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| **Client Information** | | | | | | | | |
| **Primary Client Contact** | | | | **Secondary Client Contact** | | | | |
| Name/Title: |  | | | Name:/Title: | |  | | |
| Company Name: |  | | | Company Name: | |  | | |
| Physical Address: |  | | | Physical Address: | |  | | |
| City, State, Zip: |  | | | City, State, Zip: | |  | | |
| Mailing Address: |  | | | Mailing Address: | |  | | |
| City, State, Zip: |  | | | City, State, Zip: | |  | | |
| Phone: |  | | | Phone: | |  | | |
| Fax: |  | | | Fax: | |  | | |
| Email: |  | | | Email: | |  | | |
| Tax ID Number: |  | | |  | |  | | |
|  | | | | | | | | |
| **Billing Information** | | | | | | | | |
| **Primary Billing Contact** | | | **Invoice and Invoice Detail** | | | | | |
| Name/Title: | Claire Stella | | Electronic PDF | | Preferred Logon ID: | | |  |
| Company Name: | RP Riley Management Group | | Electronic Flat File (requires SFTP) | | | | Fixed Width  Delimited | |
| Physical Address: | 822 Andover Drive | | **Additional Invoice Email Notifications** | | | | | |
| City, State, Zip: | Eagle, WI 53119 | | Name/Title: | | |  | | |
| Mailing Address: |  | | Email: | | |  | | |
| City, State, Zip: |  | | Phone: | | |  | | |
| Phone: | 262-363-2700 x 221 | | Name/Title: | | |  | | |
| Fax: | 262-363-5556 | | Email: | | |  | | |
| Email: | cstella@rpriley.com | | Phone: | | |  | | |
|  | | | | | | | | |
| **Rebate Information** | | | | | | | | |
| Payment Distribution: | Credit Applied to Clients Invoice  ACH (Requires Completed ACH Form)  Check Payable to Group  N/A | | Notification Distribution: | | | Email Payment Backup  N/A | | |
| Payable To Name: |  | | Name/Title: | | |  | | |
| Mail To Name: |  | | Email: | | |  | | |
| Company Name: |  | | Name/Title: | | |  | | |
| Mailing Address 1: |  | | Email: | | |  | | |
| Mailing Address 2: |  | | Name/Title: | | |  | | |
| City, State, Zip: |  | | Email: | | |  | | |
|  | | | | | | | | |
| **Broker / Consultant Contact** | | | | | | | | |
| Name: |  | | | | | | | |
| Company Name: |  | | | | | | | |
| Physical Address: |  | | Mailing Address: | | |  | | |
| City, State, Zip: |  | | City, State, Zip: | | |  | | |
| Phone: |  | | Fax: | | |  | | |
| Email: |  | | | | | | | |
|  | | | | | | | | |
| **Third Party Administrator** | | | | | | | | |
| Name: |  | | | | | | | |
| Company Name: |  | | | | | | | |
| Physical Address: |  | | Mailing Address: | | |  | | |
| City, State, Zip: |  | | City, State, Zip: | | |  | | |
| Phone: |  | | Fax: | | |  | | |
| Email: |  | | | | | | | |
|  | | | | | | | | |
| **Eligibility Information** | | | | | | | | |
| **Primary Eligibility Contact** | | **Additional Contacts Approved to Make Eligibility Changes** | | | | | | |
| Name/Title: |  | Name/Email: | | | |  | | |
| Company Name: |  | Name/Email: | | | |  | | |
| Phone: |  | Name/Email: | | | |  | | |
| Fax: |  | Name/Email: | | | |  | | |
| Email: |  | Name/Email: | | | |  | | |

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| **Group Setup Information** | | | |
| Group Name: |  | | |
| Group Number(s): | 20-character max Per Group Number (alpha and/or numeric) | | |
| Effective Date: | Click or tap to enter a date. | Benefit Year Start Date: | Click or tap to enter a date. |
| Sector: | Choose an item. | If Other, please describe: |  |

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| **Coordination of Benefits Rules** |
| **Coordination of Benefits allows a member with more than one prescription drug coverage plan to have their claims processed through both coverage plans. If not completed, default settings will apply.** |
| Primary Claims Only (Rejects Secondary, Tertiary, Etc. Claims)  Secondary, Tertiary, Etc. Claims Only (Rejects Primary Claims)  Default (Allows Primary, Secondary, Etc.) |

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| **Medical Customer Service** | | | | | | | | | | | | | | | |
| **Information below will be utilized to refer the caller to if call does not pertain to prescription benefits.** | | | | | | | | | | | | | | | |
| Medical Provider Company Name: | | | | |  | | | | | | | | | | |
| Medical Customer Service Number: | | | | |  | | | | | | | | | | |
| Medical Customer Service Email: | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Identification Cards** | | | | | | | | | | | | | | | |
| **Will identification cards be printed by Script Care. Ltd.?** | | | | | | | | | | | | | | | |
| Customized Plastic Cards – Combination Pharmacy & Medical Card (If checked, complete section below)  Standard Plastic Cards – Pharmacy Only Card (If checked, complete section below)  No Cards – Cards are being printed by Group, TPA, etc. (If checked, skip section below) | | | | | | | | | | | | | | | |
| **Return Undeliverable Cards To The Following Address:** | | | | | | | | | | | | | | | |
| Name/Title: | | | | |  | | | | | | | | | | |
| Company Name: | | | | |  | | | | | | | | | | |
| Mailing Address: | | | | |  | | | | | | | | | | |
| City, State, Zip: | | | | |  | | | | | | | | | | |
| **Identification Card Example (Customizable upon request)** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Instruction(s) for Mailing Identification Card** | | | | | | | | | | | | | | | |
| Mail Initial Cards to: | | | | TPA  Group  Participant’s Home (Fee Applies)  N/A  (Patient addresses are required) | | | | | | | | | | | |
| Mail Daily Cards to: | | | | TPA  Group  Participant’s Home (Fee Applies)  N/A  (Patient addresses are required) | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Eligibility Information** | | | | | | | | | | | | | | | |
| Enrollment Count: | | |  | |  | | |  | | | | | |  | |
| Total # of Employees (required): | | | | |  | | | | | | | | | | |
| Total # of Dependents: | | | | |  | | | | | | | | | | |
| Dependent Information Provided on Eligibility Files? | | | | | | | Yes (default, utilized if left blank) | | | | | | | No | |
| Use Location or Division Codes: | | | | | | | Yes (must be submitted on eligibility files) | | | | | | | No | |
|  | | | | | | | | | | | | | | | |
| **CMS Medicare Part D RDS Program** | | | | | | | | | | | | | | | |
| Is the group currently participating in the CMS Medicare Part D RDS Program? | | | | | | | | | | Yes | | No | | | N/A – Retirees are not covered |
| Number of Covered Retirees (65+): | | | | | |  | | | Dependents (65+): | | | |  | | |
|  | | | | | | | | | | | | | | | |
| **Direct Member Reimbursement** | | | | | | | | | | | | | | | |
| **Direct Member Reimbursement (DMR) is when the patient pays out-of-pocket for a medication/product that was not processed through insurance but is seeking reimbursement. Please note that compounds are not covered through direct member reimbursement.** | | | | | | | | | | | | | | | |
| Not Allowed | | | | Reimburse at contract price minus co-payment | | | | | | Reimburse at amount billed minus co-payment | | | | | |
| How many days? | | | |  | after which the Rx will be processed at contract price less copay. | | | | | | | | | | |
| **Maximum number of days to allow submission for member reimbursement.** | | | | | | | | | | | | | | | |
| Default (365 Days) | | | | | | | | | | | | | | | |
| Other: |  | | | | | | | | | | | | | | |
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| **Dispense as Written Override** | | | | | | | | | | | | | | | |
| **Dispense as Written (DAW) is a product selection code submitted by the pharmacy that indicates the instruction regarding substitution of a generic equivalent product [A close up of a sign  Description automatically generated](#Definitions). The below option(s) indicates if the patient can obtain the branded product over the generic equivalent with or without a penalty. If patient penalty is waived, then the group will incur the penalty by default.** | | | | | | | | | | | | | | | |
| Yes | | Allows patient to override generic substitution allowed by doctor and NOT BE PENALIZED. Patient will pay only the present co-payment. | | | | | | | | | | | | | |
| No | | Does not allow patient to override generic substitution allowed by doctor. Patient must pay difference in price between the BRAND NAME drug and the GENERIC drug plus the brand name co-payment. | | | | | | | | | | | | | |
|  | | DAW Penalty:  Applicable or  Not Applicable to $0 copay drugs (no cost-sharing drugs) | | | | | | | | | | | | | |
| Not Allowed | | Plan does not cover claim when the patient has requested the brand over the generic equivalence. Claim will reject at the point of sale. | | | | | | | | | | | | | |
| **Other Default DAW Settings** | | | | | | | | | | | | | | | |
| Submitted Dispense as Written Code | | | | | | | | | | | Applied Penalty | | | | |
| 1 Substitution Not Allowed by Prescriber  2 Substitution Allowed - Patient Requested That Brand Product Be Dispensed  3 Substitution Allowed - Pharmacist Selected Product Dispensed  4 Substitution Allowed - Generic Drug Not in Stock  5 Substitution Allowed - Brand Drug Dispensed as Generic  6 Override  7 Substitution Not Allowed - Brand Drug Mandated by Law  8 Substitution Allowed - Generic Drug Not Available in Marketplace  9 Other - Only Allowed if Required by Formulary | | | | | | | | | | | No Patient Penalty  Indicated by Completing Section Above  No Patient Penalty – Pharmacy Incurs Penalty  No Patient Penalty – Pharmacy Incurs Penalty  No Patient Penalty – Pharmacy Incurs Penalty  Not Allowed  No Patient Penalty  No Patient Penalty  No Patient Penalty | | | | |

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| **Refill Threshold (Tolerance Percentage)** | | | | |
| **Refill thresholds are a way of preventing prescriptions from being refilled too soon.** | | | | |
| Default Refill Threshold: | 75 % (Example: 30 day supply of a medication could not be refilled again until 23 days past the previous Rx date) | | | |
| Create Custom Refill Threshold: | | Non-Controlled Substance: |  | % |
|  | | Controlled Substance: |  | % |
|  | | Other: |  | % |
| If Other, please describe: | | |  | |

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| **Online Reports** | |
| **The amount selected below identifies specific patients that exceed the Stop Loss threshold amount** | |
| Stop Loss Spec Amount:  $500  $1000  Other: | $ |

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| **Integrated PPO/HDHP/HSA Plans (Rx and Medical) (Requires SFTP)** | |
| **Type of Integrated Plan** | |
| PPO – Preferred Provider Organization  HDHP – High Deductible Health Plan  HSA – Health Savings Account | |
| **Type of Integrated Accumulator (Select all that apply)** | |
| Combined Deductible | |
| Combined Maximum Out-of-Pocket | |
| Combined Benefit Cap | |
| Other: |  |
| N/A | |

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| **Deductible** | | | | | |
| **Deductible is the amount a member and/or family must meet first during the given period before the group begins to pay for covered prescription and/or medical claims.** | | | | | |
| Period Type **[A close up of a sign  Description automatically generated](#Definitions)** | | Choose an item. | Apply to | | Choose an item. |
| Per Member | $ |  | | | |
| And/ or Per Family | $ |  | | | |
| Brand only drugs (Generics n/a to Deductible) Apply to Deductible: | | | | Choose an item. | |
| Dispense as Written Penalty Apply to Deductible? | | | | Choose an item. | |
| Is the Deductible included in the Maximum Out of Pocket, if applicable? | | | | Choose an item. | |
| **See Definitions section for further explanation [A close up of a sign  Description automatically generated](#Definitions)** | | | | | |
| Satisfaction Type\*: | Choose an item. | | | | |
| \*If not completed, then “Lesser of Individual or Family” is utilized. | | | | | |
|  | | | | | |
| **Maximum Out-of-Pocket** | | | | | |
| **Maximum Out-of-Pocket is the most a member and/or family will pay out of pocket for covered prescription and/or medical claims.** | | | | | |
| Period Type **[A close up of a sign  Description automatically generated](#Definitions)** | | Choose an item. | Apply to | | Choose an item. |
| Per Member | $ |  | | | |
| And/ or Per Family | $ |  | | | |
| Brand only drugs (Generics n/a to Maximum Out-of-Pocket) | | | | Choose an item. | |
| Dispense as Written Penalty Apply to Maximum Out-of-Pocket: | | | | Choose an item. | |
| **See Definitions section for further explanation [A close up of a sign  Description automatically generated](#Definitions)** | | | | | |
| Satisfaction Type\*: | | Choose an item. | | | |
| \*If not completed, then “Lesser of Individual or Family” is utilized. | | | | | |
|  | | | | | |
| **Maximum Benefit** | | | | | |
| **Maximum Benefit is the maximum allowed coverage for covered prescription and/or medical claims.** | | | | | |
| Period Type **[A close up of a sign  Description automatically generated](#Definitions)** | | Choose an item. | Apply to | | Choose an item. |
| Per Member | $ |  | | | |
| And/ or Per Family | $ |  | | | |
| Applicable or  Not Applicable to $0 copay drugs (no cost-sharing drugs) | | | | | |
| **See Definitions section for further explanation [A close up of a sign  Description automatically generated](#Definitions)** | | | | | |
| Satisfaction Type\*: | | Choose an item. | | | |
| \*If not completed, then “Lesser of Individual or Family” is utilized. | | | | | |

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| **Max Dollar Per Script** | | | | |
| SCL Internal Max $5,000.00. Scripts equaling or exceeding the SCL Max $ will be rejected at the point of sale and reviewed by the SCL Clinical Dept. | | | | |
| Other: | $ |  | If other, select:  SCL Clinical Authorization  Plan Authorization | |
| Optional prior authorization requirements (fees apply):  Clinical Prior Authorization (CPA) | | | | |
| Include Co-payment in Max Dollar Calculation? | | | | Yes  No |

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| **Clinical Review Information for Prior Authorization for claims over $10,000.00** | | | |
| SCL Clinical Review and Client Authorization  SCL Clinical Review and Approval | | | |
| **Primary Clinical Contact. If client authorization is required, completed section below** | | | |
| Name/Title: |  | | |
| Company Name: |  | | |
| Phone: |  | Fax: |  |
| Email: |  | | |
| Member addresses are required if PA’s and/or CPA’s are required for drug coverage. | | | |
| Any other drug categories that require authorization, please specify authorization process | | | |
| **Any other drug categories that require authorization, please specify authorization process** | | | |
| SCL Clinical Review and Fill (**Recommended Process**)  SCL Clinical Review and Client Notification  SCL Clinical Review and Client Authorization | | | |
| **Prior Authorization Group Blank** | | | |
| Default - If the client has two or more Group Numbers, the Group Number field on the prior authorization will be blank as a default. The prior authorization would still be applicable no matter what Group Number the patient moves to.  Do not default prior authorization Group Number to blank. | | | |

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| **Client Website Online Access** | | | | | | | | | | | | | | | | | | | | |
| **User's Name** | | | | **User's Phone#** | | | | **E-mail (required)** | | | | | | | | | | | **Choose all that Apply** | |
|  | | | |  | | | |  | | | | | | | | | | | 1  2  3  4  5  All | |
|  | | | |  | | | |  | | | | | | | | | | | 1  2  3  4  5  All | |
|  | | | |  | | | |  | | | | | | | | | | | 1  2  3  4  5  All | |
|  | | | |  | | | |  | | | | | | | | | | | 1  2  3  4  5  All | |
| 1) Home Page Only (automatically added for all users)  Includes general information, forms, pharmacy locator  2) Plan Page  Includes price calculator, mail order and/or specialty pharmacy info  3) Regular Reports (non-PHI)  13 non-PHI reports available  4) PHI Reports  PHI reports available. Must have a BAA or BAA Acknowledgement for PHI  5) Download Reports (F02.7 format) – Includes PHI  PHI and/or non-PHI report available in the F02.7 format.  Must have a signed contract on file and a BAA or BAA Acknowledgement for PHI | | | | | | | | | | | | | | | | | | | | |
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| **Remote Eligibility System Management – Agent Website** | | | | | | | | | | | | | | | | | | | | |
| **The Agent Website is a web-based portal used by clients and business partners to manage patient information/demographics.** | | | | | | | | | | | | | | | | | | | | |
| **Required Documents**  Business Associate Agreement or Business Associate Agreement Acknowledgement required for each Entity due to PHI.  **Instructions for New User Setup**  Instructions/Training will be provided by the Account Manager once setup is complete. | | | | | | | | | | | | | | | | | | | | |
| **User's Name** | | | | **User's Phone#** | | | | **E-mail (required)** | | | | | | | | | | **Notes and/or Modification Details** | | |
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| **SFTP/FTP** | | | | | | | | | | | | | | | | | | | | |
| Secure SFTP | | | N/A | | | | | |  | | | | |  | | | | | | |
| External IP Address(s): | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Eligibility Information, cont.** | | | | | | | | | | | | | | | | | | | | |
| Electronic File Submission (requires SFTP)  Loaded Manually | | | | | |  | | | | | | |  | | | | | | | |
| Files will be submitted by: | | | | TPA | Plan Sponsor | | | | | | Broker | | | | | Carrier | | Other: | |  |
| File Frequency | | | | Daily (M-F) | | | | | | | | | | | | | | | | |
| Daily (M-F + Weekends) | | | | | | | | | | | | | | | | |
| Weekly (list which day(s) files will be posted): | | | | | | | | | | |  | | | | | |
| Monthly (list which day(s) files will be posted): | | | | | | | | | | |  | | | | | |
| Other (provide details) | | | | | |  | | | | | | | | | | |
| File Type | | | | Full Replacement (term by absence) | | | | | | | | | | | | | | | | |
| Update Only (must provide term dates) | | | | | | | | | | | | | | | | |
| **Contacts for Data Setup** | | | | | | | | | | | | | | | | | | | | |
| Name/Title: |  | | | | | | | | | | | Name/Title: | | | | |  | | | |
| Email: |  | | | | | | | | | | | Email: | | | | |  | | | |
| Phone: |  | | | | | | | | | | | Phone: | | | | |  | | | |
| Mapping Requirements (if applicable): | | | | | | |  | | | | | | | | | | | | | |
| Additional notes for Eligibility (if applicable): | | | | | | |  | | | | | | | | | | | | | |
| Eligibility Output File  BAA or BAA Acknowledgement required for outgoing files with PHI. | | | | | | | Yes  No | | | | | | | | | | | | | |

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| **Formulary** |
| **Please selected the formulary that will be applied to the plan design.** |
| Premier  Premier Plus |
| **Formulary Definitions** |
| Premier: SCL’s open preferred drug list that includes all drugs as Generic Preferred, Generic Non-Preferred, Brand Preferred and Brand Non-Preferred.  Premier Plus: SCL’s exclusionary preferred drug list that, in addition to Generic Preferred, Generic Non-Preferred, Brand Preferred, and Brand Non-Preferred, also excludes some drugs from coverage. |

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| **Retail Copays** | | | | |
| **Complete Option A or Option B** | | | | |
| Option | Brand with Generic |  |  | **Default Dispensing Limits:**  **Retail:** 30 day supply  **Plans without Mail Order:**  Acute Care Drugs: 34 day supply  Maintenance Drugs: 90 day supply\*  \* Charge 1 copay per 30 days |
| A | Brand without Generic |  |
| Generic |  |
|  | | |
| Option | Brand - Non-Preferred (Non-Formulary) |  |
| B | Brand - Preferred (Formulary) |  |
| Generic - Non-Preferred (Non-Formulary) |  |
| Generic - Preferred (Formulary) |  |
|  | | |
| Other: |  | |
| If adding special tiers, specify above. | | |

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| **Retail 90 Day Network Copays** | | | | |
| **Complete Option A or Option B** | | | | |
| Option | Brand with Generic |  |  | **Retail 90 Day Network Default Setup:**  1 copay per 30 days  Maintenance Drugs Only  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| A | Brand without Generic |  |
| Generic |  |
|  | | |
| Option | Brand - Non-Preferred (Non-Formulary) |  |
| B | Brand - Preferred (Formulary) |  |
| Generic - Non-Preferred (Non-Formulary) |  |
| Generic - Preferred (Formulary) |  |
|  | | |
| Other: |  | |
| If adding special tiers, specify above. | | |

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| **Mail Order Copays** | | | | | | |
| **Complete Option A or Option B** | | | | | | |
| Option | Brand with Generic |  |  | None | Mandatory After\*: | |
| A | Brand without Generic |  | Non-Mandatory | 1st Fill at Retail | |
| Generic |  | Mandatory\* | 2nd Fill at Retail | |
|  | | |  | Other: |  |
| Option | Brand - Non-Preferred (Non-Formulary) |  |  |  | |
| B | Brand - Preferred (Formulary) |  | Apply to Maintenance Drugs Only | | |
| Generic - Non-Preferred (Non-Formulary) |  | Mail Order: 90 day supply | | |
| Generic - Preferred (Formulary) |  | Products Allowed at Retail for 90 Day Supply: | | |
|  | | | 1. C-II drug or Schedule II substance 2. Insulin 3. Extended Contraceptives allowed at 91 day supply   \*Only applicable in states where allowed | | |
| Other: |  | |
| If adding special tiers, specify above. | | |  | | |

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| **SCL Specialty Pharmacy Copays** | | | | | |
| Option | Brand with Generic |  |  | None | |
| A | Brand without Generic |  |
| Generic |  | Mandatory\* | |
|  | | |  | |
| Option | Brand - Non-Preferred (Non-Formulary) |  | Flexible Specialty Copay Program\* **[A close up of a sign  Description automatically generated](#Definitions)** | |
| B | Brand - Preferred (Formulary) |  |
| Generic - Non-Preferred (Non-Formulary) |  | **Default Setup**: 30 day supply or as clinically appropriate | |
| Generic - Preferred (Formulary) |  |
|  | | |  |  |
| Other: |  | | Specialty copays apply to specialty eligible drugs at retail  \*Only applicable in states where allowed | |
| If adding special tiers, specify above. | | |
| **Note: Specialty Pharmacy requires specialty injectables to be covered and applicable supplies to administer the medication.** | | | | | |

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| **SCL Diabetic Program Copays** | | | | | | | |
|  | | Diabetic Drugs | Diabetic Supplies |  | None | | |
| Option | Brand with Generic |  |  |
| A | Brand without Generic |  |  |
| Generic |  |  | Mandatory After\*: | | |
|  | | | | 1st Fill at Retail | | |
| Option | Brand - Non-Preferred (Non-Formulary) |  |  | 2nd Fill at Retail | | |
| B | Brand - Preferred (Formulary) |  |  | Other |  | |
| Generic - Non-Preferred (Non-Formulary) |  |  | **Default Setup**: | | |
| Generic - Preferred (Formulary) |  |  | 90 day supply | |  |
|  | | | |  |  | |
| Other: |  | | | \*Only applicable in states where allowed | | |
| If adding special tiers, specify above. | | | |
| **Note: Diabetic Program requires Diabetic Supplies to be covered.** | | | | | | | |

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| **SCL Compound Program Copays** | | | | |
| Option | Brand with Generic |  |  | Mandatory for Compounds over $100 |
| A | Brand without Generic |  | Mandatory 4 Script Max/Month at Retail |
| Generic |  |  |
|  | | | Copay same as Retail |
| Option | Brand - Non-Preferred (Non-Formulary) |  |  |
| B | Brand - Preferred (Formulary) |  |  |
| Generic - Non-Preferred (Non-Formulary) |  |  |
| Generic - Preferred (Formulary) |  |  |
| Other: |  | |  |
| If adding special tiers, specify above. | | |

Member addresses are required if participating in the SCL Specialty, Diabetic or Compound Programs.

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| **Drug Coverage** | | | | |
| **Drug Category** | **Examples Subject to Formulary** | **SCL Recommended Coverage**  **Use Standard SCL Plan** | **Benefit Coverage Changes**  **Change Recommended Coverage** | **Custom Limitations** |
| **All Injectables\*** – will follow coverage unless specific medication detailed in other sections. | Enbrel, Lovenox,  Testosterone Cypionate | Include | Include  CPA  Exclude |  |
| **Anaphylaxis Therapy Agents (Injectables)** | Epinephrine Auto-Injector, Epipen | Include | Include  CPA  Exclude |  |
| **Compounds** |  |  |  |  |
| 1. Compound Products | 1. Products mixed by a Pharmacist | 1. Mandatory SCL Compound Program | 1.  Include  CPA  Exclude | 1. |
| 2. Bulk Chemicals Not Compounded | 2. Bulks Chemicals dispensed as an individual product. | 2. Exclude. No option to Cover. | 2.  Include  CPA  Exclude | 2. |
| **Contraceptives**  *(See Affordable Care Act Coverage)* | |  |  |  |
| **Cosmetic Agents:** |  |  |  |  |
| 1. Hair Loss/Growth | 1. Rogaine, Propecia, Vaniqa | 1. Exclude | 1.  Include  CPA  Exclude | 1. |
| 2. Scar Treatment/Discoloration/Misc | 2. Recedo, Tri-Luma | 2. Exclude | 2.  Include  CPA  Exclude | 2. |
| 3. Wrinkles/Lipoatrophy | 3. Botox Cosmetic,Renova | 3. Exclude | 3.  Include  CPA  Exclude | 3. |
| **Dermatology (**Acne/Skin Disease) |  |  |  |  |
| 1. Acne | 1. Differin, Claravis, Renova | 1. Include if age less than 26 years  Exclude if age greater than 25 years | 1.  Include  CPA  Exclude | 1. |
| 2. Skin Disease | 2. Bactroban, Triamcinolone | 2. Include | 2.  Include  CPA  Exclude | 2. |
| **Diabetic Supplies:** |  |  |  |  |
| 1. Syringes & Needles | 1. B-D syringes | 1. Include | 1.  Include  CPA  Exclude | 1. |
| 2. Alcohol Swabs | 2. Alcohol Swabs | 2. Include | 2.  Include  CPA  Exclude | 2. |
| 3. Insulin Injection Devices | 3. Novopen | 3. Include | 3.  Include  CPA  Exclude | 3. |
| 4. Lancets | 4. Lancets | 4. Include | 4.  Include  CPA  Exclude | 4. |
| 5. Lancet Devices | 5. Soft Touch, Monojector | 5. Include | 5.  Include  CPA  Exclude | 5. |
| 6. Test Strips (Blood) | 6. Accu-Check, Freestyle | 6. Include | 6.  Include  CPA  Exclude | 6. |
| 7. Test Strips (Urine) | 7. Chemstrip, Ketostix | 7. Include | 7.  Include  CPA  Exclude | 7. |
| 8. Glucose Monitors (Finger Stick) | 8. Accu-Check, Freestyle | 8. Exclude | 8.  Include  CPA  Exclude | 8. |
| 9. Continuous Glucose Monitor/Supplies | 9. Freestyle Libre, Dexcom | 9. CPA | 9.  Include  CPA  Exclude | 9. |
| **Diabetic Injectables** |  |  |  |  |
| 1. Insulin | 1. Novolin, Humulin | 1. Include | 1.  Include  CPA  Exclude | 1. |
| 2. Anti-Diabetic Injectables | 2. Byetta, Trulicity, Victoza | 2. Include | 2.  Include  CPA  Exclude | 2. |
| **Diagnostic Agents** | HIV tests, Pregnancy test | Exclude | Include  CPA  Exclude |  |
| **Dietary Products** | Baby Formula, Ensure, Foltx | Exclude | Include  CPA  Exclude |  |
| **Fertility Agents:** |  |  |  |  |
| 1. Injectable | 1. Gonal-F, Fertinex | 1. Exclude | 1.  Include  CPA  Exclude | 1. |
| 2. Oral | 2. Clomid | 2. Exclude | 2.  Include  CPA  Exclude | 2. |
| **Growth Hormones** | Genotropin, Humatrope | Exclude | Include  CPA  Exclude |  |

Drug Coverage continued on next page.

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| **Immunotherapy:** |  |  |  |  |
| 1. Allergen Immunotherapy | 1. Allergy Shot, Allergy sublingual | 1. Exclude | 1.  Include  CPA  Exclude | 1. |
| 2. Vaccines – ACA | 2. See ACA Coverage Section |  |  |  |
| 3. Vaccines – Non ACA | 3. Rabies, Yellow Fever | 3. Exclude | 3.  Include  CPA  Exclude | 3. |
| 4. Vaccines – Cares Act | 4. COVID-19 Vaccine | 4. Include | 4.  Include  CPA  Exclude |  |
| **Passive Immunizing & Treatment Agents:** |  |  |  |  |
| 1. Immune Serums | 1. GamaStan, Cytogam, Cuvitru | 1. Exclude | 1.  Include  CPA  Exclude | 1. |
| 2. Antitoxins/Antivenins | 2. Antivenin, Anascorp | 2. Exclude | 2.  Include  CPA  Exclude | 2. |
| 3. Monoclonal Antibodies | 3. Synagis, Zinplava | 3. Exclude | 3.  Include  CPA  Exclude | 3. |
| 4. Passive Immunizing Agents - Combinations | 4. Hyqvia | 4. Exclude | 4.  Include  CPA  Exclude | 4. |
| **Medical Devices & Supplies** | Respiratory, Ostomy, Dialysis | Exclude | Include  CPA  Exclude |  |
| **Non-Insulin Syringes/Needles** | Non-Insulin Syringes/Needles | Exclude | Include  CPA  Exclude |  |
| **Over the Counter (OTC)**  (Drugs not included in ACA Coverage) | Prilosec OTC, Nexium OTC | Exclude | Include  CPA  Exclude |  |
| **Vitamins: *(****Some products may be covered under ACA Coverage Section)* | |  |  |  |
| 1. Rx Vitamins | 1. Vitamin D | 1. Exclude | 1.  Include  CPA  Exclude | 1. |
| 2. Rx Prenatal | 2. Prenate | 2. Include | 2.  Include  CPA  Exclude | 2. |
| 3. Injectable | 3. B-12, Thiamine HCL | 3. Include | 3.  Include  CPA  Exclude | 3. |
| **Weight Loss Drugs:** |  |  |  |  |
| Anorexiants | Adipex, Qsymia, Saxenda | Exclude | Include  CPA  Exclude |  |
| **Stimulants:** |  |  |  |  |
| ADHD Drugs | Adderall, Concerta, Vyvanse | Include | Include  CPA  Exclude | Age Limit: |

\* Applicable to Route of Administration: IJ: Injection, IM: Intramuscular, IV: Intravenous, IX: Intra-Articular, SC: Subcutaneous

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| **Affordable Care Act “ACA” Exemptions** | | | |
| Accept Standard ACA Coverage Below (Non-Grandfathered)  Religious (Contraceptives will be excluded)  Grandfathered (ACA $0 copay does not apply. Benefit Coverage Must be selected below.) | | | |
|  | | | |
| **Affordable Care Act Preventive Drug Coverage, no cost-share (copay, coinsurance or deductible) $0.00** | | | |
| **All Drugs/Products require a prescription from a physician and must be purchased at a pharmacy.**  **Coverage for preventive care medications include generic products and brand products that do not have a generic equivalent.**  **The benefits below may not be covered under all formularies and/or plan designs.** | | | |
| **Drug Category** | **Applies to Limitation(s)/Example(s)** | **Benefit Coverage for ACA Exempt Plans** | **Custom Limitations for ACA Exempt Plans** |
| **Preventive Medications:** |  |  |  |
| 1. Aspirin 81mg | 1. Pregnant women at high risk for pre-eclampsia   Women ages 12 to 50 years | 1.  Include  CPA  Exclude | 1. |
| 2. Aspirin, Generic OTC, no greater than 325mg | 1. Men and women ages 50 to 69 years | 2.  Include  CPA  Exclude | 2. |
| 3. Folic Acid, Generic OTC, 0.4 and 0.8mg | 1. Women ages 12 to 50 years | 3.  Include  CPA  Exclude | 3. |
| 4. Iron Supplements, Generic OTC and RX | 1. Children ages 6 -12 months | 4.  Include  CPA  Exclude | 4. |
| 5. Fluoride Supplements, Generic OTC and Rx | 1. Children ages 6 months – 5 years | 5.  Include  CPA  Exclude | 5. |
| 6. Erythromycin Ophthalmic Ointment 0.5% | 1. Newborns | 6.  Include  CPA  Exclude | 6. |
| **Immunological Vaccines:** |  |  |  |
| 1. Tetanus | 1. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 1. |
| 2. Diptheria | 2. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 2. |
| 3. Pertussis (Td/Tdap) | 3. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 3. |
| 4. Human papillomavirus (HPV) | 4. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 4. |
| 5. Varicella | 5. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 5. |
| 6. Zoster | 6. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 6. |
| 7. Measles | 7. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 7. |
| 8. Mumps | 8. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 8. |
| 9. Rubella (MMR | 9. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 9. |
| 10. Influenza | 10. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 10. |
| 11. Pneumococcal (polysaccharide) | 11. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 11. |
| 12. Hepatitis A | 12. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 12. |
| 13. Hepatitis B | 13. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 13. |
| 14. Meningococcal | 14. Pharmacy Administered Vaccinations | 1. Include  CPA  Exclude | 14. |
| **Contraceptives:** |  |  |  |
| 1. Devices | 1. Mirena IUD, Diaphragm | 1. Include  CPA  Exclude | 1. |
| 2. Implant | 2 Implanon, Nexplanon | 1. Include  CPA  Exclude | 2. |
| 3. Injectable | 3. Depo-Provera | 1. Include  CPA  Exclude | 3. |
| 4. Oral | 4. Ortho Tri-Cyclen, Yasmin | 1. Include  CPA  Exclude | 4. |
| 5. Extended-Cycle Oral \* | 5. Seasonale, Seasonique | 1. Include  CPA  Exclude | 5. |
| 6. Transdermal | 6. Ortho Evra | 1. Include  CPA  Exclude | 6. |
| 7. Vaginal | 7. Nuvaring | 1. Include  CPA  Exclude | 7. |
| 8. Emergency | 8. Plan B | 1. Include  CPA  Exclude | 8. |
| 9. OTC | 9. Spermicides, Sponges, Condoms | 1. Include  CPA  Exclude | 9. |
| **Smoking Cessation Products:** |  |  |  |
| 1. Chantix (starter pack) | 1. 2 per year | 1. Include  CPA  Exclude | 1. |
| 1. Chantix | 1. 224 tablets per year | 1. Include  CPA  Exclude | 2. |
| 1. Bupropion | 1. 360 tablets per year | 1. Include  CPA  Exclude | 3. |
| 1. Nicotrol Inhaler | 1. 2688 cartridges per year | 1. Include  CPA  Exclude | 4. |
| 1. Nicotrol Nasal Spray | 1. 90 bottles per year | 1. Include  CPA  Exclude | 5. |
| 1. Nicoderm Patch | 1. 140 patches per year | 1. Include  CPA  Exclude | 6. |
| 1. Nicoderm Gum | 1. 480 pieces per year | 1. Include  CPA  Exclude | 7. |
| 1. Nicoderm Lozenge | 1. 480 pieces per year | 1. Include  CPA  Exclude | 8. |
| **Breast Cancer Preventive:** |  |  |  |
| 1. Tamoxifen tablets | 1. Women ages 35 and over | 1. Include  CPA  Exclude | 1. |
| 1. Raloxifene | 1. Women ages 35 and over | 1. Include  CPA  Exclude | 2. |
| **Bowel Preparation:** |  |  |  |
| 1. Solutions/Solution Packs | 1. Men and Women ages 50 and over | 1. Include  CPA  Exclude | 1. |
| **Statins, Low to Moderate Intensity, Generic Only:** |  |  |  |
| 1. Atorvastatin 10 mg, 20 mg | 1. Men and Women ages 40 to 75 | 1. Include  CPA  Exclude | 1. |
| 2. Fluvastatin 20 mg, 40 mg | 2. Men and Women ages 40 to 75 | 1. Include  CPA  Exclude | 2. |
| 3. Fluvastatin ER 80 mg | 3. Men and Women ages 40 to 75 | 1. Include  CPA  Exclude | 3. |
| 4. Lovastatin 10 mg, 20 mg, 40 mg | 4. Men and Women ages 40 to 75 | 1. Include  CPA  Exclude | 4. |
| 5. Pravastatin 10 mg, 20 mg, 40 mg, 80 mg | 5. Men and Women ages 40 to 75 | 1. Include  CPA  Exclude | 5. |
| 6. Rosuvastatin 5 mg, 10 mg | 6. Men and Women ages 40 to 75 | 1. Include  CPA  Exclude | 6. |
| 7. Simvastatin 5 mg, 10 mg, 20 mg, 40 mg | 7. Men and Women ages 40 to 75 | 1. Include  CPA  Exclude | 7. |
| **Pre-Exposure Prophylaxis (PrEP) \*\*** |  |  |  |
| 1. Truvada 200/300mg (Generic only) | 1. 30 tablets per 30 day supply | 1. Include  CPA  Exclude | 1. |

*\* Allows up to a 91 day supply to be dispensed.*

*\*\* Requires a pharmacy to submit the diagnosis code (ICD-10 code) to validate if the product is for Pre-Exposure Prophylaxis.*

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| **Quantity Limitations** | | | | | | | |
| **Drug Category** | **Recommended Limitations - Will Apply if Set to Include** | | **SCL Recommended Coverage**  **Use Standard SCL Plan** | | **Benefit Coverage** | | **Custom Limitations** |
| **Migraine Therapy:** | | **Limitations** | |  | |  | |
| 1. Amerge | 1. 9 tabs/30 days | | 1. Include | | 1. Include  CPA  Exclude | | 1. |
| 2. Axert | 2. 12 tabs/30 days | | 2. Include | | 1. Include  CPA  Exclude | | 2. |
| 3. Cambia | 3. 9 packets/30 day | | 3. Include | | 1. Include  CPA  Exclude | | 3. |
| 4. Ergomar | 4. 20 tabs/30 day | | 4. Include | | 1. Include  CPA  Exclude | | 4. |
| 5. Frova | 5. 9 tabs/30 day | | 5. Include | | 1. Include  CPA  Exclude | | 5. |
| 6. Imitrex/Sumavel/Zembrace Injection | 6. 4 Stat Dose Systems or 4 Stat  Doses or 4 vials | | 6. Include | | 1. Include  CPA  Exclude | | 6. |
| 7. Imitrex/Tosymra Nasal Spray | 7. 1 box/30 days | | 7. Include | | 1. Include  CPA  Exclude | | 7. |
| 8. Imitrex Tablets | 8. 18 tabs/30 days (all strengths) 18 tabs/30 days (all strengths) | | 8. Include | | 1. Include  CPA  Exclude | | 8. |
| 9. Maxalt, Maxalt MLT | 9. 18 tabs/30 days | | 9. Include | | 1. Include  CPA  Exclude | | 9. |
| 10. Migranal Nasal Spray | 10. 1 box/30 days | | 10. Include | | 1. Include  CPA  Exclude | | 10. |
| 11. Nurtec | 11. 15 tabs/30 days | | 11. Include | | 1. Include  CPA  Exclude | | 11. |
| 12. Onzetra Xsail | 12. 1 box/30 days | | 12. Include | | 1. Include  CPA  Exclude | | 12. |
| 13. Relpax | 13. 8 tabs/30 days | | 13. Include | | 1. Include  CPA  Exclude | | 13. |
| 14. Reyvow | 14. 8 tabs/30 days | | 14. Include | | 1. Include  CPA  Exclude | | 14. |
| 15. Treximet | 15. 9 tabs/30 days | | 15. Include | | 1. Include  CPA  Exclude | | 15. |
| 16. Ubrelvy | 16. 16 tabs/30 days | | 16. Include | | 1. Include  CPA  Exclude | | 16. |
| 17. Zomig, Zomig ZMT | 17. 8 tabs/30 days | | 17. Include | | 1. Include  CPA  Exclude | | 17. |
| 18. Zomig Nasal Spray | 18. 1 box/30 days | | 18. Include | | 1. Include  CPA  Exclude | | 18. |
| **Opioid Therapy:** | |  | |  | |  | |
| 1. OxyContin/Oxycodone (all strengths) | 1. Lesser of 30 day supply or quantity of 100 | | 1. Include | | 1. Include  CPA  Exclude | | 1. |
| 2. Stadol Nasal Spray | 2. 2 bottles/30 days | | 2. Include | | 1. Include  CPA  Exclude | | 2. |
| **Erectile Dysfunction:** | |  | |  | |  | | |
| 1. Oral (example: Viagra, Sildenafil) | 1. 6 units/30 days | | 1. Exclude | | 1. Include  CPA  Exclude | |  | |
| 2. Injectable (example: Caverject, Edex) | 2. 6 units/30 days | | 2. Exclude | | 1. Include  CPA  Exclude | |  | |
| 3. Urethral (example: Muse) | 3. 6 units/30 days | | 3. Exclude | | 1. Include  CPA  Exclude | |  | |
| **All Other Quantity Limitations:** | |  | |  | |  | |
| 1. Bydureon | 1. 4 units/28 days | | 1. Include | | 1. Include  CPA  Exclude | | 1. |
| 2. Byetta | 2. 2.4 units/30 days | | 2. Include | | 1. Include  CPA  Exclude | | 2. |
| 3. Copegus | 3. 168 tabs/28 days | | 3. Include | | 1. Include  CPA  Exclude | | 3. |
| 4. Diclofenac Sodium | 4. 100 units/30 days | | 4. Include | | 1. Include  CPA  Exclude | | 4. |
| 5. Trulicity | 5. 2 units/28 days | | 5. Include | | 1. Include  CPA  Exclude | | 5. |
| 6. Victoza | 6. 9 units/30 days | | 6. Include | | 1. Include  CPA  Exclude | | 6. |
| 7. Xyrem | 7. 540 ml/30 days | | 7. Include | | 1. Include  CPA  Exclude | | 7. |

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| **Standard Exclusions** | | | | |
| **All medications below are excluded from coverage unless the plan chooses to cover the product. This list is subject to change based on PBM Clinical review and revision.** | | | | |
| Acthar | Addyi | Arimidex (for males only) | Aromason (for males only) | Auvi-Q |
| Azeschew | Azesco | BEAU Rx | Chlorzoxazone | Compound Kits |
| Duexis | Entty Emulation Spray | Epiceram | Fortamet | Furadantin Susp |
| Glumetza | Jublia | Kamdoy | Lemtrada | Othro DF |
| PNV 20-1 | Preganna | Prenara | Sil-K Pad | Sinuva |
| Sitavig 50mg | Spravto | Suvicort Emulsion | Synerderm Emulsion | Treximet |
| Trinaz | Vimovo | Vyleesi | Xhance | Yosprala |
| Zalvit | Zegrid |  |  |  |

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| **Drug Classes that Require a Clinical Prior Authorization if Covered** | | | | |
| **All medications/classes below shall be approved and/or denied within the sole clinical discretion of SCL. This list is subject to change based on PBM clinical review and revision.** | | | | |
| Cystic Fibrosis Medications | Hemophilia | Hepatitis C | Hereditary Angioedema | Inflammatory Conditions |
| PCSK9 Inhibitors |  |  |  |  |

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| **Pain Management** | | | |
| **Force 90 Morphine Milliequivalent “MME” per day as a default (messaging only) [A close up of a sign  Description automatically generated](#Definitions). The client can elect to add soft or hard rejects. See below for details.** | | | |
| **Selections** | **MME** | **SCL Recommended Action** | **System Action(s)** |
| Default | 90 | Message | If claim exceeds 90 MME, a message will be sent in the response back to the pharmacy alerting the pharmacy that the patient has exceeded 90 MME. |
|  | 120 | Soft Reject | If claim exceeds 120 MME, the claim will reject, and a message will be sent in the response back to the pharmacy alerting the pharmacy that the patient has exceeded 120 MME. If the pharmacy wishes to still have the claim process after reviewing the patient’s records, they will be able to review and submit DUR/PPS codes within the claim to override the rejection. |
|  | 200 | Hard Reject-CPA Required | If claim exceeds 200 MME, the claim will reject, and a message will be sent in the response back to the pharmacy alerting the pharmacy that the patient has exceeded 200 MME. To override, Script Care must be contacted to have the claim reviewed. |

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| **Non-Erectile Dysfunction Program** | | | |
| **Some erectile dysfunction medications can be used to treat other diagnoses. This program allows the use of those products to treat conditions other that erectile dysfunction by allowing the pharmacy to submit the diagnosis code. By submitting the diagnosis code, the decision to cover the product for the dispensed quantity can be made instantly. Below are the diagnoses that will be allowed to process through this program. The diagnoses within this program are subject to change without notice. This program only applies if the erectile dysfunction class of products is excluded and/or quantity limitations are applied for the use of erectile dysfunction.** | | | |
| **Diagnosis** | **Product** | **Quantity Limitations** | **Allowed Diagnosis Code(s)** |
| Benign Prostatic Hypertrophy | Tadalafil 2.5 mg Tab (Cialis) | 30 Tablets Per 30 Day Supply | N40, N40.0, N40.1, N400, N401 |
| Tadalafil 5 mg Tab (Cialis) | 30 Tablets Per 30 Day Supply |
| Pulmonary Arterial Hypertension | Sildenafil 20 mg Tab (Revatio) | 90 Tablets Per 30 Day Supply | I27.21, I27.0, I27.20, I27.22, I27.23, P29.30, I2721, I270, I2720, I2722, I2723, P2930 |
| Sildenafil 10 mg/mL Oral Suspension (Revatio) | 224 ml (2 bottles) Per 30 Day Supply |
| Tadalafil 20 mg Tab (Adcirca) | 60 Tablets Per 30 Day Supply |

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| **Definitions:** |

Acute Care Drug – Drug that treats short-term illness or injury.

Flexible Specialty Copay Program – Copay Assistance is provided by the pharmaceutical manufacturer to assist the member with their copay. Script Care has developed a Flexible Specialty Copay Program that identifies specialty drugs with copay assistance and utilizes the program maximums and drug regimen to determine the copay. When the claim is processed with the pre-determined copay, the pharmacy will submit a secondary claim to the manufacturer to cover the member’s copay. By taking advantage of the manufacturer’s maximum assistance, the member will have continued assistance throughout the year and the plan will see a reduction in cost.

Generic Equivalent Product – D[rug that](https://www.lawinsider.com/dictionary/generic-equivalent) has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects.

Maintenance Drug – Drug that most common use is to treat a chronic disease state when a therapeutic endpoint cannot be determined.

Mandatory – Limit to only one pharmacy provider for the program.

Morphine Milliequivalent. The amount of morphine an opioid dose is equal to when prescribed, used as a tool to measure the risk of the abuse and overdose potential of the amount of opioid that is being given at a particular time.

Non-mandatory – Allow all network pharmacies as providers for the program.

Period Type:

1. Script: Applies per script processed
2. X Days: The individual and/or family accumulators would start over for the specified days starting at the Benefit Year Start Date
3. Calendar Month: The accumulator(s) would start over at the first of every month.
4. X Month: The individual and/or family accumulators would start over for the specified months starting at the Benefit Year Start Date
5. Calendar Year: The accumulator(s) would start over at the first of every year, January 1st.
6. Benefit Year: The accumulator(s) would start over based on the Benefit Years first day of the month
7. X Years: The individual and/or family accumulators would start over for the specified years starting at the Benefit Year Start Date
8. Lifetime: Applies to the life of the individual and/or family
9. Calendar Quarter: The accumulator(s) would start over at the first day of the new quarter (January 1st, April 1st, July 1st, October 1st)

Satisfaction Type:

1. Lesser of Indiv or Family
   1. Each individual within a family is only required to satisfy the individual deductible or maximum out of pocket. The individual amounts apply toward a shared family deductible or maximum out of pocket. The sum of the individual amounts will not exceed the family amount.
2. Greater of Indiv or Family
   1. Coverage type on the Patient record determines deductible or maximum out of pocket requirements. A shared family cap can be satisfied by one or more individuals within a family.
3. Individual Only Satisfied
   1. Each individual must satisfy the individual deductible or maximum out of pocket.
4. Family Only Satisfied
   1. A shared family deductible or maximum out of pocket that can be satisfied by one or more individuals within a family.
5. Cov Type Determines Ind/Fam Only
   1. This option will take Coverage Type, that is located on the Patient Blade, into consideration when applying deductible or maximum out of pocket amounts. If Coverage Type is set to IND: INDIVIDUAL on the Patient record, then the adjudicator will utilize the value in the Individual Deductible or Maximum Out of Pocket Amount field. If Coverage Type is set to FAM: FAMILY on the Patient record, then the adjudicator will utilize the value in the Family Deductible or Maximum Out of Pocket Amount field. A family shared deductible or maximum out of pocket can be satisfied by one or more individuals with the family

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| **Additional Benefit Coverage Notes:** | |
| **If there are additional benefit coverages not listed above, please describe below.** | |
| Additional Benefit Coverages: |  |

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| **Payment Procedures for Script Care, Ltd. Prescription Drug Programs:** |

Script Care, Ltd. (SCL) operates as a “Pharmacy Benefit Manager” and provides pharmaceutical services to plan sponsors through a national pharmacy network. SCL invoices plan sponsors for prescription drug charges twice a month for charges incurred from the 1st through the 14th and from the 15th through the end of the month. Payment for each invoice is due by the due date stated on the invoice, which coincides with the close of the next billing cycle. Charges incurred from the 1st of the month through the 14th are due by the end of the month, and charges incurred from the 15th of the month through the end of the month are due by the 14th of the following month. This procedure is required to comply with prompt payment procedures contained in provider agreements through network pharmacies.

The following procedures will apply and will be included in the Script Care, Ltd., Agreement:

* If payment for any billing cycle is not received by the due date appearing on the invoice, the invoice will be deemed ***past due***. Prescription transactions ***must be suspended*** by Script Care, Ltd. without advance notice at anytime an invoice is past due.
* The plan may be reinstated if payment of all past due amounts is ***received by Script Care, Ltd.*** within ten (10) working days of this action.
* Thereafter, a written request to reinstate and full payment of any amounts due must be received by Script Care, Ltd. before reinstatement will occur. Script Care, Ltd. as a normal business practice does not require security deposits from plan sponsors. However, Script Care, Ltd. at its sole discretion, may require a security deposit equal to an estimate of up to three (3) months projected prescription drug charges before reinstatement occurs.

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| **OPTIONAL SERVICES AND FEES:** |

* ID Card and Member Communication home delivery - $1.00 plus postage per address label. (SCL may modify this fee if due to changes in postage without advance notice)
* Claims Data Files - SCL shall provide electronic data files, upon request by the Sponsor, in an SCL approved file layout. Files will be

available to one (1) recipient at no additional cost for the term of the contract. Additional recipients - $150 setup fee / $100 charge per file

* Member Submitted Paper Claims - $3.00/transaction.
* Custom Data Reporting - Hourly rate determined by SCL based on the scope of the project
* Clinical Prior Authorization - $40.00 per review/appeal. SCL shall provide Sponsor with a form of prospective drug utilization review known as the Prior Authorization (“PA”) program. Sponsor may adopt or customize the benefit coverage suggested by SCL for the PA program, as amended from time to time by SCL. Sponsor shall have final approval over the benefit coverage. In the event Sponsor elects the auto-update option for this program, Sponsor shall notify SCL in writing within thirty (30) days of SCL updating the PA benefit coverage if Sponsor does not want to accept such updates. Sponsor shall be deemed to have approved the changes to the benefit coverage unless Sponsor timely notifies SCL in writing of Sponsor’s objection within the aforementioned thirty (30) day period. If Sponsor does not wish to utilize SCL’s standard PA benefit coverage, SCL shall work with Sponsor to develop a customized benefit coverage that is compatible with the SCL systems. Sponsor directs SCL to accept PA requests from Prescribers and approve or deny such requests in accordance with the PA benefit coverage. SCL shall make clinical pharmacists available to provide professional support to the PA unit as SCL determines necessary to evaluate PA requests and clarify Sponsor’s PA benefit coverage. SCL’s PA unit shall notify the Prescriber who submitted the PA request of the coverage determination for such request.
* Letter of Medical Necessity and Clinical Services - $6.00. Certain medications and Plan changes may require letters of medical necessity and/or SCL clinical department approval prior to implementation. Through a letter of medical necessity, a clinical pharmacist will review the accuracy of dosing, review the medication in relation to the diagnosis, and review the cost for the treatment. The letter of medical necessity shall be signed by the Participant's Prescriber, on an SCL approved form, sent by the Participant's Prescriber to SCL, and reviewed by SCL's clinical department for approval or denial. CPAs for non-controlled-substance medications shall be reviewed and assessed on a yearly basis, and CPAs for controlled-substance medications shall be reviewed and assessed on a 6 month basis. The Plan shall incur the above charge for all renewals and reassessments. In regards to Clinical Services, Sponsor initiated Plan changes that are implemented by SCL and reviewed by the SCL clinical department shall incur the above charge.
* Disease Management - $3.50 PEPM
* First Alert DM Notification - $0.50 PEPM
* Step-Therapy - $0.20 per paid transaction
* Specialized Data Integration (HDHP, HSA, etc.) - $1.00 per paid transaction
* Independent Review Organization ("IRO") Appeals performed by MCMC LLC. The costs for the appeal shall be the costs billed to SCL for the appeal by MCMC. This will range from $400.00 to $500.00 per appeal. Participants shall have the right to appeal a denied claim pursuant to the Sponsor's Plan and/or other Sponsor administrative documents listing the Participant's appeal rights. If the Sponsor's Plan and/or other Sponsor administrative documents do not include an appeal process, SCL shall have an IRO appeal process available for Sponsor's Participant to use as set forth herein.

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| **Signature:** |

***By signing in the space provided below, the authorized representative of the Client requests Script Care, Ltd. to establish a self-funded prescription drug program and acknowledges that until the Managed Prescription Drug Program Agreement is executed by the parties, this worksheet will be the sole document used to determine pharmacy benefit plan parameters for covered members and agrees to the payment procedures outlined above. By signing this worksheet, the Client stipulates and agrees that this worksheet constitutes a binding contract between the parties and that Client shall be bound by all of the terms hereof. Once the Client and Script Care, Ltd. have executed the Managed Prescription Drug Program Agreement, Client shall continue to be bound by the terms hereof to the extent that such terms do not conflict with the Managed Prescription Drug Program Agreement.***

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***Client Name Authorized Representative Signature***

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***Date***

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***TPA Name (Please Print Name and Title)***

**Changes made to this Worksheet after the Client approval has been received may delay the on-line claims processing effective date and/or the first checkwrite. In addition, if special programming is necessary in order for Script Care, Ltd. to process claims with the newly requested changes, it may not be possible to have them in place as of the scheduled effective date. The Agreement between Script Care, Ltd., and the Client will be provided for signature within ten (10) working days of receipt of this document. This document will serve as an interim contract with the following provisions in place until a fully executed contract has been received by Script Care, Ltd. Pharmacy benefit management services may be suspended if deemed necessary, pricing guarantees will not be honored until a fully executed contract has been signed and the Client will forfeit and not be eligible to receive rebates until a fully executed contract has been signed and received.**

**Submit the completed and signed PBW to your Account Manager and mail original to: Script Care, Ltd, 6380 Folsom Dr, Beaumont, TX 77706**

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| **Instructions for Contract** | |
| **Who does Script Care need to send the contract to?** | |
| TPA  Group  Other  N/A | |
| **How does Script Care need to send the contract?** | |
| E-Mail Address(es): |  |

Note: Signed contracts must be returned within 15 days of effective date to avoid termination.