Humana Pharmacy Solutions

Pharmacy Manual

Humana Healthy Horizons in Oklahoma

2026 Edition

Humana
Healthy Horizons®
in Oklahoma

Humana Healthy Horizons in Oklahoma is a Medicaid product of
Humana Wisconsin Health Organization Insurance Corporation

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Introduction

Dear pharmacy:

Humana appreciates your role in delivering quality pharmacy services to our Medicaid members. This manual pertains exclusively to Oklahoma SoonerSelect members enrolled in Humana Healthy Horizons® in Oklahoma and is an extension of your organization's agreement. It is intended to assist your staff in processing prescription claims for those members and outline Humana Compliance Program requirements for your organization.

Medicaid
Medicaid is a program run by the federal government and state governments that helps people with limited income pay for medical costs and, if qualified, long-term services and supports, such as nursing homes and home- and community-based waiver services. Each state decides what counts as income and who qualifies for Medicaid. States also decide what services are covered and how much they cost.

By contracting with various types of managed care organizations to deliver Medicaid program healthcare services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, healthcare quality and outcomes are key objectives of Medicaid managed care. Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals and building in accountability for high-quality care.

The **Humana Pharmacist Portal** provides a secure online resource where pharmacists can:

- Obtain a current list of generic maximum allowable cost (MAC) pricing
- Send email inquiries directly to Humana
- View news bulletins and link to news alerts
- Find member eligibility regarding a member's prescription drug plan, effective date and type of plan
- View claims a member has filled with your pharmacy
- Check the status of a prescription drug requiring prior authorization (PA) for a member

This resource is available to any pharmacy contracted with Humana and is provided free of charge. To obtain access, please visit **Account.Humana.com** and follow the onscreen instructions under "Don't have an account?" to create your account. If you have difficulty registering, send an email to PharmacyContracting@humana.com. Please include the pharmacy name, National Provider Identifier (NPI), pharmacy contact name and contact phone number.

We hope you find this manual informative. Thank you for your participation in the Humana pharmacy provider network.

Sincerely,
The Humana Pharmacy Network team

Contact information

Pharmacy help desk
844-918-0785, 24 hours a day, seven days a week
(for refill-too-soon overrides and PA status)

Humana Customer Care
To obtain general Medicaid plan information:
855-223-9868 (TTY: 711)
Monday – Friday, 8 a.m. – 5 p.m., Central time
Saturday, 9 a.m. – 5 p.m., Central time
Sunday, 11 a.m. – 4 p.m., Central time
(closed on state holidays)

Humana Clinical Pharmacy Review (HCPR)
To submit PA requests:

- You can obtain forms at **Provider.Humana.com/pharmacy-resources/prior-authorizations** or submit your request electronically by visiting www.covermymeds.health/prior-authorization-forms/humana.
- You can submit your request by fax to **877-486-2621.**
- You can call HCPR at **800-555-CLIN (2546),** Monday – Friday, 7 a.m. – 7 p.m., Central time.

Humana Pharmacy Solutions® Network Contracting
Pharmacy contract requests
Email: PharmacyContractRequest@humana.com
Fax number: **866-449-5380**
Phone number: **888-204-8349,** Monday – Friday, 7 a.m. – 4 p.m., Central time

Humana Ethics Help Line
877-5-THE-KEY (584-3539)

Humana's pharmacist website
Visit **Provider.Humana.com/pharmacy-resources** to access payer sheets, pharmacy news bulletins, the Humana Pharmacy Solutions Audit and Claim Review Guide, and many other resources.

Pharmacist Portal self-service website assistance
Email: PharmacyContracting@humana.com

Pharmacy compliance information website
Provider.Humana.com/pharmacy-resources/manuals-forms

Pharmacy responsibilities

The pharmacy is responsible for:

- Displaying member notices (i.e., rights for grievances and appeals and state fair hearings) in public areas of the pharmacy
- Providing physical access and reasonable accommodations to members with physical or mental disabilities
- Allowing the presence of interpreters
- Maintaining a recordkeeping system as described in the Pharmacy Provider Agreement and by state law
    - All records related to services provided to members are to be kept for a 10-year period.
- Providing a copy of the member's prescription drug record to the member and/or member's representative upon request
- Submitting reports, clinical information and encounter data in a timely manner, as required by Humana and the Oklahoma Health Care Authority (OHCA)

The pharmacy also agrees:

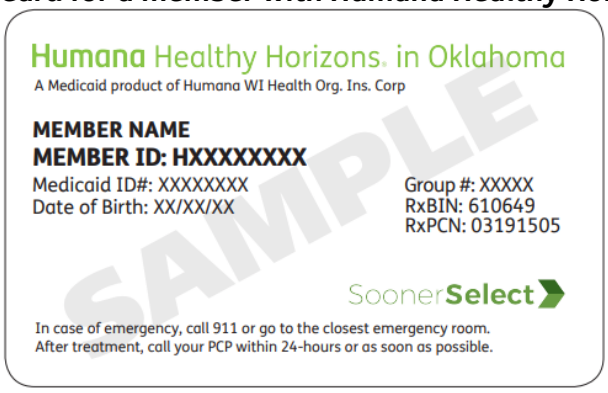
- That no one will be excluded from participating in or benefiting from Humana's program because of their disability, age, race, color, religion, sex, sexual orientation, gender identity or national origin
    - No one will face discrimination while the agreement is being carried out or in the provider's employment practices.
- To offer services in a way that respects, does not discriminate against and meets the needs of members from different backgrounds, including those with limited English skills, different cultural and ethnic backgrounds, and those with disabilities, regardless of their gender, sexual orientation or gender identity
- To accept the fee-for-service payment rate used by OHCA for the SoonerCare program, as outlined in the payment methodology at OAC 317:30-5-78, for any claims submitted for eligible members
- To follow all Medicaid laws and regulations, including any relevant guidance and contract rules, along with all other federal and state laws, regulations, and instructions from the Centers for Medicare & Medicaid Services (CMS)

Eligibility verification

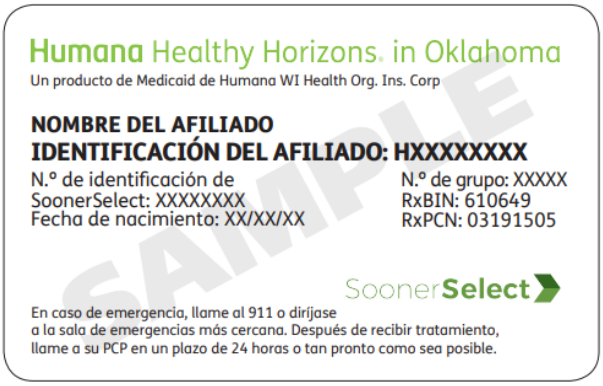
Humana member identification cards

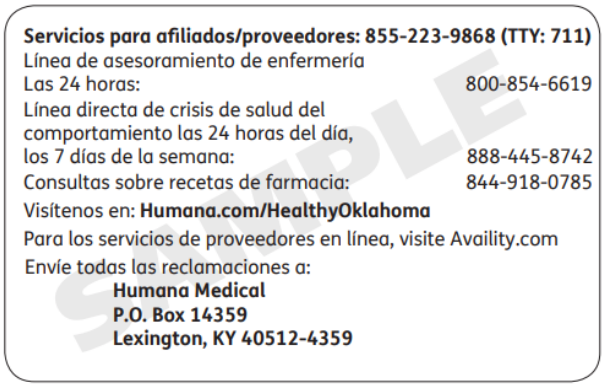
The following is an example of the member identification (ID) card pharmacy employees may see from Humana members.

Card for a member with Humana Healthy Horizons in Oklahoma (English)



Card for a member with Humana Healthy Horizons in Oklahoma (Spanish)





Note: These images meet state/compliance guidelines and could be subject to change at any time. You will be notified if the compliance guidelines change.

Cardholder ID

Pharmacies should submit the Humana member ID number in the "Cardholder ID" field whenever possible. This number can be found on the Humana member's ID card. Sample card images appear in the "Humana member identification cards" section above.

For Medicaid claims, Humana allows the cardholder ID to be submitted with the member's Medicaid ID, the Humana member ID number or their Social Security number. In addition, pharmacies may call the help desk at **844-918-0785**, select pharmacy and provide the NPI and the member's name and date of birth to obtain the Humana member ID.

Coordination of benefits

Effective Jan. 1, 2006, Medicaid members who are entitled to receive Medicare benefits under Part A or Part B no longer receive their pharmacy benefits under their state Medicaid agency, except for prescription drugs not covered under Medicare Part D. Medicaid will not pay for prescription drugs for beneficiaries who have both Medicare and Medicaid (dual eligible) with the exception of:

- Some prescription products not covered under Medicare Part D
- Some over-the-counter (OTC) products

Medicaid does not reimburse for the Medicare Part D drug copayment. Medicaid will not pay any deductibles or coinsurance for prescription drugs covered by Medicare Part D. However, Medicaid will pay for coinsurance for prescription drugs covered by Medicare Part B.

Excluded prescription drug coverage by state Medicaid program:
Each state has the option to cover medications specifically excluded under section 1927 (d)(2) of the Social Security Act.

Listed below is some of the excluded prescription drug coverage for the state of Oklahoma:

- Prescription drugs for which the manufacturer has not entered into a federal rebate agreement
- Prescription drugs used for anorexia, weight loss or weight gain
- Prescription drugs used to promote fertility
- Prescription drugs used for cosmetic purposes or hair growth
- Prescription drugs used for symptomatic relief of cough or colds

Additional information is available at www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-policy-laws-regulations-and-federal-register-notices/index.html.

Drug coverage

Drug Lists

Humana Healthy Horizons provides coverage of medically necessary medications (both prescription and select OTC medications) when prescribed by licensed providers in the state. The Preferred Drug List (PDL) is developed and maintained by the Medicaid Drug Utilization Review Board, which consists of providers and pharmacists. The PDL indicates the preferred and nonpreferred status of covered medications on the member's benefit and identifies drug utilization management requirements, such as PA, quantity limits and step therapy.

PDLs are updated regularly. To view the current PDL for Humana Healthy Horizons-eligible members, please visit **Provider.Humana.com/pharmacy-resources/tools/humana-drug-lists**.

Utilization management

Certain prescriptions must undergo a criteria-based approval process prior to a coverage decision.

- **PA:** Humana's Pharmacy and Therapeutics Committee reviews medications based on safety, efficacy and clinical benefit and may make additions or deletions to the list of prescription drugs requiring PA. Certain medications may need to be approved by the member's plan to be covered.
- **Step therapy:** Plans that are subject to step therapy as a component of Humana's standard Drug Utilization Review (DUR) program require the member to utilize medications commonly considered first-line before using medications considered second-line or third-line. These requirements promote established national treatment guidelines and assist in promoting safe, cost-effective medication therapy.
- **Quantity limits:** Humana has implemented quantity limits for various classes of prescription drugs to facilitate the appropriate and approved label use of these agents. Humana believes this program helps members obtain the optimal dose required for treating their conditions. If a member's medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to HCPR.

Coverage determinations

Prescribers may request coverage determinations, such as medication PA, step therapy, quantity limits and medication exceptions, by faxing the request to HCPR at **877-486-2621**. A prescriber can submit the request electronically by visiting www.covermymeds.health/prior-authorization-forms/humana.

The coverage determination decision will be made within 24 hours after complete information is received from the prescriber.

Please note: Humana does not accept requests for coverage determinations directly from pharmacies. The prescriber must initiate the request.

The prescriber quick reference guide can be found at
https://assets.humana.com/is/content/humana/Prescriber Quick Reference Guidepdf.

Prescribers or pharmacists with questions can call HCPR at **800-555-CLIN (2546)**.

72-hour emergency fill

Pharmacies can provide a 72-hour emergency fill for a prescription drug requiring a PA at the point of sale (POS) when the PA has not been completed and the pharmacist believes the member's health would be in serious jeopardy if they do not receive the medication.

If the pharmacy receives a denied Humana claim for a PA edit when the PA has not been completed (and the pharmacist believes the member's health would be in serious jeopardy), initiate the "Emergency 72 Hour Fill" process by entering Submission Clarification Code (SCC) = '65' and Days' Supply = '3.' The pharmacist should then fill the prescription for a three-day supply.

The Humana member will have no copayment. Applicable fees will be due when the remainder of the prescription is filled.

Copayments

The prescription copayment is $4 per prescription/refill for both brand/generic prescription drugs at network pharmacies for members 21 years old and older. Copayments will be waived after the member's household has met the 5% cost share. As a value-added benefit, the six-prescription-per-month limit is waived for Medicaid members 21 years old and older.

A copayment will not be applied for the following:

- People 20 years old and younger
- American Indians and Alaskan Natives are exempt from cost sharing when receiving services through an Indian Health Service, Tribal Health Program or Urban Indian Organization provider or pharmacy
- Pregnant women

The pharmacy agrees to provide covered services to the member at the time of service in accordance with the Pharmacy Provider Agreement and state law. The pharmacy only collects the applicable copayment and will not balance bill a member.

General claims procedures

Submitting pharmacy claims

All participating pharmacies must comply with the National Council for Prescription Drug Programs (NCPDP) transaction standards for pharmacy drug claims, coordination of benefits and related

pharmacy services. Prior to submitting a claim, the pharmacy must have a valid prescription on file.

The pharmacy may not submit test claims. Test claims are claims submissions used to confirm member eligibility or to determine the existence of any coverage restrictions or requirements and/or the maximum amount of reimbursement.

Bank Identification Numbers and Processor Control Numbers

The Bank Identification Number (BIN) and Processor Control Number (PCN) for Humana Healthy Horizons in Oklahoma is below:

Plan	BIN	PCN
Humana Healthy Horizons in Oklahoma	610649	03191505

Prescription origin code requirements

Humana requires the prescription origin code (NCPDP Telecommunications Standard D.0 field 419-DJ) to be included on all prescriptions. All claims submitted will be denied at the POS if this code is not included. If the pharmacist is not able to include this code within the pharmacy's practice management system, the pharmacist should contact the pharmacy's current software vendor for assistance. SS&C Health is not able to override this edit.

All new prescriptions must contain one of the following numeric values:

Value	Value type
1	Written
2	Telephone
3	Electronic
4	Fax
5	Situations for which a new prescription number needs to be created from an existing valid prescription, such as traditional transfers, intrachain transfers, file buys and software upgrades/migrations. This value is also the appropriate value for "pharmacy dispensing," when applicable, such as OTC, Plan B, established protocols, pharmacists' authority to prescribe, etc.

Fill number

Prescriptions, including refills, must contain the fill number, according to the following chart:

Value	Value type
00	Original dispensing – the first dispensing
01–99	Refill number – number of the replenishment

Sales tax

The sales tax should be submitted as a value equal to the percentage of the usual and customary charge that equates to the applicable sales tax rate. The pharmacist must enter a tax amount in NCPDP field 482-GE. If this field is left blank, no sales tax will be calculated.

The member's address is not a required element for the claim to process unless the medication is being shipped. The member's address should be added to where the medication is being shipped. The

pharmacy should enter the following information in the appropriate NCPDP field for the shipping tax to apply: The pharmacy service type is 03 (HIT), 05 (LTC), 6 (MO) or 8 (Specialty). If you have questions about sales tax, please email PharmacyPricingReview@humana.com.

Timely submission of claims

Claims must be submitted on the date of service (DOS). There are special circumstances under which a pharmacy may submit claims after the DOS, including the following:

- **Coordination of benefits (COB)** resolutions that necessitate claim reversals and subsequent rebilling to the correct payer are subject to the timely filing applicable to POS claims
- **POS** claims, which have 183 days from DOS for submission
- **POS** claim reversals (B2 transactions), which have 365 days from DOS for submission
- **POS** claim adjustments (B3 transactions), which have 365 days from DOS for submission

Attempting to adjudicate a POS transaction after the claims submission deadline may result in a reject with the message "Claim too old" (NCPDP reject 81). This includes:

- POS payments, reversals and/or adjustments
- Universal claim form claims for payment and reversals

Please call the Humana pharmacy help desk at **844-918-0785** for claims-processing questions. This line is staffed 24 hours a day, seven days a week.

Humana-specific SS&C Health payer sheets

Pharmacists can find the pharmacy payer sheet (D.0 Pharmacy Medicaid payer sheet) at **Provider.Humana.com/pharmacy-resources/manuals-forms.**

Prescriber National Provider Identifier submission

Humana requires the use of a valid and accurate Type 1 (also known as "individual") prescriber NPI on all electronic transactions. Claims submitted without a valid and active Type 1 NPI will be rejected at the POS with the following error message: "Prescriber Type 1 NPI required."

In addition, the error codes listed below will display in the free-form messaging returned to pharmacies. If the pharmacy believes it has received one of these codes in error (i.e., the NPI submitted is an active, valid, individual NPI number), the pharmacy may override the hard edit with the applicable SCC. Claims processed with an SCC may be subject to post-adjudication validation review.

NCPDP error code	NCPDP error code description	Free-form messaging	Applicable SCC
56	Nonmatched prescriber ID	Prescriber ID submitted not found. If validated, submit applicable SCC.	42
42	The plan's prescriber database indicates the prescriber ID submitted is inactive or is not found or is expired.	Prescriber ID not active. If validated, submit applicable SCC.	42
43	The plan's prescriber database indicates the associated United States Drug Enforcement Administration (DEA) number for submitted prescriber ID is inactive or expired.	Validation of active DEA status required. If validated, submit applicable SCC.	43

44	The plan's prescriber database indicates the associated DEA to submitted prescriber ID is not found.	Validation of active DEA for prescription required. If validated, submit applicable SCC.	43 or 45
46	The plan's prescriber database indicates associated DEA to submitted prescriber ID does not allow this drug DEA schedule.	Validation of active DEA schedule required. If validated, submit applicable SCC.	46
543	The prescriber ID qualifier value is not supported.	Prescriber Type 1 is required. Foreign prescriber ID is not allowed.	N/A
619	The prescriber Type 1 NPI is required.	Type 2 NPI submitted – Type 1 NPI required (for Humana Medical Plan)	N/A
889	The prescriber is not enrolled in state Medicaid program.	Use PAC 911911 for disaster claims.	N/A
6Z	The provider is not eligible to perform services/dispense product.	Provider is ineligible to perform service.	N/A

The pharmacy NPI field must contain accurate information identifying the pharmacy for each claim submitted. The pharmacy NPI must be submitted in NCPDP field 201-B1 (service provider ID) with the qualifier "01" in NCPDP field 202-B2 (service provider ID qualifier). The prescriber NPI also must be submitted in NCPDP field 411-DB (prescriber ID) with the qualifier "01" in NCPDP field 466-EZ (prescriber ID qualifier).

Dispense-as-written codes

Humana recognizes the NCPDP standard dispense-as-written (DAW) codes. Prescriptions with a DAW request must designate the DAW product selection code (NCPDP field 408-D8) on the submitted claim. For a prescription submitted with a DAW code other than zero, the reason for the selected code must be documented and comply with all applicable laws, rules and regulations.

Oklahoma has certain preferred brand prescription drugs when the brand-name drug is on the formulary and the generic is not. This may require the pharmacy to use DAW 9 when submitting a claim. Please refer to the PDL to identify the preferred brand-name drugs.

DAW code for multisource brand drugs

Claims will be denied if a DAW code is not entered or if the DAW code of "0" is entered when a multisource brand drug is dispensed. The SS&C error code of "100" will show with the following message: "DRUG MULTSRCE – DISP Generic or Enter DAW Code." A DAW code of "5" must be entered if the pharmacy considers the multisource brand drug to be generic.

Value	Value type
0	No product selection indicated
1	Substitution not allowed by prescriber
2	Substitution allowed — patient requested product dispensed
3	Substitution allowed — pharmacist selected product dispensed
4	Substitution allowed — generic not in stock
5	Substitution allowed — brand drug is dispensed as generic

6	Override
7	Substitution not allowed — brand drug is mandated by law
8	Substitution allowed — generic drug not available in marketplace
9	Substitution allowed by prescriber but plan requests brand — patient's plan requested brand product to be dispensed

Drug utilization review safety edits

Humana implements concurrent reviews or DUR safety edits at the point of service to assist pharmacies in identifying and addressing potentially inappropriate or unsafe prescription drug therapy before dispensing. These safety edits can present as a message, soft reject or hard reject and may include, but are not limited to, the following:

DUR type	Pharmacy information	Example
Drug–drug interactions	This DUR type identifies possible adverse interactions between the submitted medication and other medications in the patient's prescription history.	Selective serotonin reuptake inhibitors/monoamine oxidase inhibitors
Drug–age interaction	This DUR type identifies safety risk related to the use of specific medication for the patient's age.	Camzyos for patients younger than 18 years old
Drug–disease interaction	This DUR type identifies safety risk when an active medication is contraindicated for a patient's disease state. The disease may be inferred or identified via medical claims.	Amphetamines – cardiomyopathy
Drug–gender interaction	The alert of safety risk is related to the use of specific medication for reported gender. **Note:** Gender edits only apply for commercial and Medicaid when applicable.	Estradiol
Maximum dose	This DUR type identifies safety risk when dosage exceeds First Databank (FDB) maximum adult daily dose. The ratio of exceeding FDB maximum dosing is specific to the medication.	Digoxin daily dose greater than 500 mcg
MED* high dose	This DUR type identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 90 mg MED per day will trigger this error code.	MS Contin 30 mg twice daily plus Percocet 10/325 mg two tablets every eight hours as needed
Plan limitations exceeded: accumulation	This DUR type identifies the potential for an overdose resulting in single or multiple medications and cumulative doses that exceed safe daily maximums.	Acetaminophen dose greater than four grams per day
Therapeutic duplication	This DUR type identifies duplication within a therapeutic class of active medications with overlapping claims in the patient's prescription history.	Two prescriptions for different angiotensin receptor blockers

* MED: Morphine equivalent dosing

Soft reject drug utilization review

Select DUR safety alerts may be addressed at the retail pharmacy. Upon receipt of these rejects, pharmacists should apply clinical judgment to review the alert, recommend therapy changes or override the alert when clinically appropriate. The message on claim denials will indicate "Soft Reject:

Payer allows DUR/PPS code override." If the pharmacy approves the prescription fill, the rejection can be overridden utilizing the appropriate professional and results code from the following list:

NCPDP error code	NCPDP description	Reason for service	Professional service	Result of service
88: DUR reject error	This drug interacts with the patient's other drug(s) (including concurrent opioid and benzodiazepine use).	DD: Drug-drug interaction	DE: Dosing evaluation/determination M0: Prescriber consulted MP: Patient will be monitored PE: Patient education/instruction P0: Patient consulted R0: Pharmacist consulted other source SW: Literature search/review	1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment
88: DUR reject error	This drug may duplicate current patient therapy.	TD: Therapeutic duplication	M0: Prescriber consulted PE: Patient education/instruction P0: Patient consulted R0: Pharmacist consulted other source SW: Literature search/review TH: Therapeutic product interchange	1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment
88: DUR reject error 922: Morphine equivalent dose exceeds limit**	Cumulative morphine equivalent dose exceeds limits.	HD: High dose	M0: Prescriber consulted DE: Dosing evaluation/determination DP: Dosage evaluated	1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment 4K: Prescriber specialty exemption- oncology or nonhospice palliative care 4L: Prescriber specialty exemption-hospice

70: DUR reject error	This drug interacts with the patient's disease state.	DC: Drug disease	DE: Dosing evaluation/determination M0: Prescriber consulted MP: Patient will be monitored PE: Patient education/instruction P0: Patient consulted R0: Pharmacist consulted other source SW: Literature search/review	1A: Filled as is, false positive 1B: Filled prescription as is 1D: Filled with different directions 1F: Filled with different quantity 1G: Filled with prescriber approval 4A: Prescribed with acknowledgments 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment
AG: Exceeds opioid initial fill limits 925: Initial fill days' supply exceeds limit	Days' supply limitation for product/service.	MX: Excessive duration	M0: Prescriber consulted PH: Patient medication history R0: Pharmacist consulted other source	1G: Filled with prescriber approval 4B: Dispensed, palliative care 4D: Dispensed, cancer treatment 4J: Dispensed, patient is not opioid naïve 4K: Prescriber specialty exemption-oncology or nonhospice palliative care 4L: Prescriber specialty exemption-hospice

** Note 922 can apply to single claim or cumulative claim MED limits for opioids.

Submitting claims for 340B medications

When dispensing medications acquired under the 340B Program, as such terms are defined by CMS, pharmacies must utilize an SCC (42Ø-DK) field with a value of 20 or the most current NCPDP standard for identification of 340B medications. Pharmacies may be required to complete a contract addendum with Humana to be eligible to dispense 340B medications under the agreement with Humana.

Vaccine administration

The program covers administration associated with the injection of vaccines covered by the plan. Pharmacists in Humana-participating pharmacies may administer the vaccines if allowed by Oklahoma state law.

Submitting claims for vaccine administration

To submit claims for the prescription drug and the administration, the pharmacy must bill a value greater than zero in the incentive amount submitted field (438-E3) and submit professional service code "MA" in field 44Ø-E5.

Vaccines for Children Program

Humana is reminding you to enroll in the Vaccines for Children (VFC) Program if you intend to administer vaccines to children. The VFC Program is a federally funded program that provides vaccines at no cost to children under 19 years old who might not otherwise be vaccinated because of their inability to pay.

Vaccines may be obtained at no cost through the Oklahoma State Immunization Information System for Humana Healthy Horizons in Oklahoma members under 19 years old.

To enroll in the VFC Program, pharmacy providers should call the Oklahoma State Department of Health Immunization Service to begin the process at 405-426-8580 or email immunize@health.ok.gov.

Humana will pay pharmacies an administration fee for administering one of the VFC Program pediatric vaccines to eligible Humana Healthy Horizons in Oklahoma members. To receive payment of the administration fee, pharmacies must submit a claim with the NCPDP fields populated (as shown in the following table):

Field number	NCPDP field name	Required vaccine administration information for processing
440-E5	Professional Service Code	MA (Medication Administration)
438-E3	Incentive Amount Submitted	≥ $0.01 (submit administration fee)
412-DC	Dispensing Fee Submitted	≥ $0.01(submit dispensing fee)
426-DQ	Usual and Customary Charge	> $0.00
423-DN	Basis of Cost Determination	15 (free product or no associated cost)

Note: Pharmacies must be enrolled in the VFC Program to administer vaccines to eligible members and order the vaccines from that program at no cost. For additional information, please visit https://oklahoma.gov/health/services/personal-health/immunizations/imm-healthcare-professionals/vfc-program.html.

Controlled substance claims

During claims adjudication, Humana attempts to confirm the validity of the prescriber ID submitted on controlled substance (schedule II-V) claims and that the controlled substance is within the prescriber's scope of practice. Claims for prescription drugs found to be written outside of a prescriber's prescribing authority (according to the DEA) will be rejected with the following error message: "Plan's prescriber database indicates associated DEA to submitted prescriber ID does not allow this DEA drug class."

The free-form message on the claim will also state: "Validation of active DEA schedule required. If validated, submit applicable SCC."

Clarification of federal requirements—Schedule II drugs

Humana would like to remind pharmacies of the importance of monitoring pharmacy claims for accuracy and complying with federal and state laws, rules and regulations. This is especially important when filling prescriptions and submitting claims for refills and partial fills of Schedule II prescription drugs. In accordance with the Pharmacy Provider Agreement, Humana requires its pharmacies to comply with all federal and state laws, rules and regulations pertaining to the dispensing of medications.

The Controlled Substances Act established five schedules, which are based on medical use acceptance and the potential for abuse of a substance or prescription drug. Schedule II prescription drugs have a high potential for abuse, have an accepted medical use (including severe restrictions), and may lead to severe psychological or physical dependence if abused. Pursuant to 21 CFR § 1306.12(a), Schedule II prescription drugs may not be refilled.

Pharmacies should take appropriate steps to confirm (including verifying with the prescriber, when

necessary) that controlled substances, including Schedule II prescription drugs, are being filled only in accordance with federal and state law. This includes preventing refills and partial fills of Schedule II prescription drugs that are not allowable under the Controlled Substances Act.

Submitting CII claims

CMS ruling CMS-0055-F mandates that a valid Quantity Prescribed (NCPDP field 460-ET) is submitted on all federally designated controlled substance level II (CII) drug claims. This impacts pharmacy claim data submission, processor adjudication edits to validate the Quantity Prescribed and payer sheet updates to include the Quantity Prescribed field.

If the field (Quantity Prescribed 460-ET) is not populated for a CII drug, you will receive NCPDP reject code ET. Please enter a valid Quantity Prescribed and resubmit.

Access this CII claim bulletin for additional information:
https://assets.humana.com/is/content/humana/CII Claims Submission Requirements_Update_09_24_2020pdf.

Point-of-sale edits and overrides

To support state and federal regulations regarding opioid and other controlled substances, Humana employs several POS edits.

Please visit the following link for information on current guidance on edits and overrides: **Provider.Humana.com/pharmacy-resources/manuals-forms**. Please see the "Pharmacy resources" tab under "Manuals and forms."

Lock-in program

The Oklahoma Lock-In Program (OLIP) is designed for individuals enrolled in Humana Healthy Horizons in Oklahoma who need help managing their use of prescription medications. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the member.

Members who meet the program criteria are locked into one pharmacy location, one Patient-Centered Medical Home (PCMH) and up to two specialty providers as needed. Members receive written notification from Humana stating they meet the criteria for OLIP and need to respond within 30 days of the mail date of the notification to choose a pharmacy and a provider to receive services. If a pharmacy or a provider is not chosen during the appropriate time frame, selections will be made for the member.

Prior to restriction, Humana will reach out to the pharmacy, PCMH provider and specialists, if needed, to confirm lock-in at that site.

The member will receive an additional letter that provides the following information:

- Name of the designated pharmacy and provider
- Instructions for requesting a change to the designated pharmacy and/or provider
- PCMH selection criteria
- Reason for restriction
- Effective date of program enrollment
- Length of limitation
- Rights to appeal the decision

Members diagnosed with cancer, receiving chemotherapy or radiation treatment, receiving hospice care, residing in a long-term care facility, enrolled in both the Medicaid and Medicare programs, or who are under 18 years old are exempt from OLIP.

If you or the member have questions, please feel free to contact Humana Healthy Horizons in Oklahoma in one of the following ways:

- Call **833-410-2496**, Monday – Friday, 7 a.m. – 4:30 p.m., Central time. After-hours, please leave a voicemail with the member's name, member ID number, contact phone number and a detailed description of your request.
- Fax number: **502-996-8184**
- Email: CPORM@humana.com

Continuity of care

Continuity of care policy

This policy applies to prescribed medications that are subject to certain limitations, such as prescription drugs not listed on the PDL and prescription drugs requiring PA, step therapy or a quantity limit. This policy helps by providing a temporary supply to members who have limited ability to receive their prescribed drug therapy. For new members, Humana will cover a temporary supply as indicated in the chart below, including for out-of-network pharmacies. If the member presents a prescription written for less than the days' supply allowed, Humana will allow multiple fills to provide up to the total days' supply of medication allowed.

Humana will indicate that a prescription is a transition fill in the message field of the paid claim response. The pharmacist should communicate this information to the member. Providing a temporary supply gives the member time to talk to their prescriber and decide if an alternative prescription drug is appropriate or if they should request an exception or PA. Humana will not pay for additional refills of temporary supply drugs until an exception or PA has been obtained.

Continuity of care will not work under the following conditions:

- Medicaid-excluded prescription drugs
- Safety edits
- Eligibility criteria are not met

Program	Total days' supply allowed	Total days allowed for transition
Humana Healthy Horizons in Oklahoma	90	90

Home infusion billing procedure

Home infusion drug claims are billed through the member's medical benefit.

Compound claims

Submitting compound claims

The pharmacy must submit the correct amount with corresponding accurate quantities and days' supply calculations based on a valid prescription for the member. The pharmacy must submit all ingredients that make up a compound drug on the same claim. The most expensive ingredient will display at the claim level. Edits are returned for each ingredient based on the member's benefits. An

SCC of 08 can be submitted on the claim when a pharmacy accepts reimbursement for approved ingredients only.

- A free-form message will return to the pharmacy when an SCC of 08 can be submitted.
- Pharmacies are prohibited from balance billing the beneficiary for the cost of any Medicaid-excluded ingredient contained in the compound.

The pharmacy shall not attempt to circumvent a plan's benefit design or engage in inappropriate billing practices of compound drugs. Such practices include, but are not limited to:

- Submitting test claims for a compound drug
- Submitting a claim multiple times with variations in the ingredients, ingredient cost, dispensing fees, quantity amount and/or days' supply to obtain the highest reimbursement possible
- Resubmitting rejected compound prescription ingredients as individual, noncompounded ingredients
- Submitting partial fills or multiple claims for fills that are less than a 30-day supply to avoid coverage limitations or gain additional reimbursement or copayment amounts

Pharmacy audit and compliance

Pharmacy audit program

Humana maintains a pharmacy audit program to:

- Helping ensure the validity and accuracy of pharmacy claims for its clients (including CMS and state agencies overseeing a program for Medicaid-eligible members)
- Helping ensure compliance with the provider agreement between Humana, its network pharmacies and this manual
- Helping ensure compliance with federal and state laws/regulations and prescription drug-specific requirements
- Educate network pharmacies regarding proper submission and documentation of pharmacy claims

According to the Pharmacy Provider Agreement between Humana and its network pharmacies, Humana, any third-party auditor designated by Humana or any government agency allowed by law is permitted to conduct audits of any and all pharmacy books, records and prescription files related to services rendered to members, as well as the pharmacy's compliance program, during and after the term of the Pharmacy Provider Agreement.

Claim-specific audit objectives include, but are not limited to, correction of the following errors:

- Dispensing unauthorized, early or excessive refills or dispensing an incorrect drug
- Billing the wrong number or an incorrect provider
- Using an NCPDP/NPI number inappropriately
- Submitting an invalid pharmacy service type or an invalid patient residence code
- Calculating the days' supply incorrectly or using a DAW code incorrectly
- Overbilling quantities or not retaining/providing the hard copy of prescriptions or a signature log/delivery manifest
- Claims paid to the incorrect benefit

Humana notifies pharmacies of its intent to audit and provides specific directions regarding the process. Humana's on-site audits are conducted in a professional and Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant manner with respect for members and pharmacy staff. To access the Humana Pharmacy Solutions Audit and Claim Review Guide, please visit

Provider.Humana.com/pharmacy-resources/manuals-forms and select the "Audit guide, claim form and other materials" tab.

Compliance program oversight

Humana maintains a compliance program that includes oversight of pharmacies to ensure compliance with this manual, government requirements, and corresponding compliance and standards of conduct material. Entities contracted with Humana or a Humana-related entity ("Humana") that support Humana's Medicaid products are subject to ongoing monitoring of pharmacies' compliance programs, as well as audits that may occur on an ad hoc basis. Humana notifies a pharmacy of monitoring activities that require timely responses and its intent to audit and provides specific directions regarding the oversight process. If an oversight activity identifies deficiencies, a corrective action plan is issued. Humana works with the pharmacy to ensure the deficiencies are remediated in a timely manner and to ensure there is a sufficient process and policy in place to prevent recurrence.

Fraud, waste and abuse and compliance program requirements

Policy statement

Humana does not tolerate fraudulent activity or actions in violation of its standards of conduct or Compliance Policy (both available under the "Compliance education and training requirements" section at **Provider.Humana.com/pharmacy-resources/manuals-forms**), as committed by Humana employees, contracted pharmacy providers or those supporting the pharmacy providers' contractual obligations to Humana, members, customers, vendors, contractors and/or other business entities. In addition to Humana-administered plans and products that have a pharmacy benefit for Medicare-eligible beneficiaries, Humana is an administrator of Medicaid products that have a pharmacy benefit.

All organizations supporting any of the products Humana administers are required to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse (FWA). Humana is committed to:

1. Investigate any identified, reported or suspected noncompliance or fraudulent activity
2. Take additional action as necessary
3. Report the matter, when appropriate, to the impacted regulatory, federal or state agencies for further action and investigation

Humana is an administrator of Medicaid products that have a pharmacy benefit. All such organizations supporting any of these products Humana administers are required to have a comprehensive plan to detect, correct and prevent FWA. Humana has such a plan.

Training to combat FWA

Every Humana-contracted entity supporting Humana's products is responsible for:

- Providing FWA prevention, detection and correction training to its employees who administer, deliver or support Humana's plan administration
- Providing FWA prevention, detection and correction training to its contractors who administer, deliver or support Humana's plan administration, or notifying them that they must conduct such training
- Tracking adherence to the training obligation and understanding of and compliance with the requirements outlined in the FWA training materials

Material to use

Pharmacies may use their own materials to meet the FWA training requirement or adopt another organization's training material on the topic. Humana also offers content on this topic in the following documents:

- Humana Compliance Policy for Contracted Healthcare Providers and Third Parties: **https://assets.humana.com/is/content/humana/Compliance Policypdf**
- Humana Ethics Every Day for Contracted Healthcare Providers and Third Parties: **https://assets.humana.com/is/content/humana/Ethics%20Every%20Daypdf**

Note: The Humana materials alone may not be used to meet the FWA training requirement. However, a pharmacy may use these documents to supplement or integrate within your FWA training.

Training records
Humana-contracted entities must maintain FWA training records, including the completion date, attendance, topic, certificate of completion (if applicable) and test scores for all tests administered for 11 years (or longer, if required by state law).

Additional assurance
Humana and applicable government agencies overseeing Medicaid programs reserve the right to conduct oversight of contracted pharmacies to assess their commitment to FWA training requirements, including requests that require these pharmacies to provide corresponding documentation.

Requirement to report suspected or detected FWA and/or noncompliance

All pharmacy employees and subcontractors who support the pharmacy's contract with Humana, as well as governing body members (example: Board of Directors), must report suspected or detected fraudulent or noncompliant activities using one of the reporting methods provided by the pharmacy. When the subject of the reported activities impacts a plan administered by Humana or its Humana Healthy Horizons members, the pharmacy must report the matters and the actions taken by the pharmacy to Humana.

Humana offers multiple options to report concerns. The most expedient manner is by calling the Humana Special Investigation Unit (SIU) at **800-614-4126**. This toll-free hotline is available 24 hours a day, seven days a week. Callers may remain anonymous, and Humana takes great efforts to keep information confidential.

Those reporting suspected activities are protected from retaliation, according to the whistleblower provision in 31 U.S.C. § 3730(h) of the False Claims Act.

Once SIU performs its initial investigation, it will refer the case to law enforcement and/or regulatory agencies (as appropriate). Additional information about SIU and Humana's efforts to address FWA can be found at **Humana.com/legal/fraud-waste-and-abuse**.

Humana makes the following reporting options available:

Phone:

- Humana Special Investigations Hotline (voice messaging system): **800-614-4126**
- Humana Ethics Help Line: **877-5-THE-KEY (584-3539)**

Both of the phone methods above are available 24 hours a day, seven days a week and allow callers to remain anonymous. Humana requests that those who report ethics concerns and desire to remain anonymous provide enough information to allow Humana to investigate the issue.

Fax number: **920-339-3613**

Email: siureferrals@humana.com or ethics@humana.com

Mail:
Humana, Special Investigation Unit
1100 Employers Blvd.
Green Bay, WI 54344

Ethics Help Line reporting website:
https://secure.ethicspoint.com/domain/media/en/gui/60750/index.html

Note: When using a Humana option to report a concern, confidential follow-up to check on the status of an investigation is available.

If a contracted pharmacy elects to offer any reporting option(s) instead of, or in addition to, those Humana makes available, the pharmacy still must do the following in a timely manner: Relay to Humana reports that could impact Humana or its members and outline the action(s) taken.

Prohibition against intimidation or retaliation

Humana has a zero-tolerance policy for the intimidation of, or retaliation or retribution against, any person who is aware of and, in good faith, reports suspected misconduct or participates in an investigation of it.

Disciplinary standards

Humana may take any or all of the following actions related to FWA or violations of Humana's standards of conduct:

- Oral or written warnings or reprimands
- Termination(s) of employment or contract
- Requirement for select individuals to be removed from supporting Humana business
- Mandatory retraining
- Formal, written corrective action plan(s) tracked to closure
- Reporting of the conduct to the appropriate external entity or entities, such as law enforcement agencies or a state agency that has contracted Humana to administer a Medicaid product
- Other measures that may be outlined in the contract

Note: Those identified as not reporting any suspected FWA or violation of Humana's standards of conduct or Compliance Policy (available at **Provider.Humana.com/pharmacy-resources/manuals-forms**) that is determined to have adversely impacted Humana shall be confirmed as being in violation of Humana requirements and be subject to any or all of the above disciplinary actions. The rationale is the inaction resulted in unnecessary risk for the pharmacy, plan members and Humana and could have subsequently contributed to any of the following: continued, more severe or extensive violations (and even monetary loss).

Every Humana-contracted entity must have disciplinary standards and take appropriate action upon discovery of FWA and violations of Humana's standards of conduct or Compliance Policy (or actions likely to lead to FWA or the above-referenced violations).

In addition, depending on the specifics of a case, a state agency and/or CMS may elect to exclude anyone involved in an FWA violation from participating in government procurement opportunities, including work in support of any contract Humana has with a government agency.

Corresponding expectations

Pharmacies are also expected to:

- Widely publicize available methods for reporting compliance and FWA concerns and the nonretaliation policy. Examples of how to achieve this include posters, mouse pads, key cards and other prominent displays within a pharmacy's facility, such as on an intranet site and/or by email to those performing a function in support of Humana.
    - It is not sufficient to post information only within a facility and not share it by email and/or a pharmacy intranet site when any person needing the information works outside of the facility (i.e., remotely or within a home).
- Reinforce Humana's policy of nonintimidation and nonretaliation.

Standards of conduct/ethics

Every Humana-contracted entity must routinely perform the following actions and, upon Humana's request, provide certification of these actions:

- Your organization must require employees, management, governing body members and those with whom the pharmacy contracts to support the pharmacy's contractual obligations to Humana's Medicaid products to review and attest to compliance with the pharmacy's standards of conduct document upon hire or contract and annually thereafter. If the contracted pharmacy does not adopt or have its own written standards of conduct that are materially similar to Humana's written standards of conduct, then Humana's standards of conduct document may be used. A copy can be accessed, printed and downloaded by visiting the link here: **https://assets.humana.com/is/content/humana/Ethics%20Every%20Daypdf**
- Your organization must conduct the following for all new employees, management, governing body members and contracted individuals prior to hire/contract and monthly thereafter when they are designated to assist in the administration or delivery of federal healthcare program benefits in support of a Humana contract: Review the separate exclusion lists of the Office of Inspector General and General Services Administration's System for Award Management.
- Your organization must remove any person or party identified on an exclusion list above from any work, or access to information or data, related directly or indirectly to Humana's support of a state-administered program, such as Medicaid, or any federal healthcare program, such as Medicare.
- Your organization must retain evidence of the exclusion screening for 11 years (or longer, as required by state law).
  Note: If a contract with Humana is terminated, the screening evidence must be retained for a minimum of 10 years after the termination date.
- Your organization must take appropriate corrective actions for standards of conduct violations and, when FWA is involved, report findings to Humana's SIU at **800-614-4126.**

Humana's CMS and state Medicaid contracts mandate that compliance program requirements must be completed by all pharmacies contracted with Humana or Humana subsidiaries. This includes those employed or contracted by these non-Humana organizations to provide or support healthcare services for Humana's Medicare, Medicaid, and/or dual Medicare and Medicaid members.

Compliance program requirements

The information below is provided to help the pharmacy and those with whom they contract or employ to support Humana business confirm their compliance programs have the necessary elements to be effective.

Humana's compliance program requirements for contracted pharmacies include, but are not limited to:

- **Oversight:** Your organization must monitor and audit the compliance of employees and

subcontractors who provide services and/or perform any support functions related to administrative or healthcare services provided to a member of a Humana Medicare Advantage plan, Medicare prescription drug plan or a Medicaid plan administered by Humana. This is conducted from both operational and compliance perspectives and includes exclusion screening of all individuals and contracted entities that support Humana Medicare and/or Medicaid products.

- **Your organization must provide immediate notification to Humana of its intentions to utilize offshore resources in meeting any obligation to Humana:** This includes new arrangements or changes to existing relationships or offshore locations and where or how data is processed, transferred, stored or accessed.
- **Your organization must receive prior approval from Humana before moving forward with or modifying an offshore arrangement for work in support of a Humana contract:** There are multiple reasons why:
    - Humana may need to notify a state agency (contracting Humana for Medicaid plan administration) of an entity with a location outside of the United States or a U.S. territory that receives, processes, transfers, stores or accesses in oral, written or electronic form protected health information of a Medicaid member for an individual who is also eligible for Medicare.
    - A government contract may have prohibitions related to offshoring of information.
- **Your organization must demonstrate the establishment, documentation and communication of effective compliance policies:** This means having policies and procedures in place for preventing and detecting suspected FWA, then correcting and reporting identified instances, as well as other aspects of noncompliance, including, but not limited to:
    - Requiring employees, board members and subcontractors to report suspected and/or detected FWA and suspected violations of Humana's Compliance Policy or standards of conduct. (Those documents are available at **Provider.Humana.com/pharmacy-resources/manuals-forms.**). Any suspected and confirmed instances of ethical, compliance or FWA violations must be reported to Humana.
    - Safeguarding Humana's confidential and proprietary information and plan members' protected personal and health information
    - Providing accurate and timely information/data in the regular course of business
    - Monitoring and auditing activities
    - Upholding disciplinary standards
- **Training:** Your organization must ensure that all required compliance program training is completed, not simply by the compliance contact at the pharmacy, but also by those supporting the pharmacy's contractual obligations to Humana. Where applicable, operational training must be conducted. This requirement includes having a tracking method in place to provide evidence of these efforts upon request (who was trained, when, how and with what materials).
- **Cooperation:** Your organization must cooperate fully with Humana for any compliance-related requests and any government entity audits or investigations of an alleged, suspected or detected violation of this manual, Humana policies and procedures, applicable state or federal laws or regulations, and/or remedial actions.
- **Communication:** Your organization must publicize methods for how to report suspected violations of Humana policies, government regulations and corresponding disciplinary standards to employees, volunteers, board members and subcontractors.
- **Disciplinary standards:** Your organization must have established disciplinary standards in place that are carried out when violations are committed by the pharmacy provider, its employees or those it contracts to support obligations to Humana.
- **Assurance:** Your organization must comply with Humana requests to provide assurance related to the pharmacy's compliance program.

The above are examples of ways to implement an effective compliance program. For an overview of the seven elements of an effective compliance program, please refer to Humana's Compliance Policy at **https://assets.humana.com/is/content/humana/Compliance Policypdf.**

FAQ
Humana makes a guidance document publicly available online that includes FAQs and additional information regarding the compliance requirements at **https://assets.humana.com/is/content/humana/GCHJ9HTEN_FAQpdf.**

Further compliance program requirements information for pharmacies supporting Humana's Medicaid products can be found in Humana's Compliance Policy at **https://assets.humana.com/is/content/humana/Compliance Policypdf**.

Compliance training and assurance expectations, attestation requirements
Humana reserves the right to request documentation and/or a certification that certain compliance program requirements and training are in place to meet government contract obligations. When an attestation is required depends on multiple factors, such as government contract expectations and corresponding Humana compliance program oversight activities.

Additional, required compliance education and training
Network pharmacies supporting Humana Healthy Horizons must also educate those employed or contracted to perform a function in support of the plan in multiple ways (as noted below):

- Providing the following to those contracted or employed to support Humana:
  - Compliance policy or policies that outline compliance program requirements
  - Standards of conduct

  Note: Humana documents, or documents that are materially similar, may be used to meet the Compliance Policy and standards of conduct requirements. These materials are available at **Provider.Humana.com/pharmacy-resources/manuals-forms**.

- Conducting training on understanding and addressing FWA via material developed or adopted by the pharmacy
  Note: In the case of nonemployees, pharmacies may collect attestations from them (in lieu of conducting their FWA training) to confirm they are receiving FWA training elsewhere.

Frequency and timing of the above is outlined in Humana's Compliance Policy, which is available on Humana's website at **Provider.Humana.com/pharmacy-resources/manuals-forms**.

Note: Humana will notify a pharmacy if an organization-level attestation must be submitted to certify compliance with these additional requirements.

Additional guidance related to compliance program requirements are listed on Humana's website in the compliance requirements FAQ for pharmacies at the link here: **https://assets.humana.com/is/content/humana/GCHJ9HTEN_FAQpdf**.

Please note: As requirements of government contracts, regulations and/or Humana's compliance program may change, Humana reserves the right to require additional or different compliance program training or components, although it strives not to make midyear changes.

Humana pharmacy credentialing

Humana requires all network pharmacies to be credentialed during the initial contracting process and

to be recredentialed at least every three years. The recredentialing request is sent to the pharmacy by fax and requires the pharmacy to return a recredentialing application, which includes:

- Pharmacy's state licensure information
- Pharmacy's DEA licensure information
- Signed and dated attestation stating the pharmacy is free of sanctions imposed by federal, state and local authorities
- Copy of current professional liability insurance coverage that meets or exceeds a minimum requirement of $1 million in aggregate
- Pharmacy's NCPDP number
- Medicaid ID number

Pharmacies that do not meet Humana's required standards, which include having an active state Medicaid ID and not being listed on the applicable state exclusion list or on the federal exclusion lists, will be removed from Humana's pharmacy network.

Mail-order pharmacy providers must be licensed by the appropriate state board in the state the pharmacy is physically located. Additionally, out-of-state pharmacies are required to be licensed by the Oklahoma State Board of Pharmacy and must be enrolled with the Oklahoma Health Care Authority.

Conflicts of interest

All entities and individuals supporting Humana are required to avoid conflicts of interest. Pharmacies should never offer or provide, directly or indirectly, anything of value, including cash, bribes or kickbacks, to any Humana employee, contractor, representative, agent, customer or any government official in connection with any Humana Pharmacy Solutions procurement, transaction or business dealing. This prohibition includes, but is not limited to, a pharmacy offering or providing consulting, employment or similar positions to any Humana employee involved with Humana procurement or to that employee's family members or significant others.

Pharmacies are required to obtain and sign a conflict of interest statement from all employees and subcontractors within 90 days of hire or contract and annually thereafter. This statement certifies the employee or downstream entity is free from any conflict of interest for administering or delivering federal healthcare program benefits or services.

All pharmacies are required to review potential conflicts of interest and either remove the conflict or, if appropriate, request approval from Humana to continue work despite the conflict.

Humana reserves the right to obtain certifications of conflicts of interest, or the possible absence of conflicts of interest, from all providers and to require that certain conflicts be removed or that the applicable employee(s) and/or downstream entities be removed from supporting Humana.

Pharmacies and those they employ or contract are prohibited from having any financial relationship relating to the delivery of or billing for items or services covered under a federal healthcare program that:

- Would violate the federal Stark Law, 42 U.S.C. § 1395nn, if items or services delivered in connection with the relationship were billed to a federal healthcare program, or that would violate comparable state law
- Would violate the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, if items or services delivered in connection with the relationship were billed to a federal healthcare program, or that would violate comparable state law
- In the judgment of Humana, could reasonably be expected to influence a provider to utilize or bill for items or services covered under a federal healthcare program in a manner that is inconsistent with professional standards or norms in the local community

A violation of this prohibition could result in Humana terminating a pharmacy provider contract or requiring the provider to remove any applicable employed or contracted party or parties from supporting Humana business with a Medicaid component. Humana reserves the right to request information and data to ascertain ongoing compliance with these provisions.

Complaint system

Pharmacy's pricing dispute process

Network pharmacies have the right to submit a request to appeal, investigate or dispute the MAC reimbursement amount to Humana within 60 calendar days of the initial claim. The pharmacy may submit its request to appeal, investigate or dispute MAC pricing in writing to Humana by fax at **855-381-1332** or by email at PharmacyPricingReview@humana.com**.** Please submit the request using one of the Humana Pricing Review Request files below, which also are available on the **Humana.com** Pharmacist Portal.

- File for multiple requests (download this Excel file): **https://assets.humana.com/is/content/humana/Pharmacy%20Pricing%20Review%20Request%20Excel%20File_Portal**
- Pharmacy Pricing Review Request**:** **https://assets.humana.com/is/content/humana/Pharmacy%20Pricing%20Review%20Request%20Formpdf**

Please email PharmacyPricingReview@humana.com to request the file if it cannot be downloaded.

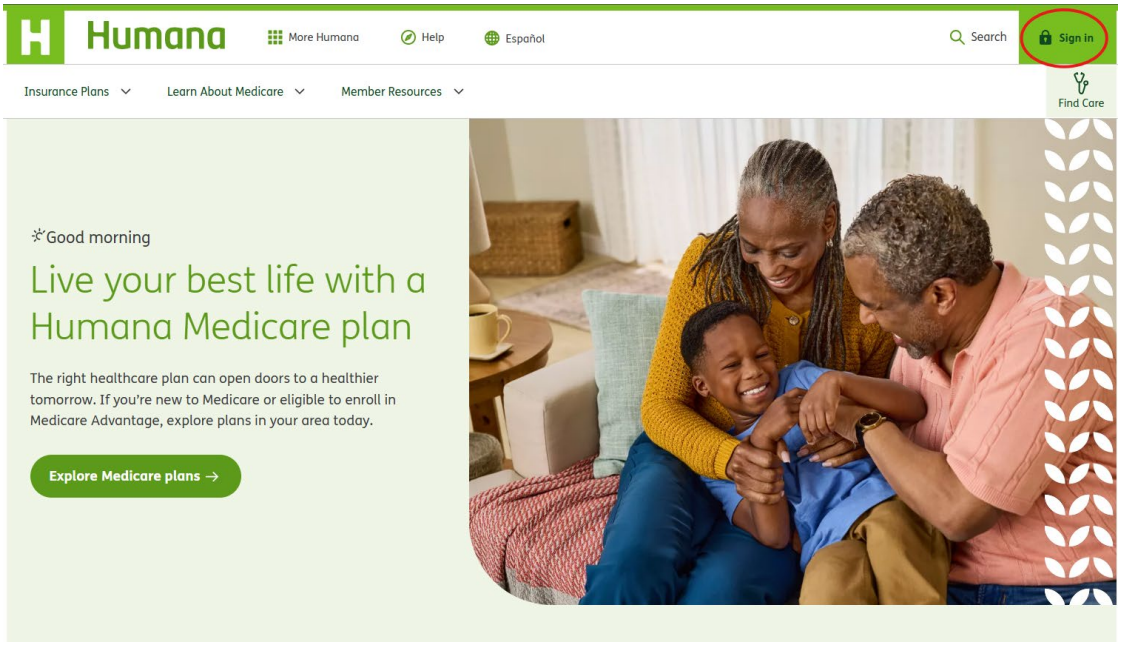
The pharmacy can call Humana and speak to a representative regarding its request at **888-204-8349** for retail. The following must be included in the request:

- Pharmacy name, address, NCPDP number and PCN
- Prescription number
- Prescription drug name and strength
- National Drug Code (NDC)
- Date of initial fill and quantity of fill
- Relevant documentation that supports the MAC is below the cost available to the pharmacy
- Any other supporting documentation as needed

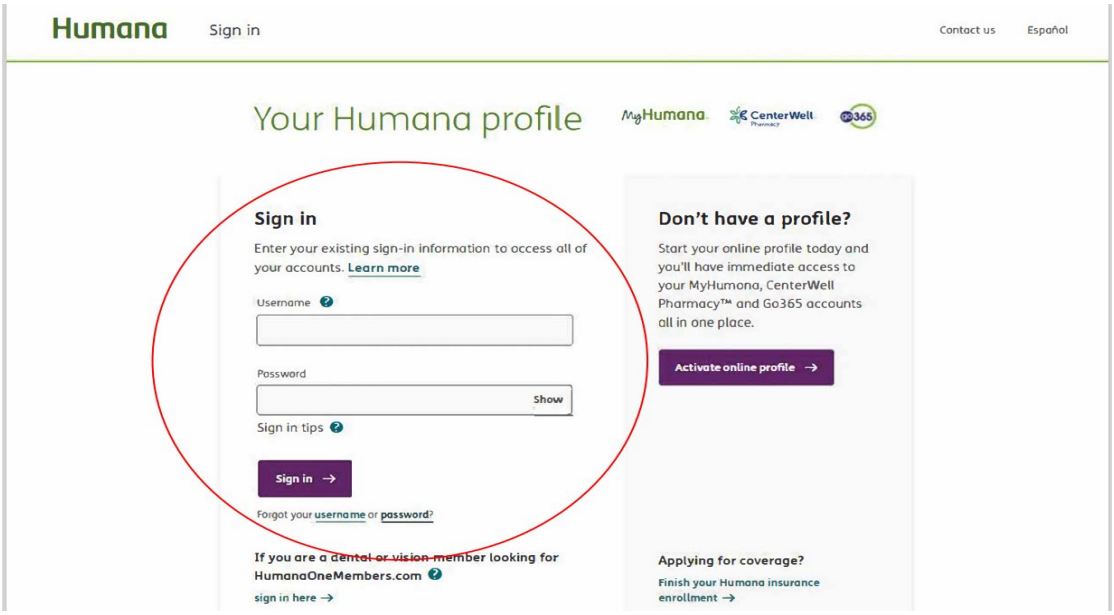
Humana will respond to the network pharmacy's request within five business days of receipt by Humana. In the event the MAC appeal is denied, Humana will provide the reason for the denial and will identify an NDC for the prescription drug product at or below the current MAC price. If the MAC request is approved, Humana will adjust the MAC price to the date of the disputed claim(s). The pharmacy is responsible for the resubmission of the claim and for collecting and/or refunding any copayment amount. **Please note:** Timelines may vary and are subject to change.

Pharmacy maximum allowable cost list location

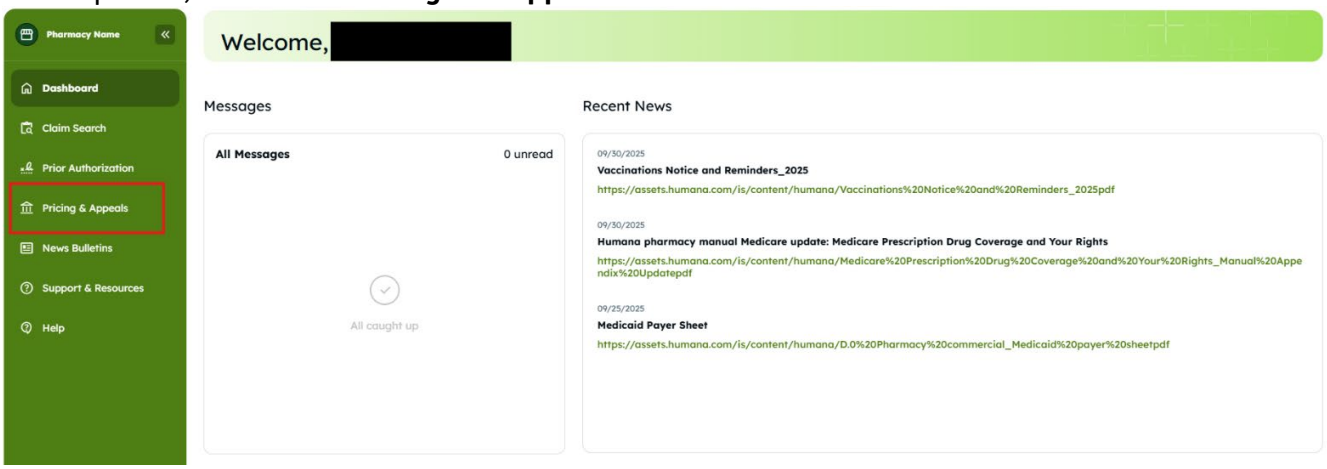
When network pharmacies need to locate the current MAC list, they can follow the steps below at **Humana.com**. They will see the screen below. Select the "Sign in" button located on the top right corner of the screen.



The pharmacy will then enter the username and password that it set up at the time it contracted with Humana. If the pharmacy is unsure of its username and password, it should email the pharmacy contracting team at PharmacyContracting@humana.com and ask to have the pharmacy's online portal account reset.



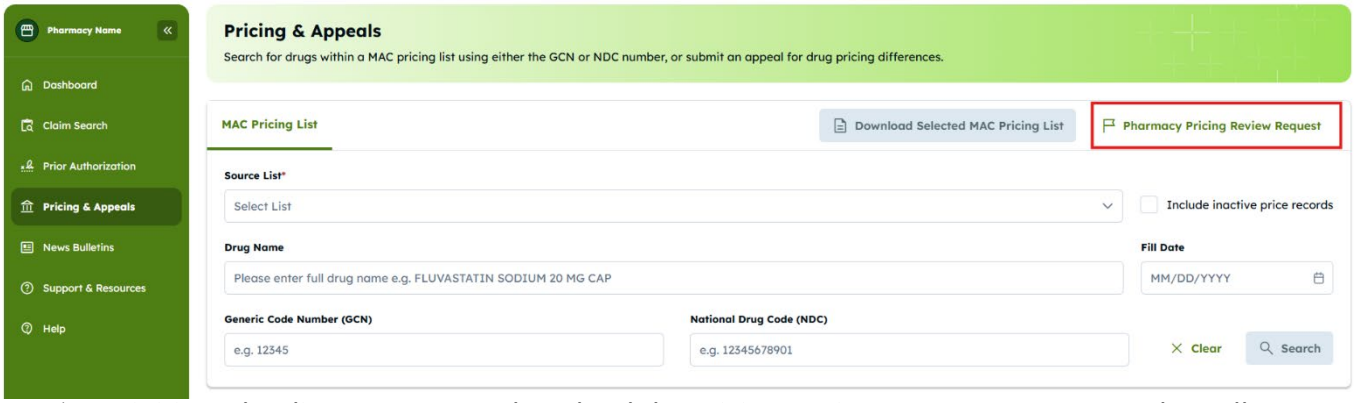
For the current MAC list applicable to the NPI the pharmacy used to register its account, which includes recent updates, select the "**Pricing and Appeals**" link.



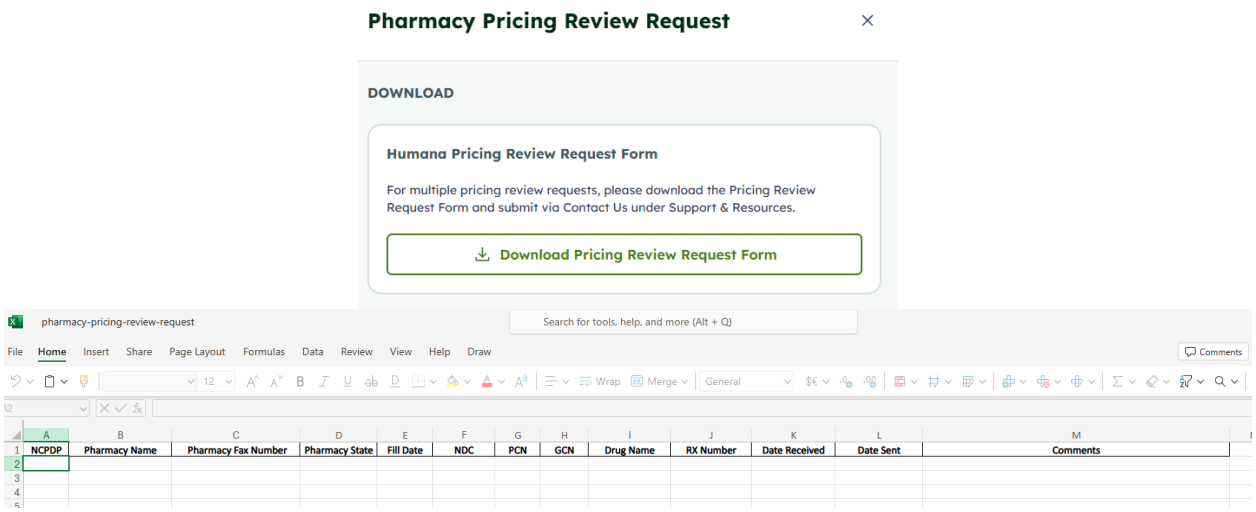
Once the pharmacy selects that link, a MAC search box will appear. The list the pharmacy chooses will show as download only or will load on the page.

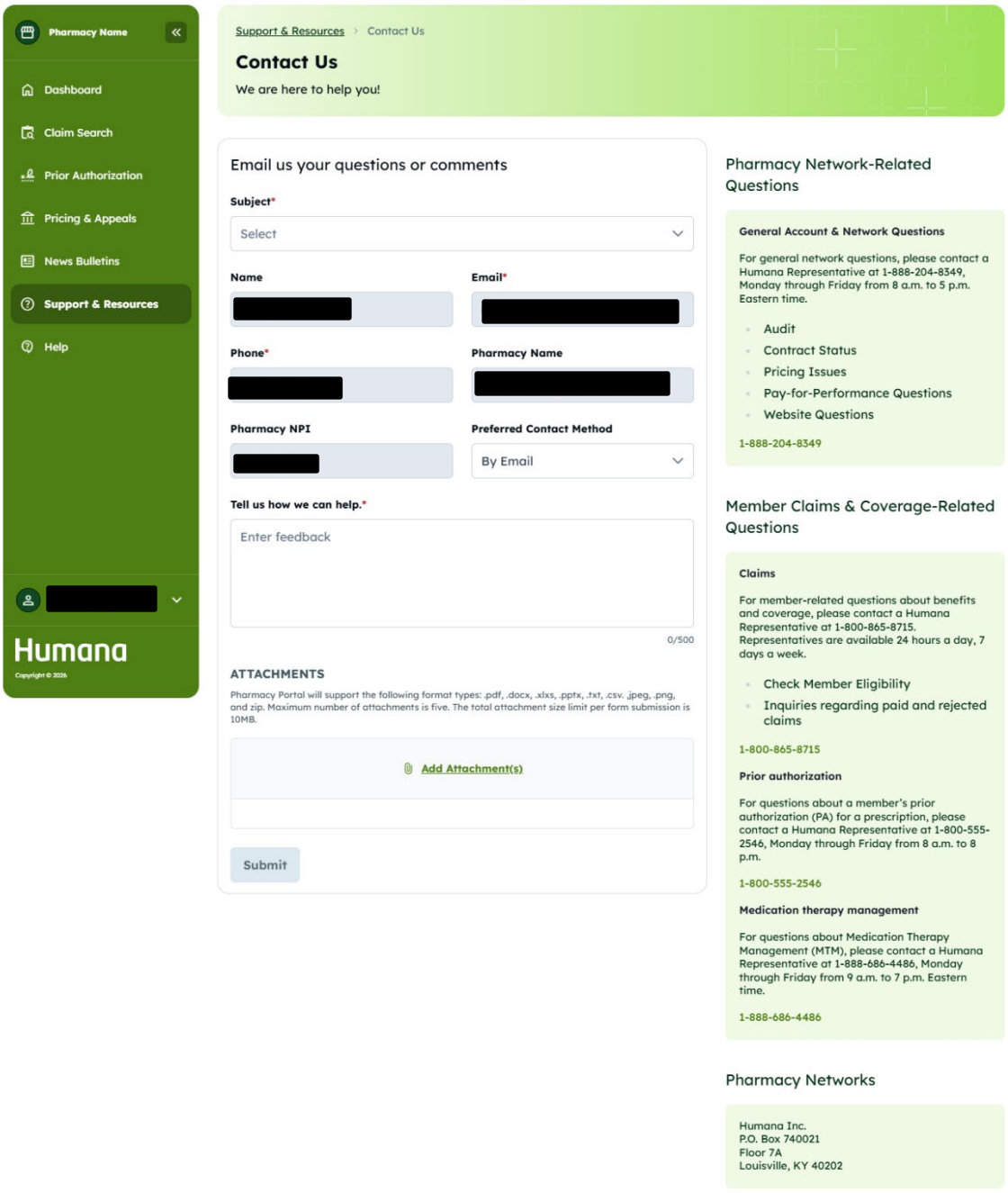
A network pharmacy with a pricing dispute should follow the steps below to submit a pricing review form to Humana.

1) Select "**Pharmacy Pricing Review Request**" in the upper right corner.



2) To initiate the dispute process, download the Pricing Review Request Form, complete all required fields, and submit the form to Humana via the Contact Us section under Support & Resources.





3) When the form is received, Humana will begin the research process and inform the pharmacy by fax or email of the results of the dispute within five business days of the date the form was received.

Pharmacy's process for filing a complaint

SS&C Health system issues
All pharmacies contracted with Humana are encouraged to call the Humana Healthy Horizons in Oklahoma pharmacy help desk at **844-918-0785** for questions or complaints related to a system issue or claims transaction. SS&C Health has a dedicated telephone support unit that provides guidance for calls related to pharmacy claims. All issues that cannot be addressed or resolved by SS&C Health are forwarded to the Pharmacy Networks Department for research and resolution at **888-204-8349**.

Pharmacy initiative inquiries
Humana has a dedicated pharmacy telephone support unit that provides support for pharmacy inquiries and complaints related to specific corporate pharmacy management initiatives. Any specific initiative question that cannot be answered by the HCPR telephone support unit is forwarded to the Pharmacy Networks Department for research and resolution at **888-204-8349**.

Member complaint system

The section below is from the member grievance and appeal procedure as set forth in the Humana Member Handbook. This information is provided to the pharmacy so that the pharmacy may assist members in this process if they request your assistance. Please contact your contracting representative if you have questions about this process.

Humana has representatives who handle complaints, which include all member grievances and appeals. A special set of records is kept with the reason, date and results. Humana keeps these records in the central office.

Member grievances
Medicaid recipients can file a grievance at any time. Grievances can be submitted using either method provided below.

- The member can submit written grievances to:

  Humana Healthy Horizons in Oklahoma
  Grievance and Appeal Department
  P.O. Box 14163
  Lexington, KY 40512-4163

  Fax: **800-949-2961**

- For verbal grievances, the member can call Customer Service at **855-223-9868 (TTY: 711)**, Monday – Friday, 8 a.m. – 5 p.m., Central time.

Member appeals
The member, prescriber or member representative may submit an expedited or standard appeal in writing within 60 calendar days of the date of the denial notice. Options for submitting the appeal:

- Download a copy of the appeal form provided on **Humana.com** and either fax or mail it to Humana:

  Humana Healthy Horizons in Oklahoma
  Grievance and Appeal Department
  P.O. Box 14163
  Lexington, KY 40512-4163

  Fax: **800-949-2961**

Please include the member's name, address, Humana member ID number, reason for the appeal and any supporting documents.

If the member is requesting an expedited appeal or is unable to write an appeal, oral appeals are accepted. Medicaid members may ask for an appeal by calling Customer Service at **855-223-9868 (TTY: 711)**, Monday – Friday, 8 a.m. – 5 p.m., Central time.

For all members, their provider, prescriber, pharmacist or someone else can make an appeal on their behalf. However, an Appointment of Representative form must be completed. This form provides permission for another person to act on the member's behalf.

To obtain an Appointment of Representative form, the member can call Customer Care and ask for one or visit Humana's website at **Humana.com/member/documents-and-forms**.

If the appeal comes from someone besides the member, Humana must receive the completed Appointment of Representative form or other appropriate documentation, such as power of attorney, before Humana can review the appeal.

Resolution for grievances and appeals
Humana will investigate the member's grievance and/or appeal and inform them of Humana's decision. If the member has questions concerning the grievance or appeal, direct them to the Humana Member Handbook or call Humana using the number on the back of their member ID card.