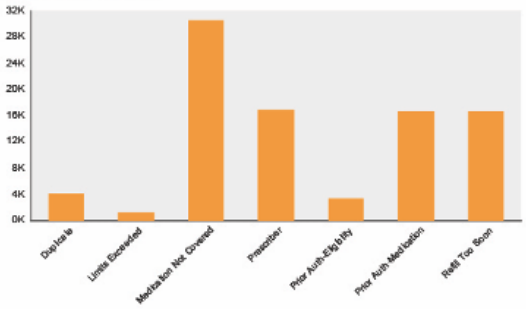
Detail Ultimate Rejects by $	Totals	% of Totals
Duplicate	$4,127	0.94%
Limits Exceeded: $'s, Qty	$1,312	0.30%
Medication Not Covered	$30,580	6.95%
Prescriber	$16,924	3.84%
Prior Auth-Eligibility	$3,401	0.77%
Prior Auth-Medication	$16,797	3.82%
Refill Too Soon	$16,663	3.79%

*Reject Legend located on the next page

Reject Counts (#) by Category



Reject ($) by Category



Rpt# 10125

5.9 Transition and Termination of Agreements

1. The Offeror must provide a narrative describing in detail:

a. Confirm the Offeror will commit to fully cooperate with the successor contractor to ensure the timely receipt of all information necessary to transfer administration of the Prescription Drug Program.

b. Provide an outline of the key elements and tasks that would be included in your separate Transition Plans for each of the Procuring Agencies to ensure that all the required duties and responsibilities are completed if the Offeror were the incumbent contractor. Include a brief explanation on how the Offeror would accomplish this with the next Selected Offeror.

c. Please detail the level of customer service that the Offeror will provide after the termination date of the Agreements resulting from this RFP.

We will work with the Department to ensure a successful, smooth transition of services and resolution of any outstanding matters while maintaining a high level of customer service during the post-termination period.

Cooperation with Successor Contractor

We confirm our commitment to cooperate fully with the successor contractor to ensure timely receipt of all information necessary to transfer administration of the PDP for DCS and NYSIF.

Key Transition Plan Elements

Upon termination of the contract with DCS, we will provide all necessary documentation, claims files, prescription history, and other data needed for the successful transition of the program to the appointed incoming vendor.

We strive to ensure that services provided post-termination support a seamless transition for DCS and DCS's members. We will collaborate with DCS to complete a mutually agreed upon termination transition plan. The account executive will meet with DCS to document requested run-out services including file transfers to the new vendor and applicable fees in an executed, post-termination services letter. Additionally, the account manager identifies and documents all post-termination requirements in a termination questionnaire, which we distribute internally to notify impacted departments of the terminated services and those services that will continue per the letter. The account manager tracks the progress of the termination using a Termination Process Project Plan. Through the end of the contract term, DCS will continue to work with the account manager to coordinate services that we will provide during the transition period.

The **5.9 Exhibits** tab includes a sample questionnaire and transition plan for DCS.

For the NYSIF transition plan, a series of essential elements and tasks will be included to ensure a smooth handover of duties and responsibilities from us to the next contractor. An outline of these key elements and tasks, along with a brief explanation of how the transition would be accomplished include:

- **I. Introduction and Overview**: Explanation of the purpose and scope of the Transition Plans. Identification of the incumbent contractor (Offeror) and the next Selected Offeror.

- **II. Project Kick-Off and Planning**: Meeting between the incumbent and the next Selected Offeror to discuss the transition process. Establishment of a transition team with clear roles and responsibilities. - Development of a detailed transition project plan with timelines and milestones.
- **III. Data and Knowledge Transfer**: Compilation and review of all project documentation, reports, and relevant data. Meetings to transfer knowledge and insights regarding project-specific details and challenges, ensuring that the next Selected Offeror has access to necessary tools, software, and systems.
- **IV. Stakeholder Communication**: Notification to all relevant stakeholders (internal and external) about the transition. Developing a communication plan to address questions, concerns, and updates throughout the transition.
- **V. Process and Workflow Transfer**: Detailed documentation of all project processes and workflows. Hands-on training sessions for the next Selected Offeror's staff on project-specific procedures. Periodic review and refinement of processes as needed.
- **VI. Quality Control and Monitoring**: Establishing a mechanism for ongoing quality control during the transition. Regular review meetings to ensure that project deliverables meet standards. Handling any discrepancies or issues promptly and efficiently.
- **VII. Risk Management**: Identification of potential risks and challenges in the transition process. Development of contingency plans to address unforeseen issues. - Regular risk assessments and mitigation efforts.
- **VIII. Financial Transition**: Transfer of financial responsibilities, including budgets, invoices, and payment procedures. Ensuring that the next Selected Offeror has access to necessary financial records. Coordination with relevant financial departments.
- **IX. Legal and Contractual Aspects**: Review of existing contracts and agreements with the Procuring Agencies. Transfer or renewal of necessary licenses and permits. Compliance with legal and regulatory requirements.
- **X. Reporting and Documentation**: Regular reporting to the Procuring Agencies on the status of the transition. Comprehensive documentation of the entire transition process for reference and audit.
- **XI. Post-Transition Evaluation**: Review and assessment of the transition's success. Recommendations for ongoing improvement in the collaboration between the incumbent and the next Selected Offeror.

The Offeror would ensure a smooth transition by fostering close collaboration with the next Selected Offeror and providing all necessary information, documentation, training, and support. The focus would be on effective knowledge transfer, clear communication, and diligent project management to minimize disruptions during the transition period. The Offeror would also emphasize ongoing quality control and risk management to address any challenges that may arise during the transition.

Post Termination Support

We will provide run-out support as mutually agreed upon, typically for up to 90 days post-contract termination, as outlined in the agreement.

The level of customer service that will be provided after the termination date of the agreements resulting from this RFP would typically be outlined in the transition and termination provisions of the agreements or contracts. The

specific level of customer service can vary depending on the terms negotiated between the parties. However, here are some general considerations for post-termination customer service:

- **Transition Period Support**: The Offeror may commit to providing support during the transition period to ensure a smooth handover of responsibilities to the new service provider or the Procuring Agencies themselves. This support could involve continued access to the Offeror's staff, systems, and documentation to facilitate the transition.
- **Data and Knowledge Transfer**: The Offeror may provide a mechanism for the transfer of data, knowledge, and documentation to the Procuring Agencies or the next service provider. This could include training sessions, access to databases, and assistance in ensuring that all necessary information is effectively transferred.
- **Ongoing Issue Resolution**: The Offeror may commit to addressing any outstanding issues or concerns related to the services provided up to the termination date. A process for reporting and resolving post-termination issues may be defined.
- **Customer Access to Records**: The Offeror might allow continued access to records and reports generated during the term of the agreement for a specified period, as required by the Procuring Agencies.
- **Communication and Reporting**: Clear communication channels may be maintained to address questions or issues that arise post-termination. Reporting mechanisms may still be in place to update the Procuring Agencies on any outstanding matters.
- **Compliance with Legal Obligations**: The Offeror should continue to meet any legal and contractual obligations, including data protection, confidentiality, and intellectual property rights, even after the termination of the agreement. It's essential for the specific terms of post-termination customer service to be detailed in the contract or agreement resulting from the RFP. These terms should be negotiated and agreed upon by the parties involved to ensure that the interests of both the Procuring Agencies and the Offeror are protected.

2. Transition and Termination Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee all Transition Plan requirements outlined in Section 3.8 of this RFP will be completed in the required time frames to the satisfaction of the Department.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each Day or part thereof that the Transition Plan requirements are not met. The forfeited amount (Standard Credit Amount) is $1,000 for each Day this guarantee is not met for each program. However, an Offeror may propose higher or lower amounts.

We agree to all transition plan requirements as noted in Section 3.8. They will be completed in the required time frames and to the satisfaction of the Department, by the applicable entity. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

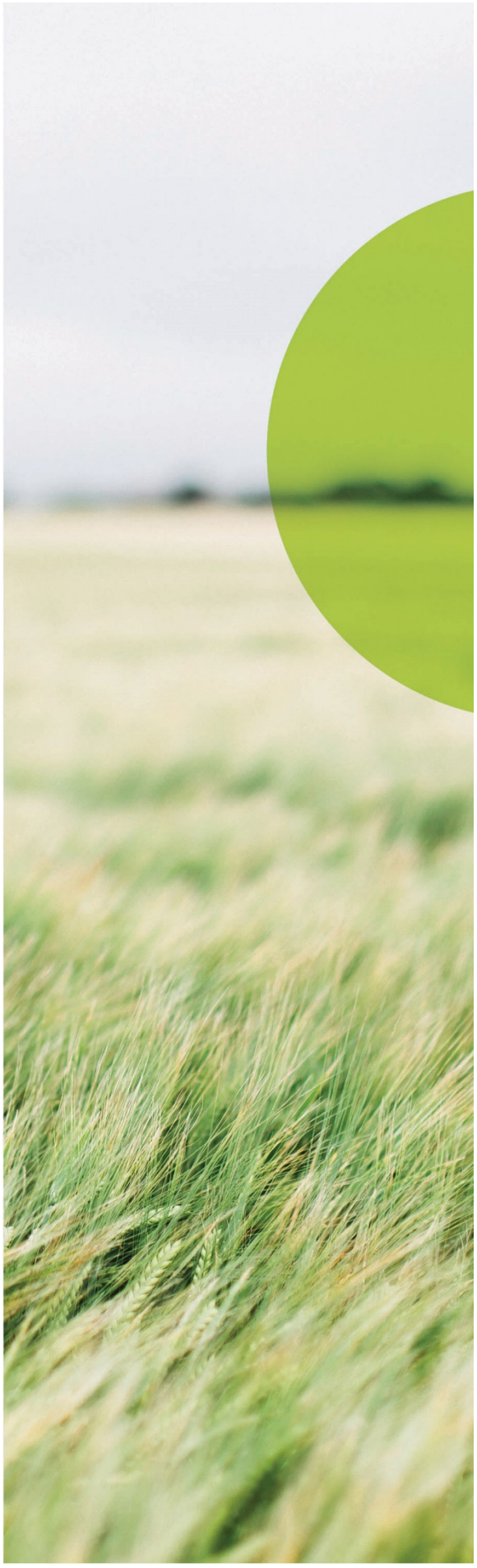
5.9 Exhibits

The following exhibits were referenced in Section 5.9 and have been provided here per RFP instructions.

Exhibit	Description
5.9 Exhibit A	Sample Implementation Questionnaire
5.9 Exhibit B	Sample Implementation Transition plan
Attachment 6	Performance Guarantees (included at the end of the Technical Proposal)

MedImpact

Termination Questionnaire



MedImpact

Add Client's Name/HQ

Termination Questionnaire

Table of Contents

Add Client's Name/HQ

Termination Questionnaire

1. Contact Information

1.1. Client Information	
Name:	
te/Run Out Date:	
Termination Date/Term Date:	
Address:	
Tax ID Number:	
Address and Phone:	
de(s): *see companion guide on terming HQ service*	
ntract ID (Part D Only)	
Action – Update new PBM of record with CMS – Date:	
r of Lives per HQ:	
the client does business in:	
Line of Business: (If more than one, please identify HQ or make comments)	☐ MCO ☐ Self-Insured ☐ Managed Medicaid ☐ Medicare Part D ☐ HIEx ☐ Cash Card ☐ **Retiree Drug Subsidy (RDS)**

1.2. Contact Names		
	Client	***MedImpact***
	Operations Primary Contact	***Client Services Manager***
Title:		
		(858) 790-
E-mail Address:		@medimpact.com
	Operations Secondary Contact	***Account Executive***
Title:		
		(858) 790-
E-mail Address:		@medimpact.com
	Clinical Contact	***Director, Client Services***
Title:		
		(858) 790-
E-mail Address:		@medimpact.com
	Information Technology	***Information Technology***
Title:		
		(858) 790-
E-mail Address:		@medimpact.com
	Part D Contact (Reporting, IT, PDE)	***Part D Specialist***
Title:		
		(858) 790-
E-mail Address:		@medimpact.com

1.2. Contact Names		
	Contractual Contact	*Customer Service*
Title:		
		(858) 790-
E-mail Address:		@medimpact.com

2. Information Technology

MedImpact Policy:

Please be advised that MedImpact will not manipulate any data/files on behalf of the client, outside vendors, etc.

While MedImpact will conduct file conversions (formatting/mapping), the integrity of the data for all files will be the accountability of the client.

General Information

2.1. Connectivity

Connectivity Termination (PGP, VPN, INIX, NI, MFT, SSH, Client IP Address)

Connectivity Entities to Term (check as many as apply)

☐ **Client**	Company Name:		☐ **TPA/Vendor**	Company Name:	
	Client Contact:			Client Contact:	
	MFT Account:			MFT Account:	
	Termination Date:			Termination Date:	
☐ **TPA/Vendor**	Company Name:		☐ **TPA/Vendor**	Company Name:	
	Client Contact:			Client Contact:	
	MFT Account:			MFT Account:	
	Termination Date:			Termination Date:	

Comments

Part D ONLY: Support of various CMS requirements necessitates connectivity to remain active for 36 months post termination. Refer to termination letter.

Part D clients who utilize PA Webservice CSM must submit a SFC to IT Security to remove client from the whitelist. See companion guide.

2.2. Outbound Files	
Please provide the final delivery date for the following outbound files (add rows as needed for any other currently scheduled outbound files).	
Claims Extract	☐ N/A ☐ Applicable: Final Delivery Date:
Accumulator Extract	☐ N/A ☐ Applicable: Final Delivery Date:
Member Eligibility Extract	☐ N/A ☐ Applicable: Final Delivery Date:
Comments	

Inbound Files- Part D ONLY: Support of various CMS requirements necessitates inbound file activity up to 36 months post termination. Refer to termination letter.

2.3. Group Termination	
Description: The group record creates the group/benefit link using the associated pharmacy carrier number for establishing member benefits. Individual group records must be sent for each group/benefit/carrier combination. This creates the buckets to which members will be added through the eligibility file.	
Will Client/TPA/Vendor provides the group linking file, when will the last production file be submitted?	☐ Yes ☐ No
• If no, Client authorizes MedImpact to terminate the group linking based on the dates provided below.	☐ Confirmed
Will the same termination date be applied to all HQs/Groups?	☐ Yes ☐ No
• If yes, please provide termination date to be applied to all HQs/Groups:	
• If no, please specify termination dates per HQ/Group:	
Comments	

Inbound Files

2.4. Member Eligibility Termination

Description: The member record established determining the member's eligibility status for PBM services under a specified group and division.

Will Client/TPA/Vendor provide an eligibility file to term all members?	☐ Yes ☐ No
• If yes, when will the last production eligibility file be submitted?	
• If no, Client authorizes MedImpact to terminate the member eligibility based on the dates provided below. This will require the completion of a Service Task which may incur a fee. Please check with your Account Executive regarding this fee.	☐ Confirmed
Will the same member termination date be applied to all HQs/Groups?	☐ Yes ☐ No
• If yes, please provide termination date to be applied to all HQs/Groups:	
• If no, please specify termination dates per HQ/Group:	

Comments

2.5. Historical Extracts

Not Applicable ☐

NOTE: All historical extracts will only be delivered in MedImpact's standard format accompanied with the appropriate file specification. Files will be delivered to the client's MFT account

Claims Extract	
Is a historical claims extract required?	☐ Yes ☐ No
• If yes, which file layout would you prefer?	☐ 110 ☐ 112
• If yes, when will you require the extracts and for which dates should they cover? **NOTE:** The date range of the data must allow a two week buffer prior to the delivery date. For example, a file for Jan 1 – Nov 30 should not have a delivery date prior to December 14 files will not contain any financial information.	Pre-Termination File Claim Date Range: Delivery Date: Post-Termination File Claim Date Range: Delivery Date:
Prior Approval Extract	
Is an extract of active prior approvals required?	☐ Yes ☐ No
• If yes, when will you require the extracts and for which date would you like the active PAs for? **NOTE:** The extract will provide all approved PAs active on the "PA Active As of Date". This date must be at least 3 business days prior to the	Pre-Termination File PA Active As of Date: Delivery Date: Post-Termination File

2.5. Historical Extracts	*Not Applicable* ☐
delivery date.	PA Active As of Date: Delivery Date:
Accumulator Extract	
Is an historical accumulator extract (Type 28) required?	☐ Yes ☐ No
• If yes, when will you require the files?	Pre-Termination File Delivery Date: Post-Termination File Delivery Date:
Comments	

3. Software Choices

3.1. MedAccess	
Instructions: MedAccess accounts terminate the day of account termination (Standard). **(SFC to Business Applications Service Delivery)**	
Account Termination Date/Time:	
Account Termination Submitted:	☐ Yes ☐ No
HQ screen: End date: Enter in the run out date. Term date: Enter in the term date (See Companion Guide) **Please note: If FDB Access/HQ Service is enabled ensure the I-FDBDATA is termed. Please see companion guide.**	

3.2. MedOptimize®.
Instructions: MedOptimize® accounts terminate the day of account termination (Standard). For full termination of a MedOptimize account, send SFC to Product Support If run out period applies please request the new security role for run out "Run Out Role" This will require a separate SFC which needs to be submitted to lock down users for run out period. Description of the new security role "Run Out Role": Limits access to only standard reports in the EOB and Accounting Reports folder. **(SFC to MedOptimize/Cognos Support)**

Add Client's Name/HQ

Termination Questionnaire

Account Run out Date/Time:
Account Run out Submitted: ☐ Yes ☐ No
Account Termination Date/Time:
Account Termination Submitted: ☐ Yes ☐ No
Comments:

3.3. MedResponse	**Not Applicable** ☐
Instructions: MedResponse accounts terminate the day of account termination (Standard). **(SFC to Health Services Business Applications)**	
Account Termination Date/Time:	
Account Termination Submitted:	☐ Yes ☐ No
Comments:	

3.4. MOR	
Instructions: This access is granted via client portal. Term date should match the run out date of HQ in MedAccess. **(SFC to IT Support)**	
Account Termination Date/Time:	
Account Termination Submitted:	☐ Yes ☐ No
Comments:	
See Companion Guide for additional directions for CSM. Please refer to the term letter.	

3.5. MedPrescription (e-Prescribing)	**Not Applicable** ☐
Instructions: Notify ePrescribing team of termination **(SFC to ePrescribing Team Queue)**	

3.5. MedPrescription (e-Prescribing)	Not Applicable ☐
Account Termination Date/Time:	
Account Termination Submitted:	☐ Yes ☐ No
Comments	

3.6. Member Portal	Not Applicable ☐

Instructions: Terminate access to Member Portal for Standard Applications or terminate Private Label custom content and sites.

PersonalHealthRx might remain accessible for 2 years post termination for members' tax purposes if they have access to MI site or client can continue pass via SSO the MI Member #.

(SFC to Business Applications Service Delivery)

Client has private label site:	☐ Yes ☐ No
Client has standard site:	☐ Yes ☐ No
Client has SSO access: *	☐ Yes ☐ No *__**NOTE**__: If Yes, it is the client's responsibility to remove all links to MedImpact applications from the client's website.
Term PersonalHealthRx: * Term Drug Price Check: Term Pharmacy Locater: Term Benefit Highlights: Term PA Status: Term Drug Information: ** Access might be kept for up to 2 years from termination date*	☐ Yes ☐ No ** Term Date/Time: ☐ Yes ☐ No ** Term Date/Time: ☐ Yes ☐ No ** Term Date/Time: ☐ Yes ☐ No ** Term Date/Time: ☐ Yes ☐ No ** Term Date/Time: ☐ Yes ☐ No ** Term Date/Time: ***Only Fill Term Date/Time if different from Member portal Term Date/Time*
Member Portal Term Date/Time: SFC #: PLBL #: LDAP Account Term Date/Time:	

3.6. Member Portal	Not Applicable ☐
Comments	

4. Pharmacy Network Management

Carrier Termination (SFC to BCRCaseAssignmentQueue)	
Carrier Termination Date/Time: The end date for active carriers reflects the termination date. **(Refer to Section 5 for run-out date)**	
Apply Carrier Message:	☐ Yes ☐ No
Indicate POS Message (NO_CRR_MESSAGE) 300 Characters:	
Notify Mail Order and Specialty Vendors of Termination:	Date/Time:

4.1. Carrier Edit Information

Carrier Edits

Edit	Description	Parameters
CLMEXP_MBR Edit must be active on all carriers see term letter for values.	Grace period for member submitted claims. .	Days: (standard 90 days) Days: Required1095 Part D
CLMEXP_PHA Edit must be active on all carriers see term letter for values.	Grace period for pharmacy paper claims	Days: (standard 90 days) Days: Required 90 Part D
CLMEXP_POS Edit must be active on all carriers see term letter for values.	Grace period for POS claims (online claims)	Days: (standard 90 days) Days: Required 90 Part D
LIMIT_PX_REVERSAL	Online claim reversal submission will be limited to **30 days** ***Please see companion guide for configuration instructions***	☐ Client Acknowledges
Claims Processing	**Description/Instructions**	**Parameters**
FIR Transactions	Grace Period default for FIR Transactions	Days: Required 1095 Part D
Information Reporting (N1) Transactions	Grace Period default for N1 Transactions	Days: Required 1095 Part D

COMMERCIAL ONLY- Term Custom BIN	Only pertains to those clients who utilize a custom BIN. ***Please see companion guide for instructions***	N/A
Term Payor Sheet	Submit SFC to POS QA	N/A

4.2 MedImpact Direct Mail Order

Instructions: Notify the following email distributions regarding termination

thawes@medimpactdirect.com ClientServices@medimpactdirect.com

Account Termination Date/Time:	
Account Termination Submitted:	☐ Yes ☐ No
Comments	

4.3 MedImpact Direct Specialty

Instructions: Notify Specialty team of termination via SFC to Specialty Pharmacy queue

Account Termination Date/Time:	
Account Termination Submitted:	☐ Yes ☐ No
Comments	

5. Direct Member Reimbursement

Not Applicable ☐

5.1. Direct Member Reimbursement Processing (Paper Claims)

(SFC to assigned CSCA)

DMR STANDARD RUN OUT ☐ YES ☐ NO

Standard run out period is 3 months post termination. Must be aligned with the termination letter.

Claim run out period: Claims will be returned to sender effective:	Date/Time: Procedure:
Appeals Notification Letters End Date (Only if MedImpact sends DMR Letters)	Date/Time: Procedure:

Comments

Part D: Support of various CMS requirements necessitate 36 months post termination run out.

5.2. SUBROGATION

Subrogation Processing Information (Government Agencies)

Not Applicable ☐

(CSM to handle)

☐ Subrogation Term date must be the last date that claims will process (e.g. For a 12/31/2014 term date with a 90 day run out, use 3/31/2015). Associated fees will be identified in the termination services letter.	Subro Term Date/Time:
☐ Subrogation Run Out Has HQ Service I-SUBRO been terminated: *(Edit Term date = Run out services date, last day claims will process)* ***Send SFC to Accounts Receivable requesting the billing matrix codes for Subro be termed using Term Date as the last date subro should process.*** ***Send SFC to Subrogation queue to term Subrogation eligibility***	☐ Yes Term Date/Time:

Part D: Support of various CMS requirements necessitate 36 months post termination run out.

6. Benefit Management

6.1. Benefit Termination (SFC to BCRCaseAssignmentQueue)	
Will the benefit codes be terminated:	☐ Yes ☐ No
Will they be termed manually or by SR:	☐ Manual ☐ SR
Comments	

7. Prior Authorization

☐ **Full Service:** Review being done by MI clinical staff, decision by MI clinical staff
☐ **Partial:** Review being done by MI clinical staff, refer non approvals to client
☐ **Self Service:** Client is responsible for PA processing

7.1. PA Procedure (SFC to PA Implementation Queue)	*Not Applicable* ☐
Prior Authorization Run Out Procedure: Standard is 1 month for PA's received on or before termination date:	Run Out Date/Time:
Prior Authorization Run Out Procedure: Custom agreement for PA requests received after termination date for service dates prior to termination date:	Run Out Date/Time:
PA's will be forwarded effective: to NOTE: Standard is 30 days. ☐ Plan Fax : ☐ PBM Fax :	Procedure:
All Appeals & Grievances will be forwarded to the client:	Date/Time:
Comments	

8. Customer Service

8.1. Customer Service Processing Information

(SFC to CS Client Administrators)

Does the client have a MedImpact assigned member toll free number:	☐ **YES** **Disconnect** **Number**: **Disconnect** ☐ **NO**
Run Out – Member Calls:	☐ Yes ☐ No Run out Date/Time:
Run Out – All Other Calls:	☐ Yes ☐ No Run out Date/Time:
Term Customer Service Notes	Date/Time:
Is IVR messaging required:	☐ Yes ☐ No
IVR msg - Standard message for referral:	
During the run out period all callers will be given the following telephone #:	Telephone #
Post Termination callers will receive a recorded voice message to refer to plan:	☐ Yes ☐ No

Comments

Please refer to term letter.

9. Production and Distribution

9.1. ID Cards – Initial Fulfillment Options

Not Applicable ☐

(SFC to Production and Distribution)

Effective Date ID Card turned off in Production: (No cards printed after this date)	☐ Date/Time_____ ☐ Not Applicable
Will MedImpact destroy the Inventory:	☐ Yes ☐ No
If no, who will the inventory be mailed to:	☐ Client ☐ Group
Type of Inventory:	☐ Mailing Material ☐ Custom Brochures ☐ Other:
Attention: (Name & Title)	
Address:	

9.1. ID Cards – Initial Fulfillment Options (SFC to Production and Distribution)	*Not Applicable* ☐
Comments	

10. Accounting

10.1. Accounting (SFC to 813-Accounts Receivable Research Queue)	
Run out of Rebates to be sent to Client (90 Days run out is Standard)	
Deposits on Plan (Balance Forward items)	☐ Yes ☐ No
Billable SR Charges for any open SR's. Note: BSA will need to be contacted for pending SR's. See companion guide	SR#
Comments	

11. Provider Audit

11.1. Network Compliance (SFC to Provider Audit Research)	*Not Applicable* ☐
Discontinue Documentation and Verification (D&V) audits: Documentation and Verification (D&V) audits: Selection for D&V audit of utilizing pharmacy claims is conducted for all participating Clients based on criteria established by MedImpact. Through a review and investigation of potentially discrepant claims, reasonable attempts to collect any overpayments are made.	☐
Discontinue Onsite Audits: MedImpact selects potentially discrepant Claims to be reviewed onsite, and make reasonable attempts to collect any overpayments made to Participating Pharmacies as determined through such onsite audits.	☐
Discontinue Reports: Summary and Detail Reports are included with EOB's in D&V and onsite audits.	☐
Comments	

11.2. Fraud Waste and Abuse	
FWA Bundle Package	☐ **NO**
PROSPECTIVE AUDIT	☐
RETROSPECTIVE AUDIT	
RESEARCH AND INVESTIGATION	

11.2. Fraud Waste and Abuse	
AUDIT REPORTS	

12. Government Program Services Deliverables

12.1. GPS Medicare Deliverables
(SFC to Medicare Part D Ops Team)

MedImpact's Part D reports:	Supported for 36 Months Post Termination[1]
	• FIR Transaction Activity Report
	• COB Recovery Reports
	  o COB Recovery Error Response Feedback File
	  o COB Recovery Adjustment Validation Log File
	  o COB Recovery Adjustment Report
	• MedAdjust (True Up)
	  o Member Selection
	  o Member Collection Report (MCR)
	  o Member Collection Mail Merge Report
	  o Member Positive Adjustment Report (MPAR)
	  o Nx Refund Report
	  o Post-Insert Difference & Summary Reports (Production Processing)
	  o RetroLICS Payment Report
	• Nx Information Reporting Transaction Activity Report
	[1] Note: Plan Sponsors may request an earlier term date for any of the 36 month supported reports.

	Supported for 3 Months Post Termination • Denied Claims Report • ESRD and Hospice Reports • Excluded Provider Files • Part B Claims Report • Precluded Provider Report • Retroactive OHI Claims Reports (aka "Mistaken Payment") • Transition Notification File Ends at Termination Date • Formulary Files • LIS BAE Reports • Part D MEOB File • Part C MEOB File • Pharmacy Directory Files • Plan Finder If there are any other required or requested reports, please list here:
CMS required reports schedule end-date:	CMS Required Reports will be generated for 36 months post termination when new or modified data is available. • Coverage Determinations & Redeterminations • Direct & Indirect Remuneration (DIR) • Grievances • Improving Drug Utilization Review Controls • Reopenings (Coverage Determinations & Redeterminations) Part C: Only if plan is contracted with MedImpact to process Part B claims. • Organization Determinations/Reconsiderations
Bridgecom termination notification should be handled by:	☐ MI ☐ Client Date/Time termination letter sent: Note: Identify which entity (MedImpact or Client) holds the contract with Bridgecom the contract ownership determines which entity is responsible for this step. The effective date of the contract termination with Bridgecom will fall one month after the termination date.
Print Vendor (if not Bridgecom)	Vendor name: Holds contract: ☐ MI ☐ Client

PDE Submitter ID:	
PDE EDI to client and client's vendor	FTP will be left open for Part D clients for 36 months following termination in accordance with the final PDE date as provided by CMS to ensure all PDE reconciliation and any necessary file exchanges are able to take place as it relates to CMS guidance.
PDE reporting schedule end-date :	PDE Reports: ✓ PDE Count Summary Report ✓ PDE file ✓ PDE Error Detail Rejection Report ✓ PDE Error Informational Rejection Report ✓ PDE Error Summary Report End Date/Time: (This date must be 36 months post termination.) Note: The coverage year reconciliation will be June 30 of the year following termination. The final reconciliation will be 36 months post termination. MedImpact will only support PDE reporting for coverage years processed by MedImpact.
Retiree Drug Subsidy (RDS)	End Date/Time: Note: Final reconciliation files to be delivered 15 months post termination.
Comments	
GPS Marketplace Deliverables **(SFC to Marketplace GPS Support)**	
HIEx CSR Standard Method Reinsurance *(refer to the Marketplace team)*	End Date/Time: End Date/Time: Note: Final reconciliation files to be delivered no later than April 15 following each calendar year.
Comments	

***** NOTE FOR ALL CLINICAL PRODUCTS: CLIENT TEAM, PLEASE REVIEW WHICH CLINICAL PRODUCTS ARE PERTINENT TO TURN OFF BASED ON WHAT IS CURRENTLY IN PLACE TODAY. *****

13. Medication Therapy Management - MTM

13.1 Medication Therapy Management -MTM (includes RxGuide, Commercial MTM) (SFC to MTMP@MedImpact.com)		
Effective Date of MTM Termination:	Date: (Typically the termination date.)	
Notify MTM team of termination: (Email to MTMP@MedImpact.com)	Date Sent:	
Final MTM Reports to be sent: (to be completed by AM)	Date/Time: (Delivered in January following termination.) Procedure:	
Comments		

14. High Cost Generics Program

Not Applicable ☐

High Costs Generics Program (HCG Choice or HCG X) (SFC to HCGProgram queue)		
Effective Date of Termination:	Date: (Typically the termination date.)	
Final HCG Reports to be sent by AM)		
Comments		

15. Clinical Services

Clinical Programs and Analytics Send email of the IQ to Clinical Analytics Programs – Implementation		
MedFocus quarterly reporting:	Final Reports to be sent:	MedFocus quarterly reporting:
Standard Commercial and/or Part D Retrospective DUEs	Final DUEs to be sent:	Standard Commercial and/or Part D Retrospective DUEs

Add Client's Name/HQ

Termination Questionnaire

Enhanced and/or Custom Retrospective DUEs:	Final DUEs to be sent:	Enhanced and/or Custom Retrospective DUEs:
Other Clinical Programs		
☐ :	Date Sent: Procedure:	
☐ :	Date Sent: Procedure:	
☐ :	Date Sent: Procedure:	
Term Clinical Services Date and SFC:	Date/Time:	
Comments		

16. Requirements Acceptance Agreement

Client Name: _____

Client Carrier HQ: _____

Acceptance Agreement – Client will review all reports, statement and invoices provided by MedImpact and shall notify MedImpact in writing of any errors or objections within thirty (30) days of Client receipt. Specifically this shall apply to all service requests, implementation questionnaires, statements of work, etc. Unless Client notifies MedImpact in writing of any errors or objections within the thirty (30) day period, all the information contained therein will be deemed accurate, complete and acceptable to Client and thereafter MedImpact shall have no liability related thereto. In any event if Client provides timely notification within the thirty (30) day period, liability is capped to that accrued during the initial thirty (30) day period.

My signature below affirms that I have authority to authorize MedImpact, and I do authorize MedImpact, to perform, implement or change the services or products described herein. I acknowledge that I have reviewed the information contained herein and I clearly understand all items to which I am agreeing.

Date

Print Name

Signature

Title

MedImpact Healthcare Systems, Inc.

10181 Scripps Gateway Ct. San Diego, CA 92131
Phone: 800.788.2949

MedImpact.com

MedImpact

Termination Process Project Plan	*SFC (if applicable)*	*Start Date*	*Due Date*	*Completed Date*	*Notes*
Send initial termination notification email					
Create Project Parent Case					
Meet with client					
Begin populating the TQ - attach to all Child Cases					
TQ Section 2 (2.2, 2.3, 2.4, 2.5) - Assign SFC to BSA (term group load and benefits)					
TQ Section 2.1 (Connectivity) - Assign SFC to IT Support **Part D clients who utilize PA Webservice CSM must submit a SFC to IT Security to remove client from the whitelist. See companion guide.**					
Confirm any scheduled reports and if still needed work with AE as some of those could become billable					
Send EWS IQ to Client (attach completed form to Section 3 SFCs)					
TQ Section 3 (MedAccess) - Assign SFC to BASD (term active users)					
TQ Section 3 (MedOptimize) - Assign SFC to Operations Reporting Services (term active users) A separate SFC will be needed for those users who will get run out role issued					
TQ Section 3 (MedResponse) - Assign SFC to Health Services Business Applications (term active users)					
TQ Section 3 (MOR) - Assign SFC to IT Support (term active users)					
TQ Section 3 (MedPrescription) - Assign SFC to ePrescribing Team Queue					
TQ Section 3 (Member Portal) - Assign SFC to Business Applications					
TQ Section 4 - Assign SFC to BCRCaseAssignmentQueue (term carriers, benefits and edits) 4.2- email thawes@medimpactdirect.com ClientServices@medimpactdirect.com 4.3- Notify Specialty team of termination via SFC to Specialty Pharmacy queue					
TQ Section 5 - Assign SFC to assigned CSCA					
TQ Section 6 - Assign SFC to BCRCaseAssignmentQueue to have benefit codes termed					
TQ Section 7 - Assign SFC to PA Implementation Queue					
TQ Section 8 - Assign SFC to CS Client Administrators (term Notes, IVR)					
TQ Section 9 - Assign SFC to Production and Distribution					
TQ Section 10 - Assign SFC to AE (need info from contract); reassign SFC to 813-Accounts Receivable Research Queue					
Send Wire Request Form and W-9 to Client (attach completed forms to Section 10 SFC)					
TQ Section 10 - Reassign SFC to 813-Accounts Receivable Research Queue					
TQ Section 11 - Assign SFC to Provider Audit Research					
TQ Section 12 - Assign SFC to Medicare Part D Ops					
TQ Section 13 - Assign SFC to MTMP@MedImpact.com					
TQ Section 14 - Assign SFC to C HCGProgram@MedImpact.com					
TQ Section 15- Send email of the IQ to Clinical Analytics Programs – Implementation **(TEMPORARY UNTIL SF QUEUE HAS BEEN CREATED)**					
Send Client TQ signature page Section 15 for sign off					
Send follow-up termination notification email with TQ attached					
Work with AE to finalize Termination letter					
Enter End Date and Cust Svc Msg in MedAccess					
Generate claims analysis reports post termination twice a day for one week					

5.10 Network Management

A. Retail Pharmacy Network

1. Propose separate access guarantees for each of the three Programs in the tables below for the Programs' Retail Pharmacy Networks that meet or exceed the minimums set forth in Section 3.9. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated in Section 3.9, Network Management.

See below.

DCS Commercial Program

% of Commercial Enrollees with Access to Retail Pharmacies	Commercial Enrollee Location	Access Guarantee One Pharmacy at least within
99.9% - Broad network 98.6% - Narrow network (CVS out)	Urban	2 miles
99.8% - Broad network 99.9% - Narrow network (CVS out)	Suburban	5 miles
99.0% - Broad network 98.8% - Narrow network (CVS out)	Rural	15 miles

DCS EGWP

% of EGWP Enrollees with Access to Retail Pharmacies	EGWP Enrollee Location	Access Guarantee One Pharmacy at least within
99.9% - Broad Part D network 98.0% - Narrow Part D network (CVS out) 99.2% - Narrow Part D network (WAGS out)	Urban	2 miles
99.9% - Broad Part D network 99.8% - Narrow Part D network (CVS out) 99.9% - Narrow Part D network (WAGS out)	Suburban	5 miles
98.9% - Broad Part D network 98.9% - Narrow Part D network (CVS out) 98.2% - Narrow Part D network (WAGS out)	Rural	15 miles

NYSIF Program

% of NYSIF Claimants with Access to Retail Pharmacies	NYSIF Claimants Location	Access Guarantee One Pharmacy at least within
99.9% - Broad network	Urban	2 miles
99.9% - Broad network	Suburban	5 miles
98.9% - Broad network	Rural	15 miles

2. Compare the current DCS Program network pharmacies that have submitted claims in 2023 with the Offeror's Proposed Retail Pharmacy Network File (Attachment 18). 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 Attachment 21, Comparison of DCS 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 attachment can be obtained by following the instructions, which requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application, included in Attachment 21.

Upon receipt of Attachments 18 and 21, we will compare our retail pharmacy network against the current DCS current network pharmacies. We have a high quality, comprehensive network that exceeds most access standards. We can also solicit retail pharmacies that have previously served DCS' members but are not in our retail network provided they meet our quality and credentialing standards. In the past, we have been successful in new pharmacy solicitation efforts by:

- Assisting in the transition to a network pharmacy
- Adding the member's existing pharmacy to the MedImpact network
- Securing home delivery service for the member through our mail order or specialty pharmacy partner

3. Confirm that if selected, the Offeror will provide an updated Attachment 18, Offeror's Proposed Retail Pharmacy Network File, Attachment 20, Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet and Attachment 21, Comparison of DCS Current Program Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network thirty days prior to the Project Services Start Date confirming that the Offeror's proposed Retail Pharmacy Network will be implemented as required on the respective Project Services Start Date. 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.

MedImpact confirms.

4. Confirm that your independent pharmacy network substantially maintains the composition of independent Network Pharmacies in the Programs' current Retail Pharmacy Network. Substantially maintain the composition shall mean that an Offeror must include contracts with independent pharmacies accounting for seventy-five percent (75%) or more of the DCS Programs' prescription drugs dispensed through independent pharmacies, based on the informational claims file for 2023 (Attachment 84, Layout Specifications for DCS Program Informational Claims Data File) as required in Section 1.8(8) and described in Sections 3.9 and 5.10. Describe the approach(es) the Offeror would use to solicit additional pharmacies to enhance your proposed Retail Pharmacy Network or to fulfill a request to add an individual independent Pharmacy.

We contract with all national pharmacies including chain, independent, grocery, etc. The foundation for these contracts is our annual network solicitation. We have strong and supportive relationships with both independent and chain pharmacies, which provide proactive environments for pricing negotiations and compliance with contracted services. We have established standard terms and conditions for network pharmacies, and any pharmacy willing to accept our terms and conditions can participate in the network. We recognize the value that both independent pharmacies and chains bring to our network and members. Rates and discounts can differ between pharmacy types based on differing circumstances and buying power or rural location.

MedImpact has at least 98%-member access across all lines of business and network types.

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

We will consider products limited distribution if they are only available through a limited number of specialty pharmacies. Pharmaceutical manufacturers determine if drugs are limited distribution (3 or fewer) or exclusive (1) distribution drugs.

We have access to 100% of LDDs.

6. Network Pharmacy Access Guarantees: The Offeror 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. Utilizing the Performance Guarantees form (Attachment 6), 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 lower amounts.

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 lower amounts.

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 lower amounts.

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 Attachment 20, Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet. The report is due thirty (30) Days after the end of the quarter.

We will commit to the network access requirements, as required, although we prefer these to be measured and reported annually for more accuracy. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

B. Pharmacy Credentialing

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?

Our legal, contracts, and regulatory compliance departments continuously review state pharmacy requirements to ensure our pharmacy contracts address applicable individual state laws. We use various resources, including PBMSource, PCMA, state and federal law, etc.

2. Describe your approach for credentialing Network Pharmacies.

a. Specify if the Offeror will 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 does the Offeror conduct a complete review?

b. What steps does the Offeror 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?

c. What steps, if any, does the Offeror take to advise members when a Pharmacy has been removed from the Retail Pharmacy Network?

All pharmacies, whether credentialing or recredentialing, must meet requirements outlined for participation or continued participation in the MedImpact network. Our credentialing committee has the authority to approve credentials, recommend participation in the network, implement corrective action plans when necessary, and recommend exclusions or terminations from the network due to credentialing deficiencies.

We will evaluate a new pharmacy (not currently in our network) in the following manner:

- Minimum of 1 year in business as a pharmacy
- Validation of all credentialing documents including:
  - Drug Enforcement Agency license, if applicable
  - State pharmacy license
  - Pharmacist in charge license
  - Copy of the liability insurance certificate
  - Current certificate of general liability insurance
- Validation that there are no state or federal sanctions and probations
- Onsite credentialing and observation visit performed by us or designee using a MedImpact-approved form and gathering photographs
- Affidavit document, signed by the pharmacy, confirming the pharmacy's PSAO (pharmacy services administrative organization) affiliation and authorizing the PSAO to enter into agreements on its behalf, if applicable

External Credentialing

We do not utilize an external credentialing verification organization for credentialing of our network pharmacies.

The credentialing committee meets monthly; the timing of the recredentialing year is dependent upon the state license renewal dates and would meet the 3-year recredentialing cycle.

Pharmacy Removal

We will automatically terminate a pharmacy if the pharmacy, not necessarily the pharmacist, has been indicted or is in an Office of Inspector General sanction; otherwise, we place them on the watch list and possibly report them to the credentialing committee for action. Terminated pharmacies cannot dispense prescriptions for members since the adjudication system denies the prescription at the point of sale.

Our Medicare Part D offering also includes the excluded provider program, which includes claims system point-of-sale rejection of all prescription claims from all excluded providers in the Medicare Part D program with NCPDP industry standard messaging to the pharmacy. The excluded provider program offers daily reports of any claims rejected due to an excluded prescriber. DCS also will receive a daily report of claims which was approved after a provider became sanctioned but before CMS made that information available to MedImpact via LexisNexis, our source for federal and state sanctioned information. DCS can use these reports for communicating to MEDIC and as any beneficiary or prescriber letters.

We generate reporting on both approved and denied claims associated with excluded providers. Plan sponsors can either manage the printing of beneficiary communication themselves or work with our preferred print vendor. If DCS wishes to use our preferred print vendor, we request a 4 to 6-week lead time. If DCS does not wish to use our preferred print vendor, they can use the data files from us to produce beneficiary communications.

Communication

The **5.10 Exhibits** tab includes a sample letter that details how we communicate with the member that a pharmacy has been removed from the network.

C. Pharmacy Contracting

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. The Offeror must confirm that it will, pursuant to the terms of this RFP and the resulting Contract, provide to the State or to a third-party acting on behalf of the State, any pharmacy network agreement(s) in scope of the Program Services, so that the State can evaluate whether a Network Pharmacy meets Program requirements and benefit design specifications. If Contractor identifies the information in writing as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 8.7, Contractor's Confidential Information. Such access is in addition to the State's Audit Authority as specified in this RFP.

MedImpact confirms. Our network pharmacy agreements require compliance with all Programs' requirements and benefit design specifications. We will provide to the State, or to a third-party acting on behalf of the State, any pharmacy network agreement for evaluation.

The **5.10 Exhibits** tab provides a sample pharmacy network agreement for the DCS Programs and a sample agreement for NYSIF. We have also provided a sample pharmacy manual for DCS which due to file size, has been included on the USB drives as **5.10 Exhibit D** .

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 the Offeror's Retail Pharmacy and Specialty Pharmacy network, if applicable.

MedImpact confirms. We can solicit retail pharmacies that have previously served DCS' members but are not in our retail network provided they meet our quality and credentialing standards. In the past, we have been successful in new pharmacy solicitation efforts by securing home delivery service for the members through our mail order or specialty pharmacy partner.

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

MedImpact confirms.

4. Please confirm that the Offeror 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.

MedImpact confirms.

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

Our PBM program is designed to maximize total cost containment opportunities throughout all aspects of the pharmacy program, which includes optimizing network penetration, including the mitigation of paper/third party billing by in-network pharmacies.

Proactive Pharmacy Engagement

Initially, the most effective way to minimize out-of-network billing, especially related to third party billers, is to proactively get in front of it and attempt to put tools in place to mitigate it from happening. This typically begins the moment a prescription reject occurs at the point of sale and the way in which you engage the pharmacy and how fast this occurs. A POS rejection is often the reason a pharmacist will route a prescription bill to a third-party biller since their goal is to service the patient in front of them and minimize the friction that prior authorizations create in workers' compensation. Since workers' compensation prescriptions only represent less than 2% of all healthcare pharmacy transactions, many pharmacists often don't understand or know the way in which they need to resolve a prescription reject since it is vastly different compared to any other healthcare prescription transaction resolution.

The integrated customer service center provides a proactive servicing role for all prior authorization activity. As opposed to waiting for pharmacies to contact us to rectify prior authorizations, we proactively engage pharmacies at the time a pharmacy transaction rejects (prior authorization) to ensure expedited and accurate resolution. This often avoids the out of network activity typically directed to third party billers since we are proactively resolving the

obstacles for the pharmacy. In addition, it also significantly reduces phone calls to the claims professional and provides a more positive experience for the injured claimant at the pharmacy counter.

Paper/Third Party Billing

We receive all third-party billing activity from each respective company via an electronic data feed (i.e. none of our customers receive paper bills from these third-party billing entities). This is highly unique in the industry since it is our understanding there are no other PBMs that are receiving all third-party billing activity electronically regardless of the source (i.e. some PBMs own or receive one feed, but not others).

Upon receipt of the electronic data feeds from the third-party billers, claims adjudicate applying all the same formulary rules and DUR edits that are applied to POS transactions to determine whether the drug, and/or claim may not be compensable. Simultaneously, we initiate a conversion process to alert the respective pharmacies about the out of network activity.

Conversion on Subsequent Scripts

Our statistics reveal that 99% of the paper bills received are from pharmacies that are in the pharmacy network due to the size and coverage of our national network. Through our direct relationships with the retail pharmacies and their designated Third-Party Billers, we can receive the third-party bills electronically instead of on paper. The electronic files we receive contain pertinent information needed to either contact the dispensing pharmacies directly, enabling pharmacies to update member profiles with the appropriate BIN for future prescriptions, or in the case of Walgreens, automate the claim conversion process. These relationships eliminate most paper transactions at the onset of a program. Our success rate in converting paper bills and electronic third-party bills to network transactions is over 90%. Regardless of the methodology, the third-party billing process is highly effective, and our customers are experiencing a significantly lower amount of third-party billing volume compared to payers using other PBMs. Customers are also presented the opportunity to deny payment on prescriptions that are out of formulary and/or not compensable.

D. Pharmacy and Program Audit

1. Confirm that ample resources will be made available to Department and NYSIF in response to OSC audits, including access to the Offeror's online claims processing system and historical claims data files.

MedImpact confirms.

2. Confirm that current Prescription Drug industry pricing source material (e.g., Medi-Span) will be made available in its entirety, for the duration of the Agreement resulting from this RFP by the Offeror for access up to 6 (six) Department Staff as determined by the Department.

MedImpact confirms.

3. Describe the Pharmacy audit program the Offeror would conduct for the Programs including a description of the criteria the Offeror uses to select pharmacies for audit and a description of the policy that the Offeror follows 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.

Our claims adjudication system provides numerous built-in edits to automatically detect inappropriate pharmacist dispensing or utilization. Upfront edits at the POS (point of sale) assist our clients by stopping inaccurate and fraudulent claims before they process, which requires less time than a pay-and-chase methodology. Our soft and hard system edits serve as the first line of defense against pharmacy FWA (fraud, waste, and abuse). Designed to address our client's varying business needs, the MedImpact portfolio of system edits can significantly reduce wasteful pharmacy errors at POS, which results in reduced costs, improved service, and enhanced quality of care.

Despite best efforts at catching inappropriate claims at the POS, evolving fraud schemes require more of a defense post adjudication. We offer the following solutions to identify, stop, and prevent FWA:

- Standard FWA Program
- Enhanced FWA Program
- Dynamic Refill Too Soon POS Edit

Standard Pharmacy FWA Program

We automatically enroll every client in our Standard Pharmacy FWA program. We maintain criteria, which we may amend from time to time, to establish when and how we select a participating pharmacy (excluding client-contracted participating pharmacies) for audit to determine contract compliance with MedImpact. We make reasonable attempts to collect any overpayments made to participating pharmacies as determined through such audits.

Desk Audits

We conduct desk audits based on our established criteria for all participating clients.

Onsite Audits

We select potentially discrepant claims for onsite review ensuring participating pharmacies compliance with federal and state laws and regulations.

Standard Pharmacy FWA Program Add-ons

We also provide the following additional items that DCS can add to the Standard Pharmacy FWA program.

- **Client Requested Desk Audit**: DCS can request specific desk audits, which follow our standard process and guidelines, in addition to the Standard Pharmacy FWA services.
- **Client Requested Onsite Audit**: DCS can request specific onsite audits, which follow our standard processes and guidelines, in addition to the Standard Pharmacy FWA services.
- **Custom FWA Audit Reports**: DCS can request custom FWA audit reports in addition to the Standard Pharmacy FWA services.

Enhanced FWA Program

The Enhanced FWA Program includes all the Standard Pharmacy FWA Program features with additional services.

Prospective Review

We review claims prior to payment removing the need to pay-and-chase. Auditors review claims that our proprietary algorithms flag as at risk for potential FWA. Claims that we have potentially billed improperly we then review with the applicable participating pharmacy.

Dynamic Refill Too Soon POS Edit

The Dynamic Refill Too Soon POS edit helps to prevent members from medication stockpiling, waste, abuse, and drug diversion caused by continuous early refills. The edit tracks gradual accumulation of excess supply by member and drug. The edit typically requires 3 or more refills for it to take effect.

FWA Thresholds POS Edit

A POS edit that helps prevent potentially inappropriate claims by flagging claims with aberrant quantity or days' supply. The edit compares claim attributes to MedImpact's established thresholds for outliers. The edit allows configuration for soft messaging, soft denials, or hard denials for claims above the established threshold. Therapeutic prior authorization or professional pharmacy services codes can override the edit.

Prescriber and Eligible Member FWA Reporting

By leveraging advanced analytics, we monitor and provide reporting relating to potential prescriber and FWA members. The scope of this reporting package focuses on outlier analysis, anomaly detection, and eligible enrollee and prescriber profiling.

Credentialing

We apply the Office of Inspector General's credentialing recommendations for fighting fraud and scrutinize individuals and entities that want to participate in our network prior to participation in healthcare programs.

Dynamic Refill Too Soon POS Edit

The Dynamic Refill Too Soon POS edit helps to prevent enrollees from medication stockpiling, waste, abuse, and drug diversion caused by continuous early refills. The edit tracks gradual accumulation of excess supply by member and drug. The edit typically requires 3 or more refills for it to take effect. The edit works by setting the following:

- Look back period for calculating the accumulation such as 180 days
- Minimum threshold for excess medication days such as 15 days
- Maximum threshold for excess medication days such as 30 days for the entire look back period
- Next fill date by calculating member's excess medication days and adjusting based on minimum threshold

Figure 4 displays how the Dynamic Refill Too Soon POS edit adjusts the next refill date based on medication accumulation of the previous 2 months.

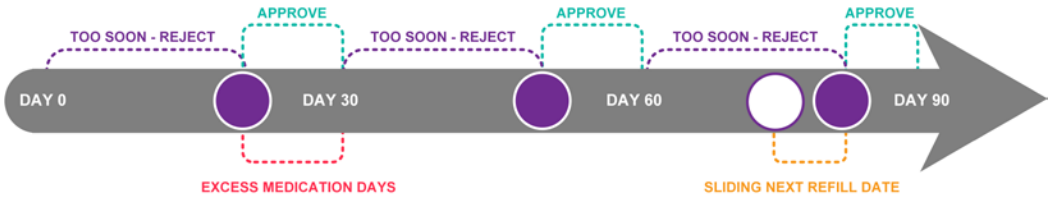


Figure 4: Dynamic Refill Too Soon Edit

The Dynamic Refill Too Soon POS edit allows some medication accumulation for convenience and adherence factors. It ignores refills for vacation overrides. A therapeutic prior authorization or professional pharmacy service codes can override the edit.

4. Describe the corrective action, monitoring and recovery efforts that take place when the Offeror finds that a Pharmacy is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether the Offeror has 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 does the Offeror have in place to address illegal or criminal activities by the Pharmacy?

If we find a pharmacy to be committing fraud, we immediately remove the pharmacy from all MedImpact networks and place the pharmacy on the pharmacy exclusion table that causes any claim to be rejected. The pharmacy network team runs utilization reports and sends the reports to all clients within 3 business days of notification of fraud and placement on the excluded pharmacy table, so clients can notify affected members to choose a different pharmacy.

We follow the same process when we find a pharmacy on the Office of Inspector General Office's list, state Medicaid exclusion list, or a reputable source discovers a certainty of fraud. In other cases, such as an unproven allegation against a pharmacy or a pharmacy violating the terms of their contract, our fraud, waste, and abuse and audit teams investigate before we decide to remove the pharmacy. If we find a pharmacy via the investigation to be suspect or to have a high error rate, we present the findings to the MedImpact pharmacy adjudication committee for a decision. The committee decides to take no action against the pharmacy, place the pharmacy on a corrective action plan, or remove the pharmacy from the network. If the committee decides to remove the pharmacy from the network, the committee also decides whether to remove the pharmacy immediately or with 30- or 60-days' notice, so members can move their prescriptions before we remove the pharmacy from the network.

We do not have a special investigation unit department; however, our FWA (fraud, waste, and abuse) department includes an FWA investigations team, who investigates FWA cases providing:

- Data analysis
- Clinical analysis
- Background research
- FWA investigative audits
- Case reporting

The FWA investigations team handles cases related to allegations of provider FWA from case initiation to case completion and subsequent case referral and reporting to law enforcement and regulatory agencies, as necessary.

5. Provide a copy of the audit language, in its entirety, pursuant to the terms of this RFP and the resulting Contract, that is contained in your standard contract(s) for Network Pharmacies.

The **5.10 Exhibits** tab includes MedImpact's sample pharmacy network agreement.

6. Confirm that the Offeror will fully cooperate with all Department, NYSIF and/or Office of the NYS Comptroller (OSC) audits, as described in Section 3.9 of this RFP, under the subheading "Pharmacy and Program Audit."

MedImpact confirms.

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 6.15, "Payments/ (Credits) to/from the Contractor" and Appendix B (Exclusive to DCS) and Appendix B-2 (Exclusive to NYSIF).

MedImpact confirms.

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

Our FWA programs use a robust suite of analytics, with outlier detection, to identify potential aberrant behavior for timely FWA detection.

Pharmacy FWA

The 2-tier analytics approach includes:

- **Isolated Behavior Outlier Detection**: Claim level outlier detection based on claim attributes such as quantity and days' supply compared to drug level norms based on vast national data.
- **Entity Profiling Outlier Detection**: Extensive aggregated behavioral profiling at the pharmacy and prescriber level. We evaluate behavioral patterns such as high claim rejection rate, controlled substance percentage, claims for distant entities, etc.

Apart from internally developed rules and analytics, we review external referrals for FWA.

There are several phases in our pharmacy audit program services where the audit team interacts with pharmacies during audits. During these interactions, potential discrepancies identified through the audit program are communicated to the pharmacy for it to remediate the findings.

Enrollee FWA

Our Enhanced FWA (fraud, waste, and abuse) program monitors opioids through audits, investigations, and reporting. Leveraging statistical analysis and outlier detection models, we select opioid claims for audit, which staff auditors review for legitimate documentation and accuracy of the claim. The Enhanced FWA program also monitors through the following pharmacy and prescriber utilization and determines when pharmacies and prescribers warrant a further review through an audit or investigation:

- **Enrollee Suspicious Activity Report**: The report identifies enrollees with drug-seeking behavior specific to controlled substances by identifying members with at least 4 claims for controlled

substances from 4 or more prescribers or 4 or more pharmacies. The report provides a member level summary and claim level detail including the distance a member lives from prescribers and pharmacies.

- **Prescriber Opioid Scoring Report**: Leveraging advance analytics, the report identifies aberrant prescribers, who score in the top 10% of the population, based on opioid prescribing behavior. A data driven approach identifies prescribers who deviate from normal behavior within the specialty. We locate the most aberrant looking prescribers in the population using a scoring algorithm. We calibrate the score between values 0 to 1,000. Higher scores indicate higher outliers and hence higher risk.

Educational Guidelines

Our audit team provides 2 annual educational guidelines to all our network pharmacies via fax. The educational guidelines include our drug submission requirements and provide pharmacies with various drug submission requirements. It shares the most common discrepancies found during audits to encourage the exercise of best pharmacy practices and more efficient and seamless pharmacy audits for all involved.

The second educational guideline is the MedImpact pharmacy guidelines for audit and appeals. This document provides guidance for the pharmacy audit process from audit claim selection to completion of the final appeal review.

Corrective Action Plans

Pharmacies that fail an audit are placed on a corrective action plan.

Under the corrective action plan, we continue to closely monitor the pharmacy's claims submissions to ensure compliance with the pharmacy agreement, provider manual, and applicable federal and state laws and regulations. If the pharmacy's claims submissions show that it may have continued activities related to the above audit discrepancies or it is participating in other potential fraud, waste, or abuse activities, the pharmacy will be subject to further audit and/or disciplinary action, up to and including, termination from MedImpact's networks. MedImpact may also report its findings to the appropriate investigative and regulatory authorities for further action.

9. Confirm that the Offeror will permit the Department, NYSIF, or a designated third-party, to audit pharmacy bills – including all elements of a claim - and drug company revenues.

Confirmed. Onsite audits at the pharmacy are restricted to the party that has a direct contract with the pharmacy. Audits can be initiated in the direction of the Department, NYSIF, or a designated party and results will be shared.

E. Mail Service Pharmacy Process

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.

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.

c. Confirmation that the facilities listed in 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 Attachment 83, Proposed Claim Reimbursement Quote.

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 2023 and customers serviced. Describe any technology and/or staffing changes necessary to service the Mail Service Pharmacy Process Prescription volume of the Programs.

e. Describe the backup mail order process facility(ies) that the Offeror 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 the Offeror would utilize to meet the mail service Prescription drug delivery requirements of the Programs.

f. Identify the facilities listed in 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 the Offeror 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.

The MedImpact Direct Mail® Program (MID Mail) is comprised of PBM services and Birdi patient care /dispensing. The program is an end-to-end solution for managing maintenance drug therapies. When clients move to MID Mail, they will achieve drug cost savings of 3% to 5% because of market-competitive rates, waste mitigation, and pharmacy oversight. Members benefit from the convenience of home delivery. Our exclusive mail-order pharmacy is Birdi. Formerly known as NoviXus, Birdi has been serving MedImpact members since 2015. Other pharmacies may be utilized, if necessary, such as WellDyne or Walgreens, to serve the injured worker population under NYSIF.

Location

The mail pharmacy is in Novi, Michigan, to dispense and deliver mail order prescriptions to members.

Pricing Confirmation

We confirm that the facilities utilized are priced in accordance with Attachment 83.

Capacity

The mail pharmacy's facility expansion is underway, which will increase mail order prescription capacity to 6 million prescriptions by 4Q2023 with an expected operating capacity of 35% by 2024.

In 2023, 774,399 prescriptions were dispensed through our mail order facility.

Backup Process

Enrollees can transfer the prescription to a local retail pharmacy from the Consumer Portal. Enrollees can also call the customer service center for assistance transferring the prescription.

Compounding Facilities

The mail pharmacy does not dispense compound drugs.

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.

Birdi processes prescriptions in compliance with all federal/state regulations.

Drug/Device Receipt

Accepting products into inventory:

- The staff member receiving the inventory confirms the legitimacy of all drugs/devices to ensure the pharmacy does not accept counterfeit or illegitimate products. This process is to ensure compliance with Section 582 of the FD&C Act.
- This process is described in the Birdi Policy titled "35PROD.4.4_CheckingInTheInventory".

Front End (ePostRx patient care management system)

- **Data Entry**: ERx, fax, mail, or verbal
  - Birdi screens and verifies every script which we receive in hardcopy form, and our processing technicians are required to take note of situations which may reflect fraudulent or problematic activity and pharmacists ultimately must exercise his or her corresponding responsibility to question the validity, integrity, or authenticity of a prescription order.
  - This process is described in the Birdi Policy titled "04RXS0215.1.4_Prescriptions 8.10".
- **Pharmacist Verification (PV1):** Pharmacist verifies data entry
- **Adjudication**: Third party billing processes exceptions including failed claims, calls for prior authorization, coupon cards, pending vacation overrides, and specialty meds. All adjudication exceptions are reviewed and resolved following laws and regulations (e.g., preventing fraud).
- **DUR**: DUR review by ePostRx and insurance

- Any state-specific regulations, including DUR requirements, are embedded within ePostRx software and will flag the pharmacist, or move the prescription to the "Sanity Check" queue if pharmacist review is required.
- This process is described in the Birdi Policy titled "07DUR0215.2_DrugUtilizationReview".

- **Inventory Check**: Inventory review is performed and allocated of current balances on hand
  - Inventory is selected based on what the provider has authorized, and in accordance with generic substitution regulations;
    Generic substitution rules may be state specific. ePostRxs screens for these rules and will flag exceptions for pharmacist review.
  - Generic substitution is described in the Birdi Policy titled "03CWL0215.1.4_Compliance".
- "Sanity checks"
  - Compliance rules set up in the system to hard stop if identified.
  - Examples include state-controlled substance rules; System has an editable table that can be set up for every state to designate rules for C2, C3, C4, C5 including days supply, expiration date, refills allowed, etc.
- **Payments**: Pre auth credit card, system check for account balances
- Order is sent to backend for filling

Back End (Symphony and Pitney Bowes)

- Fill
- Prescriptions are labeled and packaged in accordance with state and federal label requirements.
- All dispensing processes follow state and federal laws.
- Pharmacist Verification (PV2); Pharmacists complete the final verification step for all drugs and devices.
- Pack
- Ship (Birdi only ships medications to states in which Birdi is licensed to ship; currently all 50 states).

Patient Counseling

Birdi provides written information to be distributed with the prescription that includes the medication monograph, black box warnings if required, and notification that a pharmacist is available to answer questions, and the contact information of the pharmacist in order to do so.

- The requirement to counsel the patient is covered with the offer on the drug monograph sent with each prescription.
- Based on state-specific requirements, additional information may be provided (for example, an additional notice regarding Wisconsin counseling requirements is included in orders shipped to Wisconsin).
- This process is described in the Birdi Policy titled "09PAC_PatientConsultation".

Quality Control

The PIC or General Manager reviews reports quarterly to confirm clinical activities (e.g., pre- verification, final verification) are only completed by a pharmacist to ensure compliance with state and federal laws. This process is described in the Birdi Policy titled "16QIP2_AuditingTechnology".

Recordkeeping

- Birdi has adequate space for the orderly storage of physical records; all records are kept on site and stored securely in the warehouse
- Electronic records are stored within SharePoint, or within the dispensing or fulfillment software.
- All records are maintained in accordance with state and federal regulations.
- The recordkeeping process is described in the Birdi Policy titled "24REC1_Recordkeeping".

3. What steps would a member need to follow to establish their initial order and set up their billing account (exclusive to DCS), 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 does the Offeror assist the Enrollee with this process?

We have an established process in place for the mail service pharmacy.

Transition

To ensure a smooth transition to the mail pharmacy, we will work closely with DCS to help educate members on how to use their mail benefit.

For more than a decade, we have been transitioning clients from 1 pharmacy to another with high enrollee satisfaction. We provide the current mail vendor with envelopes to mail any late arriving prescriptions overnight to the mail pharmacy for immediate processing. **Figure 5** displays our well-defined process that starts 90 days prior to the new mail pharmacy going live, which DCS can adjust to meet DCS's business needs.

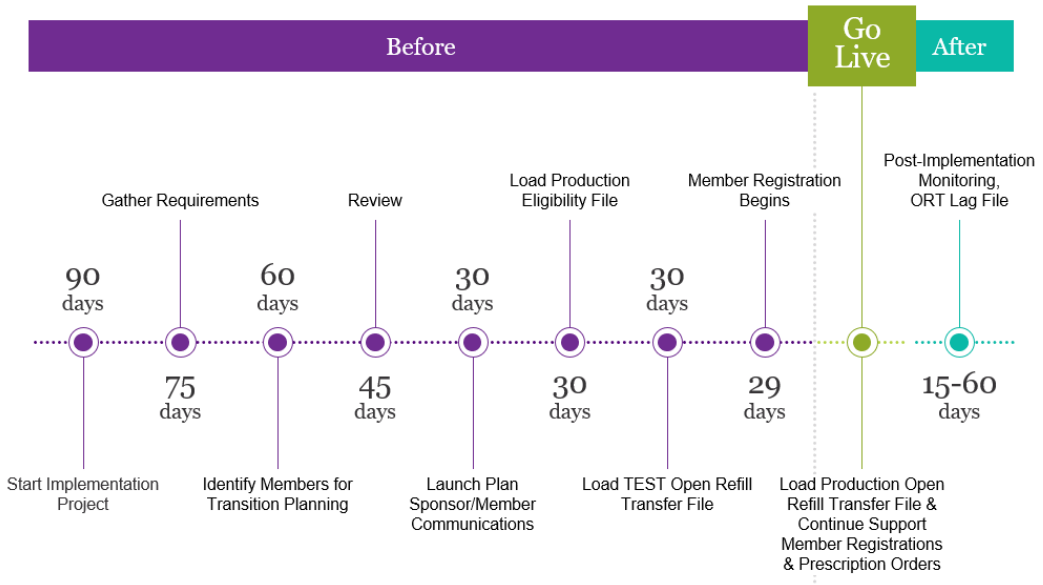


Figure 5: MedImpact's Implementation Timeline

Ordering Process

The mail pharmacy can receive new maintenance medication prescriptions as follows:

- Prescriber sends prescription to the mail pharmacy through e-prescribe or fax
- Members sign into the Consumer Portal to request prescriptions.
- Member mails the prescription to the mail pharmacy.

Prescription intake includes prescription scanning, and a pharmacist compliance review according to the client-specific formulary. The mail pharmacy calls members to collect information on chronic conditions, allergies, preferred payment method, and to verify their shipping address. The mail pharmacy accepts credit cards, checks, and money orders as payment.

Refills

Members can sign into the Consumer Portal to request a new prescription, order a refill, or transfer prescriptions from a retail pharmacy by clicking 'Request a Prescription' and following the instructions. Members can also download the medication order form by clicking 'Documents', filling out the form, and sending to Birdi™ PO Box 51580, Phoenix, AZ 85076-1580. Once the refill is processed, members can track orders within the Consumer Portal.

Members can also order refills by calling the toll-free number listed in the welcome kit, prescription insert, or member ID card. Members can speak to a live CSR (customer service representative) or use the IVR to refill their prescription.

Assistance Provided

The mail pharmacy proactively sends outbound refill reminder messages by email, text, and automated telephone calls. When a member alerts the mail pharmacy of the need for an additional refill or a new prescription with refills, a pharmacist assists the member by contacting the prescriber on the members' behalf for authorization.

The mail pharmacy drives high enrollee adherence while minimizing waste through a unique approach to autofill and auto-refill logic. The mail pharmacy refills eligible prescriptions in the auto-refill program 14 days before the prescribed quantity is set to run out. Subsequent refills arrive about 90 days after the initial prescription delivery, so the member always has at least 2 weeks' supply of medication on hand. This approach results in each member receiving at least 1 less 90-day prescription per year, which delivers savings of 1% to 1.5% of drug ingredient costs and reduces the client's and member's cost of care.

When the mail pharmacy receives a renewal prescription for a medication filled in the past 6 months, the pharmacy automatically fills and ships the medication providing greater adherence to drug therapy and improving the continuity of care.

4. Describe the capabilities of the Mail Service Pharmacy call tracking system.

Our customer service department takes calls for retail, mail order, and specialty pharmacies. We track all calls through an innovative Cisco telephone accounting system. This automated process lets management study the quantity, length of all calls, average speed of answer, and abandonment rate. We use the data generated from these

reports to monitor call activity and staff appropriately during peak periods. We also use scheduling software to further assist in forecasting staffing needs.

5. Confirm that the Offeror will supply sufficient quantities of mail order forms and pre-paid envelopes to encourage mail service utilization.

MedImpact confirms.

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?

b. Prescriptions that require "special" handling (i.e., temperature control, special preparation, controlled substances, limited shelf life, etc.);

c. Narcotics for the original fill for an Enrollee; and

d. Prescriptions requested to be mailed in easy open caps.

We have various processes and procedures in place that we use to handle various types of prescriptions.

Urgent Prescriptions

If the enrollee requests an expedited delivery for convenience, the mail pharmacy ships the prescription overnight for a fee.

Special Handling Prescriptions

We pack and ship medications in accordance with manufacturer specifications including consideration of cold chain management and heat sensitive packaging. The mail pharmacy packs the medication in a sealed Styrofoam cooler with an additional inside container and multiple freezer packs to maintain the required temperature throughout the delivery process. The mail pharmacy selects the quickest delivery pathway for enrollee medication delivery.

Narcotic Prescriptions

We accept schedule II-controlled substance prescriptions by electronic prescription submission and mailed hard copy only. Prescriptions for a 30-day supply of controlled substances are dispensed in states where permitted by law.

Easy Open Prescriptions

The mail pharmacy uses prescription vials that can convert to a non-safety cap to allow for easy access.

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.

We track prescription turnaround time from receipt of prescription to dispensing and shipping, measuring performance standards quarterly.

The mail pharmacy can receive prescriptions from prescribers by ePrescribing or fax. Enrollees can also submit new maintenance prescriptions by mail. When the mail pharmacy receives a new prescription, pharmacy staff calls the enrollee to collect their cost share and verify their mailing address and any other delivery instructions. Enrollees have the option to place credit card information on file for future orders. Enrollees can also mail in a check or money order to cover their cost share. The pharmacy requires member payment before dispensing and delivering the prescription.

Once the pharmacy receives payment, the prescription undergoes an almost completely automated dispensing process. Because the pharmacy integrates high touch dispensing with high-tech operations, these fully integrated operations bring together the latest in robotic bar code, radio frequency identification, and pharmacy technology providing a high level of precision and efficiency with member satisfaction in mind. Critical elements of dispensing automation include:

- Fully automated, up-to-date processing technology
- Software integration
- Proprietary systems for dispensing quality and efficiency
- Electronic prescription imaging for safety and precision

The only exception to the automated dispensing process is schedule II-controlled substances, which the mail pharmacy manually counts and dispenses.

8. Please describe how the Offeror's system tracks mail service fill accuracy rates including all error types tracked by the system. In addition, detail the error types the Offeror's system reports and include a mail service fill accuracy report for 2023. How are member reported errors tracked and reported? What type of investigations and process modifications would the Offeror undertake to address accuracy errors that have the potential to critically impact the Enrollee's health and safety?

Birdi calculates the mail order claims dispensing accuracy rate by the number of prescriptions shipped defined as a pharmacy reportable error divided by the total number of prescriptions shipped in a specified time frame (monthly, quarterly or annual).

Error Types

Birdi calculates the mail order claims dispensing accuracy rate by the number of prescriptions shipped defined as a pharmacy reportable error divided by the total number of prescriptions shipped in a specified time frame (monthly, quarterly or annual).

In addition, our system reports and includes a mail service fill accuracy report. Error indicators reported include patient name, drug name, drug strength, directions, quantity and prescriber name.

Reported Errors

Birdi workforce immediately transfers all reported error cases to a team lead, supervisor or registered pharmacist who consults with the affected patient and/or prescriber to review the complaint or error and correct it to the patient's satisfaction.

Birdi workforce must report errors to the Birdi Compliance department as soon as possible, but not more than three days after determining their occurrence. The Birdi Compliance department utilizes an incident management system for error reporting and tracking.

Process Modifications

The Birdi compliance team oversees a continuous quality improvement (CQI) program, in which errors are investigated for a root cause and appropriate steps are taken to prevent recurrence based on the results from the investigation. The mail pharmacy also holds a quality subcommittee meeting to review trends and remediation. The entire quality committee meets quarterly for broader scope issues and discussion.

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 the Offeror's 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?

Prescriber intervention is required for client-specified prior authorization, step therapy, or therapeutic substitutions. The pharmacy may require prescriber prescription clarification or authorization on a refill prescription. Depending on the issue, the mail pharmacy provides outreach and consults with the prescriber for clinical options. If there is no response from the initial prescriber outreach, the pharmacy contacts the enrollee to request the prescriber contact the mail pharmacy.

Pharmacy intervention is performed for medications that are out of stock and prescriptions that have aged in the processing system.

10. Describe the process that the Offeror will utilize to provide Enrollees with access to Limited Distribution Drugs when the Prescription is submitted through the Mail Service Pharmacy Process.

100% of LDDs (limited distribution drugs) are accessible through our specialty pharmacy program.

If the mail pharmacy receives a specialty prescription for an enrollee enrolled in the MedImpact Direct Specialty ® program, it forwards the prescription to our Direct Specialty team for referral to an in-network pharmacy. If the enrollees benefit plan carves-out the specialty pharmacy arrangement with another specialty pharmacy, we inform the enrollee they cannot dispense the prescription and provide the proper specialty pharmacy contact information.

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?

All prescriptions must pass 2 levels of pharmacist verification prior to shipment. Registered pharmacists not involved in the dispensing process perform a comprehensive quality control audit of every prescription prior to shipping. Verification includes comparing the vial contents against the image of the tablet displayed on the computer and visually checking the product before dispensing.

A pharmacist reviews each prescription prior to packing and shipping. Upon verification, the pharmacist signs the order. On each prescription label, the pharmacist provides their initials. This serves as the "pharmacist of record" should any quality or accuracy concerns arise. A second pharmacist ensures the label matches the medication after processing it by the robot. All prescriptions must pass this verification step. All verifications are documented in our fully integrated system.

12. Describe the process and channels (web, phone access, hard copy, etc.) the Offeror utilizes to collect the information necessary to develop and maintain an Enrollee safety profile.

We use web, phone access and hard copy medication order form to collect the information necessary to develop and maintain up-to-date enrollee safety profiles.

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;

b. What are the time frames as they relate to backorders or shipments that are from the Offeror's primary supplier;

c. What is the percentage of Prescriptions that are filled when initially submitted to the primary mail service pharmacy facility the Offeror is proposing; and

d. How are backorders and out of stock situations handled with members?

Birdi can receive drug order purchases next day from our suppliers if the prescription is received by 6 pm EST. Out-of-stock orders will ship next day if ordered prior to 6 pm EST. Birdi uses several back-up suppliers in addition to our primary supplier to address supplier issues.

Manufacturer back-orders depend on the manufacturer and vary. Birdi team members proactively monitor and reach out to both members and physicians with updates or to seek appropriate therapeutic alternatives depending on projected back-order length and clinical situation. Birdi has dedicated supplier support personal to also assist in obtaining drugs with manufacturer or drug supply chain issues.

Greater than 98% of prescriptions initially submitted to Birdi are filled. All members are contacted by a Birdi team member if their prescription cannot be filled. Birdi goes to great lengths to make sure members do not go without their medication, including overnighting prescriptions to members where and when appropriate.

14. (Exclusive to DCS) Describe the Offeror's 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.

We monitor the industry for drug availability, and we only allow multisource brand drugs to be reimbursed at a brand price when a true shortage of the drug occurs in the market. We require network pharmacies to maintain an adequate stock of drugs on hand to serve our enrollees.

The mail pharmacy confirms eligibility prior to dispensing and splits orders when a prescription in the order requires pharmacy intervention, so clean prescriptions dispense and ship without delay. There are no ancillary charges that apply to this arrangement.

The mail pharmacy requires the prescription copay before dispensing and delivering an enrollee's prescription order. The MedImpact Direct Mail program recommends an enrollee stores a credit card on file for easy payment and processing of mail prescriptions. The pharmacy also accepts checks or money orders. Enrollees with credentials for our Consumer Portal can pay for mail prescriptions or refills by credit card through a secure checkout process.

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?

Birdi pharmacists proactively reach out to prescribers on the enrollee's behalf to obtain the most cost-effective generic drug for the enrollee and plan when prescribers order brand-only products. Enrollees are counseled and notified of the changes to the originally ordered, more expensive product. Birdi pharmacists substitute cheaper generic or biosimilar equivalents where and when allowed by state law.

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?

Birdi dispenses generic substitutions in all cases allowed by the prescriber and state law where not limited by brand-over-generic plan designs.

17. Please describe how the Day's supply is determined for the following forms of Prescription Drugs, dispensed by the Mail Service Pharmacy:

a. Eye/Ear Drops

b. Lotions and Ointments

c. Syrups

Birdi strives to lower drug and out of pocket costs to both patients and clients alike on all dispenses. Days' supply is determined as follows:

Eye/Ear Drops

Daily supply is calculated using 18 drops per ml maximizing 90-day dispenses where applicable.

Lotions and Ointments

The smallest package size available is dispensed if it still meets the prescription requirements. Pharmacists obtain dosing and area(s) of application where not noted on the prescription. One fingertip unit (FTU) is equal to 0.5 grams for reference.

Syrups

The days' supply dispensed is based on prescriber directions. Manufacturer stock bottles are opened for dispensing, so the actual amount needed is dispensed and billed not the full, sealed stock bottles.

18. Please describe what proposed strategies the Offeror would implement with the Offeror's Mail Service Pharmacy to compete with Low-Cost 30- and 90-Day programs offered by Retail Pharmacies?

We support client choice when it comes to implementation of network designs and preferred dispensing locations.

We recommend a reduction in the size of the retail 90 network through our Choice90 Value Plus. This network compares mail service rates with the convenience of retail. We also recommend implementation of a plan design for maintenance fills that favors either retail 90 day or mail, but with copays that are not overly generous, typically about 2.5x the retail 30 copay.

We will also work closely with DCS to communicate these strategies. Some examples of how we have worked with other clients to promote mail service include:

- If the benefit design allows for any economic incentive to use mail-order dispensing, member communications campaigns can be effective if the message is member-specific with a clear illustration of how a drug the member utilizes could be less per 90-day supply than other dispensing channels.
- If State law permits, the first cost-share amount for a new prescription could be waived for commercial members to encourage them to try mail. This is not allowable for EGWP members but may be helpful for members broadly disbursed across NY state outside of urban areas. As we know, pharmacy closures are creating pharmacy deserts.
- If there are any case managers working with specific enrollee populations, case manager education about the availability of mail-order program with instructions on how to help enrollees enroll and get started helps increase mail-order utilization. We have seen this with used successfully by some of our clients.

19. Turnaround Time for Nonintervention Mail Service Prescriptions Guarantee: The Programs' service level standard requires that at least ninety-five percent (95%) of all nonintervention 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 nonintervention 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 lower amounts.

We will commit to the turnaround times for nonintervention mail service prescriptions, as required. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

20. Turnaround Time for Intervention Mail Service Prescriptions Guarantee: The Programs' service level standard requires that at least ninety-eight percent (98%) 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. 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-eight percent (98%) 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 lower amounts.

We will commit to the turnaround times for intervention mail service prescriptions, as required. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

F. Specialty Drugs

Specialty Drugs Received through the Retail Pharmacy Network or the Mail Service Pharmacy Process

1. Explain how the Offeror's proposed network provides access to all medically necessary covered Specialty Drugs.

MedImpact's Direct Specialty ® Program is a network of preferred pharmacies that conduct plan specific utilization management before dispensing each specialty drug. We offer an exclusive or preferred network of specialty pharmacies to provide clients access to 100% of open, limited, and exclusive specialty drugs.

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).

We will check and confirm each specialty pharmacy carries proper credentials and licensing for dispensing LDD and specialty medications. By using MedImpact Direct Specialty, DCS will have access to all LDDs.

3. (Exclusive to DCS) Confirm that the Offeror 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 vendor.

MedImpact confirms. We will solicit participation in the retail pharmacy network for all licensed pharmacies affiliated with the Empire Plan Home Care Advocacy Program. Our network pharmacies can bill claims in both the prescription benefit and medical benefit. Our network specialty pharmacies investigate whether the prescribed medication applies under the prescription benefit or medical benefit and use the appropriate processing pathway to accurately adjudicate the claim and bill the prescription benefit plan or medical benefit plan. The reconciliation process for medical claims follows the current type 110 file invoice reconciliation process in place for pharmacy claims today.

We can integrate with any medical carrier or third-party administrator to effectively support all programs. Our claims processing system can integrate and exchange member data files or custom files at any requested frequency.

4. (Exclusive to DCS) For those HCAP providers that do not have affiliated pharmacies, how does the Offeror propose coordinating with HCAP and supplying the medication to the Enrollee? Will the Offeror utilize the Mail Service Pharmacy Process?

Birdi mail pharmacy and the MedImpact Direct Specialty Program preferred network will serve as a wrap to the HCAP providers.

5. Confirm that necessary ancillary supplies that accompany certain Specialty Drugs will be delivered to the Enrollee at no additional cost to the Programs or Enrollee.

MedImpact confirms.

6. Indicate the licensed pharmacies in Attachment 32, HCAP Providers for the NYS Empire Plan, with whom the Offeror has a current Network Pharmacy contract.

We have provided an analysis of Attachment 32, confirming which providers are in our network already. We can also solicit any pharmacy not currently in our network for inclusion, assuming they meet all credentialing criteria.

7. (Exclusive to DCS) Site of Care. Confirm that the Offeror understands that there will be a Site of Care Redirection Program in effect for certain groups, which will require the waiving of copays for medications in the program.

MedImpact confirms.

G. Specialty Pharmacy Program

1. Provide a listing of the Specialty Drugs that the Offeror proposes for inclusion in the Specialty Pharmacy Program, along with an indication of how they meet the minimum criteria. Also, please state if the Offeror proposes additional criteria. Please state whether the Designated Specialty Pharmacy(ies) the Offeror proposes regularly dispense any other Specialty Drugs which the Offeror is not proposing for the Programs.

The specialty drug list is included within the **5.10 Exhibits** tab.

The following factors are considered to designate a drug as specialty:

- High cost
- Treats complex clinical conditions which may require screening or ongoing clinical monitoring is necessary to ensure drug efficacy and/or to manage potential side effects
- Administration may be complicated (e.g., injectables), requiring robust patient education and monitoring
- Drug availability only through a specialty pharmacy or limited distribution channel (e.g., limited distribution drug) or the drug may require special handling or storage conditions
- Complex monitoring requirements (e.g., REMS (Risk Evaluation and Mitigation Strategies) which may require provider and/or member registries along with laboratory monitoring or diagnostic testing)

To be considered a specialty drug, a drug must meet at least 1 of these factors; however, in some circumstances other factors may be considered to determine specialty status (e.g., market conditions, etc.).

MedImpact Direct Specialty ® offers an exclusive or preferred network of specialty pharmacies to provide clients access to 100% of open, limited, and exclusive specialty drugs. The recommended pharmacies dispense only specialty medications; although, we may augment this specialty network as needed to meet the Department's needs.

2. Provide a detailed description of the Offeror's proposed Specialty Pharmacy Program. Include the following:

a. Customer service call center

b. Administration of REMS

c. (Exclusive to DCS) Whether Specialty Drugs administration will be through the Home Care Advocacy Program (HCAP) or a Specialty Pharmacy Program contracted network

d. Clinical management, including demonstration of outcomes improvement

e. Fulfillment process, including cold-chain supply and shipping logistics

f. Transition process from Grace Fill at Retail or Mail

MedImpact's Direct Specialty® Program is a network of preferred pharmacies that conduct plan specific utilization management before dispensing each specialty drug.

Call Center

Our CRSs field calls on specialty services. Our preferred network pharmacies also have customer service departments, which are available 7 AM - 7 PM CT Monday through Friday with clinical support 24 hours per day, 7 days per week, 365 days per year.

REMS Administration

We follow 7 steps for a prescription order fulfillment process:

1. Prescription intake

2. Prescription verification
3. Member contact
4. Member counseling
5. Dispensing
6. Order verification
7. Shipping

In step 2, a pharmacist reviews prescriptions for any REMS (risk evaluation and mitigation strategy) protocol that a REMS program requires.

Specialty Drug Administration

Specialty drug administration will be handled through the specialty pharmacy program contracted network.

Clinical Management

MedImpact Direct Specialty provides clinical care for every member from the first fill of a specialty medication to the conclusion of their medication therapy regimen. A PCC (patient care coordinator) calls each member and records information related to current medications (including any vitamins or OTCs), allergies, list of current prescribers and specialist, current health condition and disease-state impact, side-effects of any prior or current medication, member attitude (positive, depression, hopelessness, frustration) towards their disease, form of payment, and member or prescriber address for overnight delivery of specialty medication. The PCC stresses member adherence and educates the member on their disease, medication treatment expectations, refill process, and 24 hours a day, 7 days a week access to a specialty pharmacist or clinician.

Fulfillment Process

Upon receipt of an initial prescription order, or refill, a PCC calls the member and records information related to current medications (including any vitamins or OTCs), allergies, list of current prescribers and specialist, current health condition and disease-state impact, side-effects of any prior or current medication, member attitude (positive, depression, hopelessness, frustration) towards their disease, form of payment, and member or prescriber address for overnight delivery of specialty medication.

The specialty fulfillment pharmacy receives the prescription referral from our Direct Specialty, contacts the member and prescriber to gather additional information, and processes the specialty prescription for fulfillment. The specialty fulfillment pharmacy dispenses and ships the medication to the member via free overnight delivery according to manufacturer guidelines. **Figure 6** depicts the fulfillment process.

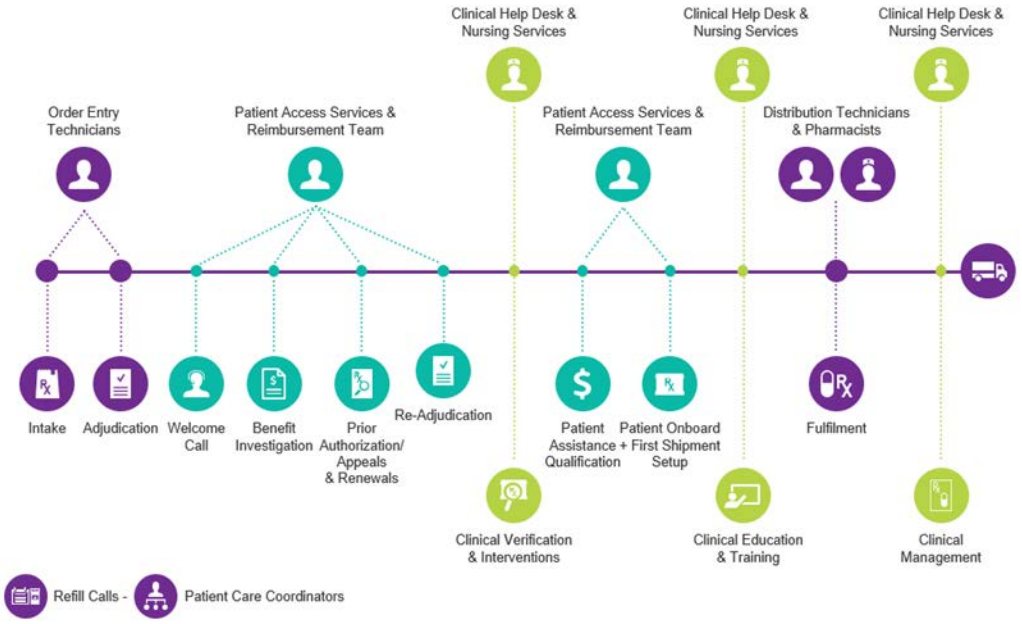


Figure 6: MedImpact Direct Specialty Order Fulfillment Process

A PCC performs monthly refill touch points with a member to ensure appropriate supply on hand and check medication adherence. High risk members receive targeted clinical interventions to improve therapy adherence and safety. When appropriate, specialty pharmacy clinicians communicate with prescribers to ensure continuity of care for the member.

Transition Process

Transitioning new members to our Direct Specialty with open specialty medication refills includes:

- Member welcome call from specialty pharmacy
- Welcome letter with a list of services
- Toll free number for member questions
- Letters to prescribers

3. Does the Offeror 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 Attachment 32, HCAP Providers for the NYS Empire Plan, will participate in the Specialty Pharmacy Program.

We use several different specialty pharmacies. Preferred pharmacies include:

- Biologics Specialty Pharmacy
- Credena Health
- CenterWell Specialty Pharmacy
- CVS Specialty
- Kroger Specialty Pharmacy
- Specialty by Birdi

The MedImpact Direct Specialty Program reduces specialty drug costs by up to 15% when moving from a big box specialty pharmacy to our network of preferred dispensing specialty pharmacies. Our focused oversight:

- Guarantees market-leading specialty pharmacy rates
- Drives appropriate utilization through point-of-sale edits, prior authorization, and implementation of plan design rules
- Reduces medication waste linked with stockpiling or excessive refills
- Improves medication possession ratios
- Offers copay assistance to plan sponsors and members
- Delivers outstanding member experience
- Provides services by high performing specialty pharmacies

For NYSIF, we recommend keeping retail pharmacy distribution options available for specialty medications to ensure injured employees are able to access their needed medications quickly.

4. Detail the mechanisms in place to ensure the prompt, safe, and effective delivery of all Specialty Drugs 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 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.

We pack and ship medications in accordance with manufacturer specifications including consideration of cold chain management and heat-sensitive packaging. The specialty fulfillment pharmacies pack the medication in a sealed Styrofoam cooler with an additional inside container and multiple freezer packs to maintain the required temperature throughout the delivery process, selecting the quickest delivery pathway.

LDD Delivery

By using our Direct Specialty, DCS will have access to all LDDs.

Emergency Delivery

If a member needs an emergency specialty prescription or replacement dispensed, our network pharmacy arranges for weekend or holiday shipping through FedEx or UPS. Our Direct Specialty's network pharmacies also engage local courier services, where appropriate, to augment national carrier deliveries.

5. (Exclusive to DCS) Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical vendor in providing HCAP services. For those HCAP providers that do not provide medications, how do you propose supplying the medication?

The level of integration between the health plan vendor and MedImpact depends on the focus and nature of the clinical program. We can integrate with any medical carrier or third-party administrator to effectively support disease management programs. Our claims processing system can integrate and exchange member data files or custom files at any requested frequency.

We can meet with the medical carrier clinical team to review the disease management program, discuss the program goal or health outcome targets, assign the different types and frequency of member outreach, designate a contact for clinical team calls regarding medication adherence or member care concerns, and delegate which clinical team will interact with prescribers. This streamlined communication process effectively manages clinical resources and minimizes the duplicative member and prescriber outreach, which can cause confusion and opt outs of disease management programs.

MedImpact, DCS health plan, and the medical vendor can improve member health by exchanging relevant data files and coordinating outreach for the clinical program.

6. How does the Offeror's system provide the ancillary supplies that accompany some of the Specialty Drugs?

Specialty pricing includes all ancillary items necessary for member or prescriber medication administration. Ancillary items may include:

- Needles
- Syringes
- Sharps containers
- Alcohol swabs

7. Describe the criteria the Offeror will use to evaluate new Specialty Drugs that enter the market and whether they should be included in the Specialty Pharmacy Process.

We consider newly approved specialty drugs as new to market until the drug appears on the National Drug Data file, which is typically within 6 months.

The default discount rate remains in effect until the new to market specialty drug is added to the National Drug Data File. Once added, our proposed specialty discount applies.

H. Vaccination Network (Exclusive to DCS)

1. The Offeror shall indicate in Attachment 21, Comparison of DCS Current Program Retail Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network, which of the Network Pharmacies participate in the Vaccination Network (as defined in Attachment 15, Glossary of Defined Terms). That is, the Offeror proposes a credentialed network of participating independent and Chain Pharmacies contracted to deliver preventive vaccines to non-Medicare primary Enrollees. The file containing the DCS Program's current network pharmacies and instructions for completing the attachment can be obtained by following the instructions, which requires that Offerors have the latest version of the IBM Aspera Web Plugin (Aspera Connect) to use the application included in Attachment 21.

Upon receipt of Attachment 21, we will provide a comparison of our vaccine network against the current DCS current network pharmacies. Our vaccine network, MedNetwork® vaccine, provides coverage for non-flu vaccinations to help improve member health and reduce overall health costs for both clients and members. The World Health Organization estimates that vaccines prevent almost 6 million deaths annually (https://www.who.int/bulletin/volumes/86/2/07-040089/en/). We expect minimal to no disruption against the pharmacies DCS members use today.

By implementing MedNetwork vaccine, plans may experience an increase in savings compared to provider site-of-care administration, per the National Institutes of Health, who also state vaccines reduce morbidity in diphtheria, paralytic poliomyelitis, and smallpox by 100% and in measles by 99.9%.

MedNetwork vaccine includes over 50,000 locations with point-of-sale adjudication improving data access to immunization rates. MedNetwork vaccine will benefit DCS by:

- Decreasing total healthcare costs such as emergency room visits and hospitalizations
- Generating site-of-care savings from medical to lower-cost pharmacy visits
- Improving workplace productivity
- Reducing absenteeism
- Optimizing plan wellness initiatives
- Improving quality performance for all plans including Star ratings for Medicare
- Coordinating with pharmacies to provide worksite immunization clinics
- Providing access to member outreach and awareness programs including letter campaigns, outbound messages, and website engagement

5.10 Exhibits

The following exhibits were referenced in Section 5.10 and have been provided here per RFP instructions.

Exhibit	Description
5.10 Exhibit A	Member Letter Pharmacy Removal from Network
5.10 Exhibit B	Sample MedCare Pharmacy Network Agreement
5.10 Exhibit C	Sample NYSIF Pharmacy Network Agreement
5.10 Exhibit D	Sample Pharmacy Manual (not included in hard copy; included on USB flash drive)
5.10 Exhibit E	DCS Specialty Drug List
5.10 Exhibit F	NYSIF Specialty Drug List
5.10 Attachment 18	Proposed Retail Network Pharmacy File (not included in hard copy; included on USB flash drive)
5.10 Attachment 20	Proposed Retail Pharmacy Network Access Prerequisite Worksheet
5.10 Attachment 21	Comparison of Current Program Network Pharmacies and Proposed Network (not included in hard copy; included on USB flash drive)
5.10 Attachment 22	Enrollment by Zip Code & Geo Access Network Report Files (not included in hard copy; included on USB flash drive)
5.10 Attachment 32	HCAP Providers for The Empire Plan (not included in hard copy; included on USB flash drive)
Attachment 6	Performance Guarantees (included at the end of the Technical Proposal)

First and Last Name
Company Name
Address
City, ST 00000

MONTH 00, 0000

Dear [Member First] [Member Last],

Our records show you filled a prescription at [Pharmacy Name] in the past six months. As of [Date], [Pharmacy Name] will no longer be a part of your Pharmacy Network.

If you continue to fill prescriptions at this pharmacy, you will be responsible for paying the total cost and any reimbursement, if at all, by your health plan will be in accordance with your benefit coverage. You can find a new participating pharmacy at [insert client URL].

You may request a new prescription from your doctor, or your new in-network pharmacy can help you transfer your prescriptions, including any remaining refills. You can take your prescription bottles to an in-network pharmacy of your choice. Visit [insert client URL] to find an in-network pharmacy near you by using our Pharmacy Locator tool. Make sure to register if you do not already have an account.

Registering is a quick and easy way to gain access to personalized tools to help you navigate your pharmacy benefit. For questions or concerns, please call our customer service team. You can find the number on your pharmacy benefit ID card.

SINCERELY,

MedImpact
Healthcare Systems, Inc.

A 10181 Scripps Gateway Ct, San Diego, CA 92131
P 800.788.2949
MedImpact.com

MedCare® Pharmacy Network Agreement

This AGREEMENT is by and between MedImpact Healthcare Systems, Inc.® ("MedImpact"), a California corporation, and _____ ("Member Pharmacy") and supersedes any previous MedCare Agreement(s) that may have been previously executed between the parties. In consideration of the mutual covenants and other good and sufficient consideration, Member Pharmacy agrees to participate in MedImpact's pharmacy networks in accordance with the following terms and conditions:

I. PROVISION OF PRESCRIPTION DRUG BENEFITS AND CLAIM SUBMISSIONS

Member Pharmacy will furnish to each Eligible Person such Prescription Drug Benefits to which the Eligible Person is entitled in accordance with this Agreement, the applicable Plan, and all applicable Laws. As a condition precedent to providing Prescription Drug Benefits, Member Pharmacy will require each person requesting such benefits to provide evidence of eligibility and proof of identification or other reasonable steps to determine that the holder of the card is eligible for Prescription Drug Benefits. MedImpact shall not be obligated to pay any claim for a Prescription Drug Benefit provided to a person who is not eligible. Member Pharmacy agrees to submit all claims for Prescription Drug Benefits provided to an Eligible Person in accordance with this Agreement and the MedCare Pharmacy Networks Policies and Procedures Manual, which is made a part hereof.

II. COLLECTION FROM ELIGIBLE PERSONS

Prior to providing Prescription Drug Benefits to an Eligible Person, Member Pharmacy will collect from each Eligible Person the applicable Copayment as communicated to Member Pharmacy via the online claims system or as otherwise notified in writing by MedImpact. Member Pharmacy cannot waive, discount, reduce, or increase the Copayment. Member Pharmacy will in no event (including, but not limited to, non-payment by MedImpact or any Payer, MedImpact or any Payer's insolvency, or breach of this Agreement) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Eligible Person or other persons acting on their behalf. This provision does not prohibit the collection of Copayments or charges for non-covered services or items; however, Member Pharmacy shall not add additional charges to the Copayment for the provision of Prescription Drug Benefits under this Agreement. If MedImpact determines that Member Pharmacy has overcharged an Eligible Person, Member Pharmacy will promptly pay such overpayment to MedImpact or such Eligible Person as directed upon notification by MedImpact. This provision will survive the termination of this Agreement and supersedes any oral or written contrary agreement now existing or hereafter entered into between Member Pharmacy and Eligible Person or someone acting on Eligible Person's behalf.

III. NETWORK PARTICIPATION

Member Pharmacy agrees that it will participate in all MedImpact pharmacy networks in which: (a) Member Pharmacy participates in as of the date of the acceptance of this Agreement by MedImpact; (b) Member Pharmacy executes a Network Participation Addendum accepted by MedImpact for such pharmacy network(s); and/or (c) Member Pharmacy agrees to participate as evidenced by its provision of Prescription Drug Benefits to an Eligible Person of a Payer utilizing such pharmacy network(s). All such pharmacy network(s) in which Member Pharmacy participates are referred to as the "Networks".

IV. PAYMENT

Member Pharmacy acknowledges that MedImpact operates only as an intermediary between Payers and Member Pharmacy with respect to payment. Payers have agreed with MedImpact to pay sufficient funds for claims submitted by Member Pharmacy. Provided that sufficient payment has been received by MedImpact from Payer and provided the applicable Copayment has been collected by Member Pharmacy, MedImpact will pay Member Pharmacy for Prescription Drug Benefits provided to Eligible Persons in accordance with the payment rate information communicated to Member Pharmacy through the electronic claims system, less the applicable Copayment. Such payments will be made within 30 days of receipt of such a clean claim. Any overpayments made to Member Pharmacy or amounts owed by Member Pharmacy to MedImpact (including but not limited to POS charges, administrative charges, claim overpayments and reversals) may be deducted from amounts otherwise payable to Member Pharmacy.

Member Pharmacy acknowledges, understands, and agrees that claim payment amounts are the sole and absolute responsibility of the Payer. Member Pharmacy further acknowledges, understands, and agrees that MedImpact is not obligated to pay Member Pharmacy for claims of a Payer if a Payer fails to provide MedImpact with sufficient funds for such payment, and MedImpact has no liability to Member Pharmacy for nonpayment or for any delay in payment from a Payer. Accordingly, Member Pharmacy agrees to recover any unpaid balances from Payer only and that Member Pharmacy shall have no claim against MedImpact, and shall not seek payment from MedImpact, above or beyond the amount of payments made to MedImpact by the applicable Payer regardless of the cause of any non-payment or delay in payment by Payer. Member Pharmacy acknowledges, understands, and agrees that MedImpact is not the Payer and that except as otherwise set forth in this Agreement, there are no third party beneficiaries under this Agreement.

In the event that a Payer makes an assignment for the benefit of creditors, files a voluntary or involuntary petition in bankruptcy, is adjudicated insolvent or bankrupt, or a receiver or trustee is appointed, MedImpact shall have the right, but not the obligation, to participate in such proceedings on behalf of Member Pharmacy. MedImpact has the right to deduct from amounts otherwise payable to Member Pharmacy the Member Pharmacy's pro rata share of any reasonable costs and fees (including attorneys' fees) incurred by MedImpact in any such proceedings. All such amounts shall become immediately due and owing by Member Pharmacy upon notification by MedImpact.

V. PRICE NON-DISCRIMINATION

Member Pharmacy agrees that it will not offer to, contract for, agree to, give to, or accept from any other pharmacy benefits manager, third party payor, or other entity a reimbursement rate or payment amount more favorable than that given to MedImpact for pharmacy and related products, services, and/or programs for existing or prospective business without giving the same or better reimbursement rate or payment amount terms to MedImpact. If at any time Member Pharmacy offers to, contracts with, agrees with, gives to, or accepts from any other pharmacy benefits manager, third party payor, or other entity reimbursement rates and/or payment amounts for pharmacy and related products, services, and programs (for existing or prospective business) which are equal to or less than those offered to, contracted for, agreed to, given to, or accepted by Member Pharmacy with respect to MedImpact, Member Pharmacy shall promptly notify MedImpact in writing, and regardless of whether such notification is provided, the reimbursement rates and/or payment amounts shall be reduced to such lower amount(s). Member Pharmacy shall certify in writing to MedImpact on an annual basis, and upon reasonable request, that Member Pharmacy is in compliance with this provision. MedImpact shall have the right to have an independent third party conduct an audit of Member Pharmacy's books, records, and other documentation to verify compliance with this provision.

In return, MedImpact agrees to market all like pharmacies on an equal basis and that no other like pharmacies will be paid an overall reimbursement amount more favorable than that paid to Member Pharmacy in connection with any applicable Plan, Network, or program unless a Plan requires that pharmacies be added to

the applicable network at differing rates. In the event a Plan requires that like pharmacies be added to a Network at more favorable rates than that paid to Member Pharmacy, MedImpact shall notify Member Pharmacy of such, and Member Pharmacy may request in writing to MedImpact an equitable adjustment to the rates within thirty (30) days of such notification. If the parties are unable to agree upon an equitable adjustment, Member Pharmacy may terminate its participation in a Network with respect to the applicable Plan by providing thirty (30) days written notice of such termination. As additional consideration to Member Pharmacy, MedImpact represents and warrants that it currently does not, and does not intend to, offer to Plans its own operated, self-contained mail order and specialty mail order pharmacy fulfillment services.

This provision shall not be construed or applied as limiting in any way either MedImpact's or Member Pharmacy's right to engage freely in agreements with other competing entities.

VI. TAXES

If any taxes, assessments and/or similar fees ("taxes") are imposed on Member Pharmacy by a governmental authority based upon Member Pharmacy's provision of Prescription Drug Benefits to Eligible Persons, Member Pharmacy may request reimbursement from Payer or Eligible Person for such taxes that are allowed and imposed by applicable Law in accordance with the Plan. Member Pharmacy must transmit the applicable tax amount allowed by Law through the online claim system. In no event does this give Member Pharmacy any additional or different rights than those allowed by Law. In no event shall MedImpact be liable for any such taxes, assessments or similar fees or the determination of the amount of such taxes, assessments or similar fees. Member Pharmacy shall assume the responsibility of making and shall timely make payments to the appropriate taxing authorities of the amount of any taxes received.

VII. COMPLIANCE WITH LAW

Member Pharmacy acknowledges that various state and federal mandates and guidelines may apply with respect to the Agreement and the pharmacy services provided under the Agreement. Member Pharmacy represents and warrants that it is, and shall remain, in compliance with all applicable laws, including but not limited to all applicable Medicare laws, regulations, and CMS instructions, all laws applicable to individuals and entities receiving Federal funds and all other applicable Federal and State laws, regulations, and governmental issuances, including but not limited to those governing participation in the Medicare+Choice Program, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, all applicable Federal and State anti-kickback statutes, and all Federal and State privacy and security requirements, including the privacy and security provisions contained in 42 CFR Section 403.812.

VIII. INDEMNIFICATION AND LIMITATION ON LIABILITY

All liability arising from the provision of prescription drugs and services by Member Pharmacy, its employees, agents or representatives, including the professional judgment of Member Pharmacy, its employees, agents or representatives, will be the sole responsibility of Member Pharmacy. Member Pharmacy shall indemnify and hold harmless MedImpact, the Payers, and their respective employees, agents, representatives, members, eligible participants and dependents, against loss, expense, liability, or damage, including, without limitation, any and all claims, causes of action, judgments, awards, settlements, costs, fees, or debts of whatever nature, including without limitation reasonable attorneys' fees and costs, arising out of or in connection with: (a) any actual or alleged malpractice, negligence, misconduct, or breach by Member Pharmacy, its employees, agents or representatives in the performance or omission of any act assumed by Member Pharmacy; or (b) the provision of pharmacy services, including the sale, compounding, dispensing, manufacturing, or use of a drug or device dispensed by Member Pharmacy, its employees, agents or representatives. Such indemnification shall include the duty to defend any such legal action against MedImpact, the Payers, and their respective employees, agents, members, representatives, eligible participants, and dependents. MedImpact is not responsible or liable

for Member Pharmacy's professional judgment in its provision of prescription drugs and services. This Section will survive the termination of this Agreement.

Notwithstanding any other term of this Agreement, in no event shall either party be liable to the other party for special, indirect, incidental, exemplary, consequential (including but not limited to loss of profits) or punitive damages arising from the relationship of the parties or the conduct of business under this Agreement (even if the other party has been advised of or has foreseen the possibility of such damages).

IX. REPRESENTATIONS AND WARRANTIES

Member Pharmacy represents and warrants that it is, and will maintain, in good standing, all federal, state, and local licenses and certifications as required by Law. Member Pharmacy further represents and warrants that it can legally dispense prescriptions for Medicare, Medicaid, and MediCal healthcare programs; and that it is not subject to exclusion, suspension or debarment from the Medicare, Medicaid, MediCal or other government healthcare programs. Member Pharmacy further represents and warrants that it has, and will maintain, policies for general and professional liability insurance in such forms and amounts reasonable for the industry, which shall in no event be less than the greater of the amount required by law or $1 million per occurrence and $3 million aggregate. Member Pharmacy agrees to immediately notify MedImpact in writing of any suspension, revocation, limitation, or disciplinary action taken by any State Board of Pharmacy or other licensing or regulatory authority (including Medicare, Medicaid, and MediCal) and of any suspensions, cancellations, or material changes of insurance coverage. Member Pharmacy acknowledges that failure to maintain the appropriate license, certifications, and/or insurance policies will result in immediate termination of Member Pharmacy from the Networks. Member Pharmacy must provide to MedImpact evidence of such licenses, certifications, and insurance policies upon request.

X. INDEPENDENT CONTRACTORS; THIRD PARTY BENEFICIARIES; NON- ASSIGNABILITY

Member Pharmacy and MedImpact are independent entities. Member Pharmacy shall perform all services under this Agreement as an independent contractor, and shall exercise its own professional judgment in providing such services. Except for the indemnity provisions of this Agreement, no provision of this Agreement is for the benefit of any person or entity who is not a party hereto, and no such party will have any right or cause of action hereunder. This Agreement shall not be assigned, sub-contracted, delegated, or transferred by Member Pharmacy without the prior written consent of MedImpact.

XI. TERM AND TERMINATION

This Agreement will be in effect from the date of acceptance by MedImpact and will continue in effect for a period of 1 year and will automatically renew for successive periods of 1 year unless either party gives written notice of non-renewal in accordance with the MedCare Pharmacy Networks Policies and Procedures Manual. This Agreement also may be terminated by MedImpact in accordance with the MedCare Pharmacy Networks Policies and Procedures Manual.

XII. ENTIRE AGREEMENT

This Agreement, the Pharmacy Network Participation Acceptance Form, the MedCare Pharmacy Networks Policies and Procedures Manual, the Pharmacy Network Addendum(s), the Authorization to Participate forms, and Payer Sheets related to the Networks constitute the entire Agreement between MedImpact and Member Pharmacy, all of which are incorporated herein by reference as if fully set forth herein and are referred to collectively as the "Agreement". Member Pharmacy's non-adherence to any of the provisions in the Agreement, including the Pharmacy Network Participation Acceptance Form, the MedCare Pharmacy Networks Policies and Procedures Manual, the Pharmacy Network Addendum(s), the Authorization to Participate forms, and/or Payer Sheets will constitute a breach of this Agreement. The Agreement may be amended from time to

time by MedImpact by providing 30 days prior written notice of such amendment. Member Pharmacy may reject such amendment by providing written notice to MedImpact of its intent not to accept such amendment prior to its taking effect. MedImpact has the right to immediately terminate the Agreement in the event any amendment is rejected by Member Pharmacy. Except as incorporated herein by reference, any prior agreements, promises, negotiations, or representations concerning the subject matter covered by the Agreement are of no force and effect. In the event any provision or part thereof contained in the Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability shall not affect the validity or enforceability or any other provision or part thereof of the Agreement. In the event of a conflict between any of the documents comprising the Agreement, the terms of any applicable state-specific addendums shall control first, then the MedCare® Pharmacy Network Agreement, the MedCare Pharmacy Networks Policies and Procedures Manual, any Network Addendums, the Authorization to Participate forms, and the Payer Sheets, in that order.

XIII. NOTICE

Except as otherwise specified in the MedCare Pharmacy Networks Policies and Procedures Manual, notices required to be given pursuant to the Agreement shall be in writing, and be delivered in person, or by certified mail, air courier, or first class mail, and addressed to the Senior Vice President, Strategic Finance Operations and/or Vice President, Contract Management at MedImpact at the address below:

MedImpact Healthcare Systems, Inc. ®
10181 Scripps Gateway Ct
San Diego, CA 92131

Any notice of dispute must also be addressed and delivered to the Sr. Vice President, Corporate Services at MedImpact.

XIV. ARBITRATION

Resolution of Disputes. Any and all disputes, controversies or claims (including without limitation tort claims, requests for provisional remedies or other interim relief and issues as to arbitrability of any matter) arising out of, in connection with, or relating to this Agreement, or the breach thereof, that cannot be settled through negotiation shall be settled by arbitration administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and pursuant to the California Arbitration Act (such arbitration to be held in San Diego, California before a single arbitrator and to commence within twenty (20) days of the appointment of the arbitrator by JAMS). The Parties agree that the Expedited Procedures set forth in JAMS Comprehensive Rules 16.1 and 16.2 shall be employed. Any controversy, claim or dispute under $250,000.00 shall be handled in accordance with the JAMS Streamlined Arbitration Rules and Procedures. The arbitrator may only award remedies provided in the Agreement. The expenses of the arbitration, including reasonable attorney's fees, will be paid for by the party against whom the award of the arbitrator is rendered. The negotiation and arbitration provisions of this Section XIV shall be the sole and exclusive method of handling any and all disputes, claims and controversies arising out of or related to this Agreement, and the award of the arbitrator will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. The arbitration proceeding provided for herein is a private proceeding and neither party shall disclose or publicize the decision of the arbitrator other than as required by Law. The parties further agree that the existence of this remedy will not preclude MedImpact from seeking or receiving injunctive relief hereunder.

Pharmacy Network Participation Acceptance Form

The undersigned agrees to participate in one or more of MedImpact's pharmacy networks and to be bound by the MedCare® Pharmacy Network Agreement attached hereto and made part hereof without any modifications, deletions, or additions. By signing below, the undersigned represents and warrants that it has received and read the MedCare® Pharmacy Network Agreement and the MedCare® Pharmacy Networks Policies and Procedures Manual. By signing below, the undersigned represents and warrants that the undersigned has been afforded ample opportunity to obtain legal or other assistance in reviewing and interpreting the MedCare® Pharmacy Network Agreement (including the MedCare® Pharmacy Networks Policies and Procedures Manual). The undersigned represents and warrants that the information contained herein is true and accurate.

NCPDP#		
Corporate Name		
Pharmacy Name (DBA)		
Pharmacy Address		
City, State, Zip Code		
Mailing Address		
City, State, Zip Code		
Phone Number		
Fax Number		
Email Address		
DEA Number		
State Pharmacy License Number		
Medicare Part D Provider	Yes _____ No _____	Medicare ID Number:
Medicaid ID Number		
Federal Tax ID Number		
Contact Name and Title		
Hours of Operation	/ Delivery: Yes _____ No _____	
Pharmacy Authorized Signature		
Printed Name and Title		
Date		
MedImpact Authorized Signature		
Printed Name and Title		
Date		

Healthe SYSTEMS

Transforming healthcare.

Healthesystems Exhibit H:
Network Pharmacy Contract

Prepared for: New York State Insurance Fund

Kristi Klecka
National Sales Director
813-463-1269
kklecka@healthesystems.com
www.healthesystems.com

PARTICIPATING PHARMACY OR PHYSICIAN PROGRAM AGREEMENT

The Participating Pharmacy or Physician Program Agreement (hereinafter referred to as "Agreement"), with an effective date of _____, 201__ ("Effective Date"), is entered into by and between Health E Systems, LLC, ("HealthE") a Florida Limited Liability Company, with an address at: 5100 W. Lemon Street, Suite 311, Tampa, FL 33609 and _____ ("Participating Pharmacy or Physician"), with an address at: _____.

WHEREAS, HealthE offers as a service to its client(s), a program for the purchase of prescription drugs; and

WHEREAS, Participating Pharmacy, as an operator of a pharmacy or pharmacies, or Physician desire to participate in the Agreement as a dispenser; and

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. DEFINITIONS

a. "Average Wholesale Price" ("AWP") means the average wholesale price of dispensed medication as listed by Wolters Kluwer Health's Medi-Span (pricing source); this pricing will be updated at least weekly. The parties agree that if: (1) changes to the pricing source for AWP take effect, (2) changes to the formula, methodology or manner in which AWP is calculated or reported by the pricing source take effect, (3) the pricing source ceases to publish AWP for the drugs covered under the Agreement, or (4) a government imposed or industry-wide change alters the economics of the Agreement, the financial terms of the Agreement will be renegotiated to attempt to return the parties to their respective economic positions as they each existed under the Agreement immediately prior to such change.

b. "Covered Drug" means any prescription Legend Drug and such other drugs which are not excluded by the on-line electronic claims adjudication system when ordered by a "Prescriber" or other drug which has been designated as covered by the designated prior authorization process for the plan. The term Covered Drug specifically does not include, and no payment will be made for, any prescription charge for any item which is excluded or deemed non-reimbursable by the On-line System.

c. "Dispense As Written" or "DAW Code" means the code promulgated by NCPDP to indicate the reason for dispensing a multi-source brand named medication.

d. "Eligible Person" means an individual who is entitled to Covered Drug benefits as indicated by the on-line electronic claims adjudication system in accordance with and under the terms of, applicable prescription drug programs administered by HealthE.

e. "Eligible Prescription Order" means a Prescription Order that qualifies for reimbursement under this Agreement and the on-line electronic claims adjudication system guidelines.

f. "Legend Drug" means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend "Caution – Federal law prohibits dispensing without a prescription" or other similar language and, for the purpose of the Agreement, shall include state restricted drugs (any non-federal legend drugs, which according to state laws, may not be dispensed without a prescription) and compounded prescriptions containing at least one federal legend or state restricted drug in a therapeutic amount.

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g. “National Drug Code” (“NDC”) means the unique three-segment number that identifies the labeler, product and trade package size of human drugs. The NDC is comprised of three (3) segments: (i) the first segment, the labeler code, is assigned by the FDA and identifies the manufacturer (including repackagers or relabelers), or distributor of the drug; (ii) the second segment, the product code, identifies a specific strength, dosage form, and formulation for a particular firm; and (iii) the third segment, the package code, identifies package sizes and types.

h. "Non-Public Personal Information" means personally identifiable information not available to the public, which includes but is not limited to, consumer description, name, social security number, health information, etc.

i. "On-line System" (on-line electronics claims adjudication system) means the current accepted NCPDP standard format and electronic transmission link between HealthE or HealthE's processing agent and Participating Pharmacy which provides information regarding medication guidelines, member eligibility, copayment charge, participating Prescriber, prescription drug coverage and all other information necessary for Participating Pharmacy to provide goods and services for which reimbursement will be received by Participating Pharmacy.

j. “Physician” means a medical doctor or other health care professional who is legally licensed to prescribe and dispense prescriptions medications within the scope of that license.

k. "Prescriber" means a medical doctor or other health care professional who is legally licensed to prescribe prescription medications within the scope of that license. For the purposes of this Agreement, "Prescriber" also includes those non-physician prescribers who are legally licensed to prescribe only when they are under the supervision of a licensed Prescriber as permitted by the medical practice laws within the state in which they practice.

l. "Prescription Order" means the legal request for prescription Legend Drugs by a Prescriber or other recognized individual duly authorized in the state of jurisdiction to create a prescription for a Legend Drug.

m. "Protected Health Information" means individually identifiable health information that is transmitted by electronic media, maintained in any medium, or transmitted or maintained in any other form or medium. Individually identifiable health information is a subset of health information, including demographic information collected from an individual and created or received by a health care provider, health plan, employer or health care clearinghouse and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual which identifies the individual or there is a reasonable basis to believe that the information can be used to identify the individual.

n. “Repackaged or Relabeled Medication” means an over-the-counter product or prescription medication removed from the original container with an original NDC and placed into a new container with new quantities, therefore, requiring a new NDC, with a new repackaging company label and price for the medication.

o. “Therapeutic Equivalent Drugs” means drugs that have been assigned the same Therapeutic Equivalent Code starting with the letter “A” in the Food and Drug Administration’s publication “Approved Drug Products with Therapeutic Equivalence Evaluations”.

p. "Usual and Customary" ("U&C") cash price means the lowest cash price that Participating Pharmacy would normally charge the Eligible Person if that Eligible Person was a cash paying customer in the pharmacy, on that same day.

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2. TERM AND TERMINATION

a. **Term.** This Agreement shall be effective as of the Effective Date and shall continue in effect for a one (1) year term, and shall automatically renew for successive one-year terms unless either party provides written notice of non-renewal to the other party at least sixty (60) days prior to the end of the initial term or any renewal thereof.

b. **Termination Without Cause.** This Agreement may be terminated by either party without cause with sixty (60) days written notice.

c. **Automatic Termination.** This Agreement will terminate automatically without notice with respect to any individual pharmacy location operated by the Participating Pharmacy as of the date on which such individual pharmacy location fails to maintain appropriate licensure, registration, certification, good standing or insurance, as required by this Agreement and/or law or regulation.

d. **Immediate Termination.** If either party institutes or consents to the institution of bankruptcy, is adjudicated insolvent or bankrupt, a receiver or trustee is appointed for the substantial part of its property, or a proceeding is commenced against it which will substantially impair its ability to perform hereunder, then this Agreement may be immediately terminated by the other party upon written notification.

e. **Default.** Either party may terminate this Agreement at any time for material breach by the other party by giving thirty (30) days written notice to the other party, which termination shall become effective at the end of such notice period if such breach is not cured to the satisfaction of the non-breaching party by such date.

f. **Transactions Prior to Effective Date of Termination.** Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

3. PHARMACY OBLIGATIONS, RESPONSIBILITIES AND PROCEDURES

a. **State and Federal Requirements.** Participating Pharmacy or Physician will comply with all applicable federal and states laws and regulations.

b. **Good Standing.** Participating Pharmacy must be able to, upon demand, provide documentary evidence as a pharmacy in good standing and fulfilling all state and federal requirements as a duly licensed pharmacy. Physician must be able to, upon demand, provide documentary evidence as a Physician in good standing and fulfilling all state and federal requirements as a duly licensed Physician. Good standing means that the Participating Pharmacy or Physician has complied with all the legal obligations of their profession and has unabated powers to conduct their professional activities, e.g., dispense medication.

c. **Participating Pharmacy Licensing.** Participating Pharmacy shall maintain all licenses required for operating a pharmacy. All staff that work as part of the operation of the Participating Pharmacy shall maintain all licenses required to dispense medications in accordance with applicable laws. This includes any licenses (DEA, federal or state) related to the practice of pharmacy. The Participating Pharmacy's endorsement of and signature upon this Agreement shall constitute verification of and certification of the existence of such licenses. Furthermore, Participating Pharmacy agrees that upon written request from HealthE, a copy of all professional pharmacy

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and pharmacist licenses in effect at the time of the request will be provided in a reasonable and timely manner.

d. **Physician Licensing.** Physician shall maintain all federal and state licenses required, including any required to dispense medications in accordance with applicable laws. The Physician's endorsement of and signature upon this Agreement shall constitute verification of and certification of the existence of such licenses. Furthermore, Physician agrees that upon written request from HealthE, a copy of all professional licenses in effect at the time of the request will be provided in a reasonable and timely manner.

e. **Network.** If a Prescriber is not part of HealthE's Client's (e.g., insurance carrier, third party administrator, etc.) medical provider network or other state network but has executed this Agreement with HealthE, the Client's medical provider network requirements or state network requirements will supersede the contractual terms and conditions documented in this Agreement.

f. **On-line System.** Participating Pharmacy or Physician shall provide Covered Drugs to all Eligible Persons and adjudicate transactions through the On-line System. Eligible Persons and Covered Drugs will be established using the On-line System. For transactions not adjudicated through the On-line System, i.e., retrospective transactions, Participating Pharmacy or Physician will be reimbursed based on the Retail Network Reimbursement Guidelines documented in Section 4.c.i.

g. **Professional Ethics and Judgment.** The compounding and dispensing of prescriptions is subject to legal restrictions and professional ethics and judgment of the dispensing pharmacy and pharmacist. The dispensing pharmacist or Physician has the obligation to refuse to dispense a Prescription Order which for any reason, in his/her professional judgment, should not be dispensed.

h. **Eligibility Verification.** Participating Pharmacy or Physician agrees, as a condition precedent to providing services, to determine the eligibility of each Eligible Person by requesting Eligible Person's identification number and verifying eligibility using the On-line System.

i. **Generic Drugs.** Participating Pharmacy or Physician will make every effort to supply, where applicable, generic drugs if commercially available and consistent with the pharmacist's professional judgment and state and federal law. Participating Pharmacy or Physician shall maintain a record on the original Prescription Order of its attempt at achieving generic dispensing. Participating Pharmacy or Physician shall use best efforts to maintain an adequate supply of generic drugs.

j. **Co-Payment.** Participating Pharmacy or Physician will not charge or collect any payment from any Eligible Person for any Covered Drug or refill in excess of the applicable copayment amount indicated by the On-line System. If the prescription charge is less than the co-payment amount, Participating Pharmacy or Physician will still transmit said transaction using the On-line System. Unless otherwise stipulated in this Agreement, Participating Pharmacy or Physician will charge their U&C cash price for an Eligible Prescription Order when the lower of On-line System calculated reimbursement amount and the U&C cash price are both less than the Eligible Person's copayment amount.

k. **DAW Codes.** Participating Pharmacy or Physician agrees to submit an accurate DAW Code in accordance with NCPDP specifications and that DAW Code submission may change the calculation of the claim and/or co-payment. Participating Pharmacy or Physician will be liable for any miscalculations and/or adjustments resulting from incorrect submission of a DAW Code.

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l. **Dispensing Limitations.** The maximum quantity the Participating Pharmacy or Physician shall dispense for each Covered Drug shall be indicated by the On-line System. Unless otherwise indicated in this Agreement, the maximum quantity allowed by the On-line System will generally be a thirty (30) day supply and should not exceed a ninety (90) day supply for Covered Drugs that are considered maintenance drugs.

m. **Refills.** Participating Pharmacy or Physician acknowledges that a Covered Drug may be refilled as allowed by state and federal laws and authorized by the Prescriber up to one (1) year from the original prescription date and subject to the provisions of Section j (Dispensing Limitations) above.

n. **Cost of Drug.** Participating Pharmacy or Physician shall furnish the lowest cost Covered Drug consistent with the Prescription Order and allowed by state and federal laws. If the Covered Drug is generically prescribed, the Participating Pharmacy or Physician shall dispense the lowest cost drug it has in stock which meets the specifications set forth concerning generic substitution in the FDA approved Drug Products with Therapeutic Equivalents guidelines (aka the Orange Book), United States Pharmacopoeia and the National Formulary, if such drug is listed therein, and which, in the best professional judgment of the dispensing pharmacist, fulfills the requirement of the Prescription Order and the benefit guidelines of the On-line System.

o. **Usual and Customary Price.** Participating Pharmacy or Physician shall furnish their Usual and Customary cash price as part of each On-line System claim transaction.

p. **Insurance.** Participating Pharmacy or Physician shall maintain general and professional liability coverage in such forms and amounts as are reasonable for the industry and for a provider of Pharmacy Services of the type and size provided which shall in no event be less than required by applicable law. The Participating Pharmacy's or Physician's endorsement of and signature upon this Agreement shall constitute verification of and certification of the existence of such insurance. Furthermore, Participating Pharmacy or Physician agrees that upon written request from HealthE, a copy of all professional liability insurance policies in effect will be provided in a reasonable and timely manner. And, in any case, if the Participating Pharmacy's or Physician's professional liability insurance represents a benefit amount of less than $1,000,000.00, the Participating Pharmacy or Physician will specify the amount of liability insurance on the Participating Pharmacy's or Physician's signed copy of the Agreement (signature page) or by including a copy of their liability insurance certificate with their signed Agreement. HealthE reserves the right to reject a Participating Pharmacy or Physician that does not carry a minimum of $1,000,000.00 in professional liability insurance from participating in select pharmacy provider networks established for payer clients that require that minimum level of professional liability pharmacy.

q. **Legal Action.** Participating Pharmacy or Physician shall notify HEALTHE of any legal or administrative claim made or action filed against Participating Pharmacy or Physician arising from this Agreement by an Eligible Person or otherwise which could affect the ability of Participating Pharmacy or Physician to carry out this Agreement, within ten (10) calendar days of receipt of such claim or action.

r. **Discrimination.** Participating Pharmacy or Physician agrees that it shall not engage in any discriminatory behavior in regard to services provided under this Agreement.

s. **Subcontractors.** Participating Pharmacy or Physician agrees that if any portion of this Agreement is subcontracted to another entity they shall ensure in writing that the subcontractor complies with all requirements documented in this Agreement.

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t. **Credentialing.** Participating Pharmacy or Physician shall be responsible for credentialing and re-credentialing; and Participating Pharmacy or Physician shall consent to and cooperate with audit conducted by HealthE in regard to credentialing/re-credentialing, which may include site reviews.

u. **Background Checks.** Participating Pharmacy or Physician agrees to preform multi-jurisdictional (i.e., national) criminal background checks on all employees that have access to HealthE Confidential Information for the greater of (a) a seven-year period before such employee's access date to HealthE Confidential Information and (b) as long as records are commercially available. Participating Pharmacy or Physician will provide said background checks to HealthE within thirty (30) days from the written request of HealthE. Upon the HealthE's request, Participating Pharmacy or Physician shall certify its compliance with this section. In the event that a background check shall indicate the commission of a felony or misdemeanor by Participating Pharmacy or Physician Personnel, Participating Pharmacy or Physician will conduct an individualized assessment and make the appropriate determination up to and including reassignment.

v. **Restricted Lists Representation.** Participating Pharmacy or Physician warrants and represents, and if requested by HealthE shall certify in writing at least once per year, that no employees that have access to HealthE Confidential Information is on any of the following lists: Specially Designated Nationals and Other Blocked Persons List, Denied Persons List, any other list of restricted or prohibited person lists maintained and/or promulgated by the US Department of Treasury, the Bureau of Industry and Security of the US Department of Commerce or any other federal governmental agency. Participating Pharmacy or Physician, shall indemnify HealthE for all loss, cost, damage and expense arising out of breach of this warranty by Participating Pharmacy or Physician.

w. **Immigration Laws.** Participating Pharmacy or Physician agrees to comply with all applicable requirements of U.S. immigration Laws and related Laws, including verification of the employment eligibility of each of its employees that have access to HealthE Confidential Information who work in the United States. For those employees that have access to HealthE Confidential Information needing a visa to enter the United States, or otherwise needing immigration status in the United States, in order to carry out activities in connection with this Agreement, Participating Pharmacy or Physician will take all steps necessary to obtain and maintain appropriate immigration classifications or status for such employees.

4. PHARMACY REIMBURSEMENT

a. **Reimbursement Definitions.** Reimbursement definitions for this Agreement and any affiliated Agreement Exhibit(s):

i. "AWP" is defined in Section 1 of this Agreement.

ii. "Usual and Customary" ("U&C") is defined in Section 1 of this Agreement.

iii. "Multi-Source Drug" ("MS") or "Generic Drug" or "Generically Available Drug" means any drug product where the innovator manufacturer's patent has expired and that same drug is available from at least two (2) different manufacturers or generic drug distributors.

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iv. "Multi-Source Brand Drug" ("MSB") means any drug product that continues to be manufactured and/or distributed as the innovator drug product once that same drug becomes a Multi-Source Drug.

v. "Multi-Source Generic Drug" ("MSG") means all multi-source alternatives for a specific drug product except for that alternative defined as the MSB alternative for the same drug product.

vi. "Single Source Brand Drug" ("SSB") means the innovators drug product while it is still under patent protection and/or still available from a single manufacturer or their licensed representatives.

b. **Payment.** HealthE will pay Participating Pharmacy or Physician for each Eligible Prescription Order according to the specific payment guidelines set forth in this Agreement. Unless otherwise specified in this Agreement, Participating Pharmacy or Physician will be paid the lesser of the applicable AWP discount amount, property and casualty rate if applicable, plus the applicable dispensing fee amount or, the amount submitted by Participating Pharmacy or Physician, or the Participating Pharmacy's or Physician's Usual and Customary cash price.

c. **Reimbursement Rates.** Reimbursement rates for Participating Pharmacy or Physician participating in the HealthE Retail pharmacy network is as follows:

i. HEALTHE Retail Network Reimbursement Guidelines:
   1) AWP Discount for SSB Covered Drugs: AWP – ___% + $_____ dispense fee.
   2) AWP Discount for MS Covered Drugs: AWP – ___% + $_____ dispense fee.

iii. Repackaged or Relabeled Medication shall be reimbursed as follows:

   1) If applicable federal and/or state laws or regulations are in effect addressing reimbursement requirements for repackaged or relabeled medication, reimbursement will be based on the applicable federal and/or state laws or regulations.
   2) If there are no applicable federal and/or state laws or regulations, reimbursement will be based on the lesser of the AWP using the NDC for the underlying drug product from the original manufacturer or the lowest cost Therapeutic Equivalent drug.

d. **Time for Reimbursement.** Participating Pharmacy or Physician will be reimbursed by HealthE for Prescription Order filled or refilled as indicated by the On-line System via a weekly reimbursement. Expediency of payment will be within industry standards or state regulations and should not be longer than thirty (30) days from the time of on-line processing and final submission for payment.

e. **Taxes.** HealthE also agrees to reimburse Participating Pharmacy or Physician the appropriate and submitted federal, state or local sales tax liability amounts for prescriptions dispensed to or goods and services provided to the plan or its members. Sales tax is defined as an excise tax based on consumer retail sales whether designated a sales tax, gross receipt tax, retail occupation tax, value added tax or tax otherwise titled or styled. It includes any tax in existence or hereafter created, whether or not the bearer of the tax is the retailer or consumer. Participating Pharmacy or Physician assumes and accepts liability for submission of accurate tax amounts according to federal and state laws.

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f. **Submission of Claim.** It is important that original claims for all Covered Drugs dispensed to Eligible Persons be submitted on a timely basis but not more than ninety (90) days after the date of service to assure payment. Pharmacy payment will be disallowed on any Covered Drug dispensed to an Eligible Person when the claim is not received by HealthE within ninety (90) days from the date such Covered Drug was dispensed, unless extraordinary circumstances prevent the timely submission of said claims. Any Covered Drugs dispensed and submitted by Participating Pharmacy or Physician which charge in excess of the reimbursement delineated in this Agreement will automatically be reduced to comply with the terms of this Agreement.

g. **Resubmission of Claim.** In the event that any such claim is rejected, suspended or additional information is required for processing, Participating Pharmacy or Physician shall re-submit the claim and it shall be processed for payment provided it is resubmitted within the aforesaid ninety (90) day time period from the date such Covered Drug was dispensed.

5. RECORD MAINTENANCE AND ACCESS

a. **Access to Records.** HealthE and any and all applicable governmental authorities shall have access at all reasonable times to Participating Pharmacy's or Physician's books, records and other papers which relate to this Agreement, including but not limited to, original Prescription Orders, patient signature logs, pharmaceutical purchase records, prescriber information, patient profiles, billing records, and payments received from, or on behalf of Eligible Persons.

b. **Record Keeping.** Participating Pharmacy or Physician will maintain complete and accurate records of and supporting documentation for the amounts billable to and payments made by HealthE under the Agreement in accordance with generally accepted accounting principles applied on a consistent basis. Participating Pharmacy or Physician agrees to provide HealthE with documentation and other information with respect to each invoice as may be reasonably requested by HealthE, to verify accuracy and compliance with the provisions of the Agreement. Participating Pharmacy or Physician will also, for so long as Participating Pharmacy or Physician retains any Confidential Information of HealthE, including any Personal Information (whether during the term of this Agreement or thereafter), maintain records and information sufficient to show its compliance with its obligations in the Agreement, including any Exhibit/Attachment or Schedule thereto, with respect to such Confidential Information.

c. **Record Retention.** Participating Pharmacy or Physician will comply with HealthE record retention policies and practices applicable to the services provided pursuant to this Agreement set forth in this paragraph, as record retention policies. Until the later of: (a) seven (7) years after expiration or termination of the Agreement; (b) seven (7) years from the creation of any records relevant to HealthE or the services provided pursuant to this Agreement; (c) the full resolution of all pending disputes and other matters relating to the Agreement or HealthE use of the services provided pursuant to this Agreement; and/or (d) expiration of the applicable retention period(s) under HealthE or Client record retention policies, Participating Pharmacy or Physician will maintain all records, documents and other information required to support HealthE audit rights hereunder, including without limitation records documenting access to HealthE Confidential Information, fees, Service Levels and compliance with Laws. Additionally, Participating Pharmacy or Physician shall, from and after receipt of written notice thereof from HealthE, comply with any "litigation hold" applicable to HealthE records in its possession.

6. AUDITS

Participating Pharmacy or Physician will maintain such records, procedures and controls, and comply with the terms and conditions with respect to audit as set forth in this following paragraphs.

INITIALS: _____/_____

a. **General.** No more than one time per calendar year for any purpose, at HealthE's sole cost, upon thirty (30) days prior written notice from HealthE, Participating Pharmacy or Physician will provide third party or internal auditors that HealthE may designate in its notice with reasonable access during mutually agreed upon normal business days and hours to Participating Pharmacy or Physician business locations for the purpose of performing audit and/or inspection of Participating Pharmacy or Physician business as set forth in this section at no additional charge to HealthE. Participating Pharmacy or Physician will provide such auditors with any assistance that they may reasonably require, and shall ensure that its personnel, subcontractors and agents provide all reasonably required assistance. Participating Pharmacy or Physician audit obligations set forth herein will continue throughout the term of this Agreement and during any additional period during which Participating Pharmacy or Physician is required to maintain records in connection with the Agreement. Any proprietary information concerning Participating Pharmacy or Physician business, finances, systems, software or relationships or other such proprietary information obtained by HealthE or by any person authorized by HealthE shall be treated as Confidential Information of Participating Pharmacy or Physician and protected consistent with the Agreement. Notwithstanding the preceding, additional audits may be initiated if allegations arise that would require an additional audit, e.g., allegations of fraud or security breach.

b. **Internal Controls.** In connection with its obligations set forth herein and consistent with Participating Pharmacy or Physician's policies, Participating Pharmacy or Physician will, at its own cost and expense: (a) maintain strong quality assurance and internal controls, documentation and procedures, including tools and methodologies, designed to ensure that the services are performed in an accurate and timely manner in accordance with the Agreement ("Participating Pharmacy or Physician Controls"); (b) develop and execute a process to ensure the continued effective operation of Participating Pharmacy or Physician Controls; and (c) maintain an internal audit function sufficient to monitor the processes and systems used to provide the services (i.e., perform audits, track control measures, communicate status to management, drive corrective action, etc.). Participating Pharmacy or Physician will reasonably cooperate with any request by HealthE designed to ensure Participating Pharmacy or Physician compliance with any Participating Pharmacy or Physician Controls, and in the design, documentation and implementation of any corrective measures to correct any Participating Pharmacy or Physician Control deficiencies.

c. **Operational Audits.** No more than one time per calendar year for any purpose, at HealthE's sole cost, upon thirty (30) days prior advance written notice from HealthE, Participating Pharmacy or Physician will provide third party or internal auditors designated by HealthE in writing with reasonable access during mutually agreed upon normal business days and hours to any facility at which the Participating Pharmacy or Physician are being performed, to Participating Pharmacy or Physician Personnel, and to the data and records maintained by Participating Pharmacy or Physician with respect to the services, which access shall be provided for each such facility: (a) for the purpose of performing audits and inspections of Participating Pharmacy or Physician and its business as they relate to the services, including any Participating Pharmacy or Physician systems, facilities or practices and procedures; (b) for the purpose of verifying the integrity of any HealthE Confidential Information, including Personal Information, including, without limitation, by examining the systems that process, store, support and transmit such data, confirming the security of such Confidential Information, including Personal Information, and verifying Participating Pharmacy or Physician compliance with the applicable HealthE data security requirements (See Exhibit D); (c) for the purpose of examining data and records pertaining to Participating Pharmacy or Physician compliance with Participating Pharmacy or Physician Controls; and (d) for the purpose of confirming that the services are being provided efficiently and in accordance with this Agreement, including the Service Levels, if any; and (e) to confirm compliance with performance obligations under this Agreement. To the extent applicable to the services, the scope of such audits and inspections may include: (i) Participating Pharmacy or Physician practices and procedures; (ii) the adequacy of general controls (e.g., organizational, input/output, system modification, processing, system design and access controls), Participating Pharmacy or Physician Controls and Participating Pharmacy or Physician security

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practices and procedures; (iii) the efficiency of Participating Pharmacy or Physician in performing the services; (iv) the adequacy of disaster recovery and back-up procedures. If any audit by an auditor designated by HealthE results in Participating Pharmacy or Physician being notified that Participating Pharmacy or Physician Participating Pharmacy or Physician is not in compliance with audit requirements set forth herein or are not in compliance with any terms or conditions of the Agreement, Participating Pharmacy or Physician will be afforded a reasonable time to respond to audit finding(s); will promptly respond to any material findings and may be required to take actions to comply with such audit requirements or with the terms of the Agreement; and Participating Pharmacy or Physician will bear the expense of any such response or other actions. Any proprietary information concerning Participating Pharmacy or Physician's business, finances, systems, software or relationships or other such proprietary information obtained by HealthE or by any person authorized by HealthE shall be treated as Confidential Information of Participating Pharmacy or Physician and protected consistent with the Agreement. Notwithstanding the preceding, additional audits may be initiated if allegations arise that would require an additional audit, e.g., allegations of fraud or security breach.

d. **Financial Audits.** No more than one time per calendar year for any purpose, upon thirty (30) days prior written notice and during mutually agreed upon normal business days and hours, Participating Pharmacy or Physician will provide third party or internal auditors designated by HealthE in writing with reasonable access to the records for purposes of confirming the accuracy and correct calculation of the fees and any other charges, credits, or fees related to this Agreement, including any adjustment in fees. If any such audit reveals an overcharge by Participating Pharmacy or Physician, Participating Pharmacy or Physician will be afforded a reasonable time to respond to audit finding(s); will promptly respond to any material audit findings; and may be required pay to HealthE the amount of such overcharge. HealthE may, at its sole discretion, deduct or offset such amount of any overpayments made to Participating Pharmacy or Physician from any amounts otherwise payable to Participating Pharmacy or Physician. Any such audits will be conducted at HealthE expense; provided that, if any such audit reveals an overcharge of more than five percent (5%) in fees or other charges over the entire audited period, Participating Pharmacy or Physician will promptly reimburse HealthE for the actual and reasonable costs it incurs for such audit. Notwithstanding the preceding, additional audits may be initiated if allegations arise that would require an additional audit, e.g., allegations of fraud or security breach.

e. **Regulatory Audits.** For seven (7) years following the later of the termination or expiration of the Agreement, the records regarding HealthE that are maintained or produced by Participating Pharmacy or Physician under this Agreement will at all times be available for examination and audit by any governmental agency or regulator that has jurisdiction over the business of HealthE. Each party will notify the other party promptly of any formal request by an authorized governmental agency or regulator to examine records regarding HealthE that are maintained by Participating Pharmacy or Physician. Upon HealthE written request, Participating Pharmacy or Physician will provide any relevant information to those agencies or regulators and will subject itself to any required examination or regulation. As part of the services, and without any additional charge to HealthE, Participating Pharmacy or Physician will provide HealthE with any relevant information regarding the records of HealthE or Client reasonably requested by HealthE in connection with applicable regulatory reporting requirements.

f. **Non-Compliance.** If Participating Pharmacy or Physician is deemed non-compliant with the Agreement, certain penalties may apply, including but not limited to, fees, interest, penalties, damages, or other charges imposed upon HealthE by governmental entities, regulatory agencies, etc. HealthE has the right to deduct any such amounts from any amounts payable to Participating Pharmacy or Physician. HealthE may report its audit findings to clients, appropriate governmental entities and/or regulatory agencies.

7. LIMITATION OF LIABILITY

HealthE shall not be liable for any claim, injury, demand, judgment, tort or other grounds arising out of the sale, compounding, dispensing, failure to sell or use of any of Covered Drug dispenses to Eligible Persons by

the Participating Pharmacy or Physician pursuant to this Agreement. Participating Pharmacy or Physician will hold HealthE harmless from any and all such claims and demands.

Neither party shall be liable to the other party pursuant to this Agreement for any special, incidental, indirect or consequential damages or loss of data, loss of profits, business interruption, or similar damages or loss, even if the party had been advised of the possibility of such damages.

8. INDEMNIFICATION

Participating Pharmacy or Physician and HealthE hereby agree to indemnify the other and to hold the other harmless from settlement, damages and expenses including attorneys' fees resulting wholly or in part by any act, error or omission of the other party, its agents, officers or employees.

9. DATA SECURITY REQUIREMENTS

a. **Definitions**

i. **Access & Use Rights.** Rights and limitations for accessing Participating Pharmacy or Physician's Facilities, Participating Pharmacy or Physician's Systems, HealthE Data, Systems or HealthE Facilities, including such rights and limitations with respect to HealthE Personnel.

ii. **Confidential Information**. Confidential Information, whether or not marked as confidential, protected or proprietary, shall mean all of the information, data and software furnished by one Party or any of its affiliates to the other Party hereto, or to which a Party hereto otherwise obtains access pursuant to this Agreement, whether in oral, written, graphic or machine-readable form, which may include but not be limited to, an Eligible Person's health information (also known as Personal Health Information, as defined below) including medical records, HealthE monthly reports and billing information. Confidential Information also includes HealthE's business policies, practices, strategies, concepts, methodologies, operations, products, services, customer lists, claims information and pricing information. Confidential Information may be provided in any form, including without limitation verbally, in written paper form or electronically (which includes, but is not limited to, emails, computer disks, video disks, CDs or tapes, whether machine or user readable). Confidential Information does not include information that Participating Pharmacy or Physician can demonstrate is (a) publicly available; (b) independently developed by Participating Pharmacy or Physician without access or reference to Confidential Information; (c) previously known to Participating Pharmacy or Physician free from any obligation to keep it confidential; or (d) rightfully obtained by Participating Pharmacy or Physician from a third party without an obligation of confidentiality.

iii. **Data Protection Laws**. Any federal, state, and local laws, or government regulations, which are now or may become effective during the term of the Agreement and for so long thereafter as Participating Pharmacy or Physician has access to or possession of Personal Information, and which relates in any way to the privacy, confidentiality, or security of Personal Health Information, including without limitation: security breach notification laws; laws imposing minimum data security requirements (including the Massachusetts data security regulations at 201 Mass. Code Regs. §§ 17.01 – 17.05); laws requiring the secure disposal of records containing certain Personal Information; laws governing the use and transmission of social security numbers; and any legislation and/or regulations implementing or made under or pursuant to or amending or succeeding all such laws.

iv. **HealthE Data**. Any Personal Information or Confidential Information in any form that is provided to, or obtained, used, accessed, maintained, created or otherwise handled by, Participating Pharmacy or Physician in connection with providing the services to HealthE.

v. **Systems.** The computer network and computing systems, equipment and devices owned, operated or controlled by HealthE or a third party retained by HealthE.

INITIALS: _____/_____

vi. **Personal Health Information.** An Eligible Person's health information, including but not limited to medical records, monthly reports, billing information and any contract-related information. Personal Health Information shall be considered Confidential Information hereunder.

vii. **Security Breach**. Any unauthorized acquisition (including any lost or stolen Confidential Information), destruction, modification, use, disclosure of or access to Confidential Information (including, without limitation, an authorized user acting outside the scope of its authority, system attacks, penetrations, misuses of access and instances of hacking or other unauthorized access or intrusion, virus dissemination or intrusion or unauthorized scans of the party's internal network or computing resources or any HealthE Data installed, running, processed, stored or maintained therein).

viii. **Participating Pharmacy or Physician's Facilities**. The facilities owned, operated or controlled by Participating Pharmacy or Physician or a third party retained by Participating Pharmacy or Physician, including facilities at which: (a) Participating Pharmacy or Physician Systems are located; or (b) HealthE Data is stored, processed or transmitted by Participating Pharmacy or Physician.

ix. **Participating Pharmacy or Physician Personnel**. Individuals employed by, or contracted with, Participating Pharmacy or Physician who are authorized to access HealthE Data to perform Services as set forth in this Agreement.

x. **Participating Pharmacy or Physician Systems.** The computer network and computing systems, equipment and devices owned, operated or controlled by Participating Pharmacy or Physician or a third party retained by Participating Pharmacy or Physician used to access, process, maintain or store HealthE Data or access Systems.

b. **Federal and State Privacy Laws.** Participating Pharmacy or Physician agrees to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, any applicable federal or state privacy laws and the Gramm-Leach-Bliley Act (GLBA) and any applicable implementing regulations issued by the Insurance Commissioner or other regulatory authority having jurisdiction.

c. **Permitted Uses and Disclosures.** Participating Pharmacy or Physician is permitted or required to use or disclose Protected Health Information (PHI) and Non-Public Personal Information (NPPI) it creates for or receives from HealthE only as follows:

i. Participating Pharmacy or Physician is permitted to use and disclose the minimum necessary PHI and NPPI created for or received from HealthE solely as necessary to perform its obligations to HealthE as set forth in this Agreement.

ii. Participating Pharmacy or Physician may use the minimum necessary PHI and NPPI created for or received from HealthE solely as necessary for Participating Pharmacy's or Physician's proper management and administration or to carry out Participating Pharmacy's or Physician's legal responsibilities under the Agreement. Participating Pharmacy or Physician may disclose such minimum necessary PHI and NPPI only as necessary for Participating Pharmacy's or Physician's proper management and administration or to carry out Participating Pharmacy or Physician's legal responsibilities under this Agreement if the disclosure is required by law.

d. **Protection of Confidential Information.**

i. Use and Disclosure of Confidential Information. Participating Pharmacy or Physician will not use or disclose Confidential Information for any purpose, and will take reasonable steps to protect and prevent the disclosure of any Confidential Information, except to the extent authorized by HealthE pursuant to this Agreement. Participating Pharmacy or Physician's

INITIALS: _____/_____

obligations to protect Confidential Information as set forth in this Agreement will continue after termination of this Agreement or any other agreement under which Participating Pharmacy or Physician provides services.

ii. Reporting Obligation. If Participating Pharmacy or Physician becomes legally compelled (by applicable law or regulation or by deposition, interrogatory, request for documents, order, subpoena, civil investigative demand or similar process issued by a court of competent jurisdiction or by a government body) to disclose any Confidential Information, Participating Pharmacy or Physician shall provide HealthE with prompt prior written notice of any such requirement so that HealthE may seek a protective order or other appropriate remedy, and Participating Pharmacy or Physician shall provide all assistance reasonably necessary for HealthE to seek such order or remedy. In the event that HealthE does not obtain such protective order or other remedy, then Participating Pharmacy or Physician may disclose only that portion of the Confidential Information that Participating Pharmacy or Physician's counsel advises Participating Pharmacy or Physician is legally required to disclose.

e. **Network Security.** Participating Pharmacy or Physician must take commercially reasonable steps to protect all networks containing HealthE Data from unauthorized access at all entry points and implement network controls and safeguards necessary to monitor for, and prevent, any "leakage" of HealthE Data from Participating Pharmacy or Physician Systems.

i. Participating Pharmacy or Physician must prohibit the use of network data monitoring tools on Participating Pharmacy or Physician Systems, unless specifically approved by appropriate Participating Pharmacy or Physician management personnel. Any permitted use must be strictly monitored and controlled by Participating Pharmacy or Physician.

ii. Participating Pharmacy or Physician must ensure that all external IP connections are protected by a firewall. Firewall logs must be monitored for suspicious activity.

iii. Participating Pharmacy or Physician shall employ network intrusion prevention systems and/or network intrusion detection systems (as such terms are commonly understood in the information technology industry) to continually monitor the Participating Pharmacy or Physician Facilities and to detect, report, and ultimately terminate malicious network-based activity from both authorized and non-authorized sources; generate network intrusion detection audit logs; and on request, provide HealthE with evidence of regular log review and event investigation. If such system(s) fails for any reason, applicable compensating controls must be implemented.

iv. No less frequently than once each quarter, Participating Pharmacy or Physician will conduct vulnerability scans on all Participating Pharmacy or Physician Systems using an information security industry standard approach and commercially available tools. No less frequently than annually, Participating Pharmacy or Physician will have a 3rd party specializing in such services conduct a penetration test of all of Participating Pharmacy or Physician publicly-accessible Systems and perimeter defenses and highest-risk internal Systems including Domain Controllers and primary database servers. Participating Pharmacy or Physician will remediate vulnerabilities identified by these tests in a timeframe appropriate to the risk, and at HealthE's request, will promptly share their risk analysis and associated remediation plans with HealthE. Thereafter, if requested by HealthE, the parties will discuss actions that may be taken by Participating Pharmacy or Physician if HealthE considers Participating Pharmacy or Physician's approach inadequate.

v. Participating Pharmacy or Physician must install, update and maintain anti-virus products on all microcomputers/PCs, desktop and laptop computers, and servers (including file servers, mail servers, Web servers and database servers) within its possession and control, accessing, processing, maintaining or storing HealthE Data or used to access Systems. All Participating Pharmacy or Physician computer devices and LAN servers must be scanned regularly for viruses/malware, minimally at power on and specifically before every backup. Participating Pharmacy or Physician will implement additional information security industry standard

safeguards against contamination, including but not limited to enforcing the use of only approved software, scanning with current software all email, CDs and other electronic media received from outside sources for malicious code, and prohibiting the use of any unauthorized software on Participating Pharmacy or Physician Systems.

vi. Participating Pharmacy or Physician must apply security patches to network devices, PCs and servers of all types that are relevant to any Participating Pharmacy or Physician-operated systems in a timeframe appropriate to their risk level. Participating Pharmacy or Physician will, at HealthE's request, promptly share their risk analysis and patching plans with HealthE. Thereafter, if requested by HealthE, the parties will discuss actions that may be taken by Participating Pharmacy or Physician if HealthE considers Participating Pharmacy or Physician's approach inadequate.

f. **Access to HealthE Data Systems.** To the extent HealthE authorizes Participating Pharmacy or Physician to access Systems under the Agreement, Participating Pharmacy or Physician will access Systems solely for the express and limited purpose of Participating Pharmacy or Physician's performance of Services in accordance with the terms of the Agreement. Any access by or on behalf of Participating Pharmacy or Physician for any other purpose shall be deemed a material breach of the Agreement by Participating Pharmacy or Physician. Participating Pharmacy or Physician access to HealthE Data Systems requires the following:

i. Participating Pharmacy or Physician will access HealthE's Systems only from locations within the United States utilizing systems installed in the United States unless Participating Pharmacy or Physician has obtained HealthE's prior written agreement.

ii. Participating Pharmacy or Physician will ensure that no person granted access to Systems in connection with Participating Pharmacy or Physician's performance of Services under the Agreement appears on any list of prohibited or restricted persons maintained by the Bureau of Industry and Security of the U.S. Department of Commerce and the Office of Foreign Assets Control of the U.S. Department of Treasury or similar domestic or international governmental agency.

iii. Participating Pharmacy or Physician access to Systems shall be only through HealthE's security gateways/firewalls.

iv. Participating Pharmacy or Physician will use industry standard virus and malware detection/scanning program as described in section 9.e on any Participating Pharmacy or Physician Systems used to access any Systems.

v. Except as expressly permitted by the Agreement, no data contained in any of the Systems to which Participating Pharmacy or Physician is given access under the Agreement shall be copied or removed from any of such Systems by Participating Pharmacy or Physician without HealthE's prior written consent.

vi. Participating Pharmacy or Physician will not knowingly attempt to gain access to, alter, or destroy any of HealthE's Data, products or services, or data or information of any of HealthE's employees, customers, claimants or any other third party, except as otherwise required by this Agreement. Participating Pharmacy or Physician will take all reasonable measures to ensure that its employees, agents and permitted subcontractors, if any, do not attempt to gain unauthorized access to any HealthE Data, products or services of HealthE. If Participating Pharmacy or Physician determines that any of its employees, agents or subcontractors has exceeded their Access & Use Rights under the Agreement, it will terminate such access immediately and immediately notify HealthE.

vii. HealthE reserves the right to interrupt, suspend or otherwise discontinue Participating Pharmacy or Physician's access to Systems when HealthE, in its sole judgment, deems it is necessary to do so to maintain the security or operational integrity of Systems and/or the confidentiality, security or integrity of HealthE Data. In such event, HealthE will provide recommendations to Participating Pharmacy or Physician to correct the problem and to resume access.

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g. **Access Controls.** Participating Pharmacy or Physician must use appropriate, fully-documented and auditable access controls to access, store or otherwise process HealthE Data that comply with these Standards and applicable Data Protection Laws. Such controls must include, at a minimum:

i. a formal user registration, identification and authentication process, including functionality that tracks users' access to HealthE Data, Systems and HealthE Facilities and includes strong passwords;
ii. limiting access to HealthE Data and Systems to the minimum number of Participating Pharmacy or Physician Personnel who require such access to provide the Services to HealthE;
iii. requiring managerial authorization for changing Access & Use Rights and access or use policies, procedures and controls;
iv. requiring Participating Pharmacy or Physician Personnel who will be provided access to, or otherwise come into contact with, HealthE Data to protect such information in accordance with the requirements of these Standards;
v. employing physical barriers and controls that prevent or mitigate against unauthorized physical access and environmental hazards (including fire, smoke, water, dust), including locked doors, entry gates, staffed reception areas and intrusion detection alarms;
vi. employing two-factor authentication, or other enhanced authentication mechanisms, for remote access to Participating Pharmacy or Physician's systems (other than Internet-facing systems intended to be publicly accessible);
vii. prohibiting persons from sharing access authentications or establishing or using generic identifications; and
viii. Employing automatic device locking mechanisms.
ix. In addition, Participating Pharmacy or Physician must also document and implement a process to ensure its Access & Use Rights reflect changes in a user's access status within twenty-four (24) hours of the change. Participating Pharmacy or Physician will immediately terminate access rights for Participating Pharmacy or Physician Personnel: (a) who have left Participating Pharmacy or Physician's organization, changed jobs, are no longer under contract or are suspected of fraud, theft or any other violation of law; (b) who have violated or exceeded Access & Use Rights; and (c) after termination of this Agreement, except as otherwise stated in this Agreement.

h. **Data Storage.** Except to the extent expressly authorized by HealthE in advance in writing, all of the designated systems, equipment and devices used by Participating Pharmacy or Physician to store, maintain or process HealthE Data will be installed in premises that are owned and/or leased by Participating Pharmacy or Physician and operated by Participating Pharmacy or Physician and not by a third party. To the extent that HealthE authorizes in writing Participating Pharmacy or Physician's use of premises operated by any third party contractor, Participating Pharmacy or Physician shall be responsible for ensuring that such third party contractor agrees in writing to comply with the requirements of applicable Data Protection Laws and to standards at least as broad in scope and restrictive as those under these Standards; provided that Participating Pharmacy or Physician will remain fully responsible to HealthE for compliance by its third party contractor.

i. The network(s) containing HealthE Data shall be located behind an information security industry standard backend firewall in a "secure zone" on a separate network from Participating Pharmacy or Physician's Internet-facing webservers and will be protected from unauthorized access at all entry points.

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ii. Participating Pharmacy or Physician must isolate all HealthE Data stored, maintained or processed in Participating Pharmacy or Physician Systems and/or Participating Pharmacy or Physician Facilities from data of any other Participating Pharmacy or Physician clients stored, maintained or processed in Participating Pharmacy or Physician Systems or Participating Pharmacy or Physician Facilities, whether by use of separate and isolated database instances, separate secure folders or other equivalent technology (including logical separation via the use of key field identifiers) so as to prohibit any comingling of Customer's Data with data of other Participating Pharmacy or Physician client.

i. **Data Transmission.** Participating Pharmacy or Physician agrees that any and all electronic transmission or exchange of data with HealthE and/or any other parties expressly designated by HealthE shall take place via secure means (using HTTPS or SFTP or equivalent).

j. **Data Transfer.** Except for data transmissions required for Participating Pharmacy or Physician to perform the Services under an Agreement, and except for the movement of backup tapes/data to a remote storage facility, Participating Pharmacy or Physician shall not permit any HealthE Data to be transferred from Participating Pharmacy or Physician Facilities for any reason without first notifying HealthE and obtaining HealthE's prior written approval of the transfer.

k. **Data Encryption.** All HealthE Data must be encrypted by Participating Pharmacy or Physician during transmission outside of Participating Pharmacy or Physician Facilities, except on private communication lines, or wirelessly and in all backup media. To the extent that the parties rely on encryption keys to control access, HealthE and Participating Pharmacy or Physician will agree to a mutually acceptable approach to changing such keys in a manner and time frame as necessary and appropriate to minimize operational impact on any automated file transfer process utilized under the Agreement. If HealthE approves Participating Pharmacy or Physician's use of any portable media to process, maintain, access or store any HealthE Data, Participating Pharmacy or Physician must encrypt all HealthE Data in such portable media or device. Participating Pharmacy or Physician must use information security industry standard encryption products and algorithms at all times, which must be updated by Participating Pharmacy or Physician as necessary to remain current. Participating Pharmacy or Physician shall safeguard the security and confidentiality of all encryption keys associated with encrypted HealthE Data.

l. **Data Re-Use**. Participating Pharmacy or Physician agrees that any and all data exchanged shall be used expressly and solely for the purposes enumerated in this Agreements. Data shall not be distributed, repurposed or shared across other applications, environments, or business units of Participating Pharmacy or Physician. Participating Pharmacy or Physician further agrees that no HealthE data of any kind shall be transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by HealthE.

m. **Destruction of Data**. Except as otherwise expressly provided in the Agreement, within thirty (30) days of the completion of Participating Pharmacy or Physician's Services for HealthE under this Agreement or upon HealthE's request, Participating Pharmacy or Physician shall, to the extent permissible under applicable law, securely destroy or render unreadable each and every original and copy of all HealthE Data in Participating Pharmacy or Physician's possession, custody or control relating to the Services furnished under this Agreement by destroying all tangible copies of such HealthE Data and purging all electronic copies of such HealthE Data from all devices, systems and media using NIST SP-800-88 compliant data cleansing procedures (as updated from time to time). System backup media may continue to follow Participating Pharmacy or Physician's normal retention schedule, but must comply with the NIST SP-800-88 when the media reaches the disposal phase of its lifecycle. Participating Pharmacy or Physician shall

provide HealthE with a written certification by an officer of Participating Pharmacy or Physician confirming that such destruction and purging has occurred.

n. **Security Breach Notification**. In the event of a Security Breach, Participating Pharmacy or Physician shall promptly (i) provide all information necessary to enable HealthE to evaluate its potential rights, obligations, remedies and security precautions; (ii) investigate the Security Breach and communicate the results of such investigation to HealthE; (iii) take all other actions reasonably necessary to remedy the impact of the Security Breach, including remedying the problem at Participating Pharmacy or Physician's sole expense; (iv) reimburse HealthE for its reasonable expenses incurred to provide notices and information to regulators regarding the Security Breach; and (v) reimburse HealthE for its reasonable expenses incurred to provide notices, information and credit monitoring services to individuals affected by the Security Breach.

o. **Audits.**

i. Right to Audit. Upon thirty (30) days written notice to Participating Pharmacy or Physician, Participating Pharmacy or Physician shall permit HealthE, its auditors, designated audit representatives, and regulators, to audit and inspect at HealthE's sole expense (except provided in this Section), and no more often than once per year (unless otherwise required by government regulators): (a) Participating Pharmacy or Physician Facilities and Participating Pharmacy or Physician Systems (including those of any third-party service providers of Participating Pharmacy or Physician previously approved by HealthE); (b) any computerized or paper systems used to share, disseminate or otherwise handle HealthE Data; and (c) Participating Pharmacy or Physician's security practices and procedures, facilities, resources, plans and procedures. Such audit and inspection rights shall be, at a minimum, for the purpose of verifying Participating Pharmacy or Physician's compliance with the Standards, the Agreement, including all Exhibits, and the Data Protection Laws. Any such audit will be scheduled to minimize the disruption to Participating Pharmacy or Physician's business operations including the Services.

ii. Right to Security Assessments. In addition, Participating Pharmacy or Physician agrees that HealthE shall have the right to conduct a security assessment at least once every year upon reasonable notice. Such assessments typically take the form of a questionnaire for Participating Pharmacy or Physician to complete and return to HealthE. Participating Pharmacy or Physician will review vulnerabilities identified by each security assessment and will certify in writing its implementation of the appropriate corrective action to address the same. If HealthE and Participating Pharmacy or Physician are unable to agree on the appropriate corrective action, or if Participating Pharmacy or Physician fails to implement any such corrective action, HealthE, at its sole option, and without limiting other remedies, may cancel the Contract and/or the Agreement.

p. **Indemnification.** Participating Pharmacy or Physician will indemnify and hold harmless HealthE and any HealthE affiliates, officers, directors, employees and agents from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with unauthorized or prohibited use or disclosure of PHI or NPPI. If HealthE is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted or violating use or disclosure of PHI or NPPI by Participating Pharmacy or Physician or any subcontractor, agent, person or entity under Participating Pharmacy's or Physician's control, HealthE will have the option at any time either to tender its defense to Participating Pharmacy or Physician and Participating Pharmacy or Physician will provide qualified attorneys to represent HealthE's interests at Participating Pharmacy's or Physician's expense or undertake its own defense, choosing the attorneys, consultants and other appropriate professionals to represent HealthE's interests and

INITIALS: _____/_____

Participating Pharmacy or Physician will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants and other professionals. HealthE maintains the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it even if HealthE has tendered the defense to Participating Pharmacy or Physician.

10. ADVERTISING AND PROMOTIONS

Participating Pharmacy or Physician and HealthE reserve the right to, and control the use of, the corporate name, symbols, trademarks, trade names and service marks presently existing or hereafter established. In addition, the Participating Pharmacy or Physician will not use any of the foregoing in advertising or promotion materials, or otherwise without the prior written consent of the other party, with the exception of identifying the Participating Pharmacy or Physician to HealthE's clients, and shall cease any such usage immediately upon written notice or upon termination of this Agreement.

12. INDEPENDENT ENTITIES

HealthE and Participating Pharmacy or Physician are independent entities, and nothing in this Agreement shall be interpreted to create any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement. In the performance of the obligations of this Agreement, regarding any services rendered under this Agreement, by either party or its agents, servants, or employees, each party is at all times acting and performing as an independent contractor with respect to the other party, and no party shall have or exercise any control or direction over the method by which the other party shall perform such work or render or perform such services and functions. It is further expressly agreed that no work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative, or employee of, or joint venture with, or fiduciary of, the other party. No provision of this Agreement shall be construed to require any pharmacist to dispense any medication or specific type of medication to any Eligible Person if, in the pharmacist's reasonable professional judgment, such medication should not be dispensed to such person.

13. NON-EXCLUSIVITY

This Agreement is non-exclusive. Both parties reserve the right, without limitation, to participate in other prescription drug programs.

14. NOTICES

All notices provided for in this Agreement shall be in writing and shall be sent by mail (US Postal Services) addressed to the other party at their business address, or such other address as may be provided to the other party in the same manner as that provided for the giving of any notice.

15. SEVERABILITY

The invalidity or unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other terms or provisions of this Agreement.

16. GOVERNING LAW

All matters relating to or arising out of this Agreement or any contemplated transaction and the rights of the parties, whether sounding in court, tort, or otherwise, will be governed by and construed and interpreted under the laws of the State of Florida without regard to conflicts of laws principles that would require the application of any other law.

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17. DISPUTE RESOLUTION

The parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Any dispute shall be resolved by: (a) reasonable negotiation by the affected individuals to settle the dispute for a fifteen (15) business day period, if an amicable solution is not reached either party may request, in writing that the dispute be escalated to senior management; (b) senior management will, within five (5) business days after written notice, meet face-to-face and use good faith efforts to resolve the dispute; (c) if an amicable resolution is not reached in fifteen (15) business days, after the initial meeting either/or both parties will submit the dispute to a one (1) day mediation with a mutually agreed upon mediator, to take place within five (5) business days with the cost of mediation to be borne equally by the parties. If the parties are unable to resolve the dispute in mediation, either/or both parties may declare impasse. An impasse will be cured by binding arbitration utilizing the American Arbitration Association Rules for Commercial Arbitration to be held within ninety (90) days of declared impasse. A single arbitrator shall be mutually agreed upon by the parties, whose fee shall be borne equally between the parties. If the parties are unable to agree upon an arbitrator, each party shall select one (1) arbitrator and the two (2) arbitrators shall agree, without further consent required of the parties, to a third arbitrator. Each party will bear the cost of the arbitrator the party selects and fifty percent (50%) of the fees of the third arbitrator. The decision of the arbitrator(s) shall be final and binding upon each party.

18. ASSIGNMENT

No part of this Agreement shall be assigned by Participating Pharmacy or Physician without HealthE's prior written consent. Participating Pharmacy or Physician acknowledges and agrees that HealthE, without consent of Participating Pharmacy or Physician, may assign all or any part of this Agreement and/or HealthE's rights, privileges or duties under this Agreement to any direct or indirect parent, subsidiary, or affiliate or to a successor company.

19. ENTIRE AGREEMENT

This Agreement, together with all Exhibit(s), if any, constitutes the entire understanding between the parties and shall not be altered or amended except in writing signed by both HealthE and Participating Pharmacy or Physician.

PARTICIPATING PHARMACY OR PHYSICIAN	**HEALTH E SYSTEMS, LLC**
_____	_____
Signature	**Signature**
_____	Daryl Corr
Printed Name	**Printed Name**
_____	CEO
Title	**Title**
_____	_____
Date	**Date**
_____	
Phone Number	

INITIALS: _____/_____

_____

Fax Number

_____

Email Address

_____

NCPDP Number

_____

NPI Number

INITIALS: _____/_____

NDC 11 Code	Drug Name	LDD	AWP_ Discount
93112589	ABIRATERONE ACETATE	Non-LDD	78.50%
143959721	ABIRATERONE ACETATE	Non-LDD	78.50%
378692078	ABIRATERONE ACETATE	Non-LDD	78.50%
378692191	ABIRATERONE ACETATE	Non-LDD	78.50%
591436560	ABIRATERONE ACETATE	Non-LDD	78.50%
904694804	ABIRATERONE ACETATE	Non-LDD	78.50%
16714096301	ABIRATERONE ACETATE	Non-LDD	78.50%
42291002412	ABIRATERONE ACETATE	Non-LDD	78.50%
42291007360	ABIRATERONE ACETATE	Non-LDD	78.50%
42292005701	ABIRATERONE ACETATE	Non-LDD	78.50%
42292005703	ABIRATERONE ACETATE	Non-LDD	78.50%
43598035804	ABIRATERONE ACETATE	Non-LDD	78.50%
51407018112	ABIRATERONE ACETATE	Non-LDD	78.50%
57894015512	ABIRATERONE ACETATE	Non-LDD	78.50%
60219116507	ABIRATERONE ACETATE	Non-LDD	78.50%
60219175406	ABIRATERONE ACETATE	Non-LDD	78.50%
60505432701	ABIRATERONE ACETATE	Non-LDD	78.50%
60505476406	ABIRATERONE ACETATE	Non-LDD	78.50%
60687045511	ABIRATERONE ACETATE	Non-LDD	78.50%
60687045521	ABIRATERONE ACETATE	Non-LDD	78.50%
63629942901	ABIRATERONE ACETATE	Non-LDD	78.50%
63629943001	ABIRATERONE ACETATE	Non-LDD	78.50%
64679002101	ABIRATERONE ACETATE	Non-LDD	78.50%
64980041812	ABIRATERONE ACETATE	Non-LDD	78.50%
68001048907	ABIRATERONE ACETATE	Non-LDD	78.50%
68462013508	ABIRATERONE ACETATE	Non-LDD	78.50%
68462088260	ABIRATERONE ACETATE	Non-LDD	78.50%
69238116507	ABIRATERONE ACETATE	Non-LDD	78.50%
69238175406	ABIRATERONE ACETATE	Non-LDD	78.50%
71921017706	ABIRATERONE ACETATE	Non-LDD	78.50%
71921017820	ABIRATERONE ACETATE	Non-LDD	78.50%
72205003092	ABIRATERONE ACETATE	Non-LDD	78.50%
72603011001	ABIRATERONE ACETATE	Non-LDD	78.50%
72603011101	ABIRATERONE ACETATE	Non-LDD	78.50%
72606056601	ABIRATERONE ACETATE	Non-LDD	78.50%
72606057301	ABIRATERONE ACETATE	Non-LDD	78.50%
72789021398	ABIRATERONE ACETATE	Non-LDD	78.50%
82249001012	ABIRATERONE ACETATE	Non-LDD	78.50%
82293000110	ABIRATERONE ACETATE	Non-LDD	78.50%
82293000210	ABIRATERONE ACETATE	Non-LDD	78.50%
68817013450	ABRAXANE	Non-LDD	20.50%
93113556	ACITRETIN	Non-LDD	39.20%
93113656	ACITRETIN	Non-LDD	39.20%
93113856	ACITRETIN	Non-LDD	39.20%
115175008	ACITRETIN	Non-LDD	39.20%
115175108	ACITRETIN	Non-LDD	39.20%
115175308	ACITRETIN	Non-LDD	39.20%
378702093	ACITRETIN	Non-LDD	39.20%
378702393	ACITRETIN	Non-LDD	39.20%
42291008630	ACITRETIN	Non-LDD	39.20%
42291008730	ACITRETIN	Non-LDD	39.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
42291008830	ACITRETIN	Non-LDD	39.20%
42794008008	ACITRETIN	Non-LDD	39.20%
42794008108	ACITRETIN	Non-LDD	39.20%
42794008308	ACITRETIN	Non-LDD	39.20%
66993089430	ACITRETIN	Non-LDD	39.20%
66993089630	ACITRETIN	Non-LDD	39.20%
50242013501	ACTEMRA	LDD with Access	17.50%
50242013601	ACTEMRA	LDD with Access	17.50%
50242013701	ACTEMRA	LDD with Access	17.50%
50242013801	ACTEMRA	LDD with Access	17.50%
50242013886	ACTEMRA	LDD with Access	17.50%
50242014301	ACTEMRA ACTPEN	Non-LDD	17.50%
63004871001	ACTHAR	LDD with Access	15.50%
63004871002	ACTHAR	LDD with Access	15.50%
75987011110	ACTIMMUNE	LDD with Access	17.25%
75987011111	ACTIMMUNE	LDD with Access	17.25%
78088361	ADAKVEO	Non-LDD	13.50%
50222034602	ADBRY	LDD with Access	14.50%
50222034604	ADBRY	LDD with Access	14.50%
50222034622	ADBRY	LDD with Access	14.50%
51144005001	ADCETRIS	LDD with Access	16.75%
43353007002	ADCIRCA	Non-LDD	18.00%
43353007004	ADCIRCA	Non-LDD	18.00%
43353007006	ADCIRCA	Non-LDD	18.00%
43353007012	ADCIRCA	Non-LDD	18.00%
66302046760	ADCIRCA	Non-LDD	18.00%
42794000308	ADEFOVIR DIPIVOXIL	Non-LDD	30.40%
60505394703	ADEFOVIR DIPIVOXIL	Non-LDD	30.40%
50419025001	ADEMPAS	LDD with Access	15.25%
50419025091	ADEMPAS	LDD with Access	15.25%
50419025101	ADEMPAS	LDD with Access	15.25%
50419025103	ADEMPAS	LDD with Access	15.25%
50419025191	ADEMPAS	LDD with Access	15.25%
50419025201	ADEMPAS	LDD with Access	15.25%
50419025203	ADEMPAS	LDD with Access	15.25%
50419025291	ADEMPAS	LDD with Access	15.25%
50419025301	ADEMPAS	LDD with Access	15.25%
50419025303	ADEMPAS	LDD with Access	15.25%
50419025391	ADEMPAS	LDD with Access	15.25%
50419025401	ADEMPAS	LDD with Access	15.25%
50419025403	ADEMPAS	LDD with Access	15.25%
50419025491	ADEMPAS	LDD with Access	15.25%
64406010101	ADUHELM	LDD with Access	15.50%
64406010202	ADUHELM	LDD with Access	15.50%
944304510	ADVATE	Non-LDD	38.20%
944304511	ADVATE	Non-LDD	38.20%
944304512	ADVATE	Non-LDD	38.20%
944304610	ADVATE	Non-LDD	38.20%
944304611	ADVATE	Non-LDD	38.20%
944304710	ADVATE	Non-LDD	38.20%
944305102	ADVATE	Non-LDD	38.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
944305103	ADVATE	Non-LDD	38.20%
944305104	ADVATE	Non-LDD	38.20%
944305202	ADVATE	Non-LDD	38.20%
944305203	ADVATE	Non-LDD	38.20%
944305204	ADVATE	Non-LDD	38.20%
944305302	ADVATE	Non-LDD	38.20%
944305303	ADVATE	Non-LDD	38.20%
944305304	ADVATE	Non-LDD	38.20%
944305402	ADVATE	Non-LDD	38.20%
944305403	ADVATE	Non-LDD	38.20%
944305404	ADVATE	Non-LDD	38.20%
944425402	ADYNOVATE	Non-LDD	28.50%
944462201	ADYNOVATE	Non-LDD	28.50%
944462202	ADYNOVATE	Non-LDD	28.50%
944462301	ADYNOVATE	Non-LDD	28.50%
944462302	ADYNOVATE	Non-LDD	28.50%
944462401	ADYNOVATE	Non-LDD	28.50%
944462402	ADYNOVATE	Non-LDD	28.50%
944462501	ADYNOVATE	Non-LDD	28.50%
944462502	ADYNOVATE	Non-LDD	28.50%
944462601	ADYNOVATE	Non-LDD	28.50%
944462602	ADYNOVATE	Non-LDD	28.50%
944462701	ADYNOVATE	Non-LDD	28.50%
944462702	ADYNOVATE	Non-LDD	28.50%
944462801	ADYNOVATE	Non-LDD	28.50%
944462802	ADYNOVATE	Non-LDD	28.50%
78056651	AFINITOR	Non-LDD	18.50%
78056661	AFINITOR	Non-LDD	18.50%
78056751	AFINITOR	Non-LDD	18.50%
78056761	AFINITOR	Non-LDD	18.50%
78059451	AFINITOR	Non-LDD	18.50%
78059461	AFINITOR	Non-LDD	18.50%
78062051	AFINITOR	Non-LDD	18.50%
78062061	AFINITOR	Non-LDD	18.50%
78062651	AFINITOR DISPERZ	Non-LDD	18.50%
78062661	AFINITOR DISPERZ	Non-LDD	18.50%
78062751	AFINITOR DISPERZ	Non-LDD	18.50%
78062761	AFINITOR DISPERZ	Non-LDD	18.50%
78062851	AFINITOR DISPERZ	Non-LDD	18.50%
78062861	AFINITOR DISPERZ	Non-LDD	18.50%
69911047402	AFSTYLA	Non-LDD	33.50%
69911047502	AFSTYLA	Non-LDD	33.50%
69911047602	AFSTYLA	Non-LDD	33.50%
69911047702	AFSTYLA	Non-LDD	33.50%
69911047802	AFSTYLA	Non-LDD	33.50%
69911048002	AFSTYLA	Non-LDD	33.50%
69911048102	AFSTYLA	Non-LDD	33.50%
69911049001	AFSTYLA	Non-LDD	33.50%
69911049101	AFSTYLA	Non-LDD	33.50%
58468007001	ALDURAZYME	Non-LDD	17.48%
50242013001	ALECENSA	LDD with Access	17.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
54746000101	ALFERON N	Non-LDD	10.50%
2762301	ALIMTA	Non-LDD	21.00%
2764001	ALIMTA	Non-LDD	21.00%
52609300100	ALKERAN	Non-LDD	17.25%
52609300200	ALKERAN	Non-LDD	17.25%
71863010950	ALKINDI SPRINKLE	LDD with Access	10.50%
71863011050	ALKINDI SPRINKLE	LDD with Access	10.50%
71863011150	ALKINDI SPRINKLE	LDD with Access	10.50%
71863011250	ALKINDI SPRINKLE	LDD with Access	10.50%
68516460101	ALPHANATE	Non-LDD	44.20%
68516460201	ALPHANATE	Non-LDD	44.20%
68516460302	ALPHANATE	Non-LDD	44.20%
68516460402	ALPHANATE	Non-LDD	44.20%
68516460501	ALPHANATE	Non-LDD	44.20%
68516460601	ALPHANATE	Non-LDD	44.20%
68516460702	ALPHANATE	Non-LDD	44.20%
68516460802	ALPHANATE	Non-LDD	44.20%
68516460902	ALPHANATE	Non-LDD	44.20%
68516461002	ALPHANATE	Non-LDD	44.20%
68516461101	ALPHANATE	Non-LDD	44.20%
68516461201	ALPHANATE	Non-LDD	44.20%
68516461302	ALPHANATE	Non-LDD	44.20%
68516461402	ALPHANATE	Non-LDD	44.20%
68516461502	ALPHANATE	Non-LDD	44.20%
68516461601	ALPHANATE	Non-LDD	44.20%
68516461701	ALPHANATE	Non-LDD	44.20%
68516461802	ALPHANATE	Non-LDD	44.20%
68516461902	ALPHANATE	Non-LDD	44.20%
68516462002	ALPHANATE	Non-LDD	44.20%
68516360102	ALPHANINE SD	Non-LDD	47.20%
68516360202	ALPHANINE SD	Non-LDD	47.20%
68516360302	ALPHANINE SD	Non-LDD	47.20%
68516360402	ALPHANINE SD	Non-LDD	47.20%
68516360502	ALPHANINE SD	Non-LDD	47.20%
68516360602	ALPHANINE SD	Non-LDD	47.20%
68516360702	ALPHANINE SD	Non-LDD	47.20%
68516360802	ALPHANINE SD	Non-LDD	47.20%
68516360902	ALPHANINE SD	Non-LDD	47.20%
68516361002	ALPHANINE SD	Non-LDD	47.20%
68516361102	ALPHANINE SD	Non-LDD	47.20%
68516361202	ALPHANINE SD	Non-LDD	47.20%
71104091101	ALPROLIX	Non-LDD	21.20%
71104092201	ALPROLIX	Non-LDD	21.20%
71104093301	ALPROLIX	Non-LDD	21.20%
71104094401	ALPROLIX	Non-LDD	21.20%
71104095109	ALPROLIX	Non-LDD	21.20%
71104095201	ALPROLIX	Non-LDD	21.20%
71104095309	ALPROLIX	Non-LDD	21.20%
71104095409	ALPROLIX	Non-LDD	21.20%
71104095509	ALPROLIX	Non-LDD	21.20%
71104095609	ALPROLIX	Non-LDD	21.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
71104096601	ALPROLIX	Non-LDD	21.20%
71104097701	ALPROLIX	Non-LDD	21.20%
63020009007	ALUNBRIG	LDD with Access	18.50%
63020009030	ALUNBRIG	LDD with Access	18.50%
63020011330	ALUNBRIG	LDD with Access	18.50%
63020018023	ALUNBRIG	LDD with Access	18.50%
63020018030	ALUNBRIG	LDD with Access	18.50%
63020019830	ALUNBRIG	LDD with Access	18.50%
70121175401	ALYMSYS	Non-LDD	16.00%
70121175407	ALYMSYS	Non-LDD	16.00%
70121175501	ALYMSYS	Non-LDD	16.00%
70121175507	ALYMSYS	Non-LDD	16.00%
93333406	ALYQ	Non-LDD	38.50%
378427093	AMBRISENTAN	LDD with Access	30.40%
378427193	AMBRISENTAN	LDD with Access	30.40%
591240530	AMBRISENTAN	LDD with Access	30.40%
591240630	AMBRISENTAN	LDD with Access	30.40%
42794005108	AMBRISENTAN	LDD with Access	30.40%
42794005208	AMBRISENTAN	LDD with Access	30.40%
47335023683	AMBRISENTAN	LDD with Access	30.40%
47335023783	AMBRISENTAN	LDD with Access	30.40%
49884035311	AMBRISENTAN	LDD with Access	30.40%
49884035362	AMBRISENTAN	LDD with Access	30.40%
49884035411	AMBRISENTAN	LDD with Access	30.40%
49884035462	AMBRISENTAN	LDD with Access	30.40%
59651049430	AMBRISENTAN	LDD with Access	30.40%
59651049530	AMBRISENTAN	LDD with Access	30.40%
60505455203	AMBRISENTAN	LDD with Access	30.40%
60505455303	AMBRISENTAN	LDD with Access	30.40%
69097038602	AMBRISENTAN	LDD with Access	30.40%
69097038702	AMBRISENTAN	LDD with Access	30.40%
70710117903	AMBRISENTAN	LDD with Access	30.40%
70710118003	AMBRISENTAN	LDD with Access	30.40%
50090641100	AMJEVITA(CF)	Non-LDD	20.50%
55513041001	AMJEVITA(CF)	Non-LDD	20.50%
55513041101	AMJEVITA(CF)	Non-LDD	20.50%
55513041301	AMJEVITA(CF)	Non-LDD	20.50%
50090642800	AMJEVITA(CF) AUTOINJECTOR	Non-LDD	20.50%
55513040001	AMJEVITA(CF) AUTOINJECTOR	Non-LDD	20.50%
55513040002	AMJEVITA(CF) AUTOINJECTOR	Non-LDD	20.50%
72511040001	AMJEVITA(CF) AUTOINJECTOR	Non-LDD	20.50%
72511040002	AMJEVITA(CF) AUTOINJECTOR	Non-LDD	20.50%
10144042760	AMPYRA	LDD with Access	14.00%
71336100301	AMVUTTRA	LDD with Access	14.50%
27505000401	APOKYN	LDD with Access	18.00%
27505000405	APOKYN	LDD with Access	18.00%
52817072001	APOMORPHINE HCL	LDD with Access	13.50%
52817072005	APOMORPHINE HCL	LDD with Access	13.50%
944280303	ARALAST NP	LDD with Access	22.50%
944280404	ARALAST NP	LDD with Access	22.50%
944281401	ARALAST NP	LDD with Access	22.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
944281501	ARALAST NP	LDD with Access	22.50%
55513000201	ARANESP	Non-LDD	19.50%
55513000204	ARANESP	Non-LDD	19.50%
55513000301	ARANESP	Non-LDD	19.50%
55513000304	ARANESP	Non-LDD	19.50%
55513000401	ARANESP	Non-LDD	19.50%
55513000404	ARANESP	Non-LDD	19.50%
55513000501	ARANESP	Non-LDD	19.50%
55513000504	ARANESP	Non-LDD	19.50%
55513000601	ARANESP	Non-LDD	19.50%
55513002101	ARANESP	Non-LDD	19.50%
55513002104	ARANESP	Non-LDD	19.50%
55513002301	ARANESP	Non-LDD	19.50%
55513002304	ARANESP	Non-LDD	19.50%
55513002501	ARANESP	Non-LDD	19.50%
55513002504	ARANESP	Non-LDD	19.50%
55513002701	ARANESP	Non-LDD	19.50%
55513002704	ARANESP	Non-LDD	19.50%
55513002801	ARANESP	Non-LDD	19.50%
55513003201	ARANESP	Non-LDD	19.50%
55513005701	ARANESP	Non-LDD	19.50%
55513005704	ARANESP	Non-LDD	19.50%
55513009801	ARANESP	Non-LDD	19.50%
55513009804	ARANESP	Non-LDD	19.50%
55513011101	ARANESP	Non-LDD	19.50%
61755000101	ARCALYST	LDD with Access	15.75%
73604091401	ARCALYST	LDD with Access	15.75%
73604091404	ARCALYST	LDD with Access	15.75%
65976010001	ARESTIN	LDD with Access	8.50%
65976010024	ARESTIN	LDD with Access	8.50%
71558059028	ARIKAYCE	LDD with Access	14.50%
78068306	ARRANON	Non-LDD	21.00%
78068361	ARRANON	Non-LDD	21.00%
781349806	ARSENIC TRIOXIDE	Non-LDD	38.50%
781349894	ARSENIC TRIOXIDE	Non-LDD	38.50%
781349895	ARSENIC TRIOXIDE	Non-LDD	38.50%
14789060007	ARSENIC TRIOXIDE	Non-LDD	38.50%
14789060010	ARSENIC TRIOXIDE	Non-LDD	38.50%
23155086931	ARSENIC TRIOXIDE	Non-LDD	38.50%
23155086941	ARSENIC TRIOXIDE	Non-LDD	38.50%
23155087031	ARSENIC TRIOXIDE	Non-LDD	38.50%
23155087041	ARSENIC TRIOXIDE	Non-LDD	38.50%
25021022610	ARSENIC TRIOXIDE	Non-LDD	38.50%
25021022706	ARSENIC TRIOXIDE	Non-LDD	38.50%
50742043810	ARSENIC TRIOXIDE	Non-LDD	38.50%
54879002710	ARSENIC TRIOXIDE	Non-LDD	38.50%
55150036601	ARSENIC TRIOXIDE	Non-LDD	38.50%
55150036610	ARSENIC TRIOXIDE	Non-LDD	38.50%
63323063703	ARSENIC TRIOXIDE	Non-LDD	38.50%
63323063710	ARSENIC TRIOXIDE	Non-LDD	38.50%
68382099701	ARSENIC TRIOXIDE	Non-LDD	38.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
68382099710	ARSENIC TRIOXIDE	Non-LDD	38.50%
69918072001	ARSENIC TRIOXIDE	Non-LDD	38.50%
69918072002	ARSENIC TRIOXIDE	Non-LDD	38.50%
69918072010	ARSENIC TRIOXIDE	Non-LDD	38.50%
70121148301	ARSENIC TRIOXIDE	Non-LDD	38.50%
70121148307	ARSENIC TRIOXIDE	Non-LDD	38.50%
70121165801	ARSENIC TRIOXIDE	Non-LDD	38.50%
70121165806	ARSENIC TRIOXIDE	Non-LDD	38.50%
70710161001	ARSENIC TRIOXIDE	Non-LDD	38.50%
70710161006	ARSENIC TRIOXIDE	Non-LDD	38.50%
70710189501	ARSENIC TRIOXIDE	Non-LDD	38.50%
70710189506	ARSENIC TRIOXIDE	Non-LDD	38.50%
70710189601	ARSENIC TRIOXIDE	Non-LDD	38.50%
70710189606	ARSENIC TRIOXIDE	Non-LDD	38.50%
70860021710	ARSENIC TRIOXIDE	Non-LDD	38.50%
78066913	ARZERRA	Non-LDD	16.50%
78066961	ARZERRA	Non-LDD	16.50%
78069061	ARZERRA	Non-LDD	16.50%
69800025001	ASCENIV	Non-LDD	14.50%
69800025002	ASCENIV	Non-LDD	14.50%
72694051501	ASPARLAS	Non-LDD	21.00%
58468021002	AUBAGIO	LDD with Access	18.50%
58468021004	AUBAGIO	LDD with Access	18.50%
58468021101	AUBAGIO	LDD with Access	18.50%
58468021104	AUBAGIO	LDD with Access	18.50%
68546017060	AUSTEDO	Non-LDD	21.00%
68546017160	AUSTEDO	Non-LDD	21.00%
68546017260	AUSTEDO	Non-LDD	21.00%
50242006001	AVASTIN	LDD with Access	17.48%
50242006010	AVASTIN	LDD with Access	17.48%
50242006101	AVASTIN	LDD with Access	17.48%
50242006110	AVASTIN	LDD with Access	17.48%
59627000206	AVONEX	Non-LDD	22.00%
59627000207	AVONEX	Non-LDD	22.00%
59627011104	AVONEX	Non-LDD	22.00%
59627022205	AVONEX	Non-LDD	22.00%
59627000301	AVONEX PEN	Non-LDD	22.00%
59627033304	AVONEX PEN	Non-LDD	22.00%
55513067001	AVSOLA	Non-LDD	21.00%
72064011030	AYVAKIT	LDD with Access	14.50%
72064012030	AYVAKIT	LDD with Access	14.50%
72064012530	AYVAKIT	LDD with Access	14.50%
72064013030	AYVAKIT	LDD with Access	14.50%
72064015030	AYVAKIT	LDD with Access	14.50%
143960601	AZACITIDINE	Non-LDD	43.50%
591289749	AZACITIDINE	Non-LDD	43.50%
781325394	AZACITIDINE	Non-LDD	43.50%
781925394	AZACITIDINE	Non-LDD	43.50%
16714057801	AZACITIDINE	Non-LDD	43.50%
16714077701	AZACITIDINE	Non-LDD	43.50%
16714092701	AZACITIDINE	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
16729030610	AZACITIDINE	Non-LDD	43.50%
43598014362	AZACITIDINE	Non-LDD	43.50%
43598030562	AZACITIDINE	Non-LDD	43.50%
43598046562	AZACITIDINE	Non-LDD	43.50%
43598067811	AZACITIDINE	Non-LDD	43.50%
51991079798	AZACITIDINE	Non-LDD	43.50%
55150039301	AZACITIDINE	Non-LDD	43.50%
63323077139	AZACITIDINE	Non-LDD	43.50%
64679009601	AZACITIDINE	Non-LDD	43.50%
64679009602	AZACITIDINE	Non-LDD	43.50%
67457025430	AZACITIDINE	Non-LDD	43.50%
68001031356	AZACITIDINE	Non-LDD	43.50%
68001050454	AZACITIDINE	Non-LDD	43.50%
68001052754	AZACITIDINE	Non-LDD	43.50%
69097080540	AZACITIDINE	Non-LDD	43.50%
70121123701	AZACITIDINE	Non-LDD	43.50%
71288011530	AZACITIDINE	Non-LDD	43.50%
71288015395	AZACITIDINE	Non-LDD	43.50%
72485020101	AZACITIDINE	Non-LDD	43.50%
72606055801	AZACITIDINE	Non-LDD	43.50%
69387000101	BAFIERTAM	LDD with Access	21.00%
59676003056	BALVERSA	LDD with Access	8.50%
59676003084	BALVERSA	LDD with Access	8.50%
59676004028	BALVERSA	LDD with Access	8.50%
59676004056	BALVERSA	LDD with Access	8.50%
59676005028	BALVERSA	LDD with Access	8.50%
2791001	BAMLANIVIMAB (EUA)	Non-LDD	47.50%
3161112	BARACLUDE	Non-LDD	18.50%
3161212	BARACLUDE	Non-LDD	18.50%
3161412	BARACLUDE	Non-LDD	18.50%
44087353501	BAVENCIO	LDD with Access	13.50%
68152010809	BELEODAQ	Non-LDD	21.00%
72893000201	BELEODAQ	Non-LDD	21.00%
63459034804	BENDEKA	Non-LDD	21.00%
58394013303	BENEFIX	Non-LDD	16.20%
58394013403	BENEFIX	Non-LDD	16.20%
58394013603	BENEFIX	Non-LDD	16.20%
58394063303	BENEFIX	Non-LDD	16.20%
58394063403	BENEFIX	Non-LDD	16.20%
58394063503	BENEFIX	Non-LDD	16.20%
58394063603	BENEFIX	Non-LDD	16.20%
58394063703	BENEFIX	Non-LDD	16.20%
49401008801	BENLYSTA	LDD with Access	17.50%
49401008835	BENLYSTA	LDD with Access	17.50%
49401008842	BENLYSTA	LDD with Access	17.50%
49401008847	BENLYSTA	LDD with Access	17.50%
49401008861	BENLYSTA	LDD with Access	17.50%
49401010101	BENLYSTA	LDD with Access	17.50%
49401010201	BENLYSTA	LDD with Access	17.50%
78082760	BEOVU	Non-LDD	14.50%
78082761	BEOVU	Non-LDD	14.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
63833082502	BERINERT	LDD with Access	18.50%
63833083501	BERINERT	LDD with Access	18.50%
8010001	BESPONSA	LDD with Access	16.75%
73536050001	BESREMI	LDD with Access	14.50%
713035281	BETAINE ANHYDROUS	LDD with Access	28.00%
55792000201	BETAINE ANHYDROUS	LDD with Access	28.00%
71863011518	BETAINE ANHYDROUS	LDD with Access	28.00%
72647090001	BETAINE ANHYDROUS	LDD with Access	28.00%
50419052201	BETASERON	Non-LDD	19.50%
50419052401	BETASERON	Non-LDD	19.50%
50419052435	BETASERON	Non-LDD	19.50%
10122082004	BETHKIS	LDD with Access	20.50%
10122082028	BETHKIS	LDD with Access	20.50%
10122082056	BETHKIS	LDD with Access	20.50%
42852000124	BEVACIZUMAB	Non-LDD	38.50%
42852000128	BEVACIZUMAB	Non-LDD	38.50%
42852000130	BEVACIZUMAB	Non-LDD	38.50%
70360000102	BEVACIZUMAB	Non-LDD	38.50%
71266800502	BEVACIZUMAB	Non-LDD	38.50%
71266800601	BEVACIZUMAB	Non-LDD	38.50%
71266800605	BEVACIZUMAB	Non-LDD	38.50%
71449009135	BEVACIZUMAB	Non-LDD	38.50%
71449009143	BEVACIZUMAB	Non-LDD	38.50%
71449009144	BEVACIZUMAB	Non-LDD	38.50%
71449009198	BEVACIZUMAB	Non-LDD	38.50%
54039925	BEXAROTENE	Non-LDD	43.50%
378695501	BEXAROTENE	Non-LDD	43.50%
591283201	BEXAROTENE	Non-LDD	43.50%
832028500	BEXAROTENE	Non-LDD	43.50%
42291007201	BEXAROTENE	Non-LDD	43.50%
42292000701	BEXAROTENE	Non-LDD	43.50%
42292000710	BEXAROTENE	Non-LDD	43.50%
43975031510	BEXAROTENE	Non-LDD	43.50%
68682000260	BEXAROTENE	Non-LDD	43.50%
68682000310	BEXAROTENE	Non-LDD	43.50%
69238125001	BEXAROTENE	Non-LDD	43.50%
69238208806	BEXAROTENE	Non-LDD	43.50%
15301260	BICNU	Non-LDD	17.48%
23155026131	BICNU	Non-LDD	17.48%
23155026141	BICNU	Non-LDD	17.48%
23155058931	BICNU	Non-LDD	17.48%
59730650201	BIVIGAM	Non-LDD	39.20%
69800650201	BIVIGAM	Non-LDD	39.20%
69800650202	BIVIGAM	Non-LDD	39.20%
69800650301	BIVIGAM	Non-LDD	39.20%
69800650302	BIVIGAM	Non-LDD	39.20%
143924001	BLEOMYCIN SULFATE	Non-LDD	43.50%
143924101	BLEOMYCIN SULFATE	Non-LDD	43.50%
409032320	BLEOMYCIN SULFATE	Non-LDD	43.50%
409033220	BLEOMYCIN SULFATE	Non-LDD	43.50%
703315401	BLEOMYCIN SULFATE	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
703315501	BLEOMYCIN SULFATE	Non-LDD	43.50%
16714088601	BLEOMYCIN SULFATE	Non-LDD	43.50%
16714090801	BLEOMYCIN SULFATE	Non-LDD	43.50%
61703032322	BLEOMYCIN SULFATE	Non-LDD	43.50%
61703033218	BLEOMYCIN SULFATE	Non-LDD	43.50%
63323013610	BLEOMYCIN SULFATE	Non-LDD	43.50%
63323013720	BLEOMYCIN SULFATE	Non-LDD	43.50%
71288010610	BLEOMYCIN SULFATE	Non-LDD	43.50%
71288010720	BLEOMYCIN SULFATE	Non-LDD	43.50%
55513015001	BLINCYTO	LDD with Access	14.50%
55513016001	BLINCYTO	LDD with Access	14.50%
143909801	BORTEZOMIB	Non-LDD	18.50%
409170001	BORTEZOMIB	Non-LDD	18.50%
409170301	BORTEZOMIB	Non-LDD	18.50%
409170401	BORTEZOMIB	Non-LDD	18.50%
10019099101	BORTEZOMIB	Non-LDD	18.50%
25021024410	BORTEZOMIB	Non-LDD	18.50%
43598042660	BORTEZOMIB	Non-LDD	18.50%
43598086560	BORTEZOMIB	Non-LDD	18.50%
50742048401	BORTEZOMIB	Non-LDD	18.50%
55150033701	BORTEZOMIB	Non-LDD	18.50%
60505605004	BORTEZOMIB	Non-LDD	18.50%
63323072110	BORTEZOMIB	Non-LDD	18.50%
63323082110	BORTEZOMIB	Non-LDD	18.50%
68001053436	BORTEZOMIB	Non-LDD	18.50%
68001054036	BORTEZOMIB	Non-LDD	18.50%
68001054136	BORTEZOMIB	Non-LDD	18.50%
70710141101	BORTEZOMIB	Non-LDD	18.50%
70860022510	BORTEZOMIB	Non-LDD	18.50%
71288011810	BORTEZOMIB	Non-LDD	18.50%
72205018301	BORTEZOMIB	Non-LDD	18.50%
72266024301	BORTEZOMIB	Non-LDD	18.50%
72266024401	BORTEZOMIB	Non-LDD	18.50%
54052021	BOSENTAN	LDD with Access	29.50%
54052121	BOSENTAN	LDD with Access	29.50%
591251160	BOSENTAN	LDD with Access	29.50%
591251260	BOSENTAN	LDD with Access	29.50%
10148012560	BOSENTAN	LDD with Access	29.50%
10148062560	BOSENTAN	LDD with Access	29.50%
47335003886	BOSENTAN	LDD with Access	29.50%
47335003986	BOSENTAN	LDD with Access	29.50%
49884005802	BOSENTAN	LDD with Access	29.50%
49884005902	BOSENTAN	LDD with Access	29.50%
65162087306	BOSENTAN	LDD with Access	29.50%
65162087406	BOSENTAN	LDD with Access	29.50%
68382044614	BOSENTAN	LDD with Access	29.50%
68382044714	BOSENTAN	LDD with Access	29.50%
69013501	BOSULIF	LDD with Access	19.50%
69013601	BOSULIF	LDD with Access	19.50%
69019301	BOSULIF	LDD with Access	19.50%
23114501	BOTOX	Non-LDD	21.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
23114502	BOTOX	Non-LDD	21.00%
23392102	BOTOX	Non-LDD	21.00%
23392103	BOTOX	Non-LDD	21.00%
70255002001	BRAFTOVI	LDD with Access	18.00%
70255002002	BRAFTOVI	LDD with Access	18.00%
70255002501	BRAFTOVI	LDD with Access	18.00%
70255002502	BRAFTOVI	LDD with Access	18.00%
70255002503	BRAFTOVI	LDD with Access	18.00%
70255002504	BRAFTOVI	LDD with Access	18.00%
68135050000	BRINEURA	Non-LDD	14.50%
68135081102	BRINEURA	Non-LDD	14.50%
73150015006	BRIUMVI	LDD with Access	13.50%
10122021201	BRONCHITOL	LDD with Access	15.50%
10122021204	BRONCHITOL	LDD with Access	15.50%
10122021214	BRONCHITOL	LDD with Access	15.50%
10122021256	BRONCHITOL	LDD with Access	15.50%
72579001102	BRUKINSA	LDD with Access	21.00%
75987006008	BUPHENYL	LDD with Access	14.50%
75987007009	BUPHENYL	LDD with Access	14.50%
409111201	BUSULFAN	Non-LDD	18.00%
409111210	BUSULFAN	Non-LDD	18.00%
517092001	BUSULFAN	Non-LDD	18.00%
517092008	BUSULFAN	Non-LDD	18.00%
16729035103	BUSULFAN	Non-LDD	18.00%
16729035192	BUSULFAN	Non-LDD	18.00%
25021024110	BUSULFAN	Non-LDD	18.00%
45963064057	BUSULFAN	Non-LDD	18.00%
45963064077	BUSULFAN	Non-LDD	18.00%
60505617700	BUSULFAN	Non-LDD	18.00%
60505617708	BUSULFAN	Non-LDD	18.00%
65219016001	BUSULFAN	Non-LDD	18.00%
65219016010	BUSULFAN	Non-LDD	18.00%
67457089300	BUSULFAN	Non-LDD	18.00%
67457089308	BUSULFAN	Non-LDD	18.00%
70121124401	BUSULFAN	Non-LDD	18.00%
70121124407	BUSULFAN	Non-LDD	18.00%
70860021610	BUSULFAN	Non-LDD	18.00%
70860021641	BUSULFAN	Non-LDD	18.00%
71288011610	BUSULFAN	Non-LDD	18.00%
71288011611	BUSULFAN	Non-LDD	18.00%
72485021001	BUSULFAN	Non-LDD	18.00%
72485021008	BUSULFAN	Non-LDD	18.00%
72606055901	BUSULFAN	Non-LDD	18.00%
72606055902	BUSULFAN	Non-LDD	18.00%
59148004790	BUSULFEX	Non-LDD	15.20%
59148004791	BUSULFEX	Non-LDD	15.20%
59148007090	BUSULFEX	Non-LDD	15.20%
59148007091	BUSULFEX	Non-LDD	15.20%
74528002001	BYLVAY	LDD with Access	15.00%
74528004001	BYLVAY	LDD with Access	15.00%
74528006001	BYLVAY	LDD with Access	15.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
74528012001	BYLVAY	LDD with Access	15.00%
62756045236	BYNFEZIA	Non-LDD	21.00%
64406001901	BYOOVIZ	Non-LDD	9.50%
64406001907	BYOOVIZ	Non-LDD	9.50%
58468022501	CABLIVI	LDD with Access	13.75%
58468022701	CABLIVI	LDD with Access	13.75%
42388002326	CABOMETYX	LDD with Access	19.50%
42388002336	CABOMETYX	LDD with Access	19.50%
42388002426	CABOMETYX	LDD with Access	19.50%
42388002526	CABOMETYX	LDD with Access	19.50%
310051260	CALQUENCE	LDD with Access	18.50%
310351260	CALQUENCE	LDD with Access	18.50%
9752903	CAMPTOSAR	Non-LDD	21.00%
9752904	CAMPTOSAR	Non-LDD	21.00%
9752905	CAMPTOSAR	Non-LDD	21.00%
73625011111	CAMZYOS	LDD with Access	15.50%
73625011211	CAMZYOS	LDD with Access	15.50%
73625011311	CAMZYOS	LDD with Access	15.50%
73625011411	CAMZYOS	LDD with Access	15.50%
54027121	CAPECITABINE	Non-LDD	43.50%
54027223	CAPECITABINE	Non-LDD	43.50%
93747306	CAPECITABINE	Non-LDD	43.50%
93747489	CAPECITABINE	Non-LDD	43.50%
378251191	CAPECITABINE	Non-LDD	43.50%
378251278	CAPECITABINE	Non-LDD	43.50%
16714046701	CAPECITABINE	Non-LDD	43.50%
16714046801	CAPECITABINE	Non-LDD	43.50%
16729007212	CAPECITABINE	Non-LDD	43.50%
16729007329	CAPECITABINE	Non-LDD	43.50%
42291016712	CAPECITABINE	Non-LDD	43.50%
50268015411	CAPECITABINE	Non-LDD	43.50%
50268015413	CAPECITABINE	Non-LDD	43.50%
51079051001	CAPECITABINE	Non-LDD	43.50%
51079051005	CAPECITABINE	Non-LDD	43.50%
51407009560	CAPECITABINE	Non-LDD	43.50%
51407009612	CAPECITABINE	Non-LDD	43.50%
51407063960	CAPECITABINE	Non-LDD	43.50%
51407064012	CAPECITABINE	Non-LDD	43.50%
55111049660	CAPECITABINE	Non-LDD	43.50%
55111049704	CAPECITABINE	Non-LDD	43.50%
59651020460	CAPECITABINE	Non-LDD	43.50%
59651020508	CAPECITABINE	Non-LDD	43.50%
59923072160	CAPECITABINE	Non-LDD	43.50%
59923072212	CAPECITABINE	Non-LDD	43.50%
60687014911	CAPECITABINE	Non-LDD	43.50%
60687014994	CAPECITABINE	Non-LDD	43.50%
62756023886	CAPECITABINE	Non-LDD	43.50%
62756023920	CAPECITABINE	Non-LDD	43.50%
64980027606	CAPECITABINE	Non-LDD	43.50%
64980027712	CAPECITABINE	Non-LDD	43.50%
65162084306	CAPECITABINE	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
65162084416	CAPECITABINE	Non-LDD	43.50%
67877045860	CAPECITABINE	Non-LDD	43.50%
67877045912	CAPECITABINE	Non-LDD	43.50%
68001048706	CAPECITABINE	Non-LDD	43.50%
68001048807	CAPECITABINE	Non-LDD	43.50%
69097094808	CAPECITABINE	Non-LDD	43.50%
69097094903	CAPECITABINE	Non-LDD	43.50%
70756081560	CAPECITABINE	Non-LDD	43.50%
70756081622	CAPECITABINE	Non-LDD	43.50%
72205000660	CAPECITABINE	Non-LDD	43.50%
72205000792	CAPECITABINE	Non-LDD	43.50%
72485020460	CAPECITABINE	Non-LDD	43.50%
72485020512	CAPECITABINE	Non-LDD	43.50%
72606055401	CAPECITABINE	Non-LDD	43.50%
72606055501	CAPECITABINE	Non-LDD	43.50%
82009011212	CAPECITABINE	Non-LDD	43.50%
58468782003	CAPRELSA	LDD with Access	13.32%
58468784003	CAPRELSA	LDD with Access	13.32%
52276031205	CARBAGLU	LDD with Access	5.50%
52276031260	CARBAGLU	LDD with Access	5.50%
703423901	CARBOPLATIN	Non-LDD	21.00%
703423981	CARBOPLATIN	Non-LDD	21.00%
703424401	CARBOPLATIN	Non-LDD	21.00%
703424481	CARBOPLATIN	Non-LDD	21.00%
703424601	CARBOPLATIN	Non-LDD	21.00%
703424681	CARBOPLATIN	Non-LDD	21.00%
703424801	CARBOPLATIN	Non-LDD	21.00%
703424881	CARBOPLATIN	Non-LDD	21.00%
703424891	CARBOPLATIN	Non-LDD	21.00%
16729029512	CARBOPLATIN	Non-LDD	21.00%
16729029531	CARBOPLATIN	Non-LDD	21.00%
16729029533	CARBOPLATIN	Non-LDD	21.00%
16729029534	CARBOPLATIN	Non-LDD	21.00%
25021020245	CARBOPLATIN	Non-LDD	21.00%
25021020251	CARBOPLATIN	Non-LDD	21.00%
47335015040	CARBOPLATIN	Non-LDD	21.00%
47335015140	CARBOPLATIN	Non-LDD	21.00%
47335028440	CARBOPLATIN	Non-LDD	21.00%
47335030040	CARBOPLATIN	Non-LDD	21.00%
50742044505	CARBOPLATIN	Non-LDD	21.00%
50742044615	CARBOPLATIN	Non-LDD	21.00%
50742044745	CARBOPLATIN	Non-LDD	21.00%
50742044860	CARBOPLATIN	Non-LDD	21.00%
55150033501	CARBOPLATIN	Non-LDD	21.00%
55150038601	CARBOPLATIN	Non-LDD	21.00%
61703015005	CARBOPLATIN	Non-LDD	21.00%
61703026205	CARBOPLATIN	Non-LDD	21.00%
61703033918	CARBOPLATIN	Non-LDD	21.00%
61703033922	CARBOPLATIN	Non-LDD	21.00%
61703033950	CARBOPLATIN	Non-LDD	21.00%
61703033956	CARBOPLATIN	Non-LDD	21.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
61703036018	CARBOPLATIN	Non-LDD	21.00%
61703060005	CARBOPLATIN	Non-LDD	21.00%
63323016721	CARBOPLATIN	Non-LDD	21.00%
63323017205	CARBOPLATIN	Non-LDD	21.00%
63323017215	CARBOPLATIN	Non-LDD	21.00%
63323017245	CARBOPLATIN	Non-LDD	21.00%
63323017260	CARBOPLATIN	Non-LDD	21.00%
66758004704	CARBOPLATIN	Non-LDD	21.00%
71288010005	CARBOPLATIN	Non-LDD	21.00%
71288010015	CARBOPLATIN	Non-LDD	21.00%
71288010045	CARBOPLATIN	Non-LDD	21.00%
71288010051	CARBOPLATIN	Non-LDD	21.00%
35573045960	CARGLUMIC ACID	LDD with Access	10.50%
71863011460	CARGLUMIC ACID	LDD with Access	10.50%
781347090	CARMUSTINE	Non-LDD	38.50%
781347432	CARMUSTINE	Non-LDD	38.50%
16729054305	CARMUSTINE	Non-LDD	38.50%
16729054563	CARMUSTINE	Non-LDD	38.50%
16729054601	CARMUSTINE	Non-LDD	38.50%
16729054863	CARMUSTINE	Non-LDD	38.50%
23155064731	CARMUSTINE	Non-LDD	38.50%
23155064941	CARMUSTINE	Non-LDD	38.50%
23155078831	CARMUSTINE	Non-LDD	38.50%
23155079041	CARMUSTINE	Non-LDD	38.50%
43598062857	CARMUSTINE	Non-LDD	38.50%
43598086111	CARMUSTINE	Non-LDD	38.50%
54879002351	CARMUSTINE	Non-LDD	38.50%
54879003664	CARMUSTINE	Non-LDD	38.50%
70121148202	CARMUSTINE	Non-LDD	38.50%
70121166801	CARMUSTINE	Non-LDD	38.50%
70710152401	CARMUSTINE	Non-LDD	38.50%
70710152509	CARMUSTINE	Non-LDD	38.50%
70860022130	CARMUSTINE	Non-LDD	38.50%
70860022361	CARMUSTINE	Non-LDD	38.50%
71288012430	CARMUSTINE	Non-LDD	38.50%
71288012690	CARMUSTINE	Non-LDD	38.50%
61755002400	CASIRIVIMAB (REGN10933) (EU	Non-LDD	47.50%
61755002401	CASIRIVIMAB (REGN10933) (EU	Non-LDD	47.50%
61755002600	CASIRIVIMAB (REGN10933) (EU	Non-LDD	47.50%
61755002601	CASIRIVIMAB (REGN10933) (EU	Non-LDD	47.50%
61958090101	CAYSTON	LDD with Access	14.05%
944417705	CEPROTIN	LDD with Access	15.50%
944417802	CEPROTIN	LDD with Access	15.50%
944417910	CEPROTIN	LDD with Access	15.50%
58468022001	CERDELGA	LDD with Access	17.50%
58468466301	CEREZYME	Non-LDD	20.50%
68974087640	CHENODAL	LDD with Access	8.50%
45043000102	CHOLBAM	LDD with Access	18.10%
45043000202	CHOLBAM	LDD with Access	18.10%
69023530	CIBINQO	Non-LDD	14.50%
69033530	CIBINQO	Non-LDD	14.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
69043530	CIBINQO	Non-LDD	14.50%
70114044001	CIMERLI	LDD with Access	13.50%
70114044101	CIMERLI	LDD with Access	13.50%
50474070062	CIMZIA	Non-LDD	21.50%
50474071079	CIMZIA	Non-LDD	21.50%
50474071081	CIMZIA	Non-LDD	21.50%
378619593	CINACALCET HCL	Non-LDD	33.50%
378619693	CINACALCET HCL	Non-LDD	33.50%
378619793	CINACALCET HCL	Non-LDD	33.50%
904706704	CINACALCET HCL	Non-LDD	33.50%
16714007801	CINACALCET HCL	Non-LDD	33.50%
16714007901	CINACALCET HCL	Non-LDD	33.50%
16714008001	CINACALCET HCL	Non-LDD	33.50%
16729044010	CINACALCET HCL	Non-LDD	33.50%
16729044015	CINACALCET HCL	Non-LDD	33.50%
16729044110	CINACALCET HCL	Non-LDD	33.50%
16729044115	CINACALCET HCL	Non-LDD	33.50%
16729044210	CINACALCET HCL	Non-LDD	33.50%
16729044215	CINACALCET HCL	Non-LDD	33.50%
31722010330	CINACALCET HCL	Non-LDD	33.50%
31722010430	CINACALCET HCL	Non-LDD	33.50%
31722010530	CINACALCET HCL	Non-LDD	33.50%
42291045930	CINACALCET HCL	Non-LDD	33.50%
42291046030	CINACALCET HCL	Non-LDD	33.50%
42291046130	CINACALCET HCL	Non-LDD	33.50%
42543096104	CINACALCET HCL	Non-LDD	33.50%
42543096204	CINACALCET HCL	Non-LDD	33.50%
42543096304	CINACALCET HCL	Non-LDD	33.50%
43598036730	CINACALCET HCL	Non-LDD	33.50%
43598036830	CINACALCET HCL	Non-LDD	33.50%
43598036930	CINACALCET HCL	Non-LDD	33.50%
47335037983	CINACALCET HCL	Non-LDD	33.50%
47335038083	CINACALCET HCL	Non-LDD	33.50%
47335060083	CINACALCET HCL	Non-LDD	33.50%
50268015311	CINACALCET HCL	Non-LDD	33.50%
50268015312	CINACALCET HCL	Non-LDD	33.50%
51407029530	CINACALCET HCL	Non-LDD	33.50%
51407029630	CINACALCET HCL	Non-LDD	33.50%
51407029730	CINACALCET HCL	Non-LDD	33.50%
60687052511	CINACALCET HCL	Non-LDD	33.50%
60687052521	CINACALCET HCL	Non-LDD	33.50%
63629876301	CINACALCET HCL	Non-LDD	33.50%
63629876401	CINACALCET HCL	Non-LDD	33.50%
63629876501	CINACALCET HCL	Non-LDD	33.50%
63629960601	CINACALCET HCL	Non-LDD	33.50%
63629960701	CINACALCET HCL	Non-LDD	33.50%
63629960801	CINACALCET HCL	Non-LDD	33.50%
64380088304	CINACALCET HCL	Non-LDD	33.50%
64380088404	CINACALCET HCL	Non-LDD	33.50%
64380088504	CINACALCET HCL	Non-LDD	33.50%
65862083105	CINACALCET HCL	Non-LDD	33.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
65862083130	CINACALCET HCL	Non-LDD	33.50%
65862083205	CINACALCET HCL	Non-LDD	33.50%
65862083230	CINACALCET HCL	Non-LDD	33.50%
65862083305	CINACALCET HCL	Non-LDD	33.50%
65862083330	CINACALCET HCL	Non-LDD	33.50%
67877050330	CINACALCET HCL	Non-LDD	33.50%
67877050430	CINACALCET HCL	Non-LDD	33.50%
67877050530	CINACALCET HCL	Non-LDD	33.50%
69097041002	CINACALCET HCL	Non-LDD	33.50%
69097041102	CINACALCET HCL	Non-LDD	33.50%
69097041202	CINACALCET HCL	Non-LDD	33.50%
70436000704	CINACALCET HCL	Non-LDD	33.50%
70436000804	CINACALCET HCL	Non-LDD	33.50%
70436000904	CINACALCET HCL	Non-LDD	33.50%
71093015201	CINACALCET HCL	Non-LDD	33.50%
71093015301	CINACALCET HCL	Non-LDD	33.50%
71093015401	CINACALCET HCL	Non-LDD	33.50%
72865015030	CINACALCET HCL	Non-LDD	33.50%
72865015130	CINACALCET HCL	Non-LDD	33.50%
72865015230	CINACALCET HCL	Non-LDD	33.50%
76282067430	CINACALCET HCL	Non-LDD	33.50%
76282067530	CINACALCET HCL	Non-LDD	33.50%
76282067630	CINACALCET HCL	Non-LDD	33.50%
59310061031	CINQAIR	Non-LDD	20.50%
59310061033	CINQAIR	Non-LDD	20.50%
42227008101	CINRYZE	LDD with Access	15.50%
42227008105	CINRYZE	LDD with Access	15.50%
42227008301	CINRYZE	LDD with Access	15.50%
143950401	CISPLATIN	Non-LDD	39.20%
143950501	CISPLATIN	Non-LDD	39.20%
703574711	CISPLATIN	Non-LDD	39.20%
703574811	CISPLATIN	Non-LDD	39.20%
16729028811	CISPLATIN	Non-LDD	39.20%
16729028838	CISPLATIN	Non-LDD	39.20%
25021025350	CISPLATIN	Non-LDD	39.20%
25021025351	CISPLATIN	Non-LDD	39.20%
44567050901	CISPLATIN	Non-LDD	39.20%
44567051001	CISPLATIN	Non-LDD	39.20%
44567051101	CISPLATIN	Non-LDD	39.20%
44567053001	CISPLATIN	Non-LDD	39.20%
47781061023	CISPLATIN	Non-LDD	39.20%
60505627700	CISPLATIN	Non-LDD	39.20%
63323010351	CISPLATIN	Non-LDD	39.20%
63323010364	CISPLATIN	Non-LDD	39.20%
63323010365	CISPLATIN	Non-LDD	39.20%
68001028324	CISPLATIN	Non-LDD	39.20%
68001028327	CISPLATIN	Non-LDD	39.20%
68001028332	CISPLATIN	Non-LDD	39.20%
68001028333	CISPLATIN	Non-LDD	39.20%
70860020650	CISPLATIN	Non-LDD	39.20%
70860020651	CISPLATIN	Non-LDD	39.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
143987101	CLADRIBINE	Non-LDD	43.50%
42658001001	CLADRIBINE	Non-LDD	43.50%
42658001091	CLADRIBINE	Non-LDD	43.50%
63323014010	CLADRIBINE	Non-LDD	43.50%
67457045010	CLADRIBINE	Non-LDD	43.50%
955174601	CLOFARABINE	Non-LDD	38.50%
43598030920	CLOFARABINE	Non-LDD	38.50%
50742051220	CLOFARABINE	Non-LDD	38.50%
60505616600	CLOFARABINE	Non-LDD	38.50%
63323057270	CLOFARABINE	Non-LDD	38.50%
67457054620	CLOFARABINE	Non-LDD	38.50%
70121123601	CLOFARABINE	Non-LDD	38.50%
71288012820	CLOFARABINE	Non-LDD	38.50%
72266010801	CLOFARABINE	Non-LDD	38.50%
24586001	CLOLAR	Non-LDD	18.50%
66435070012	CLOVIQUE	Non-LDD	70.50%
66435070020	CLOVIQUE	Non-LDD	70.50%
64208775201	COAGADEX	LDD with Access	35.50%
64208775301	COAGADEX	LDD with Access	35.50%
64208775401	COAGADEX	LDD with Access	35.50%
64208775601	COAGADEX	LDD with Access	35.50%
42388001114	COMETRIQ	LDD with Access	15.75%
42388001214	COMETRIQ	LDD with Access	15.75%
42388001314	COMETRIQ	LDD with Access	15.75%
68546031730	COPAXONE	Non-LDD	24.00%
68546032506	COPAXONE	Non-LDD	24.00%
68546032512	COPAXONE	Non-LDD	24.00%
71779011502	COPIKTRA	LDD with Access	14.25%
71779012502	COPIKTRA	LDD with Access	14.25%
73116021528	COPIKTRA	LDD with Access	14.25%
73116021556	COPIKTRA	LDD with Access	14.25%
73116022528	COPIKTRA	LDD with Access	14.25%
73116022556	COPIKTRA	LDD with Access	14.25%
63833051802	CORIFACT	Non-LDD	33.50%
62559086011	CORTROPHIN	LDD with Access	15.50%
62559086015	CORTROPHIN	LDD with Access	15.50%
78063998	COSENTYX (2 SYRINGES)	LDD with Access	18.50%
78063941	COSENTYX SENSOREADY (2 PEI	LDD with Access	18.50%
78063968	COSENTYX SENSOREADY PEN	LDD with Access	18.50%
78063997	COSENTYX SYRINGE	LDD with Access	18.50%
78105697	COSENTYX SYRINGE	LDD with Access	18.50%
55292081155	COSMEGEN	Non-LDD	17.48%
50242071701	COTELLIC	LDD with Access	18.50%
42747010201	CRYSVITA	LDD with Access	15.50%
42747020301	CRYSVITA	LDD with Access	15.50%
42747030401	CRYSVITA	LDD with Access	15.50%
69794010201	CRYSVITA	LDD with Access	15.50%
69794020301	CRYSVITA	LDD with Access	15.50%
69794030401	CRYSVITA	LDD with Access	15.50%
25010070515	CUPRIMINE	Non-LDD	18.50%
69106101	CUTAQUIG	LDD with Access	16.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
69106102	CUTAQUIG	LDD with Access	16.50%
69147601	CUTAQUIG	LDD with Access	16.50%
69147602	CUTAQUIG	LDD with Access	16.50%
69150901	CUTAQUIG	LDD with Access	16.50%
69150902	CUTAQUIG	LDD with Access	16.50%
69196501	CUTAQUIG	LDD with Access	16.50%
69196502	CUTAQUIG	LDD with Access	16.50%
68982081001	CUTAQUIG	LDD with Access	16.50%
68982081002	CUTAQUIG	LDD with Access	16.50%
68982081003	CUTAQUIG	LDD with Access	16.50%
68982081004	CUTAQUIG	LDD with Access	16.50%
68982081005	CUTAQUIG	LDD with Access	16.50%
68982081006	CUTAQUIG	LDD with Access	16.50%
68982081081	CUTAQUIG	LDD with Access	16.50%
68982081082	CUTAQUIG	LDD with Access	16.50%
68982081083	CUTAQUIG	LDD with Access	16.50%
68982081084	CUTAQUIG	LDD with Access	16.50%
68982081085	CUTAQUIG	LDD with Access	16.50%
68982081086	CUTAQUIG	LDD with Access	16.50%
944285001	CUVITRU	LDD with Access	16.00%
944285002	CUVITRU	LDD with Access	16.00%
944285003	CUVITRU	LDD with Access	16.00%
944285004	CUVITRU	LDD with Access	16.00%
944285005	CUVITRU	LDD with Access	16.00%
944285006	CUVITRU	LDD with Access	16.00%
944285007	CUVITRU	LDD with Access	16.00%
944285008	CUVITRU	LDD with Access	16.00%
944285009	CUVITRU	LDD with Access	16.00%
81802000108	CUVRIOR	LDD with Access	13.00%
81802000172	CUVRIOR	LDD with Access	13.00%
54038225	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
54038325	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
781323394	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
781324494	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
781325594	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093501	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093525	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093601	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093650	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093701	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093710	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093801	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093825	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093901	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019093950	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019094201	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019094210	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019094301	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019094325	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019094401	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019094450	CYCLOPHOSPHAMIDE	Non-LDD	78.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
10019094501	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019094510	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019095501	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019095550	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019095601	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019095616	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019095701	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019095711	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019098201	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019098209	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019098401	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
10019098409	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
16714085701	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
16714085801	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
16714085901	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
43598066011	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
43598066111	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
43598066211	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
43975030710	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
43975030810	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
50742051902	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
50742052005	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
50742052110	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
51407074802	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
51407074905	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
51407075010	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
54879002101	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
54879002201	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
55150027001	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
55150027101	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
62332061831	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
62332061931	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
62559093001	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
62559093101	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001037024	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001037027	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001037132	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001037133	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001037232	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001037233	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001044226	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001044327	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001044432	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001056422	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
68001056528	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
69097051607	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
69097051707	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
70121123801	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
70121123901	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
70121124001	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
70860021803	CYCLOPHOSPHAMIDE	Non-LDD	78.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
70860021805	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
70860021810	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
72572008301	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
72572008501	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
72572008701	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
72603010401	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
72603032601	CYCLOPHOSPHAMIDE	Non-LDD	78.50%
2766901	CYRAMZA	LDD with Access	16.50%
2767801	CYRAMZA	LDD with Access	16.50%
52276040001	CYSTADANE	LDD with Access	10.50%
52276040101	CYSTADANE	LDD with Access	10.50%
55292041005	CYSTADROPS	LDD with Access	17.00%
378904001	CYSTAGON	LDD with Access	8.50%
378904005	CYSTAGON	LDD with Access	8.50%
378904501	CYSTAGON	LDD with Access	8.50%
378904505	CYSTAGON	LDD with Access	8.50%
54482002001	CYSTARAN	LDD with Access	14.90%
54482002002	CYSTARAN	LDD with Access	14.90%
25021022320	CYTARABINE	Non-LDD	30.40%
25021022905	CYTARABINE	Non-LDD	30.40%
61703030346	CYTARABINE	Non-LDD	30.40%
61703030436	CYTARABINE	Non-LDD	30.40%
61703030538	CYTARABINE	Non-LDD	30.40%
61703030558	CYTARABINE	Non-LDD	30.40%
61703031922	CYTARABINE	Non-LDD	30.40%
63323012020	CYTARABINE	Non-LDD	30.40%
67457045220	CYTARABINE	Non-LDD	30.40%
67457045450	CYTARABINE	Non-LDD	30.40%
67457045500	CYTARABINE	Non-LDD	30.40%
67457045552	CYTARABINE	Non-LDD	30.40%
71288010920	CYTARABINE	Non-LDD	30.40%
44206053211	CYTOGAM	Non-LDD	20.50%
44206053290	CYTOGAM	Non-LDD	20.50%
70257053250	CYTOGAM	Non-LDD	20.50%
70257053251	CYTOGAM	Non-LDD	20.50%
59148004670	DACOGEN	Non-LDD	21.00%
62856060001	DACOGEN	Non-LDD	21.00%
39822210001	DACTINOMYCIN	Non-LDD	4.50%
39822210002	DACTINOMYCIN	Non-LDD	4.50%
55150043101	DACTINOMYCIN	Non-LDD	4.50%
55150092802	DACTINOMYCIN	Non-LDD	4.50%
66993048983	DACTINOMYCIN	Non-LDD	4.50%
67457051305	DACTINOMYCIN	Non-LDD	4.50%
67457092802	DACTINOMYCIN	Non-LDD	4.50%
71288012902	DACTINOMYCIN	Non-LDD	4.50%
378050991	DALFAMPRIDINE ER	Non-LDD	40.50%
591253360	DALFAMPRIDINE ER	Non-LDD	40.50%
16729029212	DALFAMPRIDINE ER	Non-LDD	40.50%
42571027560	DALFAMPRIDINE ER	Non-LDD	40.50%
51407024660	DALFAMPRIDINE ER	Non-LDD	40.50%
62756042986	DALFAMPRIDINE ER	Non-LDD	40.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
63629945001	DALFAMPRIDINE ER	Non-LDD	40.50%
65862086360	DALFAMPRIDINE ER	Non-LDD	40.50%
67877044460	DALFAMPRIDINE ER	Non-LDD	40.50%
73042020101	DANYELZA	Non-LDD	17.00%
52054033095	DARAPRIM	LDD with Access	14.70%
69413033010	DARAPRIM	LDD with Access	14.70%
69413033030	DARAPRIM	LDD with Access	14.70%
57894050205	DARZALEX	Non-LDD	21.00%
57894050220	DARZALEX	Non-LDD	21.00%
57894050505	DARZALEX	Non-LDD	21.00%
57894050520	DARZALEX	Non-LDD	21.00%
57894050301	DARZALEX FASPRO	Non-LDD	21.00%
143955001	DAUNORUBICIN HCL	Non-LDD	31.20%
143955101	DAUNORUBICIN HCL	Non-LDD	31.20%
143955110	DAUNORUBICIN HCL	Non-LDD	31.20%
703523311	DAUNORUBICIN HCL	Non-LDD	31.20%
703523313	DAUNORUBICIN HCL	Non-LDD	31.20%
703523391	DAUNORUBICIN HCL	Non-LDD	31.20%
703523393	DAUNORUBICIN HCL	Non-LDD	31.20%
42658002101	DAUNORUBICIN HCL	Non-LDD	31.20%
42658002102	DAUNORUBICIN HCL	Non-LDD	31.20%
42658002191	DAUNORUBICIN HCL	Non-LDD	31.20%
42658002192	DAUNORUBICIN HCL	Non-LDD	31.20%
63323011908	DAUNORUBICIN HCL	Non-LDD	31.20%
69029860	DAURISMO	LDD with Access	17.50%
69153130	DAURISMO	LDD with Access	17.50%
63090066001	DAYBUE	LDD with Access	10.50%
143938501	DECITABINE	Non-LDD	30.40%
781313980	DECITABINE	Non-LDD	30.40%
781329680	DECITABINE	Non-LDD	30.40%
16714074901	DECITABINE	Non-LDD	30.40%
16714092801	DECITABINE	Non-LDD	30.40%
16729022405	DECITABINE	Non-LDD	30.40%
25021023120	DECITABINE	Non-LDD	30.40%
43598034837	DECITABINE	Non-LDD	30.40%
43598042737	DECITABINE	Non-LDD	30.40%
47335036140	DECITABINE	Non-LDD	30.40%
47335036141	DECITABINE	Non-LDD	30.40%
50742043001	DECITABINE	Non-LDD	30.40%
55111055610	DECITABINE	Non-LDD	30.40%
55150037601	DECITABINE	Non-LDD	30.40%
63323082520	DECITABINE	Non-LDD	30.40%
67457031625	DECITABINE	Non-LDD	30.40%
68001034728	DECITABINE	Non-LDD	30.40%
68001034736	DECITABINE	Non-LDD	30.40%
68001042237	DECITABINE	Non-LDD	30.40%
68001057341	DECITABINE	Non-LDD	30.40%
69097028537	DECITABINE	Non-LDD	30.40%
69097090567	DECITABINE	Non-LDD	30.40%
70121164401	DECITABINE	Non-LDD	30.40%
70860021920	DECITABINE	Non-LDD	30.40%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
71288011920	DECITABINE	Non-LDD	30.40%
72205003101	DECITABINE	Non-LDD	30.40%
72205003601	DECITABINE	Non-LDD	30.40%
72603010701	DECITABINE	Non-LDD	30.40%
75834019001	DECITABINE	Non-LDD	30.40%
93351556	DEFERASIROX	Non-LDD	40.50%
93351656	DEFERASIROX	Non-LDD	40.50%
93351756	DEFERASIROX	Non-LDD	40.50%
591385330	DEFERASIROX	Non-LDD	40.50%
16714099301	DEFERASIROX	Non-LDD	40.50%
16714099401	DEFERASIROX	Non-LDD	40.50%
16714099501	DEFERASIROX	Non-LDD	40.50%
31722001130	DEFERASIROX	Non-LDD	40.50%
31722001230	DEFERASIROX	Non-LDD	40.50%
31722001330	DEFERASIROX	Non-LDD	40.50%
31722002932	DEFERASIROX	Non-LDD	40.50%
31722003031	DEFERASIROX	Non-LDD	40.50%
31722003032	DEFERASIROX	Non-LDD	40.50%
31722003131	DEFERASIROX	Non-LDD	40.50%
31722003132	DEFERASIROX	Non-LDD	40.50%
42806037130	DEFERASIROX	Non-LDD	40.50%
42806037230	DEFERASIROX	Non-LDD	40.50%
42806037330	DEFERASIROX	Non-LDD	40.50%
43598085130	DEFERASIROX	Non-LDD	40.50%
43598085230	DEFERASIROX	Non-LDD	40.50%
43598085330	DEFERASIROX	Non-LDD	40.50%
43598085430	DEFERASIROX	Non-LDD	40.50%
43598085530	DEFERASIROX	Non-LDD	40.50%
43598085630	DEFERASIROX	Non-LDD	40.50%
45963045430	DEFERASIROX	Non-LDD	40.50%
45963045530	DEFERASIROX	Non-LDD	40.50%
45963045630	DEFERASIROX	Non-LDD	40.50%
62332032430	DEFERASIROX	Non-LDD	40.50%
62332032530	DEFERASIROX	Non-LDD	40.50%
62332032630	DEFERASIROX	Non-LDD	40.50%
62332041030	DEFERASIROX	Non-LDD	40.50%
62332041130	DEFERASIROX	Non-LDD	40.50%
62332041230	DEFERASIROX	Non-LDD	40.50%
62756056883	DEFERASIROX	Non-LDD	40.50%
62756056983	DEFERASIROX	Non-LDD	40.50%
62756057083	DEFERASIROX	Non-LDD	40.50%
67877054930	DEFERASIROX	Non-LDD	40.50%
67877055030	DEFERASIROX	Non-LDD	40.50%
67877055130	DEFERASIROX	Non-LDD	40.50%
67877055230	DEFERASIROX	Non-LDD	40.50%
67877055430	DEFERASIROX	Non-LDD	40.50%
67877067584	DEFERASIROX	Non-LDD	40.50%
67877067684	DEFERASIROX	Non-LDD	40.50%
67877067784	DEFERASIROX	Non-LDD	40.50%
68462049430	DEFERASIROX	Non-LDD	40.50%
68462049530	DEFERASIROX	Non-LDD	40.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
68462049630	DEFERASIROX	Non-LDD	40.50%
69097039102	DEFERASIROX	Non-LDD	40.50%
69097039202	DEFERASIROX	Non-LDD	40.50%
69097039302	DEFERASIROX	Non-LDD	40.50%
69097055031	DEFERASIROX	Non-LDD	40.50%
69097055053	DEFERASIROX	Non-LDD	40.50%
69097056031	DEFERASIROX	Non-LDD	40.50%
69097056053	DEFERASIROX	Non-LDD	40.50%
69097057031	DEFERASIROX	Non-LDD	40.50%
69097057053	DEFERASIROX	Non-LDD	40.50%
69238148603	DEFERASIROX	Non-LDD	40.50%
69238148703	DEFERASIROX	Non-LDD	40.50%
69238148803	DEFERASIROX	Non-LDD	40.50%
69238170301	DEFERASIROX	Non-LDD	40.50%
69238170303	DEFERASIROX	Non-LDD	40.50%
69238170401	DEFERASIROX	Non-LDD	40.50%
69238170403	DEFERASIROX	Non-LDD	40.50%
69452015913	DEFERASIROX	Non-LDD	40.50%
69452016013	DEFERASIROX	Non-LDD	40.50%
69452016113	DEFERASIROX	Non-LDD	40.50%
70700026930	DEFERASIROX	Non-LDD	40.50%
70700027030	DEFERASIROX	Non-LDD	40.50%
70700027130	DEFERASIROX	Non-LDD	40.50%
70710127503	DEFERASIROX	Non-LDD	40.50%
70710127603	DEFERASIROX	Non-LDD	40.50%
70710127703	DEFERASIROX	Non-LDD	40.50%
72205007530	DEFERASIROX	Non-LDD	40.50%
72205007561	DEFERASIROX	Non-LDD	40.50%
72205007630	DEFERASIROX	Non-LDD	40.50%
72205007661	DEFERASIROX	Non-LDD	40.50%
72647037130	DEFERASIROX	Non-LDD	40.50%
72647037230	DEFERASIROX	Non-LDD	40.50%
72647037330	DEFERASIROX	Non-LDD	40.50%
54057625	DEFERIPRONE	LDD with Access	19.50%
51672419601	DEFERIPRONE	LDD with Access	19.50%
54071119	DEFERIPRONE (3 TIMES A DAY)	Non-LDD	33.50%
37440101	DEPEN	Non-LDD	18.50%
68418793906	DIACOMIT	LDD with Access	11.50%
68418794006	DIACOMIT	LDD with Access	11.50%
68418794106	DIACOMIT	LDD with Access	11.50%
68418794206	DIACOMIT	LDD with Access	11.50%
59212000101	DIBENZYLINE	Non-LDD	18.50%
59212000102	DIBENZYLINE	Non-LDD	18.50%
47335036240	DILUENT FOR DECITABINE	Non-LDD	47.50%
62935030430	DILUENT FOR ELIGARD	Non-LDD	43.95%
62935045545	DILUENT FOR ELIGARD	Non-LDD	43.95%
24582201	DILUENT FOR JEVTANA	Non-LDD	17.00%
43598039335	DILUENT FOR MELPHALAN	Non-LDD	30.40%
54288010701	DILUENT FOR MELPHALAN	Non-LDD	30.40%
67457019410	DILUENT FOR MELPHALAN	Non-LDD	30.40%
70700027696	DILUENT FOR MELPHALAN	Non-LDD	30.40%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
169701198	DILUENT FOR NOVOSEVEN RT	Non-LDD	30.40%
169701298	DILUENT FOR NOVOSEVEN RT	Non-LDD	30.40%
169701598	DILUENT FOR NOVOSEVEN RT	Non-LDD	30.40%
169701898	DILUENT FOR NOVOSEVEN RT	Non-LDD	30.40%
65757030403	DILUENT FOR VIVITROL	Non-LDD	30.40%
93921841	DIMETHYL FUMARATE	Non-LDD	77.50%
93921906	DIMETHYL FUMARATE	Non-LDD	77.50%
378039614	DIMETHYL FUMARATE	Non-LDD	77.50%
378039918	DIMETHYL FUMARATE	Non-LDD	77.50%
378039991	DIMETHYL FUMARATE	Non-LDD	77.50%
16729041604	DIMETHYL FUMARATE	Non-LDD	77.50%
16729041712	DIMETHYL FUMARATE	Non-LDD	77.50%
16729041759	DIMETHYL FUMARATE	Non-LDD	77.50%
24979012721	DIMETHYL FUMARATE	Non-LDD	77.50%
24979012804	DIMETHYL FUMARATE	Non-LDD	77.50%
31722065731	DIMETHYL FUMARATE	Non-LDD	77.50%
31722065832	DIMETHYL FUMARATE	Non-LDD	77.50%
31722068060	DIMETHYL FUMARATE	Non-LDD	77.50%
43547002414	DIMETHYL FUMARATE	Non-LDD	77.50%
43547002506	DIMETHYL FUMARATE	Non-LDD	77.50%
43598042952	DIMETHYL FUMARATE	Non-LDD	77.50%
43598043060	DIMETHYL FUMARATE	Non-LDD	77.50%
51407044160	DIMETHYL FUMARATE	Non-LDD	77.50%
51407044214	DIMETHYL FUMARATE	Non-LDD	77.50%
59651008314	DIMETHYL FUMARATE	Non-LDD	77.50%
59651008460	DIMETHYL FUMARATE	Non-LDD	77.50%
67877055514	DIMETHYL FUMARATE	Non-LDD	77.50%
67877055532	DIMETHYL FUMARATE	Non-LDD	77.50%
67877055623	DIMETHYL FUMARATE	Non-LDD	77.50%
67877055660	DIMETHYL FUMARATE	Non-LDD	77.50%
67877055739	DIMETHYL FUMARATE	Non-LDD	77.50%
68180077614	DIMETHYL FUMARATE	Non-LDD	77.50%
68180077665	DIMETHYL FUMARATE	Non-LDD	77.50%
68180077707	DIMETHYL FUMARATE	Non-LDD	77.50%
68180077748	DIMETHYL FUMARATE	Non-LDD	77.50%
68180077813	DIMETHYL FUMARATE	Non-LDD	77.50%
69097032228	DIMETHYL FUMARATE	Non-LDD	77.50%
69097032289	DIMETHYL FUMARATE	Non-LDD	77.50%
69097032303	DIMETHYL FUMARATE	Non-LDD	77.50%
69097032388	DIMETHYL FUMARATE	Non-LDD	77.50%
69097055203	DIMETHYL FUMARATE	Non-LDD	77.50%
69238131804	DIMETHYL FUMARATE	Non-LDD	77.50%
69238131906	DIMETHYL FUMARATE	Non-LDD	77.50%
69238162603	DIMETHYL FUMARATE	Non-LDD	77.50%
70512085214	DIMETHYL FUMARATE	Non-LDD	77.50%
70512085360	DIMETHYL FUMARATE	Non-LDD	77.50%
143920401	DOCETAXEL	Non-LDD	43.50%
143920501	DOCETAXEL	Non-LDD	43.50%
409001601	DOCETAXEL	Non-LDD	43.50%
409020102	DOCETAXEL	Non-LDD	43.50%
409020110	DOCETAXEL	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
409020120	DOCETAXEL	Non-LDD	43.50%
409036501	DOCETAXEL	Non-LDD	43.50%
409036601	DOCETAXEL	Non-LDD	43.50%
409036701	DOCETAXEL	Non-LDD	43.50%
409036801	DOCETAXEL	Non-LDD	43.50%
409173201	DOCETAXEL	Non-LDD	43.50%
409202601	DOCETAXEL	Non-LDD	43.50%
409423501	DOCETAXEL	Non-LDD	43.50%
409506801	DOCETAXEL	Non-LDD	43.50%
409787001	DOCETAXEL	Non-LDD	43.50%
955102001	DOCETAXEL	Non-LDD	43.50%
955102104	DOCETAXEL	Non-LDD	43.50%
955102208	DOCETAXEL	Non-LDD	43.50%
16729026763	DOCETAXEL	Non-LDD	43.50%
16729026764	DOCETAXEL	Non-LDD	43.50%
16729026765	DOCETAXEL	Non-LDD	43.50%
25021024501	DOCETAXEL	Non-LDD	43.50%
25021024504	DOCETAXEL	Non-LDD	43.50%
39822218001	DOCETAXEL	Non-LDD	43.50%
39822220001	DOCETAXEL	Non-LDD	43.50%
43066000101	DOCETAXEL	Non-LDD	43.50%
43066000601	DOCETAXEL	Non-LDD	43.50%
43066001001	DOCETAXEL	Non-LDD	43.50%
43598025811	DOCETAXEL	Non-LDD	43.50%
43598025940	DOCETAXEL	Non-LDD	43.50%
43598038957	DOCETAXEL	Non-LDD	43.50%
43598061040	DOCETAXEL	Non-LDD	43.50%
43598061111	DOCETAXEL	Non-LDD	43.50%
45963073454	DOCETAXEL	Non-LDD	43.50%
45963076552	DOCETAXEL	Non-LDD	43.50%
45963079056	DOCETAXEL	Non-LDD	43.50%
47335032340	DOCETAXEL	Non-LDD	43.50%
47335089540	DOCETAXEL	Non-LDD	43.50%
47335093940	DOCETAXEL	Non-LDD	43.50%
50742042802	DOCETAXEL	Non-LDD	43.50%
50742043108	DOCETAXEL	Non-LDD	43.50%
50742046316	DOCETAXEL	Non-LDD	43.50%
55150037801	DOCETAXEL	Non-LDD	43.50%
55150037901	DOCETAXEL	Non-LDD	43.50%
55150038001	DOCETAXEL	Non-LDD	43.50%
62332067802	DOCETAXEL	Non-LDD	43.50%
62332067808	DOCETAXEL	Non-LDD	43.50%
62332067816	DOCETAXEL	Non-LDD	43.50%
66758005001	DOCETAXEL	Non-LDD	43.50%
66758005002	DOCETAXEL	Non-LDD	43.50%
66758005003	DOCETAXEL	Non-LDD	43.50%
66758095002	DOCETAXEL	Non-LDD	43.50%
66758095003	DOCETAXEL	Non-LDD	43.50%
66758095004	DOCETAXEL	Non-LDD	43.50%
67457053102	DOCETAXEL	Non-LDD	43.50%
67457053208	DOCETAXEL	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
67457053316	DOCETAXEL	Non-LDD	43.50%
67457078108	DOCETAXEL	Non-LDD	43.50%
70700017422	DOCETAXEL	Non-LDD	43.50%
70700017522	DOCETAXEL	Non-LDD	43.50%
70700017622	DOCETAXEL	Non-LDD	43.50%
71288014408	DOCETAXEL	Non-LDD	43.50%
71288014416	DOCETAXEL	Non-LDD	43.50%
72078004008	DOCETAXEL	Non-LDD	43.50%
72485021401	DOCETAXEL	Non-LDD	43.50%
72485021504	DOCETAXEL	Non-LDD	43.50%
72485021608	DOCETAXEL	Non-LDD	43.50%
73358021008	DOCETAXEL	Non-LDD	43.50%
73358021016	DOCETAXEL	Non-LDD	43.50%
69794005050	DOJOLVI	LDD with Access	14.75%
71369002010	DOPTELET	LDD with Access	18.50%
71369002011	DOPTELET	LDD with Access	18.50%
71369002015	DOPTELET	LDD with Access	18.50%
71369002016	DOPTELET	LDD with Access	18.50%
71369002030	DOPTELET	LDD with Access	18.50%
338006301	DOXIL	Non-LDD	21.00%
338006701	DOXIL	Non-LDD	21.00%
59676096001	DOXIL	Non-LDD	21.00%
59676096002	DOXIL	Non-LDD	21.00%
338008001	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
338008601	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
574093010	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
574093125	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
16714074201	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
16714085601	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
43598028335	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
43598054125	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
43598068235	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
43598068325	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
47335004940	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
47335005040	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
63629953001	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
63629953101	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
68001034526	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
68001034536	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
68001049236	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
68001049326	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
70710153001	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
70710153101	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
72603010301	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
72603020001	DOXORUBICIN HCL LIPOSOME	Non-LDD	43.50%
378070901	D-PENAMINE	Non-LDD	21.00%
54053222	DROXIDOPA	Non-LDD	73.20%
54053322	DROXIDOPA	Non-LDD	73.20%
54053422	DROXIDOPA	Non-LDD	73.20%
27241019990	DROXIDOPA	Non-LDD	73.20%
27241020090	DROXIDOPA	Non-LDD	73.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
27241020190	DROXIDOPA	Non-LDD	73.20%
27808019901	DROXIDOPA	Non-LDD	73.20%
27808020001	DROXIDOPA	Non-LDD	73.20%
27808020101	DROXIDOPA	Non-LDD	73.20%
31722001090	DROXIDOPA	Non-LDD	73.20%
31722001490	DROXIDOPA	Non-LDD	73.20%
31722001590	DROXIDOPA	Non-LDD	73.20%
50228042990	DROXIDOPA	Non-LDD	73.20%
50228043090	DROXIDOPA	Non-LDD	73.20%
50228043190	DROXIDOPA	Non-LDD	73.20%
51407076590	DROXIDOPA	Non-LDD	73.20%
51407076690	DROXIDOPA	Non-LDD	73.20%
51407076790	DROXIDOPA	Non-LDD	73.20%
59651037590	DROXIDOPA	Non-LDD	73.20%
59651037690	DROXIDOPA	Non-LDD	73.20%
59651037790	DROXIDOPA	Non-LDD	73.20%
63304008690	DROXIDOPA	Non-LDD	73.20%
63304010490	DROXIDOPA	Non-LDD	73.20%
63304011290	DROXIDOPA	Non-LDD	73.20%
67877070490	DROXIDOPA	Non-LDD	73.20%
67877070590	DROXIDOPA	Non-LDD	73.20%
67877070690	DROXIDOPA	Non-LDD	73.20%
68180098709	DROXIDOPA	Non-LDD	73.20%
68180098809	DROXIDOPA	Non-LDD	73.20%
68180098909	DROXIDOPA	Non-LDD	73.20%
70436014006	DROXIDOPA	Non-LDD	73.20%
70436014106	DROXIDOPA	Non-LDD	73.20%
70436014206	DROXIDOPA	Non-LDD	73.20%
70710138909	DROXIDOPA	Non-LDD	73.20%
70710139009	DROXIDOPA	Non-LDD	73.20%
70710139109	DROXIDOPA	Non-LDD	73.20%
72205007290	DROXIDOPA	Non-LDD	73.20%
72205007390	DROXIDOPA	Non-LDD	73.20%
72205007490	DROXIDOPA	Non-LDD	73.20%
74301207	DUOPA	LDD with Access	15.50%
24591500	DUPIXENT PEN	Non-LDD	22.00%
24591501	DUPIXENT PEN	Non-LDD	22.00%
24591502	DUPIXENT PEN	Non-LDD	22.00%
24591520	DUPIXENT PEN	Non-LDD	22.00%
24591900	DUPIXENT PEN	Non-LDD	22.00%
24591901	DUPIXENT PEN	Non-LDD	22.00%
24591902	DUPIXENT PEN	Non-LDD	22.00%
24591920	DUPIXENT PEN	Non-LDD	22.00%
24591100	DUPIXENT SYRINGE	Non-LDD	22.00%
24591102	DUPIXENT SYRINGE	Non-LDD	22.00%
24591400	DUPIXENT SYRINGE	Non-LDD	22.00%
24591401	DUPIXENT SYRINGE	Non-LDD	22.00%
24591402	DUPIXENT SYRINGE	Non-LDD	22.00%
24591800	DUPIXENT SYRINGE	Non-LDD	22.00%
24591801	DUPIXENT SYRINGE	Non-LDD	22.00%
24591802	DUPIXENT SYRINGE	Non-LDD	22.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
23965201	DURYSTA	LDD with Access	17.48%
299596230	DYSPORT	Non-LDD	21.00%
15054050001	DYSPORT	Non-LDD	21.00%
15054053006	DYSPORT	Non-LDD	21.00%
62064001160	EGRIFTA	LDD with Access	13.30%
62064024130	EGRIFTA SV	LDD with Access	13.30%
72903085301	ELAHERE	LDD with Access	13.50%
54092070001	ELAPRASE	Non-LDD	17.48%
69010601	ELELYSO	LDD with Access	15.50%
62935022104	ELIGARD	Non-LDD	21.00%
62935022305	ELIGARD	Non-LDD	21.00%
62935030330	ELIGARD	Non-LDD	21.00%
62935030529	ELIGARD	Non-LDD	21.00%
62935045345	ELIGARD	Non-LDD	21.00%
62935045444	ELIGARD	Non-LDD	21.00%
62935046150	ELIGARD	Non-LDD	21.00%
62935075375	ELIGARD	Non-LDD	21.00%
62935075474	ELIGARD	Non-LDD	21.00%
9509101	ELLENCE	Non-LDD	20.50%
9509301	ELLENCE	Non-LDD	20.50%
71104048308	ELOCTATE	Non-LDD	23.50%
71104048408	ELOCTATE	Non-LDD	23.50%
71104048508	ELOCTATE	Non-LDD	23.50%
71104048608	ELOCTATE	Non-LDD	23.50%
71104048708	ELOCTATE	Non-LDD	23.50%
71104048808	ELOCTATE	Non-LDD	23.50%
71104048908	ELOCTATE	Non-LDD	23.50%
71104049008	ELOCTATE	Non-LDD	23.50%
71104049108	ELOCTATE	Non-LDD	23.50%
71104049208	ELOCTATE	Non-LDD	23.50%
71104080101	ELOCTATE	Non-LDD	23.50%
71104080201	ELOCTATE	Non-LDD	23.50%
71104080301	ELOCTATE	Non-LDD	23.50%
71104080401	ELOCTATE	Non-LDD	23.50%
71104080501	ELOCTATE	Non-LDD	23.50%
71104080601	ELOCTATE	Non-LDD	23.50%
71104080701	ELOCTATE	Non-LDD	23.50%
71104080801	ELOCTATE	Non-LDD	23.50%
71104080901	ELOCTATE	Non-LDD	23.50%
71104081001	ELOCTATE	Non-LDD	23.50%
72187040101	ELZONRIS	LDD with Access	14.25%
13013202	EMCYT	Non-LDD	18.00%
52856050101	EMFLAZA	LDD with Access	8.50%
52856050203	EMFLAZA	LDD with Access	8.50%
52856050303	EMFLAZA	LDD with Access	8.50%
52856050403	EMFLAZA	LDD with Access	8.50%
52856050521	EMFLAZA	LDD with Access	8.50%
52856050522	EMFLAZA	LDD with Access	8.50%
73606001001	EMPAVELI	LDD with Access	13.50%
3229111	EMPLICITI	Non-LDD	21.00%
3452211	EMPLICITI	Non-LDD	21.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
58406001001	ENBREL	Non-LDD	21.00%
58406001004	ENBREL	Non-LDD	21.00%
58406001096	ENBREL	Non-LDD	21.00%
58406002101	ENBREL	Non-LDD	21.00%
58406002104	ENBREL	Non-LDD	21.00%
58406002196	ENBREL	Non-LDD	21.00%
58406005501	ENBREL	Non-LDD	21.00%
58406005504	ENBREL	Non-LDD	21.00%
58406042534	ENBREL	Non-LDD	21.00%
58406042541	ENBREL	Non-LDD	21.00%
58406043501	ENBREL	Non-LDD	21.00%
58406043504	ENBREL	Non-LDD	21.00%
58406045501	ENBREL	Non-LDD	21.00%
58406045504	ENBREL	Non-LDD	21.00%
58406004401	ENBREL MINI	Non-LDD	21.00%
58406004404	ENBREL MINI	Non-LDD	21.00%
58406004496	ENBREL MINI	Non-LDD	21.00%
58406045601	ENBREL MINI	Non-LDD	21.00%
58406045604	ENBREL MINI	Non-LDD	21.00%
58406003201	ENBREL SURECLICK	Non-LDD	21.00%
58406003204	ENBREL SURECLICK	Non-LDD	21.00%
58406003296	ENBREL SURECLICK	Non-LDD	21.00%
58406044501	ENBREL SURECLICK	Non-LDD	21.00%
58406044504	ENBREL SURECLICK	Non-LDD	21.00%
42457042001	ENDARI	LDD with Access	13.50%
42457042060	ENDARI	LDD with Access	13.50%
65597040601	ENHERTU	LDD with Access	13.00%
80203034701	ENJAYMO	LDD with Access	15.50%
50242000701	ENSPRYNG	LDD with Access	21.00%
93578656	ENTECAVIR	Non-LDD	66.50%
93578698	ENTECAVIR	Non-LDD	66.50%
93578756	ENTECAVIR	Non-LDD	66.50%
10135061530	ENTECAVIR	Non-LDD	66.50%
10135061630	ENTECAVIR	Non-LDD	66.50%
16714071701	ENTECAVIR	Non-LDD	66.50%
16714071801	ENTECAVIR	Non-LDD	66.50%
16729038810	ENTECAVIR	Non-LDD	66.50%
16729038910	ENTECAVIR	Non-LDD	66.50%
31722083330	ENTECAVIR	Non-LDD	66.50%
31722083390	ENTECAVIR	Non-LDD	66.50%
31722083430	ENTECAVIR	Non-LDD	66.50%
42291026130	ENTECAVIR	Non-LDD	66.50%
42291026230	ENTECAVIR	Non-LDD	66.50%
42806065830	ENTECAVIR	Non-LDD	66.50%
42806065930	ENTECAVIR	Non-LDD	66.50%
43547043603	ENTECAVIR	Non-LDD	66.50%
43547043703	ENTECAVIR	Non-LDD	66.50%
50268028911	ENTECAVIR	Non-LDD	66.50%
50268028912	ENTECAVIR	Non-LDD	66.50%
51407006430	ENTECAVIR	Non-LDD	66.50%
51407006530	ENTECAVIR	Non-LDD	66.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
51991089533	ENTECAVIR	Non-LDD	66.50%
51991089633	ENTECAVIR	Non-LDD	66.50%
52343014730	ENTECAVIR	Non-LDD	66.50%
52343014830	ENTECAVIR	Non-LDD	66.50%
60687021625	ENTECAVIR	Non-LDD	66.50%
60687021695	ENTECAVIR	Non-LDD	66.50%
65162044603	ENTECAVIR	Non-LDD	66.50%
65162044903	ENTECAVIR	Non-LDD	66.50%
65862084130	ENTECAVIR	Non-LDD	66.50%
65862084230	ENTECAVIR	Non-LDD	66.50%
68382092006	ENTECAVIR	Non-LDD	66.50%
68382092106	ENTECAVIR	Non-LDD	66.50%
69097042502	ENTECAVIR	Non-LDD	66.50%
69097042602	ENTECAVIR	Non-LDD	66.50%
71921019433	ENTECAVIR	Non-LDD	66.50%
71921019533	ENTECAVIR	Non-LDD	66.50%
64764030020	ENTYVIO	Non-LDD	21.00%
61958220101	EPCLUSA	Non-LDD	22.00%
61958220301	EPCLUSA	Non-LDD	22.00%
61958220401	EPCLUSA	Non-LDD	22.00%
61958220402	EPCLUSA	Non-LDD	22.00%
61958220501	EPCLUSA	Non-LDD	22.00%
61958220502	EPCLUSA	Non-LDD	22.00%
70127010001	EPIDIOLEX	LDD with Access	21.00%
70127010006	EPIDIOLEX	LDD with Access	21.00%
70127010010	EPIDIOLEX	LDD with Access	21.00%
70127010060	EPIDIOLEX	LDD with Access	21.00%
143920201	EPIRUBICIN HCL	Non-LDD	43.50%
143920301	EPIRUBICIN HCL	Non-LDD	43.50%
25021020325	EPIRUBICIN HCL	Non-LDD	43.50%
25021020351	EPIRUBICIN HCL	Non-LDD	43.50%
45963060860	EPIRUBICIN HCL	Non-LDD	43.50%
45963060868	EPIRUBICIN HCL	Non-LDD	43.50%
59923070100	EPIRUBICIN HCL	Non-LDD	43.50%
59923070125	EPIRUBICIN HCL	Non-LDD	43.50%
61703034735	EPIRUBICIN HCL	Non-LDD	43.50%
61703034859	EPIRUBICIN HCL	Non-LDD	43.50%
61703035902	EPIRUBICIN HCL	Non-LDD	43.50%
63323015100	EPIRUBICIN HCL	Non-LDD	43.50%
63323015125	EPIRUBICIN HCL	Non-LDD	43.50%
66758004201	EPIRUBICIN HCL	Non-LDD	43.50%
66758004202	EPIRUBICIN HCL	Non-LDD	43.50%
55513012601	EPOGEN	Non-LDD	19.50%
55513012610	EPOGEN	Non-LDD	19.50%
55513014401	EPOGEN	Non-LDD	19.50%
55513014410	EPOGEN	Non-LDD	19.50%
55513014801	EPOGEN	Non-LDD	19.50%
55513014810	EPOGEN	Non-LDD	19.50%
55513026701	EPOGEN	Non-LDD	19.50%
55513026710	EPOGEN	Non-LDD	19.50%
55513028301	EPOGEN	Non-LDD	19.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
55513028310	EPOGEN	Non-LDD	19.50%
55513047801	EPOGEN	Non-LDD	19.50%
55513047810	EPOGEN	Non-LDD	19.50%
703198501	EPOPROSTENOL SODIUM	LDD with Access	13.50%
703199501	EPOPROSTENOL SODIUM	LDD with Access	13.50%
62756005940	EPOPROSTENOL SODIUM	LDD with Access	13.50%
62756006040	EPOPROSTENOL SODIUM	LDD with Access	13.50%
66733094823	ERBITUX	Non-LDD	21.00%
66733095823	ERBITUX	Non-LDD	21.00%
50242014001	ERIVEDGE	LDD with Access	16.50%
59676060012	ERLEADA	LDD with Access	21.00%
59676060430	ERLEADA	LDD with Access	21.00%
93766256	ERLOTINIB HCL	Non-LDD	38.50%
93766356	ERLOTINIB HCL	Non-LDD	38.50%
93766456	ERLOTINIB HCL	Non-LDD	38.50%
378713193	ERLOTINIB HCL	Non-LDD	38.50%
378713293	ERLOTINIB HCL	Non-LDD	38.50%
378713393	ERLOTINIB HCL	Non-LDD	38.50%
42292005101	ERLOTINIB HCL	Non-LDD	38.50%
42292005105	ERLOTINIB HCL	Non-LDD	38.50%
42292005201	ERLOTINIB HCL	Non-LDD	38.50%
42292005205	ERLOTINIB HCL	Non-LDD	38.50%
42292005301	ERLOTINIB HCL	Non-LDD	38.50%
42292005305	ERLOTINIB HCL	Non-LDD	38.50%
51991089033	ERLOTINIB HCL	Non-LDD	38.50%
51991089133	ERLOTINIB HCL	Non-LDD	38.50%
51991089233	ERLOTINIB HCL	Non-LDD	38.50%
59923072530	ERLOTINIB HCL	Non-LDD	38.50%
59923072630	ERLOTINIB HCL	Non-LDD	38.50%
59923072730	ERLOTINIB HCL	Non-LDD	38.50%
62332056530	ERLOTINIB HCL	Non-LDD	38.50%
62332056630	ERLOTINIB HCL	Non-LDD	38.50%
62332056730	ERLOTINIB HCL	Non-LDD	38.50%
63304009530	ERLOTINIB HCL	Non-LDD	38.50%
63304009630	ERLOTINIB HCL	Non-LDD	38.50%
63304013530	ERLOTINIB HCL	Non-LDD	38.50%
68382091306	ERLOTINIB HCL	Non-LDD	38.50%
68382091406	ERLOTINIB HCL	Non-LDD	38.50%
68382091506	ERLOTINIB HCL	Non-LDD	38.50%
72205008030	ERLOTINIB HCL	Non-LDD	38.50%
72205008130	ERLOTINIB HCL	Non-LDD	38.50%
72205008230	ERLOTINIB HCL	Non-LDD	38.50%
72485021730	ERLOTINIB HCL	Non-LDD	38.50%
72485021830	ERLOTINIB HCL	Non-LDD	38.50%
72485021930	ERLOTINIB HCL	Non-LDD	38.50%
81561041301	ERWINASE	LDD with Access	13.25%
81561041305	ERWINASE	LDD with Access	13.25%
57902024901	ERWINAZE	LDD with Access	14.00%
57902024905	ERWINAZE	LDD with Access	14.00%
50242012101	ESBRIET	LDD with Access	18.50%
50242012206	ESBRIET	LDD with Access	18.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
50242012301	ESBRIET	LDD with Access	18.50%
169810001	ESPEROCT	Non-LDD	32.50%
169810111	ESPEROCT	Non-LDD	32.50%
169815001	ESPEROCT	Non-LDD	32.50%
169815111	ESPEROCT	Non-LDD	32.50%
169820001	ESPEROCT	Non-LDD	32.50%
169820111	ESPEROCT	Non-LDD	32.50%
169830001	ESPEROCT	Non-LDD	32.50%
169830111	ESPEROCT	Non-LDD	32.50%
169850001	ESPEROCT	Non-LDD	32.50%
169850111	ESPEROCT	Non-LDD	32.50%
55513088001	EVENITY	Non-LDD	20.50%
55513088002	EVENITY (2 SYRINGES)	Non-LDD	20.50%
54048013	EVEROLIMUS	Non-LDD	43.50%
54048014	EVEROLIMUS	Non-LDD	43.50%
54048113	EVEROLIMUS	Non-LDD	43.50%
54048114	EVEROLIMUS	Non-LDD	43.50%
54048213	EVEROLIMUS	Non-LDD	43.50%
54049713	EVEROLIMUS	Non-LDD	43.50%
54049714	EVEROLIMUS	Non-LDD	43.50%
93776619	EVEROLIMUS	Non-LDD	43.50%
93776624	EVEROLIMUS	Non-LDD	43.50%
93776719	EVEROLIMUS	Non-LDD	43.50%
93776724	EVEROLIMUS	Non-LDD	43.50%
93776819	EVEROLIMUS	Non-LDD	43.50%
93776824	EVEROLIMUS	Non-LDD	43.50%
378000532	EVEROLIMUS	Non-LDD	43.50%
378000585	EVEROLIMUS	Non-LDD	43.50%
378000632	EVEROLIMUS	Non-LDD	43.50%
378000685	EVEROLIMUS	Non-LDD	43.50%
378000732	EVEROLIMUS	Non-LDD	43.50%
378000785	EVEROLIMUS	Non-LDD	43.50%
378309632	EVEROLIMUS	Non-LDD	43.50%
378309685	EVEROLIMUS	Non-LDD	43.50%
378309732	EVEROLIMUS	Non-LDD	43.50%
378309785	EVEROLIMUS	Non-LDD	43.50%
378309832	EVEROLIMUS	Non-LDD	43.50%
378309885	EVEROLIMUS	Non-LDD	43.50%
378309932	EVEROLIMUS	Non-LDD	43.50%
378309985	EVEROLIMUS	Non-LDD	43.50%
49884011952	EVEROLIMUS	Non-LDD	43.50%
49884011991	EVEROLIMUS	Non-LDD	43.50%
49884012552	EVEROLIMUS	Non-LDD	43.50%
49884012591	EVEROLIMUS	Non-LDD	43.50%
49884012752	EVEROLIMUS	Non-LDD	43.50%
49884012791	EVEROLIMUS	Non-LDD	43.50%
49884012852	EVEROLIMUS	Non-LDD	43.50%
49884012891	EVEROLIMUS	Non-LDD	43.50%
51991082128	EVEROLIMUS	Non-LDD	43.50%
51991082133	EVEROLIMUS	Non-LDD	43.50%
51991082199	EVEROLIMUS	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
51991082228	EVEROLIMUS	Non-LDD	43.50%
51991082233	EVEROLIMUS	Non-LDD	43.50%
51991082299	EVEROLIMUS	Non-LDD	43.50%
51991082328	EVEROLIMUS	Non-LDD	43.50%
51991082333	EVEROLIMUS	Non-LDD	43.50%
51991082399	EVEROLIMUS	Non-LDD	43.50%
51991082428	EVEROLIMUS	Non-LDD	43.50%
51991082433	EVEROLIMUS	Non-LDD	43.50%
51991082499	EVEROLIMUS	Non-LDD	43.50%
70377001022	EVEROLIMUS	Non-LDD	43.50%
70377001122	EVEROLIMUS	Non-LDD	43.50%
70377001222	EVEROLIMUS	Non-LDD	43.50%
70377001311	EVEROLIMUS	Non-LDD	43.50%
70377001322	EVEROLIMUS	Non-LDD	43.50%
61755001001	EVKEEZA	LDD with Access	9.50%
61755001301	EVKEEZA	LDD with Access	9.50%
68152010900	EVOMELA	Non-LDD	14.50%
72893000101	EVOMELA	Non-LDD	14.50%
50242017505	EVRYSDI	LDD with Access	10.50%
50242017507	EVRYSDI	LDD with Access	10.50%
78046815	EXJADE	Non-LDD	17.50%
78046915	EXJADE	Non-LDD	17.50%
78047015	EXJADE	Non-LDD	17.50%
63020004012	EXKIVITY	LDD with Access	13.50%
60923028410	EXONDYS-51	LDD with Access	8.50%
60923036302	EXONDYS-51	LDD with Access	8.50%
78056912	EXTAVIA	Non-LDD	22.00%
78056961	EXTAVIA	Non-LDD	22.00%
78056999	EXTAVIA	Non-LDD	22.00%
61755000501	EYLEA	LDD with Access	15.25%
61755000502	EYLEA	LDD with Access	15.25%
61755000554	EYLEA	LDD with Access	15.25%
61755000555	EYLEA	LDD with Access	15.25%
58468004001	FABRAZYME	Non-LDD	14.59%
58468004101	FABRAZYME	Non-LDD	14.59%
42747032730	FARESTON	Non-LDD	18.50%
78065006	FARYDAK	Non-LDD	19.50%
78065106	FARYDAK	Non-LDD	19.50%
78065206	FARYDAK	Non-LDD	19.50%
73116010006	FARYDAK	Non-LDD	19.50%
73116010106	FARYDAK	Non-LDD	19.50%
73116010206	FARYDAK	Non-LDD	19.50%
310173030	FASENRA	LDD with Access	20.50%
310173085	FASENRA	LDD with Access	20.50%
310183030	FASENRA PEN	LDD with Access	20.50%
310183085	FASENRA PEN	LDD with Access	20.50%
310072010	FASLODEX	Non-LDD	21.00%
64193032501	FEIBA NF	Non-LDD	34.20%
64193032601	FEIBA NF	Non-LDD	34.20%
64193042402	FEIBA NF	Non-LDD	34.20%
64193042502	FEIBA NF	Non-LDD	34.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
64193042602	FEIBA NF	Non-LDD	34.20%
62935015350	FENSOLVI	LDD with Access	14.50%
62935015450	FENSOLVI	LDD with Access	14.50%
62935016360	FENSOLVI	LDD with Access	14.50%
10122010010	FERRIPROX	LDD with Access	17.10%
10122010150	FERRIPROX	LDD with Access	17.10%
52609000601	FERRIPROX	LDD with Access	17.10%
52609000705	FERRIPROX	LDD with Access	17.10%
52609450207	FERRIPROX	LDD with Access	17.10%
68982034701	FIBRYGA	Non-LDD	15.50%
68982034801	FIBRYGA	Non-LDD	15.50%
378452593	FINGOLIMOD	Non-LDD	70.50%
16729034210	FINGOLIMOD	Non-LDD	70.50%
31722088930	FINGOLIMOD	Non-LDD	70.50%
43598028530	FINGOLIMOD	Non-LDD	70.50%
60505433203	FINGOLIMOD	Non-LDD	70.50%
62756006483	FINGOLIMOD	Non-LDD	70.50%
64980044903	FINGOLIMOD	Non-LDD	70.50%
67877047630	FINGOLIMOD	Non-LDD	70.50%
68382091206	FINGOLIMOD	Non-LDD	70.50%
68462016630	FINGOLIMOD	Non-LDD	70.50%
43376032230	FINTEPLA	LDD with Access	10.50%
43376032236	FINTEPLA	LDD with Access	10.50%
54092070202	FIRAZYR	Non-LDD	17.75%
54092070203	FIRAZYR	Non-LDD	17.75%
69616021103	FIRDAPSE	LDD with Access	10.50%
69616021104	FIRDAPSE	LDD with Access	10.50%
69616021106	FIRDAPSE	LDD with Access	10.50%
55566830301	FIRMAGON	Non-LDD	21.00%
55566840200	FIRMAGON	Non-LDD	21.00%
55566840301	FIRMAGON	Non-LDD	21.00%
61953000400	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000401	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000402	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000403	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000404	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000405	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000406	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000407	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000408	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000409	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000501	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000502	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000503	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000504	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000505	FLEBOGAMMA DIF	Non-LDD	19.20%
61953000506	FLEBOGAMMA DIF	Non-LDD	19.20%
173051700	FLOLAN	LDD with Access	14.50%
173051900	FLOLAN	LDD with Access	14.50%
143927001	FLOXURIDINE	Non-LDD	15.20%
63323014507	FLOXURIDINE	Non-LDD	15.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
81643927001	FLOXURIDINE	Non-LDD	15.20%
16729013130	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
24201023701	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
25021024202	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
45963060955	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
45963062151	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
59923060402	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
61703034418	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
63323019202	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
63323019606	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
67457023802	FLUDARABINE PHOSPHATE	Non-LDD	43.50%
48818000101	FOLOTYN	Non-LDD	17.48%
48818000102	FOLOTYN	Non-LDD	17.48%
72893000301	FOLOTYN	Non-LDD	17.48%
72893000501	FOLOTYN	Non-LDD	17.48%
2840001	FORTEO	Non-LDD	22.00%
45629008901	FOTIVDA	LDD with Access	14.00%
45629013401	FOTIVDA	LDD with Access	14.00%
67457083306	FULPHILA	Non-LDD	19.50%
143902201	FULVESTRANT	Non-LDD	43.50%
143902202	FULVESTRANT	Non-LDD	43.50%
310772010	FULVESTRANT	Non-LDD	43.50%
591501902	FULVESTRANT	Non-LDD	43.50%
591501911	FULVESTRANT	Non-LDD	43.50%
781307901	FULVESTRANT	Non-LDD	43.50%
781307912	FULVESTRANT	Non-LDD	43.50%
781349201	FULVESTRANT	Non-LDD	43.50%
781349212	FULVESTRANT	Non-LDD	43.50%
781905501	FULVESTRANT	Non-LDD	43.50%
781905512	FULVESTRANT	Non-LDD	43.50%
16714007001	FULVESTRANT	Non-LDD	43.50%
16714007002	FULVESTRANT	Non-LDD	43.50%
16714011801	FULVESTRANT	Non-LDD	43.50%
16714011802	FULVESTRANT	Non-LDD	43.50%
16729043630	FULVESTRANT	Non-LDD	43.50%
16729043631	FULVESTRANT	Non-LDD	43.50%
25021046274	FULVESTRANT	Non-LDD	43.50%
43598026202	FULVESTRANT	Non-LDD	43.50%
43598026211	FULVESTRANT	Non-LDD	43.50%
62332065005	FULVESTRANT	Non-LDD	43.50%
62332065010	FULVESTRANT	Non-LDD	43.50%
63323071501	FULVESTRANT	Non-LDD	43.50%
63323071505	FULVESTRANT	Non-LDD	43.50%
67457031100	FULVESTRANT	Non-LDD	43.50%
67457031105	FULVESTRANT	Non-LDD	43.50%
68001042485	FULVESTRANT	Non-LDD	43.50%
68001042486	FULVESTRANT	Non-LDD	43.50%
68001048485	FULVESTRANT	Non-LDD	43.50%
68001048486	FULVESTRANT	Non-LDD	43.50%
68001052285	FULVESTRANT	Non-LDD	43.50%
68001052286	FULVESTRANT	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
68462031732	FULVESTRANT	Non-LDD	43.50%
70121146302	FULVESTRANT	Non-LDD	43.50%
70700028498	FULVESTRANT	Non-LDD	43.50%
70710168802	FULVESTRANT	Non-LDD	43.50%
70710168808	FULVESTRANT	Non-LDD	43.50%
70860021141	FULVESTRANT	Non-LDD	43.50%
70860021174	FULVESTRANT	Non-LDD	43.50%
71288055585	FULVESTRANT	Non-LDD	43.50%
71288055586	FULVESTRANT	Non-LDD	43.50%
72603010501	FULVESTRANT	Non-LDD	43.50%
72603010502	FULVESTRANT	Non-LDD	43.50%
68152010100	FUSILEV	Non-LDD	17.48%
80803015350	FYARRO	LDD with Access	15.00%
70121162701	FYLNETRA	Non-LDD	10.50%
71904010001	GALAFOLD	LDD with Access	17.70%
13533033504	GAMASTAN	Non-LDD	17.50%
13533033512	GAMASTAN	Non-LDD	17.50%
13533033513	GAMASTAN	Non-LDD	17.50%
13533033540	GAMASTAN	Non-LDD	17.50%
13533063504	GAMASTAN S-D	Non-LDD	39.20%
13533063512	GAMASTAN S-D	Non-LDD	39.20%
13533063513	GAMASTAN S-D	Non-LDD	39.20%
13533063540	GAMASTAN S-D	Non-LDD	39.20%
66658050101	GAMIFANT	LDD with Access	13.50%
66658050501	GAMIFANT	LDD with Access	13.50%
66658051001	GAMIFANT	LDD with Access	13.50%
72171050101	GAMIFANT	LDD with Access	13.50%
72171050501	GAMIFANT	LDD with Access	13.50%
944270002	GAMMAGARD LIQUID	Non-LDD	39.20%
944270003	GAMMAGARD LIQUID	Non-LDD	39.20%
944270004	GAMMAGARD LIQUID	Non-LDD	39.20%
944270005	GAMMAGARD LIQUID	Non-LDD	39.20%
944270006	GAMMAGARD LIQUID	Non-LDD	39.20%
944270007	GAMMAGARD LIQUID	Non-LDD	39.20%
944270008	GAMMAGARD LIQUID	Non-LDD	39.20%
944270009	GAMMAGARD LIQUID	Non-LDD	39.20%
944270010	GAMMAGARD LIQUID	Non-LDD	39.20%
944270011	GAMMAGARD LIQUID	Non-LDD	39.20%
944270012	GAMMAGARD LIQUID	Non-LDD	39.20%
944270013	GAMMAGARD LIQUID	Non-LDD	39.20%
944265603	GAMMAGARD S-D	Non-LDD	39.20%
944265707	GAMMAGARD S-D	Non-LDD	39.20%
944265804	GAMMAGARD S-D	Non-LDD	39.20%
944265908	GAMMAGARD S-D	Non-LDD	39.20%
76125090001	GAMMAKED	Non-LDD	39.20%
76125090002	GAMMAKED	Non-LDD	39.20%
76125090010	GAMMAKED	Non-LDD	39.20%
76125090011	GAMMAKED	Non-LDD	39.20%
76125090020	GAMMAKED	Non-LDD	39.20%
76125090021	GAMMAKED	Non-LDD	39.20%
76125090050	GAMMAKED	Non-LDD	39.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
76125090051	GAMMAKED	Non-LDD	39.20%
64208823402	GAMMAPLEX	Non-LDD	39.20%
64208823403	GAMMAPLEX	Non-LDD	39.20%
64208823404	GAMMAPLEX	Non-LDD	39.20%
64208823406	GAMMAPLEX	Non-LDD	39.20%
64208823407	GAMMAPLEX	Non-LDD	39.20%
64208823408	GAMMAPLEX	Non-LDD	39.20%
64208823501	GAMMAPLEX	Non-LDD	39.20%
64208823502	GAMMAPLEX	Non-LDD	39.20%
64208823503	GAMMAPLEX	Non-LDD	39.20%
64208823505	GAMMAPLEX	Non-LDD	39.20%
64208823506	GAMMAPLEX	Non-LDD	39.20%
64208823507	GAMMAPLEX	Non-LDD	39.20%
13533080012	GAMUNEX-C	Non-LDD	29.20%
13533080013	GAMUNEX-C	Non-LDD	29.20%
13533080015	GAMUNEX-C	Non-LDD	29.20%
13533080016	GAMUNEX-C	Non-LDD	29.20%
13533080020	GAMUNEX-C	Non-LDD	29.20%
13533080021	GAMUNEX-C	Non-LDD	29.20%
13533080024	GAMUNEX-C	Non-LDD	29.20%
13533080025	GAMUNEX-C	Non-LDD	29.20%
13533080040	GAMUNEX-C	Non-LDD	29.20%
13533080041	GAMUNEX-C	Non-LDD	29.20%
13533080071	GAMUNEX-C	Non-LDD	29.20%
13533080072	GAMUNEX-C	Non-LDD	29.20%
68875010101	GATTEX	LDD with Access	16.00%
68875010102	GATTEX	LDD with Access	16.00%
68875010201	GATTEX	LDD with Access	16.00%
68875010301	GATTEX	LDD with Access	16.00%
50242021060	GAVRETO	LDD with Access	15.50%
50242021090	GAVRETO	LDD with Access	15.50%
72064021060	GAVRETO	LDD with Access	15.50%
72064021090	GAVRETO	LDD with Access	15.50%
50242007001	GAZYVA	LDD with Access	17.48%
143939401	GEMCITABINE HCL	Non-LDD	43.50%
409018101	GEMCITABINE HCL	Non-LDD	43.50%
409018125	GEMCITABINE HCL	Non-LDD	43.50%
409018201	GEMCITABINE HCL	Non-LDD	43.50%
409018225	GEMCITABINE HCL	Non-LDD	43.50%
409018301	GEMCITABINE HCL	Non-LDD	43.50%
409018325	GEMCITABINE HCL	Non-LDD	43.50%
409018501	GEMCITABINE HCL	Non-LDD	43.50%
409018601	GEMCITABINE HCL	Non-LDD	43.50%
409018701	GEMCITABINE HCL	Non-LDD	43.50%
16714090901	GEMCITABINE HCL	Non-LDD	43.50%
16714093001	GEMCITABINE HCL	Non-LDD	43.50%
16729009203	GEMCITABINE HCL	Non-LDD	43.50%
16729011711	GEMCITABINE HCL	Non-LDD	43.50%
16729011838	GEMCITABINE HCL	Non-LDD	43.50%
16729039130	GEMCITABINE HCL	Non-LDD	43.50%
16729041903	GEMCITABINE HCL	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
16729042333	GEMCITABINE HCL	Non-LDD	43.50%
16729042605	GEMCITABINE HCL	Non-LDD	43.50%
23155021331	GEMCITABINE HCL	Non-LDD	43.50%
23155021431	GEMCITABINE HCL	Non-LDD	43.50%
23155048331	GEMCITABINE HCL	Non-LDD	43.50%
23155048431	GEMCITABINE HCL	Non-LDD	43.50%
23155052831	GEMCITABINE HCL	Non-LDD	43.50%
23155052931	GEMCITABINE HCL	Non-LDD	43.50%
25021023410	GEMCITABINE HCL	Non-LDD	43.50%
25021023550	GEMCITABINE HCL	Non-LDD	43.50%
25021023551	GEMCITABINE HCL	Non-LDD	43.50%
25021023905	GEMCITABINE HCL	Non-LDD	43.50%
25021023926	GEMCITABINE HCL	Non-LDD	43.50%
25021023952	GEMCITABINE HCL	Non-LDD	43.50%
45963061257	GEMCITABINE HCL	Non-LDD	43.50%
45963061959	GEMCITABINE HCL	Non-LDD	43.50%
45963062060	GEMCITABINE HCL	Non-LDD	43.50%
45963062357	GEMCITABINE HCL	Non-LDD	43.50%
45963062458	GEMCITABINE HCL	Non-LDD	43.50%
45963063660	GEMCITABINE HCL	Non-LDD	43.50%
47335015340	GEMCITABINE HCL	Non-LDD	43.50%
47335015440	GEMCITABINE HCL	Non-LDD	43.50%
55111068607	GEMCITABINE HCL	Non-LDD	43.50%
55111068725	GEMCITABINE HCL	Non-LDD	43.50%
60505611306	GEMCITABINE HCL	Non-LDD	43.50%
60505611400	GEMCITABINE HCL	Non-LDD	43.50%
60505611502	GEMCITABINE HCL	Non-LDD	43.50%
63323010213	GEMCITABINE HCL	Non-LDD	43.50%
63323010294	GEMCITABINE HCL	Non-LDD	43.50%
63323012553	GEMCITABINE HCL	Non-LDD	43.50%
63323012594	GEMCITABINE HCL	Non-LDD	43.50%
63323012600	GEMCITABINE HCL	Non-LDD	43.50%
63323012603	GEMCITABINE HCL	Non-LDD	43.50%
67457046201	GEMCITABINE HCL	Non-LDD	43.50%
67457046420	GEMCITABINE HCL	Non-LDD	43.50%
67457061610	GEMCITABINE HCL	Non-LDD	43.50%
67457061730	GEMCITABINE HCL	Non-LDD	43.50%
67457061810	GEMCITABINE HCL	Non-LDD	43.50%
68001028223	GEMCITABINE HCL	Non-LDD	43.50%
68001028226	GEMCITABINE HCL	Non-LDD	43.50%
68001034234	GEMCITABINE HCL	Non-LDD	43.50%
68001034836	GEMCITABINE HCL	Non-LDD	43.50%
68001035937	GEMCITABINE HCL	Non-LDD	43.50%
70860020550	GEMCITABINE HCL	Non-LDD	43.50%
71288011310	GEMCITABINE HCL	Non-LDD	43.50%
71288011450	GEMCITABINE HCL	Non-LDD	43.50%
71288011706	GEMCITABINE HCL	Non-LDD	43.50%
71288011728	GEMCITABINE HCL	Non-LDD	43.50%
71288011754	GEMCITABINE HCL	Non-LDD	43.50%
72485022102	GEMCITABINE HCL	Non-LDD	43.50%
72485022210	GEMCITABINE HCL	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
72485022320	GEMCITABINE HCL	Non-LDD	43.50%
13262681	GENOTROPIN	Non-LDD	22.00%
13264681	GENOTROPIN	Non-LDD	22.00%
13264901	GENOTROPIN	Non-LDD	22.00%
13264902	GENOTROPIN	Non-LDD	22.00%
13265002	GENOTROPIN	Non-LDD	22.00%
13265102	GENOTROPIN	Non-LDD	22.00%
13265202	GENOTROPIN	Non-LDD	22.00%
13265302	GENOTROPIN	Non-LDD	22.00%
13265402	GENOTROPIN	Non-LDD	22.00%
13265502	GENOTROPIN	Non-LDD	22.00%
13265602	GENOTROPIN	Non-LDD	22.00%
13265702	GENOTROPIN	Non-LDD	22.00%
13265802	GENOTROPIN	Non-LDD	22.00%
78060715	GILENYA	Non-LDD	22.00%
78060789	GILENYA	Non-LDD	22.00%
78096589	GILENYA	Non-LDD	22.00%
597013730	GILOTRIF	LDD with Access	15.50%
597013830	GILOTRIF	LDD with Access	15.50%
597014130	GILOTRIF	LDD with Access	15.50%
72089030715	GIMOTI	LDD with Access	17.00%
71336100101	GIVLAARI	LDD with Access	14.50%
944288401	GLASSIA	LDD with Access	19.50%
944288402	GLASSIA	LDD with Access	19.50%
378696032	GLATIRAMER ACETATE	Non-LDD	40.50%
378696093	GLATIRAMER ACETATE	Non-LDD	40.50%
378696112	GLATIRAMER ACETATE	Non-LDD	40.50%
378696132	GLATIRAMER ACETATE	Non-LDD	40.50%
781323434	GLATOPA	Non-LDD	26.50%
781323471	GLATOPA	Non-LDD	26.50%
781325071	GLATOPA	Non-LDD	26.50%
781325089	GLATOPA	Non-LDD	26.50%
63629881501	GLATOPA	Non-LDD	26.50%
63629881601	GLATOPA	Non-LDD	26.50%
78040134	GLEEVEC	Non-LDD	20.50%
78043815	GLEEVEC	Non-LDD	20.50%
78064930	GLEEVEC	Non-LDD	20.50%
58181304005	GLEOSTINE	Non-LDD	17.50%
58181304105	GLEOSTINE	Non-LDD	17.50%
58181304205	GLEOSTINE	Non-LDD	17.50%
24338005008	GLIADEL	Non-LDD	21.00%
70482008560	GOCOVRI	LDD with Access	13.20%
70482017060	GOCOVRI	LDD with Access	13.20%
63459091001	GRANIX	Non-LDD	19.50%
63459091011	GRANIX	Non-LDD	19.50%
63459091012	GRANIX	Non-LDD	19.50%
63459091015	GRANIX	Non-LDD	19.50%
63459091017	GRANIX	Non-LDD	19.50%
63459091018	GRANIX	Non-LDD	19.50%
63459091036	GRANIX	Non-LDD	19.50%
63459091201	GRANIX	Non-LDD	19.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
63459091211	GRANIX	Non-LDD	19.50%
63459091212	GRANIX	Non-LDD	19.50%
63459091215	GRANIX	Non-LDD	19.50%
63459091217	GRANIX	Non-LDD	19.50%
63459091218	GRANIX	Non-LDD	19.50%
63459091236	GRANIX	Non-LDD	19.50%
63459091853	GRANIX	Non-LDD	19.50%
63459091859	GRANIX	Non-LDD	19.50%
63459092053	GRANIX	Non-LDD	19.50%
63459092059	GRANIX	Non-LDD	19.50%
63833082802	HAEGARDA	LDD with Access	15.50%
63833082902	HAEGARDA	LDD with Access	15.50%
62856038901	HALAVEN	Non-LDD	21.00%
61958180101	HARVONI	Non-LDD	25.50%
61958180301	HARVONI	Non-LDD	25.50%
61958180401	HARVONI	Non-LDD	25.50%
61958180402	HARVONI	Non-LDD	25.50%
61958180501	HARVONI	Non-LDD	25.50%
61958180502	HARVONI	Non-LDD	25.50%
53813202	HELIXATE FS	Non-LDD	#N/A
50242092001	HEMLIBRA	LDD with Access	18.50%
50242092101	HEMLIBRA	LDD with Access	18.50%
50242092201	HEMLIBRA	LDD with Access	18.50%
50242092301	HEMLIBRA	LDD with Access	18.50%
944394002	HEMOFIL M	Non-LDD	39.20%
944394202	HEMOFIL M	Non-LDD	39.20%
944394402	HEMOFIL M	Non-LDD	39.20%
944394501	HEMOFIL M	Non-LDD	39.20%
944394602	HEMOFIL M	Non-LDD	39.20%
61958050101	HEPSERA	Non-LDD	18.50%
50242013201	HERCEPTIN	LDD with Access	17.48%
50242013210	HERCEPTIN	LDD with Access	17.48%
50242033301	HERCEPTIN	LDD with Access	17.48%
50242007701	HERCEPTIN HYLECTA	LDD with Access	13.50%
63459030343	HERZUMA	Non-LDD	27.50%
63459030547	HERZUMA	Non-LDD	27.50%
63459030741	HERZUMA	Non-LDD	27.50%
43068022001	HETLIOZ	LDD with Access	14.27%
43068030402	HETLIOZ LQ	LDD with Access	14.27%
43068030406	HETLIOZ LQ	LDD with Access	14.27%
44206045101	HIZENTRA	Non-LDD	49.20%
44206045190	HIZENTRA	Non-LDD	49.20%
44206045202	HIZENTRA	Non-LDD	49.20%
44206045291	HIZENTRA	Non-LDD	49.20%
44206045404	HIZENTRA	Non-LDD	49.20%
44206045492	HIZENTRA	Non-LDD	49.20%
44206045510	HIZENTRA	Non-LDD	49.20%
44206045593	HIZENTRA	Non-LDD	49.20%
44206045621	HIZENTRA	Non-LDD	49.20%
44206045694	HIZENTRA	Non-LDD	49.20%
44206045722	HIZENTRA	Non-LDD	49.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
44206045795	HIZENTRA	Non-LDD	49.20%
44206045824	HIZENTRA	Non-LDD	49.20%
44206045896	HIZENTRA	Non-LDD	49.20%
63833061502	HUMATE-P	Non-LDD	19.20%
63833061602	HUMATE-P	Non-LDD	19.20%
63833061702	HUMATE-P	Non-LDD	19.20%
63833062501	HUMATE-P	Non-LDD	19.20%
63833062601	HUMATE-P	Non-LDD	19.20%
63833062701	HUMATE-P	Non-LDD	19.20%
2733511	HUMATROPE	Non-LDD	21.00%
2734901	HUMATROPE	Non-LDD	21.00%
2814701	HUMATROPE	Non-LDD	21.00%
2814801	HUMATROPE	Non-LDD	21.00%
2814901	HUMATROPE	Non-LDD	21.00%
74379902	HUMIRA	Non-LDD	21.00%
74634702	HUMIRA	Non-LDD	21.00%
74937402	HUMIRA	Non-LDD	21.00%
74433901	HUMIRA PEN	Non-LDD	21.00%
74433902	HUMIRA PEN	Non-LDD	21.00%
74433974	HUMIRA PEN	Non-LDD	21.00%
74433906	HUMIRA PEN CROHN'S-UC-HS	Non-LDD	21.00%
74433907	HUMIRA PEN PSOR-UVEITS-AD	Non-LDD	21.00%
74024302	HUMIRA(CF)	Non-LDD	21.00%
74061602	HUMIRA(CF)	Non-LDD	21.00%
74081702	HUMIRA(CF)	Non-LDD	21.00%
74006702	HUMIRA(CF) PEDIATRIC CROHI	Non-LDD	21.00%
74254003	HUMIRA(CF) PEDIATRIC CROHI	Non-LDD	21.00%
74012402	HUMIRA(CF) PEN	Non-LDD	21.00%
74012474	HUMIRA(CF) PEN	Non-LDD	21.00%
74055402	HUMIRA(CF) PEN	Non-LDD	21.00%
74055471	HUMIRA(CF) PEN	Non-LDD	21.00%
74012403	HUMIRA(CF) PEN CROHN'S-UC	Non-LDD	21.00%
74012404	HUMIRA(CF) PEN PEDIATRIC U	Non-LDD	20.50%
74153903	HUMIRA(CF) PEN PSOR-UV-AD	Non-LDD	21.00%
78067201	HYCAMTIN	Non-LDD	18.50%
78067301	HYCAMTIN	Non-LDD	18.50%
78067461	HYCAMTIN	Non-LDD	18.50%
517176701	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
517179101	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
55150030901	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
55150031001	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
66993003883	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
66993003901	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
67457088605	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
67457096701	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
69238179701	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
71225010401	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
71225010501	HYDROXYPROGESTERONE CAP	Non-LDD	43.50%
944251002	HYQVIA	LDD with Access	34.20%
944251102	HYQVIA	LDD with Access	34.20%
944251202	HYQVIA	LDD with Access	34.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
944251302	HYQVIA	LDD with Access	34.20%
944251402	HYQVIA	LDD with Access	34.20%
944271525	HYQVIA IG COMPONENT	LDD with Access	18.50%
944271605	HYQVIA IG COMPONENT	LDD with Access	18.50%
944271710	HYQVIA IG COMPONENT	LDD with Access	18.50%
944271820	HYQVIA IG COMPONENT	LDD with Access	18.50%
944271930	HYQVIA IG COMPONENT	LDD with Access	18.50%
69018721	IBRANCE	LDD with Access	19.50%
69018821	IBRANCE	LDD with Access	19.50%
69018921	IBRANCE	LDD with Access	19.50%
69028403	IBRANCE	LDD with Access	19.50%
69028407	IBRANCE	LDD with Access	19.50%
69048603	IBRANCE	LDD with Access	19.50%
69048607	IBRANCE	LDD with Access	19.50%
69068803	IBRANCE	LDD with Access	19.50%
69068807	IBRANCE	LDD with Access	19.50%
93306619	ICATIBANT	Non-LDD	43.50%
93306634	ICATIBANT	Non-LDD	43.50%
93306693	ICATIBANT	Non-LDD	43.50%
24201020701	ICATIBANT	Non-LDD	43.50%
24201020703	ICATIBANT	Non-LDD	43.50%
54092013501	ICATIBANT	Non-LDD	43.50%
54092013502	ICATIBANT	Non-LDD	43.50%
60505621401	ICATIBANT	Non-LDD	43.50%
63323057401	ICATIBANT	Non-LDD	43.50%
63323057486	ICATIBANT	LDD with Access	43.50%
63323057493	ICATIBANT	LDD with Access	43.50%
69097066434	ICATIBANT	Non-LDD	43.50%
69097066468	ICATIBANT	Non-LDD	43.50%
71225011401	ICATIBANT	Non-LDD	43.50%
63020053330	ICLUSIG	LDD with Access	13.75%
63020053430	ICLUSIG	LDD with Access	13.75%
63020053530	ICLUSIG	LDD with Access	13.75%
63020053630	ICLUSIG	LDD with Access	13.75%
76189053430	ICLUSIG	LDD with Access	13.75%
76189053530	ICLUSIG	LDD with Access	13.75%
13257691	IDAMYCIN PFS	Non-LDD	54.20%
13258691	IDAMYCIN PFS	Non-LDD	54.20%
13259691	IDAMYCIN PFS	Non-LDD	54.20%
143921701	IDARUBICIN HCL	Non-LDD	43.50%
143921801	IDARUBICIN HCL	Non-LDD	43.50%
143921901	IDARUBICIN HCL	Non-LDD	43.50%
143930601	IDARUBICIN HCL	Non-LDD	43.50%
143930701	IDARUBICIN HCL	Non-LDD	43.50%
143930801	IDARUBICIN HCL	Non-LDD	43.50%
703415411	IDARUBICIN HCL	Non-LDD	43.50%
703415511	IDARUBICIN HCL	Non-LDD	43.50%
703415611	IDARUBICIN HCL	Non-LDD	43.50%
63323019405	IDARUBICIN HCL	Non-LDD	43.50%
63323019410	IDARUBICIN HCL	Non-LDD	43.50%
63323019420	IDARUBICIN HCL	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
69911086402	IDELVION	Non-LDD	18.50%
69911086502	IDELVION	Non-LDD	18.50%
69911086602	IDELVION	Non-LDD	18.50%
69911086702	IDELVION	Non-LDD	18.50%
69911086902	IDELVION	Non-LDD	18.50%
59572070530	IDHIFA	LDD with Access	14.50%
59572071030	IDHIFA	LDD with Access	14.50%
338399101	IFEX	Non-LDD	17.25%
338399301	IFEX	Non-LDD	17.25%
143953001	IFOSFAMIDE	Non-LDD	43.50%
143953101	IFOSFAMIDE	Non-LDD	43.50%
703342711	IFOSFAMIDE	Non-LDD	43.50%
703342911	IFOSFAMIDE	Non-LDD	43.50%
10019092501	IFOSFAMIDE	Non-LDD	43.50%
10019092582	IFOSFAMIDE	Non-LDD	43.50%
10019092602	IFOSFAMIDE	Non-LDD	43.50%
10019092616	IFOSFAMIDE	Non-LDD	43.50%
63323014210	IFOSFAMIDE	Non-LDD	43.50%
63323014212	IFOSFAMIDE	Non-LDD	43.50%
63323017420	IFOSFAMIDE	Non-LDD	43.50%
63323017460	IFOSFAMIDE	Non-LDD	43.50%
78073461	ILARIS	LDD with Access	21.00%
47335017701	ILUMYA	Non-LDD	21.00%
47335017710	ILUMYA	Non-LDD	21.00%
47335017795	ILUMYA	Non-LDD	21.00%
47335017796	ILUMYA	Non-LDD	21.00%
54024822	IMATINIB MESYLATE	Non-LDD	49.00%
54024913	IMATINIB MESYLATE	Non-LDD	49.00%
93762998	IMATINIB MESYLATE	Non-LDD	49.00%
93763056	IMATINIB MESYLATE	Non-LDD	49.00%
378224577	IMATINIB MESYLATE	Non-LDD	49.00%
378224693	IMATINIB MESYLATE	Non-LDD	49.00%
904662104	IMATINIB MESYLATE	Non-LDD	49.00%
904690104	IMATINIB MESYLATE	Non-LDD	49.00%
16714070401	IMATINIB MESYLATE	Non-LDD	49.00%
16714070501	IMATINIB MESYLATE	Non-LDD	49.00%
42292004301	IMATINIB MESYLATE	Non-LDD	49.00%
42292004303	IMATINIB MESYLATE	Non-LDD	49.00%
42292004401	IMATINIB MESYLATE	Non-LDD	49.00%
42292004403	IMATINIB MESYLATE	Non-LDD	49.00%
43598034431	IMATINIB MESYLATE	Non-LDD	49.00%
43598034479	IMATINIB MESYLATE	Non-LDD	49.00%
43598034490	IMATINIB MESYLATE	Non-LDD	49.00%
43598034530	IMATINIB MESYLATE	Non-LDD	49.00%
43598034531	IMATINIB MESYLATE	Non-LDD	49.00%
43598034579	IMATINIB MESYLATE	Non-LDD	49.00%
47335047281	IMATINIB MESYLATE	Non-LDD	49.00%
47335047583	IMATINIB MESYLATE	Non-LDD	49.00%
50268042611	IMATINIB MESYLATE	Non-LDD	49.00%
50268042612	IMATINIB MESYLATE	Non-LDD	49.00%
50268042711	IMATINIB MESYLATE	Non-LDD	49.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
50268042712	IMATINIB MESYLATE	Non-LDD	49.00%
51407026990	IMATINIB MESYLATE	Non-LDD	49.00%
51407027030	IMATINIB MESYLATE	Non-LDD	49.00%
51991037690	IMATINIB MESYLATE	Non-LDD	49.00%
51991037733	IMATINIB MESYLATE	Non-LDD	49.00%
59651024090	IMATINIB MESYLATE	Non-LDD	49.00%
59651024130	IMATINIB MESYLATE	Non-LDD	49.00%
59923072390	IMATINIB MESYLATE	Non-LDD	49.00%
59923072430	IMATINIB MESYLATE	Non-LDD	49.00%
60429092590	IMATINIB MESYLATE	Non-LDD	49.00%
60429092630	IMATINIB MESYLATE	Non-LDD	49.00%
60505290009	IMATINIB MESYLATE	Non-LDD	49.00%
60505290103	IMATINIB MESYLATE	Non-LDD	49.00%
60687019211	IMATINIB MESYLATE	Non-LDD	49.00%
60687019221	IMATINIB MESYLATE	Non-LDD	49.00%
60687020325	IMATINIB MESYLATE	Non-LDD	49.00%
60687020395	IMATINIB MESYLATE	Non-LDD	49.00%
63629206701	IMATINIB MESYLATE	Non-LDD	49.00%
63629206801	IMATINIB MESYLATE	Non-LDD	49.00%
67877063390	IMATINIB MESYLATE	Non-LDD	49.00%
67877063430	IMATINIB MESYLATE	Non-LDD	49.00%
68001049005	IMATINIB MESYLATE	Non-LDD	49.00%
68001049104	IMATINIB MESYLATE	Non-LDD	49.00%
68180039009	IMATINIB MESYLATE	Non-LDD	49.00%
68180039106	IMATINIB MESYLATE	Non-LDD	49.00%
72485020290	IMATINIB MESYLATE	Non-LDD	49.00%
72485020330	IMATINIB MESYLATE	Non-LDD	49.00%
72606055601	IMATINIB MESYLATE	Non-LDD	49.00%
72606055701	IMATINIB MESYLATE	Non-LDD	49.00%
72819018509	IMATINIB MESYLATE	Non-LDD	49.00%
72819018603	IMATINIB MESYLATE	Non-LDD	49.00%
57962000712	IMBRUVICA	Non-LDD	14.75%
57962001428	IMBRUVICA	LDD with Access	14.75%
57962007028	IMBRUVICA	LDD with Access	14.75%
57962014009	IMBRUVICA	LDD with Access	14.75%
57962014012	IMBRUVICA	LDD with Access	14.75%
57962028028	IMBRUVICA	LDD with Access	14.75%
57962042028	IMBRUVICA	LDD with Access	14.75%
57962056028	IMBRUVICA	LDD with Access	14.75%
72829001001	IMCIVREE	LDD with Access	14.00%
61755002500	IMDEVIMAB (REGN10987) (EU/	Non-LDD	47.50%
61755002501	IMDEVIMAB (REGN10987) (EU/	Non-LDD	47.50%
61755002700	IMDEVIMAB (REGN10987) (EU/	Non-LDD	47.50%
61755002701	IMDEVIMAB (REGN10987) (EU/	Non-LDD	47.50%
310450012	IMFINZI	LDD with Access	21.00%
310461150	IMFINZI	LDD with Access	21.00%
310450525	IMJUDO	LDD with Access	15.50%
310453530	IMJUDO	LDD with Access	15.50%
55513007801	IMLYGIC	Non-LDD	17.10%
55513007901	IMLYGIC	Non-LDD	17.10%
10144034201	INBRIJA	LDD with Access	11.40%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
10144034260	INBRIJA	LDD with Access	11.40%
15054104005	INCRELEX	LDD with Access	19.25%
69080901	INFLECTRA	Non-LDD	21.00%
57894016001	INFLIXIMAB	Non-LDD	23.50%
62756000860	INFUGEM	Non-LDD	21.00%
62756007360	INFUGEM	Non-LDD	21.00%
62756010260	INFUGEM	Non-LDD	21.00%
62756021960	INFUGEM	Non-LDD	21.00%
62756032160	INFUGEM	Non-LDD	21.00%
62756043860	INFUGEM	Non-LDD	21.00%
62756053360	INFUGEM	Non-LDD	21.00%
62756061460	INFUGEM	Non-LDD	21.00%
62756074660	INFUGEM	Non-LDD	21.00%
62756097460	INFUGEM	Non-LDD	21.00%
70370104001	INGREZZA	LDD with Access	15.50%
70370106001	INGREZZA	LDD with Access	15.50%
70370108001	INGREZZA	LDD with Access	15.50%
70370204001	INGREZZA	LDD with Access	15.50%
70370204806	INGREZZA INITIATION PACK	LDD with Access	15.50%
517060201	INJECTAFER	Non-LDD	20.50%
517062001	INJECTAFER	Non-LDD	20.50%
517065001	INJECTAFER	Non-LDD	20.50%
69014501	INLYTA	LDD with Access	18.50%
69015111	INLYTA	LDD with Access	18.50%
64842072709	INQOVI	LDD with Access	15.50%
59572072012	INREBIC	LDD with Access	21.00%
85113301	INTRON A	LDD with Access	19.50%
85116801	INTRON A	LDD with Access	19.50%
85435001	INTRON A	LDD with Access	19.50%
85435101	INTRON A	LDD with Access	19.50%
85435201	INTRON A	LDD with Access	19.50%
310048230	IRESSA	LDD with Access	17.50%
143958301	IRINOTECAN HCL	Non-LDD	39.20%
143970101	IRINOTECAN HCL	Non-LDD	39.20%
143970201	IRINOTECAN HCL	Non-LDD	39.20%
16714002701	IRINOTECAN HCL	Non-LDD	39.20%
16714013101	IRINOTECAN HCL	Non-LDD	39.20%
16714072501	IRINOTECAN HCL	Non-LDD	39.20%
16714072601	IRINOTECAN HCL	Non-LDD	39.20%
23155017931	IRINOTECAN HCL	Non-LDD	39.20%
23155017932	IRINOTECAN HCL	Non-LDD	39.20%
25021023002	IRINOTECAN HCL	Non-LDD	39.20%
25021023005	IRINOTECAN HCL	Non-LDD	39.20%
45963061451	IRINOTECAN HCL	Non-LDD	39.20%
45963061455	IRINOTECAN HCL	Non-LDD	39.20%
45963061481	IRINOTECAN HCL	Non-LDD	39.20%
45963061485	IRINOTECAN HCL	Non-LDD	39.20%
50742040102	IRINOTECAN HCL	Non-LDD	39.20%
50742040205	IRINOTECAN HCL	Non-LDD	39.20%
55150035201	IRINOTECAN HCL	Non-LDD	39.20%
55150035301	IRINOTECAN HCL	Non-LDD	39.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
55150035401	IRINOTECAN HCL	Non-LDD	39.20%
59923071402	IRINOTECAN HCL	Non-LDD	39.20%
59923071505	IRINOTECAN HCL	Non-LDD	39.20%
59923071615	IRINOTECAN HCL	Non-LDD	39.20%
60505612800	IRINOTECAN HCL	Non-LDD	39.20%
60505612801	IRINOTECAN HCL	Non-LDD	39.20%
60505627201	IRINOTECAN HCL	Non-LDD	39.20%
61703034909	IRINOTECAN HCL	Non-LDD	39.20%
61703034916	IRINOTECAN HCL	Non-LDD	39.20%
61703034936	IRINOTECAN HCL	Non-LDD	39.20%
63323019302	IRINOTECAN HCL	Non-LDD	39.20%
63323019305	IRINOTECAN HCL	Non-LDD	39.20%
63323019352	IRINOTECAN HCL	Non-LDD	39.20%
63323019355	IRINOTECAN HCL	Non-LDD	39.20%
68001028422	IRINOTECAN HCL	Non-LDD	39.20%
68001028425	IRINOTECAN HCL	Non-LDD	39.20%
68001028434	IRINOTECAN HCL	Non-LDD	39.20%
68001028435	IRINOTECAN HCL	Non-LDD	39.20%
68001048022	IRINOTECAN HCL	Non-LDD	39.20%
68001048035	IRINOTECAN HCL	Non-LDD	39.20%
70700016922	IRINOTECAN HCL	Non-LDD	39.20%
70700017022	IRINOTECAN HCL	Non-LDD	39.20%
72485021102	IRINOTECAN HCL	Non-LDD	39.20%
72485021205	IRINOTECAN HCL	Non-LDD	39.20%
72485021315	IRINOTECAN HCL	Non-LDD	39.20%
59572096210	ISTODAX	Non-LDD	17.48%
59572098401	ISTODAX	Non-LDD	17.48%
55292032020	ISTURISA	LDD with Access	10.50%
55292032060	ISTURISA	LDD with Access	10.50%
55292032120	ISTURISA	LDD with Access	10.50%
55292032160	ISTURISA	LDD with Access	10.50%
55292032220	ISTURISA	LDD with Access	10.50%
55292032260	ISTURISA	LDD with Access	10.50%
70020191001	IXEMPRA	Non-LDD	17.25%
70020191002	IXEMPRA	Non-LDD	17.25%
70020191101	IXEMPRA	Non-LDD	17.25%
70020191102	IXEMPRA	Non-LDD	17.25%
59137027001	IXINITY	Non-LDD	16.50%
59137027101	IXINITY	Non-LDD	16.50%
59137027201	IXINITY	Non-LDD	16.50%
59137027501	IXINITY	Non-LDD	16.50%
59137027601	IXINITY	Non-LDD	16.50%
59137027701	IXINITY	Non-LDD	16.50%
59137028205	IXINITY	Non-LDD	16.50%
59137028305	IXINITY	Non-LDD	16.50%
59137028405	IXINITY	Non-LDD	16.50%
59137028705	IXINITY	Non-LDD	16.50%
59137028805	IXINITY	Non-LDD	16.50%
59137028905	IXINITY	Non-LDD	16.50%
70504027001	IXINITY	Non-LDD	16.50%
70504027101	IXINITY	Non-LDD	16.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
70504027201	IXINITY	Non-LDD	16.50%
70504027501	IXINITY	Non-LDD	16.50%
70504027601	IXINITY	Non-LDD	16.50%
70504027701	IXINITY	Non-LDD	16.50%
70504028205	IXINITY	Non-LDD	16.50%
70504028305	IXINITY	Non-LDD	16.50%
70504028405	IXINITY	Non-LDD	16.50%
70504028705	IXINITY	Non-LDD	16.50%
70504028805	IXINITY	Non-LDD	16.50%
70504028905	IXINITY	Non-LDD	16.50%
78065415	JADENU	Non-LDD	17.50%
78065515	JADENU	Non-LDD	17.50%
78065615	JADENU	Non-LDD	17.50%
78071315	JADENU SPRINKLE	Non-LDD	17.50%
78071319	JADENU SPRINKLE	Non-LDD	17.50%
78072015	JADENU SPRINKLE	Non-LDD	17.50%
78072019	JADENU SPRINKLE	Non-LDD	17.50%
78072715	JADENU SPRINKLE	Non-LDD	17.50%
78072719	JADENU SPRINKLE	Non-LDD	17.50%
50881000560	JAKAFI	LDD with Access	18.50%
50881001060	JAKAFI	LDD with Access	18.50%
50881001560	JAKAFI	LDD with Access	18.50%
50881002060	JAKAFI	LDD with Access	18.50%
50881002560	JAKAFI	LDD with Access	18.50%
2690230	JAYPIRCA	LDD with Access	15.50%
2702660	JAYPIRCA	LDD with Access	15.50%
173089803	JEMPERLI	Non-LDD	14.00%
24582315	JEVTANA	Non-LDD	17.48%
24582411	JEVTANA	Non-LDD	17.48%
26394225	JIVI	Non-LDD	18.40%
26394425	JIVI	Non-LDD	18.40%
26394625	JIVI	Non-LDD	18.40%
26394825	JIVI	Non-LDD	18.40%
26494201	JIVI	Non-LDD	18.40%
26494401	JIVI	Non-LDD	18.40%
26494601	JIVI	Non-LDD	18.40%
26494801	JIVI	Non-LDD	18.40%
71274017060	JOENJA	LDD with Access	13.00%
76431010501	JUXTAPID	LDD with Access	8.50%
76431011001	JUXTAPID	LDD with Access	8.50%
76431012001	JUXTAPID	LDD with Access	8.50%
76431013001	JUXTAPID	LDD with Access	8.50%
76431014001	JUXTAPID	LDD with Access	8.50%
76431016001	JUXTAPID	LDD with Access	8.50%
59148007907	JYNARQUE	LDD with Access	16.05%
59148007928	JYNARQUE	LDD with Access	16.05%
59148008007	JYNARQUE	LDD with Access	16.05%
59148008028	JYNARQUE	LDD with Access	16.05%
59148008213	JYNARQUE	LDD with Access	16.05%
59148008313	JYNARQUE	LDD with Access	16.05%
59148008707	JYNARQUE	LDD with Access	16.05%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
59148008728	JYNARQUE	LDD with Access	16.05%
59148008807	JYNARQUE	LDD with Access	16.05%
59148008828	JYNARQUE	LDD with Access	16.05%
59148008907	JYNARQUE	LDD with Access	16.05%
59148008928	JYNARQUE	LDD with Access	16.05%
50242008701	KADCYLA	LDD with Access	17.48%
50242008801	KADCYLA	LDD with Access	17.48%
47783010101	KALBITOR	LDD with Access	16.00%
51167020001	KALYDECO	LDD with Access	15.75%
51167030001	KALYDECO	LDD with Access	15.75%
51167040001	KALYDECO	LDD with Access	15.75%
51167060001	KALYDECO	LDD with Access	15.75%
51167077001	KALYDECO	LDD with Access	15.75%
51167078501	KALYDECO	LDD with Access	15.75%
55513013201	KANJINTI	Non-LDD	16.25%
55513014101	KANJINTI	Non-LDD	16.25%
55513016401	KANJINTI	Non-LDD	16.25%
25682000701	KANUMA	LDD with Access	17.00%
63833038602	KCENTRA	Non-LDD	28.50%
63833038702	KCENTRA	Non-LDD	28.50%
63833039601	KCENTRA	Non-LDD	28.50%
63833039701	KCENTRA	Non-LDD	28.50%
66658011201	KEPIVANCE	Non-LDD	21.00%
66658011203	KEPIVANCE	Non-LDD	21.00%
66658011206	KEPIVANCE	Non-LDD	21.00%
78100768	KESIMPTA PEN	Non-LDD	19.50%
71090000101	KEVEYIS	LDD with Access	14.00%
72065000101	KEVEYIS	LDD with Access	14.00%
24590801	KEVZARA	Non-LDD	17.50%
24591001	KEVZARA	Non-LDD	17.50%
24592001	KEVZARA	Non-LDD	17.50%
24592201	KEVZARA	Non-LDD	17.50%
6302601	KEYTRUDA	Non-LDD	17.48%
6302602	KEYTRUDA	Non-LDD	17.48%
6302604	KEYTRUDA	Non-LDD	17.48%
68152011201	KHAPZORY	Non-LDD	13.50%
68152011401	KHAPZORY	Non-LDD	13.50%
72893000401	KHAPZORY	Non-LDD	13.50%
72893000601	KHAPZORY	Non-LDD	13.50%
66658023401	KINERET	LDD with Access	13.40%
66658023407	KINERET	LDD with Access	13.40%
78086001	KISQALI	Non-LDD	18.50%
78086714	KISQALI	Non-LDD	18.50%
78086742	KISQALI	Non-LDD	18.50%
78087421	KISQALI	Non-LDD	18.50%
78087463	KISQALI	Non-LDD	18.50%
78088821	KISQALI	Non-LDD	18.50%
78089514	KISQALI	Non-LDD	18.50%
78090221	KISQALI	Non-LDD	18.50%
78090961	KISQALI FEMARA CO-PACK	Non-LDD	18.50%
78091661	KISQALI FEMARA CO-PACK	Non-LDD	18.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
78092361	KISQALI FEMARA CO-PACK	Non-LDD	18.50%
24492085056	KITABIS PAK	LDD with Access	17.50%
76125025221	KOATE	Non-LDD	44.20%
76125025620	KOATE	Non-LDD	44.20%
76125025725	KOATE	Non-LDD	44.20%
76125025902	KOATE	Non-LDD	44.20%
76125066350	KOATE	Non-LDD	44.20%
76125066502	KOATE	Non-LDD	44.20%
76125066830	KOATE	Non-LDD	44.20%
76125066931	KOATE	Non-LDD	44.20%
76125067351	KOATE	Non-LDD	44.20%
76125067650	KOATE	Non-LDD	44.20%
76125067810	KOATE	Non-LDD	44.20%
76125067912	KOATE	Non-LDD	44.20%
26378225	KOGENATE FS	Non-LDD	44.20%
26378335	KOGENATE FS	Non-LDD	44.20%
26378555	KOGENATE FS	Non-LDD	44.20%
26378665	KOGENATE FS	Non-LDD	44.20%
26378775	KOGENATE FS	Non-LDD	44.20%
26478201	KOGENATE FS	Non-LDD	44.20%
26478301	KOGENATE FS	Non-LDD	44.20%
26478501	KOGENATE FS	Non-LDD	44.20%
26478601	KOGENATE FS	Non-LDD	44.20%
26478701	KOGENATE FS	Non-LDD	44.20%
76346007301	KORLYM	LDD with Access	8.50%
76346007302	KORLYM	LDD with Access	8.50%
310061028	KOSELUGO	Non-LDD	21.00%
310061060	KOSELUGO	LDD with Access	21.00%
310062528	KOSELUGO	Non-LDD	21.00%
310062560	KOSELUGO	LDD with Access	21.00%
26382125	KOVALTRY	Non-LDD	43.50%
26382225	KOVALTRY	Non-LDD	43.50%
26382425	KOVALTRY	Non-LDD	43.50%
26382650	KOVALTRY	Non-LDD	43.50%
26382850	KOVALTRY	Non-LDD	43.50%
26482101	KOVALTRY	Non-LDD	43.50%
26482201	KOVALTRY	Non-LDD	43.50%
26482401	KOVALTRY	Non-LDD	43.50%
26482601	KOVALTRY	Non-LDD	43.50%
26482801	KOVALTRY	Non-LDD	43.50%
80739081218	KRAZATI	LDD with Access	15.00%
75987008010	KRYSTEXXA	Non-LDD	21.00%
68135030002	KUVAN	LDD with Access	15.50%
68135030111	KUVAN	LDD with Access	15.50%
68135030122	KUVAN	LDD with Access	15.50%
68135048210	KUVAN	LDD with Access	15.50%
68135048211	KUVAN	LDD with Access	15.50%
78084619	KYMRIAH	LDD with Access	13.50%
78095819	KYMRIAH	LDD with Access	13.50%
63402001001	KYNMOBI	LDD with Access	21.00%
63402001030	KYNMOBI	LDD with Access	21.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
63402001501	KYNMOBI	LDD with Access	21.00%
63402001530	KYNMOBI	LDD with Access	21.00%
63402002001	KYNMOBI	LDD with Access	21.00%
63402002030	KYNMOBI	LDD with Access	21.00%
63402002501	KYNMOBI	LDD with Access	21.00%
63402002530	KYNMOBI	LDD with Access	21.00%
63402003001	KYNMOBI	LDD with Access	21.00%
63402003030	KYNMOBI	LDD with Access	21.00%
63402008810	KYNMOBI	LDD with Access	21.00%
76075010101	KYPROLIS	LDD with Access	17.48%
76075010201	KYPROLIS	LDD with Access	17.48%
76075010301	KYPROLIS	LDD with Access	17.48%
69097087067	LANREOTIDE ACETATE	Non-LDD	26.50%
76282071167	LANREOTIDE ACETATE	Non-LDD	26.50%
68180080136	LAPATINIB	Non-LDD	23.50%
72626260101	LEDIPASVIR-SOFOSBUVIR	Non-LDD	25.50%
58468020001	LEMTRADA	LDD with Access	17.25%
378193501	LENALIDOMIDE	LDD with Access	18.50%
378193528	LENALIDOMIDE	LDD with Access	18.50%
378193601	LENALIDOMIDE	LDD with Access	18.50%
378193628	LENALIDOMIDE	LDD with Access	18.50%
378193701	LENALIDOMIDE	LDD with Access	18.50%
378193728	LENALIDOMIDE	LDD with Access	18.50%
378194001	LENALIDOMIDE	LDD with Access	18.50%
378194021	LENALIDOMIDE	LDD with Access	18.50%
378194101	LENALIDOMIDE	LDD with Access	18.50%
378194121	LENALIDOMIDE	LDD with Access	18.50%
378194201	LENALIDOMIDE	LDD with Access	18.50%
378194221	LENALIDOMIDE	LDD with Access	18.50%
480124128	LENALIDOMIDE	LDD with Access	18.50%
480124228	LENALIDOMIDE	LDD with Access	18.50%
480124328	LENALIDOMIDE	LDD with Access	18.50%
480124421	LENALIDOMIDE	LDD with Access	18.50%
480124521	LENALIDOMIDE	LDD with Access	18.50%
480124621	LENALIDOMIDE	LDD with Access	18.50%
31722025728	LENALIDOMIDE	LDD with Access	18.50%
31722025828	LENALIDOMIDE	LDD with Access	18.50%
31722025928	LENALIDOMIDE	LDD with Access	18.50%
31722026021	LENALIDOMIDE	LDD with Access	18.50%
31722026121	LENALIDOMIDE	LDD with Access	18.50%
31722026221	LENALIDOMIDE	LDD with Access	18.50%
43598051163	LENALIDOMIDE	LDD with Access	18.50%
43598051263	LENALIDOMIDE	LDD with Access	18.50%
43598051321	LENALIDOMIDE	LDD with Access	18.50%
43598051421	LENALIDOMIDE	LDD with Access	18.50%
43598051521	LENALIDOMIDE	LDD with Access	18.50%
43598051663	LENALIDOMIDE	LDD with Access	18.50%
47781048328	LENALIDOMIDE	LDD with Access	18.50%
47781048401	LENALIDOMIDE	LDD with Access	18.50%
47781048428	LENALIDOMIDE	LDD with Access	18.50%
47781048501	LENALIDOMIDE	LDD with Access	18.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
47781048528	LENALIDOMIDE	LDD with Access	18.50%
47781048601	LENALIDOMIDE	LDD with Access	18.50%
47781048677	LENALIDOMIDE	LDD with Access	18.50%
47781048777	LENALIDOMIDE	LDD with Access	18.50%
47781048801	LENALIDOMIDE	LDD with Access	18.50%
47781048877	LENALIDOMIDE	LDD with Access	18.50%
59651034228	LENALIDOMIDE	LDD with Access	18.50%
59651034328	LENALIDOMIDE	LDD with Access	18.50%
59651034428	LENALIDOMIDE	LDD with Access	18.50%
60505453202	LENALIDOMIDE	LDD with Access	18.50%
60505453302	LENALIDOMIDE	LDD with Access	18.50%
60505453402	LENALIDOMIDE	LDD with Access	18.50%
60505453502	LENALIDOMIDE	LDD with Access	18.50%
60505453602	LENALIDOMIDE	LDD with Access	18.50%
60505453702	LENALIDOMIDE	LDD with Access	18.50%
63304004127	LENALIDOMIDE	LDD with Access	18.50%
63304004227	LENALIDOMIDE	LDD with Access	18.50%
63304004327	LENALIDOMIDE	LDD with Access	18.50%
63304004422	LENALIDOMIDE	LDD with Access	18.50%
63304004522	LENALIDOMIDE	LDD with Access	18.50%
63304004622	LENALIDOMIDE	LDD with Access	18.50%
69097038173	LENALIDOMIDE	LDD with Access	18.50%
69097038273	LENALIDOMIDE	LDD with Access	18.50%
69097038381	LENALIDOMIDE	LDD with Access	18.50%
69097038481	LENALIDOMIDE	LDD with Access	18.50%
69097038581	LENALIDOMIDE	LDD with Access	18.50%
69097060473	LENALIDOMIDE	LDD with Access	18.50%
70710103007	LENALIDOMIDE	LDD with Access	18.50%
70710103107	LENALIDOMIDE	LDD with Access	18.50%
70710103207	LENALIDOMIDE	LDD with Access	18.50%
70710103308	LENALIDOMIDE	LDD with Access	18.50%
70710103408	LENALIDOMIDE	LDD with Access	18.50%
70710103508	LENALIDOMIDE	LDD with Access	18.50%
62856070405	LENVIMA	LDD with Access	18.00%
62856070430	LENVIMA	LDD with Access	18.00%
62856070805	LENVIMA	LDD with Access	18.00%
62856070830	LENVIMA	LDD with Access	18.00%
62856071005	LENVIMA	LDD with Access	18.00%
62856071030	LENVIMA	LDD with Access	18.00%
62856071205	LENVIMA	LDD with Access	18.00%
62856071230	LENVIMA	LDD with Access	18.00%
62856071405	LENVIMA	LDD with Access	18.00%
62856071430	LENVIMA	LDD with Access	18.00%
62856071805	LENVIMA	LDD with Access	18.00%
62856071830	LENVIMA	LDD with Access	18.00%
62856072005	LENVIMA	LDD with Access	18.00%
62856072030	LENVIMA	LDD with Access	18.00%
62856072405	LENVIMA	LDD with Access	18.00%
62856072430	LENVIMA	LDD with Access	18.00%
61958080101	LETAIRIS	LDD with Access	15.25%
61958080105	LETAIRIS	LDD with Access	15.25%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
61958080201	LETAIRIS	LDD with Access	15.25%
61958080205	LETAIRIS	LDD with Access	15.25%
69784061025	LEUKERAN	Non-LDD	18.00%
76388063525	LEUKERAN	Non-LDD	18.00%
80725061025	LEUKERAN	Non-LDD	18.00%
24584301	LEUKINE	Non-LDD	19.50%
24584305	LEUKINE	Non-LDD	19.50%
71837584301	LEUKINE	Non-LDD	19.50%
71837584305	LEUKINE	Non-LDD	19.50%
781300642	LEUPROLIDE ACETATE	Non-LDD	78.50%
781400332	LEUPROLIDE ACETATE	Non-LDD	78.50%
16714054001	LEUPROLIDE ACETATE	Non-LDD	78.50%
16714057201	LEUPROLIDE ACETATE	Non-LDD	78.50%
47335093640	LEUPROLIDE ACETATE	Non-LDD	78.50%
55150033801	LEUPROLIDE ACETATE	Non-LDD	78.50%
55150047801	LEUPROLIDE ACETATE	Non-LDD	78.50%
63629882101	LEUPROLIDE ACETATE	Non-LDD	78.50%
70121169502	LEUPROLIDE ACETATE	Non-LDD	78.50%
70121253706	LEUPROLIDE ACETATE	Non-LDD	78.50%
72664061128	LEUPROLIDE ACETATE	Non-LDD	78.50%
143955801	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
781320194	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
16714089001	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
16714091501	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
43598077111	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
43598077311	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
45963076257	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
50742049417	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
50742049525	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
70121109901	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
70121157201	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
71288010410	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
71288010518	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
72266012001	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
72266012101	LEVOLEUCOVORIN CALCIUM	Non-LDD	22.50%
61755000801	LIBTAYO	LDD with Access	13.50%
47335008250	LIPODOX	Non-LDD	30.40%
47335008350	LIPODOX 50	Non-LDD	30.40%
64842102001	LONSURF	LDD with Access	18.50%
64842102002	LONSURF	LDD with Access	18.50%
64842102003	LONSURF	LDD with Access	18.50%
64842102501	LONSURF	LDD with Access	18.50%
64842102502	LONSURF	LDD with Access	18.50%
64842102503	LONSURF	LDD with Access	18.50%
69022701	LORBRENA	LDD with Access	18.00%
69023101	LORBRENA	LDD with Access	18.00%
50242008002	LUCENTIS	LDD with Access	17.48%
50242008003	LUCENTIS	LDD with Access	17.48%
50242008086	LUCENTIS	LDD with Access	17.48%
50242008088	LUCENTIS	LDD with Access	17.48%
50242008202	LUCENTIS	LDD with Access	17.48%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
50242008203	LUCENTIS	LDD with Access	17.48%
50242008287	LUCENTIS	LDD with Access	17.48%
50242008288	LUCENTIS	LDD with Access	17.48%
55513048824	LUMAKRAS	LDD with Access	13.50%
55513048840	LUMAKRAS	LDD with Access	13.50%
55513050450	LUMAKRAS	LDD with Access	13.50%
58468016001	LUMIZYME	Non-LDD	20.50%
58468016002	LUMIZYME	Non-LDD	20.50%
310470001	LUMOXITI	LDD with Access	21.00%
73380470001	LUMOXITI	LDD with Access	21.00%
50242014201	LUNSUMIO	LDD with Access	13.50%
50242015901	LUNSUMIO	LDD with Access	13.50%
74105205	LUPANETA PACK	Non-LDD	20.50%
74105210	LUPANETA PACK	Non-LDD	20.50%
74105305	LUPANETA PACK	Non-LDD	20.50%
75626000101	LUPKYNIS	LDD with Access	14.75%
75626000102	LUPKYNIS	LDD with Access	14.75%
74334603	LUPRON DEPOT	Non-LDD	20.50%
74347303	LUPRON DEPOT	Non-LDD	20.50%
74364103	LUPRON DEPOT	Non-LDD	20.50%
74364203	LUPRON DEPOT	Non-LDD	20.50%
74366303	LUPRON DEPOT	Non-LDD	20.50%
74368303	LUPRON DEPOT	Non-LDD	20.50%
74364104	LUPRON DEPOT (LUPANETA)	Non-LDD	20.50%
74364107	LUPRON DEPOT (LUPANETA)	Non-LDD	20.50%
74366304	LUPRON DEPOT (LUPANETA)	Non-LDD	20.50%
74210803	LUPRON DEPOT-PED	Non-LDD	20.50%
74228203	LUPRON DEPOT-PED	Non-LDD	20.50%
74244003	LUPRON DEPOT-PED	Non-LDD	20.50%
74357501	LUPRON DEPOT-PED	Non-LDD	20.50%
74377903	LUPRON DEPOT-PED	Non-LDD	20.50%
74969403	LUPRON DEPOT-PED	Non-LDD	20.50%
69488000301	LUTATHERA	LDD with Access	14.50%
69488000370	LUTATHERA	LDD with Access	14.50%
71394006501	LUXTURNA	LDD with Access	13.00%
71394041501	LUXTURNA	LDD with Access	13.00%
310066812	LYNPARZA	LDD with Access	17.50%
310066860	LYNPARZA	LDD with Access	17.50%
310067912	LYNPARZA	LDD with Access	17.50%
310067960	LYNPARZA	LDD with Access	17.50%
15308060	LYSODREN	LDD with Access	11.00%
76336008060	LYSODREN	LDD with Access	11.00%
169140101	MACRILEN	Non-LDD	21.00%
71090000202	MACRILEN	LDD with Access	21.00%
68782000102	MACUGEN	LDD with Access	21.00%
64011024301	MAKENA	Non-LDD	18.50%
64011024702	MAKENA	Non-LDD	18.50%
64011030103	MAKENA	Non-LDD	18.50%
74527002201	MARGENZA	Non-LDD	13.00%
74527002202	MARGENZA	Non-LDD	13.00%
74527002203	MARGENZA	Non-LDD	13.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
54482005401	MATULANE	LDD with Access	12.65%
44087400000	MAVENCLAD	LDD with Access	13.50%
44087400004	MAVENCLAD	LDD with Access	13.50%
44087400005	MAVENCLAD	LDD with Access	13.50%
44087400006	MAVENCLAD	LDD with Access	13.50%
44087400007	MAVENCLAD	LDD with Access	13.50%
44087400008	MAVENCLAD	LDD with Access	13.50%
44087400009	MAVENCLAD	LDD with Access	13.50%
74260028	MAVYRET	Non-LDD	25.50%
74262501	MAVYRET	Non-LDD	25.50%
74262528	MAVYRET	Non-LDD	25.50%
74262580	MAVYRET	Non-LDD	25.50%
74262584	MAVYRET	Non-LDD	25.50%
78097912	MAYZENT	LDD with Access	21.00%
78097950	MAYZENT	LDD with Access	21.00%
78097989	MAYZENT	LDD with Access	21.00%
78098615	MAYZENT	LDD with Access	21.00%
78098645	MAYZENT	LDD with Access	21.00%
78101415	MAYZENT	LDD with Access	21.00%
78066615	MEKINIST	Non-LDD	18.50%
78066815	MEKINIST	Non-LDD	18.50%
78110515	MEKINIST	Non-LDD	18.50%
78111215	MEKINIST	Non-LDD	18.50%
78116147	MEKINIST	Non-LDD	18.50%
70255001002	MEKTOVI	LDD with Access	18.00%
25021021015	MELPHALAN HCL	Non-LDD	43.50%
25021022160	MELPHALAN HCL	Non-LDD	43.50%
42023014901	MELPHALAN HCL	Non-LDD	43.50%
43598002748	MELPHALAN HCL	Non-LDD	43.50%
43598002950	MELPHALAN HCL	Non-LDD	43.50%
43598039150	MELPHALAN HCL	Non-LDD	43.50%
43598039248	MELPHALAN HCL	Non-LDD	43.50%
45963068602	MELPHALAN HCL	Non-LDD	43.50%
45963068749	MELPHALAN HCL	Non-LDD	43.50%
54288010601	MELPHALAN HCL	Non-LDD	43.50%
54288010902	MELPHALAN HCL	Non-LDD	43.50%
63323076020	MELPHALAN HCL	Non-LDD	43.50%
63323076120	MELPHALAN HCL	Non-LDD	43.50%
67457019350	MELPHALAN HCL	Non-LDD	43.50%
67457019501	MELPHALAN HCL	Non-LDD	43.50%
67457021501	MELPHALAN HCL	Non-LDD	43.50%
67457057750	MELPHALAN HCL	Non-LDD	43.50%
67457057901	MELPHALAN HCL	Non-LDD	43.50%
70700027722	MELPHALAN HCL	Non-LDD	43.50%
70700027897	MELPHALAN HCL	Non-LDD	43.50%
70860021210	MELPHALAN HCL	Non-LDD	43.50%
70860021461	MELPHALAN HCL	Non-LDD	43.50%
71288011110	MELPHALAN HCL	Non-LDD	43.50%
71288011290	MELPHALAN HCL	Non-LDD	43.50%
71288013015	MELPHALAN HCL	Non-LDD	43.50%
71288013290	MELPHALAN HCL	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
72266012801	MELPHALAN HCL	Non-LDD	43.50%
72266014401	MELPHALAN HCL	Non-LDD	43.50%
69794000101	MEPSEVII	LDD with Access	8.50%
10148020115	MIGLUSTAT	LDD with Access	43.50%
10148020190	MIGLUSTAT	LDD with Access	43.50%
42799070815	MIGLUSTAT	LDD with Access	43.50%
43975031008	MIGLUSTAT	LDD with Access	43.50%
43975031083	MIGLUSTAT	LDD with Access	43.50%
143913501	MITOMYCIN	Non-LDD	68.50%
143913601	MITOMYCIN	Non-LDD	68.50%
143927901	MITOMYCIN	Non-LDD	68.50%
143928001	MITOMYCIN	Non-LDD	68.50%
16729010811	MITOMYCIN	Non-LDD	68.50%
16729011505	MITOMYCIN	Non-LDD	68.50%
16729011638	MITOMYCIN	Non-LDD	68.50%
16729024605	MITOMYCIN	Non-LDD	68.50%
16729024711	MITOMYCIN	Non-LDD	68.50%
16729024838	MITOMYCIN	Non-LDD	68.50%
25021025020	MITOMYCIN	Non-LDD	68.50%
25021025150	MITOMYCIN	Non-LDD	68.50%
25021025251	MITOMYCIN	Non-LDD	68.50%
55390025101	MITOMYCIN	Non-LDD	68.50%
55390025201	MITOMYCIN	Non-LDD	68.50%
55390025301	MITOMYCIN	Non-LDD	68.50%
65219056420	MITOMYCIN	Non-LDD	68.50%
65219056620	MITOMYCIN	Non-LDD	68.50%
65219056800	MITOMYCIN	Non-LDD	68.50%
67457051805	MITOMYCIN	Non-LDD	68.50%
67457051920	MITOMYCIN	Non-LDD	68.50%
67457052040	MITOMYCIN	Non-LDD	68.50%
67457099620	MITOMYCIN	Non-LDD	68.50%
67457099740	MITOMYCIN	Non-LDD	68.50%
68001038928	MITOMYCIN	Non-LDD	68.50%
68001038936	MITOMYCIN	Non-LDD	68.50%
68001039077	MITOMYCIN	Non-LDD	68.50%
68001039078	MITOMYCIN	Non-LDD	68.50%
68001039179	MITOMYCIN	Non-LDD	68.50%
68001039180	MITOMYCIN	Non-LDD	68.50%
71266847501	MITOMYCIN	Non-LDD	68.50%
71266851501	MITOMYCIN	Non-LDD	68.50%
71288013720	MITOMYCIN	Non-LDD	68.50%
71288013850	MITOMYCIN	Non-LDD	68.50%
71288013951	MITOMYCIN	Non-LDD	68.50%
72819015205	MITOMYCIN	Non-LDD	68.50%
72819015295	MITOMYCIN	Non-LDD	68.50%
72819015302	MITOMYCIN	Non-LDD	68.50%
72819015404	MITOMYCIN	Non-LDD	68.50%
71266641202	MITOMYCIN-STERILE WATER	Non-LDD	41.20%
71266642202	MITOMYCIN-STERILE WATER	Non-LDD	41.20%
703468001	MITOXANTRONE HCL	Non-LDD	43.50%
703468501	MITOXANTRONE HCL	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
703468601	MITOXANTRONE HCL	Non-LDD	43.50%
61703034318	MITOXANTRONE HCL	Non-LDD	43.50%
61703034365	MITOXANTRONE HCL	Non-LDD	43.50%
61703034366	MITOXANTRONE HCL	Non-LDD	43.50%
63323013210	MITOXANTRONE HCL	Non-LDD	43.50%
63323013212	MITOXANTRONE HCL	Non-LDD	43.50%
63323013215	MITOXANTRONE HCL	Non-LDD	43.50%
73535020801	MONJUVI	LDD with Access	13.00%
53623302	MONONINE	Non-LDD	37.20%
24586201	MOZOBIL	Non-LDD	17.48%
59630055107	MULPLETA	Non-LDD	19.50%
69448000105	MUTAMYCIN	Non-LDD	20.50%
69448000211	MUTAMYCIN	Non-LDD	20.50%
69448000338	MUTAMYCIN	Non-LDD	20.50%
55513020601	MVASI	Non-LDD	17.00%
55513020701	MVASI	Non-LDD	17.00%
76431021001	MYALEPT	LDD with Access	1.50%
69784062025	MYLERAN	Non-LDD	18.00%
76388071325	MYLERAN	Non-LDD	18.00%
80725062025	MYLERAN	Non-LDD	18.00%
8451001	MYLOTARG	LDD with Access	16.50%
10454071010	MYOBLOC	Non-LDD	21.00%
10454071110	MYOBLOC	Non-LDD	21.00%
10454071210	MYOBLOC	Non-LDD	21.00%
68135002001	NAGLAZYME	LDD with Access	15.25%
68875020201	NATPARA	LDD with Access	15.50%
68875020202	NATPARA	LDD with Access	15.50%
68875020301	NATPARA	LDD with Access	15.50%
68875020302	NATPARA	LDD with Access	15.50%
68875020401	NATPARA	LDD with Access	15.50%
68875020402	NATPARA	LDD with Access	15.50%
68875020501	NATPARA	LDD with Access	15.50%
68875020502	NATPARA	LDD with Access	15.50%
64370053201	NAVELBINE	Non-LDD	58.50%
64370053202	NAVELBINE	Non-LDD	58.50%
70437024018	NERLYNX	LDD with Access	15.75%
70437024033	NERLYNX	LDD with Access	15.75%
55513019001	NEULASTA	Non-LDD	19.50%
55513019201	NEULASTA ONPRO	Non-LDD	19.50%
55513020901	NEUPOGEN	Non-LDD	19.50%
55513020910	NEUPOGEN	Non-LDD	19.50%
55513020991	NEUPOGEN	Non-LDD	19.50%
55513053001	NEUPOGEN	Non-LDD	19.50%
55513053010	NEUPOGEN	Non-LDD	19.50%
55513054601	NEUPOGEN	Non-LDD	19.50%
55513054610	NEUPOGEN	Non-LDD	19.50%
55513092401	NEUPOGEN	Non-LDD	19.50%
55513092410	NEUPOGEN	Non-LDD	19.50%
55513092491	NEUPOGEN	Non-LDD	19.50%
50419048858	NEXAVAR	LDD with Access	18.50%
58468042601	NEXVIAZYME	Non-LDD	14.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
59212011114	NILANDRON	Non-LDD	18.00%
62559017331	NILUTAMIDE	Non-LDD	18.00%
66993021238	NILUTAMIDE	Non-LDD	18.00%
63020007801	NINLARO	LDD with Access	15.60%
63020007802	NINLARO	LDD with Access	15.60%
63020007901	NINLARO	LDD with Access	15.60%
63020007902	NINLARO	LDD with Access	15.60%
63020008001	NINLARO	LDD with Access	15.60%
63020008002	NINLARO	LDD with Access	15.60%
63020023001	NINLARO	LDD with Access	15.60%
63020023002	NINLARO	LDD with Access	15.60%
63020039001	NINLARO	LDD with Access	15.60%
63020039002	NINLARO	LDD with Access	15.60%
63020040001	NINLARO	LDD with Access	15.60%
63020040002	NINLARO	LDD with Access	15.60%
409080101	NIPENT	Non-LDD	20.50%
254302002	NITISINONE	LDD with Access	43.50%
254302102	NITISINONE	LDD with Access	43.50%
254302202	NITISINONE	LDD with Access	43.50%
13668063260	NITISINONE	LDD with Access	43.50%
63629223301	NITISINONE	LDD with Access	43.50%
63629223401	NITISINONE	LDD with Access	43.50%
63629223501	NITISINONE	LDD with Access	43.50%
70505020260	NITISINONE	LDD with Access	43.50%
70505020560	NITISINONE	LDD with Access	43.50%
70505021060	NITISINONE	LDD with Access	43.50%
70505022060	NITISINONE	LDD with Access	43.50%
70709000060	NITYR	LDD with Access	12.75%
70709000260	NITYR	LDD with Access	12.75%
70709000560	NITYR	LDD with Access	12.75%
69029101	NIVESTYM	Non-LDD	19.50%
69029110	NIVESTYM	Non-LDD	19.50%
69029201	NIVESTYM	Non-LDD	19.50%
69029210	NIVESTYM	Non-LDD	19.50%
69029301	NIVESTYM	Non-LDD	19.50%
69029310	NIVESTYM	Non-LDD	19.50%
69029401	NIVESTYM	Non-LDD	19.50%
69029410	NIVESTYM	Non-LDD	19.50%
169770321	NORDITROPIN FLEXPRO	Non-LDD	23.50%
169770421	NORDITROPIN FLEXPRO	Non-LDD	23.50%
169770521	NORDITROPIN FLEXPRO	Non-LDD	23.50%
169770821	NORDITROPIN FLEXPRO	Non-LDD	23.50%
67386082019	NORTHERA	LDD with Access	16.25%
67386082119	NORTHERA	LDD with Access	16.25%
67386082219	NORTHERA	LDD with Access	16.25%
169781001	NOVOEIGHT	Non-LDD	44.20%
169781501	NOVOEIGHT	Non-LDD	44.20%
169782001	NOVOEIGHT	Non-LDD	44.20%
169782501	NOVOEIGHT	Non-LDD	44.20%
169783001	NOVOEIGHT	Non-LDD	44.20%
169785001	NOVOEIGHT	Non-LDD	44.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
169720101	NOVOSEVEN RT	Non-LDD	32.20%
169720201	NOVOSEVEN RT	Non-LDD	32.20%
169720501	NOVOSEVEN RT	Non-LDD	32.20%
169720801	NOVOSEVEN RT	Non-LDD	32.20%
169721111	NOVOSEVEN RT	Non-LDD	32.20%
169721211	NOVOSEVEN RT	Non-LDD	32.20%
169721511	NOVOSEVEN RT	Non-LDD	32.20%
169721811	NOVOSEVEN RT	Non-LDD	32.20%
55513022101	NPLATE	Non-LDD	19.50%
55513022201	NPLATE	Non-LDD	19.50%
55513022301	NPLATE	Non-LDD	19.50%
50419039501	NUBEQA	LDD with Access	18.00%
173088101	NUCALA	LDD with Access	21.00%
173088161	NUCALA	LDD with Access	21.00%
173089201	NUCALA	LDD with Access	21.00%
173089242	NUCALA	LDD with Access	21.00%
173089261	NUCALA	LDD with Access	21.00%
173090442	NUCALA	LDD with Access	21.00%
42358029501	NULIBRY	Non-LDD	12.00%
73129000101	NULIBRY	LDD with Access	12.00%
63090010030	NUPLAZID	LDD with Access	17.50%
63090034030	NUPLAZID	LDD with Access	17.50%
50242007401	NUTROPIN AQ NUSPIN	Non-LDD	18.50%
50242007501	NUTROPIN AQ NUSPIN	Non-LDD	18.50%
50242007601	NUTROPIN AQ NUSPIN	Non-LDD	18.50%
68982013901	NUWIQ	Non-LDD	28.50%
68982014001	NUWIQ	Non-LDD	28.50%
68982014101	NUWIQ	Non-LDD	28.50%
68982014201	NUWIQ	Non-LDD	28.50%
68982014301	NUWIQ	Non-LDD	28.50%
68982014401	NUWIQ	Non-LDD	28.50%
68982014501	NUWIQ	Non-LDD	28.50%
68982014601	NUWIQ	Non-LDD	28.50%
68982014701	NUWIQ	Non-LDD	28.50%
68982014801	NUWIQ	Non-LDD	28.50%
68982014901	NUWIQ	Non-LDD	28.50%
68982015001	NUWIQ	Non-LDD	28.50%
68982015101	NUWIQ	Non-LDD	28.50%
68982015201	NUWIQ	Non-LDD	28.50%
68982015301	NUWIQ	Non-LDD	28.50%
68982015401	NUWIQ	Non-LDD	28.50%
24338020012	NYMALIZE	Non-LDD	18.20%
24338020016	NYMALIZE	Non-LDD	18.20%
24338020020	NYMALIZE	Non-LDD	18.20%
24338020510	NYMALIZE	Non-LDD	18.20%
24338020512	NYMALIZE	Non-LDD	18.20%
24338023005	NYMALIZE	Non-LDD	18.20%
24338023012	NYMALIZE	Non-LDD	18.20%
24338026008	NYMALIZE	Non-LDD	18.20%
24338026010	NYMALIZE	Non-LDD	18.20%
24338026012	NYMALIZE	Non-LDD	18.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
69032401	NYVEPRIA	Non-LDD	21.00%
944500101	OBIZUR	Non-LDD	16.50%
944500105	OBIZUR	Non-LDD	16.50%
69516000530	OCALIVA	LDD with Access	15.50%
69516001030	OCALIVA	LDD with Access	15.50%
50242015001	OCREVUS	LDD with Access	18.50%
68982084001	OCTAGAM	Non-LDD	58.50%
68982084002	OCTAGAM	Non-LDD	58.50%
68982084003	OCTAGAM	Non-LDD	58.50%
68982084004	OCTAGAM	Non-LDD	58.50%
68982084005	OCTAGAM	Non-LDD	58.50%
68982085001	OCTAGAM	Non-LDD	58.50%
68982085002	OCTAGAM	Non-LDD	58.50%
68982085003	OCTAGAM	Non-LDD	58.50%
68982085004	OCTAGAM	Non-LDD	58.50%
68982085005	OCTAGAM	Non-LDD	58.50%
641617401	OCTREOTIDE ACETATE	Non-LDD	43.50%
641617410	OCTREOTIDE ACETATE	Non-LDD	43.50%
641617501	OCTREOTIDE ACETATE	Non-LDD	43.50%
641617510	OCTREOTIDE ACETATE	Non-LDD	43.50%
641617601	OCTREOTIDE ACETATE	Non-LDD	43.50%
641617610	OCTREOTIDE ACETATE	Non-LDD	43.50%
641617701	OCTREOTIDE ACETATE	Non-LDD	43.50%
641617801	OCTREOTIDE ACETATE	Non-LDD	43.50%
703330101	OCTREOTIDE ACETATE	Non-LDD	43.50%
703330104	OCTREOTIDE ACETATE	Non-LDD	43.50%
703331101	OCTREOTIDE ACETATE	Non-LDD	43.50%
703331104	OCTREOTIDE ACETATE	Non-LDD	43.50%
703332101	OCTREOTIDE ACETATE	Non-LDD	43.50%
703332104	OCTREOTIDE ACETATE	Non-LDD	43.50%
703333301	OCTREOTIDE ACETATE	Non-LDD	43.50%
703334301	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068531	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068631	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068731	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068741	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068831	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068841	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068931	OCTREOTIDE ACETATE	Non-LDD	43.50%
23155068941	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021045101	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021045201	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021045301	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021045405	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021045505	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021046301	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021046401	OCTREOTIDE ACETATE	Non-LDD	43.50%
25021046501	OCTREOTIDE ACETATE	Non-LDD	43.50%
62756009440	OCTREOTIDE ACETATE	Non-LDD	43.50%
62756009444	OCTREOTIDE ACETATE	Non-LDD	43.50%
62756034844	OCTREOTIDE ACETATE	Non-LDD	43.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
62756034944	OCTREOTIDE ACETATE	Non-LDD	43.50%
62756035040	OCTREOTIDE ACETATE	Non-LDD	43.50%
62756035144	OCTREOTIDE ACETATE	Non-LDD	43.50%
62756035240	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323036501	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323036504	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037600	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037601	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037604	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037641	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037700	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037701	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037704	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037805	OCTREOTIDE ACETATE	Non-LDD	43.50%
63323037905	OCTREOTIDE ACETATE	Non-LDD	43.50%
63629883101	OCTREOTIDE ACETATE	Non-LDD	43.50%
67457023900	OCTREOTIDE ACETATE	Non-LDD	43.50%
67457023901	OCTREOTIDE ACETATE	Non-LDD	43.50%
67457024500	OCTREOTIDE ACETATE	Non-LDD	43.50%
67457024501	OCTREOTIDE ACETATE	Non-LDD	43.50%
67457024600	OCTREOTIDE ACETATE	Non-LDD	43.50%
67457024601	OCTREOTIDE ACETATE	Non-LDD	43.50%
78064515	ODOMZO	Non-LDD	18.50%
47335030383	ODOMZO	Non-LDD	18.50%
597014360	OFEV	LDD with Access	15.75%
597014560	OFEV	LDD with Access	15.75%
67457084550	OGIVRI	Non-LDD	20.50%
67457084744	OGIVRI	Non-LDD	20.50%
67457099115	OGIVRI	Non-LDD	20.50%
2418230	OLUMIANT	LDD with Access	21.00%
2447930	OLUMIANT	LDD with Access	21.00%
2473230	OLUMIANT	LDD with Access	21.00%
781300107	OMNITROPE	Non-LDD	19.50%
781300407	OMNITROPE	Non-LDD	19.50%
781400436	OMNITROPE	Non-LDD	19.50%
944381001	ONCASPAR	Non-LDD	17.48%
72694095401	ONCASPAR	Non-LDD	17.48%
15054004301	ONIVYDE	Non-LDD	9.50%
71336100001	ONPATTRO	LDD with Access	14.25%
6503301	ONTRUZANT	Non-LDD	14.00%
6503302	ONTRUZANT	Non-LDD	14.00%
6503401	ONTRUZANT	Non-LDD	14.00%
6503402	ONTRUZANT	Non-LDD	14.00%
78206014701	ONTRUZANT	Non-LDD	14.00%
78206014799	ONTRUZANT	Non-LDD	14.00%
78206014801	ONTRUZANT	Non-LDD	14.00%
78206014899	ONTRUZANT	Non-LDD	14.00%
59572073007	ONUREG	Non-LDD	14.50%
59572073014	ONUREG	Non-LDD	14.50%
59572074007	ONUREG	Non-LDD	14.50%
59572074014	ONUREG	Non-LDD	14.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
3373413	OPDIVO	Non-LDD	21.00%
3375614	OPDIVO	Non-LDD	21.00%
3377211	OPDIVO	Non-LDD	21.00%
3377412	OPDIVO	Non-LDD	21.00%
3712511	OPDUALAG	LDD with Access	15.50%
66215050115	OPSUMIT	LDD with Access	17.50%
66215050130	OPSUMIT	LDD with Access	17.50%
3218713	ORENCIA	Non-LDD	17.50%
3218811	ORENCIA	Non-LDD	17.50%
3218891	ORENCIA	Non-LDD	17.50%
3281411	ORENCIA	Non-LDD	17.50%
3281811	ORENCIA	Non-LDD	17.50%
3218851	ORENCIA CLICKJECT	Non-LDD	17.50%
3218890	ORENCIA CLICKJECT	Non-LDD	17.50%
66302030001	ORENITRAM ER	LDD with Access	15.50%
66302030002	ORENITRAM ER	LDD with Access	15.50%
66302030010	ORENITRAM ER	LDD with Access	15.50%
66302030201	ORENITRAM ER	LDD with Access	15.50%
66302030202	ORENITRAM ER	LDD with Access	15.50%
66302030210	ORENITRAM ER	LDD with Access	15.50%
66302031001	ORENITRAM ER	LDD with Access	15.50%
66302031002	ORENITRAM ER	LDD with Access	15.50%
66302031010	ORENITRAM ER	LDD with Access	15.50%
66302032501	ORENITRAM ER	LDD with Access	15.50%
66302032502	ORENITRAM ER	LDD with Access	15.50%
66302032510	ORENITRAM ER	LDD with Access	15.50%
66302035001	ORENITRAM ER	LDD with Access	15.50%
66302035002	ORENITRAM ER	LDD with Access	15.50%
66302035010	ORENITRAM ER	LDD with Access	15.50%
66658010260	ORFADIN	LDD with Access	0.50%
66658010560	ORFADIN	LDD with Access	0.50%
66658011060	ORFADIN	LDD with Access	0.50%
66658012060	ORFADIN	LDD with Access	0.50%
66658020490	ORFADIN	LDD with Access	0.50%
72974012001	ORGOVYX	LDD with Access	13.50%
51167012201	ORKAMBI	Non-LDD	15.70%
51167050002	ORKAMBI	LDD with Access	15.70%
51167070002	ORKAMBI	LDD with Access	15.70%
51167080901	ORKAMBI	LDD with Access	15.70%
51167090001	ORKAMBI	LDD with Access	15.70%
72769010101	ORLADEYO	LDD with Access	8.50%
72769010201	ORLADEYO	LDD with Access	8.50%
72187010103	ORSERDU	LDD with Access	15.00%
72187010203	ORSERDU	LDD with Access	15.00%
55513013728	OTEZLA	Non-LDD	19.50%
55513013750	OTEZLA	Non-LDD	19.50%
55513013760	OTEZLA	Non-LDD	19.50%
55513036955	OTEZLA	Non-LDD	19.50%
55513048595	OTEZLA	Non-LDD	19.50%
59572063027	OTEZLA	Non-LDD	19.50%
59572063106	OTEZLA	Non-LDD	19.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
59572063128	OTEZLA	Non-LDD	19.50%
59572063255	OTEZLA	Non-LDD	19.50%
703398501	OXALIPLATIN	Non-LDD	61.33%
703398601	OXALIPLATIN	Non-LDD	61.33%
781331570	OXALIPLATIN	Non-LDD	61.33%
781331780	OXALIPLATIN	Non-LDD	61.33%
781931570	OXALIPLATIN	Non-LDD	61.33%
781931780	OXALIPLATIN	Non-LDD	61.33%
955172510	OXALIPLATIN	Non-LDD	61.33%
955172720	OXALIPLATIN	Non-LDD	61.33%
955173110	OXALIPLATIN	Non-LDD	61.33%
955173320	OXALIPLATIN	Non-LDD	61.33%
16714072701	OXALIPLATIN	Non-LDD	61.33%
16714072801	OXALIPLATIN	Non-LDD	61.33%
16729033203	OXALIPLATIN	Non-LDD	61.33%
16729033205	OXALIPLATIN	Non-LDD	61.33%
25021023310	OXALIPLATIN	Non-LDD	61.33%
25021023320	OXALIPLATIN	Non-LDD	61.33%
43066001401	OXALIPLATIN	Non-LDD	61.33%
43066001801	OXALIPLATIN	Non-LDD	61.33%
45963061153	OXALIPLATIN	Non-LDD	61.33%
45963061159	OXALIPLATIN	Non-LDD	61.33%
45963063749	OXALIPLATIN	Non-LDD	61.33%
45963063858	OXALIPLATIN	Non-LDD	61.33%
47335004640	OXALIPLATIN	Non-LDD	61.33%
47335004740	OXALIPLATIN	Non-LDD	61.33%
47335017640	OXALIPLATIN	Non-LDD	61.33%
47335017840	OXALIPLATIN	Non-LDD	61.33%
47781059229	OXALIPLATIN	Non-LDD	61.33%
50742040510	OXALIPLATIN	Non-LDD	61.33%
50742040620	OXALIPLATIN	Non-LDD	61.33%
51991021898	OXALIPLATIN	Non-LDD	61.33%
51991021998	OXALIPLATIN	Non-LDD	61.33%
55150033101	OXALIPLATIN	Non-LDD	61.33%
55150033201	OXALIPLATIN	Non-LDD	61.33%
60505613206	OXALIPLATIN	Non-LDD	61.33%
60505613207	OXALIPLATIN	Non-LDD	61.33%
60505613208	OXALIPLATIN	Non-LDD	61.33%
61703036135	OXALIPLATIN	Non-LDD	61.33%
61703036250	OXALIPLATIN	Non-LDD	61.33%
61703036318	OXALIPLATIN	Non-LDD	61.33%
61703036322	OXALIPLATIN	Non-LDD	61.33%
63323017530	OXALIPLATIN	Non-LDD	61.33%
63323017650	OXALIPLATIN	Non-LDD	61.33%
63323021110	OXALIPLATIN	Non-LDD	61.33%
63323021220	OXALIPLATIN	Non-LDD	61.33%
63323065017	OXALIPLATIN	Non-LDD	61.33%
63323065020	OXALIPLATIN	Non-LDD	61.33%
63323065027	OXALIPLATIN	Non-LDD	61.33%
63323075010	OXALIPLATIN	Non-LDD	61.33%
63323075020	OXALIPLATIN	Non-LDD	61.33%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
67457044220	OXALIPLATIN	Non-LDD	61.33%
67457046910	OXALIPLATIN	Non-LDD	61.33%
68001034128	OXALIPLATIN	Non-LDD	61.33%
68001034129	OXALIPLATIN	Non-LDD	61.33%
68001034136	OXALIPLATIN	Non-LDD	61.33%
68001034137	OXALIPLATIN	Non-LDD	61.33%
68001046836	OXALIPLATIN	Non-LDD	61.33%
68001046837	OXALIPLATIN	Non-LDD	61.33%
70860020110	OXALIPLATIN	Non-LDD	61.33%
70860020120	OXALIPLATIN	Non-LDD	61.33%
71288010110	OXALIPLATIN	Non-LDD	61.33%
71288010120	OXALIPLATIN	Non-LDD	61.33%
71288014995	OXALIPLATIN	Non-LDD	61.33%
71288014996	OXALIPLATIN	Non-LDD	61.33%
72266012501	OXALIPLATIN	Non-LDD	61.33%
72266012510	OXALIPLATIN	Non-LDD	61.33%
72266012601	OXALIPLATIN	Non-LDD	61.33%
72266012610	OXALIPLATIN	Non-LDD	61.33%
72266016101	OXALIPLATIN	Non-LDD	61.33%
72266016201	OXALIPLATIN	Non-LDD	61.33%
72603010101	OXALIPLATIN	Non-LDD	61.33%
72603030101	OXALIPLATIN	Non-LDD	61.33%
79672082502	OXALIPLATIN	Non-LDD	61.33%
79672082602	OXALIPLATIN	Non-LDD	61.33%
72786010101	OXBRYTA	LDD with Access	11.50%
72786010202	OXBRYTA	LDD with Access	11.50%
72786010203	OXBRYTA	LDD with Access	11.50%
72786011102	OXBRYTA	LDD with Access	11.50%
72786011103	OXBRYTA	LDD with Access	11.50%
71981002007	OXERVATE	LDD with Access	8.50%
71336100201	OXLUMO	LDD with Access	17.00%
703321301	PACLITAXEL	Non-LDD	38.50%
703321381	PACLITAXEL	Non-LDD	38.50%
703321601	PACLITAXEL	Non-LDD	38.50%
703321681	PACLITAXEL	Non-LDD	38.50%
703321701	PACLITAXEL	Non-LDD	38.50%
703321801	PACLITAXEL	Non-LDD	38.50%
703321881	PACLITAXEL	Non-LDD	38.50%
703476701	PACLITAXEL	Non-LDD	38.50%
16714013701	PACLITAXEL	Non-LDD	38.50%
44567050501	PACLITAXEL	Non-LDD	38.50%
44567050601	PACLITAXEL	Non-LDD	38.50%
45963061353	PACLITAXEL	Non-LDD	38.50%
45963061356	PACLITAXEL	Non-LDD	38.50%
45963061359	PACLITAXEL	Non-LDD	38.50%
45963061383	PACLITAXEL	Non-LDD	38.50%
45963061386	PACLITAXEL	Non-LDD	38.50%
45963061389	PACLITAXEL	Non-LDD	38.50%
47781059307	PACLITAXEL	Non-LDD	38.50%
47781059407	PACLITAXEL	Non-LDD	38.50%
47781059507	PACLITAXEL	Non-LDD	38.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
61703034209	PACLITAXEL	Non-LDD	38.50%
61703034250	PACLITAXEL	Non-LDD	38.50%
62332062005	PACLITAXEL	Non-LDD	38.50%
62332062117	PACLITAXEL	Non-LDD	38.50%
62332062250	PACLITAXEL	Non-LDD	38.50%
63323076305	PACLITAXEL	Non-LDD	38.50%
63323076306	PACLITAXEL	Non-LDD	38.50%
63323076316	PACLITAXEL	Non-LDD	38.50%
63323076317	PACLITAXEL	Non-LDD	38.50%
63323076350	PACLITAXEL	Non-LDD	38.50%
63323076352	PACLITAXEL	Non-LDD	38.50%
67457043451	PACLITAXEL	Non-LDD	38.50%
67457044917	PACLITAXEL	Non-LDD	38.50%
67457047152	PACLITAXEL	Non-LDD	38.50%
68001051627	PACLITAXEL	Non-LDD	38.50%
70860020005	PACLITAXEL	Non-LDD	38.50%
70860020017	PACLITAXEL	Non-LDD	38.50%
70860020050	PACLITAXEL	Non-LDD	38.50%
70860021566	PACLITAXEL	Non-LDD	38.50%
70860021567	PACLITAXEL	Non-LDD	38.50%
70860021568	PACLITAXEL	Non-LDD	38.50%
72205006101	PACLITAXEL	Non-LDD	38.50%
72205006201	PACLITAXEL	Non-LDD	38.50%
72205006301	PACLITAXEL	Non-LDD	38.50%
517430001	PACLITAXEL PROTEIN-BOUND	Non-LDD	38.50%
24979071051	PACLITAXEL PROTEIN-BOUND	Non-LDD	38.50%
60505623004	PACLITAXEL PROTEIN-BOUND	Non-LDD	38.50%
51144002001	PADCEV	Non-LDD	13.00%
51144003001	PADCEV	Non-LDD	13.00%
71881010145	PALFORZIA	LDD with Access	16.50%
71881010290	PALFORZIA	LDD with Access	16.50%
71881010345	PALFORZIA	LDD with Access	16.50%
71881010415	PALFORZIA	LDD with Access	16.50%
71881010530	PALFORZIA	LDD with Access	16.50%
71881010660	PALFORZIA	LDD with Access	16.50%
71881010730	PALFORZIA	LDD with Access	16.50%
71881010860	PALFORZIA	LDD with Access	16.50%
71881010930	PALFORZIA	LDD with Access	16.50%
71881011060	PALFORZIA	LDD with Access	16.50%
71881011115	PALFORZIA	LDD with Access	16.50%
71881011130	PALFORZIA	LDD with Access	16.50%
71881011313	PALFORZIA	LDD with Access	16.50%
68135005889	PALYNZIQ	LDD with Access	15.50%
68135005890	PALYNZIQ	LDD with Access	15.50%
68135067339	PALYNZIQ	LDD with Access	15.50%
68135067340	PALYNZIQ	LDD with Access	15.50%
68135067345	PALYNZIQ	LDD with Access	15.50%
68135075619	PALYNZIQ	LDD with Access	15.50%
68135075620	PALYNZIQ	LDD with Access	15.50%
55292070254	PANHEMATIN	Non-LDD	17.48%
55292070255	PANHEMATIN	Non-LDD	17.48%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
59212060122	PANRETIN	Non-LDD	18.50%
62856060122	PANRETIN	Non-LDD	18.50%
69101101	PANZYGA	Non-LDD	30.50%
69101102	PANZYGA	Non-LDD	30.50%
69110901	PANZYGA	Non-LDD	30.50%
69110902	PANZYGA	Non-LDD	30.50%
69122401	PANZYGA	Non-LDD	30.50%
69122402	PANZYGA	Non-LDD	30.50%
69131201	PANZYGA	Non-LDD	30.50%
69131202	PANZYGA	Non-LDD	30.50%
69141501	PANZYGA	Non-LDD	30.50%
69141502	PANZYGA	Non-LDD	30.50%
69155801	PANZYGA	Non-LDD	30.50%
69155802	PANZYGA	Non-LDD	30.50%
68982082001	PANZYGA	Non-LDD	30.50%
68982082002	PANZYGA	Non-LDD	30.50%
68982082003	PANZYGA	Non-LDD	30.50%
68982082004	PANZYGA	Non-LDD	30.50%
68982082005	PANZYGA	Non-LDD	30.50%
68982082006	PANZYGA	Non-LDD	30.50%
68982082081	PANZYGA	Non-LDD	30.50%
68982082082	PANZYGA	Non-LDD	30.50%
68982082083	PANZYGA	Non-LDD	30.50%
68982082084	PANZYGA	Non-LDD	30.50%
68982082085	PANZYGA	Non-LDD	30.50%
68982082086	PANZYGA	Non-LDD	30.50%
68982082201	PANZYGA	Non-LDD	30.50%
68982082202	PANZYGA	Non-LDD	30.50%
68982082203	PANZYGA	Non-LDD	30.50%
68982082204	PANZYGA	Non-LDD	30.50%
68982082205	PANZYGA	Non-LDD	30.50%
68982082206	PANZYGA	Non-LDD	30.50%
68982082281	PANZYGA	Non-LDD	30.50%
68982082282	PANZYGA	Non-LDD	30.50%
68982082283	PANZYGA	Non-LDD	30.50%
68982082284	PANZYGA	Non-LDD	30.50%
68982082285	PANZYGA	Non-LDD	30.50%
68982082286	PANZYGA	Non-LDD	30.50%
69448000512	PARAPLATIN	Non-LDD	47.50%
69448000531	PARAPLATIN	Non-LDD	47.50%
69448000533	PARAPLATIN	Non-LDD	47.50%
69448000534	PARAPLATIN	Non-LDD	47.50%
69448000538	PARAPLATIN	Non-LDD	47.50%
55513074001	PARSABIV	LDD with Access	21.00%
55513074010	PARSABIV	LDD with Access	21.00%
55513074101	PARSABIV	LDD with Access	21.00%
55513074110	PARSABIV	LDD with Access	21.00%
55513074201	PARSABIV	LDD with Access	21.00%
55513074210	PARSABIV	LDD with Access	21.00%
4035009	PEGASYS	Non-LDD	22.00%
4035730	PEGASYS	Non-LDD	22.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
82154044901	PEGASYS	Non-LDD	22.00%
82154045101	PEGASYS	Non-LDD	22.00%
82154045104	PEGASYS	Non-LDD	22.00%
4036530	PEGASYS PROCLICK	Non-LDD	22.00%
85435301	PEGINTRON	Non-LDD	18.50%
50881002601	PEMAZYRE	LDD with Access	13.75%
50881002701	PEMAZYRE	LDD with Access	13.75%
50881002801	PEMAZYRE	LDD with Access	13.75%
409106001	PEMETREXED	Non-LDD	23.50%
409106101	PEMETREXED	Non-LDD	23.50%
409106201	PEMETREXED	Non-LDD	23.50%
480451401	PEMETREXED	Non-LDD	23.50%
480451501	PEMETREXED	Non-LDD	23.50%
480451601	PEMETREXED	Non-LDD	23.50%
338072001	PEMETREXED DISODIUM	Non-LDD	28.50%
338072201	PEMETREXED DISODIUM	Non-LDD	28.50%
409000404	PEMETREXED DISODIUM	Non-LDD	28.50%
409002002	PEMETREXED DISODIUM	Non-LDD	28.50%
409002103	PEMETREXED DISODIUM	Non-LDD	28.50%
409104501	PEMETREXED DISODIUM	Non-LDD	28.50%
409218801	PEMETREXED DISODIUM	Non-LDD	28.50%
409353201	PEMETREXED DISODIUM	Non-LDD	28.50%
781351876	PEMETREXED DISODIUM	Non-LDD	28.50%
781351990	PEMETREXED DISODIUM	Non-LDD	28.50%
781352091	PEMETREXED DISODIUM	Non-LDD	28.50%
16729022903	PEMETREXED DISODIUM	Non-LDD	28.50%
16729023011	PEMETREXED DISODIUM	Non-LDD	28.50%
16729024438	PEMETREXED DISODIUM	Non-LDD	28.50%
16729052205	PEMETREXED DISODIUM	Non-LDD	28.50%
16729052228	PEMETREXED DISODIUM	Non-LDD	28.50%
16729052235	PEMETREXED DISODIUM	Non-LDD	28.50%
16729052264	PEMETREXED DISODIUM	Non-LDD	28.50%
43598037074	PEMETREXED DISODIUM	Non-LDD	28.50%
43598038662	PEMETREXED DISODIUM	Non-LDD	28.50%
43598038711	PEMETREXED DISODIUM	Non-LDD	28.50%
50742034001	PEMETREXED DISODIUM	Non-LDD	28.50%
50742034101	PEMETREXED DISODIUM	Non-LDD	28.50%
55150038101	PEMETREXED DISODIUM	Non-LDD	28.50%
55150038201	PEMETREXED DISODIUM	Non-LDD	28.50%
55150038301	PEMETREXED DISODIUM	Non-LDD	28.50%
60505606500	PEMETREXED DISODIUM	Non-LDD	28.50%
60505606600	PEMETREXED DISODIUM	Non-LDD	28.50%
60505606700	PEMETREXED DISODIUM	Non-LDD	28.50%
60505606800	PEMETREXED DISODIUM	Non-LDD	28.50%
63323013410	PEMETREXED DISODIUM	Non-LDD	28.50%
63323045050	PEMETREXED DISODIUM	Non-LDD	28.50%
63323062100	PEMETREXED DISODIUM	Non-LDD	28.50%
63323062200	PEMETREXED DISODIUM	Non-LDD	28.50%
68001053541	PEMETREXED DISODIUM	Non-LDD	28.50%
68001053641	PEMETREXED DISODIUM	Non-LDD	28.50%
68001053841	PEMETREXED DISODIUM	Non-LDD	28.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
68001053941	PEMETREXED DISODIUM	Non-LDD	28.50%
68001054341	PEMETREXED DISODIUM	Non-LDD	28.50%
68001054441	PEMETREXED DISODIUM	Non-LDD	28.50%
68001054541	PEMETREXED DISODIUM	Non-LDD	28.50%
68001054641	PEMETREXED DISODIUM	Non-LDD	28.50%
68001055041	PEMETREXED DISODIUM	Non-LDD	28.50%
68001055141	PEMETREXED DISODIUM	Non-LDD	28.50%
70710165401	PEMETREXED DISODIUM	Non-LDD	28.50%
70710165501	PEMETREXED DISODIUM	Non-LDD	28.50%
70710167401	PEMETREXED DISODIUM	Non-LDD	28.50%
70860020210	PEMETREXED DISODIUM	Non-LDD	28.50%
70860020350	PEMETREXED DISODIUM	Non-LDD	28.50%
71288014750	PEMETREXED DISODIUM	Non-LDD	28.50%
71288014851	PEMETREXED DISODIUM	Non-LDD	28.50%
71288016610	PEMETREXED DISODIUM	Non-LDD	28.50%
71288016691	PEMETREXED DISODIUM	Non-LDD	28.50%
71288016692	PEMETREXED DISODIUM	Non-LDD	28.50%
71288016750	PEMETREXED DISODIUM	Non-LDD	28.50%
71288016795	PEMETREXED DISODIUM	Non-LDD	28.50%
71288016796	PEMETREXED DISODIUM	Non-LDD	28.50%
42367053133	PEMFEXY	Non-LDD	15.50%
254200001	PENICILLAMINE	Non-LDD	30.50%
591417101	PENICILLAMINE	Non-LDD	30.50%
43598063401	PENICILLAMINE	Non-LDD	30.50%
43975030910	PENICILLAMINE	Non-LDD	30.50%
49884014601	PENICILLAMINE	Non-LDD	30.50%
51991097401	PENICILLAMINE	Non-LDD	30.50%
60505469601	PENICILLAMINE	Non-LDD	30.50%
62559097001	PENICILLAMINE	Non-LDD	30.50%
68682002010	PENICILLAMINE	Non-LDD	30.50%
70010090701	PENICILLAMINE	Non-LDD	30.50%
70748015301	PENICILLAMINE	Non-LDD	30.50%
71205091600	PENICILLAMINE	Non-LDD	30.50%
73657002001	PEPAXTO	Non-LDD	14.50%
50242014501	PERJETA	LDD with Access	17.48%
54034925	PHENOXYBENZAMINE HCL	Non-LDD	45.50%
49884003801	PHENOXYBENZAMINE HCL	Non-LDD	45.50%
60219150201	PHENOXYBENZAMINE HCL	Non-LDD	45.50%
66993006602	PHENOXYBENZAMINE HCL	Non-LDD	45.50%
70954036510	PHENOXYBENZAMINE HCL	Non-LDD	45.50%
50242024501	PHESGO	Non-LDD	16.50%
50242026001	PHESGO	Non-LDD	16.50%
78070151	PIQRAY	Non-LDD	18.00%
78070184	PIQRAY	Non-LDD	18.00%
78070802	PIQRAY	Non-LDD	18.00%
78070851	PIQRAY	Non-LDD	18.00%
78070890	PIQRAY	Non-LDD	18.00%
78070891	PIQRAY	Non-LDD	18.00%
78071502	PIQRAY	Non-LDD	18.00%
78071561	PIQRAY	Non-LDD	18.00%
78071591	PIQRAY	Non-LDD	18.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
78071594	PIQRAY	Non-LDD	18.00%
480361087	PIRFENIDONE	LDD with Access	58.50%
480361198	PIRFENIDONE	LDD with Access	58.50%
781215832	PIRFENIDONE	LDD with Access	58.50%
781808532	PIRFENIDONE	LDD with Access	58.50%
781808692	PIRFENIDONE	LDD with Access	58.50%
16729046715	PIRFENIDONE	LDD with Access	58.50%
16729046785	PIRFENIDONE	LDD with Access	58.50%
16729046815	PIRFENIDONE	LDD with Access	58.50%
31722087227	PIRFENIDONE	LDD with Access	58.50%
31722087290	PIRFENIDONE	LDD with Access	58.50%
31722087390	PIRFENIDONE	LDD with Access	58.50%
42385092329	PIRFENIDONE	LDD with Access	58.50%
42385092490	PIRFENIDONE	LDD with Access	58.50%
42385092499	PIRFENIDONE	LDD with Access	58.50%
42385092590	PIRFENIDONE	LDD with Access	58.50%
42385092690	PIRFENIDONE	LDD with Access	58.50%
60219164008	PIRFENIDONE	LDD with Access	58.50%
60219164009	PIRFENIDONE	LDD with Access	58.50%
60219164109	PIRFENIDONE	LDD with Access	58.50%
60219164207	PIRFENIDONE	LDD with Access	58.50%
62332047964	PIRFENIDONE	LDD with Access	58.50%
62332047990	PIRFENIDONE	LDD with Access	58.50%
62332048090	PIRFENIDONE	LDD with Access	58.50%
69097094093	PIRFENIDONE	LDD with Access	58.50%
69097098793	PIRFENIDONE	LDD with Access	58.50%
69097098805	PIRFENIDONE	LDD with Access	58.50%
72205018130	PIRFENIDONE	LDD with Access	58.50%
72205018136	PIRFENIDONE	LDD with Access	58.50%
72205018138	PIRFENIDONE	LDD with Access	58.50%
72205018230	PIRFENIDONE	LDD with Access	58.50%
72205018236	PIRFENIDONE	LDD with Access	58.50%
76282071527	PIRFENIDONE	LDD with Access	58.50%
76282071690	PIRFENIDONE	LDD with Access	58.50%
76282071727	PIRFENIDONE	LDD with Access	58.50%
64406001501	PLEGRIDY	LDD with Access	19.50%
64406001502	PLEGRIDY	LDD with Access	19.50%
64406001601	PLEGRIDY	LDD with Access	19.50%
64406001701	PLEGRIDY	LDD with Access	19.50%
64406001702	PLEGRIDY	LDD with Access	19.50%
64406001101	PLEGRIDY PEN	LDD with Access	19.50%
64406001102	PLEGRIDY PEN	LDD with Access	19.50%
64406001201	PLEGRIDY PEN	LDD with Access	19.50%
50242010301	POLIVY	Non-LDD	16.50%
50242010501	POLIVY	Non-LDD	16.50%
59572050100	POMALYST	LDD with Access	16.75%
59572050121	POMALYST	LDD with Access	16.75%
59572050200	POMALYST	LDD with Access	16.75%
59572050221	POMALYST	LDD with Access	16.75%
59572050300	POMALYST	LDD with Access	16.75%
59572050321	POMALYST	LDD with Access	16.75%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
59572050400	POMALYST	LDD with Access	16.75%
59572050421	POMALYST	LDD with Access	16.75%
50458070714	PONVORY	LDD with Access	13.50%
50458072030	PONVORY	LDD with Access	13.50%
2771601	PORTRAZZA	LDD with Access	16.50%
42747076101	POTELIGEO	LDD with Access	10.50%
18860072010	PRIALT	Non-LDD	21.00%
18860072210	PRIALT	Non-LDD	21.00%
18860072310	PRIALT	Non-LDD	21.00%
70720072010	PRIALT	Non-LDD	21.00%
70720072210	PRIALT	Non-LDD	21.00%
70720072310	PRIALT	Non-LDD	21.00%
44206043605	PRIVIGEN	Non-LDD	39.20%
44206043690	PRIVIGEN	Non-LDD	39.20%
44206043710	PRIVIGEN	Non-LDD	39.20%
44206043791	PRIVIGEN	Non-LDD	39.20%
44206043820	PRIVIGEN	Non-LDD	39.20%
44206043892	PRIVIGEN	Non-LDD	39.20%
44206043940	PRIVIGEN	Non-LDD	39.20%
44206043993	PRIVIGEN	Non-LDD	39.20%
52440010014	PROBUPHINE	LDD with Access	13.50%
59676030200	PROCRIT	Non-LDD	19.50%
59676030201	PROCRIT	Non-LDD	19.50%
59676030300	PROCRIT	Non-LDD	19.50%
59676030301	PROCRIT	Non-LDD	19.50%
59676030400	PROCRIT	Non-LDD	19.50%
59676030401	PROCRIT	Non-LDD	19.50%
59676031000	PROCRIT	Non-LDD	19.50%
59676031001	PROCRIT	Non-LDD	19.50%
59676031002	PROCRIT	Non-LDD	19.50%
59676031200	PROCRIT	Non-LDD	19.50%
59676031204	PROCRIT	Non-LDD	19.50%
59676032000	PROCRIT	Non-LDD	19.50%
59676032004	PROCRIT	Non-LDD	19.50%
59676034000	PROCRIT	Non-LDD	19.50%
59676034001	PROCRIT	Non-LDD	19.50%
75987010004	PROCYSBI	LDD with Access	8.50%
75987010108	PROCYSBI	LDD with Access	8.50%
75987014013	PROCYSBI	LDD with Access	8.50%
75987014014	PROCYSBI	LDD with Access	8.50%
75987014513	PROCYSBI	LDD with Access	8.50%
75987014514	PROCYSBI	LDD with Access	8.50%
68516320101	PROFILNINE	Non-LDD	41.71%
68516320202	PROFILNINE	Non-LDD	41.71%
68516320302	PROFILNINE	Non-LDD	41.71%
68516320401	PROFILNINE	Non-LDD	41.71%
68516320502	PROFILNINE	Non-LDD	41.71%
68516320602	PROFILNINE	Non-LDD	41.71%
68516320701	PROFILNINE	Non-LDD	41.71%
68516320802	PROFILNINE	Non-LDD	41.71%
68516320902	PROFILNINE	Non-LDD	41.71%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
68516321001	PROFILNINE	Non-LDD	41.71%
68516321102	PROFILNINE	Non-LDD	41.71%
68516321202	PROFILNINE	Non-LDD	41.71%
13533070002	PROLASTIN C	LDD with Access	10.00%
13533070211	PROLASTIN C	LDD with Access	10.00%
13533070310	PROLASTIN C	LDD with Access	10.00%
13533070501	PROLASTIN C	LDD with Access	10.00%
13533070511	PROLASTIN C	LDD with Access	10.00%
65483011607	PROLEUKIN	Non-LDD	21.00%
76310002201	PROLEUKIN	Non-LDD	21.00%
55513071001	PROLIA	Non-LDD	20.50%
78068415	PROMACTA	Non-LDD	19.50%
78068515	PROMACTA	Non-LDD	19.50%
78068615	PROMACTA	Non-LDD	19.50%
78068655	PROMACTA	Non-LDD	19.50%
78068715	PROMACTA	Non-LDD	19.50%
78069719	PROMACTA	Non-LDD	19.50%
78069723	PROMACTA	Non-LDD	19.50%
78069761	PROMACTA	Non-LDD	19.50%
78097219	PROMACTA	Non-LDD	19.50%
78097223	PROMACTA	Non-LDD	19.50%
78097261	PROMACTA	Non-LDD	19.50%
50242010039	PULMOZYME	Non-LDD	18.50%
50242010040	PULMOZYME	Non-LDD	18.50%
60311045001	PURIXAN	LDD with Access	14.50%
62484000202	PURIXAN	LDD with Access	14.50%
62484002001	PURIXAN	LDD with Access	14.50%
62484002002	PURIXAN	LDD with Access	14.50%
480372001	PYRIMETHAMINE	LDD with Access	43.50%
480372056	PYRIMETHAMINE	LDD with Access	43.50%
43598067201	PYRIMETHAMINE	LDD with Access	43.50%
43598067230	PYRIMETHAMINE	LDD with Access	43.50%
47781092501	PYRIMETHAMINE	LDD with Access	43.50%
47781092530	PYRIMETHAMINE	LDD with Access	43.50%
59651059001	PYRIMETHAMINE	LDD with Access	43.50%
72647033001	PYRIMETHAMINE	LDD with Access	43.50%
72647033003	PYRIMETHAMINE	LDD with Access	43.50%
71334020505	PYRUKYND	LDD with Access	12.00%
71334020507	PYRUKYND	LDD with Access	12.00%
71334020514	PYRUKYND	LDD with Access	12.00%
71334021007	PYRUKYND	LDD with Access	12.00%
71334021014	PYRUKYND	LDD with Access	12.00%
71334021020	PYRUKYND	LDD with Access	12.00%
71334021507	PYRUKYND	LDD with Access	12.00%
71334021514	PYRUKYND	LDD with Access	12.00%
71334021550	PYRUKYND	LDD with Access	12.00%
71334022011	PYRUKYND	LDD with Access	12.00%
71334022512	PYRUKYND	Non-LDD	12.00%
71334023013	PYRUKYND	Non-LDD	12.00%
64406010901	QALSODY	LDD with Access	12.50%
73207010130	QINLOCK	LDD with Access	15.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
70510217101	RADICAVA	LDD with Access	15.50%
70510217102	RADICAVA	LDD with Access	15.50%
70510232101	RADICAVA ORS	LDD with Access	15.50%
70510232102	RADICAVA ORS	LDD with Access	15.50%
70510232201	RADICAVA ORS	LDD with Access	15.50%
75987005006	RAVICTI	LDD with Access	15.75%
44087002203	REBIF	Non-LDD	22.00%
44087002209	REBIF	Non-LDD	22.00%
44087004403	REBIF	Non-LDD	22.00%
44087004409	REBIF	Non-LDD	22.00%
44087882201	REBIF	Non-LDD	22.00%
44087018801	REBIF REBIDOSE	Non-LDD	22.00%
44087332201	REBIF REBIDOSE	Non-LDD	22.00%
44087332209	REBIF REBIDOSE	Non-LDD	22.00%
44087334401	REBIF REBIDOSE	Non-LDD	22.00%
44087334409	REBIF REBIDOSE	Non-LDD	22.00%
169790101	REBINYN	Non-LDD	16.50%
169790201	REBINYN	Non-LDD	16.50%
169790301	REBINYN	Non-LDD	16.50%
169790501	REBINYN	Non-LDD	16.50%
169791111	REBINYN	Non-LDD	16.50%
169792211	REBINYN	Non-LDD	16.50%
169793311	REBINYN	Non-LDD	16.50%
169795511	REBINYN	Non-LDD	16.50%
59572071101	REBLOZYL	Non-LDD	21.00%
59572077501	REBLOZYL	Non-LDD	21.00%
944283101	RECOMBINATE	Non-LDD	41.16%
944283201	RECOMBINATE	Non-LDD	41.16%
944283301	RECOMBINATE	Non-LDD	41.16%
944284110	RECOMBINATE	Non-LDD	41.16%
944284210	RECOMBINATE	Non-LDD	41.16%
944284310	RECOMBINATE	Non-LDD	41.16%
944284410	RECOMBINATE	Non-LDD	41.16%
944284510	RECOMBINATE	Non-LDD	41.16%
72065000301	RECORLEV	LDD with Access	14.50%
70121156801	RELEUKO	Non-LDD	15.50%
70121156807	RELEUKO	Non-LDD	15.50%
70121156901	RELEUKO	Non-LDD	15.50%
70121156907	RELEUKO	Non-LDD	15.50%
70121157001	RELEUKO	Non-LDD	15.50%
70121157007	RELEUKO	Non-LDD	15.50%
70121157101	RELEUKO	Non-LDD	15.50%
70121157107	RELEUKO	Non-LDD	15.50%
73063003503	RELYVRIO	LDD with Access	12.50%
73063003504	RELYVRIO	LDD with Access	12.50%
61958290101	REMDESIVIR (EUA)	Non-LDD	47.50%
61958290201	REMDESIVIR (EUA)	Non-LDD	47.50%
57894003001	REMICADE	Non-LDD	22.00%
66302010101	REMODULIN	LDD with Access	15.75%
66302010201	REMODULIN	LDD with Access	15.75%
66302010501	REMODULIN	LDD with Access	15.75%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
66302011001	REMODULIN	LDD with Access	15.75%
6430501	RENFLEXIS	Non-LDD	21.00%
6430502	RENFLEXIS	Non-LDD	21.00%
78206016201	RENFLEXIS	Non-LDD	21.00%
78206016299	RENFLEXIS	Non-LDD	21.00%
69130501	RETACRIT	Non-LDD	19.50%
69130510	RETACRIT	Non-LDD	19.50%
69130601	RETACRIT	Non-LDD	19.50%
69130610	RETACRIT	Non-LDD	19.50%
69130701	RETACRIT	Non-LDD	19.50%
69130710	RETACRIT	Non-LDD	19.50%
69130801	RETACRIT	Non-LDD	19.50%
69130810	RETACRIT	Non-LDD	19.50%
69130901	RETACRIT	Non-LDD	19.50%
69130904	RETACRIT	Non-LDD	19.50%
69131101	RETACRIT	Non-LDD	19.50%
69131110	RETACRIT	Non-LDD	19.50%
69131801	RETACRIT	Non-LDD	19.50%
69131810	RETACRIT	Non-LDD	19.50%
59353000201	RETACRIT	Non-LDD	19.50%
59353000210	RETACRIT	Non-LDD	19.50%
59353000301	RETACRIT	Non-LDD	19.50%
59353000310	RETACRIT	Non-LDD	19.50%
59353000401	RETACRIT	Non-LDD	19.50%
59353000410	RETACRIT	Non-LDD	19.50%
59353001001	RETACRIT	Non-LDD	19.50%
59353001010	RETACRIT	Non-LDD	19.50%
59353012001	RETACRIT	Non-LDD	19.50%
59353012010	RETACRIT	Non-LDD	19.50%
59353022001	RETACRIT	Non-LDD	19.50%
59353022010	RETACRIT	Non-LDD	19.50%
2298026	RETEVMO	LDD with Access	21.00%
2298060	RETEVMO	LDD with Access	21.00%
2397760	RETEVMO	LDD with Access	21.00%
10122050201	REVCOVI	LDD with Access	16.30%
57665000201	REVCOVI	LDD with Access	16.30%
59572040200	REVLIMID	LDD with Access	16.75%
59572040228	REVLIMID	LDD with Access	16.75%
59572040500	REVLIMID	LDD with Access	16.75%
59572040528	REVLIMID	LDD with Access	16.75%
59572041000	REVLIMID	LDD with Access	16.75%
59572041028	REVLIMID	LDD with Access	16.75%
59572041500	REVLIMID	LDD with Access	16.75%
59572041521	REVLIMID	LDD with Access	16.75%
59572042000	REVLIMID	LDD with Access	16.75%
59572042021	REVLIMID	LDD with Access	16.75%
59572042500	REVLIMID	LDD with Access	16.75%
59572042521	REVLIMID	LDD with Access	16.75%
71332000501	REZLIDHIA	LDD with Access	14.75%
79802020030	REZUROCK	LDD with Access	13.75%
55513022401	RIABNI	Non-LDD	15.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
55513032601	RIABNI	Non-LDD	15.50%
74104328	RINVOQ	Non-LDD	21.00%
74230630	RINVOQ	Non-LDD	21.00%
74230670	RINVOQ	Non-LDD	21.00%
74231030	RINVOQ	Non-LDD	21.00%
50242005110	RITUXAN	LDD with Access	17.48%
50242005121	RITUXAN	LDD with Access	17.48%
50242005306	RITUXAN	LDD with Access	17.48%
50242010801	RITUXAN HYCELA	LDD with Access	15.50%
50242010901	RITUXAN HYCELA	LDD with Access	15.50%
944302602	RIXUBIS	Non-LDD	34.50%
944302802	RIXUBIS	Non-LDD	34.50%
944303002	RIXUBIS	Non-LDD	34.50%
944303202	RIXUBIS	Non-LDD	34.50%
944303402	RIXUBIS	Non-LDD	34.50%
76961010101	ROLVEDON	LDD with Access	11.50%
69096101	ROMIDEPSIN	Non-LDD	38.50%
69098301	ROMIDEPSIN	Non-LDD	38.50%
703312501	ROMIDEPSIN	Non-LDD	38.50%
703312508	ROMIDEPSIN	Non-LDD	38.50%
703400401	ROMIDEPSIN	Non-LDD	38.50%
63323092517	ROMIDEPSIN	Non-LDD	38.50%
63323092688	ROMIDEPSIN	Non-LDD	38.50%
50242009130	ROZLYTREK	LDD with Access	21.00%
50242009490	ROZLYTREK	LDD with Access	21.00%
69660020191	RUBRACA	LDD with Access	13.50%
69660020291	RUBRACA	LDD with Access	13.50%
69660020391	RUBRACA	LDD with Access	13.50%
68012035001	RUCONEST	LDD with Access	16.00%
68012035002	RUCONEST	LDD with Access	16.00%
71274035001	RUCONEST	LDD with Access	16.00%
71274035002	RUCONEST	LDD with Access	16.00%
69023801	RUXIENCE	Non-LDD	20.50%
69024901	RUXIENCE	Non-LDD	20.50%
49938011001	RUZURGI	LDD with Access	11.90%
57894050100	RYBREVANT	Non-LDD	13.50%
57894050101	RYBREVANT	Non-LDD	13.50%
78069802	RYDAPT	Non-LDD	18.50%
78069819	RYDAPT	Non-LDD	18.50%
78069851	RYDAPT	Non-LDD	18.50%
78069899	RYDAPT	Non-LDD	18.50%
70573009901	RYPLAZIM	LDD with Access	8.50%
70573009902	RYPLAZIM	LDD with Access	8.50%
67386011101	SABRIL	LDD with Access	16.50%
67386021165	SABRIL	LDD with Access	16.50%
44087100502	SAIZEN	Non-LDD	19.50%
44087108801	SAIZEN	Non-LDD	19.50%
44087001601	SAIZEN-SAIZENPREP	Non-LDD	19.50%
70709001301	SAJAZIR	LDD with Access	16.50%
70709001303	SAJAZIR	LDD with Access	16.50%
59148002050	SAMSCA	LDD with Access	17.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
59148002150	SAMSCA	LDD with Access	17.00%
78018001	SANDOSTATIN	Non-LDD	20.50%
78018061	SANDOSTATIN	Non-LDD	20.50%
78018101	SANDOSTATIN	Non-LDD	20.50%
78018161	SANDOSTATIN	Non-LDD	20.50%
78018201	SANDOSTATIN	Non-LDD	20.50%
78018261	SANDOSTATIN	Non-LDD	20.50%
78079061	SANDOSTATIN LAR DEPOT	Non-LDD	20.50%
78079761	SANDOSTATIN LAR DEPOT	Non-LDD	20.50%
78080461	SANDOSTATIN LAR DEPOT	Non-LDD	20.50%
78081181	SANDOSTATIN LAR DEPOT	Non-LDD	20.50%
78081881	SANDOSTATIN LAR DEPOT	Non-LDD	20.50%
78082581	SANDOSTATIN LAR DEPOT	Non-LDD	20.50%
310304000	SAPHNELO	LDD with Access	13.50%
31722004512	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
31722004701	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
31722004730	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
31722004801	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
31722004830	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
43598047711	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
43598047730	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
43598074904	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
49884072008	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
49884087352	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
49884087372	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
49884094852	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
49884094872	SAPROPTERIN DIHYDROCHLOR	Non-LDD	43.50%
24065401	SARCLISA	LDD with Access	13.00%
24065601	SARCLISA	LDD with Access	13.00%
78109120	SCEMBLIX	Non-LDD	14.25%
78109820	SCEMBLIX	Non-LDD	14.25%
55513007330	SENSIPAR	Non-LDD	18.50%
55513007430	SENSIPAR	Non-LDD	18.50%
55513007530	SENSIPAR	Non-LDD	18.50%
44087000401	SEROSTIM	LDD with Access	12.50%
44087000407	SEROSTIM	LDD with Access	12.50%
44087000501	SEROSTIM	LDD with Access	12.50%
44087000507	SEROSTIM	LDD with Access	12.50%
44087000601	SEROSTIM	LDD with Access	12.50%
44087000607	SEROSTIM	LDD with Access	12.50%
71127100001	SEVENFACT	LDD with Access	15.50%
71127110001	SEVENFACT	LDD with Access	15.50%
71127500001	SEVENFACT	LDD with Access	15.50%
71127510001	SEVENFACT	LDD with Access	15.50%
78063306	SIGNIFOR	LDD with Access	10.50%
78063320	SIGNIFOR	LDD with Access	10.50%
78063361	SIGNIFOR	LDD with Access	10.50%
78063406	SIGNIFOR	LDD with Access	10.50%
78063420	SIGNIFOR	LDD with Access	10.50%
78063461	SIGNIFOR	LDD with Access	10.50%
78063506	SIGNIFOR	LDD with Access	10.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
78063520	SIGNIFOR	LDD with Access	10.50%
78063561	SIGNIFOR	LDD with Access	10.50%
55292013101	SIGNIFOR	LDD with Access	10.50%
55292013106	SIGNIFOR	LDD with Access	10.50%
55292013160	SIGNIFOR	LDD with Access	10.50%
55292013201	SIGNIFOR	LDD with Access	10.50%
55292013206	SIGNIFOR	LDD with Access	10.50%
55292013260	SIGNIFOR	LDD with Access	10.50%
55292013301	SIGNIFOR	LDD with Access	10.50%
55292013306	SIGNIFOR	LDD with Access	10.50%
55292013360	SIGNIFOR	LDD with Access	10.50%
78064161	SIGNIFOR LAR	LDD with Access	10.50%
78064181	SIGNIFOR LAR	LDD with Access	10.50%
78064281	SIGNIFOR LAR	LDD with Access	10.50%
78064381	SIGNIFOR LAR	LDD with Access	10.50%
78074181	SIGNIFOR LAR	LDD with Access	10.50%
78074881	SIGNIFOR LAR	LDD with Access	10.50%
78075561	SIGNIFOR LAR	LDD with Access	10.50%
78076961	SIGNIFOR LAR	LDD with Access	10.50%
55292013401	SIGNIFOR LAR	LDD with Access	10.50%
55292013501	SIGNIFOR LAR	LDD with Access	10.50%
55292013601	SIGNIFOR LAR	LDD with Access	10.50%
55292013701	SIGNIFOR LAR	LDD with Access	10.50%
55292013801	SIGNIFOR LAR	LDD with Access	10.50%
55292013901	SIGNIFOR LAR	LDD with Access	10.50%
55292014001	SIGNIFOR LAR	LDD with Access	10.50%
55292014101	SIGNIFOR LAR	LDD with Access	10.50%
55292014201	SIGNIFOR LAR	LDD with Access	10.50%
55292014301	SIGNIFOR LAR	LDD with Access	10.50%
591405094	SILDENAFIL CITRATE	Non-LDD	63.50%
27241017529	SILDENAFIL CITRATE	Non-LDD	63.50%
31722013631	SILDENAFIL CITRATE	Non-LDD	63.50%
51672423108	SILDENAFIL CITRATE	Non-LDD	63.50%
59762205801	SILDENAFIL CITRATE	Non-LDD	63.50%
68180028301	SILDENAFIL CITRATE	Non-LDD	63.50%
69097090344	SILDENAFIL CITRATE	Non-LDD	63.50%
69238157401	SILDENAFIL CITRATE	Non-LDD	63.50%
69543041972	SILDENAFIL CITRATE	Non-LDD	63.50%
70710171604	SILDENAFIL CITRATE	Non-LDD	63.50%
70954016810	SILDENAFIL CITRATE	Non-LDD	63.50%
72205003576	SILDENAFIL CITRATE	Non-LDD	63.50%
72205005976	SILDENAFIL CITRATE	Non-LDD	63.50%
187000400	SILIQ	Non-LDD	14.50%
187000402	SILIQ	Non-LDD	14.50%
57894007001	SIMPONI	Non-LDD	18.50%
57894007002	SIMPONI	Non-LDD	18.50%
57894007101	SIMPONI	Non-LDD	18.50%
57894007102	SIMPONI	Non-LDD	18.50%
57894035001	SIMPONI ARIA	Non-LDD	18.50%
59676070101	SIRTURO	LDD with Access	11.25%
59676070260	SIRTURO	LDD with Access	11.25%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
73179025090	SKYCLARYS	LDD with Access	14.00%
74105001	SKYRIZI	Non-LDD	18.50%
74204201	SKYRIZI	Non-LDD	18.50%
74501501	SKYRIZI	Non-LDD	18.50%
74204202	SKYRIZI (2 SYRINGES) KIT	Non-LDD	18.50%
74106501	SKYRIZI ON-BODY	Non-LDD	15.50%
74106601	SKYRIZI ON-BODY	Non-LDD	15.50%
74106901	SKYRIZI ON-BODY	Non-LDD	15.50%
74107001	SKYRIZI ON-BODY	Non-LDD	15.50%
74210001	SKYRIZI PEN	Non-LDD	18.50%
73362000301	SKYTROFA	Non-LDD	13.00%
73362000302	SKYTROFA	Non-LDD	13.00%
73362000401	SKYTROFA	Non-LDD	13.00%
73362000402	SKYTROFA	Non-LDD	13.00%
73362000501	SKYTROFA	Non-LDD	13.00%
73362000502	SKYTROFA	Non-LDD	13.00%
73362000601	SKYTROFA	Non-LDD	13.00%
73362000602	SKYTROFA	Non-LDD	13.00%
73362000701	SKYTROFA	Non-LDD	13.00%
73362000702	SKYTROFA	Non-LDD	13.00%
73362000801	SKYTROFA	Non-LDD	13.00%
73362000802	SKYTROFA	Non-LDD	13.00%
73362000901	SKYTROFA	Non-LDD	13.00%
73362000902	SKYTROFA	Non-LDD	13.00%
73362001001	SKYTROFA	Non-LDD	13.00%
73362001002	SKYTROFA	Non-LDD	13.00%
73362001101	SKYTROFA	Non-LDD	13.00%
73362001102	SKYTROFA	Non-LDD	13.00%
54962857	SODIUM OXYBATE	LDD with Access	15.50%
69238239101	SODIUM OXYBATE	LDD with Access	15.50%
42794008614	SODIUM PHENYLBUTYRATE	Non-LDD	43.50%
49884000604	SODIUM PHENYLBUTYRATE	Non-LDD	43.50%
49884017004	SODIUM PHENYLBUTYRATE	Non-LDD	43.50%
68462085320	SODIUM PHENYLBUTYRATE	Non-LDD	43.50%
72626270101	SOFOSBUVIR-VELPATASVIR	Non-LDD	22.00%
50004072501	SOLESTA	LDD with Access	14.00%
25682000101	SOLIRIS	LDD with Access	17.00%
15054106003	SOMATULINE DEPOT	Non-LDD	21.00%
15054106004	SOMATULINE DEPOT	Non-LDD	21.00%
15054109003	SOMATULINE DEPOT	Non-LDD	21.00%
15054109004	SOMATULINE DEPOT	Non-LDD	21.00%
15054112003	SOMATULINE DEPOT	Non-LDD	21.00%
15054112004	SOMATULINE DEPOT	Non-LDD	21.00%
9517502	SOMAVERT	LDD with Access	15.75%
9517510	SOMAVERT	LDD with Access	15.75%
9517702	SOMAVERT	LDD with Access	15.75%
9517710	SOMAVERT	LDD with Access	15.75%
9517902	SOMAVERT	LDD with Access	15.75%
9517910	SOMAVERT	LDD with Access	15.75%
9520104	SOMAVERT	LDD with Access	15.75%
9520110	SOMAVERT	LDD with Access	15.75%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
9537604	SOMAVERT	LDD with Access	15.75%
9537610	SOMAVERT	LDD with Access	15.75%
9716601	SOMAVERT	LDD with Access	15.75%
9716630	SOMAVERT	LDD with Access	15.75%
9716801	SOMAVERT	LDD with Access	15.75%
9716830	SOMAVERT	LDD with Access	15.75%
9718801	SOMAVERT	LDD with Access	15.75%
9718830	SOMAVERT	LDD with Access	15.75%
9719901	SOMAVERT	LDD with Access	15.75%
9719930	SOMAVERT	LDD with Access	15.75%
9720001	SOMAVERT	LDD with Access	15.75%
9720030	SOMAVERT	LDD with Access	15.75%
378120178	SORAFENIB	LDD with Access	41.50%
480542589	SORAFENIB	LDD with Access	41.50%
13668068212	SORAFENIB	LDD with Access	41.50%
24979071544	SORAFENIB	LDD with Access	41.50%
43598045804	SORAFENIB	LDD with Access	41.50%
51407076012	SORAFENIB	LDD with Access	41.50%
145009025	SORIATANE	Non-LDD	21.00%
145009125	SORIATANE	Non-LDD	21.00%
3089511	SOTYKTU	Non-LDD	15.50%
3089591	SOTYKTU	Non-LDD	15.50%
61958150101	SOVALDI	Non-LDD	21.00%
61958150301	SOVALDI	Non-LDD	21.00%
61958150401	SOVALDI	Non-LDD	21.00%
61958150402	SOVALDI	Non-LDD	21.00%
61958150501	SOVALDI	Non-LDD	21.00%
61958150502	SOVALDI	Non-LDD	21.00%
64406005801	SPINRAZA	LDD with Access	12.50%
3052411	SPRYCEL	Non-LDD	18.00%
3052711	SPRYCEL	Non-LDD	18.00%
3052811	SPRYCEL	Non-LDD	18.00%
3085222	SPRYCEL	Non-LDD	18.00%
3085522	SPRYCEL	Non-LDD	18.00%
3085722	SPRYCEL	Non-LDD	18.00%
57894005427	STELARA	Non-LDD	20.00%
57894006002	STELARA	Non-LDD	20.00%
57894006003	STELARA	Non-LDD	20.00%
57894006103	STELARA	Non-LDD	20.00%
52919001104	STERILE WATER FOR ARALAST	Non-LDD	30.40%
63833076515	STERILE WATER FOR BERINERT	Non-LDD	30.40%
338000137	STERILE WATER FOR GAMMAG	Non-LDD	30.40%
338000177	STERILE WATER FOR GAMMAG	Non-LDD	30.40%
63833076553	STERILE WATER FOR HUMATE-	Non-LDD	30.40%
63833076554	STERILE WATER FOR HUMATE-	Non-LDD	30.40%
63833076555	STERILE WATER FOR HUMATE-	Non-LDD	30.40%
13533000006	STERILE WATER FOR PROLASTI	Non-LDD	30.40%
13533010070	STERILE WATER FOR PROLASTI	Non-LDD	30.40%
13533020020	STERILE WATER FOR PROLASTI	Non-LDD	30.40%
53765320	STERILE WATER FOR ZEMAIRA	Non-LDD	30.40%
50419017101	STIVARGA	LDD with Access	18.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
50419017103	STIVARGA	LDD with Access	18.50%
50419017105	STIVARGA	LDD with Access	18.50%
50419017106	STIVARGA	LDD with Access	18.50%
25682001001	STRENSIQ	LDD with Access	12.35%
25682001012	STRENSIQ	LDD with Access	12.35%
25682001301	STRENSIQ	LDD with Access	12.35%
25682001312	STRENSIQ	LDD with Access	12.35%
25682001601	STRENSIQ	LDD with Access	12.35%
25682001612	STRENSIQ	LDD with Access	12.35%
25682001901	STRENSIQ	LDD with Access	12.35%
25682001912	STRENSIQ	LDD with Access	12.35%
67871011101	SUCRAID	LDD with Access	12.75%
67871011104	SUCRAID	LDD with Access	12.75%
67871011106	SUCRAID	LDD with Access	12.75%
67871011107	SUCRAID	LDD with Access	12.75%
93819928	SUNITINIB MALATE	LDD with Access	33.50%
93822428	SUNITINIB MALATE	LDD with Access	33.50%
93822928	SUNITINIB MALATE	LDD with Access	33.50%
93823128	SUNITINIB MALATE	LDD with Access	33.50%
378667828	SUNITINIB MALATE	LDD with Access	33.50%
378667928	SUNITINIB MALATE	LDD with Access	33.50%
378668028	SUNITINIB MALATE	LDD with Access	33.50%
378668128	SUNITINIB MALATE	LDD with Access	33.50%
16714067601	SUNITINIB MALATE	LDD with Access	33.50%
16714067701	SUNITINIB MALATE	LDD with Access	33.50%
16714067801	SUNITINIB MALATE	LDD with Access	33.50%
16714067901	SUNITINIB MALATE	LDD with Access	33.50%
43598004563	SUNITINIB MALATE	LDD with Access	33.50%
43598004663	SUNITINIB MALATE	LDD with Access	33.50%
43598004763	SUNITINIB MALATE	LDD with Access	33.50%
43598004863	SUNITINIB MALATE	LDD with Access	33.50%
63304009127	SUNITINIB MALATE	LDD with Access	33.50%
63304009227	SUNITINIB MALATE	LDD with Access	33.50%
63304009327	SUNITINIB MALATE	LDD with Access	33.50%
63304009427	SUNITINIB MALATE	LDD with Access	33.50%
67979000201	SUPPRELIN LA	Non-LDD	21.00%
50242007812	SUSVIMO	LDD with Access	15.50%
50242007855	SUSVIMO	LDD with Access	15.50%
10042059001	SUSVIMO IMPLNT AND INSERT	Non-LDD	15.50%
69055038	SUTENT	LDD with Access	18.50%
69077038	SUTENT	LDD with Access	18.50%
69083038	SUTENT	LDD with Access	18.50%
69098038	SUTENT	LDD with Access	18.50%
85434701	SYLATRON	LDD with Access	17.48%
85434801	SYLATRON	LDD with Access	17.48%
57894042001	SYLVANT	Non-LDD	21.00%
57894042101	SYLVANT	Non-LDD	21.00%
73090042001	SYLVANT	Non-LDD	21.00%
73090042101	SYLVANT	Non-LDD	21.00%
51167011301	SYMDEKO	LDD with Access	15.70%
51167066101	SYMDEKO	LDD with Access	15.70%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
60574411301	SYNAGIS	LDD with Access	21.00%
60574411401	SYNAGIS	LDD with Access	21.00%
66658023001	SYNAGIS	LDD with Access	21.00%
66658023101	SYNAGIS	LDD with Access	21.00%
25016608	SYNAREL	Non-LDD	18.50%
63459017714	SYNRIBO	LDD with Access	17.48%
187212010	SYPRINE	Non-LDD	18.50%
69784063025	TABLOID	Non-LDD	17.50%
76388088025	TABLOID	Non-LDD	17.50%
80725063025	TABLOID	Non-LDD	17.50%
78070956	TABRECTA	Non-LDD	21.00%
78071656	TABRECTA	Non-LDD	21.00%
378697691	TADALAFIL	Non-LDD	33.50%
13668058130	TADALAFIL	Non-LDD	33.50%
27241012302	TADALAFIL	Non-LDD	33.50%
31722064730	TADALAFIL	Non-LDD	33.50%
33342027809	TADALAFIL	Non-LDD	33.50%
42291080460	TADALAFIL	Non-LDD	33.50%
43547099006	TADALAFIL	Non-LDD	33.50%
43598057860	TADALAFIL	Non-LDD	33.50%
65862088060	TADALAFIL	Non-LDD	33.50%
68180091407	TADALAFIL	Non-LDD	33.50%
69097052603	TADALAFIL	Non-LDD	33.50%
82009008060	TADALAFIL	Non-LDD	33.50%
46287004515	TADLIQ	Non-LDD	17.50%
78068166	TAFINLAR	Non-LDD	18.50%
78068266	TAFINLAR	Non-LDD	18.50%
78115421	TAFINLAR	Non-LDD	18.50%
310134930	TAGRISSO	LDD with Access	17.50%
310135030	TAGRISSO	LDD with Access	17.50%
47783064401	TAKHZYRO	LDD with Access	15.00%
47783064501	TAKHZYRO	LDD with Access	15.00%
47783064601	TAKHZYRO	LDD with Access	15.00%
2144501	TALTZ AUTOINJECTOR	LDD with Access	15.80%
2144511	TALTZ AUTOINJECTOR	LDD with Access	15.80%
2144527	TALTZ AUTOINJECTOR (2 PACK	LDD with Access	15.80%
2144509	TALTZ AUTOINJECTOR (3 PACK	LDD with Access	15.80%
2772401	TALTZ SYRINGE	LDD with Access	15.80%
2772411	TALTZ SYRINGE	LDD with Access	15.80%
69029630	TALZENNA	LDD with Access	18.00%
69103130	TALZENNA	LDD with Access	18.00%
69119530	TALZENNA	LDD with Access	18.00%
69123530	TALZENNA	LDD with Access	18.00%
69150130	TALZENNA	LDD with Access	18.00%
69175130	TALZENNA	LDD with Access	18.00%
50242006201	TARCEVA	LDD with Access	21.50%
50242006301	TARCEVA	LDD with Access	21.50%
50242006401	TARCEVA	LDD with Access	21.50%
187552560	TARGRETIN	Non-LDD	21.00%
187552675	TARGRETIN	Non-LDD	21.00%
81749000401	TARPEYO	LDD with Access	12.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
78052651	TASIGNA	Non-LDD	18.50%
78052687	TASIGNA	Non-LDD	18.50%
78059251	TASIGNA	Non-LDD	18.50%
78059287	TASIGNA	Non-LDD	18.50%
78095166	TASIGNA	Non-LDD	18.50%
480449056	TASIMELTEON	LDD with Access	26.50%
69238254803	TASIMELTEON	LDD with Access	26.50%
71332000101	TAVALISSE	LDD with Access	21.00%
71332000201	TAVALISSE	LDD with Access	21.00%
73556016801	TAVNEOS	LDD with Access	14.50%
73556016802	TAVNEOS	LDD with Access	14.50%
72607010000	TAZVERIK	LDD with Access	12.50%
50242091701	TECENTRIQ	Non-LDD	15.50%
50242091801	TECENTRIQ	Non-LDD	15.50%
64406000501	TECFIDERA	LDD with Access	20.75%
64406000602	TECFIDERA	LDD with Access	20.75%
64406000703	TECFIDERA	LDD with Access	20.75%
72126000701	TEGSEDI	LDD with Access	8.50%
72126000702	TEGSEDI	LDD with Access	8.50%
85136603	TEMODAR	Non-LDD	18.50%
85136604	TEMODAR	Non-LDD	18.50%
85136605	TEMODAR	Non-LDD	18.50%
85138101	TEMODAR	Non-LDD	18.50%
85141702	TEMODAR	Non-LDD	18.50%
85141703	TEMODAR	Non-LDD	18.50%
85142503	TEMODAR	Non-LDD	18.50%
85142504	TEMODAR	Non-LDD	18.50%
85142505	TEMODAR	Non-LDD	18.50%
85143003	TEMODAR	Non-LDD	18.50%
85143004	TEMODAR	Non-LDD	18.50%
85143005	TEMODAR	Non-LDD	18.50%
85151903	TEMODAR	Non-LDD	18.50%
85151904	TEMODAR	Non-LDD	18.50%
85151905	TEMODAR	Non-LDD	18.50%
85300403	TEMODAR	Non-LDD	18.50%
85300404	TEMODAR	Non-LDD	18.50%
85300405	TEMODAR	Non-LDD	18.50%
93759941	TEMOZOLOMIDE	Non-LDD	48.50%
93759957	TEMOZOLOMIDE	Non-LDD	48.50%
93760041	TEMOZOLOMIDE	Non-LDD	48.50%
93760057	TEMOZOLOMIDE	Non-LDD	48.50%
93760141	TEMOZOLOMIDE	Non-LDD	48.50%
93760157	TEMOZOLOMIDE	Non-LDD	48.50%
93760257	TEMOZOLOMIDE	Non-LDD	48.50%
93763841	TEMOZOLOMIDE	Non-LDD	48.50%
93763857	TEMOZOLOMIDE	Non-LDD	48.50%
93763941	TEMOZOLOMIDE	Non-LDD	48.50%
93763957	TEMOZOLOMIDE	Non-LDD	48.50%
781269144	TEMOZOLOMIDE	Non-LDD	48.50%
781269175	TEMOZOLOMIDE	Non-LDD	48.50%
781269244	TEMOZOLOMIDE	Non-LDD	48.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
781269275	TEMOZOLOMIDE	Non-LDD	48.50%
781269344	TEMOZOLOMIDE	Non-LDD	48.50%
781269375	TEMOZOLOMIDE	Non-LDD	48.50%
781269444	TEMOZOLOMIDE	Non-LDD	48.50%
781269475	TEMOZOLOMIDE	Non-LDD	48.50%
781269544	TEMOZOLOMIDE	Non-LDD	48.50%
781269575	TEMOZOLOMIDE	Non-LDD	48.50%
781269675	TEMOZOLOMIDE	Non-LDD	48.50%
16571081641	TEMOZOLOMIDE	Non-LDD	48.50%
16571081651	TEMOZOLOMIDE	Non-LDD	48.50%
16571081741	TEMOZOLOMIDE	Non-LDD	48.50%
16571081751	TEMOZOLOMIDE	Non-LDD	48.50%
16571081841	TEMOZOLOMIDE	Non-LDD	48.50%
16571081851	TEMOZOLOMIDE	Non-LDD	48.50%
16571081941	TEMOZOLOMIDE	Non-LDD	48.50%
16571081951	TEMOZOLOMIDE	Non-LDD	48.50%
16571082041	TEMOZOLOMIDE	Non-LDD	48.50%
16571082051	TEMOZOLOMIDE	Non-LDD	48.50%
16571082151	TEMOZOLOMIDE	Non-LDD	48.50%
16729004853	TEMOZOLOMIDE	Non-LDD	48.50%
16729004854	TEMOZOLOMIDE	Non-LDD	48.50%
16729004953	TEMOZOLOMIDE	Non-LDD	48.50%
16729004954	TEMOZOLOMIDE	Non-LDD	48.50%
16729005053	TEMOZOLOMIDE	Non-LDD	48.50%
16729005054	TEMOZOLOMIDE	Non-LDD	48.50%
16729005153	TEMOZOLOMIDE	Non-LDD	48.50%
16729012953	TEMOZOLOMIDE	Non-LDD	48.50%
16729012954	TEMOZOLOMIDE	Non-LDD	48.50%
16729013053	TEMOZOLOMIDE	Non-LDD	48.50%
16729013054	TEMOZOLOMIDE	Non-LDD	48.50%
43975025205	TEMOZOLOMIDE	Non-LDD	48.50%
43975025214	TEMOZOLOMIDE	Non-LDD	48.50%
43975025305	TEMOZOLOMIDE	Non-LDD	48.50%
43975025314	TEMOZOLOMIDE	Non-LDD	48.50%
43975025405	TEMOZOLOMIDE	Non-LDD	48.50%
43975025414	TEMOZOLOMIDE	Non-LDD	48.50%
43975025505	TEMOZOLOMIDE	Non-LDD	48.50%
43975025514	TEMOZOLOMIDE	Non-LDD	48.50%
43975025605	TEMOZOLOMIDE	Non-LDD	48.50%
43975025614	TEMOZOLOMIDE	Non-LDD	48.50%
43975025705	TEMOZOLOMIDE	Non-LDD	48.50%
47335089021	TEMOZOLOMIDE	Non-LDD	48.50%
47335089060	TEMOZOLOMIDE	Non-LDD	48.50%
47335089072	TEMOZOLOMIDE	Non-LDD	48.50%
47335089074	TEMOZOLOMIDE	Non-LDD	48.50%
47335089080	TEMOZOLOMIDE	Non-LDD	48.50%
47335089121	TEMOZOLOMIDE	Non-LDD	48.50%
47335089160	TEMOZOLOMIDE	Non-LDD	48.50%
47335089172	TEMOZOLOMIDE	Non-LDD	48.50%
47335089174	TEMOZOLOMIDE	Non-LDD	48.50%
47335089180	TEMOZOLOMIDE	Non-LDD	48.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
47335089221	TEMOZOLOMIDE	Non-LDD	48.50%
47335089260	TEMOZOLOMIDE	Non-LDD	48.50%
47335089272	TEMOZOLOMIDE	Non-LDD	48.50%
47335089274	TEMOZOLOMIDE	Non-LDD	48.50%
47335089280	TEMOZOLOMIDE	Non-LDD	48.50%
47335089360	TEMOZOLOMIDE	Non-LDD	48.50%
47335089374	TEMOZOLOMIDE	Non-LDD	48.50%
47335089380	TEMOZOLOMIDE	Non-LDD	48.50%
47335092921	TEMOZOLOMIDE	Non-LDD	48.50%
47335092960	TEMOZOLOMIDE	Non-LDD	48.50%
47335092972	TEMOZOLOMIDE	Non-LDD	48.50%
47335092974	TEMOZOLOMIDE	Non-LDD	48.50%
47335092980	TEMOZOLOMIDE	Non-LDD	48.50%
47335093021	TEMOZOLOMIDE	Non-LDD	48.50%
47335093060	TEMOZOLOMIDE	Non-LDD	48.50%
47335093072	TEMOZOLOMIDE	Non-LDD	48.50%
47335093074	TEMOZOLOMIDE	Non-LDD	48.50%
47335093080	TEMOZOLOMIDE	Non-LDD	48.50%
50268076111	TEMOZOLOMIDE	Non-LDD	48.50%
50268076112	TEMOZOLOMIDE	Non-LDD	48.50%
50268076211	TEMOZOLOMIDE	Non-LDD	48.50%
50268076212	TEMOZOLOMIDE	Non-LDD	48.50%
50268076311	TEMOZOLOMIDE	Non-LDD	48.50%
50268076312	TEMOZOLOMIDE	Non-LDD	48.50%
51862008314	TEMOZOLOMIDE	Non-LDD	48.50%
51862008351	TEMOZOLOMIDE	Non-LDD	48.50%
51862008514	TEMOZOLOMIDE	Non-LDD	48.50%
51862008551	TEMOZOLOMIDE	Non-LDD	48.50%
51862008714	TEMOZOLOMIDE	Non-LDD	48.50%
51862008751	TEMOZOLOMIDE	Non-LDD	48.50%
51862008851	TEMOZOLOMIDE	Non-LDD	48.50%
59923070305	TEMOZOLOMIDE	Non-LDD	48.50%
59923070414	TEMOZOLOMIDE	Non-LDD	48.50%
59923070505	TEMOZOLOMIDE	Non-LDD	48.50%
59923070614	TEMOZOLOMIDE	Non-LDD	48.50%
59923070705	TEMOZOLOMIDE	Non-LDD	48.50%
59923070814	TEMOZOLOMIDE	Non-LDD	48.50%
59923070905	TEMOZOLOMIDE	Non-LDD	48.50%
59923071014	TEMOZOLOMIDE	Non-LDD	48.50%
59923071105	TEMOZOLOMIDE	Non-LDD	48.50%
59923071214	TEMOZOLOMIDE	Non-LDD	48.50%
59923071305	TEMOZOLOMIDE	Non-LDD	48.50%
62559092014	TEMOZOLOMIDE	Non-LDD	48.50%
62559092051	TEMOZOLOMIDE	Non-LDD	48.50%
62559092114	TEMOZOLOMIDE	Non-LDD	48.50%
62559092151	TEMOZOLOMIDE	Non-LDD	48.50%
62559092214	TEMOZOLOMIDE	Non-LDD	48.50%
62559092251	TEMOZOLOMIDE	Non-LDD	48.50%
62559092314	TEMOZOLOMIDE	Non-LDD	48.50%
62559092351	TEMOZOLOMIDE	Non-LDD	48.50%
62559092414	TEMOZOLOMIDE	Non-LDD	48.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
62559092451	TEMOZOLOMIDE	Non-LDD	48.50%
62559092551	TEMOZOLOMIDE	Non-LDD	48.50%
64980033305	TEMOZOLOMIDE	Non-LDD	48.50%
64980033314	TEMOZOLOMIDE	Non-LDD	48.50%
64980033405	TEMOZOLOMIDE	Non-LDD	48.50%
64980033414	TEMOZOLOMIDE	Non-LDD	48.50%
64980033505	TEMOZOLOMIDE	Non-LDD	48.50%
64980033514	TEMOZOLOMIDE	Non-LDD	48.50%
64980033605	TEMOZOLOMIDE	Non-LDD	48.50%
64980033614	TEMOZOLOMIDE	Non-LDD	48.50%
64980033705	TEMOZOLOMIDE	Non-LDD	48.50%
64980033714	TEMOZOLOMIDE	Non-LDD	48.50%
64980033805	TEMOZOLOMIDE	Non-LDD	48.50%
65162080114	TEMOZOLOMIDE	Non-LDD	48.50%
65162080151	TEMOZOLOMIDE	Non-LDD	48.50%
65162080214	TEMOZOLOMIDE	Non-LDD	48.50%
65162080251	TEMOZOLOMIDE	Non-LDD	48.50%
65162080314	TEMOZOLOMIDE	Non-LDD	48.50%
65162080351	TEMOZOLOMIDE	Non-LDD	48.50%
65162080414	TEMOZOLOMIDE	Non-LDD	48.50%
65162080451	TEMOZOLOMIDE	Non-LDD	48.50%
65162080514	TEMOZOLOMIDE	Non-LDD	48.50%
65162080551	TEMOZOLOMIDE	Non-LDD	48.50%
65162080651	TEMOZOLOMIDE	Non-LDD	48.50%
67877053707	TEMOZOLOMIDE	Non-LDD	48.50%
67877053714	TEMOZOLOMIDE	Non-LDD	48.50%
67877053807	TEMOZOLOMIDE	Non-LDD	48.50%
67877053814	TEMOZOLOMIDE	Non-LDD	48.50%
67877053907	TEMOZOLOMIDE	Non-LDD	48.50%
67877053914	TEMOZOLOMIDE	Non-LDD	48.50%
67877054007	TEMOZOLOMIDE	Non-LDD	48.50%
67877054014	TEMOZOLOMIDE	Non-LDD	48.50%
67877054107	TEMOZOLOMIDE	Non-LDD	48.50%
67877054114	TEMOZOLOMIDE	Non-LDD	48.50%
67877054207	TEMOZOLOMIDE	Non-LDD	48.50%
68382075167	TEMOZOLOMIDE	Non-LDD	48.50%
68382075196	TEMOZOLOMIDE	Non-LDD	48.50%
68382075267	TEMOZOLOMIDE	Non-LDD	48.50%
68382075296	TEMOZOLOMIDE	Non-LDD	48.50%
68382075367	TEMOZOLOMIDE	Non-LDD	48.50%
68382075396	TEMOZOLOMIDE	Non-LDD	48.50%
68382075467	TEMOZOLOMIDE	Non-LDD	48.50%
68382075496	TEMOZOLOMIDE	Non-LDD	48.50%
68382075596	TEMOZOLOMIDE	Non-LDD	48.50%
68382075696	TEMOZOLOMIDE	Non-LDD	48.50%
75834013205	TEMOZOLOMIDE	Non-LDD	48.50%
75834013214	TEMOZOLOMIDE	Non-LDD	48.50%
75834014205	TEMOZOLOMIDE	Non-LDD	48.50%
75834014214	TEMOZOLOMIDE	Non-LDD	48.50%
75834014305	TEMOZOLOMIDE	Non-LDD	48.50%
75834014314	TEMOZOLOMIDE	Non-LDD	48.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
75834014405	TEMOZOLOMIDE	Non-LDD	48.50%
75834014414	TEMOZOLOMIDE	Non-LDD	48.50%
75834014505	TEMOZOLOMIDE	Non-LDD	48.50%
75834014514	TEMOZOLOMIDE	Non-LDD	48.50%
75834014605	TEMOZOLOMIDE	Non-LDD	48.50%
16729022130	TEMSIROLIMUS	Non-LDD	21.00%
16729022361	TEMSIROLIMUS	Non-LDD	21.00%
65219020005	TEMSIROLIMUS	Non-LDD	21.00%
65219020505	TEMSIROLIMUS	Non-LDD	21.00%
72611078001	TEMSIROLIMUS	Non-LDD	21.00%
72611078502	TEMSIROLIMUS	Non-LDD	21.00%
44567050701	TENIPOSIDE	Non-LDD	4.50%
70121163001	TEPADINA	Non-LDD	21.00%
70121163101	TEPADINA	Non-LDD	21.00%
75987013015	TEPEZZA	LDD with Access	21.00%
44087500003	TEPMETKO	LDD with Access	13.25%
44087500006	TEPMETKO	LDD with Access	13.25%
47781065289	TERIPARATIDE	Non-LDD	22.00%
54046823	TETRABENAZINE	Non-LDD	31.50%
54046923	TETRABENAZINE	Non-LDD	31.50%
31722082111	TETRABENAZINE	Non-LDD	31.50%
31722082211	TETRABENAZINE	Non-LDD	31.50%
42291080630	TETRABENAZINE	Non-LDD	31.50%
42291080730	TETRABENAZINE	Non-LDD	31.50%
43598039467	TETRABENAZINE	Non-LDD	31.50%
43598039567	TETRABENAZINE	Non-LDD	31.50%
47335017923	TETRABENAZINE	Non-LDD	31.50%
47335027723	TETRABENAZINE	Non-LDD	31.50%
51224042510	TETRABENAZINE	Non-LDD	31.50%
51224042610	TETRABENAZINE	Non-LDD	31.50%
51407048012	TETRABENAZINE	Non-LDD	31.50%
51407048112	TETRABENAZINE	Non-LDD	31.50%
60505388207	TETRABENAZINE	Non-LDD	31.50%
60505388307	TETRABENAZINE	Non-LDD	31.50%
68180040858	TETRABENAZINE	Non-LDD	31.50%
68180040958	TETRABENAZINE	Non-LDD	31.50%
68682042112	TETRABENAZINE	Non-LDD	31.50%
68682042225	TETRABENAZINE	Non-LDD	31.50%
69452011721	TETRABENAZINE	Non-LDD	31.50%
69452011821	TETRABENAZINE	Non-LDD	31.50%
70436010109	TETRABENAZINE	Non-LDD	31.50%
70436010209	TETRABENAZINE	Non-LDD	31.50%
55513011201	TEZSPIRE	LDD with Access	15.50%
55513011296	TEZSPIRE	LDD with Access	15.50%
55513012301	TEZSPIRE	LDD with Access	15.50%
59572020514	THALOMID	LDD with Access	17.48%
59572020517	THALOMID	LDD with Access	17.48%
59572021015	THALOMID	LDD with Access	17.48%
59572021513	THALOMID	LDD with Access	17.48%
59572022016	THALOMID	LDD with Access	17.48%
178090001	THIOLA	LDD with Access	12.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
178090190	THIOLA EC	LDD with Access	12.50%
178090201	THIOLA EC	LDD with Access	12.50%
143930901	THIOTEPA	Non-LDD	38.50%
143956501	THIOTEPA	Non-LDD	38.50%
25021024602	THIOTEPA	Non-LDD	38.50%
43598017111	THIOTEPA	Non-LDD	38.50%
43598065011	THIOTEPA	Non-LDD	38.50%
54879001413	THIOTEPA	Non-LDD	38.50%
65219002920	THIOTEPA	Non-LDD	38.50%
72205004501	THIOTEPA	Non-LDD	38.50%
72205004601	THIOTEPA	Non-LDD	38.50%
58468003001	THYROGEN	LDD with Access	21.00%
58468003002	THYROGEN	LDD with Access	21.00%
71334010001	TIBSOVO	LDD with Access	14.50%
72694061760	TIBSOVO	LDD with Access	14.50%
70726030301	TIGLUTIK	LDD with Access	10.50%
70726030302	TIGLUTIK	LDD with Access	10.50%
93790901	TIOPRONIN	LDD with Access	28.50%
51144000301	TIVDAK	Non-LDD	15.50%
78049461	TOBI	LDD with Access	19.50%
78049471	TOBI	LDD with Access	19.50%
49502034573	TOBI	LDD with Access	19.50%
49502034599	TOBI	LDD with Access	19.50%
78063011	TOBI PODHALER	LDD with Access	19.50%
78063019	TOBI PODHALER	LDD with Access	19.50%
78063035	TOBI PODHALER	LDD with Access	19.50%
78063056	TOBI PODHALER	LDD with Access	19.50%
49502034611	TOBI PODHALER	LDD with Access	19.50%
49502034624	TOBI PODHALER	LDD with Access	19.50%
49502034656	TOBI PODHALER	LDD with Access	19.50%
49502040111	TOBI PODHALER	LDD with Access	19.50%
49502040124	TOBI PODHALER	LDD with Access	19.50%
49502040156	TOBI PODHALER	LDD with Access	19.50%
93375004	TOBRAMYCIN	Non-LDD	20.50%
93375028	TOBRAMYCIN	Non-LDD	20.50%
93375063	TOBRAMYCIN	Non-LDD	20.50%
93408563	TOBRAMYCIN	Non-LDD	20.50%
781717156	TOBRAMYCIN	Non-LDD	20.50%
781717175	TOBRAMYCIN	Non-LDD	20.50%
781717184	TOBRAMYCIN	Non-LDD	20.50%
16714011902	TOBRAMYCIN	Non-LDD	20.50%
16714011903	TOBRAMYCIN	Non-LDD	20.50%
17478034038	TOBRAMYCIN	Non-LDD	20.50%
43598060504	TOBRAMYCIN	Non-LDD	20.50%
43598060511	TOBRAMYCIN	Non-LDD	20.50%
43598060556	TOBRAMYCIN	Non-LDD	20.50%
43598060558	TOBRAMYCIN	Non-LDD	20.50%
47335017148	TOBRAMYCIN	Non-LDD	20.50%
47335017149	TOBRAMYCIN	Non-LDD	20.50%
60687073179	TOBRAMYCIN	Non-LDD	20.50%
60687073183	TOBRAMYCIN	Non-LDD	20.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
65162091446	TOBRAMYCIN	Non-LDD	20.50%
66993019544	TOBRAMYCIN	Non-LDD	20.50%
66993019594	TOBRAMYCIN	Non-LDD	20.50%
67877067869	TOBRAMYCIN	Non-LDD	20.50%
67877067870	TOBRAMYCIN	Non-LDD	20.50%
68180096204	TOBRAMYCIN	Non-LDD	20.50%
68180096256	TOBRAMYCIN	Non-LDD	20.50%
70644089999	TOBRAMYCIN	Non-LDD	20.50%
70756060444	TOBRAMYCIN	Non-LDD	20.50%
70756060456	TOBRAMYCIN	Non-LDD	20.50%
70756061756	TOBRAMYCIN	Non-LDD	20.50%
31722086803	TOLVAPTAN	Non-LDD	40.50%
31722086831	TOLVAPTAN	Non-LDD	40.50%
31722086901	TOLVAPTAN	Non-LDD	40.50%
31722086903	TOLVAPTAN	Non-LDD	40.50%
31722086931	TOLVAPTAN	Non-LDD	40.50%
49884076852	TOLVAPTAN	Non-LDD	40.50%
49884076854	TOLVAPTAN	Non-LDD	40.50%
49884077052	TOLVAPTAN	Non-LDD	40.50%
49884077054	TOLVAPTAN	Non-LDD	40.50%
60505431700	TOLVAPTAN	Non-LDD	40.50%
60505431800	TOLVAPTAN	Non-LDD	40.50%
60505470400	TOLVAPTAN	Non-LDD	40.50%
60505470402	TOLVAPTAN	Non-LDD	40.50%
60505470500	TOLVAPTAN	Non-LDD	40.50%
60505470501	TOLVAPTAN	Non-LDD	40.50%
67877063502	TOLVAPTAN	Non-LDD	40.50%
67877063533	TOLVAPTAN	Non-LDD	40.50%
67877063602	TOLVAPTAN	Non-LDD	40.50%
67877063633	TOLVAPTAN	Non-LDD	40.50%
409030201	TOPOTECAN HCL	Non-LDD	39.20%
703471401	TOPOTECAN HCL	Non-LDD	39.20%
703471471	TOPOTECAN HCL	Non-LDD	39.20%
16729015131	TOPOTECAN HCL	Non-LDD	39.20%
16729024330	TOPOTECAN HCL	Non-LDD	39.20%
16729024331	TOPOTECAN HCL	Non-LDD	39.20%
25021023604	TOPOTECAN HCL	Non-LDD	39.20%
45963061556	TOPOTECAN HCL	Non-LDD	39.20%
50742040401	TOPOTECAN HCL	Non-LDD	39.20%
62756002340	TOPOTECAN HCL	Non-LDD	39.20%
63323076210	TOPOTECAN HCL	Non-LDD	39.20%
63323076217	TOPOTECAN HCL	Non-LDD	39.20%
63323076294	TOPOTECAN HCL	Non-LDD	39.20%
67457066205	TOPOTECAN HCL	Non-LDD	39.20%
64980040403	TOREMIFENE CITRATE	Non-LDD	18.50%
72205005030	TOREMIFENE CITRATE	Non-LDD	18.50%
8117901	TORISEL	Non-LDD	21.00%
8117905	TORISEL	Non-LDD	21.00%
66215010103	TRACLEER	LDD with Access	13.25%
66215010106	TRACLEER	LDD with Access	13.25%
66215010203	TRACLEER	LDD with Access	13.25%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
66215010206	TRACLEER	LDD with Access	13.25%
66215010314	TRACLEER	LDD with Access	13.25%
66215010356	TRACLEER	LDD with Access	13.25%
66215023214	TRACLEER	LDD with Access	13.25%
66215023256	TRACLEER	LDD with Access	13.25%
69030501	TRAZIMERA	Non-LDD	21.00%
69030601	TRAZIMERA	Non-LDD	21.00%
69030801	TRAZIMERA	Non-LDD	21.00%
63459039008	TREANDA	Non-LDD	21.00%
63459039120	TREANDA	Non-LDD	21.00%
23590203	TRELSTAR	Non-LDD	18.50%
23590204	TRELSTAR	Non-LDD	18.50%
23590411	TRELSTAR	Non-LDD	18.50%
23590412	TRELSTAR	Non-LDD	18.50%
23590622	TRELSTAR	Non-LDD	18.50%
23590623	TRELSTAR	Non-LDD	18.50%
74676590200	TRELSTAR	Non-LDD	18.50%
74676590201	TRELSTAR	Non-LDD	18.50%
74676590400	TRELSTAR	Non-LDD	18.50%
74676590401	TRELSTAR	Non-LDD	18.50%
74676590600	TRELSTAR	Non-LDD	18.50%
74676590601	TRELSTAR	Non-LDD	18.50%
57894064001	TREMFYA	Non-LDD	17.50%
57894064011	TREMFYA	Non-LDD	17.50%
703066601	TREPROSTINIL	LDD with Access	28.50%
703067601	TREPROSTINIL	LDD with Access	28.50%
703068601	TREPROSTINIL	LDD with Access	28.50%
703069601	TREPROSTINIL	LDD with Access	28.50%
781342080	TREPROSTINIL	LDD with Access	28.50%
781342580	TREPROSTINIL	LDD with Access	28.50%
781342780	TREPROSTINIL	LDD with Access	28.50%
781343080	TREPROSTINIL	LDD with Access	28.50%
42023020601	TREPROSTINIL	LDD with Access	28.50%
42023020701	TREPROSTINIL	LDD with Access	28.50%
42023020801	TREPROSTINIL	LDD with Access	28.50%
42023020901	TREPROSTINIL	LDD with Access	28.50%
43598064611	TREPROSTINIL	LDD with Access	28.50%
43598064711	TREPROSTINIL	LDD with Access	28.50%
43598064811	TREPROSTINIL	LDD with Access	28.50%
43598064911	TREPROSTINIL	LDD with Access	28.50%
555080802	TRETINOIN	Non-LDD	38.50%
904686704	TRETINOIN	Non-LDD	38.50%
904686760	TRETINOIN	Non-LDD	38.50%
10370026801	TRETINOIN	Non-LDD	38.50%
42291084301	TRETINOIN	Non-LDD	38.50%
42291087001	TRETINOIN	Non-LDD	38.50%
63629228501	TRETINOIN	Non-LDD	38.50%
63629875201	TRETINOIN	Non-LDD	38.50%
68084007511	TRETINOIN	Non-LDD	38.50%
68084007521	TRETINOIN	Non-LDD	38.50%
68462079201	TRETINOIN	Non-LDD	38.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
169701301	TRETTEN	LDD with Access	14.50%
169711311	TRETTEN	LDD with Access	14.50%
527406837	TRIENTINE HCL	Non-LDD	30.40%
591491001	TRIENTINE HCL	Non-LDD	30.40%
16571081001	TRIENTINE HCL	Non-LDD	30.40%
31722068301	TRIENTINE HCL	Non-LDD	30.40%
43598045901	TRIENTINE HCL	Non-LDD	30.40%
49884006001	TRIENTINE HCL	Non-LDD	30.40%
64980045001	TRIENTINE HCL	Non-LDD	30.40%
66435070010	TRIENTINE HCL	Non-LDD	30.40%
68682021210	TRIENTINE HCL	Non-LDD	30.40%
69238154501	TRIENTINE HCL	Non-LDD	30.40%
70710120301	TRIENTINE HCL	Non-LDD	30.40%
72205000891	TRIENTINE HCL	Non-LDD	30.40%
51167010602	TRIKAFTA	LDD with Access	15.60%
51167033101	TRIKAFTA	LDD with Access	15.60%
51167044501	TRIKAFTA	LDD with Access	15.60%
51167044601	TRIKAFTA	LDD with Access	15.60%
24338015001	TRIPTODUR	LDD with Access	11.90%
24338015020	TRIPTODUR	LDD with Access	11.90%
63459060106	TRISENOX	Non-LDD	21.00%
63459060111	TRISENOX	Non-LDD	21.00%
55135013201	TRODELVY	LDD with Access	13.50%
72730010101	TRUSELTIQ	LDD with Access	13.00%
72730011101	TRUSELTIQ	LDD with Access	13.00%
72730020201	TRUSELTIQ	LDD with Access	13.00%
72730050601	TRUSELTIQ	LDD with Access	13.00%
63459010310	TRUXIMA	Non-LDD	21.00%
63459010450	TRUXIMA	Non-LDD	21.00%
51144000160	TUKYSA	LDD with Access	21.00%
51144000212	TUKYSA	LDD with Access	21.00%
51144000260	TUKYSA	LDD with Access	21.00%
65597040220	TURALIO	LDD with Access	13.75%
65597040228	TURALIO	LDD with Access	13.75%
65597040720	TURALIO	LDD with Access	13.75%
65597040728	TURALIO	LDD with Access	13.75%
78067119	TYKERB	Non-LDD	18.50%
70539000101	TYMLOS	LDD with Access	17.50%
70539000102	TYMLOS	LDD with Access	17.50%
70539000198	TYMLOS	LDD with Access	17.50%
70539000199	TYMLOS	LDD with Access	17.50%
64406000801	TYSABRI	LDD with Access	15.20%
66302020603	TYVASO	LDD with Access	15.25%
66302060002	TYVASO DPI	LDD with Access	15.25%
66302061002	TYVASO DPI	LDD with Access	15.25%
66302061601	TYVASO DPI	LDD with Access	15.25%
66302061603	TYVASO DPI	LDD with Access	15.25%
66302062003	TYVASO DPI	LDD with Access	15.25%
66302063201	TYVASO DPI	LDD with Access	15.25%
66302063203	TYVASO DPI	LDD with Access	15.25%
66302064801	TYVASO DPI	LDD with Access	15.25%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
66302064803	TYVASO DPI	LDD with Access	15.25%
66302066401	TYVASO DPI	LDD with Access	15.25%
66302066403	TYVASO DPI	LDD with Access	15.25%
66302071604	TYVASO DPI	LDD with Access	15.25%
66302073204	TYVASO DPI	LDD with Access	15.25%
66302074804	TYVASO DPI	LDD with Access	15.25%
66302076404	TYVASO DPI	LDD with Access	15.25%
66302020604	TYVASO INSTITUTIONAL START	LDD with Access	15.25%
66302020602	TYVASO REFILL KIT	LDD with Access	15.25%
66302020601	TYVASO STARTER KIT	LDD with Access	15.25%
70114010101	UDENYCA	Non-LDD	19.50%
25682002201	ULTOMIRIS	LDD with Access	16.50%
25682002501	ULTOMIRIS	LDD with Access	16.50%
25682002801	ULTOMIRIS	LDD with Access	16.50%
72677055101	UPLIZNA	LDD with Access	13.50%
75987015001	UPLIZNA	Non-LDD	13.50%
75987015003	UPLIZNA	Non-LDD	13.50%
66215060206	UPTRAVI	LDD with Access	15.50%
66215060214	UPTRAVI	LDD with Access	15.50%
66215060406	UPTRAVI	LDD with Access	15.50%
66215060606	UPTRAVI	LDD with Access	15.50%
66215060806	UPTRAVI	LDD with Access	15.50%
66215061006	UPTRAVI	LDD with Access	15.50%
66215061206	UPTRAVI	LDD with Access	15.50%
66215061406	UPTRAVI	LDD with Access	15.50%
66215061606	UPTRAVI	LDD with Access	15.50%
66215062820	UPTRAVI	LDD with Access	15.50%
66215071801	UPTRAVI	LDD with Access	15.50%
50242009601	VABYSMO	Non-LDD	15.50%
50242009677	VABYSMO	Non-LDD	15.50%
50242009686	VABYSMO	Non-LDD	15.50%
69639012001	VALCHLOR	LDD with Access	15.00%
24201010101	VALRUBICIN	Non-LDD	15.75%
24201010104	VALRUBICIN	Non-LDD	15.75%
67979000101	VALSTAR	Non-LDD	17.48%
67979050001	VANTAS	Non-LDD	16.25%
55513095401	VECTIBIX	Non-LDD	21.00%
55513095601	VECTIBIX	Non-LDD	21.00%
61958290102	VEKLURY	Non-LDD	17.00%
63020004901	VELCADE	Non-LDD	16.15%
63020004904	VELCADE	Non-LDD	16.15%
66215040201	VELETRI	LDD with Access	13.25%
66215040301	VELETRI	LDD with Access	13.25%
61958230101	VEMLIDY	Non-LDD	17.50%
74056111	VENCLEXTA	LDD with Access	18.50%
74056114	VENCLEXTA	LDD with Access	18.50%
74056607	VENCLEXTA	LDD with Access	18.50%
74056611	VENCLEXTA	LDD with Access	18.50%
74057611	VENCLEXTA	LDD with Access	18.50%
74057622	VENCLEXTA	LDD with Access	18.50%
74057630	VENCLEXTA	LDD with Access	18.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
74057634	VENCLEXTA	LDD with Access	18.50%
74057928	VENCLEXTA STARTING PACK	LDD with Access	18.50%
66215030200	VENTAVIS	LDD with Access	13.50%
66215030230	VENTAVIS	LDD with Access	13.50%
66215030300	VENTAVIS	LDD with Access	13.50%
66215030330	VENTAVIS	LDD with Access	13.50%
2448354	VERZENIO	LDD with Access	17.50%
2481554	VERZENIO	LDD with Access	17.50%
2533754	VERZENIO	LDD with Access	17.50%
2621654	VERZENIO	LDD with Access	17.50%
59572010201	VIDAZA	Non-LDD	17.48%
74309328	VIEKIRA PAK	Non-LDD	22.00%
574020101	VIGABATRIN	LDD with Access	32.50%
574047000	VIGABATRIN	LDD with Access	32.50%
574047050	VIGABATRIN	LDD with Access	32.50%
591385101	VIGABATRIN	LDD with Access	32.50%
591395511	VIGABATRIN	LDD with Access	32.50%
591395550	VIGABATRIN	LDD with Access	32.50%
16729052111	VIGABATRIN	LDD with Access	32.50%
16729052163	VIGABATRIN	LDD with Access	32.50%
31722000950	VIGABATRIN	LDD with Access	32.50%
42799095001	VIGABATRIN	LDD with Access	32.50%
43598065101	VIGABATRIN	LDD with Access	32.50%
43598069711	VIGABATRIN	LDD with Access	32.50%
43598069750	VIGABATRIN	LDD with Access	32.50%
49884035803	VIGABATRIN	LDD with Access	32.50%
49884035852	VIGABATRIN	LDD with Access	32.50%
59651036607	VIGABATRIN	LDD with Access	32.50%
59651036650	VIGABATRIN	LDD with Access	32.50%
59651036701	VIGABATRIN	LDD with Access	32.50%
67877067463	VIGABATRIN	LDD with Access	32.50%
69097096453	VIGABATRIN	LDD with Access	32.50%
69238142401	VIGABATRIN	LDD with Access	32.50%
69238142501	VIGABATRIN	LDD with Access	32.50%
69238142505	VIGABATRIN	LDD with Access	32.50%
70710128701	VIGABATRIN	LDD with Access	32.50%
245055650	VIGADRONE	LDD with Access	17.50%
245055689	VIGADRONE	LDD with Access	17.50%
245600111	VIGADRONE	LDD with Access	17.50%
78102151	VIJOICE	Non-LDD	15.50%
78102184	VIJOICE	LDD with Access	15.50%
78102884	VIJOICE	LDD with Access	15.50%
78103502	VIJOICE	LDD with Access	15.50%
78103561	VIJOICE	Non-LDD	15.50%
73292001101	VILTEPSO	LDD with Access	17.00%
68135010001	VIMIZIM	LDD with Access	15.25%
63323027810	VINBLASTINE SULFATE	Non-LDD	30.40%
703418201	VINORELBINE TARTRATE	Non-LDD	68.50%
703418301	VINORELBINE TARTRATE	Non-LDD	68.50%
25021020401	VINORELBINE TARTRATE	Non-LDD	68.50%
25021020405	VINORELBINE TARTRATE	Non-LDD	68.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
45963060755	VINORELBINE TARTRATE	Non-LDD	68.50%
45963060756	VINORELBINE TARTRATE	Non-LDD	68.50%
55390006901	VINORELBINE TARTRATE	Non-LDD	68.50%
55390007001	VINORELBINE TARTRATE	Non-LDD	68.50%
63323014801	VINORELBINE TARTRATE	Non-LDD	68.50%
63323014805	VINORELBINE TARTRATE	Non-LDD	68.50%
69468015104	VISTOGARD	LDD with Access	15.50%
69468015110	VISTOGARD	LDD with Access	15.50%
69468015120	VISTOGARD	LDD with Access	15.50%
187560015	VISUDYNE	LDD with Access	12.25%
50419039001	VITRAKVI	LDD with Access	15.90%
50419039101	VITRAKVI	LDD with Access	15.90%
50419039201	VITRAKVI	LDD with Access	15.90%
50419039302	VITRAKVI	LDD with Access	15.90%
50419039303	VITRAKVI	LDD with Access	15.90%
71777039001	VITRAKVI	LDD with Access	15.90%
71777039101	VITRAKVI	LDD with Access	15.90%
69019730	VIZIMPRO	LDD with Access	21.00%
69119830	VIZIMPRO	LDD with Access	21.00%
69229930	VIZIMPRO	LDD with Access	21.00%
72482010012	VONJO	LDD with Access	14.50%
944755001	VONVENDI	LDD with Access	13.00%
944755102	VONVENDI	LDD with Access	13.00%
944755201	VONVENDI	LDD with Access	13.00%
944755302	VONVENDI	LDD with Access	13.00%
50633021011	VORAXAZE	LDD with Access	16.20%
61958240101	VOSEVI	Non-LDD	17.50%
78067066	VOTRIENT	Non-LDD	18.50%
78107766	VOTRIENT	Non-LDD	18.50%
68135008236	VOXZOGO	LDD with Access	15.50%
68135011966	VOXZOGO	LDD with Access	15.50%
68135018193	VOXZOGO	LDD with Access	15.50%
54092070104	VPRIV	Non-LDD	17.48%
64406002001	VUMERITY	LDD with Access	21.00%
64406002003	VUMERITY	LDD with Access	21.00%
67386013051	VYEPTI	LDD with Access	12.50%
69873001	VYNDAMAX	LDD with Access	21.00%
69873030	VYNDAMAX	LDD with Access	21.00%
69197512	VYNDAQEL	LDD with Access	21.00%
69197540	VYNDAQEL	LDD with Access	21.00%
60923046502	VYONDYS-53	LDD with Access	8.50%
73475304105	VYVGART	LDD with Access	14.00%
68727074501	VYXEOS	LDD with Access	15.50%
68727074502	VYXEOS	LDD with Access	15.50%
68727074505	VYXEOS	LDD with Access	15.50%
72028004503	WAKIX	LDD with Access	14.50%
72028017803	WAKIX	LDD with Access	14.50%
6533101	WELIREG	LDD with Access	14.00%
67467018101	WILATE	Non-LDD	48.50%
67467018102	WILATE	Non-LDD	48.50%
68982018201	WILATE	Non-LDD	48.50%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
68982018202	WILATE	Non-LDD	48.50%
70257030013	WINRHO SDF	Non-LDD	22.50%
70257030051	WINRHO SDF	Non-LDD	22.50%
70257031004	WINRHO SDF	Non-LDD	22.50%
70257031051	WINRHO SDF	Non-LDD	22.50%
70257033011	WINRHO SDF	Non-LDD	22.50%
70257033051	WINRHO SDF	Non-LDD	22.50%
70257035002	WINRHO SDF	Non-LDD	22.50%
70257035051	WINRHO SDF	Non-LDD	22.50%
70504300001	WINRHO SDF	Non-LDD	22.50%
70504300002	WINRHO SDF	Non-LDD	22.50%
70504310001	WINRHO SDF	Non-LDD	22.50%
70504310002	WINRHO SDF	Non-LDD	22.50%
70504350001	WINRHO SDF	Non-LDD	22.50%
70504350002	WINRHO SDF	Non-LDD	22.50%
69814020	XALKORI	LDD with Access	18.50%
69814120	XALKORI	LDD with Access	18.50%
52652200101	XATMEP	Non-LDD	21.00%
52652200106	XATMEP	Non-LDD	21.00%
69100101	XELJANZ	Non-LDD	19.50%
69100201	XELJANZ	Non-LDD	19.50%
69102901	XELJANZ	Non-LDD	19.50%
69102902	XELJANZ	Non-LDD	19.50%
69050114	XELJANZ XR	Non-LDD	19.50%
69050130	XELJANZ XR	Non-LDD	19.50%
69050230	XELJANZ XR	Non-LDD	19.50%
4110020	XELODA	Non-LDD	18.50%
4110150	XELODA	Non-LDD	18.50%
61269047060	XELODA	Non-LDD	18.50%
61269047512	XELODA	Non-LDD	18.50%
13533081005	XEMBIFY	LDD with Access	16.50%
13533081006	XEMBIFY	LDD with Access	16.50%
13533081010	XEMBIFY	LDD with Access	16.50%
13533081011	XEMBIFY	LDD with Access	16.50%
13533081020	XEMBIFY	LDD with Access	16.50%
13533081021	XEMBIFY	LDD with Access	16.50%
13533081050	XEMBIFY	LDD with Access	16.50%
13533081051	XEMBIFY	LDD with Access	16.50%
67386042101	XENAZINE	LDD with Access	16.50%
67386042201	XENAZINE	LDD with Access	16.50%
58468005001	XENPOZYME	Non-LDD	16.25%
58468005101	XENPOZYME	Non-LDD	16.25%
259160501	XEOMIN	Non-LDD	21.00%
259161001	XEOMIN	Non-LDD	21.00%
259162001	XEOMIN	Non-LDD	21.00%
259415001	XEOMIN	Non-LDD	21.00%
46783016001	XEOMIN	Non-LDD	21.00%
46783016101	XEOMIN	Non-LDD	21.00%
70183012503	XERMELO	LDD with Access	13.75%
70183012522	XERMELO	LDD with Access	13.75%
70183012584	XERMELO	LDD with Access	13.75%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
70183012585	XERMELO	LDD with Access	13.75%
70720012585	XERMELO	LDD with Access	13.75%
55513073001	XGEVA	Non-LDD	20.50%
66887000301	XIAFLEX	LDD with Access	11.40%
50242004062	XOLAIR	LDD with Access	22.00%
50242004086	XOLAIR	LDD with Access	22.00%
50242021401	XOLAIR	LDD with Access	22.00%
50242021501	XOLAIR	LDD with Access	22.00%
50242021586	XOLAIR	LDD with Access	22.00%
469142590	XOSPATA	LDD with Access	14.75%
72237010101	XPOVIO	LDD with Access	9.50%
72237010102	XPOVIO	LDD with Access	9.50%
72237010103	XPOVIO	LDD with Access	9.50%
72237010104	XPOVIO	LDD with Access	9.50%
72237010105	XPOVIO	LDD with Access	9.50%
72237010106	XPOVIO	LDD with Access	9.50%
72237010107	XPOVIO	LDD with Access	9.50%
72237010111	XPOVIO	LDD with Access	9.50%
72237010112	XPOVIO	LDD with Access	9.50%
72237010113	XPOVIO	LDD with Access	9.50%
72237010114	XPOVIO	LDD with Access	9.50%
72237010115	XPOVIO	LDD with Access	9.50%
72237010116	XPOVIO	LDD with Access	9.50%
72237010117	XPOVIO	LDD with Access	9.50%
72237010202	XPOVIO	LDD with Access	9.50%
72237010206	XPOVIO	LDD with Access	9.50%
72237010207	XPOVIO	LDD with Access	9.50%
72237010212	XPOVIO	LDD with Access	9.50%
72237010216	XPOVIO	LDD with Access	9.50%
72237010217	XPOVIO	LDD with Access	9.50%
72237010305	XPOVIO	LDD with Access	9.50%
72237010315	XPOVIO	LDD with Access	9.50%
72237010401	XPOVIO	LDD with Access	9.50%
72237010411	XPOVIO	LDD with Access	9.50%
469012599	XTANDI	LDD with Access	18.00%
469062599	XTANDI	LDD with Access	18.00%
469072560	XTANDI	LDD with Access	18.00%
69468015202	XURIDEN	LDD with Access	13.50%
69468015230	XURIDEN	LDD with Access	13.50%
58394001201	XYNTHA	Non-LDD	39.20%
58394001301	XYNTHA	Non-LDD	39.20%
58394001401	XYNTHA	Non-LDD	39.20%
58394001501	XYNTHA	Non-LDD	39.20%
58394011501	XYNTHA	Non-LDD	39.20%
58394001603	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394002203	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394002303	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394002403	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394002503	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394011603	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394012203	XYNTHA SOLOFUSE	Non-LDD	39.20%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
58394012303	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394012403	XYNTHA SOLOFUSE	Non-LDD	39.20%
58394012503	XYNTHA SOLOFUSE	Non-LDD	39.20%
68727010001	XYREM	LDD with Access	8.50%
68727015001	XYWAV	LDD with Access	8.50%
3232711	YERVOY	Non-LDD	21.00%
3232822	YERVOY	Non-LDD	21.00%
71287011901	YESCARTA	LDD with Access	13.50%
71287011902	YESCARTA	LDD with Access	13.50%
59676061001	YONDELIS	Non-LDD	21.00%
47335040181	YONSA	Non-LDD	21.00%
24584001	ZALTRAP	Non-LDD	17.48%
24584101	ZALTRAP	Non-LDD	17.48%
703463601	ZANOSAR	Non-LDD	20.50%
61314031801	ZARXIO	Non-LDD	21.25%
61314031805	ZARXIO	Non-LDD	21.25%
61314031810	ZARXIO	Non-LDD	21.25%
61314032601	ZARXIO	Non-LDD	21.25%
61314032605	ZARXIO	Non-LDD	21.25%
61314032610	ZARXIO	Non-LDD	21.25%
66215020118	ZAVESCA	LDD with Access	8.50%
66215020190	ZAVESCA	LDD with Access	8.50%
173090913	ZEJULA	LDD with Access	14.50%
173091213	ZEJULA	LDD with Access	14.50%
173091261	ZEJULA	Non-LDD	14.50%
173091513	ZEJULA	LDD with Access	14.50%
173091561	ZEJULA	Non-LDD	14.50%
69656010330	ZEJULA	LDD with Access	14.50%
69656010361	ZEJULA	LDD with Access	14.50%
69656010390	ZEJULA	LDD with Access	14.50%
50242009002	ZELBORAF	LDD with Access	17.50%
53720102	ZEMAIRA	LDD with Access	22.50%
53721101	ZEMAIRA	LDD with Access	22.50%
6307401	ZEPATIER	Non-LDD	21.00%
6307402	ZEPATIER	Non-LDD	21.00%
59572081007	ZEPOSIA	LDD with Access	21.00%
59572082030	ZEPOSIA	LDD with Access	21.00%
59572089007	ZEPOSIA	LDD with Access	21.00%
59572089021	ZEPOSIA	LDD with Access	21.00%
59572089028	ZEPOSIA	LDD with Access	21.00%
59572089030	ZEPOSIA	LDD with Access	21.00%
59572089091	ZEPOSIA	LDD with Access	21.00%
68727071201	ZEPZELCA	Non-LDD	16.25%
61314086601	ZIEXTENZO	Non-LDD	21.00%
69031501	ZIRABEV	Non-LDD	21.00%
69034201	ZIRABEV	Non-LDD	21.00%
73079005030	ZOKINVY	LDD with Access	9.50%
73079007530	ZOKINVY	LDD with Access	9.50%
70720095036	ZOLADEX	Non-LDD	20.50%
70720095130	ZOLADEX	Non-LDD	20.50%
71894012002	ZOLGENSMA	LDD with Access	14.00%

NDC 11 Code	Drug Name	LDD	AWP_ Discount
71894012103	ZOLGENSMA	LDD with Access	14.00%
71894012203	ZOLGENSMA	LDD with Access	14.00%
71894012303	ZOLGENSMA	LDD with Access	14.00%
71894012404	ZOLGENSMA	LDD with Access	14.00%
71894012504	ZOLGENSMA	LDD with Access	14.00%
71894012604	ZOLGENSMA	LDD with Access	14.00%
71894012705	ZOLGENSMA	LDD with Access	14.00%
71894012805	ZOLGENSMA	LDD with Access	14.00%
71894012905	ZOLGENSMA	LDD with Access	14.00%
71894013006	ZOLGENSMA	LDD with Access	14.00%
71894013106	ZOLGENSMA	LDD with Access	14.00%
71894013206	ZOLGENSMA	LDD with Access	14.00%
71894013307	ZOLGENSMA	LDD with Access	14.00%
71894013407	ZOLGENSMA	LDD with Access	14.00%
71894013507	ZOLGENSMA	LDD with Access	14.00%
71894013608	ZOLGENSMA	LDD with Access	14.00%
71894013708	ZOLGENSMA	LDD with Access	14.00%
71894013808	ZOLGENSMA	LDD with Access	14.00%
71894013909	ZOLGENSMA	LDD with Access	14.00%
71894014009	ZOLGENSMA	LDD with Access	14.00%
71894014109	ZOLGENSMA	LDD with Access	14.00%
71894014210	ZOLGENSMA	LDD with Access	14.00%
71894014310	ZOLGENSMA	LDD with Access	14.00%
71894014410	ZOLGENSMA	LDD with Access	14.00%
71894014511	ZOLGENSMA	LDD with Access	14.00%
71894014611	ZOLGENSMA	LDD with Access	14.00%
71894014711	ZOLGENSMA	LDD with Access	14.00%
71894014812	ZOLGENSMA	LDD with Access	14.00%
71894014912	ZOLGENSMA	LDD with Access	14.00%
71894015012	ZOLGENSMA	LDD with Access	14.00%
71894015113	ZOLGENSMA	LDD with Access	14.00%
71894015213	ZOLGENSMA	LDD with Access	14.00%
71894015313	ZOLGENSMA	LDD with Access	14.00%
71894015414	ZOLGENSMA	LDD with Access	14.00%
71894015514	ZOLGENSMA	LDD with Access	14.00%
71894015614	ZOLGENSMA	LDD with Access	14.00%
6056840	ZOLINZA	Non-LDD	18.50%
55566180101	ZOMACTON	Non-LDD	19.50%
55566190101	ZOMACTON	Non-LDD	19.50%
55566190201	ZOMACTON	Non-LDD	19.50%
44087338807	ZORBTIVE	Non-LDD	17.25%
61958170101	ZYDELIG	LDD with Access	18.50%
61958170201	ZYDELIG	LDD with Access	18.50%
78064070	ZYKADIA	Non-LDD	17.50%
78069484	ZYKADIA	Non-LDD	17.50%
57894015012	ZYTIGA	Non-LDD	21.50%
57894019506	ZYTIGA	Non-LDD	21.50%

Healthe SYSTEMS

Transforming healthcare.

Healthesystems Exhibit I:
Specialty Drug List

Prepared for: New York State Insurance Fund

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2023 Specialty Drug List

Specialty medicines treat complex and chronic (long-term) conditions. Examples include multiple sclerosis, hepatitis C, HIV and cancer. Depending on the condition and prescribed therapy, these drugs may be taken by mouth, through a vein, or by injection. Specialty medicines often require specialty handling such as refrigeration. The following specialty medications are covered by WellDyne. This list is not all-inclusive and is subject to change without notice.

ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS

IMCIVREE[PA, QL]
WAKIX[PA, QL]

AMINOGLYCOSIDES

ARIKAYCE[PA, QL]
TOBI PODHALER[PA, QL]
TOBRAMYCIN[PA, QL]

ANALGESICS - ANTI-INFLAMMATORY

ENBREL MINI[PA, QL]
ENBREL SURECLICK[PA, QL]
ENBREL[PA, QL]
HUMIRA PEDIATRIC CROHNS START[PA]
HUMIRA PEN-CD/UC/HS STARTER[PA, QL]
HUMIRA PEN-PEDIATRIC UC START[PA, QL]
HUMIRA PEN-PS/UV/ADOL HS START[PA, QL]
HUMIRA PEN-PSOR/UVEIT STARTER[PA, QL]
HUMIRA PEN[PA, QL]
HUMIRA[PA, QL]
ILARIS[PA]
KEVZARA[PA, QL]
OTEZLA[PA, QL]
OTREXUP[PA, QL]
RINVOQ[PA, QL]

ANALGESICS - OPIOID

PROBUPHINE IMPLANT KIT[PA, QL]
SUBLOCADE[PA, QL]

ANTI-INFECTIVE AGENTS - MISC.

CAYSTON[PA, QL]
colistimethate sodium (cba)
IMPAVIDO[PA, QL]

ANTIARRHYTHMICS

dofetilide

ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NUCALA[PA, QL]
XOLAIR[PA]

ANTICONVULSANTS

EPIDIOLEX[PA]
FINTEPLA[PA, QL]
vigabatrin[PA, QL]
vigadrone[PA, QL]

ANTIDEPRESSANTS

SPRAVATO (56 MG DOSE)[PA, QL]
SPRAVATO (84 MG DOSE)[PA, QL]

ANTIDIABETICS

KORLYM[PA, QL]

ANTIDOTES AND SPECIFIC ANTAGONISTS

ANDEXXA
deferasirox granules[PA]
deferasirox[PA]
deferiprone[PA]
deferoxamine mesylate[PA]
FERRIPROX TWICE-A-DAY[PA, QL]
VIVITROL[PA, QL]

ANTIHYPERLIPIDEMICS

JUXTAPID[PA, QL]
REPATHA PUSHTRONEX SYSTEM[PA, QL]
REPATHA SURECLICK[PA, QL]
REPATHA[PA, QL]

ANTIHYPERTENSIVES

metyrosine[PA, QL]

ANTIMYASTHENIC/CHOLINERGIC AGENTS

RUZURGI[PA, QL]

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

abiraterone acetate[PA, QL]
ALECENSA[PA, QL]
ALFERON N
ALUNBRIG[PA, QL]
ARZERRA[PA]
AYVAKIT[PA, QL]
BALVERSA[PA, QL]
BESREMI[PA, QL]
bexarotene[PA]
BOSULIF[PA, QL]
BRAFTOVI[PA, QL]
BRUKINSA[PA, QL]
CABOMETYX[PA, QL]
CALQUENCE[PA, QL]
capecitabine[PA]
CAPRELSA[PA, QL]
COMETRIQ (100 MG DAILY DOSE)[PA, QL]
COMETRIQ (140 MG DAILY DOSE)[PA, QL]
COMETRIQ (60 MG DAILY DOSE)[PA, QL]
COPIKTRA[PA, QL]
COTELLIC[PA, QL]
cyclophosphamide
CYCLOPHOSPHAMIDE
CYTARABINE
DARZALEX FASPRO[PA]
DAURISMO[PA, QL]
ELIGARD[PA, QL]
EMCYT
ERIVEDGE[PA, QL]
ERLEADA[PA, QL]
erlotinib hcl[PA, QL]
ETOPOSIDE
everolimus[PA, QL]
FARYDAK[PA, QL]
FIRMAGON (240 MG DOSE)[PA, QL]
FIRMAGON[PA, QL]
FOTIVDA[PA, QL]
GAVRETO[PA, QL]
GAZYVA[PA]
gefitinib[PA, QL]
GILOTRIF[PA, QL]
GLEOSTINE[PA]
GLIADEL WAFER
HYCAMTIN[PA]
IBRANCE[PA, QL]
ICLUSIG[PA, QL]
IDHIFA[PA, QL]
imatinib mesylate[PA, QL]
IMBRUVICA[PA, QL]
IMLYGIC[PA]
INLYTA[PA, QL]
INQOVI[PA, QL]
INREBIC[PA, QL]
INTRON A[PA]
JAKAFI[PA, QL]
KISQALI (200 MG DOSE)[PA, QL]
KISQALI (400 MG DOSE)[PA, QL]
KISQALI (600 MG DOSE)[PA, QL]
KISQALI FEMARA (400 MG DOSE)[PA, QL]
KISQALI FEMARA (600 MG DOSE)[PA, QL]
KISQALI FEMARA(200 MG DOSE)[PA, QL]
KOSELUGO[PA, QL]
lapatinib ditosylate[PA, QL]
leucovorin calcium
LEUPROLIDE ACETATE (3 MONTH)
leuprolide acetate[PA]
LONSURF[PA]
LORBRENA[PA, QL]
LUMAKRAS[PA, QL]
LUPRON DEPOT (1-MONTH)[PA, QL]
LUPRON DEPOT (3-MONTH)[PA, QL]
LYNPARZA[PA, QL]
LYSODREN[PA, QL]
MATULANE[PA]
MEKINIST[PA, QL]
MEKTOVI[PA, QL]
MELPHALAN[PA]
MESNEX
MVASI[PA]
MYLERAN[PA]
NERLYNX[PA, QL]
NINLARO[PA, QL]
NUBEQA[PA, QL]
ODOMZO[PA, QL]
PEMAZYRE[PA, QL]
PHESGO[PA, QL]
POMALYST[PA, QL]
PURIXAN
QINLOCK[PA, QL]
RETEVMO[PA, QL]
ROZLYTREK[PA, QL]
RUBRACA[PA, QL]
RUXIENCE[PA]
RYDAPT[PA, QL]
sorafenib tosylate[PA, QL]
SPRYCEL[PA, QL]
STIVARGA[PA, QL]
sunitinib malate[PA, QL]
SYLATRON[PA]
SYNRIBO[PA]
TABLOID
TABRECTA[PA, QL]
TAFINLAR[PA, QL]
TAGRISSO[PA, QL]
TALZENNA[PA, QL]
TASIGNA[PA, QL]
TAZVERIK[PA, QL]
temozolomide[PA]
TEPMETKO[PA, QL]
TIBSOVO[PA, QL]
TICE BCG
TRUSELTIQ (100MG DAILY DOSE)[PA, QL]
TRUSELTIQ (125MG DAILY DOSE)[PA, QL]
TRUSELTIQ (50MG DAILY DOSE)[PA, QL]
TRUSELTIQ (75MG DAILY DOSE)[PA, QL]
TUKYSA[PA, QL]
TURALIO[PA, QL]
UKONIQ[PA, QL]
VANTAS[PA, QL]
VENCLEXTA[PA, QL]
VERZENIO[PA, QL]
VITRAKVI[PA, QL]
VIZIMPRO[PA, QL]
VOTRIENT[PA, QL]
WELIREG[PA, QL]
XALKORI[PA, QL]
XOSPATA[PA, QL]
XTANDI[PA, QL]
YONSA[PA, QL]
ZEJULA[PA, QL]
ZELBORAF[PA, QL]
ZIRABEV[PA]

(Continued)

2023 Specialty Drug List

ZOLADEX[PA, QL]
ZOLINZA[PA, QL]
ZYDELIG[PA, QL]
ZYKADIA[PA, QL]

ANTIPARKINSON AND RELATED THERAPY AGENTS

DUOPA
INBRIJA[PA, QL]

ANTIPSYCHOTICS/ANTIMANIC AGENTS

NUPLAZID[PA, QL]

ANTIVIRALS

abacavir sulfate-lamivudine[QL]
abacavir sulfate[QL]
abacavir-lamivudine-zidovudine[QL]
adefovir dipivoxil[PA, QL]
APTIVUS[QL]
atazanavir sulfate[QL]
BARACLUDE[PA, QL]
BIKTARVY[QL]
CABENUVA[QL]
CIMDUO[QL]
darunavir[QL]
DESCOVY[QL]
DIDANOSINE[QL]
EDURANT[QL]
efavirenz-emtricitab-tenofo df[QL]
efavirenz-lamivudine-tenofovir[QL]
EFAVIRENZ[QL]
emtricitabine-tenofovir df[QL]
emtricitabine[QL]
EMTRIVA[QL]
entecavir[PA, QL]
EPCLUSA[PA, QL]
etravirine[QL]
EVOTAZ[QL]
fosamprenavir calcium[QL]
FUZEON[PA, QL]
GENVOYA[QL]
HARVONI[PA, QL]
INTELENCE[QL]
ISENTRESS[QL]
JULUCA[QL]
lamivudine-zidovudine[QL]
lamivudine[QL]
LIVTENCITY[PA, QL]
lopinavir-ritonavir[QL]
maraviroc[QL]
MAVYRET[PA, QL]
NEVIRAPINE ER[QL]
NEVIRAPINE[QL]
NORVIR[QL]
ODEFSEY[QL]
PEGASYS[PA, QL]
PEGINTRON[PA, QL]
PREZISTA[QL]
RESCRIPTOR[QL]
REYATAZ[QL]
RIBASPHERE RIBAPAK (1000 PACK)[PA, QL]
RIBASPHERE RIBAPAK (1200 PACK)[PA, QL]
RIBASPHERE RIBAPAK (600 PACK)[PA, QL]
RIBASPHERE RIBAPAK (800 PACK)[PA, QL]
RIBASPHERE[PA, QL]
RIBAVIRIN[PA, QL]
ritonavir[QL]
RUKOBIA[PA, QL]
SELZENTRY[QL]
STAVUDINE[QL]
SYMTUZA[QL]
TEMIXYS[QL]
tenofovir disoproxil fumarate[QL]
TIVICAY PD[QL]
TIVICAY[QL]
TRIUMEQ PD[QL]
TRIUMEQ[QL]
TYBOST[QL]
VIREAD[QL]
VOSEVI[PA, QL]
zidovudine[QL]

CARDIOVASCULAR AGENTS - MISC.

ADEMPAS[PA, QL]
alyq[PA, QL]
ambrisentan[PA, QL]
bosentan[PA, QL]
epoprostenol sodium[PA]
OPSUMIT[PA, QL]
ORENITRAM[PA, QL]
sildenafil citrate[PA, QL]
tadalafil (pah)[PA, QL]
TRACLEER[PA, QL]
treprostinil[PA]
TYVASO DPI MAINTENANCE KIT[PA, QL]
TYVASO DPI TITRATION KIT[PA, QL]
TYVASO REFILL[PA]
TYVASO STARTER[PA]
TYVASO[PA]
UPTRAVI[PA, QL]
VENTAVIS[PA, QL]
VYNDAMAX[PA, QL]
VYNDAQEL[PA, QL]

CORTICOSTEROIDS

EMFLAZA[PA]
TARPEYO[PA, QL]

DERMATOLOGICALS

ADBRY[PA, QL]
CIBINQO[PA, QL]
DUPIXENT[PA, QL]
SCENESSE[PA, QL]
SKYRIZI (150 MG DOSE)[PA, QL]
SKYRIZI PEN[PA, QL]
SKYRIZI[PA, QL]
STELARA[PA, QL]
TALTZ[PA, QL]
TREMFYA[PA, QL]
VALCHLOR[PA]

DIURETICS

dichlorphenamide[PA, QL]

ENDOCRINE AND METABOLIC AGENTS - MISC.

ACTHAR[PA]
BRINEURA[PA, QL]
BYNFEZIA PEN[PA]
carglumic acid[PA]
cetrorelix acetate
CHORIONIC GONADOTROPIN
cinacalcet hcl[PA]
CORTROPHIN[PA]
CRYSVITA[PA, QL]
EVENITY[PA, QL]
FORTEO[PA, QL]
fyremadel[PA]
GALAFOLD[PA, QL]
ganirelix acetate[PA]
GENOTROPIN MINIQUICK[PA]
GENOTROPIN[PA]
GONAL-F RFF REDIJECT
GONAL-F RFF
GONAL-F
HCG
ibandronate sodium[PA, QL]
ISTURISA[PA, QL]
javygtor[PA]
JYNARQUE[PA, QL]
LUPANETA PACK[PA, QL]
LUPRON DEPOT-PED (1-MONTH)[PA, QL]
LUPRON DEPOT-PED (3-MONTH)[PA, QL]
MYALEPT[PA]
nitisinone[PA]
NITYR[PA]
NOVAREL
OCTREOTIDE ACETATE[PA]
OMNITROPE[PA]
ORFADIN[PA]
ORILISSA[PA, QL]
OVIDREL[PA]
PALYNZIQ[PA]
PAMIDRONATE DISODIUM
PARSABIV[PA]
PREGNYL
PROLIA[PA, QL]
RAVICTI[PA, QL]
RECORLEV[PA, QL]
sapropterin dihydrochloride[PA]
SEROSTIM[PA]
SIGNIFOR[PA, QL]
sodium phenylbutyrate[PA]
SOMAVERT[PA]
STRENSIQ[PA]
SUPPRELIN LA[PA, QL]
SYNAREL[PA]
TOLVAPTAN[PA, QL]
TRIPTODUR[PA, QL]
TYMLOS[PA, QL]
VOXZOGO[PA, QL]
XGEVA[PA, QL]
XURIDEN[PA, QL]
ZOLEDRONIC ACID[PA, QL]
ZORBTIVE[PA]

ESTROGENS

MYFEMBREE[PA, QL]
ORIAHNN[PA, QL]

GASTROINTESTINAL AGENTS - MISC.

AVSOLA[PA]
BYLVAY (PELLETS)[PA, QL]
BYLVAY[PA, QL]
CHOLBAM[PA]
CIMZIA STARTER KIT[PA, QL]
CIMZIA[PA, QL]
ENTYVIO[PA, QL]
GATTEX[PA]
OCALIVA[PA, QL]
RENFLEXIS[PA]
XERMELO[PA, QL]

GENITOURINARY AGENTS - MISCELLANEOUS

CYSTAGON[PA]
OXLUMO[PA]
PROCYSBI[PA]
THIOLA EC[PA]
tiopronin

GOUT AGENTS

KRYSTEXXA[PA]

HEMATOLOGICAL AGENTS - MISC.

AFSTYLA
ALPHANATE/VWF COMPLEX/HUMAN
ALPHANATE
ALPHANINE SD
ALPROLIX
CABLIVI[PA, QL]
COAGADEX
CORIFACT
ELOCTATE
EMPAVELI[PA, QL]
GIVLAARI[PA]
HAEGARDA[PA]
HEMLIBRA[PA]
HUMATE-P
icatibant acetate[PA]
IXINITY
JIVI[PA]
KALBITOR[PA]
KCENTRA
KOGENATE FS
MONONINE
NOVOEIGHT

(Continued)

2023 Specialty Drug List

NUWIQ
OBIZUR
ORLADEYO[PA, QL]
PROFILNINE
REBINYN
RIXUBIS
RUCONEST[PA]
sajazir[PA]
SEVENFACT
TAKHZYRO[PA, QL]
TAVALISSE[PA, QL]
TRETTEN
VONVENDI
WILATE
XYNTHA SOLOFUSE
XYNTHA

HEMATOPOIETIC AGENTS

ARANESP (ALBUMIN FREE)[PA]
CERDELGA[PA, QL]
DOPTELET[PA, QL]
ENDARI[PA, QL]
FULPHILA[PA, QL]
GRANIX[PA]
LEUKINE[PA]
miglustat[QL]
MULPLETA[PA, QL]
NEULASTA ONPRO[PA]
NEULASTA[PA]
NEUPOGEN[PA, QL]
NPLATE[PA]
NYVEPRIA[PA]
OXBRYTA[PA, QL]
PROCRIT[PA]
PROMACTA[PA, QL]
REBLOZYL[PA]
RETACRIT[PA]
ZIEXTENZO[PA]

HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS

tasimelteon[PA, QL]

MIGRAINE PRODUCTS

AIMOVIG (140 MG DOSE)[PA, QL]
AIMOVIG[PA, QL]
AJOVY[PA, QL]
EMGALITY (300 MG DOSE)[PA, QL]
EMGALITY[PA, QL]
QULIPTA[PA, QL]
UBRELVY[PA, QL]
VYEPTI[PA, QL]

MISCELLANEOUS THERAPEUTIC CLASSES

BENLYSTA[PA, QL]
clovique[QL]
D-PENAMINE[QL]
ENSPRYNG[PA, QL]
lenalidomide[PA, QL]
LUPKYNIS[PA, QL]
penicillamine[PA, QL]
REZUROCK[PA, QL]
SOLESTA[PA]
THALOMID[PA]
trientine hcl[QL]
ZOKINVY[PA, QL]

MUSCULOSKELETAL THERAPY AGENTS

DUROLANE[PA, QL]
EUFLEXXA[PA, QL]
GELSYN-3[PA, QL]
MONOVISC[PA, QL]
ORTHOVISC[PA, QL]
SODIUM HYALURONATE[PA, QL]
SYNOJOYNT[PA, QL]

NASAL AGENTS - SYSTEMIC AND TOPICAL

SINUVA[PA, QL]

NEUROMUSCULAR AGENTS

DYSPORT[PA]
EVRYSDI[PA, QL]
XEOMIN[PA]

NUTRIENTS

DOJOLVI[PA]

OPHTHALMIC AGENTS

CYSTARAN[PA, QL]
DEXTENZA[PA, QL]
DEXYCU[PA, QL]
EYLEA[PA]
ILUVIEN[PA]
JETREA[QL]
LUXTURNA[PA, QL]
OXERVATE[PA, QL]
OZURDEX[QL]
RETISERT[PA]
VISCOAT

PASSIVE IMMUNIZING AND TREATMENT AGENTS

ASCENIV[PA]
BIVIGAM[PA]
CARIMUNE NF[PA]
CUVITRU[PA]
CYTOGAM
FLEBOGAMMA DIF[PA]
GAMASTAN[PA]
GAMMAGARD S/D LESS IGA[PA]
GAMMAGARD[PA]
GAMMAPLEX[PA]
GAMUNEX-C[PA]
HYPERRHO S/D
HYQVIA[PA]
MICRHOGAM ULTRA-FILTERED PLUS
OCTAGAM[PA]
PRIVIGEN[PA]
RHOGAM ULTRA-FILTERED PLUS
RHOPHYLAC
SYNAGIS[PA]
WINRHO SDF
XEMBIFY[PA]
ZINPLAVA[PA, QL]

PROGESTINS

hydroxyprogesterone caproate[PA, QL]
MAKENA[PA, QL]

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

AUSTEDO[PA, QL]
AVONEX PEN[PA, QL]
AVONEX PREFILLED[PA, QL]
BAFIERTAM[PA, QL]
dalfampridine er[PA, QL]
dimethyl fumarate starter pack[PA, QL]
dimethyl fumarate[PA, QL]
fingolimod hcl[PA, QL]
glatiramer acetate[PA, QL]
glatopa[PA, QL]
INGREZZA[PA, QL]
KESIMPTA[PA, QL]
MAVENCLAD (10 TABS)[PA, QL]
MAVENCLAD (4 TABS)[PA, QL]
MAVENCLAD (5 TABS)[PA, QL]
MAVENCLAD (6 TABS)[PA, QL]
MAVENCLAD (7 TABS)[PA, QL]
MAVENCLAD (8 TABS)[PA, QL]
MAVENCLAD (9 TABS)[PA, QL]
MAYZENT STARTER PACK[PA, QL]
MAYZENT[PA, QL]
OCREVUS[PA, QL]
PLEGRIDY STARTER PACK[PA, QL]
PLEGRIDY[PA, QL]
PONVORY STARTER PACK[PA, QL]
PONVORY[PA, QL]
REBIF REBIDOSE TITRATION PACK[PA, QL]
REBIF REBIDOSE[PA, QL]
REBIF TITRATION PACK[PA, QL]
REBIF[PA, QL]
SODIUM OXYBATE[PA, QL]
TASCENSO ODT[PA, QL]
TEGSEDI[PA, QL]
teriflunomide[PA, QL]
tetrabenazine[PA, QL]
XYWAV[PA, QL]
ZEPOSIA 7-DAY STARTER PACK[PA, QL]
ZEPOSIA STARTER KIT[PA, QL]
ZEPOSIA[PA, QL]

RESPIRATORY AGENTS - MISC.

ARALAST NP[PA]
GLASSIA[PA]
KALYDECO[PA, QL]
OFEV[PA, QL]
ORKAMBI[PA, QL]
PIRFENIDONE[PA, QL]
PROLASTIN-C[PA]
PULMOZYME[PA, QL]
SYMDEKO[PA, QL]
TRIKAFTA[PA, QL]

VASOPRESSORS

droxidopa[PA, QL]

Products covered by a member's prescription benefit plan may change from time to time. Preferred brand products are listed in UPPERCASE LETTERS, generic products are listed in lower-cased italics, and other products listed are non-preferred. Specialty medications are covered based on member's benefit plan design, regardless of their appearance on this document. Additionally, medications listed in this document may require prior authorization.

[PA] = Prior Authorization Required
[ST] = Step Therapy Required
[QL] = Quantity Level Required

ATTACHMENT 20

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet - RFP entitled: "Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs"

DCS Commercial Prescription Drug Program

Location Column (1)	# of Empire Plan Commercial Enrollees With Access Column (2)	# of Empire Plan Commercial Enrollees Without Access Column (3)	Total Empire Plan Commercial Enrollees Column (4)	% With Access Column (5)
Urban	136,638	331	136,969	99.8%
Suburban	77,179	76	77,255	99.9%
Rural	108,682	1,145	109,827	99.0%
Total	**322,499**	**1,552**	**324,051**	**99.5%**

A. Enter the number of Empire Plan Commercial Enrollees who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (Column 2).

B. Enter the number of Empire Plan Commercial Enrollees who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (Column 3).

C. Column (4) equals Column (2) plus Column (3).

D. Column (5) equals Column (2) divided by Column (4).

E. The Offeror's proposed retail pharmacy network access %'s in column (5) 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 Commercial Enrollees in the Offeror's Geo Access Accessibility Summaries should equal the totals in Column (4).

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.

DCS EGWP Prescription Drug Program

Location Column (1)	# of Empire Plan EGWP Enrollees With Access Column (2)	# of Empire Plan EGWP Enrollees Without Access Column (3)	Total Empire Plan EGWP Enrollees Column (4)	% With Access Column (5)
Urban	71,103	514	71,617	99.3%
Suburban	59,913	106	60,019	99.8%
Rural	94,454	1,130	95,584	98.8%
Total	**225,470**	**1,750**	**227,220**	**99.2%**

A. Enter the number of Empire Plan EGWP Enrollees who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (Column 2).

B. Enter the number of Empire Plan EGWP Enrollees who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (Column 3).

C. Column (4) equals Column (2) plus Column (3).

D. Column (5) equals Column (2) divided by Column (4).

E. The Offeror's proposed retail pharmacy network access %'s in column (5) 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 EGWP Enrollees in the Offeror's Geo Access Accessibility Summaries should equal the totals in Column (4).

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

Location Column (1)	# of NYSIF Claimants With Access Column (2)	# of NYSIF Claimants Without Access Column (3)	Total NYSIF Claimants Column (4)	% With Access Column (5)
Urban	48,538	31	48,569	99.9%
Suburban	16,793	42	16,835	99.8%
Rural	34,086	341	34,427	99.0%
Total	**99,417**	**414**	**99,831**	**99.6%**

A. Enter the number of NYSIF Claimants who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (Column 2).

B. Enter the number of NYSIF Claimants who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (Column 3).

C. Column (4) equals Column (2) plus Column (3).

D. Column (5) equals Column (2) divided by Column (4).

E. The Offeror's proposed retail pharmacy network access %'s in Column (5) 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 Claimants in the Offeror's Geo Access Accessibility Summaries should equal the totals in Column (4).

Note: All Claimants must be counted in calculating whether the Offeror meets the Retail Pharmacy Network access guarantees. No Claimant may be excluded even if there is no pharmacy located within the minimum mandatory access requirements.

5.11 Claims Processing

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in claims processing as specified in Section 3.10 of this RFP, including the following:

a. Provide a flow chart and step-by-step description of the Offeror's proposed claims processing methodology for adjudicating each of the following claim types: Mail Order, Specialty Pharmacy, Network Pharmacy, Enrollee-submitted claims. For NYSIF Program the additional following claims types must be included and Non-Network Pharmacy claims, network pharmacy claims submitted by third party billers, network pharmacy claims submitted directly to NYSIF, Instant Enrollment (short fill) Claims. Provide a description of the comprehensive edits the Offeror proposes at the point of service to ensure proper claim adjudication, including a detailed description and example of how the Offeror's proposed refill-too-soon (RTS) edit will operate to ensure cost effective dispensing of Drugs under the Programs. Confirm that the Offeror will implement the Offeror's proposed full RTS edit on the respective Project Services Start Date.

b. Please describe the Offeror's claims processing system platform including any backup system utilized. Describe the Offeror's 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?

c. Describe the capabilities of the Offeror's claim processing system to perform, at the point of service, for each of the following required Programs' components:

i. The Programs generic substitution requirements based on the Programs' definition of a Generic Drug as set forth in the Glossary of Defined Terms (Attachment 15) of this RFP.

ii. A Prior Authorization Program for specific drugs that have an increased risk of inappropriate utilization.

iii. A concurrent DUR program identifying Enrollee drug therapy safety edits and Programs' benefit edits.

iv. Messaging capabilities to the Network Pharmacy.

v. Eligibility verification.

vi. Customized edits for individual Enrollees.

vii. Utilization of some medications intended to treat conditions limited to one sex.

viii. Historic claims look up capability to reduce Enrollee disruption at the point of sale.

ix. (Exclusive to DCS) Multi-level cost sharing.

x. Identification and pricing of compounded Prescriptions consistent with the Programs' definitions and requirements set forth in this RFP.

xi. 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.

d. Describe how the Offeror's 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.

e. Describe how the Offeror's claims processing system will ensure that the Programs are charged according to the Programs' Lesser of Logic.

f. Describe how the Offeror's adjudication system feeds the reporting and billing systems and any claim update data delays.

g. Does the Offeror own the adjudication system, license the software, or contract out this service?

h. How quickly are the Offeror's systems brought into compliance when a new version or capability of the standard NCPDP format for claims transmission is released?

i. Describe the current Network Pharmacy available overrides to the Offeror's 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 the Offeror's claims processing system and confirm whether it overrides the Offeror's client's program benefit design? If so, provide the circumstances where the Offeror would load an override edit at the point of service. If applicable, describe the circumstances where the Offeror would approve the dispensing of quantities in excess of the benefit design amounts within the Offeror's concurrent DUR program.

j. 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?

k. 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.

l. Identify the resources that are available to a Pharmacist who is having difficulty processing a claim at the point of service. How does the Offeror ensure that the Pharmacist is able to get through to a person to resolve the issue

m. (Exclusive to DCS) Confirm that the Offeror's 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.

n. Explain how the Offeror's claims processing system collects overpayments from the Offeror's Retail Pharmacy Network.

o. Confirm the Offeror will reverse all attributes of claim records, e.g., AWP, quantity, Day's 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.

p. 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.

q. (Exclusive to DCS) Can the adjudication system interact with a debit card program for flexible spending accounts?

r. What data elements are required by the Offeror's claims system to process a compound claim? How does the Offeror guard against inappropriate or inaccurate compound claims? How does the Offeror ensure that only those claims that meet the definition of a Compound in the Glossary of Defined Terms (Attachment 15) of this RFP are processed as compound claims thereby protecting the Programs' financial interest?

Our system is available 24 hours a day, 7 days a week, 365 days a year and delivers a high degree of accuracy and efficiency.

Flow Chart

DCS

The **5.11 Exhibits** tab provides MedImpact's claim adjudication process workflow from claim request to claim adjudication system response. All claim types process in the same manner.

NYSIF

Please see the **5.11 Exhibits** tab for the NYSIF PBM Workflow. All bills, regardless of whether they are from participating or non-participating pharmacies, are entered and adjudicated into the Healthesystems point of sale system - applying the same rules and edits as prescriptions being submitted as POS transactions.

Claims Processing System and Backup

DCS

We deliver a claims processing solution in a single, integrated platform. Our single platform delivers a higher degree of claims processing accuracy and efficiency and is available 24 hours a day, 7 days a week, 365 days a year. Our system has had no unplanned downtime in the last 2 years. Our adjudication architecture has an unlimited overall capacity. Our system operates at 50% capacity to allow for new and expanded business. Quarterly, we review

system capacity and performance to ensure we are ready to meet future user requirements. We can expand our processing and storage capabilities to satisfy any performance requirements.

Because of our unique, dual, redundant, highly available data centers, we often implement changes to systems with little to no impact on client processes, and no effect on members' ability to obtain prescriptions. Our information security policy and procedure and disaster recovery plan are included within the **5.11 Exhibits** tab.

NYSIF

Verticē is Healthesystems' web application for claims professionals, which provides a single platform for all prescription drug activity associated with our PBM customers' injured worker claims, as well as any activity for ancillary medical products and services for customers participating in our ancillary benefits management program. Verticē delivers an intuitive and configurable experience to account for customizable workflow management and incorporates additional data-driven decision-making support tools. Verticē provides an efficient claims management experience through a robust suite of real-time, web-based tools to assist claims representatives and nurse case managers monitor and manage a claimant's prescription activity. Verticē allows clients to create workflow rules to embed custom alert messages, and present clinical documentation to claims professionals at the time of authorization.

These services are available to customers 24 hours a day, 365 days a year with uptime at nearly 100% with no reported downtime over 10 minutes. The Healthesystems Information Security Policy, included in the **5.11 Exhibits** tab, addresses the business continuity plan and disaster recovery plan.

Capabilities

Our diverse, sophisticated systems exceed the capabilities required by the Department

Generic Substitution Requirements

Through the administration of DAW logic and other plan design requirements we can administer the Program requirements based on the definition of Generic Drugs.

PA Program

Our clinical teams closely monitor utilization and recommend PAs as appropriate. This includes recommendations of PAs based on client-specific criteria and based on demonstrated inappropriate or overutilization patterns. ePA capabilities inform prescribers at the point of prescribing when PAs are required for proactive approval. Additionally, PA edits at the POS (point-of-sale) direct pharmacies to the appropriate next steps to ensure medication coverage.

Concurrent DUR and Safety Edits

POS concurrent DUR edits apply to all prescriptions adjudicated. These include the entire spectrum of NCPDP D.0 concurrent DUR options. Concurrent DUR capabilities support medication safety and the prevention of overutilization and underutilization of prescribed medications. Through the MedImpact Concurrent DUR program, pharmacists receive online messages and warnings at POS before the pharmacist dispenses the prescription. To promote safe and cost-effective drug prescribing, the system supports numerous standard and customized edits to

warn pharmacists of the potential harm involved in dispensing particular medications. Standard drug safety edits include:

- **Overutilization**: Messages the pharmacist about potential member overutilization of medications through a combination of edits
- **Underutilization**: Detects when a member picks up a refill late based on the days' supply of the previous claim for that medication
- **Age/Gender**: Identifies drugs based on the age group or gender of the member
- **Duplicate Prescription/Therapeutic Duplication**: Denies a second claim filled on the same day with the same member information and drug information
- **Refill Too Soon**: Rejects a claim when a member attempts to refill a prescription sooner than allowed
- **Incorrect dosage**: Accepts or rejects claims based on the quantity dispensed, days' supply, and minimum and maximum dosage
- **Drug-to-drug Interaction**: Provides a message to the pharmacy based on the severity level established by the drug compendia publisher's DUR module
- **Concomitant Therapy**: Alerts the pharmacist when an overlap exists with the same therapeutic class or duplicate ingredients
- **Drug Disease Interaction**: Alerts the pharmacist when a conflict exists between the drug and member's disease using ICD-10 codes
- **Drug Allergies**: Alerts the pharmacist if allergies are present based on ICD-10 codes and member history

Pharmacy Messaging

All POS transactions are processed electronically and include hard or soft messaging, as applicable. We can configure prospective DUR and concurrent DUR edits for the following outcomes:

- **Informational Alert**: The pharmacist receives a DUR NCPDP conflict code that identifies the reason or type of drug conflict such as drug-drug interaction along with necessary information for a pharmacist evaluation.
- **Soft Reject**: The pharmacist receives DUR NCPDP conflict code along with necessary information for a pharmacist evaluation. After the evaluation the pharmacist must respond with acceptable DUR or PPS codes for the claim to be approved.
- **Hard Denial**: The claim rejects and requires a prior authorization or plan approved override. The pharmacist cannot override a hard denial using standard DUR or PPS codes.

If a hard denial for a PA occurs:

1. The pharmacy receives a real-time electronic message stating a prior authorization is required and to contact customer service. In some cases, we may proactively call the pharmacy to alert them that we are working to resolve the prior authorization proactively.

2. While speaking with the pharmacist, the CSR reviews the detailed claim notes and history to determine if the medication can be allowed.

3. If the CSR is unable to determine whether the medication should be allowed, the specialist electronically messages the claims professional regarding the required prior authorization

Eligibility Verification

Eligibility is verified at the point of sale based on real-time review of the member profile.

Custom Edits

Due to the flexibility of our adjudication system, we can customize DUR edits based upon 's request(s) including the POS messaging. In addition, our ongoing review and measurements of your pharmacy program performance (e.g., trends and patient population), our team may proactively make recommendations to enhance the overall safety, efficiency, and cost containment of the program design.

Gender Edits

We standardly implement drug-gender edits that return DUR information to the pharmacy if the system determines the requested drug to have a gender precaution with the gender in their member profile.

POS Claim Review

Our system includes, at the point of sale, an automated claim lookback period for step therapy of 180 days to confirm the member has a history of receiving the medication without a break in coverage. The system also reviews member history for prior authorizations and other utilization parameters, based on the claim adjudicating. For example, for opioids there may be a 180-day lookback period applied to review average MME. This can be customized at our Program's direction.

Cost Sharing

We can support multi-level cost sharing in accordance with the plan design(s).

Compounds

When MedImpact receives a claim for a compounded medication or intravenous infusion therapy, a system flag overrides the AWP discount calculations, and the prescription pays the amount billed by the pharmacy plus the applicable dispensing fee. If the pharmacy submits a compound code of 2, the system typically labels the claim pay as billed. The billing amount must include the dispensing fee and compounds are identified by the respective benefit state rules for the NYSIF program.

To prevent FWA (fraud, waste, and abuse), we have numerous POS edits that price compounds and only allow Federal Legend ingredients within the compound. We suggest blocking bulk chemicals from adjudication and setting a low maximum dollar claim amount for compounds ($100 that rejects a compound claim over $100). We can also require a PA for all compounds to ensure no commercial product is available and/or the member has tried the commercial product first.

We can receive multiple NDCs via NCPDP D.0 compounds. We can set up processing to do pay-as-billed or pay based on sum of ingredient costs, which requires compound segment, or both. We apply restrictions based on all ingredient NDCs in the claim.

Pharmacy Submitted Claims

The adjudication system ensures all program components receive the lesser of logic, regardless of where it was dispensed from.

DAW-0 Rejections

We adjudicate drugs based upon the DAW codes submitted and in accordance with client benefit requirements. Multisource brand claims submitted with a DAW 0, which means that no product selection is indicated, can return messaging at 's request requesting appropriate DAW submission in support of the Programs' mandatory generic substitution provisions.

Lesser of Logic

Our standard lesser of logic charges the member the lesser of the pharmacy's U&C rate, pharmacy contract rate, or member's stated copay or coinsurance amount. We define the pharmacy's U&C as the lowest price a member of the public would pay at that pharmacy on that day, inclusive of any discounts. Pharmacies are required to submit U&C with each dispensed claim. We maintain parallel billing transaction auditing to help ensure pharmacy claims are processed as intended.

Reporting and Billing

The adjudication system data updates the reporting system on a nightly basis. This allows for data to be readily available to our clients for reporting, and billing, purposes.

System Ownership

DCS

MedImpact owns its proprietary, single platform claims processing system.

NYSIF

Healthesystems owns its adjudication systems software, Verticē.

NCPDP Version Compliance

The adjudication platforms are currently on NCPDP version D.0. Both organizations have been working on implementing changes to bring the platform up to version F6. As there is currently no final rule naming F6 or implementation dates by HHS (Health and Human Services), we continue to work towards having the systems ready when they are.

DCS

MedImpact's systems support the NCPDP standards and use NCPDP standard files. We have active NCPDP staff representing different functional areas, and membership allows for participation in task groups, voting during the work groups, and access to NCPDP standards and any educational materials We review changes to the standards

and updates our applications when appropriate. We test these modifications prior to moving them to the production environment. There are no known gaps or discrepancies between the NCPDP standards and our systems.

NYSIF

ECL (External Code List) changes do not require a new NCPDP version so that Healthesystems and its partner can monitor and work on implementing in time for customers to upgrade to UAT and Production. These changes are effective in October annually. After NCPDP approval, these have a much longer implementation timeframe. Our partner typically implements these changes annually in January, which allows us to upgrade prior to the October implementation dates. Emergency ECL changes must be turned around quickly and must meet NCPDP requirements to be considered emergency. The minimum time between approval and implementation date is 180 days.

Overrides

DCS

Override criteria and ability are based on the client's benefit designs, DUR outcomes, etc. Override capabilities associated with POS messages include:

- **Soft Reject**: Denied claim, which PPS codes can override
- **Hard Reject**: Denied claim, which a prior authorization can override

We can set customization options at the plan, line of business, or group levels. Additional options are available, including the following common configurations:

- **PA Override**: Override PA (prior authorization) and UM (utilization management) type edits on the COB claim
- **Administrative Overrides**: refill too soon, emergency supply, vacation supply, etc.

NYSIF

Retail pharmacists must contact Healthesystems for authorization to override our adjudication system. Our workflow process for supporting the decisions that must meet New York workers' compensation requirements are conducted outside of the New York portal, but we can manage decisions from the customer related to this process. Other override scenarios include drug-drug interactions, step therapy, and generic drugs enforcement via DAW1. Overrides align with the client's benefit design requirements.

DUR Edits by Pharmacy Type

All claims dispensed, regardless of the dispensing pharmacy, are subject to the same PA, quantity limit, DUR, and any other POS edits in place through the electronic adjudication system.

Benefit Design Monitoring

DCS

Our benefit change policy employs a rigorous change and quality assurance process that includes:

- Gathering requirements
- Coding and programming system and benefit changes
- Staging changes
- Performing end-to-end testing
- Transitioning to a live production environment
- Regression testing
- Confirming accuracy through quality control

Benefit changes typically require 5 days to complete but can take up to 15 business days for complex changes. For items such as system changes and implementations, turnaround times are mutually agreed upon. is responsible for reviewing test claims and providing sign off.

NYSIF

Every customer requires custom setup on our adjudication platform. When the accounts are created, a mirror image is also created in our test environment. The team implements the requested changes in the test environment and begins processing test transactions that directly affect and do not affect the changes. This procedure ensures that current processes are not impacted by the changes.

Once all the changes are documented, entered, and tested, it is sent in for quality assurance. Quality assurance ensures the changes are properly applied and testing is reviewed so that all scenarios are covered. Once the item has passed quality assurance teams it is migrated into the production environment.

The migration ensures the mirror image is intact. Changes in the production environment are monitored by our audit team, and pricing (payables and billables) are monitored daily.

Pharmacist Resources

DCS

Our pharmacy help desk is available 24 hours a day, 7 days a week to support pharmacists in resolving claim processing challenges.

EGWP Processing System

We will implement POS COB (coordination of benefits) functionality within the same time frame as all other aspects of the pharmacy benefit design and make it available at go live. If needs new or custom claims adjudication logic, we identify this during the implementation process.

Overpayment and Reversals

DCS

MedImpact's MedAdjust® reprocessing platform for claims adjustment allows both automatic and targeted reprocessing of approved member claims. This platform allows us to adjust cost sharing and accumulators based on changes to member eligibility, pricing, drug status, and benefit configuration. MedAdjust currently supports pharmacy payment recalculation and FWA-based adjustments.

We execute MedAdjust via an internal user interface that produces client-friendly extracts, which provides adjustment detail activity at the member summary and individual claim detail levels.

We will require all pharmacies to reverse claims for prescriptions that they have filled but enrollees have not picked up. Chain pharmacies have a corporate policy limiting the number of days that they can hold a prescription before they reverse and return it to stock. Generally, they use either a 7- or 14-day limit. We process reversals at POS, when received, and electronic reversals occur daily. We settle all client claims in full during each invoice cycle (weekly, bi-weekly, semi-monthly, or 5 times per month, etc.).

We track reversed claims in our claim history record along with the original claim. For example, if a pharmacist enters a claim and later makes a reversal, the first claim shows as a positive transaction and the second claim displays as a negative transaction. We can report all reversed claims back to.

To monitor reversals, we developed a proprietary Return to Stock report. This specialized report lists all pharmacies in specific networks with the number and percentages of claims that they have reversed during various timeframes.

We automatically monitor chain pharmacies with low percentages of reversals quarterly. The auditors contact the pharmacies and remind them to monitor the chain's policy regarding return to stock medications not picked up by members.

NYSIF

We process and pay all prescription transactions on behalf of NYSIF. Following the weekly billing cycle and upon receipt of payment from NYSIF for the respective transactions, we will pay the pharmacy on NYSIF's behalf. Any payment in error such as overpayments or reversals will be credited to NYSIF. These credit transactions generally are submitted in the weekly billing file.

We will reverse all attributes of claim records (e.g., AWP, quantity, day's supply) 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.

Claim Submission Monitoring

DCS

Our claims adjudication system provides numerous built-in edits to automatically detect inappropriate pharmacist dispensing or utilization. Upfront edits at the POS assist our clients by stopping inaccurate and fraudulent claims before they process, which requires less time than a pay-and-chase methodology. Our soft and hard system edits serve as the first line of defense against pharmacy FWA. Designed to address our client's varying business needs, our portfolio of system edits can significantly reduce wasteful pharmacy errors at POS, which results in reduced costs, improved service, and enhanced quality of care.

We will identify overpayments and items that need corrections through a pharmacy audit, and we then make claim adjustments in the MedAdjust reprocessing platform. A credit will appear on DCS' invoice.

NYSIF

DUR edits occur immediately at the point of sale, using online, real-time adjudication to identify potential fraud or abuse prior to the script being filled. We will notify NYSIF via phone call and/or email (via Verticē) when such instances occur, as defined by The NYSIF program rules and parameters.

The audit review process helps us identify instances of potential fraud occurring at all participating party levels (e.g., injured worker, pharmacy, physician). The objective is to identify and deter FWA that may occur through the submission of claims by providers and subscribers, and to uncover any instances of provider non-compliance with Participating Pharmacy Agreements, State and Federal Pharmacy laws, and injured workers engaged in "doctor shopping" or similar activities.

The recovery process is initiated after an error is identified through our audit process. The transaction is typically reversed and re-billed, where appropriate, with accurate claim information. This allows us to maintain an accurate audit trail. The recovered credit will be shown on the next client billing cycle after the reversal posting in our claims payment system.

Debit Card Interaction

We will provide real-time accumulator exchange for and their FSA (flexible spending account) and HRA (health reimbursement account). This real-time exchange between current and future third-party vendors will improve accumulator and deductible tracking and the member experience at pharmacy. We will work to determine how best to support them.

We also have a batch accumulator sharing process for deductible, out-of-pocket, lifetime maximum, annual maximum, FSA, and HRA. We also integrate with HRA/HSA processor Wex Health for exchange of accumulator information and display of HSA/HRA account information in MedImpact's Consumer Portal.

Compound Claim

DCS

We require pharmacies to indicate a compound claim and include all ingredients within the compound. We review each ingredient and determine ingredient type, brand or generic status, topical, transmucosal immediate-release fentanyl, and formulary status. We adjudicate the compound claim based on the identification of the primary ingredient. will determine whether to cover ingredients that are normally not on their formulary, and we base the cost of the compound on the calculated cost of the sum of all ingredient costs. The pay-as-billed option is not available for Medicare Part D compounds as CMS does not pay for all ingredients. also can employ the following plan designs and PA strategies that help control compound drug spend.

- Excluding all bulk chemicals
- Excluding kits used for compounding
- Implementing dollar limits on compounds
- Implementing a PA on all or some compounds (over a certain dollar limit)

NYSIF

We can process and adjudicate both POS and retrospectively billed compound drug transactions. Compound drugs:

- Are adjudicated at the individual ingredient level.
- Require additional review for clinical appropriateness
- Generate an alert to the claims professional
- Are identified through coding strategies
- Evaluated for drug-to-drug interactions

We also support the NCPDP version D.0 data standard which supports ingredient level adjudication of compound scripts being processed as POS transactions by retail pharmacies. In addition, we offer an enhanced second-level review option as another tool to prevent processing of compounds and allow increased oversight by a higher-level supervisor or nurse case manager. Our compound drug strategy is included as part of our standard service and there is no associated fee.

2. Claims Processing Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following four program service level standards:

a. 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 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 lower amounts.

b. Programs' Claims Processing System Accuracy Guarantee: The Programs' service level standard requires that the online claims processing system will accurately process claims at the point of service in accordance with the Program's benefit design 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, (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 does not accurately process claims at the point of service in accordance with the Programs Benefit design, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, the Offeror may propose higher or lower amounts.

c. (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 lower amounts.

d. (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 lower amounts.

We commit to the claim system guarantees, as required. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

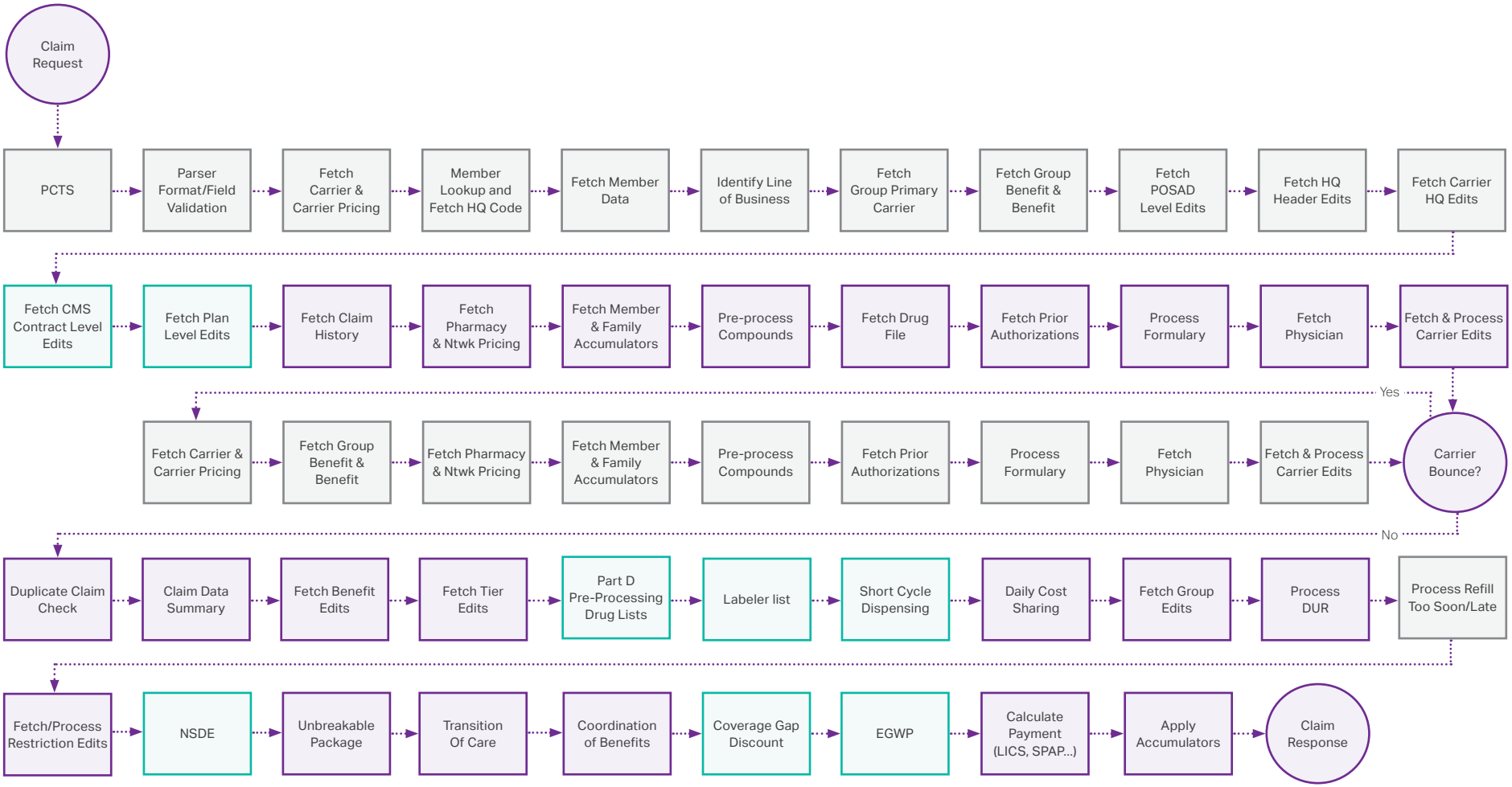
5.11 Exhibits

The following exhibits were referenced in Section 5.11 and have been provided here per RFP instructions.

Exhibit	Description
5.11 Exhibit A	DCS Pharmacy Claims Adjudication Workflow
5.11 Exhibit B	NYSIF PBM Workflow
5.11 Exhibit C	DCS Disaster Recovery Plan
5.11 Exhibit D	NYSIF Information Security Policy
Attachment 6	Performance Guarantees (included at the end of the Technical Proposal)

GENERAL WORKFLOW

Pharmacy claims adjudication.



Teal shading indicates the process is specific to Part D only.

Healthe SYSTEMS

Transforming healthcare.

Healthesystems Exhibit J:
PBM Workflow

Prepared for: New York State Insurance Fund

Kristi Klecka
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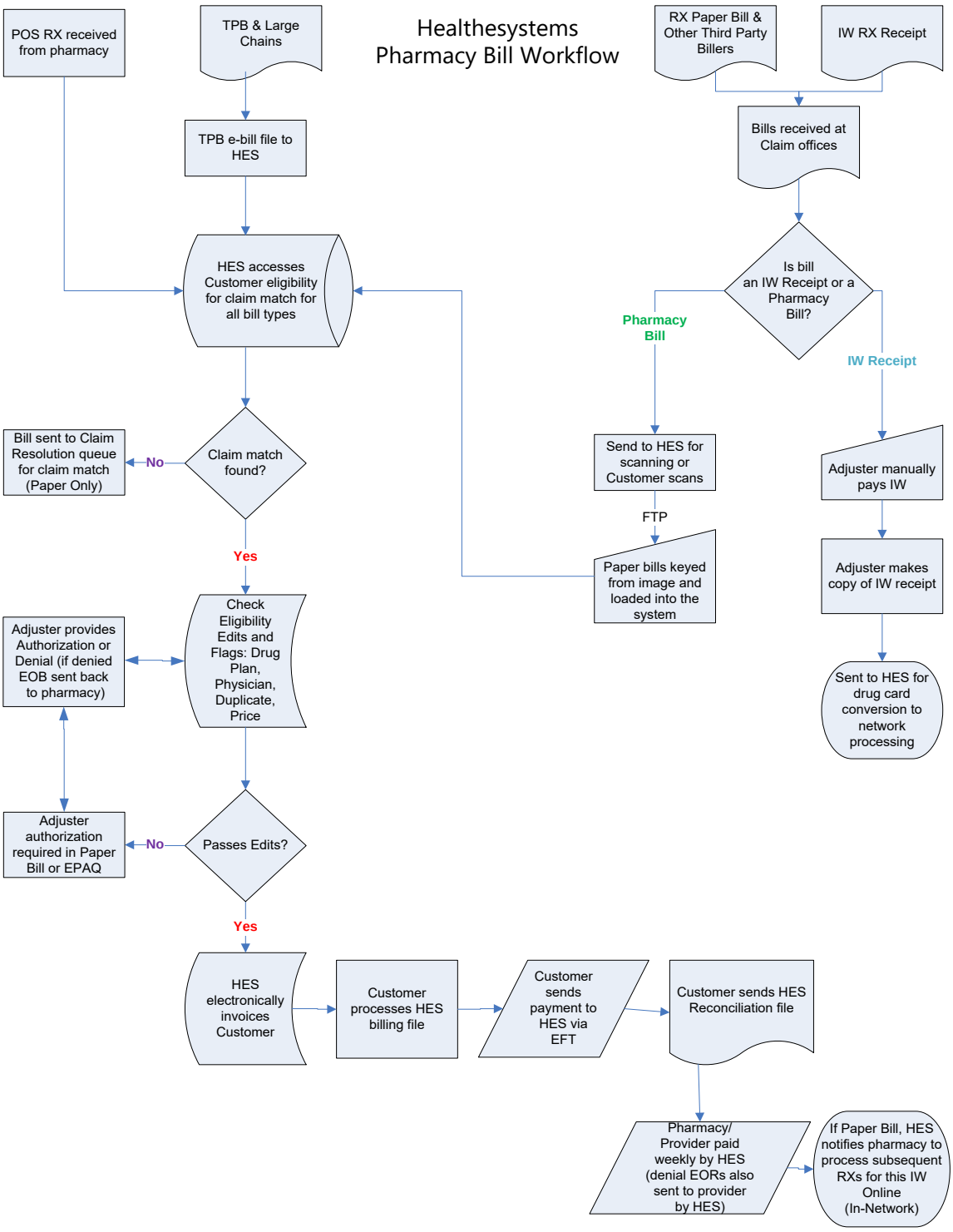
Exhibit I: PBM Workflow



DOCUMENT TITLE	IT Disaster Recovery Plan				
DOCUMENT #	200-PD-1005	**VERSION**	12.0	**SUPERSEDES**	11.0
PROCESS OWNER	Mabuti Ng'andu, IT Director Database Middleware			**EFFECTIVE DATE:**	**12/1/2022**
EXTERNAL SHARING	YES ☒	NO ☐		**PRINTING ALLOWED**	Yes
SHARE WITH	Regulatory Agencies ☒ Clients ☒ Other ☒ URAC- onsite review only				

SUPPORTING DOCUMENTATION	
Document #	**Document Title**
100-PL-1001	MedImpact Business Continuity Plan - Public
299-PI-1040	MedImpact Data Backup Policy
Multiple	Business Unit Recovery Plan documents created by critical business units
(GD)Guide=Overview | (PL)Policy=Rule | (PD)Procedure=Action | (FD)Flow Diagram=Visual (WI)Work Instruction=Details | (FM)Form=Predefined | (RD)Reference Document=Supporting	

REQUIRED APPROVALS

Approvers' Signature and Approval are recorded electronically and stored via Compliance 360 (C360).

Approvers	**Title**
Denise Burns	Chief Operations Officer
Frank Bunton	VP, Chief Information Security Officer
Mike Callagy	Director, Network Engineering
Mabuti Ng'Andu	Director, IT Database Middleware
Steve Cramer	Director, System Engineering
Susan Xing	VP, Software Engineering

C360 Approval Audit Record: Initial Audit Record inserted by Process Management before document is finalized and published. If document renewal, additional annual audit records included on the last page.

Approver Name	Job Title	Approval Date	Title	Process Document Number	Version	EffectiveDate
Ng'Andu, Mabuti	Director IT Database Middleware	11/16/2022 3:48 PM	IT Disaster Recovery Plan	200-PD-1005	12.0	12/1/2022
Cramer, Steven	Director System Engineering	11/21/2022 4:23 PM	IT Disaster Recovery Plan	200-PD-1005	12.0	12/1/2022
Callagy, Michael	Director Network Engineering	11/25/2022 11:40 AM	IT Disaster Recovery Plan	200-PD-1005	12.0	12/1/2022
Xing, Shunhua (Susan)	VP Software Engineering	11/28/2022 9:06 AM	IT Disaster Recovery Plan	200-PD-1005	12.0	12/1/2022
Bunton, Frank	VP Chief Information Security Officer	11/28/2022 1:36 PM	IT Disaster Recovery Plan	200-PD-1005	12.0	12/1/2022
Burns, Denise	Chief Operations Officer	11/28/2022 1:40 PM	IT Disaster Recovery Plan	200-PD-1005	12.0	12/1/2022

DOCUMENT DEFINITIONS (When using definition in document Capitalize First Word)	
Word/Term	**Definition**
DR	Disaster Recovery
DRP	Disaster Recovery Plan
BURP	Business Unit Recovery Plan

PURPOSE	Disaster Recovery (DR) is an ongoing process to plan, develop, test and implement changes, processes and procedures supporting the recovery and continuation of the critical business functions (including the technology infrastructure) in the event of a disaster. The IT Disaster Recovery Plan (DRP) is a subset of business continuity that outlines the process, procedures and management actions to be taken if a disaster results in an extended service disruption or outage supported by the MedImpact Information Technology (IT) infrastructure and/or systems residing in the Data Center.

For the latest version **ALWAYS** check the Process Library

Contents

1. Information Technology: Statement of Intent

Safeguarding MedImpact's IT infrastructure is a priority in delivering critical business services. This vital platform shall operate effectively without excessive interruption or failure. Disaster recovery planning supports this requirement by establishing thorough plans, procedures, and technical controls that enable MedImpact IT infrastructure to be restored quickly and effectively following a service disruption or disaster event. Technical knowledge, vigilance and timely execution are required for full recovery to normal operations.

2. Overview

The IT Disaster Recovery Plan (DRP) is designed to provide guidance and critical information for trained and experienced staff to recover core IT systems and/or applications that have been impacted by a service disruption or disaster event. MedImpact can recover and restore business operations and establish an availability of information in the time frame required by the business objectives and without a deterioration of the security measures. MedImpact shall identify the critical business processes requiring business continuity, which shall include an assessment of internal and external business dependencies. Agreed policies and procedures shall be documented and tested. Critical business processes, systems and dependencies are identified as part of the Business Unit Recovery Plan (BURP) process. Please refer to the BURP and Business Continuity Plan (BCP).

When new requirements are identified, any existing emergency procedures are amended as appropriate.

Interim measures may include the relocation of processing to alternate IT systems and operations locally or at an alternate site, the recovery of IT functions using alternate equipment, or executing key IT functions using manual methods.

The DRP provides disaster recovery guidance and is divided into the following content areas:

- Supporting Information
- Responsibilities
- Event Detection & Plan Execution
- Recovery
- Return to Normal Operations
- Appendices

3. Supporting Information

3.1. Definitions

Primary Data Center

The “Primary Data Center” is defined as the physical, IT operations facility where primary claims adjudication transaction and other PBM-related services are currently operating.

Secondary Data Center

The “Secondary Data Center” is defined as the physical, IT operations facility where standby claims adjudication transaction and other PBM-related services are hosted.

Alternate Systems

“Alternate Systems” are defined as the secondary systems within the Primary or Secondary Data Center facilities where standby claims adjudication transactions and other PBM-related services are hosted for additional **local** redundancy.***Service Disruption***

A “service disruption” is an unplanned event that interrupts the normal flow of a business operation for an appreciable length of time but can be managed at the current location or through redundancy of systems or services.

MedImpact’s level of redundancy for critical systems ensures a high level of service at all times. Machine failures, storage failures, power failures and network failures at MedImpact’s Primary Data Center could necessarily require operating out of the Secondary Data Center.

Disaster Events

A “disaster event” is the disruption of an essential business operation for a period of time beyond what can be managed at the current location. During a disaster, the needed resources of personnel, hardware, software, power, communication or facilities are greater than those available. Disasters are further delineated as follows:

- **Site failure**

  Results in the loss of resources inside a single IT operations facility due to an event such as fire, water damage, utility or facility damage, chemical or radiation release, bomb threat, or employee shortage.

- **Regional Disaster**

  Occurs outside of the MedImpact IT operations facility but prevents business units from executing essential operations, or that which causes business interruption to all local user departments and the computer facilities. The computer facilities and equipment may be intact but not accessible.

Examples of such events include earthquake, brushfire, flood, power outage, transportation interruption, terrorist attack or disease/pandemic.

Short Outage

A short outage (power, physical damage, etc.) is one that is initially assessed as containable, transitory, or falls within a predetermined scope. A building evacuation may create a known, short outage for one or more production applications, and/or may impact staffing of the Contact Center. In a typical short outage event, failover to redundant systems, and/or onsite application recovery at the Primary Data Center would be initiated by authorized users empowered to triage such an event as the first line of action.

By nature of its limited scope, a short outage is a non-disaster event; however, a heightened state of readiness is required until the condition has cleared and the threat of an extended or indefinite outage has been mitigated.

Extended Outage

An extended outage is the period of time that MedImpact would exceed the known scope of a Short Outage. During this type of recovery, MedImpact may operate out of the Secondary Data Center and/or contingent Contact Center and provide support for critical production applications and mitigated service levels for minor applications.

Indefinite Outage

An indefinite outage is defined as the period of time that MedImpact would exceed the scope of an Extended Outage. In this instance, MedImpact will permanently move to a reconstructed or new recovery facilities and begin full restoration of all applications and services from backup.

MedImpact will recover operations from the Secondary Data Center **after** a disaster has been declared. The Secondary Data Center will be used to manage recovery operations. A disaster can be declared at any level depending on recovery capabilities and circumstances.

Condition Codes

Condition code declaration (see Table 1, *Condition Codes*) is used to communicate the assessed emergency level and required response (see *Section 5: Event Detection & Plan Execution*).

Code	Description
Yellow	A potential threat has been identified that could lead to a service disruption or disaster event. A heightened state of readiness is required. Pre-disaster communications are initiated to ensure an efficient response to developing conditions.
Orange	A service disruption event has occurred. Senior management remains engaged in service recovery triage until code level decreases. Action items contained within the Business Continuity Plan or Disaster Recovery Plan may be activated at this time as risk assessments are received and validated.
Red	MedImpact has declared a disaster event. One or more business continuity processes, as outlined in the Business Continuity Plan and supported by the Disaster Recovery Plan, has been activated. All contingent supporting team members are instructed and advised.
Clear	Normal operation state of MedImpact systems and processes.

Table 1: Condition Codes

3.2. Dependencies/Critical Requirements

Recovery of the MedImpact computer facilities is dependent on the following:

1. Power to key systems and facilities backed up by uninterrupted power supply (UPS) units and generators
2. Maintenance of a Secondary Data Center for core systems' redundancy with equivalent capacity and active data replication
3. Multiple communication systems designed for survivability and redundancy
4. Multiple telco carriers for voice/data circuit redundancy
5. Cloud-based employee notifications system (voice, text, email)
6. A copy of the Disaster Recovery Plan (DRP) stored at the Secondary Data Center
7. Vital records required for recovery of critical systems and applications backed up and stored at an offsite and/or Internet-accessible location
8. A disaster at the Primary Data Center does not affect vendors within the disaster area who support MedImpact. Critical vendor services are available as planned to assist in recovery efforts.
9. All participants understand their roles and responsibilities, undergo periodic training to ensure familiarity with the DRP and are capable of executing the disaster procedures contained herein.
10. MedImpact maintains current standard operating procedures for each of the applications covered by the DRP that will be recovered. Each application is classified with a Recovery Time Objective (see Section 3.4, *Recovery Time Objective [RTO] Tiers*) so that it may be treated according to the DR strategy.

11. The DRP, including the appendices, are kept current by periodic updates and review.
12. The recovery procedures are tested at the Secondary Data Center as defined in this DRP.
13. The remote Contact Center supports:
    - Site-to-Site Virtual Private Network (VPN) and terminal emulation to the MedImpact Secondary Data Center.
    - Printers/faxes.
    - Phone system with Auto Call Distribution (ACD).
14. During a disaster event, affected 1-800 numbers will be redirected to the corporate DR support center.

3.3. Protection Levels

For each of the applications listed in Section 3.4, MedImpact has identified critical infrastructure/technology components and business processes required for the operations of the application. The Business Continuity Plan covers each critical technology and business process.

MedImpact uses multiple levels of redundancy to protect its information technology assets. These levels of redundancy can be stratified into three levels:

- ***Level 1 – Platform & Server Redundancy***

  In the case of individual system failure, MedImpact's multiple redundant systems will allow Claims Processing to continue with only a minor interruption as processing is moved to a hot-standby server. Claims processing systems are run on redundant and/or high-availability hardware. Workload requirements are facilitated by dynamic reallocation of system resources without rebooting the partition or system, which can help improve speed of recovery in case of a single server failure.

- ***Level 2 – Storage Redundancy***

  MedImpact's strategy of replicated databases on isolated storage frames provides critical protection against storage system failure. Critical data is replicated locally and to the Secondary Data Center to protect against a single site failure.

- ***Level 3 – Data Center Redundancy***

  MedImpact IT systems and critical data are safeguarded by physical data centers with geographic isolation and application redundancy.

3.4. Recovery Time Objective (RTO) Tiers

In the instance of a service disruption or disaster event, a Recovery Time Objective (RTO) is the projected duration of time required to restore an application to normal operations. RTO Tiers (see Table 2, *Application RTO Tiers*) are defined by the business units in coordination with the IT Disaster Recovery Management Team for use in emergency level assessments. IT maintains alliance to RTO Tiers by meeting or exceeding the discrete RTO.

RTO		
RTO Tiers	**Definition**	**Service Functions**
Tier 1	Within 15 minutes	Claims Adjudication Domestic International Both POS and Web Services
Tier 2	0-30 minutes Minimal downtime level for critical production applications	Contact Center Call Handling Telco Systems MedAccess IVR Prior Authorization
Tier 3	0.5-4 hours	Client Portal (Enterprise Portal Platform) Email RightFax ePrescribing Membership (Eligibility) (SFTP/Load Capabilities) File Management (scheduler and load)
Tier 4	4-8 Hours	Benefit Highlights
Tier 5	8 - 24 hours Moderate downtime level for ancillary or supporting production applications	Benefits/Network/Carriers (QSP/TAC) PDE Processing Direct Member Reimbursement Member Portal Pharmacy Locator Drug Price Check Formulary Management (EFS, Part D Template, CTI) Reporting Financial Processing MOR Drug Pricing (Medi-Span/FDB) Call Recording/Monitoring
Tier 6	24 - 48 hours Long downtime level for ancillary or supporting production applications	Clinical Programs Testing and Validation Pharmacy Portal
Tier 7	> 48 hours Extended downtime level for ancillary or supporting applications	Rebates Processing Physician Portal

Table 2: Application RTO Tiers

3.5. Recovery Point Objective

The Recovery Point Objective (RPO) is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident.

The RPO for MedImpact's Tier 1 application is fifteen (15) minutes.

The database is configured to allow recovery of the last committed transaction. The Director, Database & Middleware, will initiate recovery of transactions through the standard database recovery procedures in the event of a disruption of service.

4. Responsibilities

4.1. IT DR Management Team

Team Responsibilities

It is the role of the Chief Operations Officer (COO) to provide the overall direction of the IT DR Management team (ITDRMT) and the IT recovery operations. Activities will be coordinated under the direction of the Business Continuity/Disaster Recovery Leadership Team (BCDRLT). The DRPMT will establish the emergency command center where IT damage assessment and recovery operations will be directed. It will analyze damage reports from the Damage Assessment team and make recommendations to the BCDRLT as needed for disaster declaration.

The ITDRMT notifies the IT Technical Recovery Team (ITTRT) with concurrence from the BCDRLT. If a disaster declaration is made, this team coordinates all the IT internal recovery procedure activities and monitors its progress. ITDRMT schedules IT recovery personnel for appropriate support activities and serves as the focal point for all technical questions posed by others during the recovery process. This team has a key role in ongoing disaster recovery preparedness. It is responsible for all planning, testing and maintenance activities necessary to sustain the IT recovery capability over time. All IT disaster recovery teams report to the ITDRMT.

The ITDRMT is responsible for overseeing the MedImpact IT Disaster Recovery Program.

Pre-Disaster Responsibilities

1. Provide overall leadership in the development and implementation of the MedImpact IT Disaster Recovery Plan (DRP)
2. Ensure that IT personnel are familiar with the MedImpact disaster notification procedures
3. Review test plans and test results at the test facility and/or Secondary Data Center
4. Review and approve results of the periodic IT DRP review
5. Director IT, Database, Configuration Management and Middleware distributes updated soft copies of the DRP via email to members of the IT DR Management Team annually or as needed.
6. IT DR Management Team shall review the BCP annually for any new or modified requirements and amend the DRP accordingly.

Disaster Responsibilities

1. Establish and maintain a consistent communication schedule with a pre-established command center.
2. Dispatch MedImpact Damage Assessment Team to assess situation in the computer facility.
3. Notify the BCDRLT.
4. Alert the Secondary Data Center of a possible disaster (pre-declaration).
5. Review damage assessment report and make recommendations to the BCDRLT.
6. Execute final alert procedures based on the severity of the situation.
7. Provide for the well-being of MedImpact IT recovery personnel at the Secondary Data Center.
8. Provide overall leadership, management and direction to the ITTRT.
9. If necessary, and in conjunction with, Human Resources and logistics vendor:
    - Provide road maps, directions, and transportation to the Secondary Data Center for people, equipment, and supplies.
    - Arrange lodging, medical services, etc., at the Secondary Data Center.
    - Arrange for personal expenses and payment of invoices at Secondary Data Center.
    - Verify hours worked, permit sufficient time off, and hire temporary personnel as required.

Post-Disaster Responsibilities

1. Assess overall performance of IT teams during recovery process.
2. Assess overall effectiveness of the IT Disaster Recovery Plan (DRP).
3. Assess overall effectiveness of the Secondary Data Center.

4.2. ITDRMT Team

ITDRMT Team
SVP, Chief Operations Officer
SVP, Digital Development & Renewal
VP, Software Engineering
Director, Software Engineering
Director, IT Database, Configuration Management & Middleware
Director, Network Engineering
Director, System Engineering
Manager, Application Support
Manager, IT Configuration & Release
Manager, Data Management Engineering
Manager, IT Middleware Administration
Manager, Security & Network Operations

Table 3: IT DR Management Team

4.3. IT Technical Recovery Team(s)

The IT Technical Recovery Team (ITTRT) is responsible for the restoration and recovery of the equipment, server systems, utility, application software and data for internal business systems at the Secondary Data Center location or at the reconstructed MedImpact Data Center.

Pre-Disaster Responsibilities

1. Maintain a current inventory of all hardware systems, utilities, and application software operating in the enterprise.
2. Maintain a current list of vendors, and other support contacts.
3. Conduct walk-throughs of the Data Centers to eliminate hazards.
4. Establish system backup and recovery procedures for MedImpact systems.
5. Establish, review, test and support the *Multiple Contact Center Strategy (MCCS)*.
6. Facilitate the recovery of MedImpact systems.
7. Work with other recovery teams to establish appropriate application and data backup procedures at application synchronization points.
8. Review and identify required disaster recovery documentation.
9. Have support agreements and documentation available at the recovery sites.
10. Follow *MedImpact Data Backup Policy (299-PI-1040)*.
11. Establish a team notification plan and a predetermined team meeting location for actual declaration.
12. Cross train team members in system and application software.
13. Test and document backup/recovery procedures at the computer facility and the Secondary Data Center.
14. Review and analyze test results and implement modifications as necessary.

Disaster Responsibilities

1. Execute team notification plan.
2. Meet at predetermined location and ensure all team members are available.
3. Contact alternate or substitute team members as required.
4. Review current disaster situation, recovery procedures, and roles and responsibilities.
5. At the Secondary Data Center location, ensure all documentation and backup tapes are available.
6. Execute application failover plans and validate application functionality.

7. Establish alternatives and acquisition procedures for missing documentation and tape media.
8. Restore operating system, subsystems, utilities, application software and data using stored recovery procedures and software runbooks.
9. Verify system availability.
10. Provide other recovery teams with an ongoing status and notification of system availability.
11. Provide technical support for other teams as necessary.
12. At the conclusion of the damage assessment, assume responsibility from the Damage Assessment team for necessary salvage, repair or replacement of IT equipment.
13. Prepare for and execute procedures to return to the renovated/reconstructed MedImpact computer facility when ready.

Post-Disaster Responsibilities

1. Revise/update team tasks and procedures as needed.
2. Implement updated tasks and procedures into plan testing requirements.
3. Revise/update existing production procedures.

5. Event Detection & Plan Execution

During an IT DR event, "Event Detection & Plan Execution" can be divided into five major phases (see Table 4, *Event Detection & Plan Execution Phases*).

Phase	Action	Detail
I	***Identify & Declare***	Initial identification of the extent of damage resulting from an incident causing system inaccessibility or downtime. Appropriate Condition Code/outage level is declared.
II	***Establish Command Center***	Depending on the severity and nature of the event, a command center is established as a communication access point for participating disaster recovery team members. The command center may be established at a physical, offsite location or "virtual location" via 1-800 conference call. ***Note***: Core IT disaster recovery staff members have access to the 1-800 conference call hosting system and may act as a first responder.
III	***Mobilize Team Members***	Team member travel may be required to staff the Secondary Data Center. Mobilization services are provided by Human Resources or MedImpact's logistics vendor.
IV	***Secondary Data Center Operation***	Utilization of the Secondary Data Center is based on the nature of the disaster event and would be exercised at the discretion of the IT Management Team. In the event the Secondary Data Center is utilized, authorized and trained personnel would be deployed to the Secondary Data Center location, as required.
V	***Retrieve Data Backup Tapes***	IT Technical Recovery Team will contact offsite storage vendor to deliver data backup tapes to the Secondary Data Center. Transportation for tape delivery will be confirmed. Team will verify that items requested have been retrieved.

Table 4: Event Detection & Plan Executive Phases

5.1. Phase I: Identify & Declare

Performed by: Business Continuity and Disaster Recovery Leadership Team (BCDRLT)

Declaration Determination

Declaration initiatives are associated with recovery terms and disaster durations. The BCDRLT will declare a disaster state based upon the Condition Codes. The Declaration Determination Process is outlined in Figure 1, *Declaration Determination Process*.

(See additional details in the *MedImpact Business Continuity Plan*.)

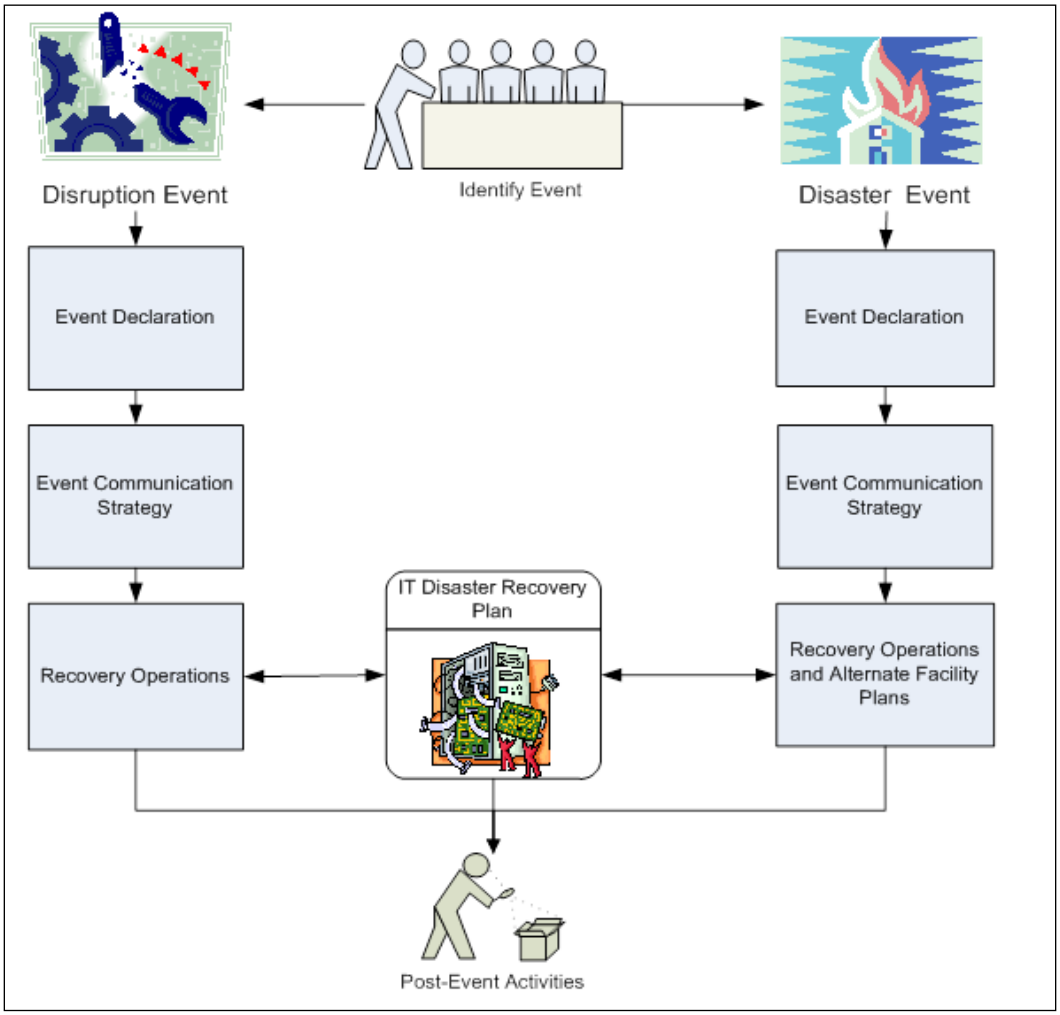


Figure 1: Declaration Determination Process

5.2. Phase II: Establish Command Center

Performed by: IT DR Management Team

In the event of a disaster, a command center is established as a communication access point for participating disaster recovery team members. Depending on the nature and severity of the event, a command center may be established at a physical, offsite location or "virtual location" via conference call.

Example of command center options:

- Conference Room, Hotel Suite or Temporary Office
- 1-800 Conference Call Number
- Teams Chat Room

(For details, see 8.1, *Multiple Contact Center Strategy [MCCS].)*

5.3. Phase III: Mobilize Team Members

Performed by: IT DR Management Team

After the potential disaster situation has been assessed, and the BCDRLT has determined that a disaster situation exists, all members of the disaster recovery team(s) are contacted. An authorized member of the IT DR Management Team designates an individual present to notify all recovery team leaders to be put on call or instructed to contact all group members and/or report to the command center (or designated meeting point) for further instructions.

5.4. Phase IV: Secondary Data Center Operations

Performed by: IT DR Management Team

Utilization of the Secondary Data Center is based on the nature of the disaster event.

In the event the Secondary Data Center is utilized, authorized and trained personnel would be deployed to the Secondary Data Center location, as required.

5.5. Phase V: Retrieve Data Backup Tapes

Performed by: IT Technical Recovery Team

The ITTRT contacts the offsite storage vendor to deliver data backup tapes to the Secondary Data Center. Transportation for tape delivery is confirmed and items requested are verified.

6. Recovery

The Recovery Phase will commence after the DRP has been activated, the appropriate DR teams have been notified and mobilized, and the damage assessment has determined which critical production systems will need to be switched/recovered to the Secondary Data Center or recovered at the primary location.

Recovery phase activities will include the appropriate actions required to mitigate loss of service, repair damage to the original system, and/or restore operational capabilities at the original or Secondary Data Center.

IT Technical Recovery Team members are required to possess an intimate knowledge of MedImpact systems in order to execute recovery strategies during the initial and final stages of the DR event.

6.1. Critical Application Recovery

All mission-critical, production-level applications are managed by the respective application owner. Discrete recovery procedures include the following information:

1. Recovery Plan/Procedures
2. DR Test Plan, including documentation and retention of test results to demonstrate plan effectiveness
3. Return to Normal Operations Plan/Procedures
4. Vendor Contact Information

7. Return to Normal Operations

After affected services have been restored and normal IT processes have resumed, the recovered system shall be transitioned back to the original Primary Site (if needed). Return to Normal Operations will be handled by the respective IT teams as outlined by the IT Return to Normal Operations Plan/Procedures for the respective IT application.

8. Appendices

8.1. Multiple Contact Center Strategy (MCCS)

Emergency events (Code Orange, Code Red), and other events that demand a heightened state of disaster-readiness (Code Yellow), may require the deployment to an offsite location to support IT software, hardware and support services. In such cases, at the discretion of the IT DR Management Team, the MedImpact Multiple Contact Center Strategy (MCCS) may need to be activated to ensure continuous and seamless business operations.

The MCCS provides contingency hardware, personnel and responsibilities for an additional and/or remote Contact Center when the Corporate Contact Center is physically unavailable or cannot be adequately staffed. The MCCS should be implemented as required, provided the required dependencies are true.

8.2. Network Information

In the event of Secondary Data Center migration, MedImpact teams will quickly coordinate to activate the necessary services in the Secondary Data Center.

- Customers with site-to-site VPNs will automatically failover to the site-to-site gateway at the Secondary Data Center.
- Customers with internet connections to our services will automatically failover to the services available at the Secondary Data Center.
- Customers with dedicated circuits are either actively sending traffic to both data centers or will dynamically failover in the event of an outage.

8.3. Backup Strategy

For more information, see the *MedImpact Data Backup Policy (299-PL-1040)*.

8.4. Offsite Storage Information

Offsite storage information includes the physical location and contact information for retrieving DR data and artifacts.

8.5. Vendor Contact Information

As required, contact information for third-party vendors is needed to expedite recovery procedures.

8.6. Disaster Recovery Plan (DRP) Testing

Periodic testing of recovery procedures is important to validate the effectiveness of the backup and recovery procedures. It is expected that the system and network environment of MedImpact will change regularly as MedImpact continues to take advantage of information technology advances. Therefore, the DRP is tested regularly to ensure MedImpact critical applications would be available to support business operations in the event of a disaster.

MedImpact's DRP Test Results are strictly confidential.

8.7. Disaster Recovery Plan (DRP) Maintenance

The DRP shall be reviewed periodically or whenever there are substantial changes to the technology or systems.

Annual Maintenance:

On an annual basis, the IT DR Management Team will meet and review existing DRP documentation to determine whether updates are required. If updates to the DRP are necessary, the IT DRP Management Team will modify DRP documentation and follow the standard review, approval, and distribution process to communicate the current DRP and prepare in the case of an event.

Substantial changes to technology or systems:

If substantial changes to the technology are necessary, systems or operations (changes impacting IT identified in the Business Unit Recovery Plan [BURPs]), the IT DR Management team will meet to discuss changes and impacts. The IT DRP Management Team will update existing DRP documentation and follow the standard review, approval and distribution process to communicate the current DRP and prepare in the case of an event.

8.8. Security Safeguards

MedImpact's redundant, always on, replicated data centers contain duplicate IT Security technology at each location to ensure that the exact same protections for electronic protected health information (ePHI) that existed prior to a disaster will be in place during a disaster (emergency mode operation) and after a disaster. No separate recovery process or procedure is required to enable MedImpact's ePHI security safeguards in the event of a disaster. In the event of the loss of either data center, MedImpact's ePHI security safeguards are automatically in place and working upon failover.

The Disaster Recovery Plan addresses a specific, minimal set of Information security requirements as documented in the individual Business Unit Recovery Plans.

BUSINESS UNIT LEADER	Denise Burns, Chief Operations Officer
PROCESS OWNER	Mabuti Ng'andu, Director IT Database Middleware

RELATED EXTERNAL REFERENCES(Use of Links to external references requires additional maintenance of document to ensure accuracy – Use this sparingly)	
Name	**Link**

CHANGE HISTORY / VERSION CONTROL	
Version	**Comments**
5.0	Revision (J. Hays 4/9/2013)
6.0	Revision (K. Wilshe with input from Brandi Sanford, Frank Bunton and Tony Roach 12/30/2015)
7.0	Revision (K. Wilshe with input from Brandi Sanford, Frank Bunton, Michael Andrews and Tony Roach)
8.0	Revision (K.Wilshe with input from Frank Bunton, IT Management Team and Michael Andrews regarding RPO; section 8.9 added 4/2019)
9.0	Revision (K. Wilshe with input from Frank Bunton, Michael Andrews and IT DRP Leadership team). (11/2019)
10.0	Revision (K. Wilshe updated approvers and IT DR Management Team) 10/2020
11.0	Updated to comply with HITRUST language requirements per HITRUST team (10/2021)
12.0	Revision (M. Andrews, M. Callagy, S. Cramer, M. Ng'Andu and IT DR Management Team) 11/2022

* *Annual Review Approval Audit Records—no document content updates made*: Audit Record inserted by Process Management before document is finalized and published.

Healthe SYSTEMS

Transforming healthcare.

Healthesystems Exhibit N:
Information Security Policy

Prepared for: New York State Insurance Fund

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HEALTHESYTEMS INFORMATION SECURITY POLICY

Security policies for all facilities

Document Control

Healthesystems Information Security Policy Version History:

Version Number	Date	Reason/Comments
Version 1.0	02/13/2009	Implementation
Version 2.0	07/25/2010	IS policy changes due to new Record Management Policy
Version 3.0	08/25/2010	Annual review changes
Version 4.0	08/10/2011	Annual review changes
Version 5.0	12/17/2012	Annual review changes
Version 6.0	04/10/2013	Conversion to ISO format
Version 6.1	05/06/2013	Incorporating suggestions and changes
Version 7.0	3/17/2014	Annual review changes
Version 7.1	5/31/2014	Approved with HIPAA/HITECH revisions
Version 8.0	7/19/2018	Approved by CEO
Version 9.0	8/12/2020	Approved by CEO
Version 9.1	11/28/2022	Annual review changes

Contents

Introduction

Information security is a holistic discipline, meaning that its application or lack thereof affects all facets of an organization or enterprise. The goal of the Healthesystems Information Security Program is to protect the Confidentiality, Integrity, and Availability of the data employed within the organization while providing value to the way we conduct business.

Healthesystems has recognized that our business information is a critical asset and as such our ability to manage, control, and protect this asset will have a direct and significant impact on our future success. This document establishes the information security policies to ensure that the enterprise can efficiently and effectively manage, control and protect its business information assets and those information assets entrusted to Healthesystems by its Business Partners. The Healthesystems Information Security Program is built around the information contained within these policies.

These policies incorporate a risk assessment approach to security using Security Threat and Risk Assessments to consider:

- Business process and service delivery implications.
- Technological implications; and,
- Communications strategies**,** including information security awareness programs.

The risk assessment approach enables:

- Compliance with legislative and policy objectives.
- Cost-effective allocation of resources based on a risk assessment.
- Responsible governance of Healthesystems' information assets; and,
- Secure provision of e-services.

Preamble – "In February 2014, NIST released the Framework for Improving Critical Infrastructure Cybersecurity (Cybersecurity Framework) as directed in Executive Order 13636, Improving Critical Infrastructure Cybersecurity. The Cybersecurity Framework provides a voluntary, risk-based approach—based on existing standards, guidelines, and practices—to help organizations in any industry to understand, communicate, and manage cybersecurity risks. In the health care space, entities (covered entities and business associates) regulated by the Health Insurance Portability and Accountability Act (HIPAA) must comply with the HIPAA Security Rule to ensure the confidentiality, integrity, and availability of electronic protected health information (ePHI) that they create, receive, maintain, or transmit. In 2016, NIST and OCR from Health and Human Services published a crosswalk document that identifies "mappings" between the Cybersecurity Framework and the HIPAA Security Rule. This crosswalk document is titled "*HIPAA Security Rule Crosswalk to NIST Cybersecurity Framework".*

Organizations that have already aligned their security programs to either the NIST Cybersecurity Framework or the HIPAA Security Rule will find this crosswalk helpful as a starting place to identify potential gaps in their programs. Addressing these gaps can bolster their compliance with the Security Rule and improve their ability to secure ePHI and other critical information and business processes." Led by the Healthesystems CIO or designate, Healthesystems will use this crosswalk to address gaps that may exist within our Information Security Program.

Strategy and Goals

Healthesystems' current business strategy and framework for risk management are the guidelines for identifying, assessing, evaluating, and controlling information related risks through establishing and maintaining the information security policy (this document).

It has been decided that information security is to be ensured by the policy for information security and a set of underlying and supplemental documents. In order to secure operations at Healthesystems even after serious incidents, Healthesystems shall ensure the availability of continuity plans, backup procedures, defense against damaging code and malicious activities, system and information access control, incident management and reporting.

The term information security is related to the following basic concepts:

- ***Confidentiality***: The property that information is not made available or disclosed to unauthorized individuals, entities, or processes.
- ***Integrity***: The property of safeguarding the accuracy and completeness of assets.
- ***Availability***: The property of being accessible and usable upon demand by an authorized entity.

The Healthesystems Information Security Policy applies equally to any individual, entity or process that interacts with any Healthesystems Information Resource in any tangible manner. Information resources include host computer systems and workstations, communication networks, software, and files.

Portions of this policy are more restrictive in scope than others, but all persons should read the policy in its entirety.

All individuals employed by Healthesystems are required to protect the Confidentiality, Integrity, and Availability of the information resources, data generated, accessed, modified, transmitted, stored and/or used by Healthesystems, irrespective of the medium on which the data resides and regardless of format (i.e., electronic, paper or other physical form).

A violation of these policies constitutes unacceptable use of computing resources and may violate other state and/or federal laws. Suspected or known violations should be reported to Information Technology Management and General Counsel/Compliance Officer. Violations may result in disciplinary action, up to an including termination, or civil and/or criminal legal action.

A violation of these policies constitutes unacceptable use of computing resources and may violate other state and/or federal laws. Suspected or known violations should be reported to Information Technology Management and General Counsel/Compliance Officer. Violations may result in disciplinary action, up to an including termination, or civil and/or criminal legal action.

R1: Establishing and Managing Security Risk

Risk assessments must be documented during the conceptual design phase of a project and updated throughout the lifecycle of the information system (e.g., prior to and following technical or business process changes to the information system).

R.1.1	Healthesystems approach to security should be based on risk assessments.
R.1.2	Healthesystems should continuously assess the risk and evaluate the need for protective measures. Measures must be evaluated based on efficiency, cost, and practical feasibility. See Quality Assurance Process
R.1.3	An overall risk assessment of the information systems should be performed annually. See Quarterly Firewall Audit and Internal File Systems Audit
R.1.4	Risk assessments must identify, quantify, and prioritize the risks according to relevant criteria for acceptable risks. See PBM Software Release Development
R.1.5	Risk assessments are to be carried out when implementing changes impacting information security. Recognized methods of assessing risks should be employed. See Production Change Request Process
R.1.6	The ELT is responsible for ensuring that the risk management processes at Healthesystems are coordinated in accordance with the policy.
R.1.7	The System Owners are responsible for ensuring that risk assessments within their area of responsibility are implemented in accordance with the policy. See Production Change Request Process
R.1.8	Risk management is to be carried out according to criteria approved by the management at Healthesystems.
R.1.9	Risk assessments must be approved by the management at Healthesystems and/or the system owners.
R.1.10	If a risk assessment reveals unacceptable risks, measures must be documented to reduce the risk to an acceptable level. See PBM Software Release Development
R.1.1	Healthesystems approach to security should be based on risk assessments.

A.5: Information Security Policy

This Information Security Policy contains operational policies intended to establish minimum requirements for the secure delivery of services. Secure service delivery requires the assurance of confidentiality, integrity, availability, and privacy of information assets and data through:

- Management of business processes that include and enable the application of security best practices.
- Ongoing personnel training and awareness of security policies, processes, and procedures.
- Physical and logical security requirements for securing network connections, information systems, and data.
- Governance processes for securing information technology, data processing, and user access.
- Reporting of potential information security risks, threats, vulnerabilities, and related events.
- Creating and maintaining business continuity and cyber security incident response plans.
- Continuous monitoring of system events for network awareness and compliance.

Healthesystems senior management recognizes that information security is a process, which to be effective, requires management commitment, the active participation of all personnel and ongoing awareness programs. To support that effort:

A.5.1.1	The ELT shall ensure that the information security policy, as well as guidelines and standards, are utilized and acted upon.
A.5.1.1a	The ELT must ensure the availability of sufficient training and information material for all users, in order to enable the users to protect Healthesystems' data and information systems.
A.5.1.2	The security policy shall be reviewed and updated annually or when significant changes occur.
A.5.1.2a	All important changes to Healthesystems' activities, and other external changes related to the threat level, should result in a revision of the policy and the guidelines relevant to the information security.

A.6: Organization of Information Security

Executive Leadership Team (ELT) **-** The ELT provides information security protections commensurate with the risk and magnitude of the harm resulting from unauthorized access, use, disclosure, disruption, modification, or destruction of information collected or maintained by or on behalf of Healthesystems, and on information systems used or operated by Healthesystems or by a contractor of Healthesystems or other organization on behalf of Healthesystems; Ensures that an information security program is developed, documented, and implemented to provide security for all systems, networks, and data that support the operations of the organization; Ensures that information security processes are integrated with strategic and operational planning processes to secure the organization's mission; and Ensures that senior management within the organization is given the necessary authority to secure the operations and assets under their control within the scope of the Healthesystems global information security program.

Chief Information Officer (CIO) **-** The CIO is accountable for all information resources and applying the appropriate level of information security safeguards to reduce risk; Appoints and directs the Information Security Analyst to ensure the preparation and maintenance of plans, policies and procedures to address information security and continuity of operations for information systems that support the operations and assets of Healthesystems; Ensure that Healthesystems has trained personnel to identify, develop and implement security safeguards to monitors and protects information resources in compliance with information security and technological

policies, processes, standards, and guidelines; Establish an IT incident management program that readily identifies, protects, detects, responds and recovers from unauthorized security events; and reports annually, in coordination with the other Healthesystems senior managers, to Executive Management on the effectiveness of the Healthesystems information security program, including progress of remedial actions; Assess risk and magnitude of the harm resulting from unauthorized access, use, disclosure, disruption, modification, or destruction of information and information systems that support the operations and assets of Healthesystems; Review information security policies, procedures, and control techniques to address all applicable requirements throughout the life cycle of each Healthesystems information resource; Analyze and assess the technological risk for the acquisition of hardware, software, and 3rd party vendors and service providers supplying digital assets, platforms and/or resources in support of Healthesystems operations; and Facilitates development of subordinate plans for providing adequate information security for networks, facilities, and systems or groups of information systems.

Compliance Officer – The Compliance Officer acquires and maintains comprehensive knowledge of the legal, ethical, and other specific handling requirements for information in the assigned area; Promotes the widespread, appropriate, efficient, and effective use of information; Acquires and maintains knowledge of the high level issues surrounding the security and privacy of information and supporting technology resources; Acquires and maintains knowledge of Healthesystems' Information Security and Privacy Program and its supporting policies, standards, and other resources; Provides periodic information security and privacy compliance briefings to Executive Leadership Team to ensure that compliance and privacy risks are understood and that appropriate controls are implemented; Receives periodic direction and/or briefings on compliance related items from Executive Leadership Team for information security and privacy and communicates concerns and issues, provides expertise and advice, and direct appropriate compliance actions; Provides guidance and support to ensure that awareness and training activities of Healthesystems satisfy requirements that the assigned area has in common with the other represented areas; Provides guidance and support for all Healthesystems compliance related audits and risk assessments; Identifies contracts that will involve handling, sharing, or allowing access to information or information technology resources and ensures that contracts include up-to-date contract language addressing appropriate information security and privacy; and Acts as an expert privacy resource to users.

Information Security Analyst – The Information Security Analyst, acquires and maintains knowledge of all security related threats, vulnerabilities and associated risks impacting information resources to identify and implement the appropriate security safeguards; Appointed by and reports to the CIO serving as the expert information security entity responsible for providing guidance and direction in the planning, design and implementation of secure administrative, logical and physical solutions in accordance with the Information Security Policy; Manages and administrates the day-to-day operations of in-place security solutions to ensure the confidentiality, integrity and availability of all information resources; Spearheads information security risk assessments and cybersecurity incident response efforts to identify, detect and respond to threats, assess impact to information resources and provide appropriate mitigation solutions to System Administrators or applicable personnel to restore network operations; Provides guidance and support for all information security related audits and risk assessments; Acquires and maintains knowledge of the Healthesystems Information Security program and its supporting policies, standards, resources, processes and procedures; Provides periodic information security updates and briefings to Executive Leadership to raise awareness of potential risks and threats impacting the Healthesystems cybersecurity landscape; Receives direction and guidance from the CIO and ELT when applicable on the execution and implementation of approved safeguards and mitigation solutions.

Internal Audit - Internal Audit are persons responsible for directing and administrating internal/ external audits impacting Healthesystems operations; Evaluates the adequacy and effectiveness of Healthesystems business processes and procedures to ensure alignment with all applicable Information Security policies and regulatory requirements; Provides support and guidance to business areas in the planning and development of audit related activities and functions; Conducts periodic audits updates and briefings to Executive Leadership to ensure awareness and understanding of internal/external assessments and communicate any areas of concern and recommended solutions.

System Owner - The system owner, in consultation with the IT department, is responsible for purchasing requirements, development and maintenance of information and related information systems. All systems and all types of information must have a defined owner. The system owner must define which users or user groups are allowed access to the information and what authorized use of this information consists of.

System Administrator - System administrators are persons responsible for the administration of Healthesystems' information systems and the data entrusted to the Company by other parties. Each data type and system may have one or more dedicated System Administrators. These are responsible for maintaining, configuring, updating, patching, protecting the information, including implementing systems for access control to safeguard confidentiality, and carry out backup procedures to ensure that critical information is not lost. They will further implement, run, and maintain the security posture of all systems in accordance with the security policy. Each system must have one or more system administrators.

Information Owners - Information Owners have the responsibility and decision-making authority for information throughout its life cycle, including creating, classifying, restricting, regulating, and administering its use, disclosure, and disposition to include its deletion and destruction.

Information Custodians - Information Custodians maintain or administer information assets and infrastructure on behalf of the Information Owners by providing and managing security for the information asset throughout its lifecycle.

Information Assets – Data on any media format that is created, processed, and used by the business.

Users - All individuals employed by Healthesystems are required to protect the Confidentiality, Integrity, and Availability of the data generated, accessed, modified, transmitted, stored and/or used by Healthesystems, irrespective of the medium on which the data resides and regardless of format (i.e., electronic, paper, or other physical form).

Consultants and Contractual Partners - Contractual partners and contracted consultants must sign a confidentiality agreement prior to accessing sensitive information and are required to protect the Confidentiality, Integrity, and Availability of the data generated, accessed, modified, transmitted, stored and/or used by Healthesystems, irrespective of the medium on which the data resides and regardless of format (i.e., electronic, paper, or other physical form). The System Owner is responsible for ensuring that this is implemented.

Policy Exceptions

The entity desiring to waive a policy provision shall forward it to the appropriate senior manager for review by the ELT. The ELT will review the submitted Waiver and determine if the unusual and/or exceptional circumstances will introduce additional risk, or adversely affect the overall security of Healthesystems, Healthesystems customers or Business Partners.

Any waiver request, which is determined by the ELT to have a potential adverse impact on the security of Healthesystems, or any customer or partner, or adverse impact on compliance with applicable laws or regulations, shall not be approved by the ELT.

A.7: Asset Management Policy

Information and information systems services constitute valuable resources. This section establishes the blueprint to identify the rules of acceptable use and the rules for protection: what assets to protect, who protects them and how much protection is adequate.

A.7.1 – Responsibility for Assets

A.7.1.1	An inventory of all important assets associated with information systems must be documented and maintained.
A.7.1.1.a	Assets include both information assets and physical assets.

A.7.2 – Information Classification

A.7.2.1	Information and infrastructure should be classified according to security level and access control. See Securing Sensitive Data Elements in SQL Server Databases
A.7.2.1.a	The information security classification system must take into account the value, sensitivity, intended use of the information and potential impact if compromised.
A.7.2.1.b	Users administrating information on behalf of Healthesystems should treat said information according to its designated classification.
A.7.2.2	Sensitive documents should be clearly marked.
A.7.2.2.a	Information must be identified, labeled when appropriate and handled in accordance with the assigned information security classification. See Record Management Policy.

A.8: Human Resources Security Policy

Management and personnel have different security responsibilities and liabilities that apply prior, during, and at the time of termination of employment. Prior to employment, emphasis is on the awareness of the expected roles and responsibilities, the screening of prospects and the existence of agreements. During employment, policies establish management responsibilities, education, training, and formal processes to handle problematic security situations. This policy also set forth rules to ensure a secure transition when employment is ended or changed.

A.8.1 - Prior to Employment

A.8.1.1	Security roles and responsibilities for personnel must be documented.
A.8.1.2	A background check is to be carried out of all potential employees to positions at Healthesystems according to relevant laws and regulations.
A.8.1.3	A confidentiality agreement must be signed by employees, contractors or others who may gain access to sensitive and/or internal information.

A.8.2 - During Employment

A.8.2.1	Management must ensure personnel comply with security policies and procedures.
A.8.2.2	All new users must complete an approved Security Awareness training class prior to, or at least within 30 days of, being granted access to any Healthesystems Information Resources. See Information Security Training.
A.8.2.2.a	Healthesystems IT management must prepare, maintain, and distribute one or more information security manuals that concisely describe Healthesystems information security policies and procedures. All users (employees, consultants, contractors, temporaries, etc.) must be provided with this policy to allow them to properly protect Healthesystems Information Resources. All users must acknowledge they have read and understand the Healthesystems Corporate Information Security Policy in writing.
A.8.2.2.b	Healthesystems IT management must develop and maintain a communications process to be able to communicate new computer security program information, security bulletin information, and security items of interest.
A.8.2.3	Where applicable suspected security incidents, breaches and/or policy violations by personnel must be reviewed by the CIO, Information Security, IT Services and/or General Counsel/Compliance Officer with appropriate sanctions levied by ELT.

A.8.3 - Termination or Change of Employment

A.8.3.1	Responsibilities for employment termination must be documented.
A.8.3.2	Personnel must return all company owned assets upon termination or change of employment.
A.8.3.3	The access rights of personnel to information systems must be removed upon termination of employment and reviewed upon change of responsibilities. See User Account Termination

A.9: Physical and Environmental Security Policy

Requirements for the installation, operation, protection and maintenance of computer equipment are identified to preserve the confidentiality, integrity and availability of information and information systems.

A.9.1 - Secure Areas

A.9.1.1	All Information Resource facilities must be physically protected in proportion to the criticality or importance of their function at Healthesystems. Physical security systems must comply with all applicable regulations including but not limited to building codes and fire prevention codes. See Environmental Equipment Inspection.
A.9.1.2	Access to Information Resources facilities must be granted only to Healthesystems support personnel and contractors whose job responsibilities require access to that facility. Each individual that is granted access rights to an Information Resource facility must sign the appropriate access and non-disclosure agreements. See Data Center Physical Access Procedures.
A.9.1.3	Physical security requirements must be designed, documented, and applied for all areas in and around an information processing facility.
A.9.1.4	Physical security controls must be designed to protect against damage from natural or man-made disaster.

A.9.1.5	The process for granting card and/or key access to Information Resource facilities must include the approval of the person responsible for physical facility management. Cards and/or keys must not have any identifying information other than a return mail address, excluding photo access badges required by third party vendors. The person responsible for Information Resource physical facility management must remove the card and/or key access rights of individuals that change roles within Healthesystems or are separated from their relationship with Healthesystems Access cards and/or keys that are no longer required must be returned to the person responsible for Information Resource physical facility management. Cards must not be reallocated to another individual, bypassing the return process. Lost or stolen access cards and/or keys must be reported to the person responsible for physical facility management as soon as practicable. The person responsible for physical facility management must review card and/or key access rights for the facility on a periodic basis and remove access for individuals that no longer require access. See Physical Access Procedures.
A.9.1.5.a	Additional security controls and procedures must be used by personnel working in secure areas such as data centers, areas that process protected health information, or other areas that contain or process sensitive information. See Data Center Physical Access Procedures.
A.9.1.5.b	All Information Resources facilities that allow access to visitors will track visitor access with a sign in/out log. Card access records and visitor logs for facilities must be kept for routine review based upon the criticality of the Information Resources being protected. The person responsible for physical facility management must review visitor logs for the facility on a periodic basis and investigate any unusual access. Visitors in card access-controlled areas of Information Resource facilities must be accompanied by authorized personnel at all times.
A.9.1.6	Access to delivery, loading areas, and other public spaces must be controlled, and were possible separated from information processing facilities.

A.9.2 - Equipment Security

A.9.2.1	Equipment must be protected to reduce the risks from unauthorized access, environmental threats and hazards.
A.9.2.2	Power protection must be supplied to ensure the availability of information systems. This equipment must be regularly checked to ensure it has adequate capacity and tested in accordance with the manufacturer's recommendations. See UPS Inspection Procedure.
A.9.2.3	Power and telecommunications cabling must be protected from interception and damage.
A.9.2.4	Equipment must be correctly maintained to enable continued availability and integrity.
A.9.2.5	Equipment must be protected using documented security controls when off-site from Healthesystems' premises.
A.9.2.6	Prior to selling, donating, or discarding equipment, any storage device within the device, or attached as a peripheral, must by sanitized by Healthesystems IT using appropriate data destruction standards.
A.9.2.7	Equipment, information, or software belonging to Healthesystems must not be removed from company premises without prior authorization.

A.10: Communications and Operations Management Policy

Planning and management of the day-to-day activities is required to ensure the availability and capacity of the resources that provide services. Services can be delivered by external parties and by computer networks and by all services that exchange information. This framework identifies requirements to control and monitor operations for service delivery and to manage changes as the operations evolve.

Controls for operations include documented processes, staff duties and formal methods to implement changes to facilities. This includes methods to protect information, create copies for back-up and to manage the media where those copies are stored. Network protection requirements from threats such as viruses or unauthorized disclosure are also described.

A.10.1 - Operational Responsibilities

A.10.1.1	Operating procedures and responsibilities for information systems and information processing facilities must be authorized, documented, and maintained.
A.10.1.2	Changes to information systems and information processing facilities must be controlled.
A.10.1.3	Duties and areas of responsibility must be segregated to reduce opportunities for unauthorized access, modification, misuse, or destruction of information systems.
A.10.1.4	Development and test information systems must be separated from production information systems with controls in place to prevent the unauthorized access, modification, misuse, or destruction of the environments resources.

A.10.2 - Third Party Service Delivery Management

A.10.2.1	Prior to using external services, security controls, service definitions and delivery levels must be identified and included in the agreement with the external party.
A.10.2.1.a	Third-Party service providers must comply with all applicable Healthesystems policies, practice standards and agreements. Vendors are required to comply with all regulatory and Healthesystems auditing requirements, including the auditing of the vendor's work. Each vendor with access to Healthesystems Information Systems must sign a Non-Disclosure agreement. Vendors with access to Healthesystems internal information resources must acknowledge having read the Information Security Policy. Vendor must comply with all applicable Healthesystems change control processes and procedures as well as records management policies.
A.10.2.1.b	Vendor access must be uniquely identifiable. Vendor personnel must report all security incidents directly to Healthesystems personnel. Upon termination of contract or at the request of Healthesystems, the vendor must surrender all Healthesystems badges, access cards, equipment and supplies immediately. All software used by the vendor in providing service to Healthesystems must be properly licensed.
A.10.2.1.c	Each vendor employee with access to Healthesystems Confidential Data must handle that information at the level commensurate with its classification level. The vendor must only use Healthesystems information and Information Resources for the purpose of the business agreement. Any other Healthesystems information acquired by the vendor in the course of the contract cannot be used for the vendor's own purposes or divulged to others. Upon termination of contract or at the request of Healthesystems, the vendor will return or destroy all Healthesystems information and provide written certification of that return or destruction within 24 hours unless contractually agreed to otherwise. Upon departure of a vendor employee from the contract for any reason, the vendor will

	ensure that all sensitive information is collected and returned to Healthesystems or destroyed within 24 hours.
A.10.2.2	Healthesystems must regularly monitor and review services, reports, and records provided by external parties and carry-out regular audits.
A.10.2.3	Change management processes for information system services delivered by external parties must take into account the criticality of the information systems, processes involved and assessment of risks.

A.10.3 - System Planning and Acceptance

A.10.3.1	The use of information system resources must be monitored, optimized and projections made of future capacity requirements.
A.10.3.2	Acceptance criteria for new information systems, upgrades and new versions must be established and suitable tests of the system carried out prior to acceptance.

A.10.4 - Protection against Malicious and Mobile Code

A.10.4.1	Security awareness, prevention and detection controls must be utilized to protect information systems against malicious code. See Firewall Implementation Standards
A.10.4.2	Mobile code must be restricted to the intended information system or environment. See Firewall Implementation Standards
A.10.4.2.a	E-mail attachments should not be opened unless they are confirmed to come from a trusted source. If an e-mail and/or attachment appears to be suspicious, then it should be immediately reported to the Healthesystems Information Security department or Service Hub.
A.10.4.2.b	All workstations to include laptops, desktops, netbooks, tablet computers and mobile devices must use malware protection software and a personal firewall solution when connected to the Healthesystems network.
A.10.4.2.c	All Healthesystems owned workstations must use the Healthesystems IT management approved malware protection software and configuration where appropriate. The settings for the malware protection software must not be altered in a manner that will reduce the effectiveness of the software. System Administrators are responsible for installation of approved Endpoint protection software on all Healthesystems client workstations at the time of deployment and automatically update malware signature files at least once per week. Client workstations on site shall use malware signature files no more than 14 days old.
A.10.4.2.d	Each server attached to the Healthesystems network must utilize Healthesystems IT management approved malware protection software. Protected servers must automatically update malware signature files at least once per week. All servers shall be scanned by an automatic agent to determine their update status. System administrators shall monitor the scans results for any server not compliant with this policy. See Service Overview Brief
A.10.4.2.e	Each E-mail gateway must utilize Healthesystems IT management approved e-mail malware protection software and must adhere to the Healthesystems rules for the setup and use of this software. This includes, but is not limited to, scanning of all inbound and outbound emails.

A.10.5 - Backup

A.10.5.1	IT Management must document each system's backup and recovery process. A process will be implemented to verify the success of the Healthesystems electronic information
	backup. Backups must be periodically tested to ensure that they are recoverable. Physical access controls implemented at offsite backup storage locations must meet or exceed the physical access controls of the source systems; backup media must be protected in accordance with the highest Healthesystems sensitivity level of information stored. See Disaster Recovery/Business Continuity.

A.10.6 - Network Management

A.10.6.1	Security features, service levels and management requirements of all network services must be documented and included in any network service agreement.
A.10.6.2	The Healthesystems network infrastructure supports a well-defined set of approved networking protocols. Any use of non-sanctioned protocols must be approved by Healthesystems IT Management. Firewalls must be installed and configured to the Healthesystems Firewall Standard. The networking addresses for the supported protocols are allocated, registered, and managed centrally by IT Management. All connections of the network infrastructure to external third-party networks are the responsibility of IT Management. See Firewall Implementation Standards.

A.10.7 - Media Handling

A.10.7.1	All removable computer media must be managed with controls appropriate for the sensitivity of the data contained on the media.
A.10.7.2	Media must be disposed of securely and in a manner appropriate for the sensitivity of the data contained on the media.
A.10.7.3	Media must be handled and stored so as to prevent unauthorized information disclosure or misuse. See HIPAA – Health Insurance Portability And Accountability Act of 1996
A.10.7.4	Systems documentation must be protected from unauthorized access.

A.10.8 - Exchange of Information

A.10.8.1	Information exchange policies, procedures and controls must be documented and implemented to protect the exchange of information through all types of electronic communication services.
A.10.8.2	Information and software exchange agreements between Healthesystems and other organizations must be documented.
A.10.8.3	Media being physically transported must be appropriately labeled and protected.
A.10.8.4	Information transmitted by electronic messaging must be appropriately labeled and protected. See Data Confidentiality & Security
A.10.8.5	Security controls must be identified and implemented to mitigate the business and security risks associated with the interconnection of business information systems.

A.10.9 - Electronic Commerce Services

A.10.9.1	Information in electronic commerce information systems must be protected from fraudulent activity, contract dispute, unauthorized, access, disclosure, and modification.
A.10.9.2	Information systems utilizing on-line transactions must have security controls commensurate with the value and classification of the information. See Data Confidentiality & Security
A.10.9.3	Management must pre-authorize the publication of information on publicly available information systems and implement processes to prevent unauthorized modification.

A.10.10 - Monitoring

A.10.10.1	Continuous Monitoring of audit logs for information resources recording all user actions, system and security events must be stored and capable of being reproduced as needed to assist in the monitoring of access and/or abnormal events as well as information security related investigations or incident response analysis. See System Logging
A.10.10.2	The use of information systems must be continuously monitored, and the result of the monitoring activities must be regularly reviewed. See Network Monitoring Review
A.10.10.3	Information system logging facilities and log information must be protected against tampering and unauthorized access. See Data Center Physical Access Procedure
A.10.10.4	Activities of privileged users must be logged, and the log must be subject to regular independent review. See Database Security Audit and Review Domain Administrators Group
A.10.10.5	System faults and errors must be logged, analyzed and appropriate action taken.
A.10.10.6	Computer clocks shall be synchronized to a commonly known accurate source for precise reporting.

A.11: Access Control

Access control policies provide the blueprint for the management of user access, authorizations and control mechanisms for computer networks, operating systems, applications, and information. This chapter identifies security best practices and responsibilities for administrators and personnel.

A.11.1 - Business Requirement for Access Control

A.11.1.1	Access to information systems and services must be consistent with business needs job role and operational requirements with the appropriate security safeguards applied.

A.11.2 - User Access Management

A.11.2.1	There must be a formal user registration and de-registration process for granting access to all information systems. See Setting A New Employee Instructions
A.11.2.1.a	System Administrators or designated personnel are responsible for creating, modifying and/or removing the accounts of individuals that change roles within Healthesystems or are separated from their relationship with Healthesystems. System Administrators or designated personnel must have a documented process to modify a user account to accommodate situations such as username changes, network account changes, privileges, and/or permission changes. System Administrators, or designated personnel are subject to independent audit review. See User Account Change Procedure.

A.11.2.1.b	When special network accounts are needed for internal or external access, software development, software installation, system audits or other defined needs, they must have prior authorization and must be created with the appropriate level of access long with an expiration date and must be removed when the work is completed. See Temporary Account Procedure.
A.11.2.2	The allocation and use of system privileges must be restricted, controlled, and actively monitored by the appropriate personnel.
A.11.2.2.a	All users must sign the Healthesystems Corporate Information Security Policy Acknowledgement before access is granted to an account. See Training Procedure.
A.11.2.2.b	Each individual that uses Administrative/Special access accounts must refrain from abuse of privilege and must only perform the tasks required to complete his/her job function. Each individual that uses Administrative/Special access accounts must use the account privileges most appropriate with the work being performed, e.g., user account vs. administrator account.
A.11.2.3	All created accounts must have an associated request with documented approval. Each account must be uniquely identifiable using the username assigned by Healthesystems System Administrators. All accounts must be configured with a password expiration date. All new user accounts that have not been accessed within 30 days of creation will be disabled. Accounts used by individuals on extended leave (more than 30 days) will be disabled. See User Account Procedure.
A.11.2.4	Information Owners and Information Custodians must formally review user access rights at regular intervals.

A.11.3 - User Responsibilities

A.11.3.1	Users must follow good security practices in the selection and use of passwords.
	User-Level/Domain-Level Password Criteria
	• All User-Level/Domain-Level Passwords must be routinely changed every ninety (90) days. This policy is enforced via Healthesystems Group Policy and Active Directory infrastructure.
	  • User-Level/Domain Level Passwords must be complex. Minimum length should be eight (8) characters. Where technically feasible, the following criteria should be observed:
	  • Password should not contain all or part of the owner's account name.
	  • Password should not contain all or part of the owner's name.
	  • Password should not include repeating or sequential characters, e.g., 1111, ABCD, etc.
	  • Password should not be constructed using a basic sequence of characters that is then partially changed based on the date or some other predictable factor, e.g., users should not employ passwords like "X34JAN" in January and "X34FEB" in February, etc.
	  • Password must not be set to vendor default.
	  • Password should contain a mix of upper- and lower-case letters, at least one number and one special character.
	• Mobile Device Password Criteria for Accessing Corporate E-Mail:
	  • The following policies are enforced on mobile devices connecting to Healthesystems e-mail system:
	  • 4-digit PIN
	  • 1-hour policy refresh interval
	  • 5-minute time out before password must be re-entered
	  • Mobile Device Storage Media Encryption
	  • Option for total wipe/erase of mobile device
	All user-level passwords, including initial and/or temporary passwords, must not be easily tied back to the account owner such as: username, social security number, nickname, relative's names, birth date and/or temporary passwords.

A.11.3.1.a	The password for a shared Administrative/Special Account must be changed when an individual with knowledge of the password transfers to a new role, position, or department and no longer requires access or is no longer employed by Healthesystems.

A.11.3.1.b	Passwords must not be divulged to anyone, and a password history must be kept to prevent the reuse of passwords.
A.11.3.1.c	Passwords must not be inserted into email messages or other forms of electronic communications. If the security of a password is in doubt, the password must be changed immediately.
A.11.3.1.d	In the event a password is found or discovered, users are required to secure the password, to protect it from unauthorized disclosure and immediately report the discovery to Healthesystems IT Support.
A.11.3.1.e	Passwords must not be shared with anyone or written down. If passwords must be recorded, then an encrypted password manager that is approved by Healthesystems IT must be used.
A.11.3.1.f	System-Level Passwords must be changed on at least a quarterly basis. See DBA SA Password Change.
A.11.3.2	Users must ensure unattended equipment has appropriate protection. Never leave an unsecured laptop computer unattended. Laptops and mobile devices should remain in the possession of the system owner at all times to include when travelling through public places or airports. If a laptop or mobile devices has to be left unattended in a location such as an office, meeting room or hotel room, the devices must be securely kept in a locked container or safe or secured through the use of a laptop security cable or similar device attached to unmovable furniture or equipment. A laptop security cable can be obtained from the Healthesystems IT Services group. Laptops and mobile devices must be secured out of sight when not in use and must never be visibly unattended in a vehicle.
A.11.3.3	Users must ensure the safety of sensitive information from unauthorized access, loss, or damage by ensuring sensitive information is not left unattended on a desk, visible on an unattended screen, or left on an unattended printer. All systems must be locked with the screensaver activated when the user needs to leave the area of the system.

A.11.4 - Network Access Control

A.11.4.1	Users are permitted to use only those networks and host addresses issued to them by IT Management. Users must not download, install, or run security programs or utilities that reveal weaknesses or risks in the security of a system unless directly provided by System Administrators or designee with proper authorization from IT management.
A.11.4.1.a	Wireless network access to Healthesystems' information resources must be restricted to authorized personnel only. All wireless access points and base stations connected to the network must be documented and are subject to periodic penetration tests and audits. See Wireless Network Security Procedure.
A.11.4.2	Remote access to the Healthesystems network or its devices must be secured by utilizing Virtual Private Network (VPN) technology in conjunction with Multi-Factor Authentication (MFA) and NACs (Network Access Controls).
A.11.4.3	Automatic equipment identification must be used, as appropriate, to authenticate connections from specific locations and equipment.
A.11.4.4	Physical and logical access to diagnostic ports must be strictly monitored and securely controlled. See Data Center Physical Access Procedure
A.11.4.5	Groups of information services, users and information systems must be segregated on networks.
A.11.4.5.a	Systems requiring public access are placed within the Healthesystems secure DMZ network. Any new systems that need to be placed in the HES DMZ will be scanned for vulnerabilities before allowing access from the public Internet. Information Security will scan and audit all systems in the DMZ periodically for new vulnerabilities. See Service Overview Brief.

A.11.4.6	The connection capability of users must be restricted in shared networks in accordance with the access control policy of the information system.
A.11.4.6.a	Connecting a personal device to the Healthesystems internal wired network without Healthesystems IT Senior Management approval is strictly prohibited. This includes any personal device that has wired Ethernet networking capabilities such as laptops, desktops, storage devices, VoIP phones, wireless access points, etc. Personal devices may be granted use of the Healthesystems wireless network in conjunction with a VPN client that has been authorized and approved by IT Management.
A.11.4.7	Networks must have routing controls in place to ensure that computer connections and information flows do not breach the access control policy of the information system.

A.11.5 - Operating System Access Control

A.11.5.1	Access to information systems must use a secure logon process. See HIPAA – Health Insurance Portability And Accountability Act of 1996
A.11.5.2	All users must be issued a unique identifier for their use only, and an approved authentication technique must be used to substantiate the identity of the user.
A.11.5.3	A password management system must be in place to provide an effective, interactive facility that ensures quality passwords.
A.11.5.4	The use of system utility programs that are designed to assess system or application security or otherwise circumvent or test security in any way must be restricted to those with a need to possess via job requirements.
A.11.5.5	Desktops or laptops should never be unattended without initiating the Microsoft Windows Lock feature first. Healthesystems, IT enforces an automatic screen lock if the computer is inactive for 5 minutes
A.11.5.6	Restrictions on connection times must be considered to provide additional security for high value/risk applications.

A.11.6 - Application and Information Access Control

A.11.6.1	Access to information systems functions and information must be restricted in accordance with the access control policy.
A.11.6.2	Information systems managing data of a sensitive nature must have an isolated dedicated computing environment.

A.11.7 - Mobile Computing and Teleworking

A.11.7.1	All devices connecting remotely to the Healthesystems network will be subject to qualifying tests before they will be granted access. Authorized remote access users attempting to connect using devices which do not conform to Healthesystems' IT standards, even temporarily, will be denied their assigned class of remote access service and restricted. Restricted access will permit no access beyond that required to establish a connection to a restricted terminal server and to update corporate antivirus and firewall software. See Remote User Access
A.11.7.2	Healthesystems user accounts authorized for remote access are assigned to connection classes based on their roles and responsibilities. Connection classes may be configured to restrict access to sub-networks environments and/or resources within the Healthesystems domain or the Internet. Connection classes may also restrict traffic to specific application layer protocols within those sub-networks. See Remote User Access
A.11.7.2.a	Users authorized to connect remotely to the Healthesystems network must identify themselves with a username, password and second form of authentication, i.e., MFA, security token. A password must be entered manually each time the user connects and may not be saved.

A.11.7.2.b	All remote access connections to the Healthesystems corporate networks will be made through the approved VPN employing data encryption. Remote users may connect to Healthesystems Information Resources using only the protocols approved by Healthesystems IT.
A.11.7.2.c	A secure connection to another private network is prohibited while connected to the Healthesystems corporate network unless approved in advance by Healthesystems IT management. See Client Network Connectivity Procedure.
A.11.7.2.d	Workstations that have not been provided by Healthesystems must have prior authorization prior to connecting to the Healthesystems VPN system and must have a malware protection software and firewall solution in place. The workstation, system software and the malware signature definitions must also be up to date.
A.11.7.2.e	Approved mobile devices may be used to access Healthesystems Information Resources. Mobile devices are defined to include, but are not limited to, netbooks, cell phones and/ smartphones, tablet computers, PDAs, etc. IT reserves the right to require individuals to install company-approved 3rd party security software on the personally owned mobile device in order to access company information.
A.11.7.2.f	Access to mobile devices which store or transmit confidential data, or which can be used to connect to other confidential systems, must be password protected in accordance with the Healthesystems' Mobile Device Password Policy.
A.11.7.2.g	Files containing confidential or sensitive data, including Protected Health Information, may not be stored on mobile devices unless authorized and protected by encryption.
A.11.7.2.h	Mobile devices connected to Healthesystems' network must never be left outside the users control (e.g., in a hotel room) where it can be tampered with lost or stolen.
A.11.7.2.i	Users of mobile devices connected to Healthesystems' network should not open email attachments on their mobile device unless they are sure they have come from a trusted source.
A.11.7.2.j	Users of mobile devices connected to Healthesystems' network must immediately notify the Service Desk in case of theft or loss and in case of unauthorized access. In case of loss, theft, or departure from the company, Healthesystems reserves the right to wipe all information within the Mobile Device Management application. This will permanently delete all information stored in the Mobile Device Management e-mail client, contact list, calendar program and associated applications. If personal information is stored anywhere in the Mobile Device Management client, then it will be deleted when the application is wiped.
A.11.7.2.k	Healthesystems is not liable for the loss of personal mobile devices or personal data.

A.12: Information Systems Acquisition, Development, and Maintenance Policy

This section establishes requirements for incorporating security measures into the life cycle of an information system. Security controls must be identified as part of the business requirements for new information systems or enhancements to existing information systems.

Information security is integrated into the creation, modification, implementation, and expansion by ongoing security practices such as the management of vulnerable points and securing system files. For applications, information security can be applied to the validation of data input and output and by encoding information using electronic keys.

A.12.1 - Security Requirements of Information Systems

A.12.1.1	Security controls must be identified as part of the business requirements for new information systems or enhancements to existing information systems.
A.12.1.1.a	Systems on the network must have adequate security installed and maintained. All systems accessible from the internet or by the public must operate IT approved active intrusion detection software anytime the public have access to the system. Healthesystems IT will maintain log filtering and notification system to report on potential threats identified from the network event log entries. The use of departmental firewalls is not permitted without the written authorization from Healthesystems IT Management. Users must not extend or re-transmit network services in any way, i.e., users may not install a router, switch, hub, or wireless access point to the Healthesystems network without Healthesystems IT Management approval. Users must not install network hardware or software that provides network services to other clients, e.g., rogue networks, without Healthesystems IT Management approval. Users are not permitted to alter existing network hardware in any way. See Network Log Procedure.
A.12.1.1.b	IT Management is responsible for managing and maintaining the Data Centers, network environments, cloud platforms, servers, workstations, applications, and databases that support or provide additional capabilities for Healthesystems. This responsibility includes the administration, monitoring, upgrading, patching, and resolving of problems or issues that arise on any Healthesystems owned and/or operated network resource.

A.12.2 - Correct Processing in Applications

A.12.2.1	Data input to an information system must be validated to ensure that it is correct and appropriate.
A.12.2.2	Internal processing checks must be performed to minimize the risk of processing failures or deliberate acts leading to a loss of confidentiality, integrity, or availability.
A.12.2.3	Message integrity controls must be used for information systems where there is a security requirement to protect the authenticity of the message content.
A.12.2.4	Data output from an information system must be validated to ensure that the processing of stored information is correct and appropriate to the circumstances.

A.12.3 - Cryptographic Controls

A.12.3.1	To prevent the risk of unauthorized access or disclosure of Healthesystems resources the use of cryptographic controls must be applied in accordance with the classification of the information and information systems that is to be protected.
A.12.3.2	A key management system based on an agreed set of standards, procedures, and methods must be used to support the use of cryptographic controls.

A.12.4 - Security of System Files

A.12.4.1	The implementation of software on operational information systems must be strictly managed and controlled.
A.12.4.2	Test data must be protected and controlled using the same procedures as for data from operational information systems.
A.12.4.3	Access controls must be actively monitored and maintained for program source libraries to ensure only authorized users have access to source code.

A.12.5 - Security in Development and Support Processes

A.12.5.1	Every change to a Healthesystems information resource is subject to the Change Management Policy. Unless prior authorization is granted, a formal written change request must be submitted for changes impacting production environment information resources. See Change Management Procedures.
A.12.5.1.a	All changes must be tested in a controlled acceptance-testing environment prior to implementation. See HES IT Quality Assurance Process.
A.12.5.1.b	Each scheduled change request must receive formal Change Management Committee approval before proceeding with the change. See Production Change Request Process
A.12.5.1.c	A Change Management Log must be maintained for all changes. All emergency releases will follow the emergency change process. See Production Change Request Process
A.12.5.1.d	Unless prior authorization is granted, Healthesystems Information Technology will establish a standardized maintenance window to be used for installations, upgrades, repairs, testing, patches, and other processes which may cause limited or no access to IT system resources. During the scheduled maintenance window, a user may or may not experience a complete disruption of service, slow response times, limited access, or no connectivity whatsoever. See Maintenance Window Schedule Procedure.
A.12.5.2	Business critical information systems must be reviewed and tested when operating system changes occur to ensure security mechanisms and controls operating as intended. See Production Change Request Process
A.12.5.3	Modification of software is limited to essential changes that are strictly controlled and documented. See Production Change Request Process
A.12.5.4	All applicable controls must be applied to reduce risk and limit opportunities for exposure, information leakage, unauthorized access and/or exploitation of sensitive data.
A.12.5.5	Controls must be applied to protect and secure outsourced information system development.

A.12.6 – Technical Vulnerability Management

A.12.6.1	Regular assessments of Healthesystems network resources must be accomplished to identify potential vulnerabilities and take the appropriate actions to effectively mitigate all associated risks. See Vulnerability Management and External Network Perimeter Scan.
A.12.6.2	A vulnerability management strategy that allows for the monitoring, assessment, tracking, and mitigation of vulnerabilities must be in place. The strategy will be managed and maintained by Information Security with support provided by designated personnel to ensure its proper execution.
A.12.6.3	Standardized vulnerability assessment and mitigation procedures must be in place that allow for the quick response to vulnerabilities in accordance with their level of severity. The procedures must include processes that accurately assesses their potential impact, identify the appropriate level of response as well conduct the appropriate follow-up actions to ensure proper mitigation.

A. 13: Information Security Incident Management Policy

Information security incident management policies identify mechanisms to detect and report when information security events occur and the directives for the consistent management of such events. The information collected about the events can be analyzed to identify trends and to direct efforts continually improve and strengthen the information security infrastructure of Healthesystems.

An Information Security Incident includes, but is not restricted to:

- The loss, theft, or unauthorized disclosure of data or information.
- The transfer of data or information to those who are not entitled to receive that information.
- Attempts to gain unauthorized access to data, fileshares, storage devices or information systems.
- Unauthorized changes to data, information, system hardware, firmware, software, or network resources.
- Unwanted disruption, manipulation, or denial of service to a system.
- The unauthorized use of a system for the processing or storage of data by any person.

A.13.1 - Reporting Information Security Events and Weaknesses

A.13.1.1	All Healthesystems personnel are responsible for reporting suspected security incidents. Personnel using information systems must immediately note and report any observed or suspected security threat or unusual or abnormal events in those systems.
A.13.1.2	Information security events must be immediately reported to the Service Hub or Information Security. If after hours' users must report suspected incidents to the Service Hub using the Security Breach number. See Incident Security Procedures.

A.13.2 - Management of Information Security Incidents and Improvements

A.13.2.1	Healthesystems Information Security must develop and maintain guidelines on how to identify, protect, detect, respond, and recover from suspected security incidents. Information Security will manage, maintain, and coordinate all security incident response efforts.
A.13.2.1.a	Reported security incidents shall be documented by Healthesystems' employees or contractors with as much detail as possible to describe the incident, time discovered, and impact within two (2) hours of discovery.

A.13.2.1.b	Information Security will immediately evaluate all suspected security incidents and where applicable provide detailed reports to the CIO, IT Services and/or General Counsel/Compliance Officer. See Incident Security Procedures.
A.13.2.1.c	Information Security will ensure that pre-defined roles for security incident management are in place with distinct responsibilities identified for proper and effective incident response.
A.13.2.2	The types, severity, volumes, impact, and costs of information security incidents must be quantified and monitored. See Incident Management Procedure
A.13.2.3	Investigations into information security incidents must ensure evidence is collected, retained and presented in conformance with the rules for collection of evidence.

A.14: Business Continuity Management Policy

This section provides direction from a security focus for planning the resumption of business or services where a man-made or natural disaster has occurred. Healthesystems plans to be prepared and to re-establish business or services as swiftly and smoothly as possible. Business continuity plans include the evaluation of security risks in line with the directions set by Healthesystems Executive Management.

A.14.1 - Information Security Aspects of Business Continuity Management

A.14.1.1	There must be a managed process to ensure that business continuity programs address information security requirements. See Disaster Recovery / Business Continuity
A.14.1.2	A risk assessment must be conducted to identify information security events that may interrupt business processes.
A.14.1.3	Business continuity plans must be developed to resume and maintain business operations to the required level following interruption to, or failure of, essential services.
A.14.1.4	A framework of business continuity plans must be maintained to ensure consistent handling of information security requirements.
A.14.1.5	Business continuity plans must be regularly exercised and updated. See Disaster Recovery / Business Continuity

A.15: Compliance Policy

Compliance policies identify what to do to ensure that Healthesystems is in compliance with applicable laws and policies. Processes to monitor the extent in which information systems follow policies include conducting security reviews, assessments, and the systematic analysis of logged information.

A.15.1 - Compliance with Legal Requirements

A.15.1.1	The statutory, regulatory, and contractual requirements for each information system and the organization must be explicitly defined, documented, and maintained.
A.15.1.2	Third party software in the possession of Healthesystems must not be copied unless such copying is consistent with relevant license agreements and prior management approval of such copying has been obtained, or copies are being made for contingency planning purposes.

A.15.1.2.a	Users must refrain from knowingly violating license agreements and/or requirements. Third party copyrighted information or software, that Healthesystems does not have specific approval to store and/or use, must not be stored on Healthesystems systems or networks. Systems administrators reserve the right to remove such information and software unless the involved users can provide proof of authorization from the rightful owner(s).
A.15.1.2.b	Management must make appropriate arrangements with the involved vendor(s) for additional licensed copies when additional copies are needed for business activities.
A.15.1.3	Healthesystems records must be protected from loss, destruction, and falsification.
A.15.1.4	Security controls must be applied to protect data and personal information in accordance with relevant legislation and customer requirements.
A.15.1.5	Controls must be in place to deter misuse of information systems.
A.15.1.6	Cryptographic controls must be used in conjunction with relevant agreements, laws and regulations.

A.15.2 - Compliance with Security Policies and Standards

A.15.2.1	Management must ensure security procedures are followed in their areas of responsibility and facilitate regular reviews to ensure compliance with security policies and standards.
A.15.2.2	Information systems must be regularly checked for compliance with security policies and standards. See Database Security Audit, Quarterly Firewall Audit, and Information Systems Services and Network Resource Access Procedures

A.15.3 - Information Systems Audit Considerations

A.15.3.1	Audit requirements and activities involving checks on operational systems must be planned and approved to minimize disruption to business processes.
A.15.3.2	Access to system audit tools must be controlled to prevent misuse or compromise.

Acceptable Use Policy

This section provides direction from a security focus on the constraints and practices that a user must agree to for access and usage of the Healthesystems corporate network, information resources and/or the internet.

AUP.1	Users must not share their Healthesystems account(s), passwords, Personal Identification Numbers (PINs), Security Tokens (i.e., Smartcard), digital certificates, or similar information or devices used for identification and authorization purposes.
AUP.2	Healthesystems employees accessing corporate information from outside Healthesystems offices must utilize security software and settings approved by Healthesystems IT Management. Webmail can be accessed from a public computer, but it is critical that the employee never leave the session unattended, save any information, and must logout of the application and shutdown any sessions when finished.
AUP.3	Storing and/or sharing company information on systems that are outside the Healthesystems network is strictly prohibited. This includes the sharing and/or storing of e-mails, data, password files, database files, etc. This restriction applies to social media sites, cloud storage or backup sites, FTP servers, file drop sites, etc. This section is not applicable in regard to situations involving disclosure of information pursuant to federal and/or state laws and regulations, including but not limited to Section 7 of the National Labor Relations Act and Title VII of the Civil Rights Act. (See Social Media Policy in Employee Handbook).
AUP.4	Emails created, stored, sent, or received by employees on the Healthesystems computer network may be viewed by Healthesystems at any time without prior notice. Employee email accounts must not be used to send or respond to spam, phishing, or malicious email messages.
AUP.5	Employees must exercise utmost caution when sending any email from inside Healthesystems to an outside network. Confidential and/or proprietary information will not be forwarded via any means, unless that email is critical to business and sent over a secure encrypted TLS connection, or the contents of the message is encrypted.
AUP.6	Auto-forwarding electronic messages to e-mail or text addresses other than those within the Healthesystems internal email system is prohibited.
AUP.7	An employee's personal e-mail account may not be used to send or receive Healthesystems confidential information.
AUP.8	Using Healthesystems networking and computing resources to make or attempt unauthorized entry to any network or computer accessible via the Internet is prohibited.
AUP.7	Users are required to respect and comply with all legal protections provided by patents, copyrights, trademarks, and intellectual property rights for any software and/or materials viewed, used, or obtained via the Internet using Healthesystems networking or computing resources.
AUP.9	Users must not download, install, or run security programs or utilities that reveal or exploit system flaws or weakness in the security of a system unless authorized to do so for internal risk assessments.
AUP.10	Disabling or altering security applications or services installed (e.g., anti-virus/anti-malware software, personal Firewalls, etc.) and configured on Healthesystems network resources and/or information systems is strictly prohibited.

AUP.11	Users may access, use, or share Healthesystems resources only to the extent it is authorized and necessary to fulfill your assigned job duties. The storage of personal information to include but not limited to personal documents, images and/or music files on Healthesystems resources is strictly prohibited. All unauthorized files will be removed. Users are also prohibited from installing any unapproved applications, toolbars, or application add-ins on Healthesystems information resources.
AUP.10	Users must not make unauthorized copies of copyrighted software or material. Users must not download, install, or use non-standard software, shareware, or freeware applications without prior approval by Healthesystems IT Management.
AUP.11	Healthesystems information system resources must not be used for personal benefit. Users must not engage in acts using Healthesystems information resources against the aims and purposes of Healthesystems as specified in its rules, regulations, and procedures. Confidential and/or sensitive information/data, including electronic protected health information (ePHI), is not to be sent via email, unless protected and secured through the use of Healthesystems approved encryption applications or services.
AUP.12	Users must not purposely engage in activity that may harass, threaten, or abuse others, degrade the performance of Healthesystems information system resources.
AUP.13	Users must not intentionally access, create, store, or transmit material that Healthesystems may deem to be offensive, indecent, obscene, or illegal. Use of the Internet with Healthesystems networking or computing resources for recreational games, or for obtaining or distributing pornographic or sexually oriented materials, is strictly prohibited.
AUP.14	Users must immediately report to the Service Hub or Information Security all potential cybersecurity threats, suspected security incidents, abnormal activity, events, and possible misuse or violations of this policy that may pose a risk to the Healthesystems network environment.
AUP.15	The use of personal network devices (routers, switches, extenders, access points, etc.) to connect to the Healthesystems organizational network is strictly prohibited.
AUP.16	Users may only access the organizational network environment through Healthesystems owned or managed endpoints or Virtual Desktop Infrastructure (VDI) resources, that are physically or logically located within the United States unless prior authorization has been granted. The use of a proxy server or non-organizational provided VPNs to bypass Healthesystems' security and internet web filtering mechanisms is strictly prohibited.
AUP.17	Electronic Protected Health Information (ePHI) will only be transmitted via encrypted email or secure network connections upon verification that each recipient has a legitimate need to view the information and the sender has determined that the proper authority exists to transmit ePHI.
AUP.18	Email containing ePHI will be clearly marked to identify the presence of such information to the recipients, by use of a notice with guidance for actions unintended recipients are to take for reporting. The content for this notice will be provided by the HIPAA Compliance Officer or designee.
AUP 19	Personally owned devices will not be used to process or store ePHI at any time.
AUP.20	EPHI will not be transmitted from or to personal email accounts, removable media, or cloud storage locations.

5.12 Retrospective Coordination of Benefits (Exclusive to DCS)

1. Provide a flow chart and step-by-step description of the process the Offeror will employ to conduct the DCS Program's retrospective coordination of benefits (COB) requirement. Specifically, please detail how the Offeror will collect, store, and investigate COB information for other insurance.

Figure 7 depicts the high-level flowchart of MedImpact's COB (coordination of benefits) process. We process most of our COB claims electronically.

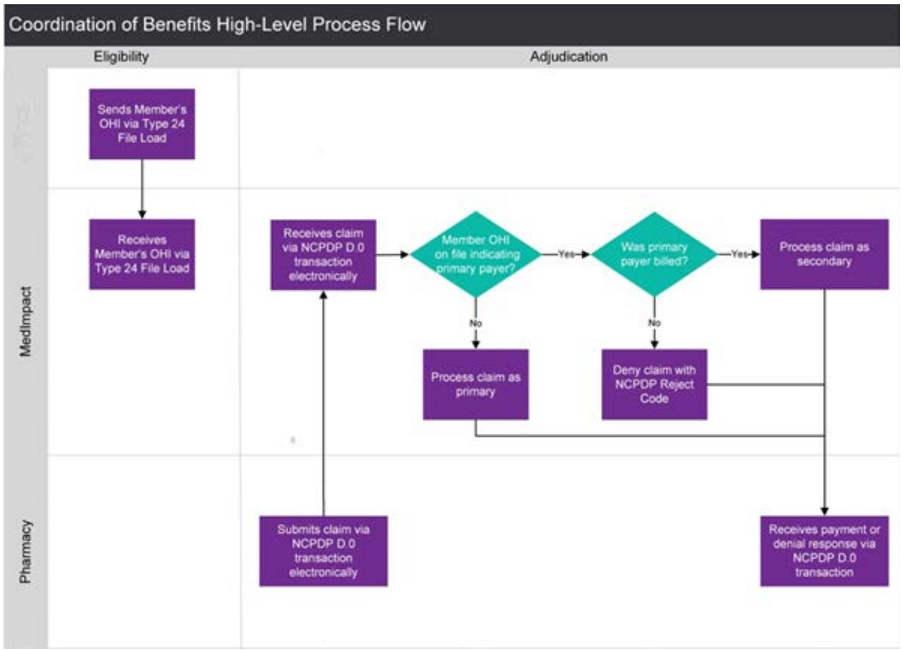

Figure 7: COB Flow Chart

MedImpact offers both online and manual paper process options that require the submission of primary payer information on the claim when the eligibility file flags the enrollee as having primary coverage with another carrier. We provide online COB claims processing services to our clients using standard NCPDP COB logic that conforms to CMS regulations.

We accept other coverage codes that the pharmacy submits on the claim transaction, and we adjudicate the COB claim based on the plan and enrollee payer amounts provided and plan specific configuration. The accepted other coverage codes indicating presence of a primary payer are as follows:

- **02 Other Coverage Exists**: Payment is collected. We bill the claim as a secondary claim, and the primary insurer has approved and paid the claim. When the pharmacy submits OCC (other coverage code) 2, they must also submit the amount that the other payer has paid. (NCPDP field 431- DV).
- **03 Other Coverage Exists**: This claim is not covered. The primary insurer has rejected the claim. When submitting OCC 3, we require the pharmacy to submit the NCPDP rejection code from the primary claim, which we validate to determine if it is an accepted reject code.
- **04 Other Coverage Exists**: Payment is not collected. The claim is secondary, and the primary payer has approved the claim and has paid nothing (e.g., the enrollee has a 100% copay benefit or is still in deductible coverage range). When the pharmacy submits OCC 4, they must also submit the amount that the other payer(s) has paid as 0.
- **08 Other Coverage Exists**: Claim is billed for a copay. The claim is secondary, and the primary payer has approved and paid the claim. When the pharmacy submits OCC 8, they must also submit the enrollee's total OOP (out-of-pocket) expense from the primary claim.

MedImpact can set customization options at the plan, line of business, or group levels. Additional options are available, including the following common configurations:

- **Copay**: Charge or waive the enrollee's copay or reducing it by the other payer paid amount
- **Payment limit**: Apply a payment limit to the amount that COB claim covers
- **PA override**: Override PA (prior authorization) and UM (utilization management) type edits on the COB claim
- **Reject codes**: Custom, defined list of accepted primary payer reject codes (when OCC is 03 – Other Coverage Exists, this claim does not have coverage)

For electronic submission to work most effectively, DCS must provide appropriate COB eligibility information, and network pharmacies must be willing or contractually obligated to participate. A pharmacy's ability to participate depends on their claim submission software capabilities. Our eCOB program is fully compliant with NCPDP D.0 standards for claim submission; however, some pharmacies cannot participate due to constraints.

The pharmacy generally submits COB claims electronically. In limited scenarios today, pharmacies may submit paper COB claims; however, paper COB claims follow the same logic as eCOB.

5.12 Exhibits

There are no referenced exhibits in Section 5.12.

5.13 Utilization Management

A. Mandatory Generic Substitution at Retail and Mail

1. Please explain in detail the process the Offeror 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 the Offeror's claims processing system will enforce the Programs' generic substitution requirement for a Generic Drug within the time limits specified in 3.12(1)(d) under Mandatory Generic Substitution at Retail and Mail.

MedImpact's mandatory generic program provides the following options:

- Charge the enrollee the difference between the cost of the generic and brand (DAW difference)
- Deny the multisource brand claims with a point-of-sale message that the pharmacy must dispense the generic

For the nonmandatory generic program, we can place the multisource brand at a higher tier level with no edits in place to charge the enrollee the difference or deny the claim.

MedImpact's formularies promote brand medications over generic medications when a strategy provides the client with the lowest net cost option. Our brand for generic strategy allows the enrollee to receive the brand medication at the generic medication's copay while saving money for the client by delivering the lowest net cost option. We use DAW 9 to administer the brand for generic strategy.

For NYSIF, our "Generics First" program employs a multifaceted approach to ensure the best available outcomes for brand to generic conversion rates. This program utilizes strategic intervention and contractual or legislative enforcement at prescriber, patient, pharmacy, and retrospective paper bill levels. Beyond the traditional brand to generic conversion process, our clinical team deploys advanced step therapy protocols and real-time pharmacy messaging to provide greater guidance to dispensing pharmacies regarding generic drug use. These strategies also include interventions to connect with the prescribing physicians at the point of care.

We continue to leverage our pharmacy contracts which requires pharmacies to dispense generic drugs when they are available and permitted by state law. One of the online edits in our DUR process is the generic conversion edit to ensure compliance. Additionally, part of the paper bill program for non-POS transactions includes an adjudication process which will apply generic rule editing as permitted.

We systematically integrate State rules around the processing of Brand vs. Generic dispensing utilizing DAW codes in our pharmacy benefit application. There are two scenarios that are commonly established in our pharmacy processing:

- The state fee schedule indicates that generics are mandatory
- DAW 1, prescriber requested dispense as written and DAW 2, patient requested brand over generic not allowed

- The state fee schedule indicates that generics are mandatory but will allow the injured worker to request brand over generic with the injured worker being responsible for the cost differential between the brand and generic
- DAW 2, patient requested brand over generic would be allowed
- The system would message the pharmacy to collect the difference of the brand from the generic from the injured worker
- If the injured worker did not want to pay the difference, then the pharmacy would need to substitute and dispense generic and change the DAW code accordingly

The Generic Efficiency Performance (for NYSIF, is our ability to convert to generics at the point of sale when a generic is available and there isn't a DAW1 or 2) is 99.3% for all states combined and in generic mandatory states we are consistently over 99.7% (many months we achieve 100%). Therefore, we are successful at converting in all states, regardless of whether there are generic mandatory rules in place.

Our support for NYSIF includes Clinical Services Program monitors physician prescribing patterns, including brand and generic dispensing. Physician profiling can also identify doctors who more frequently prescribe brand drugs by indicating, "dispense as written" or "no substitution." When identified through patient prescription monitoring, letters to physicians are used to communicate generic dispensing options. Initiatives to drive physician compliance include Independent Pharmacy Evaluations, Therapeutic Alert Letters, and Physician Tele-consultations.

We have also promoted the use of generics by implementing additional levels of formulary design to incorporate "Step Therapy" type protocols at POS. This would include introducing generic agents as a first line dispensing recommendation prior to moving towards higher-priced brand drugs. We can customize the implementation of these types of tools to NYSIF's needs (by jurisdiction, client, etc.). We would report these outcomes to NYSIF's and inform the physician of his/her prescribing patterns compared to that of their peers.

2. How does the Offeror's 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?

MedImpact protects the financial interests of our clients by applying the appropriate DAW code, in accordance with NCPDP specifications. DAW submissions may change the calculation of the claims adjudication depending on payer specifications. Failure to submit a correct DAW code shall be grounds for reversal of the claim(s), suspension, and/or termination of Provider's participation. In addition, the provider will be liable for any miscalculations and/or adjustments resulting from incorrect submission of a DAW code. Pharmacies are contractually obliged to keep an adequate stock of generics and dispense the lowest cost drug they have available, as indicated in the contract provisions shown in the sample pharmacy network agreements which are included within the **5.10 Exhibits** tab.

3. Explain in detail the process the Offeror intends to follow to ensure that drugs meeting the definition of generic as set forth in this RFP are identified in the Offeror's system as Generic Drugs subjecting them to the generic pricing requirements set forth in Section 6 and mandatory generic substitution for A-rated or authorized Generic Drugs.

We understand the importance of adhering to the appropriate generic drug definition as it relates to the mandatory generic program.

DCS

Our adjudication system supports client-required generic classification, allowing the system to adjudicate claims in accordance with specific programs, such as a mandatory generic substitution program. Our system utilizes A-rated generics and employs DAW logic to ensure appropriate claim administration.

NYSIF

Our workers' compensation specific formulary is based on a hybrid of GPI and NDC. GPI is used as a starting point to establish the formulary framework and includes a range of 2-digit to 14-digit GPIs, depending on the level of granularity within a specific medication class. For example, 2-digit and 4-digit GPIs are used to restrict to a medication group or class, and in some cases a 12-digit and 14-digit GPI are used to restrict to a specific dosage form or strength. Other fields or indicators may also be used to attain even more granularity.

Additionally, part of our paper bill program for non-POS transactions includes an adjudication process which applies generic rule editing as permitted. In states where applicable, when an attempt for a brand fill comes through when a generic is available and there is no DAW code = "01," the pharmacist will receive an online message that a to substitute a generic drug for a brand drug. In non-generic mandatory states, we will send a similar message that generic drug is preferred. For states that do not have generic mandatory provisions but implicitly encourage generic dispensing, we would consult with NYSIF on how aggressively to enforce on its behalf.

4. Please detail how the Offeror's 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 the Offeror's 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.

We flag all authorized generics as A-rated in our system, which allows for generic substitution. Codes beginning with B indicate drug products the FDA does not consider therapeutically equivalent to other equivalent drug products. For MAC pricing, our logic can apply the MAC pricing to only A-rated drugs and can be configured to specify when not to enforce the mandatory generic substitution requirement.

5. Please detail the process for updating the Offeror's claims processing system upon distribution of a new Generic Drug to ensure prompt application of MAC pricing and/or mandatory generic substitution.

We seek new generics weekly, and when wholesalers have adequate inventory, we promptly add them to the MAC list.

Before a drug is added to the MedImpact MAC lists, the VP of Generic Strategies will (i) confirm that the criteria set forth in Section 1 of this Policy and Procedure have been met with respect to the specific drug(s); and, if so, (ii) send a request to our P&T Committee from the MAC Team requesting approval for inclusion of the drug on our MAC lists. If the P&T Committee approves the request in the original email, the VP of Generic Strategies or his/her designee will open a Salesforce Case and send it to the MAC Team, documenting that the drug should be added to all the MAC

lists. The MAC Team will add the drug(s) to all the MAC lists and effectuate the change in the system. The Quality Review Team reviews all changes prior to committing them to the POS system.

Before we place a particular drug on our MAC list, or continue a particular drug this list, the drug must have at least 2 nationally available and therapeutically equivalent multiple source drugs, or a generic drug must be available from at least one manufacturer.

We use Medi-Span as our primary AWP pricing reference source for retail pharmacy transactions, which is updated weekly. All AWP pricing schedules are updated within our adjudication system as they are loaded from Medi-Span. When calculating lowest cost AWP, our system logic scans the entire Medi-Span database to identify the lowest cost NDC within the same GPI class.

6. (Exclusive to DCS) Please describe how the Offeror will manage the NTI list for the DCS Program including the parties responsible for making NTI recommendations.

MedImpact's drug information team reviews NTI (narrow therapeutic index) drugs using a composite of clinical expertise, FDA designations such as product-specific guidance for generic drug development documents, and, where appropriate, evidence-based literature. Concurrent with FDA guidance, our team considers NTI drugs to be those in which especially small variances in drug concentration will result in disproportionately severe effects on the member in relation to loss of efficacy, secondary adverse effects, or both, compared to more typical drug products. We review the NTI drug list annually to determine if newer standards of practice or guidance predicate addition or removal of products to or from the list. We evaluate all new drugs for inclusion on the NTI drug list at product launch.

B. Mandatory Generic Substitution Appeal Process (Exclusive to DCS)

1. Describe in detail how the Offeror would administer the required generic appeal processes (also referred to as a "Dispense as Written exception request") 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 the Offeror's criteria? Does the Offeror require generic appeals to be updated after a specific time period? If so, what is the process?

d. Does the Offeror currently administer a generic appeals process? If yes, provide the number of appeals the Offeror reviews 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:

i. Combigan

ii. Keppra

iii. Divigel

iv. Crestor

v. Lexapro

e. How the Enrollee's claim will be handled during the appeal processing. In the event of a successful appeal, confirm that the Offeror 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.

Therapeutic PA (prior authorization) requests include formulary exception, DAW exception, step therapy, quantity limit, and tier exception requests. Pharmacy staff initially perform these reviews for possible approval. Our formulary exceptions guidelines and formulary analyzer systems provide a unique and accurate tool for our pharmacy staff to adequately review such formulary exceptions.

Turnaround Time

The following are the average turnaround times for standard and urgent new PAs.

- **Standard PAs**:
  - Commercial: 2 business days
  - Medicare: 72 hours
- **Urgent PAs**:
  - 24 hours for all LOBs (lines of business)

Staff Qualifications

The MedImpact PA department reviews all therapeutic related PA requests. Licensed pharmacy technicians provide the first level of review using established PA guidelines and protocols. We require all technicians to successfully complete 1 of the national certifications exams or obtain state licensure (in a US state or territory).

Licensed clinical pharmacists are available to review PA requests that do not meet established evidenced-based criteria. A clinical pharmacist must review all PA denials. We require the clinical pharmacist reviewers to maintain and expand their clinical knowledge through continuing education programs. A pharmacist or supervisor of PA and UM (utilization management) programs with oversight by the manager and/or director of PA/UM programs monitor and supervise clinical pharmacists.

Additionally, physician reviewers with a current nonrestricted license to practice medicine review denials based on various accreditation bodies and state and UM requirements.

Criteria

Coverage guidelines are medication specific and may include dollar thresholds in some cases. Appeal timelines and criteria are reviewed and updated from time-to-time.

Generic Appeals Process

We process generic appeals, as applicable, using the same process as for brands.

Appeal Processing

Enrollees or prescribers may request coverage determinations by telephone, fax, mail, or electronically. Pharmacy technicians perform PA case intake and initial review work using our established PA guidelines. DCS will approve all PA guidelines. We refer PA cases that a pharmacy technician cannot approve to a clinical specialist for review. We conduct outreach via telephone and fax if we require additional information to complete the PA appeal review. MedResponse® PA allows for automated provider notification via mail stream as a secondary source of contact when a provider fax number is unavailable. Our MedResponse PA native provider verification allows for validation of contact information, which reduces the risk of HIPAA violations.

2. Confirm that the Offeror will load previously approved Generic Appeals data into the Offeror's claims adjudication system.

MedImpact confirms we will load previously approved generic appeals data into our claims adjudication system.

5.13 Exhibits

There are no referenced exhibits in Section 5.13

5.14 Clinical Management / Drug Utilization Review (DUR)

A. Prior Authorization

1. Referring to the drugs or the drug categories subject to Prior Authorization, describe in detail how the Offeror would propose to administer Prior Authorizations including:

a. The process and criteria the Offeror utilize to identify drugs that the Programs should consider for prior authorization.

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 the Offeror's projected staffing level for this unit?

c. A description of any current prior authorization programs the Offeror manages 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).

d. The process the Offeror utilizes to contract and collect the appropriate information from Physicians in order to make a determination. Provide a timeline for completion of approvals and denials.

e. The methods the Offeror utilizes to measure program effectiveness (Do not include any reference to specific monetary savings).

f. How the Offeror will transition Enrollees with current prior authorizations and their Prescriptions into the Offeror's system. Specifically address whether the Offeror's system has the flexibility to issue prior use exceptions for Enrollees currently taking drugs that would require Prior Authorization.

MedImpact has extensive experience administering PAs. The following are our PA goals:

- Provide a coverage determination process for enrollees to receive certain drugs with utilization management or restricted medications when medically necessary (including medications subject to online edits)
- Ensure appropriate and cost-effective medication use that is consistent with the enrollee's benefit
- Control utilization of high-cost medications by assuring that enrollees use alternative medications when appropriate
- Promote formulary alternatives use
- Promote medication safety

Criteria

Our drug information department develops the criteria for approving PA requests that the P&T Committee reviews and approves. The following provide examples of requirements for general PA criteria:

- Review of appropriate diagnosis
- Review of clinically appropriate formulary alternatives

- Review of formulary alternatives indicate they are contraindicated or can be detrimental to the member's care

We will seek the list of drugs that would require a PA from the State's published WC formulary so we can customize it for NYSIF, if desired. Outside of a state published formulary, we rely on our P&T Committee reviews for recommendations for Prior Authorization with the general criteria of safety, efficacy, and cost- effectiveness.

In servicing customers across the country, we have repeatedly worked with multiple closed drug formularies specific to individual states, including the closed formulary based on the ACOEM (American College of Occupational and Environmental Medicine) guidelines that New York implemented in December 2019. Our clinical team worked directly to help develop the ACOEM formulary that served as the basis for the New York state formulary.

The clinical pharmacy services team also provides timely review and evaluation of new molecular entities and new dosage forms of existing drugs as they become available for use. To ensure our customers comply with state regulations, our clinical team works with the compliance department to create a drug plan that addresses state regulations, in addition to customer-specific requirements. Our flexibility allows us to layer state-specific formularies onto customer-specific formularies to address the level of stringency our customers require while remaining in compliance with state regulations.

This plan includes all necessary PA requirements and alert messaging. Customized alerts to pharmacies as well as claims staff (e.g., case management team, supervisors, nurses, or claims adjusters) provides further education and information to aid in clinical decision making at the time of medication authorization.

The first step of our overall formulary strategy is to develop a robust, well-designed formulary that promotes clinical appropriateness and cost-effective prescribing. The P&T Committee provides a systematic and comprehensive approach for recommendations regarding medication therapy using evidence-based guidelines and medical literature. During P&T Committee meetings, the pharmacists review collected evidence-based information (e.g., randomized controlled clinical trials, peer-reviewed literature, outcomes research data, reputable meta-analyses publications) and current well-established treatment guidelines to make appropriate drug plan recommendations for specific medications or medication classes.

Staff Qualifications

Licensed pharmacy technicians provide the first level of review using established PA guidelines and protocols. We require all technicians to successfully complete one of the national certifications exams or obtain state licensure in a US state or territory.

Current PA Programs

MedImpact uses evidence-based PA guidelines to evaluate coverage determinations. In addition, we maintain an extensive library of PA guidelines that our pharmacy and therapeutics committee approved. We can accept and manage several delegation models, including full service, shared delegation, and self-service options.

For NYSIF, we have implemented the NY State Workers' Compensation Formulary and PA requirements on behalf of multiple customers. Many aspects of the formulary require a flexible formulary design including phase of injury, perioperative status, second- and third-line therapies, formulation specifications, and days' supply limitations. The formulary structure and workflows can be tailored to meet your needs. These can include customized authorization

workflows such as routing to a designated reviewer, a two-step review or second level review, and guidance messaging with details of the state formulary requirements.

Details regarding the prior authorization requirements for the New York Formulary are available at: https://www.wcb.ny.gov/content/main/hcpp/DrugFormulary/overview.jsp

We have developed a highly efficient and automated process that has significantly increased the effectiveness of the PA process for all POS and retroactive bill transactions. We also provide each of our clients with flexibility to incorporate their own specific workflow and rules. Our electronic PA tools incorporate client-defined automated messaging and advanced workflow and routing to help facilitate more effective prior authorization decisions.

We take a proactive approach to PA requests. Our real-time pharmacy intervention process begins when a reject occurs at the pharmacy counter so we can triage the PA with the pharmacy and expedite its workflow. On average, the total turnaround time on our prior authorization process from the time the reject occurs at the pharmacy to the time the pharmacy is responded to with an approval or denial is 2-3 hours.

- When a prescription is initially blocked due to formulary, DUR, or patient eligibility edits, the pharmacy receives a real-time electronic message from the POS stating a prior authorization is required and contacts the 24/7 help desk. In many cases, we proactively call the pharmacy to alert them we are trying to resolve the prior authorization rather than waiting on outreach from them.
- While speaking with the pharmacist, the CSR reviews the detailed claim notes and history to determine if the medication can be allowed.
- If the customer service specialist is unable to determine whether the medication should be allowed, the specialist electronically messages the claims professional regarding the required prior authorization.
- The electronic prior authorization message directs the claims staff to the Verticē web portal. The claims professional can electronically determine whether to authorize or deny the prescription in question.

The workflow and escalation of PA transactions can be customized to the client's needs. For example, high- risk drugs such as opioids can be automatically routed to a designated medical professional (i.e., nurse or pharmacy expert) to perform the PA decision instead of the claims staff. This can also include escalations of an approved PA for a high-risk therapy for a second-level review before it is communicated to the pharmacy. Regardless of the workflow chosen, the customer service team immediately communicates the prior authorization decision back to the pharmacy.

Post implementation, we provide formulary adherence monitoring and reporting of claims professional authorization behaviors. We offer clinical decision support, formulary enhancement, and clinical education to improve staff success. Our book of business formulary adherence for first-time medication use runs at about 75%, meaning that nearly three out of four first-time non-formulary medications reviewed are ultimately denied due to lack of medical necessity, showcasing the strength of our formulary design.

Prescriber Contact

Enrollees or prescribers may request coverage determinations by telephone, fax, mail, or electronically. Pharmacy technicians perform PA case intake and initial review work using our established PA guidelines. will approve all PA guidelines. We refer PA cases that a pharmacy technician cannot approve to a clinical specialist for review. We

conduct outreach via telephone and fax if we require additional information to complete the PA appeal review. MedResponse® PA allows for automated provider notification via mail stream as a secondary source of contact when a provider fax number is unavailable. Our MedResponse PA native provider verification allows for validation of contact information, which reduces the risk of HIPAA violations.

For NYSIF, the automated LOMN (Letter of Medical Necessity) service allows claims professionals to start communication with the prescribing physician about appropriateness of a medication at the PA stage. This automated tool generates a customized LOMN template to prescribers which can be triggered based on various areas of focus such as opioid or non-opioid justification. This user-friendly tool automates the timely distribution of LOMNs to prescribers, improving turnaround time for notifying prescribers and acquiring their response regarding the justification of the prescribed medication prior to authorization. In addition, the proprietary tool uses OMR technology that automatically associates responses received from the prescribers to the corresponding claim and distributes an automated notification to the individuals responsible for managing the claim when the returned LOMN has been received. This functionality exists within the PA screens within Verticē's web portal.

The prescriber can fax the document back to us whereby the document is automatically uploaded and indexed in our system as part of the patient profile record. The claims staff receives an alert when the document has been received and can retrieve and view the document and all the prescriber responses at any time.

We can customize the LOMN for NYSIF. In many cases, LOMN can result in a change in the prescribed medication regimen to an appropriate alternative. Employment of an LOMN strategy by a customer led to a prescription change in 2 out of 3 instances.

On average, the total turnaround time on our prior authorization process from the time the reject occurs at the pharmacy to the time the pharmacy is responded to with an approval or denial is 2-3 hours.

Methods to Measure Effectiveness

We have many tools to measure and monitor the effectiveness of our comprehensive program. These tools leverage technology and range from automated reports and data visualization dashboards to in-person business reviews/stewardship meetings. We offer a standard suite of reporting tools driven by data analytics and predictive analytics and can create custom reports or dashboards to meet your needs. Some examples include measures of formulary adherence, risk, morphine milligram equivalents (MME), step therapy conversion, intervention outcomes, etc.

We also measure the interactions of users in our system to continuously improve our program and customer experience.

Transition

As part of the implementation process, MedImpact's clinical pharmacists will work with DCS to develop guidelines, so they are in place prior to the go-live date.

A critical component of our implementation process is converting historical pharmacy data from the previous PBM program into our system. We regularly provide data transformation and conversion services for clients to load historical pharmacy data into our system. This includes converting all historical data that would be performed as part of the "go-live"/program conversion to our program, as well as ongoing services to assist NYSIF with bringing on

new customers to our program in the future. We flag all historical data converted into our program, so it is easy to identify what transactions occurred prior to being in our program.

In addition, as part of the process of loading pharmacy history data into our program, we use the data to identify drugs that would require prior authorization after going live (i.e., drug is not covered in formulary). This allows NYSIF to proactively identify how the program plan design will impact existing drug therapies prior to going live and help determine whether the affected prescriptions should continue to be allowed and avoid any disruption at the pharmacy counter.

2. For each of the drugs currently subject to Prior Authorization under the DCS Program, please list the time period of the authorizations that the Offeror would apply to each. Also, please confirm what steps the Offeror will perform to reauthorize at the end of the authorization period.

The duration of each PA approval and reauthorization duration is driven by P&T Committee-approved guidelines. If DCS uses our standard guidelines, the duration of authorization varies by drug. Most drugs are approved for 12 months and reauthorized annually. Some drugs may require a shorter duration period of 1, 3, or 6 months if follow up clinical criteria are required. PA reauthorization takes the same steps as the initial PA.

3. Confirm that the Offeror 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.

MedImpact confirms.

For NYSIF, our understanding is that physicians receive all the decisions prospectively prior to the dispensing of the medication within the NY Portal. Thus, the enrollee would be notified by the physician on the outcome of the prescribing event. If necessary, we would be open to communicating with the enrollee or physician about these decisions.

4. Confirm that the Offeror currently respond to DFS External Appeals within the required time frames. [Note: Do not include any financial / cost information in the Technical Proposal.]

MedImpact confirms.

For NYSIF, we have a long-standing policy and procedure for responding to appeals filed by state agencies, including the NY DFS. The nature of workers' compensation claims requires the claims staff and/or the insurer to make an initial coverage determination based upon multiple factors. Drug coverage is determined by the state formulary and medical treatment guidelines and does not rest with the PBM.

5. (Exclusive to NYSIF) Provide a flow chart detailing the Prior authorization Process as detailed in Attachment 68, NYSIF PBM Prior Authorization Process, of this RFP.

Please see the **5.14 Exhibits** tab for NYSIF PA workflow and an overview of our prior authorization process. We have also included select screens from the Verticē web portal for claims staff, which highlight our POS authorization tool and its capabilities in supporting the management of pharmacy transactions and related decision-making at POS. We look forward to the opportunity to discuss both in more detail with NYSIF and how our workflows and tools can best support your specific needs.

6. (Exclusive to NYSIF) Confirm that the Offeror will provide training to NYSIF staff in the utilization of automated Prior Authorization System. Provide copies of the training materials.

MedImpact confirms.

As part of implementation, we will have dedicated resources to coordinate customized training for leaders and users as identified by NYSIF. We believe that superior training will result in stronger program utilization, and ultimately better outcomes for NYSIF and their injured workers. In addition, we are committed to ongoing training both for new employees and as a refresher for claims staff to ensure the best results.

We provide in-application guidance and tips within Verticē that walks users through workflows with step-by-step guides, offers helpful advice, and generates context-driven alerts. A robust library of informative support documents is also easily accessible, along with right-time clinical guidance and education. Training resources for the Verticē web portal also includes computer-based training modules. These self-directed training modules can be accessed at any time. We continuously evaluate the need for training and typically focus on items claims staff find unclear.

We will develop a training module based on those issues and highlight any new system enhancements. Please see the **5.14 Exhibits** tab for sample training materials.

7. (Exclusive to DCS) Turnaround Time for Prior Authorizations Guarantee: The Program's service level standard requires that at least ninety-five percent (95%) of Prior Authorization requests that are received by the Offeror will be turned around within two (2) Business Days. Turnaround time is measured from the date the Prior Authorization request is received by the Offeror, by any origin (i.e., electronically, telephonically, via fax, or in the Programs designated Post Office Box), to the date the Offerors response is received by the mailing agent.

The Standard Credit Amount for each .01 to .25% of the Prior Authorizations received by the Offeror not turned around within two (2) Business Days from the date the Prior Authorization request is received by the Offeror, by any origin (i.e., electronically, telephonically, via fax, or in the Programs designated Post Office Box), to the date the Offerors response letter is received by the mailing agent below the standard of ninety-five percent (95%) is $25,000 per each quarter for DCS. However, the Offeror may propose higher or lower amounts.

MedImpact commits to have the required PA turnaround times for DCS understanding the timelines exclude pending or tolling time. Applicable penalty amounts have been included within **Attachment 6** at the end of the Technical Proposal.

B. Concurrent Drug Utilization Review (DUR)

1. Please detail the full scope of the Concurrent DUR program that the Offeror proposes to utilize for the Programs. Include the qualifications of the staff responsible for oversight of the Offeror's Concurrent DUR program.

Concurrent DUR supports preventing over-utilization and under-utilization of prescribed medications and monitors for appropriate prescribing and safety alerts.

DCS

Through our Concurrent DUR program, pharmacists receive online messages and warnings at POS before dispensing the prescription. To promote safe and cost-effective drug prescribing, the system supports numerous standard and customized edits to warn pharmacists of the potential harm involved in dispensing particular medications. Standard drug safety edits include:

- **Overutilization**: Messages the pharmacist about potential enrollee overutilization of medications through a combination of edits
- **Underutilization**: Detects when an enrollee picks up a refill late based on the days' supply of the previous claim for that medication
- **Age/Gender**: Identifies drugs based on the age group or gender of the enrollee
- **Duplicate Prescription**: Denies a second claim filled on the same day with the same enrollee information and drug information
- **Refill Too Soon**: Rejects a claim when an enrollee attempts to refill a prescription sooner than allowed
- **Incorrect Dosage**: Accepts or rejects claims based on the quantity dispensed, days' supply, and minimum and maximum dosage
- **Drug-to-drug Interaction**: Provides a message to the pharmacy based on the severity level established by the drug compendia publisher's DUR module
- Concomitant Therapy: Alerts the pharmacist when an overlap exists with the same therapeutic class or duplicate ingredients
- **Drug Disease Interaction**: Alerts the pharmacist when a conflict exists between the drug and enrollee's disease using ICD-10 codes

Our DUR Committee reviewed the enhancement of all DUR safety edits. Their mission was to enhance the DUR edits to allow flexibility that allows customization and the ability to make client-requested implementation changes quickly. The DUR Committee consisted of technical, pharmacy, medical, and regulatory enrollees, and was led by the chair of our P&T Committee, who is also the Director of Drug Information. Other members of the Committee included the Vice President Medical Director of Health Services and members from our DUR Board. Clinical pharmacists on the DUR Board create the PA guidelines for current DUR edits that stop claims and require clinical review and utilization management.

NYSIF

The real-time DUR system ensures the highest-level quality of care coupled with cost containment. The system screens each prescription to detect potential safety concerns. Since pharmacy bill consolidation is a vital piece of our service model, DUR components apply to all pharmacy bill types. Our DUR process typically blocks a much as 10% more drugs than other PBMs, based upon analysis of our client program conversion histories. Our clinical staff has developed their own automated online POS DUR edits, which include many clinical intervention services. These DUR edits target prospective, concurrent, and retroactive adjudication. We design Concurrent DUR (before prescription is dispensed) with a series of edits to identify potential problems. These edits are performed when the pharmacist keys in the details of the injured worker and the prescription(s), along with any pertinent information, and transmits that information to the adjudication system. The system checks for eligibility and checks the drug formulary, comparing historical and pharmacy data on file for that injured worker.

Examples of real-time DUR that occur on every transaction include:

- **Duplicate medication**: Prescribing of duplicate therapy can occur due to the involvement of multiple prescribers, or the prescribing of different formulations (e.g., topical vs oral). Identifying duplicate therapy eliminates cost redundancies and protects the enrollee from safety concerns, such as ingesting a higher-than-intended dose. May also uncover opportunity to communicate with multiple prescribers.
- **Therapeutic duplication**: Identifies prescribed drugs that have the same therapeutic effects as currently used medications. Warnings provide the names of potentially duplicate drugs and their therapeutic class. Therapeutic duplication adds unnecessary cost without increasing therapeutic benefit, increases safety concerns about side effects or drug-drug interactions, and may accrue additional pharmacy costs as additional therapies are added on to address side effects ("meds for meds").
- **Excessive dosage**: Increases safety and side effect risks for the enrollee without providing increased therapeutic benefit. This problem is most often associated with opioids and can harm the enrollee and prolong claim outcomes.
- **Early refill**: Consistent early refill patterns seen with certain medications, especially opioids. This may indicate opioid misuse.
- **Drug/drug interaction**: Warns of potentially interacting drug combinations and assists in assessing the risk of administering the prescribed drugs concurrently. Warning messages to the pharmacist identify the possible clinical effect of the interaction. A full-text monograph describes the mechanism, management, and clinical aspects of the potential interaction. Monographs also include comprehensive lists of primary literature references. DDIs present safety risk to enrollees, as the potential to increase pharmacy costs as other therapies are added to address the consequences of the interaction ("meds for meds").
- **Drug allergies**: Presents safety risk to the enrollee. The potential to increase pharmacy costs as additional therapies are added to address the consequences of the interaction ("meds for meds").
- **Duration of therapy**: Medications that may be appropriate during a specific phase of treatment may not continue to be appropriate, adding long-term costs to claim and worsening claim outcomes.

Additional DUR screening also includes:

- **Phase of Therapy**: Identifies drugs appropriate in acute phase of treatment (e.g., first 45 days) vs chronic phase.
- **Compliance Checking**: Detects early refill attempts and past-due refills as the prescriptions are presented for refills. It also anticipates refills on prescriptions due for refill.
- **Drug/Disease Contraindication**: Provides warnings when a new drug may be contraindicated based on the patient's known medical conditions. In addition to specific disease state contraindications, broader conditions such as pregnancy, lactation, and patient age are considered. This includes a disease indication to establish medical conditions by inference (e.g., insulin usage implies diabetes mellitus) when medical condition information is not directly available.
- **Drug Dosage**: Evaluates the daily dosage and the duration of therapy for each prescription. It provides warnings to identify those that are outside generally recognized safe and effective ranges.
- **Patient Counseling**: Provides printouts that contain clear and concise information concerning the purpose, use, precautions, common side effects, and additional information of prescription drug

products. The printouts provide a guide for the healthcare professional and give the patient a permanent reference for this important information. These printouts are available in English, Spanish, or Canadian (French), depending on your version of the drug table.

- **Prior Adverse Reactions**: Given a patient's history of a previous drug allergy or other adverse experience, this provides warnings if a new entry includes drugs or ingredients to which the patient may react similarly.

Additional edits include financial and reimbursement edits, predefined state formulary edits where applicable, generic rules and other edits that can be customized by the customer. The number and scope of the edits is virtually unlimited.

2. Describe the software the Offeror will utilize to administer the Concurrent DUR program that you will implement for the Programs. Please specify if the Offeror has developed this software, purchased it from a third-party source, or is it a system the Offeror purchased and have adapted for the Offeror's use.

MedImpact's Concurrent DUR program is administered through MedAccess, our claims adjudication web- based system. There is no software installation required.

We manage and maintain all the in-house developed pharmacy processing system infrastructure. The maintains and supports its own instance of the application. In addition to the adjudication system, we have developed our proprietary workers' compensation systems which includes the Verticē portal as well as our clinical risk management system. Most of the workers' compensation related system functionality is built within this proprietary environment, which is integrated via real time APIs into our pharmacy adjudication system.

3. Program Safety Edits

a. Within the Offeror's Concurrent DUR program describe all safety edits currently enforced through the Offeror's claims processing system including, but not limited to the safety edits below:

i. drug-drug interaction including OTC drugs and herbal supplements, if applicable

ii. drug-allergy interaction

iii. drug-medical condition interaction

iv. minimum daily dosage

v. exceeding maximum dosage

vi. therapeutic duplication

vii. drug-gender interaction

viii. drug-age interaction

ix. drug-pregnancy interaction

x. compliance with FDA approved drug utilization guidelines

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 does the Offeror monitor the effectiveness of the safety alerts program?

Concurrent DUR edits are consistent regardless of dispensing channel.

DUR Safety Edits

DCS

Table 5 shows common prospective and concurrent DUR edits performed by our adjudication system at the POS.

Edit	Description
Drug-Drug Interaction	
Drug-to-Drug Interaction	Returns DUR information to the pharmacy if the system determines the requested drug to have a drug-drug interaction with any qualified drugs in the enrollee's prescription history. We can configure the edit for multiple outcomes based on severity level. For example, a client can choose a different outcome for level 1 versus level 2 or 3. Additionally, we can turn off the lower severity levels if DCS worries about alert fatigue.
Drug-Dosing	
High and Low Dosing Limits by Enrollee Age	Returns DUR information to the pharmacy if the quantity of the requested drug falls outside (higher or lower) of a safe dosing range. The drug information Modules define recommended quantities and not-to-exceed values specified for pediatric, adult, or geriatric age ranges. We will base the edit outcome on DCS-specified high or low daily dose and maximum daily claim dollar amount.
Precautions and Medical Conditions	
Drug-Disease Conflict	Returns DUR information to the pharmacy if the system determines the requested drug to have a drug-disease contraindication.
Drug-Enrollee Age	Returns DUR information to the pharmacy if the system determines the requested drug to have a precaution based on the enrollee's age.
Drug-Pregnancy Precautions	Returns DUR information to the pharmacy if the system determines the requested drug to have a pregnancy precaution and the enrollee is female between the age range coded within the edit.

Table 5: Common Prospective and Concurrent DUR Edits

NYSIF

We deploy real-time DUR with every transaction including:

- **Duplicate Medication**: Prescribing of duplicate therapy can occur due to the involvement of multiple prescribers, or the prescribing of different formulations (e.g., topical vs oral). Identifying duplicate therapy eliminates cost redundancies and protects the enrollee from safety concerns, such as ingesting a higher-than-intended dose. May also uncover opportunity to communicate with multiple prescribers.
- **Therapeutic Duplication**: Identifies prescribed drugs that have the same therapeutic effects as currently used medications. Warnings provide the names of potentially duplicate drugs and their

therapeutic class. Therapeutic duplication adds unnecessary cost without increasing therapeutic benefit, increases safety concerns about side effects or drug-drug interactions, and may accrue additional pharmacy costs as additional therapies are added on to address side effects ("meds for meds").

- **Excessive Dosage**: Increases safety and side effect risks for the enrollee without providing increased therapeutic benefit. This problem is most often associated with opioids and can harm the enrollee and prolong claim outcomes.
- **Early Refill**: Consistent early refill patterns seen with certain medications, especially opioids. This may indicate opioid misuse.
- **Drug/Drug Interaction**: Warns of potentially interacting drug combinations and assists in assessing the risk of administering the prescribed drugs concurrently. Warning messages to the pharmacist identify the possible clinical effect of the interaction. A full-text monograph describes the mechanism, management, and clinical aspects of the potential interaction. Monographs also include comprehensive lists of primary literature references. DDIs present safety risk to enrollees, as the potential to increase pharmacy costs as other therapies are added to address the consequences of the interaction ("meds for meds").
- **Drug Allergies**: Presents safety risk to the enrollee. The potential to increase pharmacy costs as additional therapies are added to address the consequences of the interaction ("meds for meds").
- **Duration of Therapy**: Medications that may be appropriate during a specific phase of treatment may not continue to be appropriate, adding long-term costs to claim and worsening claim outcomes.
- **Phase of Therapy**: Identifies drugs appropriate in acute phase of treatment (e.g., first 45 days) vs chronic phase.
- **Compliance Checking**: Detects early refill attempts and past-due refills as the prescriptions are presented for refills. It also anticipates refills on prescriptions due for refill.
- **Drug/Disease Contraindication**: Provides warnings when a new drug may be contraindicated based on the patient's known medical conditions. In addition to specific disease state contraindications, broader conditions such as pregnancy, lactation, and patient age are considered. This includes a disease indication to establish medical conditions by inference (e.g., insulin usage implies diabetes mellitus) when medical condition information is not directly available.
- **Drug Dosage**: Evaluates the daily dosage and the duration of therapy for each prescription. It provides warnings to identify those that are outside generally recognized safe and effective ranges.
- **Patient Counseling**: Provides printouts that contain clear and concise information concerning the purpose, use, precautions, common side effects, and additional information of prescription drug products. The printouts provide a guide for the healthcare professional and give the patient a permanent reference for this important information. These printouts are available in English, Spanish, or Canadian (French), depending on your version of the drug table.
- **Prior Adverse Reactions**: Given a patient's history of a previous drug allergy or other adverse experience, this provides warnings if a new entry includes drugs or ingredients to which the patient may react similarly.

Edit Classification

DCS

We can code PA edits hard or soft at DCS's discretion. Soft messages are notifications to the pharmacy, and hard messages are rejections with messages that prevent a pharmacy from dispensing the script. We typically classify our point-of-sale edits into the following general categories:

- **Administrative messaging (claim rejects or denials)**: We base edits on current NCPDP reject messaging standards.
- **Custom messaging**: We program custom messaging as hard or soft at DC's discretion with 200 freeform characters of custom text messaging available.
- **Clinical messaging**: We can program clinical messaging as hard or soft at DCS's discretion.

NYSIF

We apply soft or hard edits depending on DCS's formulary strategy. We process all POS prescription transactions electronically from the respective pharmacies via real-time/online communication. We have created custom messaging for certain drugs and scenarios to provide the dispensing pharmacy with more concrete guidance around the uniqueness of the situation related to workers' compensation, and therefore reducing the confusion for the pharmacist and providing resolution guidance, in addition to improving the interaction with the patient attempting to fill the prescription.

Additionally, when a prescription is initially blocked due to formulary, DUR, or patient eligibility edits, the pharmacy receives a real-time electronic message from the POS stating a prior authorization is required and to contact the 24/7/365 help desk number. However, in many cases we do not wait for the pharmacy to reach out; we proactively call to alert the pharmacist that we are attempting to resolve the PA.

While speaking with the pharmacist, the customer service specialist reviews the detailed claim notes and history to determine if the medication can be allowed. If the customer service specialist is unable to determine whether the medication should be allowed, the specialist electronically messages the claims staff regarding the required prior authorization. This is a differentiator in the industry and aims to ensure care delays are prevented.

Our pharmacy contracts require pharmacies to dispense generic drugs when generics are available and when permitted by state law. One of the many online edits in the DUR process is the generic conversion edit to ensure compliance. Examples of alerts we deploy to the pharmacist include:

- **Formulary Alerts (Pharmacist)**: Customizable prospective component of the formulary that notifies the pharmacist about various drug utilization patterns including but not limited to high quantities, excessive days' supply, high dose, duration of therapies, brand versus generic, and excessive number of fills.
- **Prior Authorization Alerts (Pharmacist and Claims Staff)**: Customizable prospective information sent to the claims staff and to the pharmacy when a prior authorization request is triggered. Information in an alert message may include state requirements and documentation, clinical recommendations regarding the target medication or alternatives, patient risk concerns, pricing information, quantity limitations, or any additional information that may be deemed important by the client in making a coverage decision.

- **DUR Alerts (Pharmacist)**: A series of edits are performed when the pharmacist enters the data into their pharmacy system which includes the details about the injured worker, the prescription(s), and other pertinent information. This transmits to our real-time online adjudication system. Should the submitted information trigger any of the 100+ edits within the DUR program, the system sends an immediate message back to the dispensing pharmacy with appropriate recommendations.
- **Step Therapy (Pharmacist and Physician)**: If a concurrent alert process to the dispensing pharmacy, the program utilizes a stepwise approach to guide physicians towards prescribing safe and effective alternative drugs as first-line treatment options at a lower cost. Customized edits prompt pharmacists to contact the physician regarding recommended agents.

In addition, our ongoing review and measurement of each customer's pharmacy program performance (e.g., trends and patient population), includes ongoing quality assurance processes that evaluate appropriate recommendations to enhance the overall safety, efficiency, and cost containment of the program design.

4. Program Benefit Edits

a. Within the Offeror's Concurrent DUR program describe how the Offeror's 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:

i. Refill too soon, including a description of the methodology utilized

ii. Prior authorization

iii. Drug exclusions or limitations

MedImpact monitors these edits in the following ways:

- **Refill Too Soon**: Hard denial that will require authorization based on DCS-defined limits with the ability to use multiple limits for different therapeutic categories such as opioids.
- **Prior Authorization**: Hard denial that will require this prior authorization or plan approved override. The pharmacist cannot override a hard denial using standard DUR or PPS codes.
- **Drug Exclusions/Limitations**: This stops a claim if the enrollee is naïve to therapy (such as opioids) and does not have sufficient history of use of the product within a specified timeframe, and the requested drug exceeds the configured maximum days' supply.

For NYSIF our system incorporates edits and monitoring for overrides including:

- **Compliance Checking**: Detects early refill attempts and past-due refills as the prescriptions are presented for refills. It also anticipates refills on prescriptions due for refill.
- **Prior Authorization Alerts (Pharmacist and Claims Staff)**: Customizable prospective information sent to the claims staff and to the pharmacy when a PA request is triggered. Information in an alert message may include state requirements and documentation, clinical recommendations regarding the target medication or alternatives, patient risk concerns, pricing information, quantity limitations, or any additional information that may be deemed important by the client in making a coverage decision.

- **Exclusions**: The system checks eligibility and checks the drug formulary, comparing historical and pharmacy data on file for that injured worker.

5. Describe the methods the Offeror utilizes to measure Program effectiveness (Do not include any reference to specific monetary savings).

Several reports within MedOptimize can be utilized to measure program effectiveness, including identifying drug problems or concerns. In addition, DCS's CPM will conduct a BFR each quarter with the client. This includes most reports, and DCS's own CPM discusses the results with the client to determine that objectives are being met and if changes should be made.

We will perform ongoing analytics of the PBM program while providing comparative results to our overall book of business. All analytics are normalized to ensure "like business" comparisons are being performed while also illustrating areas of program performance results that may be unique to NYSIF based on the strategies being deployed. Examples of program metrics include drug cost (price) and utilization trends, clinical and population assessments related to drug therapies, prescribers, and jurisdictional influences. The analytics system performance will be provided as part of an annual business review and we will collaborate with NYSIF to define any desired metrics or output to be included. The following is a sample of the type of metrics used to measure service quality:

- Measurement
  - Rx Cost per Claim
  - Rx Cost per Pill
  - Rx Cost per Script
- Network Management
  - Mail Order Penetration
  - Network Penetration
  - Paper Savings %
  - POS Network Savings %
- Utilization Management
  - Compounds as a percentage of Total Drug Costs
  - Generic Fill Rate
  - Opioid as a percentage of Total Drug Costs
  - Opioid Rx per Claim (annual)
  - Physician-Dispensed as a percentage of Total Drug Costs
  - Specialty Drugs as a percentage of Total Drug Cost
  - Total Prescriptions per Claim (annual)
- Cost and Operational Effectiveness (3-month data)
  - Percentage of Calls Answered in < 30 seconds
  - State Reporting Timeliness and Accuracy

Additionally, our customers benefit from monthly (or more frequently if needed) meetings where our clinical teams would meet regularly to discuss both claim level and program level strategies and next steps.

Clinical decision support continues through the onsite business review meetings where the clinical pharmacist provides an overview of the medication-related aspects of the patient population as well as forward-looking insights and medication trends that are occurring in healthcare and pharmacy that may become impactful or concerning to worker's compensation, and subsequent new opportunities for cost savings.

6. Describe any other programs the Offeror proposes to provide to administer utilization management on behalf of the Programs.

We have additional clinical programs available to assist DCS in administering UM.

DCS

For DCS we propose our medical rebate program. Medical rebate management optimizes rebate yield available for certain specialty drugs billed under the medical benefit. Medical rebate services include:

- Consultation to maximize rebate yield
- Provision of administrative services to support billing and collections with pharmaceutical manufacturers
- Delivery of quarterly medical rebate summary reports

Specialty drugs covered in the medical benefit and administered at hospital, outpatient facility, provider office, or home infusion can generate medical rebate savings. There is no impact to pharmacy benefit rebates. We offer 2 formulary approaches:

- **Preferred Program**: Yielding higher rebates within each category by using a formulary with step edits and lower list price alternatives to drive utilization to preferred drugs
- **Open Program**: Providing an open access approach with less restrictive utilization management that still provides moderate rebate yield with no nonpreferred products

Additional medical rebate services include:

- Analysis of historical medical claims to identify additional savings opportunities
- Assessment and determination of optimal rebate strategy for select high-impact drugs
- Provision of administrative services to facilitate billing and collections with pharmaceutical manufacturers
- Delivery of quarterly medical rebate summary reports

Our medical drug rebate and pharmacy drug rebate programs are separately managed with separate product contracting and separate rebate administration.

NYSIF

We employ multiple strategies to ensure patients are utilizing clinically appropriate and cost-effective care. In addition to our previously described Therapeutical Alert Letter, IPE, and enhanced IPE+, we offer:

- Our POS Step Therapy program targets medication formulations that have therapeutically similar, cheaper alternatives. Pharmacists are prompted by a customized edit to contact the physician regarding recommended agents.
- Triggered at the time of prior authorization, our automated LOMN requests of the provider documentation related to the necessity of a customizable list of targeted medication (e.g., compounds or other high-cost topical formulations) over safer and/or more cost-conscious therapy. The LOMN program has been proven to deter the use of these formulations as a front-line therapy.
- MedMatters includes a direct pharmacist-to-patient outreach program connecting injured workers with a clinician to discuss medication-related concerns. We identify injured enrollees as candidates for outreach based on predetermined clinical criteria including but not limited to controlled substance use; excessive polypharmacy; over- or under-adherence to therapy; medication concerns related to patient safety; use of compounds or private label topicals; and physician dispensing activity.

Additionally, there are targeted strategies in the areas that serve as key drivers for prescription drug utilization in workers' compensation populations, including but not limited to:

- Physician dispensing
- Topicals and Compounds
- Opioids
- Specialty
- Retrospective DUR

C. Retrospective DUR Program

1. Describe the Retrospective DUR Program that the Offeror propose to put in place for the Programs including:

a. The qualifications of the staff that would perform these reviews.

b. How the Offeror identifies and selects areas for retrospective review and the methods utilized to inform and educate Physicians.

c. A timeline for these reviews.

d. What type of follow-up the Offeror conducts after communicating the information to the Physician.

e. How the Offeror measures the effectiveness of their Retrospective DUR Program including any statistical measures of the success of the Offeror's efforts (Do not include any reference to specific monetary savings).

f. Whether the Offeror currently administers a Retrospective DUR Program for other clients and, if applicable, how the Retrospective DUR Program for the Commercial Plan differs from the Retrospective DUR Program for the EGWP.

g. The reporting capability for the Offeror's described program.

h. Provide examples of the communications to physicians resulting from the retrospective DUR Program.

i. Provide examples of reports of the Offeror's described program.

We offer retrospective DUR programs to support our clients' needs.

MedImpact designed the Retrospective DUE (Drug Utilization Evaluation) program to identify potentially inappropriate enrollee drug utilization patterns and provide a mechanism to notify prescribers. We provide targeted information to prescribers to assist them in re-evaluating therapy and making modifications, where appropriate, to enhance the quality of an enrollee's prescription drug therapy. We offer an Enhanced Retrospective DUE program that provides prescriber outreach focusing on quality care interventions that identify enrollees using medications in a manner with less than optimum drug therapy utilization, which provides written communication to the prescriber requesting a reassessment of therapy. We can work with DCS to customize the topic of interest, appropriate target population, outreach schedule, and intervention criteria used in the Enhanced Retrospective DUE program.

In collaboration with our workers compensation benefit partner, we offer a variety of retrospective programs to ensure enrollee safety, including:

- **STAT Review:** The STAT review (Suspect Transactions and Alternative Therapies) is a complimentary retrospective review of all high-priced medication transactions conducted by a clinical pharmacist weekly. These reviews include clinical appropriateness of processed pharmacy transactions, and billing errors such as incorrect package size or number of units. Upon identification of billing errors, we contact the appropriate stakeholder to provide a review of the concern identified and a corresponding recommended action. Stakeholders include, but are not limited to, the pharmacy, prescriber, and/or claims staff member. Requests submitted to the pharmacy focus on correcting the original transaction and rebilling it appropriately. Upon identification of potential clinical concerns that may warrant further intervention and discussion, our designated client support clinical pharmacist provides a report of clinical recommendations to their client contacts.
- **Prescriber Monitoring and Outreach Programs:** Providers are targeted for intervention based on prescribing behavior. Provider outreach and education is accomplished through our Therapeutic Alert Letter (TAL), Step Therapy, Letter of Medical Necessity (LOMN) and Independent Pharmacotherapy Evaluation (IPE) programs.
- **Therapeutic Alert Letters (TALs):** TALs address all claimants that have specific therapy concerns. These may include either a therapeutic class, a specific medication, or a potentially high dose of a medication. Our clinical pharmacy team identifies medications or prescribing characteristics that pose clinical concerns and creates TALs to address them. We send the letters to all prescribers that meet the designated criteria. Therapeutic alert letters are measured based on clinical outcomes as well as financial savings. Clinical outcomes include a reduction in the duration of therapy based on the number of medication fills following a therapeutic alert letter intervention.
- **LOMN: Letter of Medical Necessity is a complimentary service to all customers.** The LOMN is available on any transaction that hits a formulary prior authorization edit for review. Our customizable LOMN templates deliver targeted questions to request medical justification and documentation for a variety of concerning medications or when relationship to the workplace injury is ambiguous. Savings are calculated based on the medication where an LOMN is generated, and the medication is either not authorized or never dispensed within 30 days of the generation of the LOMN to the prescriber.
- I**ndependent Pharmacotherapy Evaluation Plus (IPE Plus):** IPE Plus is a comprehensive review of prescription transactions and enrollee medical history conducted by a clinical pharmacist. We partner with our clients to create specific criteria for enrollee selection. The criteria are centered

around evidence-based guidelines related to enrollee safety, inappropriate therapy, and therapies with more cost-effective alternatives.

- **IPE (Standard) Program** provides recommendations on the appropriateness of an injured enrollee's medication regimen, based on the most current clinically sound evidence-based guidelines. Standard (traditional) IPE reviews are based on 6 months of an enrollee's prescription transaction history, a description of the injury, and no medical record review or prescriber consult.

Staff Qualifications

MedImpact holds our national P&T Committee meeting quarterly and our Medicare Part D P&T Committee meeting annually. Physicians and pharmacists with an active license to practice in the US make up our P&T Committee. At least one physician and 1 pharmacist must be experts in elderly or disabled care, and at least one enrollee must be a licensed psychiatrist.

Identification of Areas for Review and Outreach Methods

We do not survey prescribers regarding the value of the retrospective DUE (drug utilization evaluation) information provided. We can work with DCS to establish a meaningful prescriber survey focused on retrospective DUE information with both the survey frequency and cost mutually agreed upon.

We regularly monitor physician prescribing and injured worker drug utilization trends via our data analysis and reporting tools. Often, we discover inappropriate prescribing patterns and/or injured workers over utilizing medication. Based on NYSIF's needs, we customize clinical analysis criteria to electronically review our prescription transaction data to pinpoint drug regimen characteristics that place claimants at-risk, which can result in the use of additional, unnecessary health care resources. The retrospective review process ranges from the automated identification of enrollees and their related drug treatments that require additional clinical review, alerting and communicating these concerns to the appropriate claim stakeholders, to the intervention and communication with the prescriber.

Outreach Timelines

Through our **IPE+ (enhanced)** program, we review the claim at the time of intervention and utilize a 90-day look-back and a 180-day look-forward to quantify savings. We build in an additional 30-day gap into the after period to allow for prescribing changes. We take measurements in 30-day increments in the post IPE period. We use a 90-day pre-intervention period as the activity period measured by the triggering criteria.

Our **IPE (standard)** reviews are based on 6 months of an enrollee's prescription transaction history, as well as a description of the injury and do not include a medical record review or prescriber consult All IPE outcomes are measured at 2 outcome dates: outcome 1 and outcome 2. Date ranges may vary by client but are typically 90 and 180-days post-intervention.

Prescriber Follow-up

For the standard retrospective DUE (drug utilization evaluation) programs, we provide the intervention data file along with a letter template and mail merge instructions to the client to send to the prescriber outlining the therapy issue identified along with a recommendation to re-evaluate therapy.

For the Enhanced and Custom Retrospective DUE programs, we contact the prescriber to outline the therapy issue identified along with a recommendation to re-evaluate therapy. We provide outcome reporting, which includes pre- and post-intervention comparison to identify successes. Clients have the option to receive intervention data files only; in which case, we do not provide outcome reporting.

Our prescriber follow-up differs by program type:

- **Letters of Medical Necessity (LOMN):** Our proprietary tool uses OMR technology that automatically associates responses received from the prescribers to the corresponding claim and distributes an automated notification to the individuals responsible for managing the claim when the returned LOMN has been received. The tool allows a claims staff to generate a prepopulated LOMN which includes all the pertinent claim information as well as customized comments and subsequently automate the distribution of the document fax communication to the prescriber. This functionality exists within the Verticē web portal. The claims staff receives an alert when the document has been received and can retrieve and view the document and all the prescriber responses at any time. In many cases, LOMN can result in a change in the prescribed medication regimen to an appropriate alternative.
- **Therapeutic Alert Letters:** We solicit feedback from TALs, and we provide prescribers contact information for Clinical Service staff should they want to discuss the content of the letter.
- **Independent Pharmacotherapy Evaluation (IPE) Services:** Our Clinical Intervention Team pharmacists monitor the results and progress of a prescription regimen after the outreach to the prescriber is completed.

Effectiveness Measures

Enhanced Retrospective DUE program savings vary from client to client depending on the edits, programs, and interventions implemented. We calculate savings by comparing baseline figures from before and after the implementation process.

The Independent Pharmacotherapy Evaluation Plus (IPE Plus) program provides a comprehensive review of prescription transactions and enrollee medical history conducted by a clinical pharmacist and subsequent outreach to the prescriber. We partner with our clients to create specific criteria for enrollee selection, which are centered around evidence-based guidelines related to enrollee safety, inappropriate therapy, and therapies with more cost-effective alternatives. A written assessment of these concerns and recommendations is provided to the prescriber. Reviews may be customized by client and may include multiple outreaches to various participants in the injured workers' care plan, written or telephonic therapy recommendations, and internal or external consultations providing pharmacy expertise to a customer's stakeholders.

Our definition of value is a combination of improvement in enrollee-centered outcomes measures and increased financial savings from appropriate clinical management of injured workers. Enrollee-centered measures of success for clients may include:

- Lower average MME stratifications pertaining to opioid use
- Reductions in potentially toxic acetaminophen dosages
- Reductions in the number of enrollees receiving opioids
- Reduction in the number of enrollees taking high-risk drug combinations

- Reductions in the duration of therapy for enrollees receiving opioids and high-risk drug combinations

RDUR for Other Clients

We administer their respective RDUR programs successfully for other clients.

Reporting

Depending on the program, we typically provide enhanced retrospective DUE reports quarterly.

Several reporting suites and data visualization tools are also available to review pharmacy and clinical activity on a claim such as drug history, controlled substance utilization, medication adherence, prescribing patterns, claim interventions and adherence to formulary. These self-service tools are available to customers to follow progress and monitor prescriber adherence to recommended medication changes and overall enrollee outcomes after the intervention(s) occurred. This is monitored monthly and reported back to the customer as identified and at a regular cadence during monthly Therapeutic Advisory Group meetings.

NYSIF would be assigned a dedicated pharmacist who will coordinate with our clinical resources to proactively monitor and alert NYSIF about claims and overall population trends. Our clinical team utilizes data analytics and data visualization dashboards to determine opportunities where evidence-based guidelines are not being followed or where potential fraud, waste and abuse is occurring. The clinical team will provide NYSIF with strategies to ensure these enrollees can achieve improved functional restoration, and benefit from effective cost containment.

The assigned clinical pharmacist and the supporting pharmacist team will be available to NYSIF for telephonic and email consultation to resolve specific claim-level questions regarding medication use relative to a specific injured worker's treatment, as well as assistance with clinical services such as formulary, step therapy, and letter of medical necessity. In addition, the consultative approach extends to regularly scheduled calls with NYSIF claims team that are more strategic in nature. Enrollees benefit from monthly (or more frequently if needed) Therapeutic Advisory Group meetings (H-TAG) where the clinical team meet regularly to discuss both claim level and program level strategies and next steps.

Clinical decision support continues through onsite business review meetings where the clinical pharmacist provides an overview of the medication-related aspects of NYSIF's enrollee population as well as forward looking insights and medication trends that are occurring in healthcare and pharmacy that may become impactful or concerning to worker's compensation.

Prescriber Communication Examples

Please see the **5.14 Exhibits** tab for examples of our Therapeutic Alert Letter and Letter of Medical Necessity.

Report Examples

Please see the **5.8 Exhibits** tab for sample pharmacy reports.

D. Medical Exception Program (Exclusive to DCS)

1. Provide a flow chart and step-by-step description of the process the Offeror will employ to conduct the DCS Program's medical exception program. Specifically, please detail the process for receiving, assessing, and responding to the prescribing Medical Professional's Medical Exception requests.

We utilize our PA process to administer medical exception requests. A sample PA workflow is included as **Figure 8**.

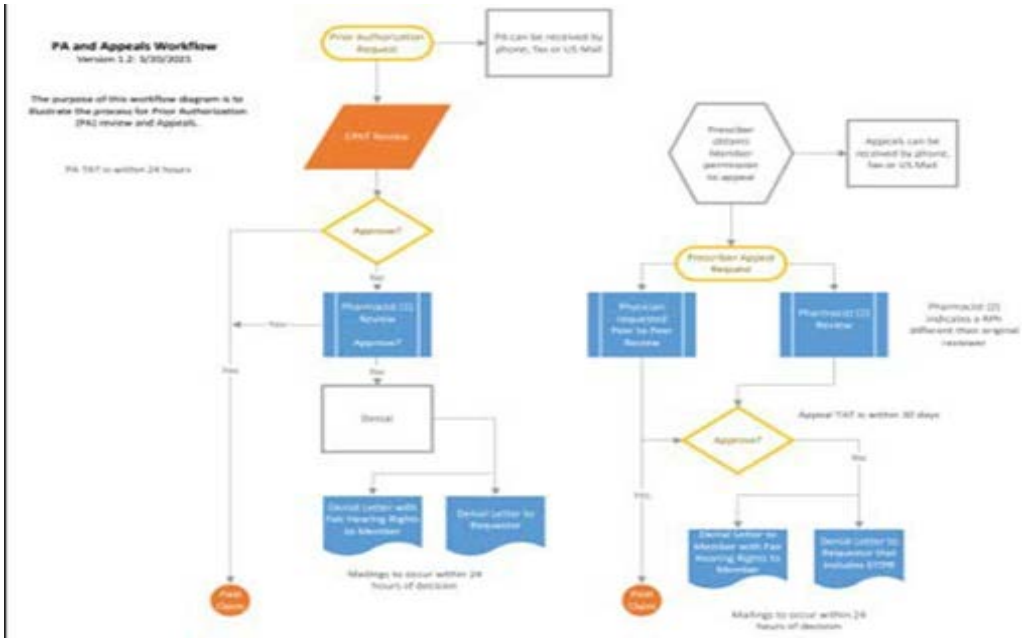

Figure 8: Sample PA Workflow

2. Does the Offeror currently have a program in place similar to the DCS Program's medical exception program? If so, please describe in detail the structure of the Offeror's program including, but not limited to:

a. Define the specific criteria required for approval of a medical exception request including the required number of trials of formulary alternatives that must be undertaken before a medical exception can be approved.

b. Provide examples of all communication materials related to the Offeror's Program that it uses for other clients.

Our therapeutic PA request process includes formulary exception, step therapy, quantity limit, and tier exception requests. Pharmacy staff initially perform these reviews for possible approval. Our formulary exceptions guidelines and formulary analyzer systems provide a unique and accurate tool for our pharmacy staff to adequately review formulary exceptions. If required by accrediting body or state utilization management regulations, a licensed pharmacist within the PA department or a physician subsequently reviews. This pharmacist intervention offers a high level of accuracy by providing an efficient PA review.

The individual PA guidelines dictate the required number of trials of formulary alternatives and criteria required for the medical exception to be approved.

3. Will the Offeror accept a letter of medical necessity from an enrollee's physician, which details the enrollee's formulary alternative trials and any other clinical documentation supporting medical necessity? If so, explain in detail what specific information is required for approval.

Yes. We can accept letters of medical necessity from prescribers. The letter needs to include the elements dictated by the individual PA guidelines.

4. The Offeror must confirm that it possesses adequate qualified staffing resources to perform the services of the DCS Medical Exception Program. Attachment 80, Medical Exception Program Claims Experience, provides data regarding the number of exception requests for a select time frame.

MedImpact confirms.

Our PA, appeals, and grievances teams includes staffing resources to support the DCS program.

E. Physician Education

1. Describe/present the Physician communication/education programs you propose for the Programs. Describe the Offeror's objectives and approach to Physician profiling and education including:

a. Whether the Offeror currently administers a Physician profiling and education program for other clients similar to the Programs.

b. A description of the method(s) and analysis the Offeror uses to select Physicians for profiling and whether the Offeror's clinical programs involve peer-to-peer Physician discussions.

c. The frequency of the Offeror's educational efforts.

d. The number of Physicians the Offeror has 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.

e. How the Offeror measures the effectiveness of their Physician profiling program including any statistical measures of the success of their efforts. [Note: Do not include any reference to specific monetary savings.]

f. Whether the Offeror will adapt their Physician Education Program standards to meet the Program's needs as specified by the Department.

g. Confirm that the Physician Education program will not be funded by pharmaceutical manufacturers.

MedImpact offers physician education for the DCS and NYSIF program.

DCS

Physician Profiling Administration

We propose an academic detailing program, based on training and documentation provided by our corporate training partner, Alosa Health. This program is designed to help improve prescribing through interactive educational outreach.

Alosa Health is a Boston-based 501(c)(3) non-profit organization founded in 2004 by Dr. Jerry Avorn, Professor of Medicine at Harvard Medical School and Chief emeritus of the Division of Pharmacoepidemiology and Pharmacoeconomics at the Brigham and Women's Hospital. Dr. Avorn pioneered the academic detailing approach. Alosa-based academic detailing programs have been put in place in 25 states, and with major collaborations with the nationwide Veterans Affairs Academic Detailing Program, and the health insurer Aetna. This combination of knowledge and skills has provided Alosa with unparalleled program implementation experience.

Profiling Methods and Analysis

We will provide educational materials that are developed by faculty enrollees of HMS and other centers of excellence, who evaluate and synthesize the latest information on medication effectiveness, risk, and cost, then package it into a user-friendly format that is concise, clinically relevant, and actionable for interactive training and educational outreach work. These materials are accredited for continuing medical education through HMS.

We will provide a trained pharmacist for academic detailing to improve the clinical quality and cost-effectiveness of prescribing in DCS's program.

Potential topics include:

- Acute and Chronic Pain Management
- Opioid Use Disorder (OUD)
- Depression
- Managing Type 2 Diabetes
- Sexually transmitted diseases (syphilis, chlamydia, HIV)
- Vaccinations
- Other clinical areas relevant to the DCS program

MedImpact proposes conducting Academic detailing activities throughout the contact year, with results reported on a quarterly basis. We propose 1 FTE pharmacist included in the administrative fee who will work through different modalities (phone, in-person, lettering) to improve select metrics (e.g., financial or quality) for DCS's program.

Adapting New Standards

We are happy to discuss customization of our physician education program to meet your needs.

Program Funding

We confirm that our programs are pharmaceutical manufacturer funded.

NYSIF

Physician Profiling Administration

For NYSIF, physician profiling and education efforts are included within the offered programs. Prescriber Monitoring and Outreach Programs: Providers are targeted for intervention based on prescribing behavior. Provider outreach and education is accomplished through our TAL, Step Therapy, LOMN, and IPE programs.

Profiling Methods and Analysis

Providers are targeted for intervention based on prescribing behavior. Provider outreach and education is accomplished through many channels. Our POS Step Therapy program targets medication formulations that have therapeutically similar, less expensive alternatives. Prior to dispensing a medication, we notify pharmacists at the point-of-sale pharmacy through a customized edit to contact the physician regarding recommended agents. Triggered at the time of prior authorization, our automated LOMN requests the provider to submit documentation related to the necessity of the targeted medications (e.g., compound or other high-cost topical formulation) over equally effective, safer and/or more cost-conscious therapy. The Step Therapy and LOMN programs target several medications and have been proven to deter the use of these formulations as front-line therapy.

DCS will also have access to our Prescriber Monitoring Score Card, an analytics-driven dashboard of various prescriber metrics that highlights prescribing trends and behaviors, benchmarks them against their peers, and provides actionable insight. An analytics-driven dashboard stratifies prescriber risk based on clinically inappropriate, potentially unsafe, and high-cost prescribing behavior. The prescriber scorecard visually depicts these prescribers by risk severity to facilitate effective clinical decision support and targeted intervention. Identification of high-risk prescribing behaviors may include high MME, prescribing risky therapies and drug combinations, controlled substance prescribing, excessive use of brand mediations, physician dispensing, and inappropriate adherence to state formularies, among other customer selected parameters.

As part of our IPE program, pharmacists on our Clinical Interventions Team conduct our IPE and enhanced IPE+ reviews. In the event a doctor-to-doctor/peer-to-peer engagement or external parties are required, we can facilitate the workflow and transition of these cases to the elected parties. For example, at a clients' requests we have partnered with independent medical evaluation providers, such as MES Solutions, for peer-to-peer case escalations. We can also work instead to directly transition these cases to the appropriate NYSIF personnel, if desired. For example, once the clinical pharmacist completes the IPE, a NYSIF medical director may review the report and conduct a verbal consult with the treating provider. All documentation and feedback is provided to the claims staff following these interactions.

Our program can also establish similar workflows with other components of NYSIF's clinical program, as well as external partners such as IME, UR, and nurse case management companies. We have worked with clients to establish workflows to integrate external providers such as UR companies and urine drug screen providers. In each of these cases, they were based on existing vendor relationships our customers requested us to use.

Frequency

Physician outreach/educational efforts are ongoing as needed and can be customized to suit DCS and each program component's needs.

Physician Outreach Metrics

Outreach metrics:

- **Therapeutic Alert Letters:** Therapeutic Alert Letters target specific therapy concerns or prescribing patterns such as brand prescribing, high-risk medications, or potentially inappropriate therapy. The letters are sent to all prescribers that meet the designated criteria. Over the last 3 years, the

Therapeutic Alert Letters program has resulted in more than 10,000 letters being sent to prescribers. This program drives proper evidence-based prescribing.

- **LOMN:** The LOMN program delivers a targeted questionnaire to request medical justification and documentation for a variety of concerning medications or when medication relationship to the workplace injury is ambiguous. Over the last 3 years, we have sent more than 11,000 LOMNs to prescribers.
- **IPE:** Verbal consults (where allowed by state law) are sought to engage the provider(s) and affect appropriate care. Prescriber follow-up within the IPE+ program includes several touchpoints: written evaluation and recommendations, prescriber consultation, and multiple written outreach reminders. These interventions have positive overall clinical improvements post outreach, including reduction in average MME, reduction in medication fills, and reduction in the total number of medications across the claim.

Physician Profiling Effectiveness

Program effectiveness:

- **Therapeutic Alert Letters:** These efforts impact enrollee safety measures such as lower average MME stratifications pertaining to opioid use (47% reduction) and decreases in potentially toxic acetaminophen dosages (24% reduction).
- **LOMN:** The LOMN program results in a change in therapy over 56% of the time.
- **IPE program:** These interventions have demonstrated positive overall clinical improvements at 180 days post intervention, including an average MME reduction of 41%, a reduction in medication fills of 43%, and reduction in the total number of medications in the claim by 38%.

Adapting New Standards

We are happy to discuss customization of our physician education program to meet your needs.

Program Funding

These programs are not pharmaceutical manufacturer funded.

F. Patient Education (Exclusive to DCS)

1. Describe the Offeror's objectives and approach to patient education including:

a. Whether the Offeror currently administers a patient education program for other clients.

b. The identification and selection of categories of drugs to apply retrospective review and the method(s) the Offeror proposes to use to educate and inform patients.

c. The number of educational interventions and the expected Enrollee response rate.

d. How the Offeror measures the effectiveness of their patient education program including any statistical measures of the success of the Offeror's efforts. [Note: Do not include any reference to specific monetary savings.]

e. Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

MedImpact offers programs and services to provide education to enrollees at the direction of the client. Our MedEmpower Fuel program is one way that we do this.

Patient Education Program

We offer three enrollee education programs: the MedEmpower Fuel program includes Diabetes Management, Diabetes Prevention, and Healthy Weight, all offered through a user-friendly app and supported with clinical coach engagement.

Identification of Categories

Drugs used to treat diabetes and stimulate weight loss are reviewed retrospectively by the health coaches after the enrollee uploads the regimen into the app. Feedback and education are provided verbally to enrollees via secure video sessions, as well as offered via self-help access to educational material provided in the library of clinically reviewed guidance.

Number of Educational Interventions

Educational sessions are unlimited if the enrollees remain engaged in the programs offered for one year.

Measures Effectiveness

Effectiveness is measured via enrollee feedback provided to the health coaches, nutritional food scores collected through the app, and through biometric measurement of blood sugar, A1C, and body weight.

Program Funding

We confirm that this program is not and will not be funded by pharmacy manufacturers.

G. Patient Education (Exclusive to NYSIF)

1. Describe the Offeror's objectives and approach to patient education including:

a. Whether the Offeror 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) the Offeror proposes to use to educate and inform patients.

c. The number of educational interventions and the expected Enrollee response rate.

d. How the Offeror measures the effectiveness of their patient education program including any statistical measures of the success of the Offeror's efforts. [Note: Do not include any reference to specific monetary savings.]

e. Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

[Note: The cost of all the programs listed above are required to be in the Offeror's Proposed Claims Administration Fee.]

We offer a variety of options for educational and introduction for the PBM program, including hosted events, video, print material, website, and emails. All of these can be customized to meet DCS's needs.

Enrollee Education Programs

We provide client-customizable claim kits and supporting pharmacy program materials for all entities. This includes materials included with our First Fill program, which incorporates enrollee communications and materials to direct them to network pharmacies.

Clinical, educational, pharmacy and medical documents are provided for specific target audiences. Enrollee education centers on safe use of pain medicine, alternative options to opioid therapy, high-risk medication combinations and safety concerns, common terminology in pain management, questions to ask the prescriber, information on side effects and the risk of addiction and abuse, just to name a few.

We have a new digital experience available to help injured workers navigate their workers' compensation care and benefits. The experience includes an application that can be accessed on their mobile phone or desktop, to suit their channel preferences. The Jarvis app gives injured workers access to their benefits information, important documents, and helpful tools right in their smartphones, in real-time, making it easy for injured workers to:

- Message claims team instantly
- Keep track of appointments
- Complete claims tasks and paperwork
- Find a pharmacy or provider

In addition, the Enrollee Resources page on our public website includes technology and clinical resources and a pharmacy locator tool. The search tool simply requires an address (at minimum a city/state combination or zip code), and users can find in-network pharmacies closest to the patient's location by adjusting distance. We currently integrate our network data with several clients' channeling tools. We will work with NYSIF to provide a feed of our pharmacy network providers.

Categories for Education

Our Enrollee Engagement Med Matters Program is an enrollee outreach service to assist injured workers with managing the medications they take for their workplace injury. This service benefits injured workers by addressing concerns related to their medications that could present risk to their health and recovery. An injured worker's engagement in their care is a proven driver for better health outcomes, and direct outreach can significantly impact high-risk enrollee behaviors such as nonadherence. This also helps aid conversation between the enrollee and their doctor, with the goal of aligning prescribing behaviors with evidence-based recommendations.

Med Matters includes direct pharmacist-to-enrollee outreach program connecting injured workers with a clinician to discuss medication-related concerns. Injured workers are identified as candidates for outreach based on predetermined clinical criteria, including but not limited to:

- Controlled substance use

- Excessive polypharmacy
- Over- or under-adherence to therapy
- Medication concerns related to enrollee safety
- Use of compounds or private label topicals
- Physician dispensing activity

As a part of our program, we employ a staff of clinical pharmacists dedicated to ensuring the safe and effective care of injured workers. Med Matters connects these pharmacists directly with injured workers who need help managing their medications, specifically by identifying medication-related safety concerns the injured worker can address with their doctor; ensuring the injured worker is taking the medications as prescribed; addressing negative side effects the injured worker is experiencing and increasing the injured worker's engagement in their overall care.

The Enrollee Engagement MedMatters Program provides enrollee engagement through telephonic and video outreach and mailer communications.

Number of Interventions and Expected Response Rate

The Enrollee Engagement Med Matters Program includes up to 3 call sessions with the enrollee within a 30-day period and 1 additional follow-up call at the 90-day mark.

Program response rate:

- 43% success rate in reaching the enrollee telephonically
- 48% success rate in completing enrollee call once contact is made. We expect similar responses rates for NYSIF.

Effectiveness Measures

Program Outcomes:

- 100% enrollee satisfaction rate
- 45% of claims have shown success in behavioral change at 120 days after the outreach including decreased opioid use, reduction in prescriber count, and improvement in medication adherence measures
- Adherence specific measures:
  - Improvement in over-adherence (goal is to decrease inappropriate medication use)
- 49% of identified instances showed improvement in over-adherence at 120 days
  - Improvement in under-adherence (goal to increase appropriate medication use as prescribed)
- 67% of identified instances showed improvement under-adherence at 120 days

Program Funding

The Enrollee Education Programs/Resources are not and will not be funded by pharmacy manufacturers.

H. Other Safety-Related Programs

1. Describe the purpose of any other clinical management or drug utilization review programs that the Offeror proposes 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 offer a concierge-style approach to clinical management that puts the enrollee first, beginning at the point of care through specialized formulary development designed to guide safe, appropriate, cost-effective prescribing. It continues at the pharmacy counter and throughout the entirety of the claim lifecycle through the integration of clinical intelligence into our automated rules, edits and workflow decision support, medical management, and more.

Additional Clinical Management Offerings for DCS

We offer many clinical programs that DCS can leverage to support your enrollees.

- **Opioid Overutilization and Safety Controls:** We offer a comprehensive program that works to curtail misuse and increase enrollee safety through edits designed to deter the fulfillment of excess opioid and acetaminophen prescriptions. Edits include APAP safety controls at POS, opioid cumulative dosing at POS, opioid naive cumulative dosing at POS, opioid single claim dosing at POS, opioid- benzodiazepine concurrent use at POS, duplicative long-acting opioid therapy at POS, lock-in functionality at POS, opioid overutilization benzodiazepine/potentiators retrospective intervention, and naloxone for high-risk opioid use retrospective intervention.
- **Opioid Case Management:** Our Case Management Services monitors opioid overutilization and requires participation in the Opioid Overutilization-Benzodiazepine Concurrent Use intervention. This service includes review of the prescriber fax-back forms from the program. We work with prescribers to make sure all opioid or opioid-benzodiazepine utilization is medically necessary, safe, and appropriate. We also work with the prescriber to resolve overutilization, which may include decreasing potentially inappropriate opioid or opioid-benzodiazepine overutilization. We manage notifications to prescribers of any enrollee level restrictions deemed necessary after case management.
- **HCG X™ (High-Cost Generic Exclusion):** This program identifies and excludes low value, high-cost generic drugs and brand equivalents. It also recommends the use of clinically appropriate lower-cost generic alternatives to manage rising generic drug spend. We leverage multichannel, comprehensive outreach to educate prescribers, enrollees, and pharmacies to minimize enrollee disruption. The HCG X program is an opportunity for new MedImpact clients with enrollee populations already familiar with exclusions on plan formulary to maximize savings and minimize potential disruption. This applies to the commercial line of business only.
- **MedIntegrate:** MedImpact Direct Specialty® offers MedIntegrate® to help manage specialty drug costs and improve care across the medical and pharmacy benefits. DCS can save up to 20% of medical specialty spend with improved medical management. MedIntegrate provides:
  - Near real-time decision support and predictive analytics through MedIntegrate IQ™ software
  - Strategy independent of fulfillment to help ensure no conflict of interest on drug pricing or service strategy
  - Identification and transfer of targeted medical specialty drugs to pharmacy benefit for improved control/cost savings or vice versa if data indicate greater savings in medical benefit
  - Effective benefit management using utilization management protocols

- Efficient administration of medical specialty drugs at most optimal sites of care
- Maximization of savings through medical rebate management
- Comprehensive reporting to guide decisions and identify savings opportunities

- **Medical Rebates:** Medical rebate services include:
  - Analysis of historical medical claims to identify additional savings opportunities
  - Assessment and determination of optimal rebate strategy for select high-impact drugs
  - Provision of administrative services to facilitate billing and collections with pharmaceutical manufacturers
  - Delivery of quarterly medical rebate summary reports

Additional Clinical Management Offerings for NYSIF

Our full-service clinical program stands apart from the industry, beginning with the depth of our in-house pharmacology and occupational health experience, and the way this knowledge is embedded with the tools and workflows included in our platform and service delivery. All clients are assigned a clinical pharmacist who provides concierge-style consultative support that includes ongoing analysis and program consultation, claims staff support, and the deployment of high-touch intervention and outreach services designed to influence prescriber and enrollee behaviors.

Our clinical services include but are not limited to customized formulary design, implementation, and ongoing monitoring through our P&T Committee, along with custom workflow and overall pharmacy program design. This includes services such as our opioid management, specialty pharmacy, and step therapy programs, program documentation and educational materials. A dedicated clinical pharmacist as part of the overall account management team will regularly highlight trends and make program recommendations, reporting, and more.

We offer a comprehensive, customizable suite of clinical strategies that work across the continuum of care to manage specific pharmacy management goals such as clinical appropriateness and cost containment. These clinical strategies are supported by various clinical decision support tools and advanced analytics and utilize prospective, concurrent, and retrospective processes to identify and provide actionable insight into concerning claims.

Clinical services include:

- **Formulary:** A customizable, prospective first line of defense that identifies medications that are appropriate for acute and chronic treatment of an injury. Medications not included in the formulary trigger a PA request with an alert message and corresponding education to the claims team requiring approval or denial of the medication. In addition, these medications simultaneously trigger real-time alert messaging to the pharmacy informing the pharmacist they are not part of the formulary. The alert also provides the pharmacist with more appropriate alternative options.
- **Emerging Trend Management:** Continuing clinical analysis to identify and curtail concerning prescribing trends (e.g., PLTs and Packs/Kits) is conducted on an ongoing basis by our clinical services team. Cost-containment strategies to mitigate emerging trends are implemented including drug plan edits, alert messaging, and position papers to help educate the claims team on cost-effective alternatives. Additionally, the P&T Committee provides a systematic and comprehensive approach for recommendations regarding medication therapy using evidence-based guidelines and medical literature. Newly FDA-approved drugs and indications are also monitored to ensure these

are addressed in a timely manner in client drug plans. State-mandated formularies (e.g., ODG) are also monitored to apply updates when applicable.

- **Alert Messages:** This is customizable prospective information sent to the claims team and the pharmacy when a PA request is triggered. Information in an alert message may include state requirements and documentation, clinical recommendations regarding the target medication, alternative recommended therapeutic options, enrollee risk concerns, pricing information, quantity limitations, or any additional information that may be deemed important by the client in making a coverage decision.
- **Step Therapy:** This is a concurrent alert process to the point-of-sale pharmacist that relies on established evidence-based treatment guidelines to ensure that enrollees receive the most therapeutically appropriate, cost-effective treatment regimen for an injury. The program utilizes a stepwise approach to guide physicians towards prescribing safe and effective alternative drugs as first-line treatment options at a lower cost. In cases where the enrollee does not positively respond to the initial therapy, physicians can subsequently prescribe other medication options as needed. Step Therapy rules apply based on the claimants' prescription history. Cases where Step Therapy is often applied include requesting use of a cost-effective alternative that is of similar therapeutic efficacy, requesting use of a generic before the brand version, and requesting use of a lower strength prior to a higher strength medication.
- **Quantity Limits:** Use of quantity or fill limits by medication or therapeutic class drive prescribing behaviors to align with best practices in pain management. Quantity limits at the point of sale are prospective in nature and offer the opportunity for the injured worker to have timely accessibility to needed medications but may prevent the prescribing from becoming excessive or over-utilized. Early intervention and limitations placed around prescribing of high-risk medications from the onset allows clients to effectively manage claims from the onset of the injury.
- **Drug Information Line:** Claim adjusters, nurse case managers, and other stakeholders can utilize this service to ask a pharmacist a variety of questions including appropriate medication use, medication alternatives, and questions regarding prior authorizations. The use of this complementary service promotes informed decision-making. A clinical pharmacist can be reached during normal business hours (ET) by telephone or email. Clinicians are also available to partner with NYSIF and its partners to provide prospective education to claimants, adjusters and nursing staff.
- **Opioid and Risk Management:** Our program continually identifies and manages risk throughout the claim lifecycle, beginning prospectively with formulary and DUR edits at the transactional level to identify concerns that include, but are not limited to, dangerous drug combinations, high MME, overutilization of therapy, therapeutic duplication, and drug-drug and drug-disease interactions--all of which ultimately contribute to greater overall risk a downstream in the claim. Our goal is to identify and eliminate risk factors early in the process whenever possible to reduce future negative impacts, proactively reducing risk among our customers' injured worker populations. Specific data analytics tools that track and flag prescription trends known to be clinically detrimental (and subsequently, cost detrimental) to a claim are detailed below:
  - **Opioid Risk Index (ORI)** is a powerful predictive analytic tool available to our Clinical Interventions Team. Developed by our data scientists and clinical pharmacy staff, this tool evaluates the likelihood of a specific enrollee exceeding either of the two national MME thresholds for 40 consecutive days within the next 12 months, and is based on prior medication history, demographics, and other relevant conditions. The output and findings are used to present to prescribers and assist them while considering the proper course of treatment for an individual enrollee.

- **MME Forecast Graphic:** The MME Forecast Graphic is a supporting data visualization output that is presented to a prescribing physician within the IPE+ clinical intervention program. The graphic is produced by a statistical technique (autoregressive integrated moving average) which uses data over time to predict future trends. The modeling technique is among the most used forecasting methods and can consider numerous trends and data variables. The shaded forecast range displayed in the graphic represents the 95% confidence interval of the predicted trend.
- **Risk Queue:** An alert-based action queue within the Verticē portal that notifies the appropriate stakeholders regarding any criteria related to an enrollee drug regimen, prescriber activity, and third-party vendor notifications (i.e., UR and external case management). This allows clients to trigger enrollee-specific criteria such as notification regarding an enrollee whose total drug therapy displays areas of concern, waste, abuse or potential fraud. This also includes identification of prescribers displaying concerning or questionable activity. This queue leverages basic and advanced analytics that continuously monitor enrollee data and transaction history data to identify scenarios requiring immediate attention beyond the need for processing a prior authorization.

2. Identify the funding source behind any of the programs the Offeror proposes and confirm whether or not the costs for the Program are included in the Claims Administration Fee.

External funding is not used for the administration of any recommended programs.

All programs are included in the proposed pricing structures with the following exceptions:

- Opioid Case Management
- HCG X™ (High-Cost Generic Exclusion)
- MedIntegrate
- Medical rebates
- IPE
- Targeted Therapeutic Alert Letters: Future Therapeutic Alert Letters, future enrollee engagement communications and custom letters may require additional charges.
- Med Matters

Should you elect any of these programs, costs will be quoted upon request.

5.14 Exhibits

The following exhibits were referenced in Section 5.14 and have been provided here per RFP instructions.

Exhibit	Description
5.14 Exhibit A	NYSIF Prior Authorization Workflow
5.14 Exhibit B	Sample Training Documents
5.14 Exhibit C	TAL & LOMN Samples

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Exhibit K:
Prior Authorization Workflow and Portal

Prepared for: New York State Insurance Fund

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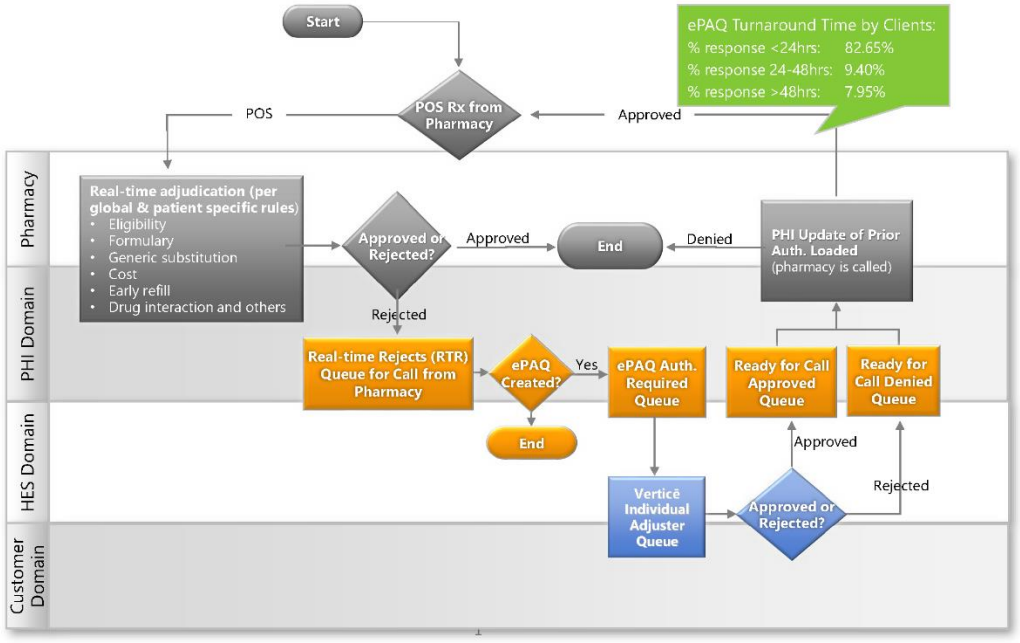
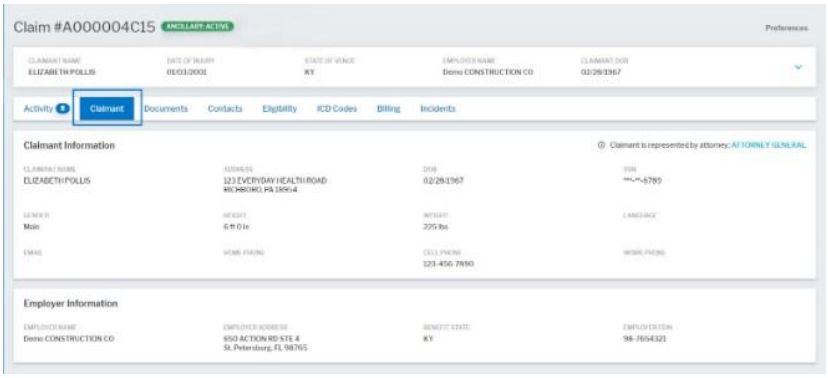
ePAQ High Level Process Flow



Vertice Web Portal for Claims Professionals

IMPROVE DECISION-MAKING

CLAIM VIEW: CENTRALIZED VISIBILITY



Claim View provides a holistic view of a claim. Our tab system allows the user to toggle between information.

Activity Tab: Overview of all activity, including types and status of referrals, servicing vendor, provider, requestor.

Claimant Tab: Contains information about the IW, including name, address and contact info, employer, attorney representation, and more.

Documents Tab: Provider notes, evaluation results, or other documents associated with the claim.

Contacts Tab: Information for all stakeholders on claim, including attorney, employer and supervisor, insurer, and assigned claims handler and case manager.

Eligibility Tab: Includes DOI, effective claim date(s), ID numbers, and other information related to eligibility.

ICD Codes Tab: Details regarding cause of injury, diagnosis, and relevant ICD codes

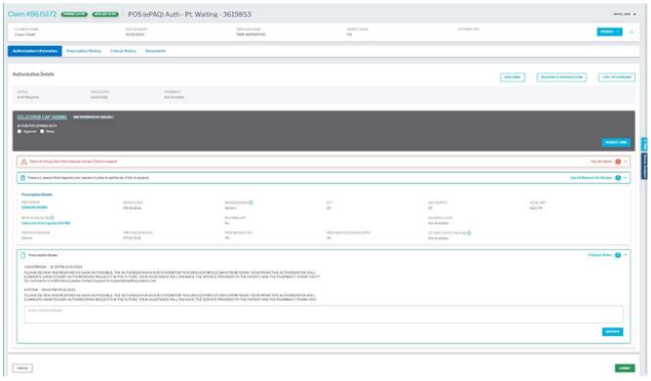
Billing Tab : Centralizes all billing activity, includingservice or product, service date, provider name, billed and paid amounts, status, and any associated images or EOBs.

Incidents Tab : Captures any reported incidents related to fulfillment of a referral

IMPROVE DECISION-MAKING

SUPPORT FOR POINT-OF-SALE AUTHORIZATIONS

Verticē allows claims staff to manage pharmacy transactions at the point of sale (POS), providing context and right-time decision support when users are required to make authorization decisions.



POS Authorization Tool

This tool allows users to quickly approve or deny pharmacy transactions, providing key information to help claims staff make educated authorization decisions that promote safe and cost-effective drug therapy.

Each component of the POS Authorization tool details a different piece of prescription information that a user may wish to consider when deciding whether to approve or deny a transaction.

Benefits of POS Authorization Tool

- Presents all prescription history at claim level
- Immediate and easy access to complete prescription history including payments
- Ability to pull export data into common formats for use in claims reviews
- Quick access that does not require a separate reporting environment

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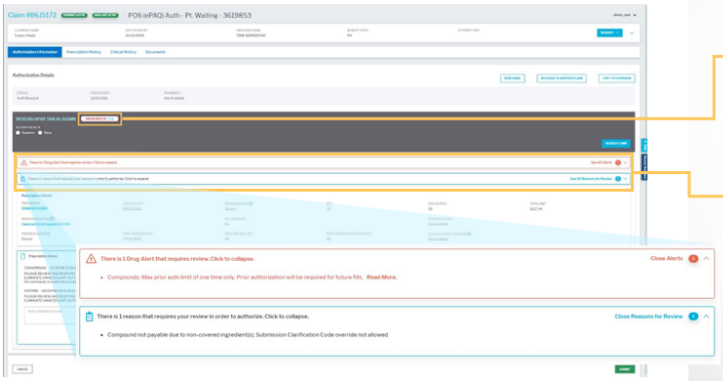
IMPROVE DECISION-MAKING

POS AUTHORIZATION FEATURES

A primary goal of our Verticē design for pharmacy management is to provide claims adjusters with the support they need to help drive timely authorization decisions that are consistent with our customers' formulary and program rules.

Our POS Authorization tool was designed based on extensive research to achieve this. It provides key information for a pharmacy transaction including:



MME

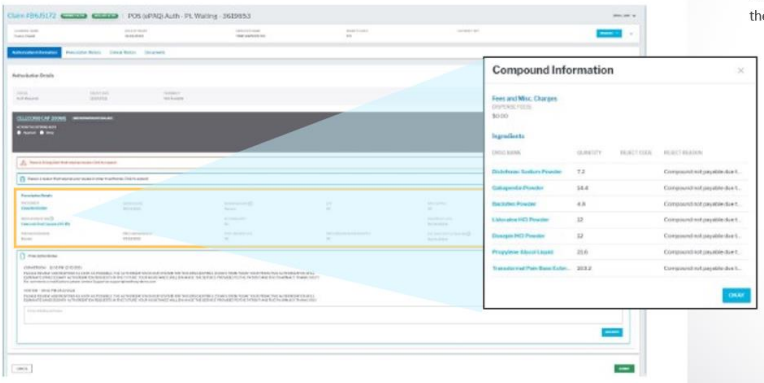
All opioid transactions will feature MME data that reflects opioid potency across individual prescriptions. This lets the adjuster know how approving the authorization would impact a claim's overall MME.

Drug Alerts and Reasons for Review

The adjuster will receive a notification when the prescribed therapy does not follow evidence-based guidelines, with explanations why therapy is being flagged and needs special attention. This includes explaining any program-specific rules that have triggered the alert on the transaction.

IMPROVE DECISION-MAKING

POS AUTHORIZATIONS FEATURES (CONT'D)



Prescription Details

Comprehensive prescription details provide greater context into the prescription, including:

- Medication Detail – Drug strength, AWP cost information, therapeutic class, generic name and availability
- Previous Decisions made for similar prescriptions, along with Previous Decision Dates, which can indicate patterns
- Federal DEA Class, giving visibility into controlled substances on a claim
- Estimated Days' Supply on Hand, which details how much medication a patient should still have. Requests for more medication than necessary could indicate problematic use

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Healthesystems Exhibit M:
Sample Training Documents

Prepared for: New York State Insurance Fund

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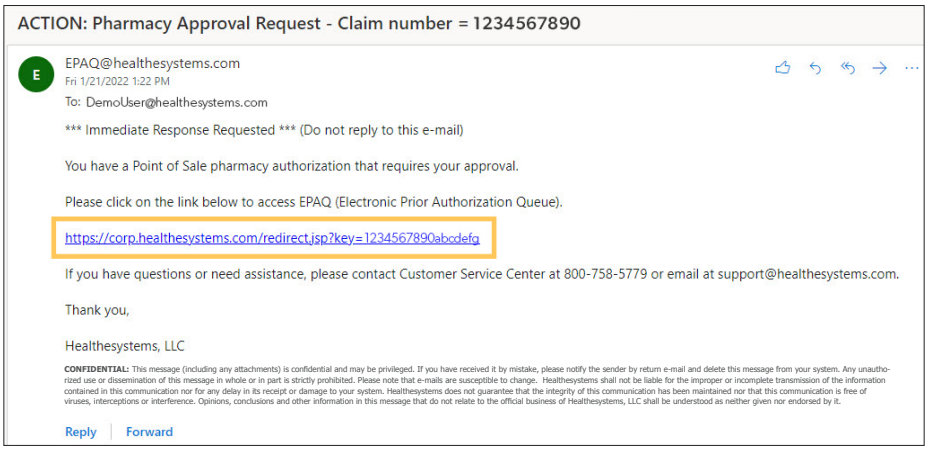
Verticē
Point of Sale (POS) Authorizations

The POS Authorization tool in Verticē makes approving and denying pharmacy transactions easier. Also known as the electronic prior authorization queue (ePAQ), POS Authorization delivers helpful information that assists in authorization decisions.

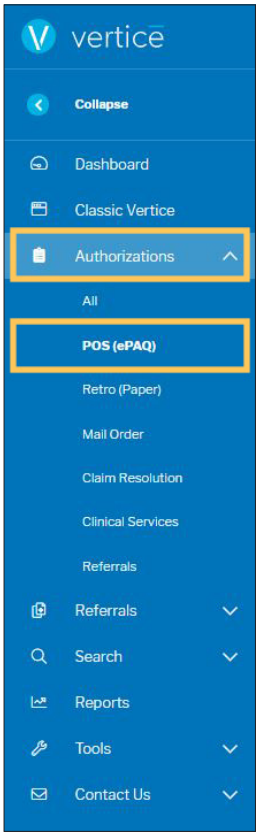
Access POS Authorizations

There are two ways to access POS Authorizations:

1. If your organization's business rule allows it, you may receive an email with a specific pharmacy authorization request. Click the link in the email to access the authorization in Verticē.



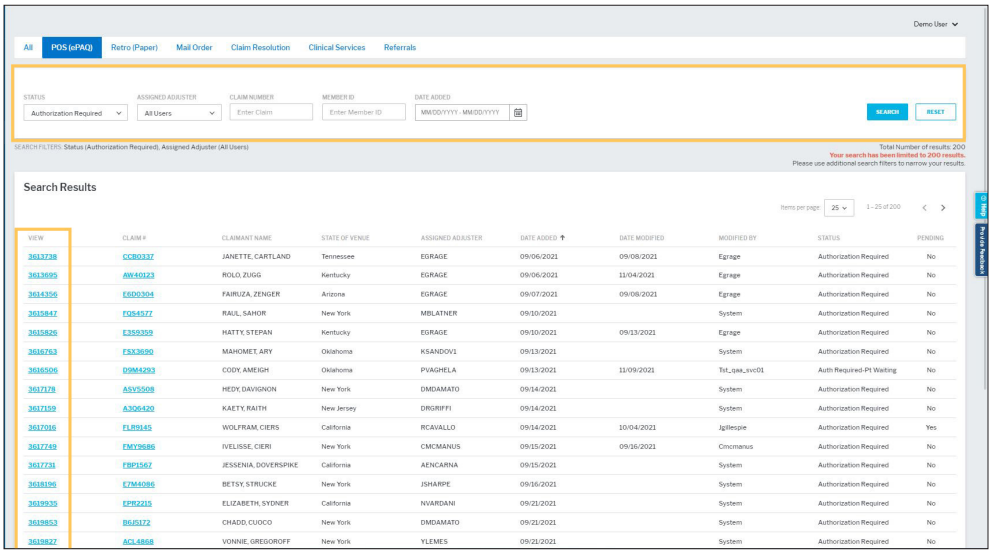
2. Search for an authorization using the Navigation Menu. Select **Authorizations**, then click on **POS (ePAQ).**



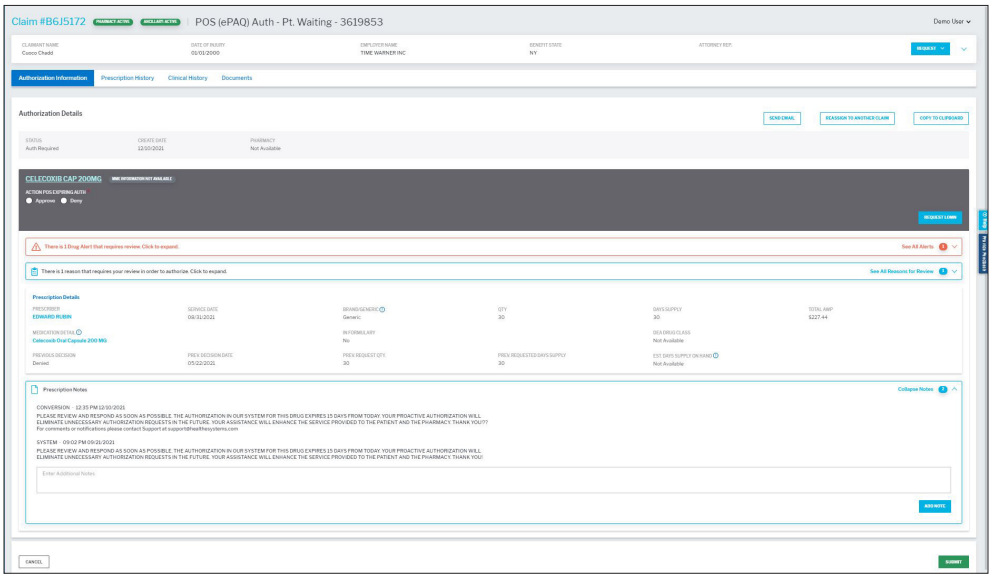
Verticē Point of Sale (POS) Authorizations

This screen displays all pending POS pharmacy authorizations tied to your claims. If necessary, use the search tool to narrow results. Please note that when using the search tools, results may include completed POS authorizations.

Upon locating the authorization, click the hyperlink under the **View** column.



Upon selecting an authorization, a screen like this will appear:



When accessing POS Authorizations, your screen will automatically default to the **Authorization Information** tab.

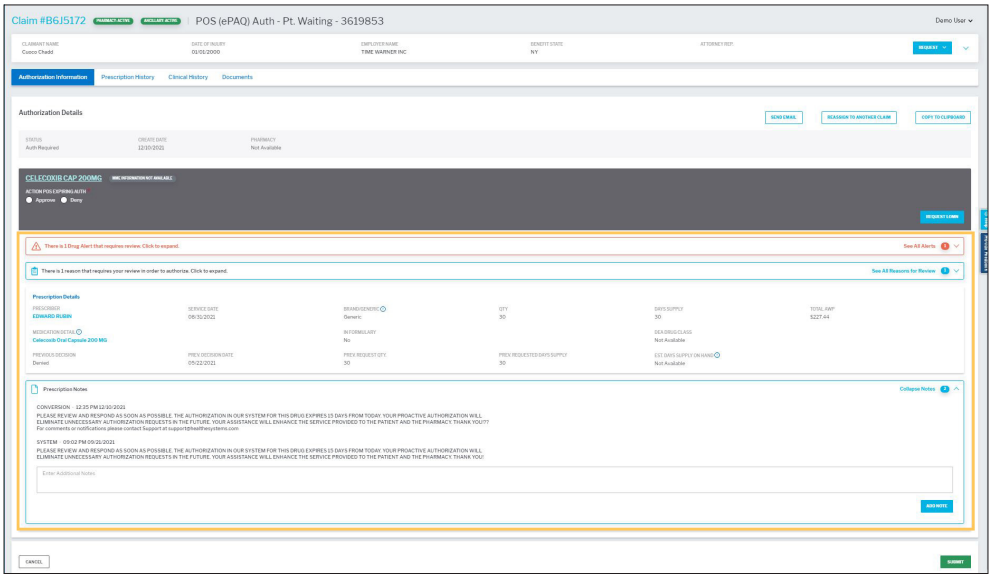
This main tab provides details regarding the prescription(s) that require authorization, and it is also where you can approve or deny the authorization request.

How to Review Prescription Information

The sections highlighted below give context on prescriptions, and this can help determine whether to approve or deny authorizations.

Please note, sometimes POS Authorizations will feature multiple drugs. If there are multiple drugs, make sure to scroll through the entire screen. Each individual drug will have a section to approve or deny the drug, displayed in a dark gray bar. Remember to review them all.

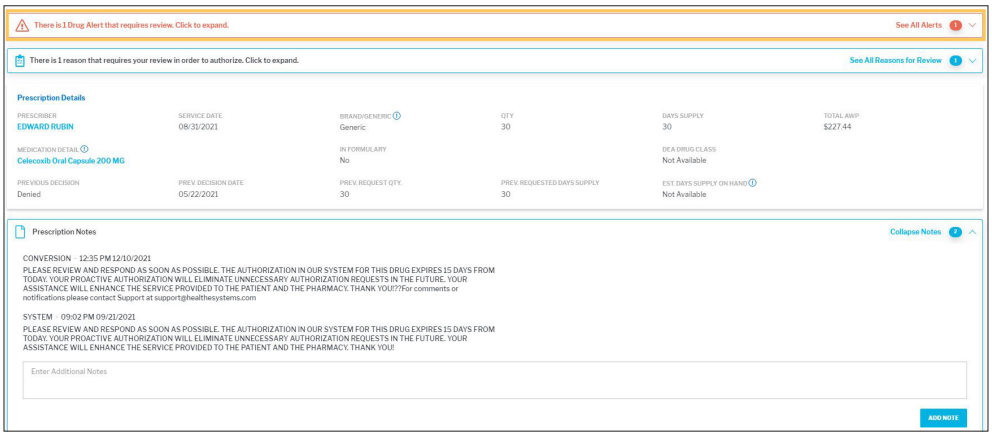
In this example, only one drug requires authorization.



Drug Alerts

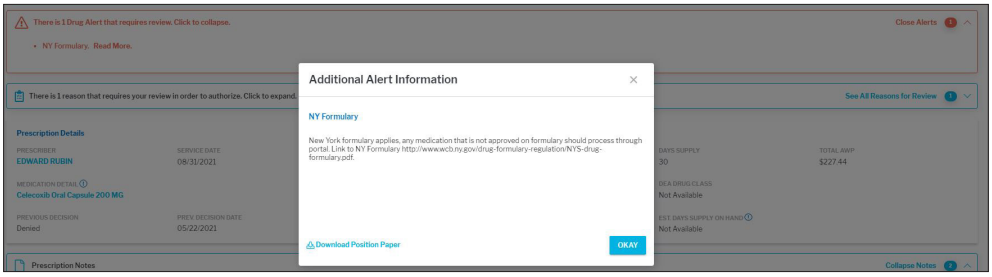
In some cases, a pharmacy authorization request may flag one or more Drug Alerts – notifications that drug therapy may not follow clinical guidelines, state regulations, safety considerations, or other concerns. These alerts will explain why therapy should be reconsidered.

To view the drug alert, click anywhere on the orange bar to expand this section and view more information. A list of specific drug alerts will state why the prescription was flagged.



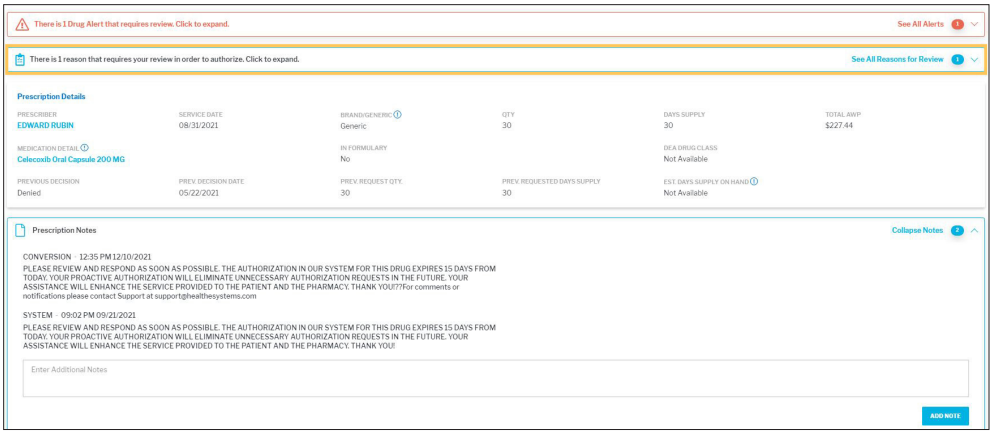
In this example, there is only 1 drug alert, but sometimes there can be more. Click on **Read More** for further information.

Depending on the alert, you may be able to download a Position Paper for further details. This will open a new tab with a PDF which explains a particular drug concern. You can also copy the information here for your notes. Click **Okay** to close this window.



Reason(s) for Review

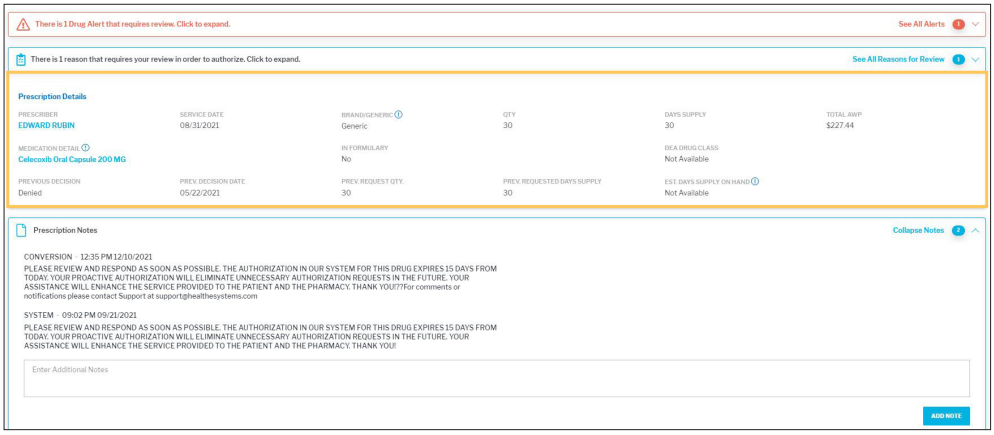
Every prescription within a POS Authorization will list the reason(s) a prescription requires your review. To view the reason(s), click anywhere on the blue bar highlighted here.



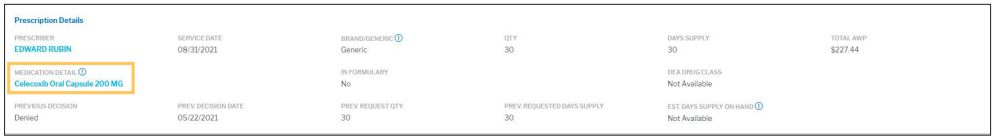
This will expand the **Reason(s) for Review** section with more information.

Prescription Details

This section provides specific information on the prescription in question. This includes prescriber name, medication details, previous decision for the drug, key dates, estimated days' supply of a drug on hand, and more.

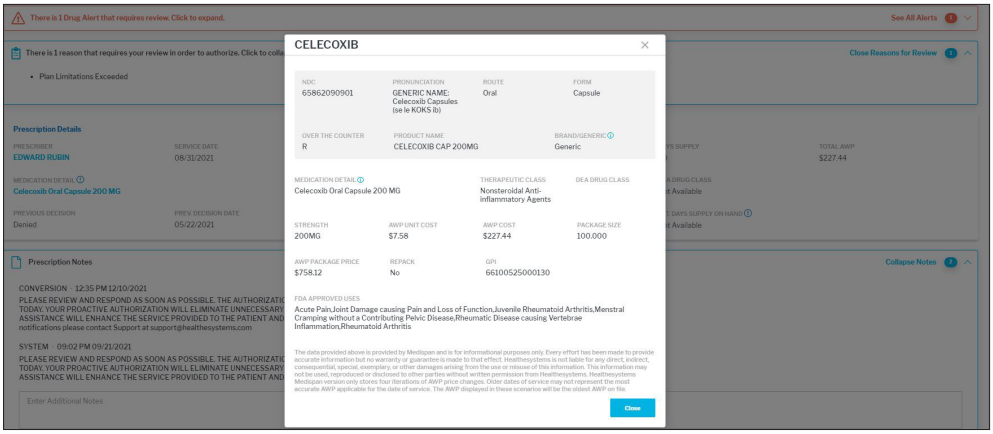


Some items within this section are hyperlinked in blue text. You can click these links for further details. For this example, see the **Medication Detail** section displayed below.



When you click on the link, a pop-up window opens with more information on this drug.

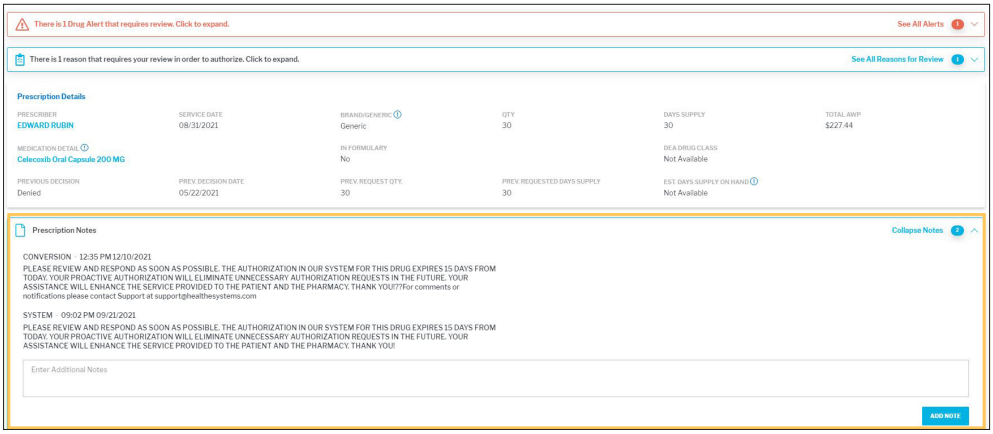
When you're finished reviewing, click **Close**.



Prescription Notes

This section displays the notes left on the POS Authorization by other stakeholders, typically from Healthe's customer service center.

If necessary, you can type your own notes into the text field and click **Add Note** to add them to the notes' history.

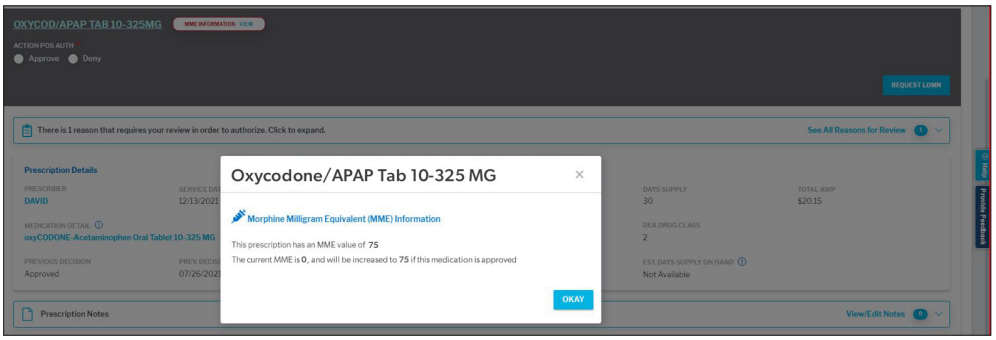


MME – For Opioids Only

Opioid pain medications come with inherent risks, even when used appropriately. Whenever an opioid medication requires authorization, the MME feature will be available.

MME – or morphine milligram equivalents – is an opioid dosage's equivalency to morphine. This measure is used to standardized opioid potency across different types of opioids. Individual opioid prescriptions have an MME, as does a patient's entire opioid regimen.

Clicking the MME button provides more information on the transaction's MME, and how it will impact your claimant's overall MME.



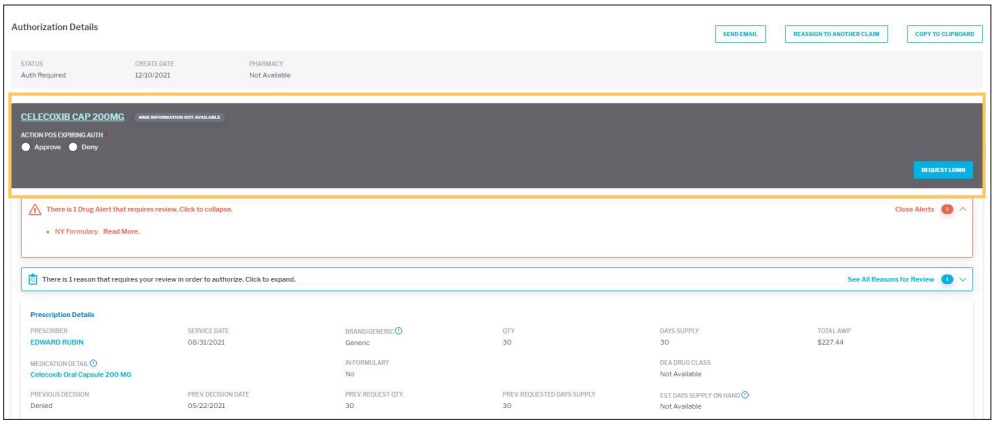
Verticē Point of Sale (POS) Authorizations

The Centers for Disease Control and Prevention (CDC) recommends reassessing opioid treatment before increasing dosage to 50 MME or more per day, and to avoid or carefully justify opioid titration to 90 MME or more per day.

Non-opioid transactions will not have the MME feature enabled.

How to Approve or Deny a POS Authorization

This is where you can choose to approve or deny a medication. Please note, **for authorization requests with multiple drugs**, you will see several individual authorization boxes, one for each prescription. For this example, there is only one medication that requires authorization.



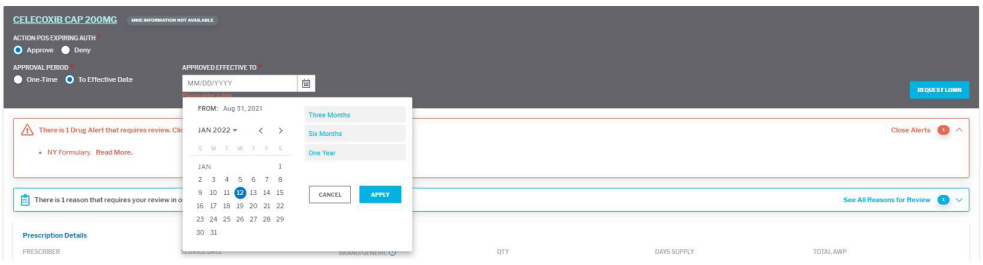
Approve an Authorization

When selecting the **Approve** button, you must then select whether this is a one-time approval or an approval with an effective date range.

If this is for is a one-time approval, click the **One-Time** button. To complete the authorization, click **Submit** at the bottom of the screen. This approves the single prescription.

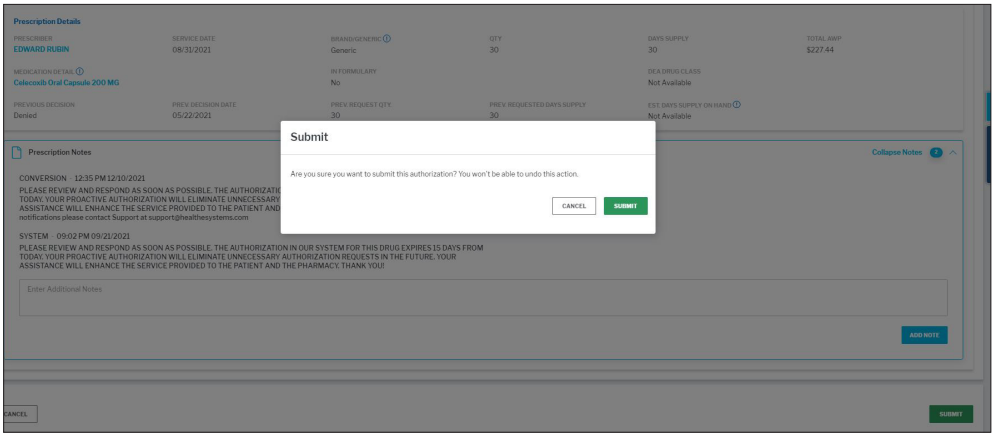
However, if you select **To Effective Date**, you will need to select a calendar date.

This means that the prescription in question would receive automatic approvals for refill or renewal requests – no longer requiring authorization – up to the date selected. Once you pick a date, click **Apply**. To finalize your decision, scroll to the bottom of the screen and click **Submit**.



A pop-up box will ask you to verify your decision. Once you finalize the authorization, this action cannot be undone.

After successfully completing the authorization, the authorization will disappear from your list of pending authorizations. You will then be redirected to the Authorizations page to view other pending authorizations.



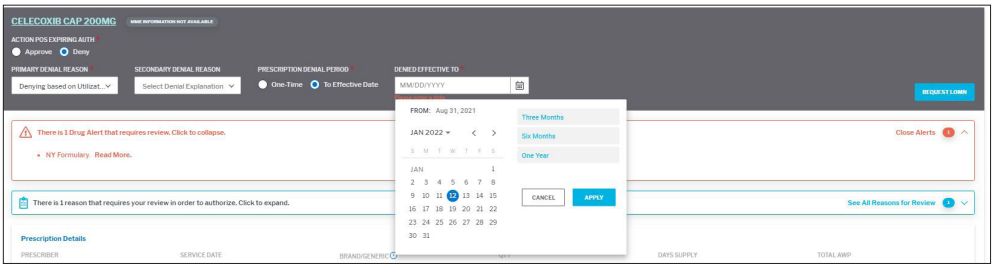
Deny an Authorization

If you select the **Deny** option, your screen will look like this:

Depending on your organization's business rules, you may have to select **Denial Reasons**. Select a **Primary Denial Reason** from the dropdown menu to deny the medication. You may also select a **Secondary Denial Reason**. The dropdown menus for these two items are identical. Only the **Primary Denial Reason** is required, but the secondary dropdown menu can be used to note multiple concerns.

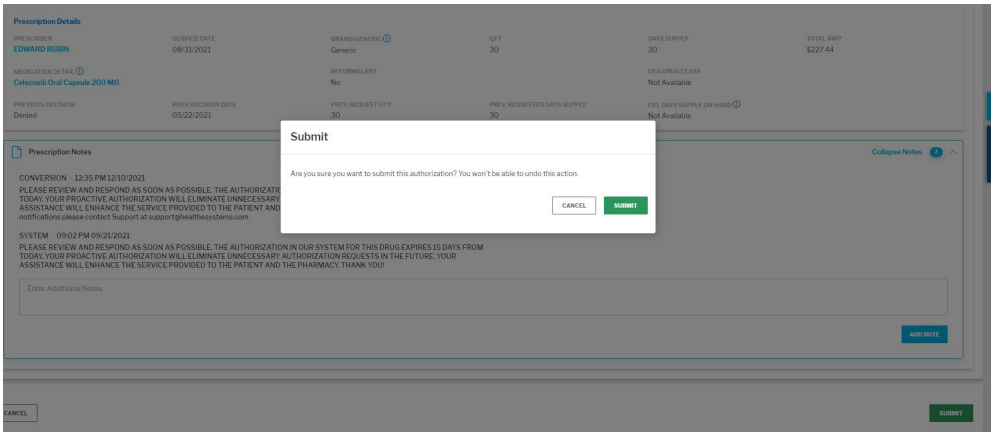
After settling denial reason(s), decide if this is a one-time denial or a denial with an effective date range. If it is a one-time denial, click the **One-Time** button, then click **Submit** at the bottom of the screen.

However, if you select **To Effective Date**, you will need to select a calendar date.



Selecting this option means that the drug in question will receive automatic denials for any other attempts to process the transaction – no longer requiring authorization – up to the date you selected. Once you pick a date, click **Apply**. To finalize your decision, scroll to the bottom of the screen and click **Submit**.

A pop-up box will ask you to verify your decision. Once you finalize the authorization, the action cannot be undone.



After successfully completing the authorization, the authorization will disappear from your list of pending authorizations. You will then be redirected to the Authorizations page to view other pending authorizations.

How to Send an LOMN

The Letters of Medical Necessity (LOMN) tool allows you to quickly and easily request additional information from the prescribing physician to understand why a prescription is medically necessary.

When to Use the LOMN Tool

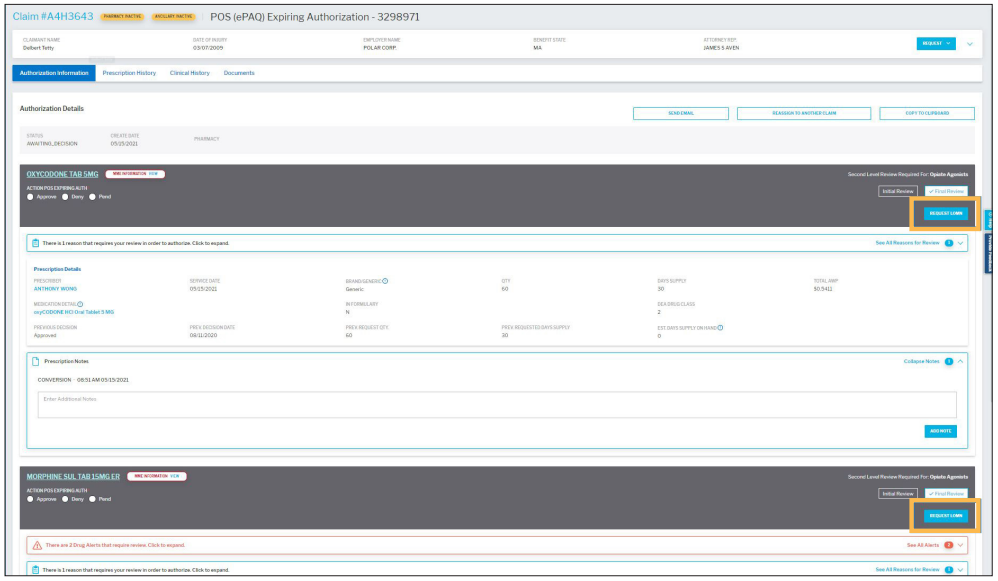
LOMNs can be sent for any pharmacy authorization unless state law or business rules determine otherwise. It is up to your discretion as a claims professional whether or not to send an LOMN, based on claim details.

LOMNs can be used:

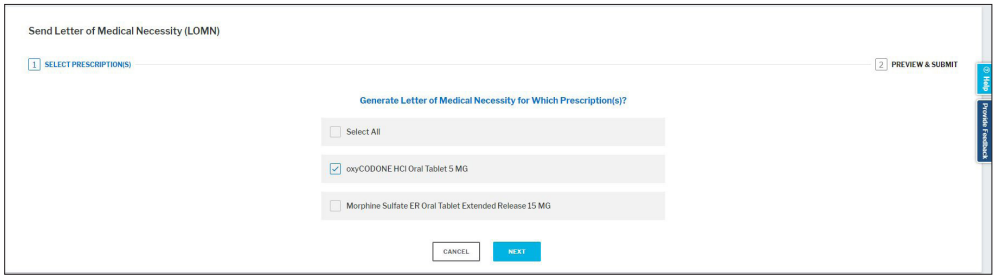
- To question the relationship of a drug to an injury
- In response to Healthe's Drug Alerts or Clinical Strategy alerts
- In response to state regulations
- For any other reason a claims professional questions the medical justification for a particular medication

Our LOMN tool creates the request and sends it to the prescribing physician. While prescribers are not required to reply to LOMNs, the delivery of an LOMN informs prescribers that their prescriptions are being monitored, and this can influence their prescribing patterns going forward. Healthe tracks the rate at which LOMNs succeed in changing prescriptions.

When reviewing a pharmacy authorization, use this feature by clicking on the **Request LOMN** box present on each drug authorization request, as highlighted here.



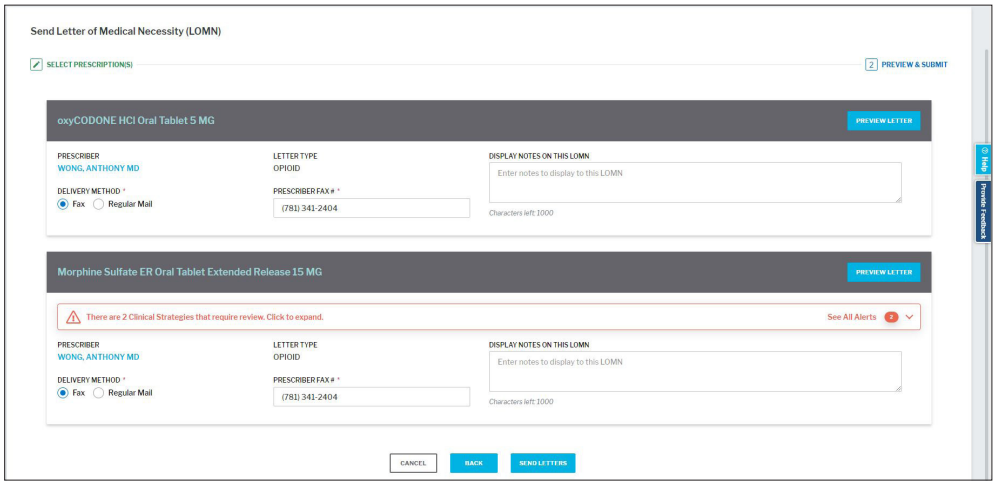
This will generate a pop-up window.



This screen displays a list of all the drugs listed on the pharmacy authorization. The drug for which you selected the LOMN option will automatically be selected, but you can select as many medications as needed. For each drug selected, an individual LOMN will be created.

For this example, we are selecting both drugs. After selections are made, click **Next**. You should now see a screen like this:

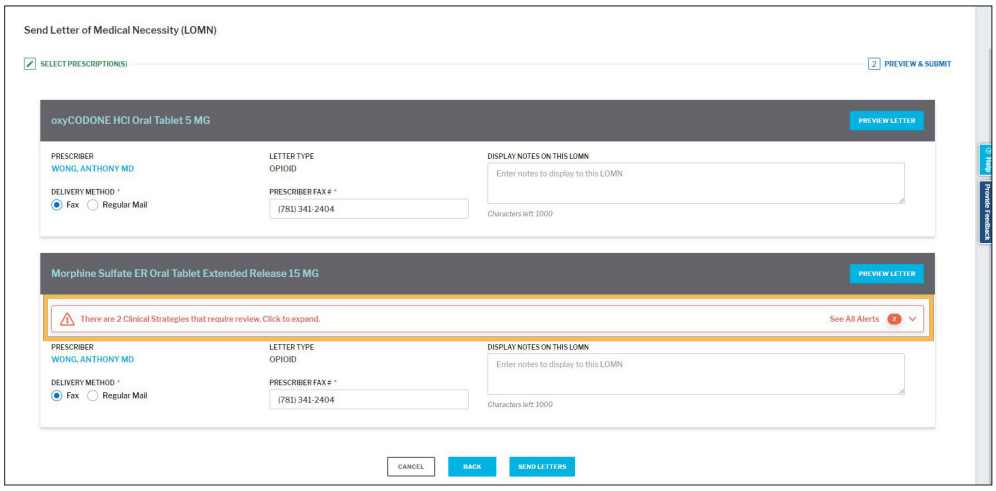
For each drug selected, you will see prescriber information, letter type, and other details. Before sending the LOMN, it is important to review a few items on this screen.



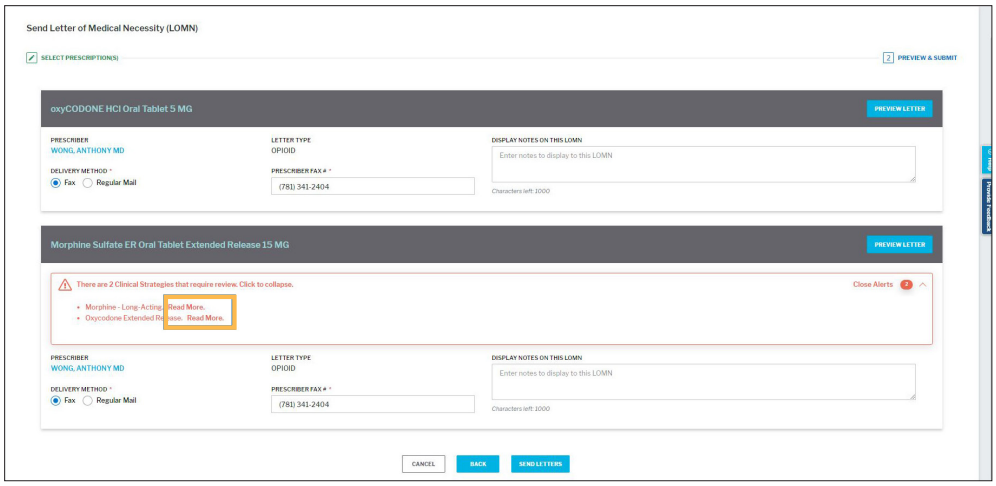
Clinical Strategy Alerts

In some cases, a pharmacy authorization request may flag a Clinical Strategy alert – notifications that drug therapy is not following evidence-based guidelines and why therapy should be reconsidered – as seen below:

Clicking on this will open a dropdown menu with reasons why the prescription was flagged.

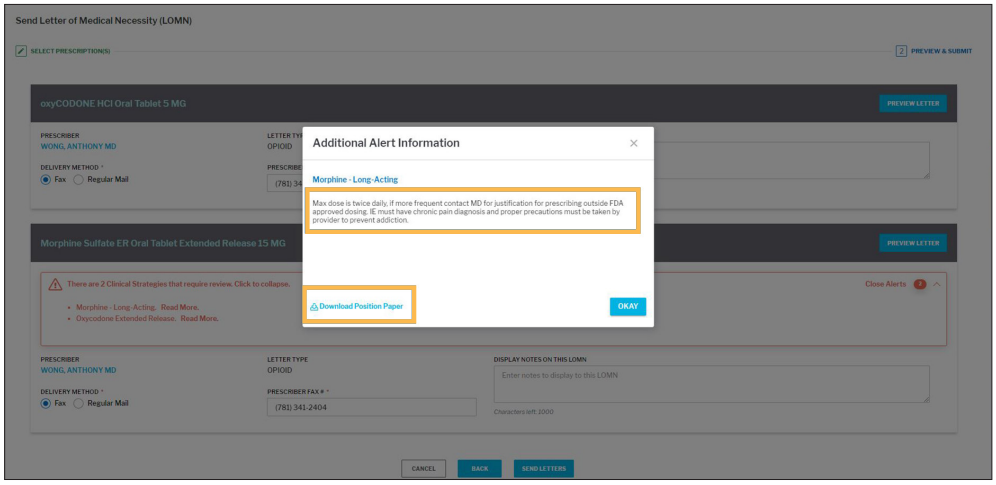


For each reason listed, there is a **Read More** link – this will generate a pop-up window with more information.



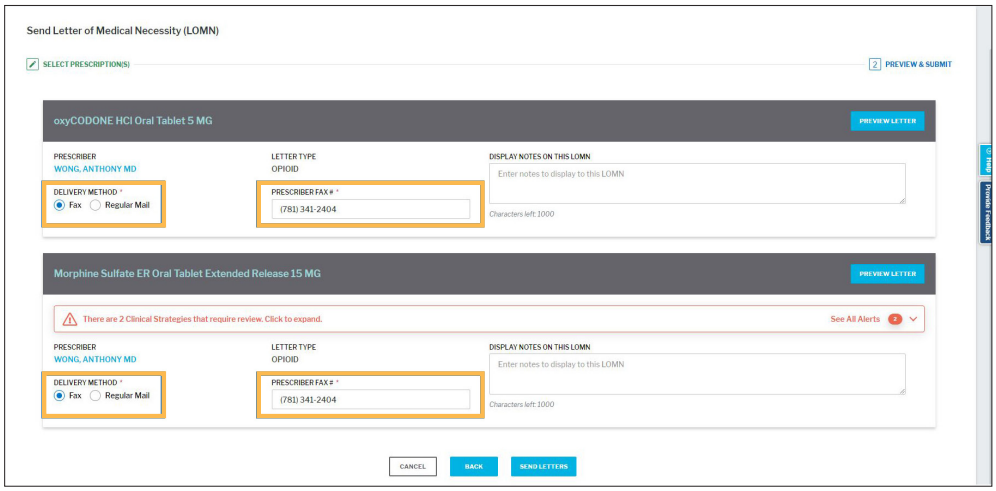
The information contained within this alert can be copy-and-pasted to the notes section if you'd like to provide the prescribing physician with a reason why you are requesting an LOMN.

For more information on the alert, click **Download Position Paper**. This will open a new tab with a copy of the Position Paper, which goes into more detail about the particular medical concern that the prescription in question raises.

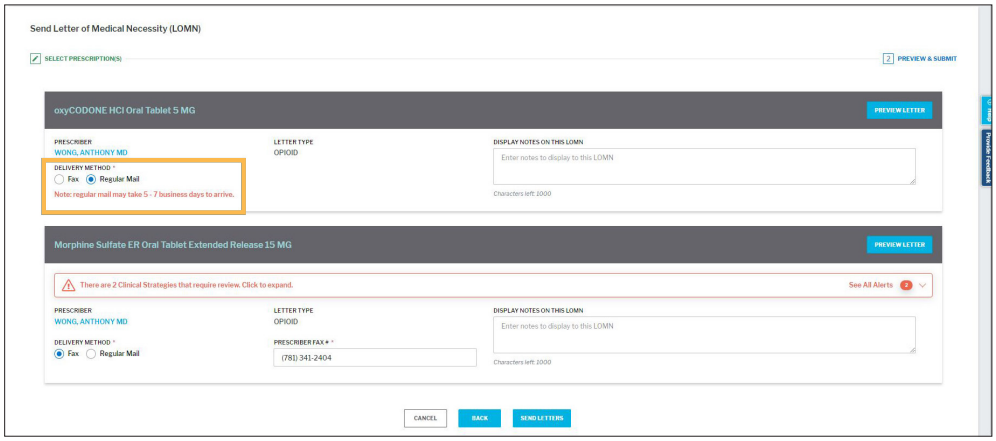


Fax or Mail

The LOMN tool automatically defaults to sending the prescribing physician a fax of the LOMN, and this requires the prescriber's fax number. The fax number can be changed, but a valid fax number is required to continue. You can choose to send the LOMN via regular mail by selecting that option as highlighted here.



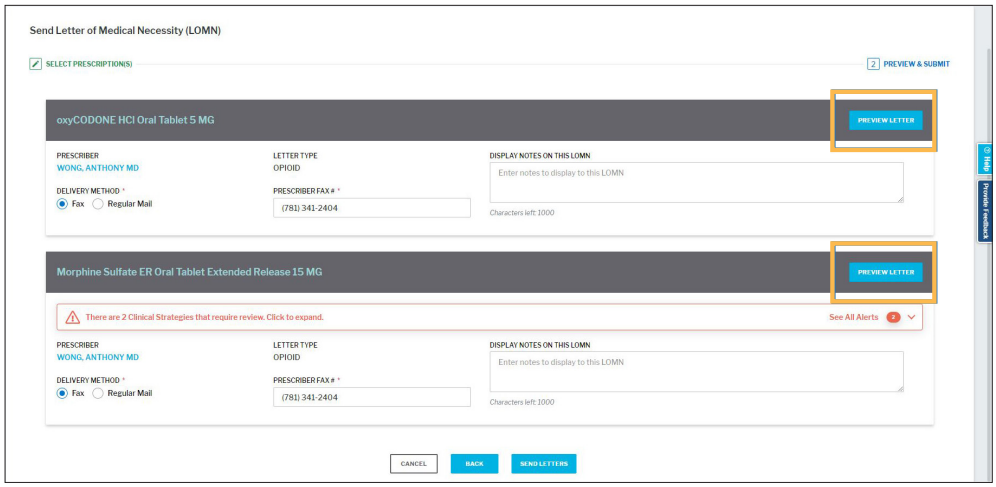
If selecting the **Regular Mail** option for an LOMN, a notification will state the LOMN may take 5-7 business days to arrive.



Preview the LOMN

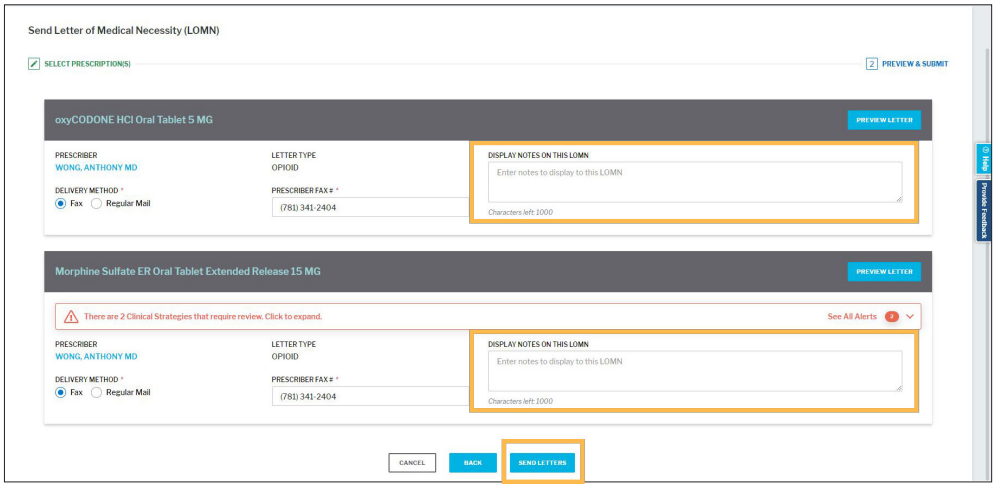
When you're almost ready to send out your LOMN(s), you can preview the letter(s) by clicking on any of the **Preview Letter** buttons.

This button will open a new tab with a preview copy of the letter.



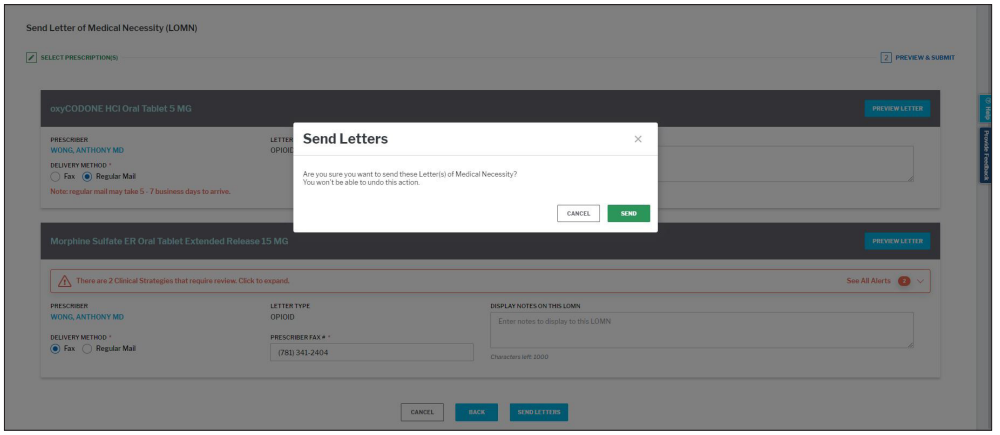
Send the Letters

To submit the request for an LOMN, fill out the notes section with any relevant questions or information, and then click **Send Letter**s.

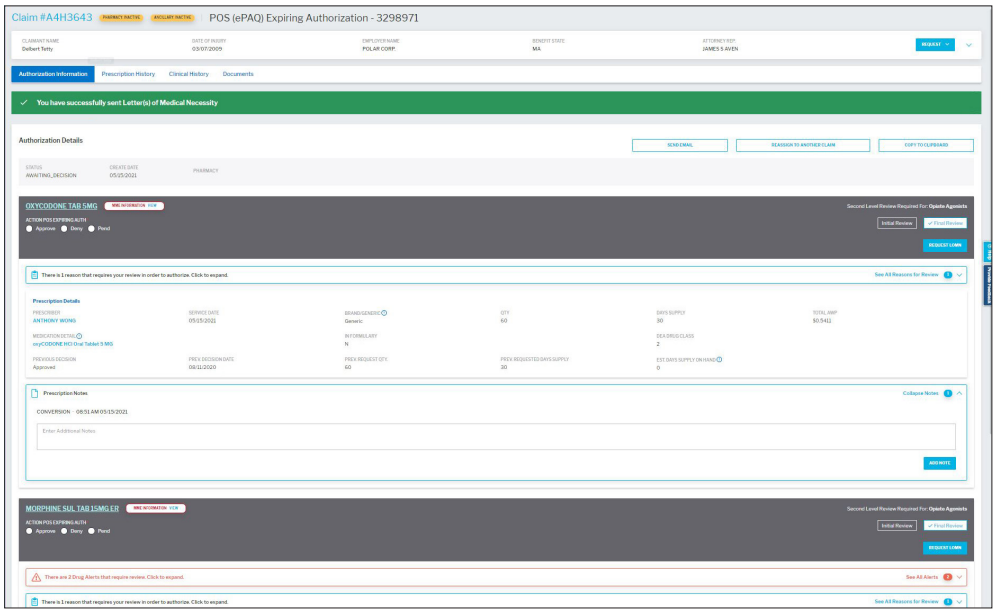


A pop-up window will ask you to confirm your decision.

Make sure you have properly filled out your request prior to sending out the LOMN(s). Once you send a letter, it cannot be undone.



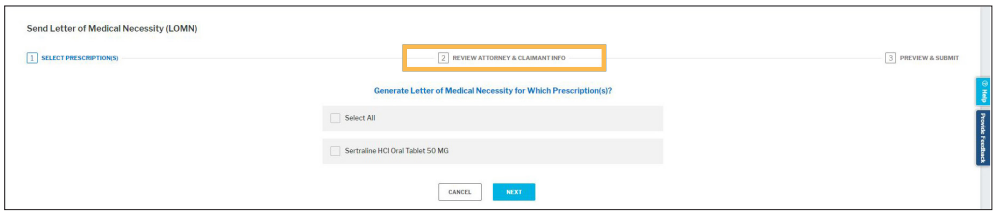
After submitting the letter, you will return to the pharmacy authorization screen, with a green notification bar indicating that your action was recorded.



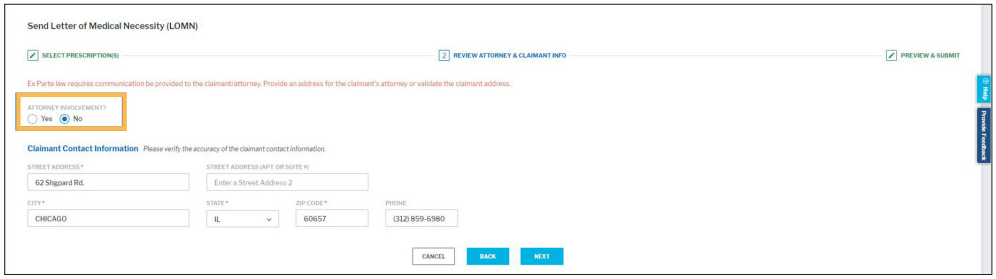
An Extra Step for Ex Parte States

In some states you are legally required to send a copy of the LOMN to the claimant, as well as any attorneys representing the claimant. For pharmacy authorizations in these states, there is an extra step in the LOMN process.

Like other LOMNs, select which drugs to create an LOMN for, then click **Next**.

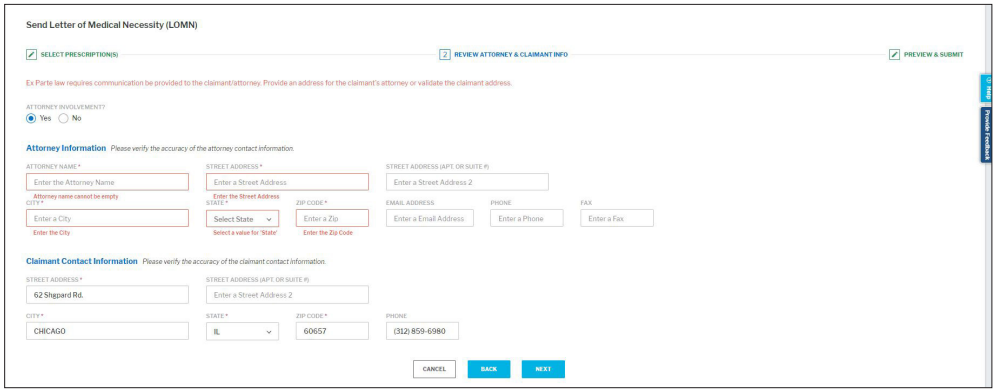


Now on step 2 you will see a screen like this:



Verify the claimant information, as they will receive a copy of the LOMN in the mail. However, if an attorney is involved in the claim, you must select "Yes" in the **Attorney Involvement** section highlighted above.

Doing this will expand the screen, requiring you to enter contact information for the attorney:

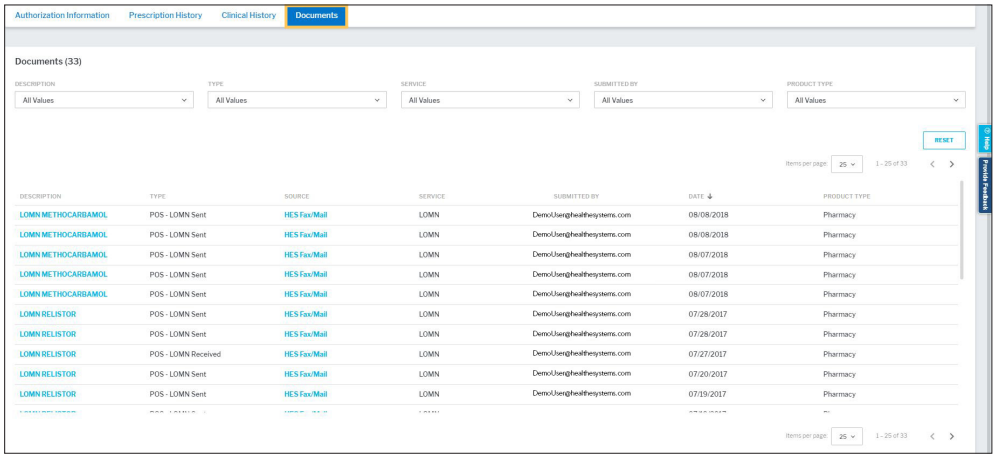


Once you have all contact information properly verified, click **Next**. Then the process will continue exactly like other LOMNs.

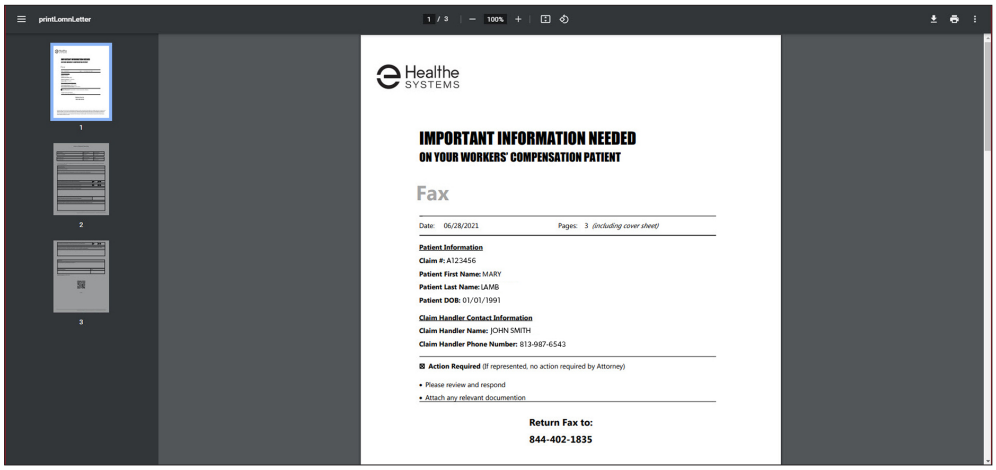
Access Previous LOMNs

To access any previous LOMNs that were sent out for you claims, click on the Documents Tab at the top of the screen.

This will display a list of claims-related documents, which will include LOMNs sent, as well as any responses that prescribers send back to Healthe.

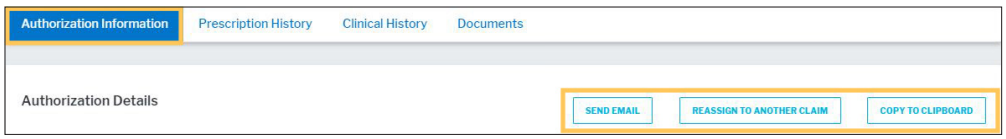


Click on the hyperlink for an LOMN and a new tab will open with a PDF copy of the LOMN.



Additional Features

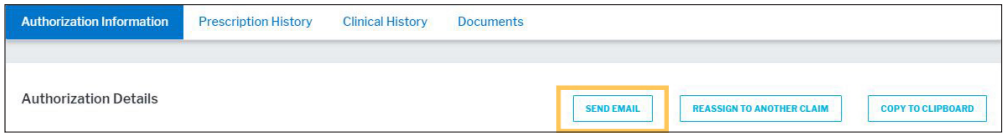
Within the **Authorization Information Tab** are three additional buttons that can assist you when servicing an Authorization.



Forward an Authorization to a Colleague

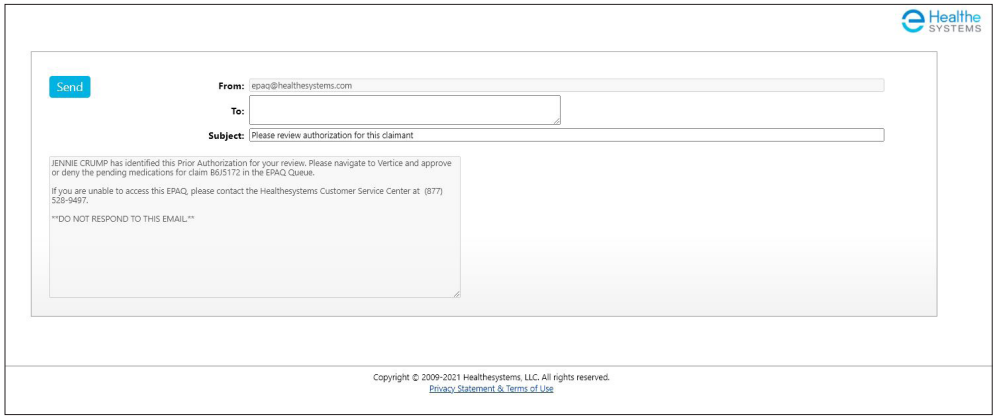
This button will send the authorization to another claims professional on your team. This can be used if you require help with an authorization, if a claim should not be assigned to you, or to remind someone else they must action the claim.

To use this feature, first click on the **Send Email** button.



A pop-up window will appear, generating an email to forward the Authorization to a colleague.

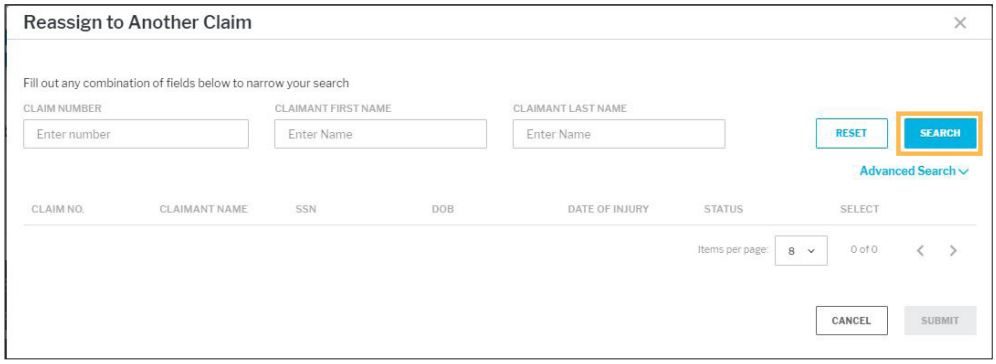
Enter an email address in the **To** field, then click **Send**.



Reassign an Authorization to Another Claim

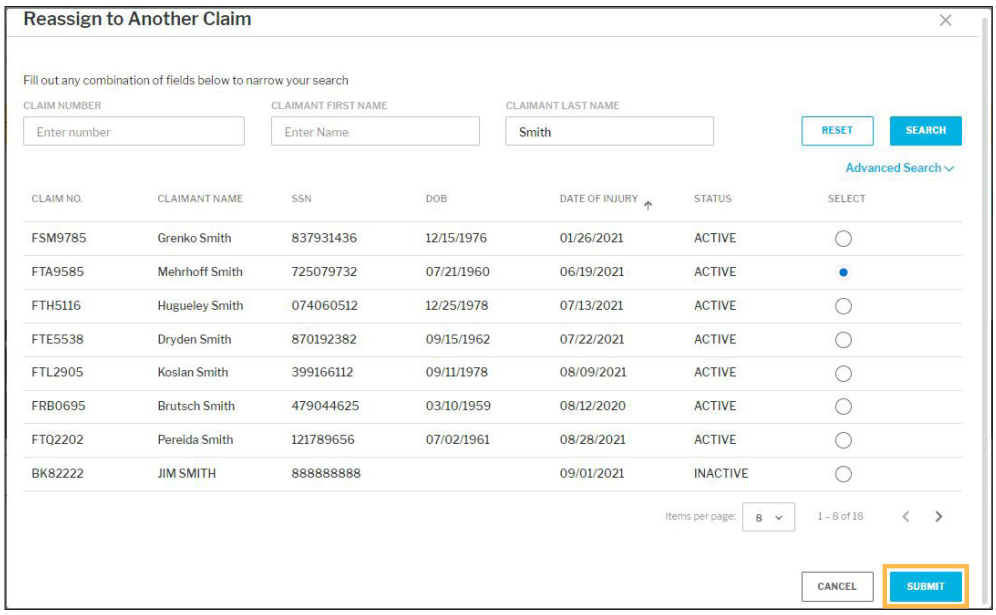
If you review an Authorization and believe that it is tied to the wrong claim, you can assign it to the proper claim by clicking **Reassign to Another Claim.**

This generates a pop-up window where you may search for other claims to reassign the Authorization to. Enter information into search criteria and click **Search**.



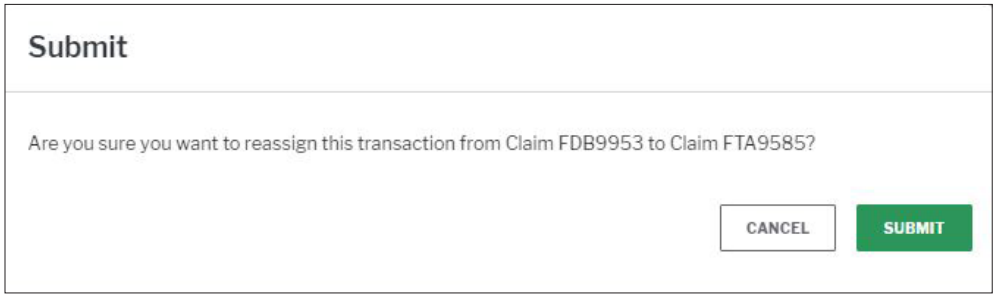
From the search results, locate the correct claim and then click the button under the **Select** column.

You will then be able to click **Submit** to reassign the Authorization.



A verification window will ask you to finalize your reassignment.

This action cannot be undone, so make sure you are certain before reassigning the Authorization. Once this is complete, your screen will verify that the reassignment was successful, and the Authorization will no longer be present.



Copy to Clipboard

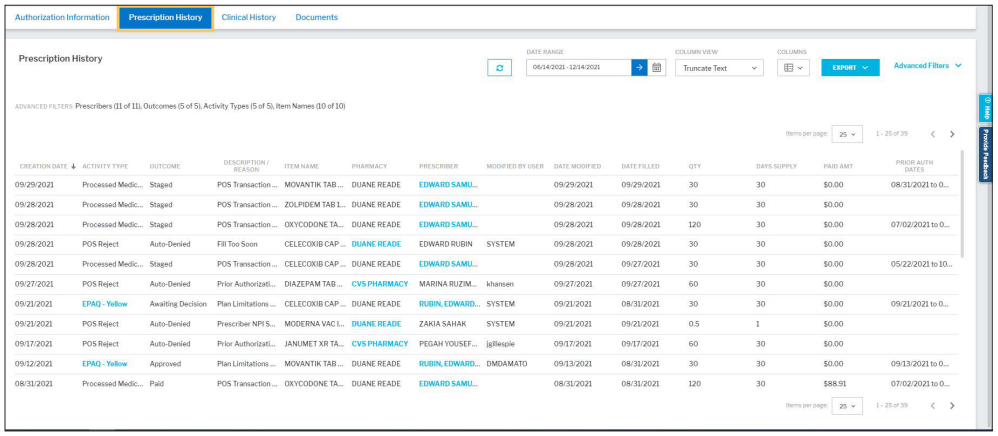
If you need to save authorization information for your own notes, click **Copy to Clipboard**.

This will save all authorization information into your clipboard so you may paste it elsewhere, similar to other tools. Please be aware that no special messages will confirm this. If there are multiple drugs in an authorization, all drug information will be included.

Prescription History Tab

The **Prescription History Tab** lists all the prescriptions that have been prescribed to a claimant, including prescriptions that were denied.

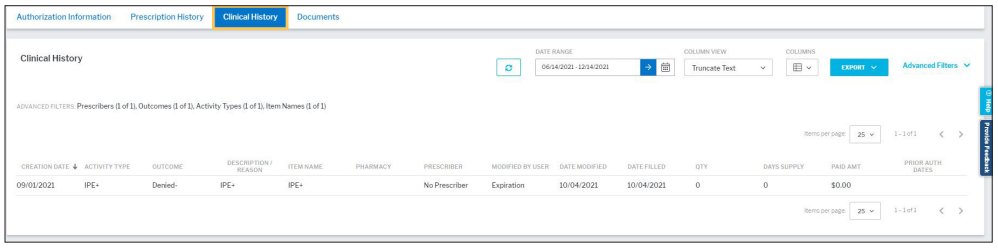
You may click on any available hyperlinks (shown in blue) for further information on the pharmacy transaction, medication information, pharmacy details, prescriber information, and more.



Clinical History Tab

This tab displays all clinical items that have been sent regarding the claimant's treatment. This includes Independent Pharmacotherapy Evaluations (IPEs and IPE+), therapeutic alert (TA) letters, and Letters of Medical Necessity (LOMNs).

You may click on any of the available hyperlinks to view more information.

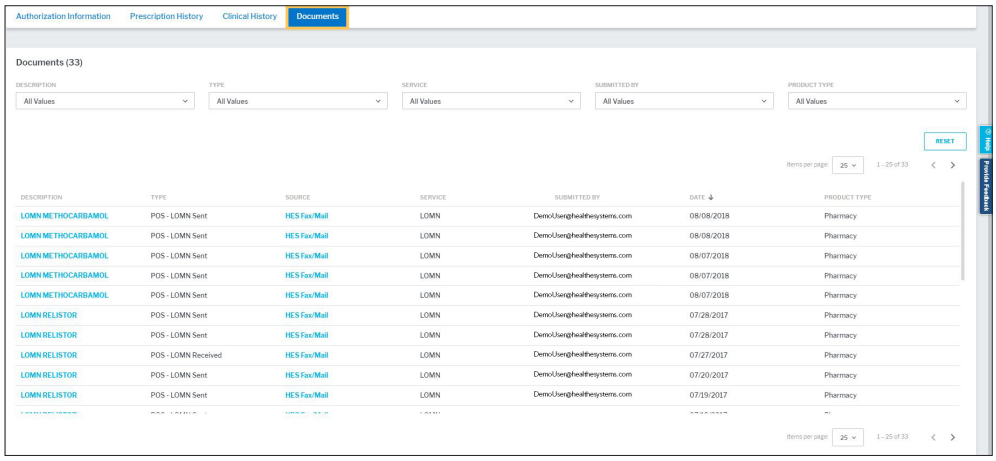


Verticē Point of Sale (POS) Authorizations

Documents Tab

To view any documents tied to the claim or Authorization, click on the **Documents** tab at the top of the screen. Documents on this screen can include LOMNs sent, LOMN responses that prescribers send back to Healthe, Paper Bills, and more.

You may click on any of the available hyperlinks to view more information.



Further Assistance

If you have any unanswered questions regarding POS Authorizations, please email VerticeHelp@healthesystems.com and we will do our best to clarify your concerns.

Also, don't forget about the **Feedback** tab. If you have any suggestions, issues, or ideas on how Verticē can better serve you, let us know by clicking this tab in Vertice. Don't forge to include your email address so we can address your concern. We're always eager to improve our program, and your insights can help make a difference.

Ongoing Support

Website

Website and Login:
corp.healthesystems.com

Healthesystems BIN# 012874

Customer Service Center

Contact the Customer Service Center
800.758.5779

Email
support@healthesystems.com

- Urgent Requests/Live Person
- All Pharmacy Matters
- Updating an Injured Worker Profile
- Explanation of Benefits
- Immediate termination of a claim

Clinical Services

Contact Clinical Services
866.646.2838

Email
druginformation@healthesystems.com

Use the Ask a Pharmacist feature on the My Tools tab.

- Explanation of Drug Plan Coverage
- Claimant related medication questions
- Pharmacist claim support

Verticē
LOMN Comment Support

Below are examples of questions that could be considered for use in the comment section of LOMNs.

Questions that can be used for all physician-dispensed medications:

- Is this an FDA-approved medication?
- Is this medication available in retail or mail order pharmacies?
- Is there a clinical reason that would prevent the patient from using a retail or mail order pharmacy? If so, please explain.

In the comments to the provider, note that the injured worker can still receive a prescription for an OTC and have the pharmacy process it at a local pharmacy.

Medication-specific questions:

Private-label topical (PLT):

- Is this an FDA-approved medication?
- What are the documented clinical reasons that prevent this patient from using a similar OTC or prescription products? Please explain.
- Indicate any similar OTC or prescription products that have been previously tried and the outcomes of each.

In the comments to the provider, note that the injured worker can still receive a prescription for an OTC and have the pharmacy process it at a local pharmacy.

Lidocaine:

- What are the documented clinical reasons that prevent this patient from using a similar OTC or prescription products? Please explain.

In the comments to the provider, note that the injured worker can still receive a prescription for an OTC and have the pharmacy process it at a local pharmacy.

Cyclobenzaprine 7.5mg:

- Has the patient been prescribed the 5mg or 10mg cyclobenzaprine tablets?
- If yes, why were they discontinued?
- What are the documented clinical reasons that prevent this patient from using a similar 5mg or 10mg product? Please explain.

In the comments to the provider, note that the injured worker can still receive a prescription for an OTC and have the pharmacy process it at a local pharmacy.

Diclofenac 3%:

- Does the patient have a clinical condition that prevents the use of an OTC or prescription oral NSAID? If so, please explain.
- Is the patient using this to treat actinic keratosis (condition for which diclofenac 3% is indicated)?
- Has the patient been prescribed a trial of diclofenac 1% gel? Please explain.

In the comments to the provider, note that the injured worker can still receive a prescription for an OTC and have the pharmacy process it at a local pharmacy.

Diclofenac 1.5%:

- Does the patient have a clinical condition that prevents the use of an OTC or prescription oral NSAID? If so, please explain.
- Has the patient been prescribed a trial of diclofenac 1% gel? Please explain.

In the comments to the provider, note that the injured worker can still receive a prescription for an OTC and have the pharmacy process it at a local pharmacy.

Ongoing Support and Service Incidents

Call the Healthesystems Customer Service Center
800.758.5779

Email
support@healthesystems.com

Healthe SYSTEMS

Transforming healthcare.

Healthesystems Exhibit L:
Therapeutic Alert and Medical Necessity Letters

Prepared for: New York State Insurance Fund

Kristi Klecka
National Sales Director
813-463-1269
kklecka@healthesystems.com
www.healthesystems.com

October 28, 2022

Therapeutic Alert # 1234567XXX_9876543210_XXX_01
re: JOHN DOE, DOB 05/23/81
Claim Number 1234567

Provider: DRJOHN DRDOE
456 MAIN STREET
ANYTOWN, US 123456789

High-Risk Opioid Use

Dear **Prescriber**,

Healthesystems is working with **CustomerName** to provide certain pharmacy benefit-related services in connection with workers' compensation claims. After reviewing recent opioid prescription transactions for **JOHN DOE, DOB 05/23/81**, we believe that **this patient's therapy warrants re-evaluation.**

The Centers for Disease Control (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain states that many patients do not experience benefit in pain management or functional improvement from increasing opioid dosages to ≥50 MME/day but are exposed to progressively increased patient safety risks as dosage increases.

The use of non-pharmacologic and non-opioid pharmacologic therapies should be maximized prior to initiation of opioids. If opioids are deemed necessary, the following measures are recommended:

- Utilize the lowest effective dose for the shortest duration possible.
- Carefully evaluate the benefits and risks of opioids within 1–4 weeks of starting long-term opioid therapy or of dosage escalation and document discussion with patient. If benefits do not outweigh risks of continued opioid therapy, optimize other therapies, and work closely with patient to gradually taper and/or discontinue opioids, if appropriate.
- Mitigate risk of opioid therapy by utilizing information from state prescription drug monitoring program (PDMP) and toxicology results to discuss expectations and to improve patient safety.
- Exercise particular caution when co-prescribing opioids with benzodiazepines and other central nervous system (CNS) depressants, including alcohol, muscle relaxants, nonbenzodiazepine sedative hypnotics, and potentially sedating anticonvulsant medications such as gabapentin and pregabalin, while documenting benefits and risks. [1]

Opioid prescriptions contributing to Claim MME:

Date	Medication Name	Qty	Pharmacy Name	Prescriber Name
08/04/22	PRODUCT1	30	BOB'S PHARMACY	DRJOHN DOE

Note: Transaction data displayed in this letter is based on current information provided to Healthesystems for this claim. Transactions (reversals and deletions) occurring after the generation of this letter may change the accuracy of the information reported above.

5404 Cypress Center Dr, Suite 210 :: Tampa, FL 33609 :: p: 866.646.2838 :: f: 866.506.3670 :: www.healthesystems.com

We appreciate your time and attention to the information contained in this report. Your response to this Therapeutic Alert is very important. Please complete and fax the enclosed Confidential Provider Response Form to (866) 506-3670 as soon as possible. If you would like more information or wish to discuss patient-specific clinical alternatives, please contact Clinical Services at (866) 646-2838 or e-mail druginformation@healthesystems.com.

Respectfully,

Clinical Services Division

Healthesystems

cc:

REFERENCES

[1] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a. Accessed December 13,2022.

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THERAPEUTIC ALERT
CONFIDENTIAL PROVIDER RESPONSE FORM

To ensure confidentiality, please fax this feedback form to (866) 506-3670.
Your patient is identified by: Therapeutic Alert 1234567XXX_9876543210_XXX_01
Alert Letter: High-Risk Opioid Use

I have received and reviewed the above referenced High-Risk Opioid Use regarding my patient and have provided my initial feedback below. If appropriate, I have also enclosed additional information (e.g., more detailed diagnosis, laboratory results, consultations, literature references) that may be helpful to **CustomerName** with respect to this matter.

(Check all that apply)

□ I am providing documentation of the risk/benefit assessment(s) discussed with the patient.

□ I am providing documentation of the non-pharmacological and non-opioid pharmacological agents that have been maximized/optimized for this patient

□ I am providing the documentation of PDMP and toxicology review and discussions with patient.

□ I would like to report suspected abuse or diversion.

□ I have written a prescription for this patient, not limited to any location, but not for a work-related illness or injury.

□ I have written a prescription for this patient in the past, not limited to any location, but am not currently treating this patient for work-related illness or injury.

For internal quality management, also indicate below whether you found the information in this Therapeutic Alert to be helpful in connection with this patient's care.

□ Helpful □ Not helpful □ No opinion

Comments:

Signature:_____ **Date:**_____

DR JOHN DOE

5404 Cypress Center Dr, Suite 210 :: Tampa, FL 33609 :: p: 866.646.2838 :: f: 866.506.3670 :: www.healthesystems.com

Letter of Medical Necessity for **Opioid Therapy**

Patient Name:	Claim Number:	Date of Birth:
Prescriber Name:	**Phone Number:**	**NPI:**

Item(s)/Service(s)		
What is the rationale for initiating new opioid therapy?		
If proposing to continue opioid therapy beyond the acute phase, please provide clinical rationale for medical necessity.		
List other treatment that has already been provided to reduce pain (medications and non-medication therapies):		
Is the patient taking, seeking, or obtaining ANY other mood-modifying medications, including pain relievers, muscle relaxants, or sedatives/hypnotics? If YES, please list below.	☐ **Yes**	☐ **No**
Have you used screening tools to determine the patient's risk for drug abuse? **If YES, please describe screening tool used, the date administered, and provide a brief summary of results.**	☐ **Yes**	☐ **No**
Does the patient request early refills, ask for replacement of lost medication or prescriptions, insist on brand-name or specific products, resist switching to non-opioid analgesics, or demonstrate other signs of potential addiction or drug abuse? If YES, please describe.	☐ **Yes**	☐ **No**

Letter of Medical Necessity for **Opioid Therapy**

Is a signed agreement in place regarding opioid therapy? **If YES, how often is this reviewed with the patient?**	☐ **Yes**	☐ **No**
Is the patient subject to random laboratory-confirmed urine, blood, or saliva testing to verify compliance with this medication regimen? **If YES, describe test type, dates, and results, or attach lab reports.**	☐ **Yes**	☐ **No**
Has the patient exhibited a significant improvement in function as a result of opioid therapy?	☐ **Yes**	☐ **No**
What objective measures are being used to document improvement?		
List functional improvements observed as a result of opioid therapy:		
Does the patient attend and participate fully in any other pain treatment programs which may be recommended by the prescriber at any time? **If YES, please list programs and dates.**	☐ **Yes**	☐ **No**
Has the patient been referred to an addiction specialist? **If YES, please indicate date, to whom, and results.**	☐ **Yes**	☐ **No**
If NO, should the patient be referred?	☐ **Yes**	☐ **No**

Letter of Medical Necessity for **Opioid Therapy**

Comments	
Physician Signature	**Date**

Please fax back to: <Enter Fax Number Here>

5.15 Drug List Development and Management

1. Preferred Drug List Management – General (Exclusive to DCS)

a. Does the Offeror currently develop, maintain and administer plans with three copay level benefit designs utilizing one or more Preferred drug lists? Detail the Offeror's proposed plan and their capability to administer the Program's formulary benefit according to the Program's benefit designs.

Yes. MedImpact develops, maintains, and administers plans with 3 copay level benefit designs that utilize one or more preferred drug lists.

Our proprietary claims adjudication system allows us to manage complex groups with multiple employers. Our system has unparalleled capabilities including flexible rules-based processing options, data integrity, reliability, and stability. The platform uses Uniplexed Information and Computing System-based open systems and Oracle relational databases for security and stability. Our personnel regularly maintain and update its tiered architecture to provide the flexibility needed for business and operational requirements.

Our claim's processing system has no limit to the number of groups, locations, or subgroups available to DCS. Within groups, we support the further breakdown by divisions where we can set up each group or division to have a separate benefit structure. For example, a group may have an active enrollee division with a particular benefit structure, a separate retiree division with a different benefit, and a Consolidated Omnibus Budget Reconciliation Act division with another benefit. We can use the following region code fields for each group or division for specialized reporting within that group:

- **HQ code:** Typically, a 5-position alphanumeric code MedImpact assigns unique to each client, e.g., XYZ01. Each client is under a unique HQ code
- **Groups:** Breakdown of DCS's population represented by a group number and name supplied by DCS
- **Divisions:** A further breakdown of groups (e.g., 1 – Medical Group; 2 – County)
- **E**nrollee**:** Client membership with unique enrollee information including enrollee demographic information
- **Benefit Code:** Unique benefit plan design that represents a benefit structure/plan design for a group of enrollees. Benefit structures can vary depending upon where the enrollee purchases the prescription, days' supply, type of claim, etc., including the following:
  - Formulary
  - Covered products
  - Utilization management edits
  - Copay/coinsurance
  - Other plan requirements
- **Carrier Code:** Unique pharmacy network that houses a group of pharmacies contracted with the plan at a specific contracted rate
- **Regions:** Fields that clients can use for reporting purposes at the group level, such as lines of business

We can customize plan benefits at the client, group, pharmacy, prescriber, or enrollee level, and can administer them on a calendar- or contract-year basis.

b. Describe the various preferred drug lists the Offeror has available:

i. Does the Offeror have a standard three copay level preferred drug list used for your Book of Business?

ii. Does the Offeror maintain multiple standard and custom preferred drug lists? Provide a description of the differences.

iii. What is the goal of these alternative preferred drug lists?

iv. What role do clients play in the development of the Offeror's preferred drug lists?

v. How often are changes made for both additions and deletions?

vi. Are there special considerations for biological and specialty Pharmacy products in the Offeror's preferred drug list and/or process?

MedImpact has clients who have both standard and custom preferred drug lists.

Formulary Options

We offer 2 standard formulary options paired with NCQA (National Committee for Quality Assurance) clinical trend management packages designed to provide options to balance access to covered medications with UM criteria while also maintaining high enrollee satisfaction.

Commercial Broad Access (Portfolio Formulary)

Strategic tiering drives the resulting enrollee drug utilization with appropriate clinical UM edits. Our national broad PDL (prescription drug list) is the basis of the Portfolio formulary with the widest access to medications for enrollees.

Commercial Restricted Access (MedPerform®)

MedPerform is our narrower PDL and based off the Portfolio PDL. It is a good solution for clients seeking a more restricted formulary offering. This formulary offers a combination of tiering, NCQA UM, and limited PDL drives enrollee utilization to the lowest net cost. MedPerform excludes select nonpreferred branded agents in highly rebateable drug classes. The exclusion of these nonpreferred brands delivers low net cost through 2 main mechanisms:

1. We maximize rebates for preferred agents when we exclude nonpreferred agents
2. Enrollees using preferred agents increases because we exclude the nonpreferred agents, which provides additional savings on preferred branded agents

Our standard Portfolio and MedPerform formularies include clinical trend management edits. DCS can select from low, medium, or high impact clinical edit levels. Moving from low to high impact increases the level of UM (utilization management) and potential for savings.

Medicare Part D Formularies

We offer the following 3 standard Medicare Part D formularies:

- **Core:** Selected drug coverage with a significant number of generics on a higher tier
- **Advantage:** Drug coverage with option for placing generics on a higher tier to preferred brand and a second specialty tier formulary structure option
- **Plus:** Broadens the Advantage formulary drug coverage with the option to select second specialty tier

We consistently manage standard formularies' UM, such as PAs, step therapy edits, and quantity limits. Therefore, we cannot accommodate UM customizations except for high-risk medications PAs. Any other formulary UM customization requires a custom formulary.

Client Role in PDL Development

We know that DCS has unique needs and offers a consultative approach. We will review formulary change requests providing financial impact in coordination with your clinical program manager, so DCS receives all information necessary to make an informed choice. Depending on the specific drug, or drug categories, these changes can impact rebate guarantees.

Custom formularies are maintained by our clients, with assistance from MedImpact (e.g., PT support, drug monograph). The goal is to provide our clients with more options based on their specific program objectives and the demographics of the population(s) they serve.

Custom clients have full control over their preferred drug list. Standard clients have much less control and cede responsibility for management of the preferred drug list to MedImpact.

Standard Formulary Changes

We update standard formularies quarterly. To limit enrollee disruption, negative formulary changes usually occur twice a year. We provide Affordable Care Act compliant negative change notification processes to clients. Our notification process provides enrollee notifications timelines and facilitates plan savings by converting enrollees from nonpreferred to preferred drugs sooner. Negative formulary change communications for clients using the standard formularies occur as follows:

- We provide negative change information to the client about 120 days before the formulary change effective date.
- We provide an affected enrollee report to the client about 75 days before the formulary change effective date.
- We send letters to affected enrollees approximately 60 days prior to the formulary change effective date.

Biologics and Specialty

There are special considerations for biologicals and specialty products in our lists. Our overall strategy is to drive to the net lowest cost drug. Accordingly, the cost and efficacy of these drugs are contemplated when placement decisions are made. Specialty medications are included in our standard formularies.

c. What Preferred Drug Lists is the Offeror proposing to use in managing the DCS Program? Please provide a list by NDC in Excel format that includes the tier (1=generic, 2=preferred brand, 3=non-preferred brand). 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 the Offeror's clinical rationale for limiting these drugs to Level 3?

We propose our MedPerform Medium formulary as a base for the commercial lives and a hybrid formulary for EGWP. Due to file size restrictions, these formularies have not been printed for the hard copies; however, they are included by NDC in Excel format that includes the tier on the USB flash drives as **5.15 Exhibit A and 5.15 Exhibit B**.

Tiers 4 and 6 include nonpreferred drugs as determined by our P&T Committee and/or rebate departments. All nonpreferred drugs include a therapeutic equivalent in a lower tier.

d. Explain how the Offeror would work with the medical carrier and the mental health and substance use carrier to ensure that participating providers in their networks are fully apprised of the level status of Covered Drugs.

We will work with medical carriers as needed to ensure the appropriate information is shared.

e. Confirm that the Empire Plan Flexible and Advanced Flexible Formulary Drug List(s) 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 used for the DCS Program, including how it will encourage physicians to prescribe lower-cost alternative medications to Enrollees.

MedImpact confirms.

We will utilize Rx Hub (Surescripts) functionality such as RTBC (Real Time Benefits Check). RTBC as part of the MedPrescription Insight® program, offers enrollee-specific cost and coverage details, including low-cost therapeutic alternative drugs and preferred alternative pharmacies, to help reduce enrollee/plan costs and improve formulary adherence.

Our RTBC solution works with each of the following major connectivity vendors: CenterX, CoverMyMeds, DrFirst, and Surescripts. These vendors provide behind-the-scenes enablement for the electronic exchange of information between the prescriber and MedImpact.

How Real-Time Benefit Check Works

RTBC presents an opportunity to reduce enrollee costs and improve medication adherence. RTBC occurs when a prescriber uses a computer or handheld device with software that enables a prescriber to get the real-time cost, coverage information, and drug alternatives for the enrollee for a drug and a pharmacy.

When an RTBC request is submitted, it is processed similarly to an online pharmacy claim, returning the most accurate enrollee-specific coverage and cost information for the submitted drug and pharmacy. We then find the

alternate drugs/pharmacies, get the enrollee specific coverage and cost information for drug/pharmacy combination, compare coverage/cost information for all combination, and return appropriate results.

Alternate Drug and Pharmacy Selection

Alternate drugs are selected based on First Databank's ETC (Enhanced Therapeutic Classification) System. ETC_ID is identified for the submitted drug based on the default use indicator flag (ETC_DEFAULT_USE_INDICATOR value is 1).

Alternate drugs are identified where the ETC_ID matches the ETC_ID of the submitted drug. Alternates are picked with unique combination of HICL, brand name, dosage form, generic flag and generic product flag combination. Drugs where the HICL, brand name, and dosage form is same as the submitted drug are excluded from the alternate list. Quantity supply, days' supply and NDC for the alternate drug is selected based on the most prescribed drugs for the last quarter. Clients can provide the custom alternate list at HICL level, brand name level or label name level.

f. Describe the strategy which would be implemented to control Prescription Drug AWP increases.

MedImpact focuses on client and enrollee satisfaction to avoid price spikes, increases in AWP, and other price-related surprises at POS. Ideally, prices remain stable or declining; however, unforeseen circumstances out of our control may result in price increases. For example, manufacturer shortages driven by multiple potential factors can raise prices. We will share all information and supporting communication with DCS as needed to facilitate ongoing awareness of market situations that can impact pricing, and at the same time, we can explore creative approaches with DCS to mitigate these situations.

g. Describe how the Offeror will develop, recommend, and implement Brand for Generic strategies for the formularies that are financially beneficial to the State.

Our formularies provide strategies to promote brand medications over generic medications. Our brand for generic strategy allows the enrollee to receive the brand medication at the generic co-pay while saving money for the plan by delivering the lowest net cost option.

When evaluating brand for generic opportunities, we work with our rebate services vendor to determine the low net cost solution at a therapy class level. We monitor the brand for generic strategy monthly to ensure it is generating the lowest net cost. When the brand for generic strategy no longer delivers the lowest net cost solution, we will cancel the strategy. The current brand for generic strategy includes:

- Advair HFA
- Azopt
- Breo Ellipta
- Epclusa
- Harvoni
- Livalo
- Restasis
- Semglee (YFGN)
- Soolantra
- Spiriva Handihaler
- Tresiba Flextouch
- Vascepa

2. Preferred/Non-Preferred/Excluded Determination (Exclusive to DCS)

a. Describe in detail the process employed to determine whether a drug is designated as preferred, non-preferred or excluded, and confirm the Offeror's ability to exclude drugs, and/or change the tiering of drugs, subject to State approval, based on the Flexible Formulary or Advanced Flexible Formulary criteria in Section 3.14, Drug List Development and Management, including:

i. All standards and criteria used in this determination

ii. 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

iii. The role of net cost in this determination

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

iv. Whether the process is governed by formal procedures to ensure sound clinical examination resulting in quality pharmaceutical care

v. 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

vi. 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

vii. Whether the process is different for innovative new therapies than for therapies that already have a competitive alternative

viii. The conditions that would cause a drug's preferred, non- preferred, or excluded status to change – understanding the constraints of the frozen formulary law and collectively bargained agreements - and several recent examples.

Our comprehensive formulary development process incorporates clinical efficacy and appropriateness with low net cost to support our clients and their members.

Drug Designation Process

MedImpact determines cost-effectiveness by reviewing drug cost, net cost after discounts, and actual outcome of treatment while considering total healthcare costs through utilization of pharmacoeconomic principles. We base formulary decisions and therapeutic designations on the objective evaluation of the products' relative therapeutic efficacy, safety, enrollee outcome, and cost- effectiveness.

The P&T Committee uses clinical reviews, plus the clinical considerations listed as follows to determine formulary drug coverage, tier placement, and clinical criteria:

- Efficacy
- Clinical appropriateness, including genomic testing
- Safety
- Cost
- Ongoing treatment criteria

Our clinical department proactively monitors new specialty drugs in the FDA pipeline nearing approval and market launch. We apply the same clinical process as with non-specialty drugs including the P&T Committee recommendations for utilization management coverage as well as formulary inclusion and tiering. The list of individuals involved includes 11 to 13 practicing clinicians (prescribers and pharmacists). The P&T Committee includes members who specialize in internal and family medicine, cardiology, obstetrics, gynecology, endocrinology, and geriatrics.

The FBRC (Formulary Business Review Committee) serves in an advisory capacity to our clinical management, medical, and clinical professionals on matters pertaining to clinical and financial management of rebatable drug initiatives. They abide by all recommended therapeutic designations and prescribing guidelines of the P&T Committee in identifying, evaluating, and initiating implementation of clinically appropriate strategies that are cost effectively sound.

The Department can work with its CPM to determine the impact of not excluding drugs or changing tiers that deviate from the recommendations of our P&T Committee.

Standards and Criteria

Designation of drug formulary recommendations includes a combination of clinical review and therapeutic advantage as well as a consideration of total healthcare costs. We examine this by applying pharmacoeconomic principles, published pharmacoeconomic, and outcomes research evaluations where available. We base our formulary decisions on efficacy, safety, and cost. We coordinate formulary UM techniques, such as promoting the use of generic products, while balancing rebate opportunities to optimize overall savings for the client.

P&T Committee Qualifications

Physicians and pharmacists with an active license to practice in the United States make up our P&T Committee. At least one physician and one pharmacist must be experts in elderly or disabled care, and at least 1 member must be a licensed psychiatrist. No more than 2 members are MedImpact employees who do not vote, and there are 11 to 13 members at any given time. P&T Committee members must not appear on the Office of Inspector General List of Excluded Individuals and Entities.

We identify potential P&T Committee members through their professional reputations and invite them to participate. We select new members based on the need for a particular clinical expertise (internal medicine or cardiology) on the P&T Committee.

We consider specific information regarding P&T Committee members confidential. We adopted this policy to avoid undue influence from outside entities. Drug manufacturers do not employ or contract with any P&T Committee members.

Net Cost Impact

Our P&T Committee provides clinical oversight over the standard formularies. We follow the philosophy of low net cost and clinically appropriate medication. We create formulary placement and benefit design that optimize rebates for rebatable drugs. Because MedImpact is not owned by a drug manufacturer, drug wholesaler, chain drug store, insurance company, or HMO, we can develop formularies based on objective, unbiased evaluations.

Designation Determination

Drug designation is governed by information provided by FBRC, P&T Committee, formulary administrative services, and our trade relations teams.

We apply formulary exclusions to select medications to drive utilization to preferred products and reduce plan spend. Excluded products must have clinically appropriate alternatives on the formulary. We organize standard commercial formulary exclusions into the following categories:

- **Rebate driven exclusions**: Nonpreferred products in rebatable drug classes
- **Nonessential exclusions**: High-cost products in non-rebatable drug classes
- **MSB (multisource brand) exclusions**: Brand drugs with FDA approved AB rated generics

DCS can operationalize formulary exclusions with or without an exception process in accordance with state and federal regulations.

DCS is welcome to be silent participants at our national P&T Committee meetings. We will provide the minutes from the quarterly P&T Committee meetings upon request. In addition, we provide monographs with our final formulary decisions within 30 days of the P&T Committee meetings.

Review of Drug Status

We update the standard formularies quarterly. To limit enrollee disruption, negative formulary changes usually occur twice a year. As new drugs enter the market, more frequent review of drug status may be warranted.

New to Market Drugs

We review drugs and drug classes containing comparative efficacy, safety, pricing, and utilization data quarterly. The process for adding products that are new to the market is the following:

- Integrate new drug data with an automated and managed process
- Enter new drugs in the system for formulary review each week
- Provide automated coding rules to classify the drug and to apply formulary status and utilization management
- Review and approve ensuring inclusion of compliance validation for regulated formularies
- Publish changes to the adjudication system every Friday afternoon, effective Saturday for new drugs

Drug Status Change

We seek the lowest net cost and make every attempt to balance net cost with the rebate guarantees we offer clients. Our formularies provide strategies to promote brand medications over generic medications. Our brand for

generic strategy allows the enrollee to receive the brand medication at the generic co-pay while saving money for the plan by delivering the lowest net cost option.

When evaluating brand for generic opportunities, we work with our rebate services vendor to determine the low net cost solution at a therapy class level. On a monthly basis, we monitor the brand for generic strategy to ensure it is generating the lowest net cost. When the brand for generic strategy no longer delivers the lowest net cost solution, we will cancel the strategy.

We also evaluate market events to determine if coverage or status changes are required. For example, we monitor the insulin landscape and work with all manufacturers to determine the optimal insulin strategies.

Our rebate strategy is to force multiple aggregators and pharmaceutical manufacturers to bid against each other for low net cost by key therapeutic class. For example, if rebate aggregator A has the best low net cost strategy for the asthma class and aggregator B has the best low net cost strategy for the oncology class, we can package the best options. We evaluate these strategies from both a clinical perspective to ensure appropriate access to drugs and a net cost perspective after rebates. This strategy has lowered net costs for our clients.

b. Describe the type of analysis the Offeror would perform when a Preferred Brand Drug is being considered for movement to a Non-Preferred Brand Drug list and vice versa.

We determine cost-effectiveness by reviewing drug cost, net cost after discounts, and actual outcome of treatment under real life conditions including considerations of total healthcare costs through utilization of pharmacoeconomic principles. We base formulary decisions and therapeutic designations on the objective evaluation of the products' relative therapeutic efficacy, safety, enrollee outcome, and cost- effectiveness.

c. Provide a diagrammatic illustration of the process from receipt of notification of a new drug entry into the marketplace from the manufacturer to the PDL decision-making process, identifying any and all clinical and financial considerations impacting the placement of the product. Please include estimated time frames.

We review drugs and drug classes containing comparative efficacy, safety, pricing, and utilization data quarterly.

Process

The process for adding products that are new to the market is the following:

- Integrate new drug data with an automated and managed process
- Enter new drugs in the system for formulary review each week
- Provide automated coding rules to classify the drug and to apply formulary status and utilization management
- Review and approve ensuring inclusion of compliance validation for regulated formularies
- Publish changes to the adjudication system every Friday afternoon, effective Saturday for new drugs

We announce formulary changes on our website, through weekly updates, executive pharmacy briefings, and ongoing communication. Current processes provide for client notification with a list of affected enrollees and prescribers. We notify pharmacies of changes through the ChainDrugStore.net website.

Clinical and Financial Considerations

Designation of drug formulary recommendations includes a combination of clinical review and therapeutic advantage, as well as a consideration of total healthcare costs. In this process we apply pharmacoeconomic principles, review published pharmacoeconomic, and seek outcomes research evaluations where available. We base formulary decisions on efficacy, safety, and cost. We coordinate formulary UM techniques, such as promoting the use of generic products, while balancing rebate opportunities to optimize overall savings for the client.

We determine cost-effectiveness by reviewing drug cost, net cost after discounts, and actual outcome of treatment, while considering total healthcare costs through utilization of pharmacoeconomic principles. We base formulary decisions and therapeutic designations on the objective evaluation of the products' relative therapeutic efficacy, safety, enrollee outcome, and cost- effectiveness.

The P&T Committee uses clinical reviews, plus the clinical considerations listed as follows to determine formulary drug coverage, tier placement, and clinical criteria:

- Efficacy
- Clinical appropriateness, including genomic testing
- Safety
- Cost
- Ongoing treatment criteria

Our clinical department proactively monitors new specialty drugs in the FDA pipeline nearing approval and market launch. We apply the same clinical process as with non-specialty drugs including the P&T Committee recommendations for UM coverage as well as formulary inclusion and tiering.

The FBRC serves in an advisory capacity to our clinical management, medical, and clinical professionals on matters pertaining to clinical and financial management of rebatable drug initiatives. They abide by all recommended therapeutic designations and prescribing guidelines of the P&T Committee in identifying, evaluating, and initiating implementation of clinically appropriate strategies that are cost effectively sound.

3. Preferred Drug List Strategy (Exclusive to DCS)

a. How are Generic equivalents considered in the Offeror's assessment of individual therapeutic categories on your PDL?

MedImpact provides comprehensive clinical documents for DCS's review including TCRs (therapeutic class reviews) and drug monographs to assist in evaluating the safety and efficacy of the drugs DCS's DPAC (Drug Policy Advisory Council) and DUR board reviews.

TCRs focus on direct comparative clinical effectiveness and safety trials, published outcomes evidence, and national consensus guidelines highlighting distinguishing characteristics among medications in each therapeutic class. Our clinical pharmacists utilize a variety of clinical databases and resources to prepare TCRs including:

- PubMed®
- Ovid®
- UpToDate®

- MD Consult®
- MICROMEDEX®
- Vast Online and Print Libraries
- 2 Medical School Clinical Resources

These diverse resources offer an array of peer-reviewed medical literature. In addition, the team reviews product information from pharmaceutical manufacturers in compliance with the Academy of Managed Care Pharmacy-endorsed formulary dossier submission requirements.

b. How does the Offeror's PDL development process promote the use of the most cost-effective drug within the therapeutically equivalent drugs in the class, including Generics, rapid-acting insulin and biosimilars? Provide three examples. Confirm that the Offeror will include "low list" rapid-acting insulins on the formularies.

We use rebate management strategies to deliver an overall low net cost strategy for our clients. We use rebates intelligently to manage costs effectively while providing appropriate formulary access. Our MedPerform and Portfolio formularies are fine tuned to deliver low net cost.

Strategies to drive low net cost include:

- UM edits
- Brand over Generic programs
- Prior Authorizations
- Quantity Level Limits
- Referring Clinically Effective Low Ingredient Cost Agents
- Leveraging the Value of Pharmaceutical Rebates

Examples of this include:

- **Biosimilar Example:** For the commercial line of business, we added Amjevita, Cyltezo at parity to Humira with PA in 2023. We added Hyrimoz and Adalimumab-adaz to formulary in 2024. The availability of these products on formulary helps provide access to enrollees to newly launched biosimilars and limits enrollees disruption for those on Humira.
- **DPP4:** Januvia and Janumet/XR are the preferred DPP4 products on formulary. Januvia and Janumet have the lowest net cost of all available branded and nonbranded DPP4 products.
- **Irritable Bowel and Constipation:** Linzess, Movantik and lubiprostone are all preferred products on formulary. While lubiprostone is generic, net cost of Linzess and Movantik are comparable to the cost of lubiprostone. Having multiple options on formulary for this class provides enrollee access and maintains a low net cost strategy.

Low list rapid acting insulins are included on the formularies.

c. Does the Offeror's PDL strategy currently allow for drug exclusions? Do the Offeror's proposed Flexible, and Advanced Flexible PDLs contain Drug exclusions? Is the Offeror able to exclude drugs based on the Flexible Formulary or Advanced Flexible Formulary criteria set forth below and in Sections 3.14 and 5.15, Drug List Development and Management (Exclusive to DCS)? Using the excluded drug by NDC Excel list provided in Attachment 52 Excluded Drug Lists - January 2024 (by NDC), Offerors must compare their Proposed Excluded Drug List to the list provided, and for any addition to the list, provide the side letter exclusion criteria applicable to each

drug's exclusion. That is, for each new drug exclusion proposed, the Offeror must identify which of the following criteria is met:

Flexible Formulary:

- **Contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;**
- **Contain an active ingredient that is a modified version of and therapeutically equivalent to another covered Prescription Drug Product; or**
- **Are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.**

Advanced Flexible Formulary:

- **Contain an active ingredient available in or are therapeutically equivalent to another drug covered in the class;**
- **Contain an active ingredient that is a modified version of or are therapeutically equivalent to another covered Prescription Drug Product; or**
- **Are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.**

Indicate any instance if a currently excluded drug is covered by the Offeror. Describe how the Offeror uses exclusion leverage to negotiate rebates with Pharmacy manufacturers to provide the best value to the DCS Program.

MedImpact's drug information team identifies and reviews new brand and generic products to determine FDA approval status on a weekly basis. Through this review process we identify and evaluate products for formulary exclusion including medications considered to be high-priced, unsafe, ineffective, or non-FDA approved. We may consider some non-FDA approved medications for formulary inclusion if deemed reasonably priced and medically appropriate, whereas we recommend products deemed unsafe or exorbitantly priced and not medically appropriate for formulary exclusion. Our drug information team regularly monitors and carefully evaluates these products as part of its comprehensive process for supporting cost-effective and clinically appropriate utilization management.

MedImpact offers managed formulary exclusion lists for non-FDA approved products, which includes the following:

- High-cost non-FDA approved kits, patches, or repacks regardless of whether the active ingredient within the pack or if the FDA approved the kit
- Products considered to be medical foods

Due to file size, the excluded drug list comparison is included in the USB drive as **5.15 Exhibit C**. We used the excluded drug by NDC Excel list provided in **Attachment 52 Excluded Drug Lists** to create this exhibit.

d. Describe the Offeror's strategy and process for evaluating and determining the appropriate PDL designation for the introduction of "me too" drugs including drugs with OTC equivalents. Please describe the Offeror's current strategy and its rationale for the proton pump inhibitor class, statin class, and lifestyle drugs (Cialis, Levitra, etc.).

MedImpact identifies, evaluates, and initiates clinically appropriate rebate strategies monthly to deliver value to clients, be market competitive, and prepare for market and legislative changes. For example, we evaluate new brand drugs to market on their therapy placement as it compares to its competitors already in the market. We then apply utilization management to help drive utilization to lower net cost drugs. We exclude Duexis, and the preferred lower cost alternatives include famotidine and ibuprofen, which are available as separate products. We exclude Vimovo, and the preferred lower cost alternatives include naproxen and esomeprazole, which are available as separate products.

e. Describe the Offeror's strategy and process for determining the appropriate PDL designation for the introduction of "successor drugs," including extended-release products. Provide an example of this strategy.

Designation of drug formulary recommendations includes a combination of clinical review and therapeutic advantage as well as a consideration of total healthcare costs. Successor drugs/new formulations/line extensions are reviewed as part of our standard formulary management process and are reviewed at our P&T Committee meetings. The P&T Committee uses clinical reviews and the clinical considerations listed as follows to determine formulary drug coverage, tier placement, and clinical criteria:

- Efficacy
- Clinical appropriateness, including genomic testing
- Safety
- Cost
- Ongoing treatment criteria

Our clinical department proactively monitors new specialty drugs in the FDA pipeline nearing approval and market launch. We apply the same clinical process as with non-specialty drugs including the P&T Committee recommendations for UM coverage as well as formulary inclusion and tiering. When new successor drugs become available in the drug system, the drug is reviewed during the weekly process. We evaluate the product for clinical efficacy, safety, and cost compared to similar products available. Rebate strategies and impacts are also considered during the evaluation. The drug will be managed based on clinical and financial value.

For example, Rinvoq and Skyrizi are considered successor drugs of Humira and are currently preferred on our standard formulary. While both Rinvoq and Skyrizi treat many of the same indications are Humira, these immunomodulatory products work through different mechanisms of actions. Based on current utilization of products in the autoimmune class and net cost of products in the autoimmune class, we determined that Rinvoq and Skyrizi should be preferred on formulary. The formulary strategy for these drugs is continuously being evaluated to ensure an overall low net cost strategy. Gralise is a daily gabapentin product indicated for the management of post-therapeutic neuralgia. Due to limited clinical benefits along with significantly high cost compared to generic gabapentin capsules and products, Gralise was designated as non-essential and excluded from our standard formulary.

f. Please detail the Offeror's 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.

MedImpact does not have a set strategy for combination drugs. Net cost is evaluated along with place in therapy. The "convenience" of a drug being combined into a single pill is not generally considered as a factor unless improved enrollee compliance is considered essential (e.g., HIV antiretrovirals). Combination SSBs are often more costly than their separate ingredients combined, and when that is the case the combination product is usually excluded or put on a non-preferred brand tier. If a combination product has strengths that are different than what is available as an individual ingredient, or vice versa, those are managed on a case-by-case basis.

g. Explain how the Offeror's business model ensures that the placement of drugs on the PDLs will result in the best value to the DCS Program and Enrollees. Describe how manufacturer contracting is integrated into this process.

MedImpact uses rebate management strategies to deliver an overall low net cost strategy for our clients. We use rebates intelligently to manage costs effectively while providing appropriate formulary access. Our MedPerform and Portfolio formularies are fine tuned to deliver low net cost.

Strategies to drive low net cost include:

- Utilization management edits
- Brand over Generic programs
- Prior authorizations
- Quantity level limits
- Referring clinically effective low ingredient cost agents
- Leveraging the value of pharmaceutical rebates

We do not lock rebates into a single source as we would if we contracted directly with pharmaceutical manufacturers; instead, we use a rebate services vendor that forces multiple sources/aggregators to bid against each other by therapeutic class providing the best overall low net cost. By not focusing on maximizing rebates, we can provide DCS with a decline in ingredient costs, greater value, and more flexibility with our rebate strategy.

h. Describe how the anticipated upcoming release of a new Generic drug or biosimilar 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 the Offeror's proposed PDL have drugs anticipated to go generic or have biosimilars available in 2025 as non- preferred? Please explain the rationale for such classification.

MedImpact continuously evaluates advancements in biosimilar development by assessing the clinical effectiveness of biosimilars versus the innovator product. Our evaluations address clinical, regulatory, and legal issues that can impact the approval, launch, and utilization of the biosimilar. We provide strategic recommendations and services for clients, including:

- **Quarterly Updates:** Pipeline updates and strategic recommendations

- **Formulary Strategy:** In-depth analyses to determine placement of new drugs on the formulary based on clinical factors and net cost
- **Utilization Management:** UM information to drive utilization toward low net-cost agents considering discounts and rebates
- **Specialty Pharmacy Strategy:** Preferred products enforcement dispensing to support formulary and optimize utilization of preferred products for low net cost via cost-effective, clinically appropriate pharmacy
- **Enrollee and Prescriber Education:** Payers, prescribers, and enrollees receive information to understand each biosimilar
- **Reporting:** Reports highlighting the biosimilar usage and showing savings by new agents, larger rebates, or discounts on products

DCS's CPM (clinical program manager) will review the pipeline on a quarterly basis and discuss drugs that can potentially impact DCS during quarterly reviews.

Discussions with pharmaceutical manufacturers before the biosimilar launches assist in securing best pricing and rebates on all products.

We will leverage biosimilars to achieve low net cost in the applicable therapeutic category. We currently provide the following support for biosimilars:

- Monitor, through our clinical pharmacists, all biosimilars in development and review the clinical and pharmacokinetic nature of each new biosimilar to determine similarity to the reference product
- Perform a cost assessment, through our industry relations pharmacists, considering current and new rebate offers for all products associated with the biosimilar
- Determine the resultant net cost for the biosimilar and reference product

For the commercial line of business, MedImpact is preferring Amjevita, Cyltezo, Hyrimoz, and Adalimumab-ADAZ at parity to Humira with PA in 2024. For the Medicare Part D line of business, we prefer Humira exclusively and expect adding a biosimilar in 2024.

We are monitoring the biosimilar landscape and working with biosimilar manufacturers to ensure our biosimilar strategies provide low net cost.

4. Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements (Exclusive to DCS)

a. Describe the Offeror's process for complying with the applicable Program requirements in the event of a drug recall or drug withdrawal including the time notification standards the Offeror employs. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?

MedImpact takes timely and appropriate action in the event of a safety-related FDA drug recall or voluntary manufacturer drug withdrawal. We notify clients via email of drug recalls affecting all lots of a product within 48 hours of receiving the information from the FDA. The client communication contains the following:

- Description of the recall
- MedImpact's action plan

- Affected enrollee reports
- Template enrollee notification letters
- Template provider notification letters

At the discretion of the medical director, we notify clients of recalls that affect select lots/partial lots of a product that pose a significant safety risk of serious harm or death. Additional actions related to drug recalls can include the following:

- Placing edits in the claims adjudication system that either blocks the drug (hard edit) or warns the pharmacist and enrollee of the drug's recall (soft edit)
- Providing recommendations for drug substitutions, prior authorizations, or benefit changes as appropriate
- Implementing a withdrawal notice in the call center

A reimbursement does not occur when a medication is recalled or withdrawn as incurred claims are not reversed.

b. Describe the Offeror's 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.

MedImpact offers customized solutions for class action engagement to support client needs and will do so for DCS. We can provide timely notice of potentially relevant class actions and file a Proof of Claim including DCS's precise drug data. If DCS prefers that we handle the class action(s), then we will do so, including regular reporting of its filing, collection, and redistribution efforts.

If DCS prefers to self-file, we will provide a file-ready drug report to facilitate DCS's own submission. If DCS is involved in a financial settlement associated with a pharmaceutical-related class action litigation, we will support DCS's claim by providing specific cost related data, as defined by the settlement, to validate and substantiate DCS's claim to be included in the settlement. We will provide the requested data to DCS typically within the following parameters:

- MedImpact was the PBM during the relevant timeframe
- MedImpact is notified at least 60 days prior to the court-defined submission deadline

We may charge an administrative fee associated with the retrieval of the data, which is typically minimal, and rolled up at the client level (not by the individual plan).

Depending on DCS's preferences, we can lead with negotiating post-filing actions with the parties to the class action. These services do not typically extend to terminated clients, but to the extent there is relevant claims data available for filing, that data will be provided upon client request and at no charge.

Notification

We will notify DCS of pharmaceutical manufacturer class action lawsuits or settlements that we become aware of.

Recoveries

Our standard process does not include participating in pharmaceutical manufacturer class action lawsuits or settlements on behalf of our clients, as these lawsuits and settlements commonly exclude PBMs from the defined class.

5. Preferred Drug List Development and Management (Exclusive to NYSIF)

a. Describe how the Offeror will maintain a formulary compliant with the WCB standard, including the categorization of drugs and the NYS WCB Medical Treatment Guidelines, e.g., drugs requiring prior authorization, Covered Drugs dispensed not requiring prior authorization Certain drugs will have time frames during which prior authorization is not required;

We have a dedicated Advocacy and Compliance Department which monitors and reviews statutory and regulatory changes via various channels such as State Work Comp Websites, advisory committee meetings, regulatory email subscription services, Lexis-Nexis®, industry news and blogs, as well as a paid subscription service for State Fee Schedule updates. We are acutely focused on compliance with state and federal mandates and adhere to all standards and practices as required by law.

To ensure that our customers comply with state regulations, our clinical team works collaboratively with the compliance department and our customers to create a drug plan that addresses state regulations, in addition to customer-specific requirements. Our flexibility allows us to layer state-specific formularies onto customer-specific formularies to address the level of stringency our customers require while remaining in compliance with state regulations. Customizations can include formulary rules and routing based on medications or medication classes, injury types, job codes, utilization review, etc.

This plan includes all necessary prior authorization requirements and alert messaging. Customized alerts to pharmacies as well as claims staff (e.g., case management team, supervisors, nurses, claims adjusters) offer the opportunity to provide further education and information to aid in clinical decision making at the time of medication authorization.

To ensure accurate and timely compliance, the clinical team works diligently to make the appropriate updates. If there are changes that impact how our Customer Service Center would interact with the relevant pharmacies, we would provide notification ahead of time. If there are updates to the formulary that would impact legacy claimants who receive medications affected by formulary changes, an analysis can be performed to identify those enrollees and create approvals and/or notifications to avoid any disruption in filling their prescriptions for the specified period.

Once the state formulary is implemented, the clinical and compliance teams continue to monitor for any updates to the formulary and make changes accordingly. Our Formulary Management Team can make regulatory formulary changes proactively on behalf of our customers or following customer review and approval. This is based on each customer's preference.

b. Confirm that the Offeror does not and will not accept payments from drug companies to promote specific products;

c. Confirm the Offeror will provide NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GPI and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

We can provide an electronic file of all formulary drugs at the frequency required to meet your needs. This file can include all drugs included and/or excluded in the formulary, the corresponding GPIs and NDCs encompassed within the GPI codes.

5.15 Exhibits

The following exhibits were referenced in Section 5.15 and have been provided here per RFP instructions.

Exhibit	Description
5.15 Exhibit A	MedPerform Medium Formulary (not included in hard copy; included on USB flash drive)
5.15 Exhibit B	EGWP Formulary (not included in hard copy; included in USB flash drive)
5.15 Exhibit C	MedPerform Excluded Comparison (not included in hard copy; included in USB flash drive)

5.16 Consolidated Appropriations Act (CAA) (Exclusive to DCS)

1. The Offeror must provide a narrative describing how it will conduct and document a NQTL comparative analysis and confirm the analysis will be provided upon request at no additional charge. This narrative should also include a summary of its planned activities to ensure compliance with other provisions of the CAA, including, but not limited to, posting machine-readable files related to claims payments, and enrollee transparency tools when required. T
the Offeror must provide a narrative describing how it will collect and report on prescription drug information (RxDC
Reporting) and confirm that the reports will be provided upon request. The Offeror must confirm the collection and reporting will be included in the Administration Fee and not charged separately.

MedImpact has designed a system for review and assessment of each NQTL-type (Non-Quantitative Treatment Limitations) and associated operations measures. Each NQTL is maintained, and the associated operations measures and comparative analyses are updated ongoing to ensure data is accurate and current. We will support DCS with regulatory engagements by providing full narrative comparative analysis as applicable to your pharmacy benefit and regulatory scope. The analysis is provided at no additional charge.

The process of documenting the NQTL operations measures data includes:

1. Review of a statistically valid sample of PA review denials for mental health and substance use disorder drugs to ensure such determinations align with the clinical review criteria and that such criteria have been applied comparably to and no more stringently than criteria applied to medical or surgical drug.

2. Review of our policies for the automatic or systematic non-payment or application of a particular drug for mental health and substance use disorder drugs to ensure that they are comparable to and applied no more than stringently than non-payment of medical or surgical drugs.

3. Review of all mental health and substance use disorder drugs subject to nonquantitative treatment limitations, including the following.

   - Formulary tiering placement
   - Step-therapy protocols or other preauthorization requirements
   - Factors such as cost and latency periods, processes, strategies, and evidentiary standards relied upon to determine whether to apply the nonquantitative treatment limitation were comparable to and applied no more stringently than the factors, processes, strategies, and evidentiary standards relied upon to determine whether to apply nonquantitative limitations, including step therapy or other PA requirements, to drugs to treat medical or surgical conditions
   - Review of any fail-first requirements applicable to mental health or substance use disorder drugs to ensure that they are comparable to and applied no more stringently than any fail-first requirements applicable to medical or surgical drugs

Our regulatory compliance team conducts ongoing review of enacted state and federal legislation, determines applicability, and ensures internal operations align with requirements as related to the PBM, which includes applicable provisions of the CAA. This management and implementation of such new laws includes applicable DCS communication to provide insight into our activities and any additional activities required by DCS.

Collection and Reporting on Prescription Drug Information

Section 204 requires group health plans and health insurance issuers offering group or individual health insurance coverage, including both insurance companies and employer-based health plans, to submit information about prescription drugs and health care spending to DCS of HHS, the Department of Labor, and the Department of the Treasury. In addition, the director of the OPM (Office of Personnel Management) requires federal employees health benefit carriers to submit Section 204 data to HHS. CMS collects Section 204 data submissions on behalf of the departments and OPM.

The term RxDC report refers to the data submission required under Section 204 of Division BB, Title II (Section 204) of the CAA. The CMS RxDC webpage contains RxDC (prescription drug data collection) reporting instructions. To support DCS's prescription drug reporting requirements, we offer two options:

1. We can provide the D3 to D8 data files along with the narrative information in the required format directly to DCS. DCS will then incorporate the D3 to D8 data, along with the narratives, with DCS's healthcare spending data from the medical side into DCS's final submissions directly to HHS, the Department of Labor, and the Department of Treasury. This option is available to DCS at no cost.

2. We can provide D3 to D8 data files along with narratives directly to CMS through the HHS portal on behalf of DCS. If DCS will prefer MedImpact to submit this information in the required format directly to CMS, DCS will need to submit all other healthcare spending data files required by Section 204 of the CAA to HHS, DOL, and Department of Treasury directly to CMS and indicate that we will provide the D3 through D8 data. This option is available at a fee per upload.

5.16 Exhibits

There are no referenced exhibits in Section 5.16

5.17 Consulting (Exclusive to DCS)

1. The Offeror must provide a narrative describing how it will inform the Department 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, formulary configuration, technological improvements, e-prescribing, Pharmacy innovations, and State/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the DCS Program. The Offeror must confirm that it will make available to the State one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The Offeror must confirm its understanding that the Department is not under any obligation to act on such advice or recommendation; and

MedImpact continuously monitors the pharmacy, regulatory, and technological landscapes for changes that drive better outcomes, results in savings, and create innovation or efficiencies in PBM. To that end, our leadership and subject matter experts work with organizations such as NCPCP, AMCP, PCMA, SALGBA and participate in various workgroups and technical advisory groups. These leaders support our account teams who will keep DCS informed of any opportunities to improve services through new cost containment strategies, formulary changes, new generic drugs as well as new technology and PBM innovations.

In addition, DCS's account management team presents a quarterly and year-end BFR (business financial review). The BFR shares a detailed review of DCS's prescription benefit plan, including comparison to past years and our book of business. Every quarterly and annually BFR provides suggestions to improve DCS's program performance and enhance the quality of enrollee care.

2. The Offeror must provide a narrative description of how it will assist the Department with recommendations and evaluation of proposed benefit design changes. The Offeror must confirm that it will implement any changes necessary to accommodate DCS Program modifications resulting from collective bargaining (using Department benefit codes), legislation, or within the statutory discretion of the State. In the event of a design change and the Contractor requests any change in compensation such change will be in accordance with Modification of Program Services provision (Section 8.8).

MedImpact's proprietary analytic models combine clinical, financial, and compliance data to forecast the effect of changes to a client's pharmacy benefit plan design. Leveraging state-of-the-art tools, our proprietary adjudication technology produces accurate, actionable benefit models. We use these models as the basis for contract performance guarantees for clinical, financial, and compliance benefits administration service delivery.

We will provide access to these tools and models via detailed consultations with DCS's personnel. Historical claims and normalization of data often requires extensive analysis and effort. We make all modeled data available via mutually agreed upon formats to facilitate review and comparisons.

Our interactive benefit management solution will allow DCS staff to simulate changes to plan designs before production. The Enterprise Configuration Solution will provide an intuitive online benefit configuration interface via the PCE (production claim experience) feature to enable DCS's staff to create copies of existing benefit plans, make adjustments (e.g., copay, coinsurance, number of copay tiers, deductible, out of pocket limits), and assess those changes by reprocessing production claims to determine the impact of these changes to enrollee and plan costs. While PCE provides a data extract today, our roadmap includes enhancements to provide visualization and

interactive capabilities to enhance the user experience and leverage the data to perform benefit modeling and analysis. Key PCE features include self-service functionality such as:

- Inline dynamic decision support in managing formulary tiering and strategy
- Real-time impact analysis including enrollee disruptions, rebate guarantees, prior authorization, and key plan performance indicators
- Plan design optimization based upon business drivers (clinical, compliance, and financial)

MedImpact will also provide DCS with benefit modeling and consultative services recommendations that will help achieve the low net cost while improving health outcomes and reducing out-of-pocket costs.

5.17 Exhibits

There are no referenced exhibits in Section 5.17.

Attachment 6 – Performance Guarantees

MedImpact and Healthesystems provides our completed Attachment 6, which contains our proposed performance guarantees and association amounts at risk.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Performance Guarantees RFP entitled: "Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs"**

Offeror Name: MedImpact Healthcare Systems, Inc.

Offerors must submit this Attachment 6 with the Offeror's Technical Proposal Submission – not the Offeror's Financial Proposal.

Offerors shall not propose guarantee(s) that are not listed on this Attachment 6. If guarantee(s) which have not been requested are proposed by an Offeror, such guarantee(s) will not be scored.

Implementation and Start-Up Guarantee – Section 5.3(3): The Offeror proposes a credit of [redacted] percent (%) of the 2025 Claims Administration Fee (prorated on a daily basis) for the DCS Program and [redacted] percent (%) of the 2025 Claims Administration Fee (prorated on a daily basis) for the NYSIF Program 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 2025 Claims Administration Fee (prorated on a daily basis). However, Offerors may propose higher or lower percentages.

Customer Service/Call Center Telephone Guarantees

Call Center Telephone Response Time Guarantee – Section 5.4(8)(a): The Offeror proposes a credit of [redacted] per quarter for DCS and [redacted] per quarter for NYSIF 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. 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 lower amounts.

Call Center Availability Guarantee – Section 5.4(8)(b): The Offeror proposes a credit of [redacted] per quarter for DCS and [redacted] per quarter for NYSIF 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. 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 lower amounts.

Telephone Abandonment Rate Guarantee – Section 5.4(8)(c): The Offeror proposes a credit of [redacted] per quarter for DCS and [redacted] per quarter for NYSIF 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. 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 lower amounts.

Telephone Blockage Rate Guarantee – Section 5.4(8)(d): The Offeror proposes a credit of [redacted] per quarter for DCS and [redacted] per quarter for NYSIF 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. 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 lower amounts.

Secure Online Customized Website Guarantees

Website Accuracy Guarantee – Section 5.4(9)(a) (Exclusive to DCS): The Offeror proposes a credit of [redacted] per quarter for DCS against the Claims Administration Fee for each Business Day in excess of the standard of 3 Business Days (or the Offeror's proposed guarantee) to correct inaccurate information on the customized website, calculated on a quarterly basis. The Standard Credit Amount for each 1 Business Day in excess of the standard of 3 Business Days is $25,000 per each quarter for DCS. However, Offerors may propose higher or lower amounts.

Website Update Timeliness Guarantee – Section 5.4(9)(b) (Exclusive to DCS): The Offeror proposes a credit of [redacted] per quarter for DCS against the Claims Administration Fee for each Business Day in excess of the standard of 5 Business Days (or the Offeror's proposed guarantee) to post accurate information on the customized website, calculated on a quarterly basis. The Standard Credit Amount for each 1 Business Day in excess of the standard of 5 Business Days is $25,000 per each quarter for DCS. However, Offerors may propose higher or lower amounts.

Member Communication Support Guarantee – Section 5.6(10) (Exclusive to DCS): The Offeror proposes a credit of [redacted] for DCS against the Claims Administration Fee for each

occurrence of a form or letter, including but not limited to, notification of drug recalls or withdrawals and notification of mid-year formulary changes, that is not mailed within 30 Calendar Days of DCS' requested effective date (e.g., for a Prior Authorization change that will be effective April 1, letters need to mail by March 1). The Standard Credit Amount for each occurrence beyond thirty Calendar Days of a form, or letter mailing after DCS' requested effective date is $1,000 per occurrence, calculated quarterly. However, Offerors may propose higher or lower amounts.

Formulary Coding Accuracy Guarantee – Section 5.6(11) (Exclusive to DCS): The Offeror proposes a credit of [redacted] per quarter for DCS against the Claims Administration Fee for each instance of incorrect coding being applied to the Plan, such as coding not updating to reflect formulary decisions for the start of the Plan Year, or the Offeror applying Book changes to the Plan without DCS approval. The Standard Credit Amount for each occurrence of incorrect coding being applied to the Plan is $1,000 per occurrence, calculated quarterly. However, Offerors may propose higher or lower amounts. This amount is separate, and not part of any amount the Contractor may owe the Department due to incorrect coding.

Enrollment Management Guarantee – Section 5.7(9): The Offeror proposes a credit of [redacted] for DCS and [redacted] for NYSIF against the Claims Administration Fee for each 24-hour period beyond twenty-four (24) hours from release by the Department, and for each 24-hour period beyond twelve (12) hours from 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. The Standard Credit Amount for each 24-hour period beyond twenty-four (24) hours from release by the Department that one hundred percent (100%) of the Commercial 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 lower amounts. The Standard Credit Amount for each 24-hour period beyond twelve (12) hours from 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 lower amounts.

Reporting Services and Claim File Guarantees (Exclusive to DCS) – Section 5.8(1)(f): The Offeror proposes a credit of [redacted] for DCS against the Claims Administration Fee for each management report or claim file, including MAC Alert Notices, that is not accurate or is not received by its respective due date, 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. The Standard Credit Amount for each management report or claim file that is not accurate or is not received by its respective due date is $1,000 per report per 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. However, Offerors may propose higher or lower amounts.

Performance Guarantees
RFP entitled:
"Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs"

Reporting Services and Claim File Guarantees (Exclusive to NYSIF) – Section 5.8(2)(v): The Offeror must propose a forfeiture amount (Standard Credit Amount) for each Calendar Day the Department has not received the NYSIF Program management report and claims file by their respective due date. The forfeited amount (Standard Credit Amount) for each management report or claim file that is not received by its respective due date is $100 per Calendar Day per report. However, an Offeror may propose a higher amount.

Transition and Termination Guarantee – Section 5.9(2): The Offeror proposes to forfeit $_____ for each Day or part thereof that the Transition Plan requirements are not met for the DCS Program and $_____ for NYSIF. The forfeited amount (Standard Credit Amount) is $1,000.00 for each Day this guarantee is not met for each program. However, an Offeror may propose higher or lower amounts.

Network Management Guarantees

Retail Network Pharmacy Access Guarantees – Section 5.10(A)(6)

The Offeror proposes a credit of [redacted] for DCS Commercial, [redacted] for DCS EGWP, and [redacted] for NYSIF against the Claims Administration Fee 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 Retail 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 Retail 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 lower amounts.

The Offeror proposes a credit of [redacted] for DCS Commercial, [redacted] for DCS EGWP, and [redacted] for NYSIF against the Claims Administration Fee 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 Retail 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 ninety percent (90%) minimum access guarantee for any quarter in which the Retail 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 lower amounts.

The Offeror proposes a credit of [redacted] for DCS Commercial, [redacted] for DCS EGWP, and [redacted] for NYSIF against the Claims Administration Fee 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 Retail Network Pharmacy Access for Rural 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 Retail 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 lower amounts.

Mail Service Pharmacy Process

Turnaround Time for Nonintervention Mail Service Prescriptions Guarantee – Section 5.10(E)(19): The Offeror proposes a credit of [redacted] for DCS and [redacted] for NYSIF 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. The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) of all nonintervention 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 lower amounts.

Turnaround Time for Intervention Mail Service Prescriptions Guarantee – Section 5.10(E)(20): The Offeror proposes a credit of [redacted] for DCS and [redacted] for NYSIF against the Claims Administration Fee for each .01 to 1.0% below ninety-eight percent (98%) (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. The Standard Credit Amount for each .01 to 1.0% below the ninety-eight percent (98%) 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 lower amounts.

Claims Processing Guarantees

Programs' Claims Processing System Availability Guarantee – Section 5.11(2)(a): The Offeror proposes a credit of [redacted] for DCS and [redacted] for NYSIF 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 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 lower amounts.

Programs' Claims Processing System Accuracy Guarantee – Section 5.11.(2)(b): The Offeror proposes a credit of [redacted] for DCS and [redacted] for NYSIF 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, does not accurately process claims at the point of service in accordance with the Program's benefits design, as calculated on a quarterly basis. 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 does not accurately process claims at the point of service in accordance with the Programs Benefit design, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, the Offeror may propose higher or lower amounts.

Turnaround Time for Claims Adjudication Guarantee (Exclusive to DCS) – Section 5.11(2)(c): The Offeror proposes a credit of [redacted] for DCS 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. 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 lower amounts.

Turnaround Time for Claims Adjudication Guarantee (Exclusive to NYSIF) – Section 5.11(2)(d): The Offeror proposes a credit of [redacted] for NYSIF 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. 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 lower amounts.

Prior Authorization

Turnaround Time for Prior Authorizations Guarantee (Exclusive to DCS) – Section 5.14(A)(7): The Offeror proposes a credit of [redacted] for DCS against the Claims Administration Fee for each .01 to .25% of Prior Authorization requests that are received by the Offeror not turned around within two (2) Business Days from the date received by the Offeror, by any origin (i.e., electronically, telephonically, via fax, or in the Programs designated Post Office Box), to the date the Offeror's response is received by the mailing agent, below the standard of ninety-five percent (95%) as calculated on a quarterly basis. The Standard Credit Amount for each .01 to .25% of the Prior Authorizations received by the Offeror not turned around within two (2) Business Days from the date the Prior Authorization request is received by the Offeror, by any origin (i.e., electronically, telephonically, via fax, or in the Programs designated Post Office Box), to the date the Offerors response letter is received by the mailing agent below the standard of ninety-five percent (95%) is $25,000 per each quarter for DCS. However, the Offeror may propose higher or lower amounts.

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