AICE

Date: _____

PHARMACY CREDENTIALING EXHIBITS AND ATTESTATIONS APPLICATION TO THE PARTICIPATING PHARMACY AGREEMENT

This PHARMACY CREDENTIALING EXHIBITS AND ATTESTATIONS to the Participating Pharmacy Agreement that includes Exhibit A (Pharmacy Locations), Exhibit C (Participating Pharmacy Attestations and Credentialing Application), Exhibit D (Operational Assessment), Exhibit E (Pharmacy Contact Information), Exhibit F (Navitus Contact Information), the Annual Compliance Attestation for Governmental Programs, and the Medicare Attestation: Standardized Notice (CMS-10147), collectively titled Pharmacy Credentialing Exhibits and Attestations Application ("Pharmacy Application") are documents required of pharmacy to be completed by pharmacy for application into Navitus pharmacy networks. This Pharmacy Application completed in its entirety by pharmacy, including any and all requested supporting documents and credential verification documents, will be used to assess and verify the qualifications of pharmacy for participation and will hereby be incorporated to the executed Participating Pharmacy Agreement entered into and between Participating Pharmacy and Navitus.

EXHIBIT A
PHARMACY LOCATIONS

Provide the following information for all locations of your Pharmacy. If necessary, attach additional information sheets to this Agreement or provide a list of all store locations of your Pharmacy which includes the name, address, NCPDP and/or NPI number, telephone number and federal tax identification number, if applicable, for each location.

Participating Pharmacy Name: _____

Corporation Name (if different from Participating Pharmacy name): _____

Affiliation; if any: _____Open date (if new pharmacy)_____

(Please list all affiliation codes associated with corporate address)

Pharmacy Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

E-mail address: _____

Website address: _____

Telephone Number: _____ NCPDP Number: _____

Fax Number: _____ NPI Number: _____

After Hours Phone Number: _____

Federal Tax ID Number _____ State Medicare Provider Number _____

State Pharmacy License Number _____ State Medicaid Provider Number _____

Hours of Operation: 24 hours? ☐

Monday: _____ to _____
Tuesday: _____ to _____
Wednesday: _____ to _____
Thursday: _____ to _____
Friday: _____ to _____
Saturday: _____ to _____
Sunday: _____ to _____

Languages Spoken:

English ☐
Chinese ☐
German ☐
Spanish ☐
Vietnamese ☐
Arabic ☐
Language Line ☐
Other: (list all) _____

For Office Use Only

EXHIBIT C

PARTICIPATING PHARMACY ATTESTATIONS AND CREDENTIALING APPLICATION

Please complete the following information, attach copies of licenses, policy numbers and expiration dates as indicated below. All sections must be completed and returned with the necessary documentation to enroll as a participating pharmacy in one of Navitus Health Solutions, LLC's networks.

Participating Pharmacy agrees to notify Navitus in writing within seven (7) business days of any event that causes or could cause a violation of any of the foregoing continuing representations, warranties and covenants ("Legal Event"). Participating Pharmacy acknowledges and agrees that any violation of any of the foregoing continuing representations, warranties or covenants or Participating Pharmacy's failure to provide timely notice of any Legal Event shall constitute a material breach of this Agreement, which is not subject to cure.

Section I

(All Participating Pharmacy(s) must complete this section)

NOTE: Electronic or paper copies MUST be provided where indicated and all licenses and certificates must be current and valid.

(Locations in Puerto Rico must also provide Department De Salud Certificado De Registro)

Pharmacist-in-Charge License Number: _____ State Issued: _____
Issue Date: _____ Expiration Date: _____
NPI *(if applicable)* _____

► **COPY REQUIRED FOR AGREEMENT TO BE PROCESSED**

Participating Pharmacy State License Number: _____ State Issued: _____

Issue Date: _____ Expiration Date: _____

► **COPY REQUIRED FOR AGREEMENT TO BE PROCESSED**

Participating Pharmacy DEA Number: _____

Issue Date: _____ Expiration Date: _____

► **COPY REQUIRED FOR AGREEMENT TO BE PROCESSED**

Navitus requires that Participating Pharmacy maintain a minimum of $1 million per person and $3 million per occurrence of general public liability, professional liability and malpractice insurance. If your facility provides less than the minimum, Participating Pharmacy may not be included as a participating pharmacy in the Navitus network.

Participating Pharmacy Liability Insurance (Name of Insurer): _____

Policy Number: _____ Expiration Date: _____

► **COPY REQUIRED FOR AGREEMENT TO BE PROCESSED**

Photo of Pharmacy store front (including signage) and Photo of Pharmacy dispensing area

► **COPY REQUIRED FOR AGREEMENT TO BE PROCESSED**

Sections II

(All Participating Pharmacy(s) must complete this section)

Participating Pharmacy has a current valid permit and conducts business as a (please check one):
☐ Corporation ☐ Sole Proprietorship ☐ Partnership
☐ Limited Liability Company ☐ Other: _____

Participating Pharmacy attestations:

(1) Other than the name listed, has another business or trade name ever been or is currently being used by Participating Pharmacy(ies)? ☐ No. ☐ Yes.
If yes, what was the Participating Pharmacy's previous NCPDP#? _____

(2) Has Participating Pharmacy(ies) ever been denied a permit or pharmacy license in any state, or had its permit or license revoked or suspended? ☐ No. ☐ Yes. If yes, please explain:

_____
_____

(3) Has the Participating Pharmacy(ies) had the DEA license revoked or suspended in the last 10 years? ☐ No. ☐ Yes. If yes, please explain:

_____
_____

(4) Has the Participating Pharmacy(ies) or any of its present owners, employees or officers ever been charged with a criminal offense involving government business or has the Participating Pharmacy(s) or any of its present owners, employees or officers ever been convicted of federal or state drug or pharmacy service-related law convictions? ☐ No. ☐ Yes. If yes, please explain:

_____
_____

(5) Has the Participating Pharmacy(ies) ever been the subject to any outstanding regulatory or disciplinary action by either State, Federal, Government or civil entities or disciplinary action in front of the State Board of Pharmacy? ☐ No. ☐ Yes. If yes, please explain:

_____
_____

(6) Has Participating Pharmacy (ies) had one or more public agreements or transactions (Federal, state, or local) terminated for cause or default? ☐ No. ☐ Yes. If yes, please explain:

_____

(7) Is Participating Pharmacy(ies) under any restrictions of practice as imposed by the State Board of Pharmacy? ☐ No. ☐ Yes. If yes, please explain:

_____

(8) What is the most recent date that Participating Pharmacy(ies) was inspected by the State Board of Pharmacy? (mm/dd/yyyy) _____

(9) Has Participating Pharmacy(ies) ever been terminated by a third party payor, prescription benefit management organization, managed care organization or other similar organization(s)?
☐ No. ☐ Yes. If yes, please explain:

_____

(10) Has Participating Pharmacy(ies) been excluded from participation for a Federal program, including but not limited to, Medicare, Medicaid, federal health care programs or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. section 1320a-7 and other applicable federal statutes? ☐ No. ☐ Yes. If yes, please explain:

_____

_____

(11) Has Participating Pharmacy(ies) ever been listed by a governmental agency as debarred from work with that agency, proposed for debarment from a governmental agency, or suspended from any government work, or otherwise precluded from participating in any Federal program?

☐ No. ☐ Yes. If yes, please explain:

_____

_____

(12) Will the Pharmacy disclose any disciplinary actions or investigations taken against the Pharmacy?

☐ No. ☐ Yes. If no, please explain:

_____

_____

(13) Has Participating Pharmacy(ies) ever filed for bankruptcy, receivership or reorganization?

☐ No. ☐ Yes. If yes, please explain:

_____

(14) Has Participating Pharmacy(ies) liability insurance ever been denied or canceled in the past 5 years?

☐ No. ☐ Yes. If yes, please explain:

_____

Section III

(Attestation signatories)

REQUIRED SIGNATURES

The undersigned hereby authorizes Navitus Health Solutions, LLC ("Navitus"), and its designated agents to review any and all records that it reasonably deems necessary within its credentialing procedures.

Further, the undersigned represents and warrants that any and all information provided to Navitus in connection with its credentialing process is true, accurate and complete, and it has not failed to state any facts or provide any documents that may be material to Navitus Health Solutions in connection with its credentialing process.

Potential participating pharmacies have the right to review the information obtained from any outside primary source and the right to correct erroneous information submitted by another party.

By signing this Exhibit C, Participating Pharmacy(ies) agrees that all locations are bound by the terms and conditions of this Agreement.

Provider Name: (Please print) _____ NCPDP: _____

Name of Owner/ Authorized Agent: (Please print) _____

Signature: _____ Date: _____

Title: _____Degree:_____

Pharmacy Ownership Information

Attach additional sheet(s) for EACH owner to show 100% ownership

Any changes made to the pharmacy ownership must be reported to Navitus within 90 days of the change

Name of pharmacy owner:				Birth Date:
Address:				
City:			State:	Zip Code:
Phone:	Ext:	Email:		
Degree:		Licensed Pharmacist? Yes ☐ No ☐		
License Number:			Expiration Date:	
Owner's NPI *(If applicable)*		Owner's Tax ID *(if applicable)*		
Percentage of ownership in the pharmacy?				

Yes ☐	No ☐	1. Does the owner of this pharmacy have any ownership or control interest in any other pharmacy, fiscal agent or managed care entity? *If yes, please list other pharmacies below. Attach additional pages to include all pharmacies*
Name of pharmacy _____		NCPDP _____
Name of pharmacy _____		NCPDP _____
Name of pharmacy _____		NCPDP _____
Name of pharmacy _____		NCPDP _____

Yes ☐	No ☐	2. Is the owner of this pharmacy related to another person(s) with ownership or control interest in the pharmacy? *If yes, please provide information below.*
Name of related person:		Relationship to person:
Name of related person:		Relationship to person:

**Attach one page per each owner of the pharmacy. Pharmacy ownership percentage should equal 100%

EXHIBIT D
OPERATIONAL ASSESSMENT
(Please check "no" if question doesn't apply)

(1) Are you a 340B provider? (As defined by 42 U.S.C §256b (a)(4)) ☐ Yes ☐ No
(ATTACHED COPY OF THE 340(b) PHARMACEUTICAL PURCHASING WAIVER, IF APPLICABLE)

340 ID Number: _____

Entity Type: _____

Start date: _____

(a) Are you owned or operated by FQHC (Federally Qualified Health Care) ☐ Yes ☐ No

(2) Is your pharmacy set up for online claim processing? ☐ Yes ☐ No

(3) Switch Link (check one): ☐ Relay Health ☐ Emdeon ☐ Freedom
☐ DataRx ☐ QS/1 ☐ Other: _____

(4) Can your pharmacy software receive the following NCPDP messages? (check all that apply):
☐ Duplicate Therapy ☐ Drug Interactions ☐ All messages returned in the additional message field 526-FQ

(5) Does your pharmacy offer delivery service? ☐ Yes ☐ No
If yes, do you charge a fee? ☐ Yes ☐ No If yes, fee amount: _____
Approximate Delivery Range (miles)_____

(6) Does your pharmacy ship or mail prescriptions? ☐ Yes ☐ No
If yes, do you charge a fee and postage? ☐ Yes ☐ No If yes, fee amount: _____

(7) Does your pharmacy provide durable medical equipment? ☐ Yes ☐ No
If yes, is it: ☐ Full line or ☐ Limited? DMEPOS certification number _____

(8) Does your pharmacy provide special packaging of prescriptions that are required for skilled and/or assisted living facilities? ☐ Yes ☐ No

(9) Does your pharmacy routinely dispense written drug information with its prescriptions?
☐ Yes ☐ No If yes, attach a sample of your drug information to this application.

(10) Does your pharmacy compound medication? ☐ Yes ☐ No
If yes, what percent of your business is devoted to compounding? _____
When was your Compounding Pharmacy inspected? _____

(11) Does your pharmacy perform vaccinations/immunization administration? (i.e. flu shots)?
☐ Yes ☐ No
If yes, provide the Mass Immunization Provider Number _____
Immunization Certificate Expiration date _____

(12) Does your pharmacy have areas set aside for patient consultation? ☐ Yes ☐ No

(13) If you have more than one Participating Pharmacy location, would you like to be set up for central payment? ☐ Yes ☐ No

(14) Payment Information Format: (Select one) ☐ Paper Remittance or ☐ Electronic ANSI 835

(15) Emergency Services available after hours? ☐ Yes ☐ No

(16) Internet Service? ☐ Yes ☐ No

(17) Auto Refill Reminder Program? ☐ Yes ☐ No

(18) Is your pharmacy easily accessible and open to the general public? ☐ Yes ☐ No

(19) Does your pharmacy comply with the ADA (American Disability Act) accessibility standards for the physically disabled? ☐ Yes ☐ No

(20) Do you coordinate with Medicare Part B? ☐ Yes ☐ No

Section IV
(Medicare Attestations)

Long Term Care / Home Infusion Attestation

Conflict of Interest: Please initial to confirm that the undersigned has policies and procedures in place to ensure that ALL staff responsible for the administration or delivery of Part D services has evidence of receiving and acknowledging a conflict of interest statement, certification, or attestation at the time of hire. _____(initial)

OIG and GSA Certification: Please initial to confirm that the undersigned has policies and procedures in place to review the Office of the Inspector General (OIG) and General Services Administration (GSA) exclusions material at the time of hire and monthly thereafter throughout their employment to ensure that ALL staff is not currently excluded from any Federal health care programs. Should a staff member be identified on the list(s), the staff member will be immediately removed from any and all work relating to a Federal health care program. _____ (initial)

LONG TERM CARE PHARMACY Check here if not applicable ☐

Long Term Care (LTC)
Service & Requirements
Percentage of pharmacy services for LTC facilities_____

Comprehensive Inventory and Inventory Capacity	☐ Yes	☐ No
Special Packaging	☐ Yes	☐ No
IV Medications	☐ Yes	☐ No
Compounding/Alternative Drug Composition	☐ Yes	☐ No
Pharmacist On-Call Service	☐ Yes	☐ No
Delivery Service	☐ Yes	☐ No
Emergency Boxes	☐ Yes	☐ No
Emergency Log Books and Services	☐ Yes	☐ No
Distribution to LTC facilities	☐ Yes	☐ No
Consulting for LTC facilities	☐ Yes	☐ No

Please list all of the states in which your pharmacy is licensed to provide Long Term Care prescription services:

State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____

[Include a separate document with all additional active state licensures if number exceeds the space above]

Low-income Subsidy Cost-Sharing Certification:

Participating Pharmacy is required to follow CMS regulations that states the Medicare Part D plans must work with network pharmacies to provide them with direct reimbursement for any cost sharing amounts not collected from LIS (Low Income Subsidy)-eligible enrollees. Before copayment reimbursement is made for beneficiaries that are deemed LIS-eligible and living in long-term care facilities, plans must ensure that the

pharmacies in question have not collected cost-sharing amounts, otherwise waived the cost-sharing, and are in fact carrying a debt for the amounts incorrectly charged to the beneficiary.

I hereby attest that the undersigned pharmacy does or does not collect cost sharing (copayment) charges for LIS-eligible beneficiaries who reside in a Long Term Care facility, and that any statements of such cost sharing (copayment) charges submitted by the pharmacy to Navitus Health Solutions are appropriate, owed and payable. The pharmacy agrees to notify Navitus Health Solutions within 30 days of changes to the collection of cost sharing charges for LIS-eligible beneficiaries. Please initial **one** of the following:

A). initial: _____ Participating Pharmacy **does** collect co pays from LIS-eligible enrollees for claims adjudicated for beneficiaries residing in long-term care facilities.

B). initial: _____ Participating Pharmacy **does not** collect co pays from LIS-eligible enrollees for claims adjudicated for beneficiaries residing in long-term care facilities.
Subject to the remaining terms of this Addendum, this attestation shall be re-signed and certified by Participating Pharmacy on an annual basis, and/or if there is a change in the Participating Pharmacy's;

1. Ownership; or
2. Merger/buyout
3. LIS cost share policy (note: Participating Pharmacy must notify Navitus immediately if pharmacy's policy changes.)

HOME INFUSION PHARMACY Check here if not applicable ☐
Home Infusion State Licensure

Percentage of pharmacy services dedicated to Home Infusion services _____

Per CMS [42 CFR §423.120(a)(4)], a Home Infusion pharmacy must meet the minimum requirements as defined below:

- **(i)** Are capable of delivering home-infused drugs in a form that can be administered in a clinically appropriate fashion.
- **(ii)** Are capable of providing infusible Part D drugs for both short-term acute care and long-term chronic care therapies.
- **(iii)** Ensure that the professional services and ancillary supplies necessary for home infusion therapy are in place before dispensing Part D home infusion drugs.
- **(iv)** Provide delivery of home infusion drugs within 24 hours of discharge from an acute care setting, or later if so prescribed.

(Initial) _____ My Pharmacy location meets the minimum requirements listed above from CMS and is indeed a Home Infusion pharmacy.

(i) Does your pharmacy maintain active accreditation(s) from one or more of the following: ACHC, JCAHO, CHAP, URAC, or others? ☐ Yes ☐ No If others, please list here:_____

a. Include date(s) of initial accreditation: _____

(ii) Does your pharmacy provide Non-Sterile Compounding services and maintain policy and procedures for USP 795 Non-Sterile Compounds? ☐ Yes ☐ No

(iii) Does your pharmacy provide Sterile Compounding services and maintain policy and procedures for USP 797 Sterile Compounds? ☐ Yes ☐ No

(iv) Does your pharmacy have a written Home Infusion Policy and Procedure manual and provide annual training for staff compliant to the USP 795/797 & 800 Standards? ☐ Yes ☐ No

(v) Does your pharmacy have a negative pressure compounding room for storing hazardous drug products? ☐ Yes ☐ No

(vi) Is there a Home Infusion Pharmacist available 24 hours a day/7 days a week? ☐ Yes ☐ No

Please list all of the states in which your pharmacy is licensed to provide Home Infusion prescription services to Medicare Part D beneficiaries: (For States that offer a separate Home Infusion designation on licenses, please provide a copy.)

State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____

[Include a separate document with all additional active state licensures if number exceeds the space above]

Pharmacy Name: (Please print) _____ NCPDP: _____

Name of Owner/ Authorized Agent: (Please print) _____

Authorized Signature: _____Date: _____

MAIL ORDER
Check here if Not Applicable ☐

(1) Is your pharmacy URAC Accredited? ☐ Yes ☐ No
If Yes, provide the URAC Accreditation date: _____

(2) Is your pharmacy VIPPS (Verified Internet Pharmacy Practice Sites Program) Accredited?
☐ Yes ☐ No
If Yes, provide the VIPPS Accreditation date: _____

(3) Does your pharmacy understand mailing under the retail pharmacy contract is prohibited?
☐ Yes ☐ No

(4) Is your pharmacy licensed in each state that it will mail Covered Prescription Services, including compliance with any non-resident pharmacy requirements? ☐ Yes ☐ No

Pharmacy State	**License Number**	**Expiration Date**

[Include a separate document with all additional active state licensures if number exceeds the space above]

Pharmacist State	**License Number**	**Expiration Date**

[Include a separate document with all additional active state licensures if number exceeds the space above]

EXHIBIT E
Pharmacy Contact Information

Contracting Contact: (Third Party Contracting/primary contact)
Name: _____
Address: _____
City: _____ ST: _____ Zip code: _____
Phone: _____ Fax: _____
Email Address: _____

Credentialing Contact: (Request for updating all pharmacy credentialing information)
Name: _____
Address: _____
City: _____ ST: _____ Zip code: _____
Phone: _____ Fax: _____
Email Address: _____

Operations Contact: (for chain pharmacy adds/deletes/updates)
Name: _____
Address: _____
City: _____ ST: _____ Zip code: _____
Phone: _____ Fax: _____
Email Address: _____

Audit Contact: (for discussing audits and audit issues)
Name: _____
Address: _____
City: _____ ST: _____ Zip code: _____
Phone: _____ Fax: _____
Email Address: _____

Electronic Remittance Contact:
Name: _____
Address: _____
City: _____ ST: _____ Zip code: _____
Phone: _____ Fax: _____
Email Address: _____

Help Desk Contact: (chain or PSAO support line for pharmacies)
Phone: _____ Email Address: _____

EXHIBIT F
NAVITUS CONTACT INFORMATION

Pharmacy Help Desks

Please see member card for information regarding the number to call for questions or issues.

When member card is not available: call Navitus Customer Care (866) 333-2757.

The Navitus Customer Care call center can be reached 24 hours a day, seven days a week except Thanksgiving and Christmas. The pharmacy help desk is available to assist you with the following:

> Claims processing issues, billing and payment inquiries, formulary questions, prior authorizations, plan and group information, and general inquiries

Provider Services

The Navitus Provider Services Department hours of operation are Monday through Friday 8:30 am – 5:00 pm CST. We are available to assist you with the following:

> Provider relations, credentialing, contract services, policy communication, orientation, reimbursement and network set-up, MAC pricing, and inquiries regarding Navitus and/or client programs

Navitus Health Solutions
2601 West Beltline Highway, Suite 600
Madison, WI 53713
Provider Relations: phone (608) 298-5775, fax (608) 298-5875, email- ProviderRelations@navitus.com
Credentials: phone (608) 298-5776, fax (608) 298-5876, email- credentials@navitus.com
Remittance/Payment: phone (608) 298-5777, fax (608) 298-5877, email- remittanceinquiry@navitus.com
Pricing Research Team: phone (608) 298-5778, fax (608) 298-5878, email- pricingresearch@navitus.com
Customer Care: (866) 333-2757

Navitus Health Solutions Website

Navitus makes every effort to keep pharmacies informed and up-to-date on the latest operational information, procedures and requirements for Navitus on our website located at www.navitus.com. The following information is updated on a regular basis:

> Network updates (payer sheets, new clients, etc.); pharmacy network bulletins, changes in pay cycle schedule; changes in contracting provisions; formulary information; MAC pricing research request forms, and Pharmacy Handbook

Auditing

Please forward auditing questions to Auditing@navitus.com

Fraud, Waste and Abuse Hotline

855-673-6503 this goes directly to our Special Investigations Unit voicemail box for assessment and investigation of the reported issue. Some examples of reportable fraud include forgery, suspicious claims, pharmacy and/or doctor shopping, identity theft, kickbacks and drug diversion.

Reminder Check List

☐ Application is completed

☐ Application is signed and dated

☐ Copy of Pharmacy State License

☐ Copy of Owner's Pharmacist License (if applicable)

☐ Copy of DEA license

☐ Copy of Pharmacist-in-Charge State License

☐ Copy of Professional and General Liability Insurance Certificate(s)

☐ Photos of the dispensing area and store front of your pharmacy

☐ Fraud, Waste and Abuse Attestation
Annual Compliance Attestation (only required for Med D/Medicaid and during initial credential process)

☐ Medicare Part D Drug Coverage and Your Rights Attestation
Standardized Notice (CMS-10147) Issued when Claim is Denied Coverage Attestation (only required for Med D and during initial credential process)

Welcome to Navitus Health Solutions!
What It Means to be a First Tier, Downstream or Related Entity

As a contracted Navitus pharmacy providing services to Medicare and Medicaid members, it is important to know that you qualify as a First Tier, Downstream or Related Entity (FDR). Navitus participating pharmacies are FDRs and as such must have strong practices related to compliance and prevention and detection of fraud, waste, and abuse. FDRs must also engage in training, exclusion checks, policies, records management, and reporting of issues.

Navitus understands that these requirements may be new to you or you have not recently reviewed them. Navitus receives many questions from FDRs on meeting these requirements which are outlined below.

Frequently Asked Questions:

- Does Navitus monitor FDR compliance?
    - Yes. Navitus requests attestations annually from pharmacies. This must be completed for Navitus to evaluate your ongoing compliance.
- Does Navitus request documentation about pharmacy FDR compliance?
    - Yes. Navitus audits a sample of pharmacies annually to validate the information provided during the attestation process. We may request training records, policies, and other documentation.
- Can we develop our own training to teach staff about FDR requirements?
    - Yes and No. At minimum, you must use the CMS Compliance and Fraud, Waste, and Abuse training materials without modification. However, you can supplement these with additional training information.
- Does Navitus need to know about any subcontractors a participating pharmacy uses?
    - Yes. Navitus needs to know about subcontractors. Navitus needs to evaluate the service the subcontractor provides, the subcontractor's involvement with patient information, and any offshore locations.
- Why does Navitus need to know if my subcontractor is offshore?
    - For Medicare and Medicaid program patients, the offshore subcontractor will need to be evaluated for reporting to the health plan. For example, Medicare requires notification within 30 days of contracting with an offshore vendor.

- Where can a pharmacy learn more about FDR compliance?
    - Navitus provides online resources for FDRs at its website at https://www.navitus.com/vendor-fdr. This includes:
        - Compliance Requirements
        - Code of Conduct
        - Compliance and Fraud Poster
        - Fraud, Waste, and Abuse Reporting Forms and Hotlines
    - Navitus provides an FDR Manual on your pharmacy portal.

By the signature below, Participating Pharmacy certifies and attests that:

Section I

Fraud, Waste & Abuse (FWA) and General Compliance

1. Monthly during the past twelve (12) months, and going forward on at least a monthly basis, Participating Pharmacy has and will continue to review the Office of Inspector General List of Excluded Individuals and Entities (LEIE) and General Services Administration (GSA) System for Awards Management (SAM) exclusion list and no Participating Pharmacy employee, contractor, or agent providing services directly or indirectly ("Covered Individual"), and no Participating Pharmacy, is excluded from participation in government funded health care programs. Participating Pharmacy is subscribed to the OIG LISTSERV via the OIG website or is subscribed via a third-party exclusion screening provider to receive immediate notice of updates to the LEIE. If any such Participating Pharmacy and/or Covered Individual appear on either the LEIE or GSA SAM list, Participating Pharmacy or Pharmacy Services Administration Organization (PSAO), on behalf of Pharmacy, has and will continue to promptly remove that Covered Individual from the performance of services in support of government funded healthcare programs, including but not limited to Medicare Part D services.

2. Indicate the applicable statement by checking the appropriate box:

- ☐ All Covered Individuals have participated in a compliance and fraud, waste and abuse training program which complies with all applicable CMS and Federal regulations related to Medicare Part D and Chapters 9 and 21, Section 50.3.2 of the Medicare Part D Prescription Drug Benefit Manual. In accordance with CMS 4182-F Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program guidance dated April 2, 2018, Reducing the Burden of the Compliance Program Training Requirements ("Guidance"); effective January 1, 2019, Plan Sponsor's First Tier Downstream Related Entities (FDRs) are no longer required to complete the CMS generated FWA training. Plan Sponsors are still required to ensure FWA oversight of Participating Pharmacies and their Covered Individuals. To meet this requirement, Participating Pharmacies and their Covered Individuals are required to complete FWA and general compliance training that meets all applicable CMS and Federal requirements. Participating Pharmacy provides additional, specialized or refresher training on issues posing fraud, waste and abuse risks specific to a Covered Individual as follows: (i) appointment to the job function, (ii) changed requirements, (iii) when a Covered Individual is found to be noncompliant, (iv) as a corrective action to address a noncompliance issue, and (v) when a Covered Individual works in an area implicated in past fraud, waste and abuse. In addition to this certification, Participating Pharmacy has and will maintain for ten (10) years training records, copies of training material, including the date of the training, attendance, training completion records, test results or test scores (where applicable) and a copy of the training materials, all of which records shall be available upon request. In addition, Medicare Part D Plan Sponsors may distribute to Participating Pharmacy the Medicare Part D Plan Sponsor's standards of conduct and/or general compliance and fraud, waste and abuse policies and procedures. Participating Pharmacy has and will continue to distribute such materials to its Covered Individuals, provided it has not done so through its own general compliance program and code of conduct, setting forth the Medicare Part D Plan Sponsor's compliance expectations for Participating Pharmacy and FDRs that do not have their own general compliance or code of conduct training. A Participating Pharmacy that does not have its own fraud, waste and abuse, general

compliance or code of conduct program is required to use a Medicare Part D Plan Sponsor's training that meets Chapters 9 and 21 requirements. Participating Pharmacy will document which Medicare Part D Plan Sponsor's material is used for training.

- ☐ Participating Pharmacy is deemed to have met the fraud, waste, and abuse training certification requirements through enrollment into Parts A or B of the Medicare program or accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). NOTE TO CHAIN PHARMACIES: If this box is checked, it must be true for each individual Participating Pharmacy location. **Specify the date and organization that provided accreditation:**

Date of accreditation:	**Select the appropriate organization from the list below of accepted Medicare vendors:**
_____/_____/_____ Mm / dd / yyyy	☐Accreditation Commission for Health Care, Inc. ☐American Board for Certification in Orthotics & Prosthetics, Inc. ☐Board of Certification/Accreditation International ☐Commission on Accreditation of Rehabilitation Facilities ☐HealthCare Quality Association on Accreditation ☐Community Health Accreditation Program ☐National Association of Boards of Pharmacy ☐The Compliance Team, Inc. ☐The Joint Commission

3. Participating Pharmacy's managers, officers, and directors responsible for the administration or delivery of Medicare Part D benefits are free from any conflict of interest in administering or delivering Medicare Part D benefits.
4. Participating Pharmacy has reported and will continue to promptly report in writing to the Medicare Part D Plan Sponsor's or Pharmacy Benefits Manager's (PBM's) Compliance Officer any concerns related to compliance, suspected or actual violations of law or policy related to the services provided to beneficiaries covered by the Medicare Part D Plan Sponsor or PBM. Participating Pharmacy or Covered Individuals may report fraud, waste, and abuse to the Medicare Part D Plan Sponsor's or PBM's hotline, email, or other reporting method
5. Participating Pharmacy has provided and will continue to provide Medicare Part D beneficiaries with notices as required by CMS instructing the beneficiaries to contact their plans to obtain a coverage determination or request an exception if the beneficiary disagrees with the information provided by the pharmacist.
6. Participating Pharmacy's FDRs have attested to the Participating Pharmacy compliance with the attestation requirements set forth herein.

Section II

Offshore Activities

For purposes of this attestation, the term "Offshore" shall be determined in accordance with CMS rules, regulations and guidance and the Health Insurance Portability and Accountability Act of 1996, as amended and all rules and regulations promulgated there under ("HIPAA") and currently refers to any location that is not one of the fifty (50)

United States or one of the territories of the United States (American Samoa, Guam, Northern Marianas, Puerto Rico and the United States Virgin Islands). Please check the appropriate box below regarding the use of Offshore subcontractors to perform activities that involve receiving, processing, transferring, handling, storing, or accessing PHI under or in connection with Medicare Part D:

- ☐ Participating Pharmacy **DOES NOT** utilize Offshore subcontractors who have access to PHI.

- ☐ Participating Pharmacy **DOES** utilize Offshore subcontractors who have access to PHI. If this box is checked, Participating Pharmacy will be asked by the Part D Plan Sponsor or its PBM to provide all necessary information required to comply with CMS rules and regulations.

If there are any changes to the statuses of Section I or Section II indicated above during the current Plan Year, Participating Pharmacy shall promptly notify the Medicare Part D Plan Sponsor or its PBM.

Disclaimer: Any CMS changes to Fraud, Waste and Abuse regulations outlined in the sections above are automatically included as part of the overall Fraud, Waste and Abuse attestation and pharmacies are expected to comply.

<table>
<tr><td colspan="3">Signature of Responsible Party:</td><td colspan="3">Date:</td></tr>
<tr><td colspan="2">Print Name of Responsible Party:</td><td colspan="4">Name of Participating Pharmacy:</td></tr>
<tr><td>NCPDP:</td><td>NPI:</td><td colspan="2">Phone:</td><td colspan="2">Fax:</td></tr>
<tr><td colspan="6">Email Address:</td></tr>
<tr><td colspan="2">Pharmacy address:</td><td colspan="2">City:</td><td>State:</td><td>Zip:</td></tr>
</table>

OFFSHORE SUBCONTRACTOR ATTESTATION

Enter your pharmacy name, name and title of person completing this form, and the date that you completed this attestation:	
Name:	**Title:**
Signature:	**Date:**
NCPDP(s):	

Please provide a copy to:
Navitus Health Solutions, LLC,
Provider Services
361 Integrity Drive
Madison, WI 53717
You may also email credentials@Navitus.com or fax the form to 608-298-5876

Part I. Offshore Subcontractor Information	
Offshore Subcontractor Name:	
Offshore Subcontractor Country:	
Offshore Subcontractor Address:	
Describe Offshore Subcontractor Functions:	
State Actual Effective Date for Offshore Subcontractor: (Month, Day, Year: Example January 15, 2015)	

Part II. Precautions for Protected Health Information (PHI)	
Describe the PHI that will be provided to the offshore subcontractor:	
Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:	
Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	+

Part I. Attestation of Safeguards to Project Beneficiary Information in the Offshore Subcontract		
Item	**Attestation**	**Response: Yes No**
I.1	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary PHI and other personal information remains secure	
I.2	Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with the sponsor's contract with the offshore subcontractor	
I.3	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach	
I.4	Offshore subcontracting arrangement includes all required Medicare Part C and D language such as record retention requirements, compliance with all Medicare Part C and D requirements, etc.	

Part II. Attestation of Audit Requirements to Ensure Protection of PHI		
Item	**Attestation**	**Response: Yes No**
II.1	Organization will conduct an annual audit of the offshore subcontractor	
II.2	Audit results will be used by the Organization to evaluate the continuation of its relationship with the offshore subcontractor	
II.3	Organization agrees to share offshore subcontractors audit results with CMS upon request	

Medicare Part D Drug Coverage and Your Rights Attestation

The Center of Medicare and Medicaid Services (CMS) requires all Medicare Network Pharmacies to distribute the Medicare Drug Coverage and Your Rights Notice when applicable to Medicare enrollees. Each time an enrollee is denied coverage and/or disagrees with cost-sharing information, and the issue cannot be resolved at Point of Sale, your facility is required to hand out the Medicare Drug Coverage and Your Rights Notice (CMS-10147). In other words, the notice must be provided if the pharmacy receives a transaction response indicating the claim is not covered by the Part D and the designated National Council for prescription Drug Programs (NCPDP) response code is returned.
For auditing purposes, please indicate below whether your pharmacy agrees to provide the notice at Point of Sale for Retail locations and within 72 hours for Long Term Care, Home Infusion, Specialty and Mail Order locations.

Participating Pharmacy certifies, represents and warrants the information below as to whether Participating Pharmacy is in agreement to provide Medicare D Beneficiary with the Medicare Drug Coverage and Your Rights Notice (CMS-10147) form.
Please initial **one** of the following:

A). initial: _____ Participating Pharmacy is a Retail pharmacy and agrees to provide notice to beneficiary at Point of Sale.

B). initial: _____ Participating Pharmacy is Long Term Care, Home Infusion, Specialty or Mail Order pharmacy and attests to provide notice to beneficiary within 72 hours from the pharmacy's receipt of the original transaction response indicating the claim is not covered by Part D.

C) Participating pharmacy agrees the Notice (CMS-10147) may not be altered in any way, except to increase the dimensions and/or font. Content of the Notice (CMS-10147) must remain the same.

This attestation shall be re-signed and certified by Participating Pharmacy if there is a change in the Participating Pharmacy's;

4. Ownership; or
5. Merger/buyout

By signing this attestation, Participating Pharmacy is attesting that the above is true and accurate. Furthermore, Participating Pharmacy agrees to the terms and conditions of this attestation:

Signature: _____
Print Name of Signer: _____
Date: _____
Name of Pharmacy: _____
NCPDP/NPI : _____

Please fax to (608) 298-5876. A cover letter is not required.

*If the enrollee is a self-pay resident, and the pharmacy cannot fill the prescription under the Part D benefit, the pharmacy must, upon receipt of the transaction response, fax or otherwise deliver the notice to the enrollee, the enrollee's representative, prescriber or an appropriate staff person at the LTC facility. After distribution of the notice, the LTC pharmacy should continue to work with the prescriber or facility to resolve the matter and ensure the resident receives the needed medication or an appropriate substitute.(Per CMS memo dated 12/27/12-Revised Guidance for Distribution of Standardized Pharmacy Notice CMS-10147)

* For enrollees brought on service by the home infusion pharmacy, the pharmacy can also choose to deliver the notice in person with delivery of home infusion drugs or through an infusion nurse, as long as the next scheduled visit is within 72 hours of the receipt of the transaction code indicating the claim cannot be covered by Part D. (Per CMS memo dated 12/27/12-Revised Guidance for Distribution of Standardized Pharmacy Notice CMS-10147)