

Pharmacy Provider Manual

APPLICABLE TO ALL PROVINCES AND TERRITORIES (EXCLUDING
QUÉBEC)

May 2022

Version 6.0



Any comments or requests for information may be transmitted to:

Express Scripts Canada
Attention: Provider Relations
10th Floor
5770 Hurontario Street
Mississauga, ON L5R 3G5

Email: <mailto:prorelationstor@Express-Scripts.com>

Express Scripts Canada reserves the right to update this manual and content referenced in this manual. Data used in examples are fictitious unless otherwise noted. In the event that there are discrepancies between the English and the French version, the English version will prevail.

© 2009 – 2022 Express Scripts Canada. All Rights Reserved.

Express Scripts Canada is a registered business name of ESI Canada, an Ontario partnership.

All reproduction, adaptation or translation is prohibited without prior written authorization, except for cases stipulated by the Copyright Act. Registered or non-registered trademarks and registered product names belong to their respective owners.

DOCUMENT REVISION HISTORY

Version	Date last revised	Publication date	Details
1.0	December 2010	December 2010	Revision
2.0	November 2012	November 2012	Revision
3.0	April 2016	April 2016	Revision
3.1	February 2019	April 2019	Revision
4.0	June 2019	July 2019	Revision
5.0	December 2019	December 2019	Revision
6.0	March 2022	April 2022	Revision

Note: The publication date takes precedence over the date last revised.

Table of Contents

1. DEFINED TERMS	7
2. INTRODUCTION.....	10
2.1. Purpose.....	10
2.2. Terms.....	10
2.3. Exemption.....	10
2.4. Deleted/Reserved.....	11
2.5. Express Scripts Canada (ESC).....	11
2.6. Express Scripts Canada Sponsors (Clients).....	11
3. REGISTRATION AND MODIFICATION TO PHARMACY PROVIDER INFORMATION.....	12
4. PHARMACY PROVIDER AGREEMENT.....	13
4.1. Pharmacy Provider Agreement.....	13
4.1.1 Credentialing/Re-credentialing	13
4.2. Liability Insurance and Indemnity	14
4.3. Copayments/No Balance Billing.....	15
4.4. Effect of Termination	16
5. DISPENSING QUANTITIES AND UNITS OF MEASURE.....	16
5.1. Extended Supply – Vacation Supply.....	17
5.2. Lost, Stolen or Damaged Medication.....	17
5.3. Compliance Packaging and Frequent Dispensing.....	17
5.4. Pack Sizes and Units of Measure.....	17
6. PRESCRIPTION SAVINGS CARDS.....	18
7. ADJUDICATION SYSTEM OVERVIEW	18
7.1. Real-time Processing	18
7.2. Adjudication System Functionality	18
7.3. Variations in Pharmacy Practice Management Systems (PPMS)	18
8. COORDINATION OF BENEFITS (CoB).....	19
8.1. Provincial and Private CoB.....	19
8.2. Private and Private CoB	19
8.2.1. CoB – Coverage Termination.....	19
8.2.2. CoB – Spouse or Dependent.....	19
9. PRIOR AUTHORIZATIONS AND LIMITATIONS.....	20
9.1. Prior Authorizations.....	20
9.2. Coverage Limitations	21
10. CLAIM SUBMISSION PROCESS.....	22
10.1. Claim Submission Requirements – General	23
10.1.1. Prescription Documentation Requirements.....	23
10.1.2. Prescriptions for Diabetic Supplies	23

10.1.3.	Product Selection Code Requirement	23
10.1.4.	Intervention Code Requirement	23
10.1.5.	Prescriber ID Reference Number Requirement.....	23
10.1.6.	Pharmacist Prescribing Requirement.....	24
10.1.7.	Actual Day Supply Requirements	24
10.2.	Direct Electronic Claim Submissions	24
10.3.	Deferred Claim Submissions	25
10.4.	Claim Submissions Exceeding \$9,999.99.....	25
10.4.1.	Claim submission field values	25
10.4.2.	Coordination of benefits.....	26
10.4.3.	Reversals	26
11.	CLAIM REIMBURSEMENT PROCESS	27
11.1.	Provider Reimbursement.....	27
11.2.	Reimbursement Schedule	27
11.2.1.	Reimbursement Method	28
11.2.2.	Remittance Advice.....	28
11.2.3.	Reimbursement errors	28
11.3.	Extemporaneous Preparations /Compound Claim Submissions Guidelines.....	28
11.3.1.	Eligible compounds	28
11.3.2.	Ineligible compounds	29
11.3.3.	Mixture breakdown requirements	29
11.3.4.	Compounding Commercially Available Products	30
11.3.5.	Unlisted Compound Codes.....	30
11.3.6.	Reimbursement Guidelines for Compounded Covered Medications	31
11.3.7.	Purchased compounds	31
11.4.	Methadone and Buprenorphine/Naloxone Claim Submissions	31
11.5.	Medical Cannabis Claim Submissions.....	32
12.	CLAIM REVERSALS	32
12.1.	Electronic Claim Reversals	32
12.2.	Deferred Claim Reversals.....	32
12.3.	Manual Claim Reversals	32
13.	PROGRAMS.....	32
13.1.	Provincial Integration Program	32
13.2.	Drug Utilization Review	33
13.3.	Step Therapy Program	35
13.3.1.	Step Therapy Cognitive Fee	36
13.4.	Opioid Management Program	36
13.4.1.	Opioid Management Program – Long-acting opioid module.....	36
13.4.2.	Opioid Management Program – Short-acting opioid module.....	36

13.4.3.	Opioid Management Program – Intervention codes	37
14.	PRICING FUNCTIONALITIES.....	37
14.1.	Maximum Allowable Cost (MAC).....	37
14.2.	Substituting Medication.....	38
14.2.1.	Mandatory Generic Substitution.....	38
14.2.2.	Standard Generic Substitution	38
14.2.3.	Product Selection Codes	38
15.	FRAUD, WASTE AND ABUSE (FWA) PROGRAM	39
15.1.	Provider Responsibility for audits and investigations	40
15.2.	Audits.....	40
15.2.1.	Claim Verifications.....	40
15.2.2.	Written Desk Audit.....	41
15.2.3.	On-site Audit	41
15.2.4.	Audit Response Guidelines and Timelines.....	41
15.3.	Investigations	42
15.3.1.	Written Desk Investigation.....	42
15.3.2.	On-Site Investigation	43
15.3.3.	Investigation Response Guidelines and Timelines.....	43
15.4.	Additional Audit and Investigation Activities.....	43
15.4.1.	Member Verification	43
15.4.2.	Prescriber Verification	43
15.4.3.	Purchase invoices	44
15.4.4.	Bin checks.....	44
15.4.5.	Post Assessment Ranking.....	44
15.5.	Fraud Tip Line.....	45
16.	CONTACT US	45
16.1. Express Scripts Canada Website for Health Care Providers	45
16.2.	Express Scripts Canada Provider Call Centre	45
17.	OTHER CONTACTS.....	46
17.1.	Canadian Pharmacists Association.....	46
18.	APPENDICES.....	47
	Appendix A Sample Remittance Advice	47
	Appendix B Reimbursement Guidelines for Compounded Medications in BC, MB, ON and SK	48
	Appendix C Ineligible Ingredients, Bases and Formats for Compound Preparations.....	50

1. DEFINED TERMS

The glossary below lists terms and definitions that may be relevant as background information when reading the pharmacy provider manual.

Term	Definition
Assigned Claim	means a Claim submitted electronically or manually by the Provider to Express Scripts Canada with payment by Express Scripts Canada to such Provider in compliance with the Provider Agreement.
Cannabis provider	means a Provider bound by the terms and conditions detailed in the Cannabis Provider Agreement.
Claim	means a request related to payment of a Covered Medication submitted by the Provider.
Coordination of benefits or CoB	means a situation in which a Member is covered under more than one public and/or private insurance plan and payment of the Member's Covered Medications must be coordinated between the plans and their respective payers to determine the amount payable under each plan.
Copayment	means that portion of the total charge for each prescription drug that a Member is required to pay to Provider or to the Pharmacy(ies) in accordance with that Member's Pharmacy Benefit Plan and the relevant provisions of the Provider Agreement, whether designated as a "copay," "co-insurance" or "deductible" under the applicable Pharmacy Benefit Plan.
Covered medication(s)	means those drugs, services, supplies and other items covered and approved by a Pharmacy Benefit Plan.
CPhA	means the Canadian Pharmacists Association.
CPhA pharmacy claim standard (CPhACS)	standard rules of electronic claim transmission published and updated by the CPhA accepted and approved by ESC. A copy may be obtained by Provider directly from the following address Canadian Pharmacists Association 1785 Alta Vista Drive Ottawa, ON K1G 3Y6 Phone: 613 523-7877 Fax: 613 523-0445
Days supply	number of days of treatment relative to the quantity dispensed for Covered Medications.
Deferred claim	means a Claim submitted electronically by the Provider to Express Scripts Canada, without payment by Express Scripts Canada to such Provider; provided, in which case, Members are responsible for full payment of Covered Medications to the Provider and will later be reimbursed by Sponsor pursuant to the terms of the applicable Pharmacy Benefit Plan.

Term	Definition
DIN	means the drug identification number specific to a particular drug in Canada.
ESC	means Express Scripts Canada
Extemporaneous compound code	means the code used to designate the applicable compound type (such as an injection, cream, et cetera) for an extemporaneous compound.
Formulary	means the list of certain preferred medications, services and supplies prepared by Express Scripts Canada for a Sponsor and revised periodically, which prescribers are encouraged to prescribe, pharmacists are encouraged to dispense, consistent with their professional judgment and applicable medical and pharmaceutical laws and procedures, and which Members are encouraged to use. Express Scripts Canada will send Formulary information to the Provider and Pharmacies online at time of claim submission or in such other manner as Express Scripts Canada deems appropriate
Identification Information	means the identification information issued by the Sponsor to the Member pursuant to the applicable Pharmacy Benefit Plan.
In writing	refers to a written communication rather than a verbal communication, sent via fax, mail or available on-line.
Intervention code	means a code that is required to indicate the reason for overriding a claim rejection or a claim cutback, where applicable, in compliance with the CPhA pharmacy claim standard (CPhACS). Written documentation to support the use of an intervention code is required. This can be documented either directly on the prescription or on the hard copy of the dispensing record or electronic version of the member's profile, at the time of dispensing.
Manual claim	means a Claim submitted by a Provider in any manner other than electronically through Express Scripts Canada's adjudication system and without payment by Express Scripts Canada to said Provider; provided, however, that any manual Claim submitted in connection with an Assigned Claim to Express Scripts Canada by a Provider will be processed by Express Scripts Canada and paid to such pharmacy along with the respective Assigned Claim.
Member	means an eligible person and his or her eligible dependents to whom Covered Medications are available pursuant to a Pharmacy Benefit Plan.
Net Reimbursement or Net Payment	means the amount payable by Express Scripts Canada for a Claim following a deduction of Copayments
OPINIONS	means online Product Identification Number Index of Nova Scotia.

Term	Definition
Pharmacy Benefit Plan	means a health care plan pursuant to which pharmacy benefits are available to Members as provided by a Sponsor pursuant to an agreement with ESC, including any Formulary.
Pharmacy practice management system (PPMS)	means software provided used by the Provider to submit Claims and capture all relevant data when dispensing medication in accordance with the CPhA pharmacy claim standard (CPhACS), the prescription and Express Scripts Canada procedures.
Pharmacy Provider Agreement	means a legal contract between Express Scripts Canada and a pharmacy Provider.
Provider	a Provider bound by the terms and conditions detailed in the Pharmacy Provider Agreement.
Primary cardholder	means the principal beneficiary of a Pharmacy Benefit Plan as indicated on the Identification Information.
Product selection code	means the code to indicate the reason for “no substitution” or other reason for the selection of the Covered Medication dispensed included in the CPhA pharmacy claim standard (CPhACS), as it may be revised from time to time. Subject to applicable laws and regulations within the Provider’s province or territory, the use of product selection codes must be supported by appropriate documentation on the original prescription.
Remittance advice	is the statement indicating the Assigned Claim(s) adjudicated by the Express Scripts Canada adjudication system during a particular payment cycle for the associated Provider including any reversals or adjustments as a result of an audit or investigation.
Real-time processing (RTP)	has the meaning set forth in Section 7.1 of this Pharmacy Provider Manual.
Service date	means the dispensing date for the Covered Medication.
Software vendor	means the entity that provides the Pharmacy practice management system (PPMS) used by the Provider to capture all relevant data when submitting a Claim to Express Scripts Canada for adjudication.
Sponsor	means any client of Express Scripts Canada (i.e. insurance company, employer or other organization) having principal financial responsibility for payment of Covered Medications provided to Members under a Pharmacy Benefit Plan.

2. INTRODUCTION

2.1. Purpose

The Pharmacy Provider Manual is a written description of practices, policies, rules, operational requirements and procedures Providers and cannabis Providers are to follow as part of the Express Scripts Canada (ESC) provider network. Any reference to a Provider is also applicable to a cannabis Provider where applicable to benefit plan design.

2.2. Terms

Terms and conditions governing the relationship between the Provider and ESC are detailed in the Pharmacy Provider Agreement. The obligations in this Pharmacy Provider Manual supplement and are in addition to the terms and conditions of the Pharmacy Provider Agreement.

It is the Provider's responsibility to refer to the most recent version of the Pharmacy Provider Manual.

The Pharmacy Provider Manual may be revised from time to time by ESC in its sole discretion. It shall be the Provider's responsibility to check for any updates to the Pharmacy Provider Manual. Provider's failure to comply with any of the provisions of the Pharmacy Provider Manual shall be considered a breach of this Agreement. Following a revision to the Pharmacy Provider Manual, Providers will be sent a minimum 30-day written advance notification of the revisions. The Provider will be given thirty (30) calendar days from the date of advanced written notice to terminate their agreement if they do not agree with the proposed change(s) to the Pharmacy pProvider Manual. If no notice of termination is received within thirty (30) calendar days, the Provider is deemed to accept the amendment/revision.

Unless otherwise stated, all sections of the Pharmacy Provider Manual apply to all Claim submissions and all Providers.

The Pharmacy Provider Manual may be obtained from www.express-scripts.ca.

2.3. Exemption

This Pharmacy Provider Manual does not apply to Providers operating in the province of Québec.

This Pharmacy Provider Manual does not apply to any claims processed through the Non-Insured Health Benefits (NIHB) Program for Indigenous Services Canada (ISC). Providers interested in submitting any eligible claims through the NIHB Program can enrol by completing and signing the NIHB Pharmacy enrolment package located <https://nihb.express-scripts.ca/NIHBProvider/enrol>.

NIHB Pharmacy Providers	Contact
Website	https://nihb.express-scripts.ca/NIHBProvider/home/en
NIHB Call Centre at Express Scripts Canada	1 888 511-4666 Monday to Friday: 6:30 a.m. to midnight (ET) Saturday, Sunday and statutory holidays: 8 a.m. to midnight (ET)

2.4. Deleted/Reserved

2.5. Express Scripts Canada (ESC)

In the context of pharmacy benefit management, a pharmacy benefit manager (PBM) is mandated by its clients to receive, analyze, audit and reimburse (as applicable) any claim submitted by Providers on behalf of a Client's Members (i.e., patients). A PBM is not an insurance company. As a PBM, ESC is a third party to the relationship between a Sponsor and a Member and does not interfere with the Member – Sponsor relationship.

ESC offers Sponsors a variety of services including but not limited to:

- Pharmacy benefit management services
- Pharmacy network management
- Provider registration services
- Real-time electronic adjudication of Claims
- Provider communication services
- Express Scripts Canada Provider Call Centre
- Audits, investigations, and quality assurance services
- Clinical programs
- Training and education

2.6. Express Scripts Canada Sponsors (Clients)

ESC adjudicates Provider Claims on behalf of these Sponsors:

Client ID	Sponsor
02	Manulife Financial
07	Manion Wilkins & Associates Ltd.
11	Industrial Alliance
15	Non-Insured Health Benefits (NIHB) Program (The NIHB Program is not governed by this Pharmacy Provider Manual)
25	Teamsters National Benefit Plan
29	Humania Assurance Inc.
31	Ministère de l'Emploi et de la Solidarité Sociale (MESS)
32	STI Technologies Ltd. (STI)
37	Cowan Insurance Group
38	Syndicat des Fonctionnaires Municipaux de Montréal (SFMM)

Client ID	Sponsor
39	Coughlin & Associates Ltd.
40	RWAM
43	Manulife Affinity Markets
47	Benecaid (effective until August 1, 2022)
49	Group Medical Services (GMS)
50	GMS Insurance Inc.
53	Groupe Premier Médical (GPM)
55	Johnson Inc.
73	Excellence
90	Empire Life

3. REGISTRATION AND MODIFICATION TO PHARMACY PROVIDER INFORMATION

To start the registration process and join the Express Scripts Canada's (ESC's) Pharmacy Provider Network, please complete the Provider Registration Declaration available at express-scripts.ca/health-care-downloads-and-resources. ESC must be notified a minimum of 30-days in advance for any pharmacy openings by receiving a newly completed form from Providers.

Once the Provider Registration Declaration is received and verified at ESC, Providers registering either a new pharmacy or ownership change will be sent a copy of the Pharmacy Provider Agreement. Providers are required to complete and sign the Pharmacy Provider Agreement and send it back to ESC along with supporting documentation, including but not limited to a copy of:

- The pharmacy's governance documents (e.g. articles of incorporation etc.)
- The pharmacy's share certificates
- Proof of the pharmacy's liability insurance including name of the insurance company and coverage amount
- Government approved photo identification for each owner, officer and director of the company, including the pharmacy manager

All pharmacies under the same corporate ownership must be listed on the Pharmacy Provider Agreement. Providers will receive a unique ESC provider number for each pharmacy business location they own. All Provider information for each pharmacy where the same corporate ownership exists, including the corresponding ESC provider number(s), will be documented under one Pharmacy Provider Agreement. This unique provider number for each pharmacy is required on all correspondence with ESC, including but not limited to Claim submissions and prior authorizations.

Upon ESC verifying the provider registration information and confirming all pharmacy locations and managers are in good standing with their regulatory body and the pharmacy has received their College or licensing board

accreditation, ESC will send a Welcome Letter following the Provider's successful registration. The Welcome letter will include the ESC provider number for each pharmacy location, where to locate this Pharmacy Provider Manual and the Provider Registration Declaration to be used by the Provider to notify ESC of pharmacy changes.

To modify any information included on the Provider's approved Pharmacy Provider Agreement, the Provider must complete the Provider Registration Declaration which is available at express-scripts.ca/health-care-downloads-and-resources.

For any changes to the pharmacy legal business name or ownership changes (including changes to the owner name(s), director name(s) or other shareholder name(s)), Providers must notify ESC to register the name change and will be required to complete a new ESC Pharmacy Provider Agreement. To initiate the process, please complete the Provider Registration Declaration available at express-scripts.ca/health-care-downloads-and-resources.

A new Provider number may be issued in response to these changes. If a new Provider number is issued, records associated with the old Provider number are transferred to the new Provider number to allow for continuity in records management. Providers must notify ESC immediately in writing of any pharmacy acquisitions or pharmacy closures. Immediate notification to ESC is required for changes to the Provider's membership with their respective pharmacy regulatory or licensing bodies.

4. PHARMACY PROVIDER AGREEMENT

4.1. Pharmacy Provider Agreement

The approval and execution of the applicable fully completed Express Scripts Canada (ESC) Pharmacy Provider Agreement and its exhibits are required to become a Provider on the ESC pharmacy Provider network. ESC requires that each Provider fully complete, sign and submit a Pharmacy Provider Agreement along with, and not limited to the pharmacy articles of incorporation and share certificates, proof of pharmacy liability insurance, and government photo Identification for all owners, officers, directors of the company and for the pharmacy manager. ESC reserves the right to verify any information provided in the Pharmacy Provider Agreement which can include but may not be limited to, a review of information about the Provider and the staff available from the provincial regulatory body, and cross referenced with ESC's Provider watch list. Notwithstanding the foregoing, any Provider who submits a Claim and is reimbursed by ESC is to abide by this Pharmacy Provider Manual. The obligations in this Pharmacy Provider Manual supplement and are in addition to the terms and conditions of each Pharmacy Provider Agreement.

4.1.1 Credentialing/Re-credentialing

ESC frequently re-credentials all active Providers to ensure Provider records are accurate based on the information available from the respective provincial regulatory bodies. In cases where college information does not match what the Provider has shared with ESC, the Provider is either contacted for a follow-up and/or is terminated, if it is determined that the Provider is in violation of the Agreement.

While re-credentialing, ESC will also confirm that all stakeholders, including staff members of the Provider remain in good standing. Concerns of professional or proprietary misconduct may be referred to the Fraud Waste and Abuse team for further investigation, and added to ESC's Provider watch list. In the event that fraud is suspected or the Provider's license is suspended or revoked by their college, the Provider may be immediately deactivated from the network, terminating the Provider's billing privileges.

Failure to provide updated information to the Provider Registration Declaration or to comply with any other credentialing/re-credentialing requirements required by ESC within 10 calendar days of ESC's request may lead to the termination of the Provider's billing privileges.

4.2. Liability Insurance and Indemnity

The Provider shall obtain and maintain, and shall cause the pharmacies to obtain and maintain, in full force and effect and throughout the term of the Pharmacy Provider Agreement such policies of general liability, professional liability and other insurance of the types and amounts as are reasonably and customarily carried by pharmacies with respect to their operations.

The Provider shall obtain and maintain, for itself and each pharmacy, or shall cause each Provider to obtain and maintain during the term of the Pharmacy Provider Agreement, comprehensive general liability insurance coverage that is equivalent to the amounts outlined with the provincial pharmacy regulatory body; or a minimum of \$2,000,000 when not outlined by the Provider's provincial pharmacist regulatory body per occurrence per pharmacy, including pharmacist's professional liability insurance, for protection from claims for bodily injury and personal injury to Members from Provider's operation or the operation of the Pharmacies under the Pharmacy Provider Agreement.

By signing the Pharmacy Provider Agreement, the Provider represents that these insurance requirements are being met. The Provider shall furnish or cause to be furnished not less than thirty (30) days prior written notice to ESC in the event of termination or material modification of any such policies of insurance. Upon ESC's request, the Provider shall provide ESC with evidence of such insurance coverage satisfactory to ESC. If the insurance purchased to satisfy the requirements of this section is of the "claims made" variety, the Provider shall purchase an extended period of indemnity so that ESC is protected from any and all claims brought against ESC for a period of not less than three (3) years subsequent to the date of termination of the Pharmacy Provider Agreement.

ESC shall not be liable or suffer loss for any claim, injury, demand or judgment of any kind whatsoever arising out of the sale, compounding, preparation, dispensing, manufacturing labeling, consultation, communication of information on the prescribed or recognized use of medication, use of any medication or any service provided, records made or pharmacological study of such records preferred, by a pharmacy or the Provider pursuant to the Pharmacy Provider Agreement. Regardless of the insurance coverage required, the Provider shall indemnify, defend and hold harmless ESC, its officer, directors and employees against the full amount of any and all loss, expense, claim, or damage arising out of or attributable to any of the foregoing.

4.3. Copayments/No Balance Billing

In no event shall a Provider “balance bill” any Member, including charging, collecting a deposit from, or seeking any other fees, taxes/surcharges, or any other compensation other than the applicable Copayment. As such, the total reimbursement to the Provider by ESC and the plan member for the provision of a covered medication shall not exceed the amount contracted for, or accepted as payment by such Provider from any other private payer or cash paying customer for that covered medication. If this practice is evident, the relevant claims could be subject to audit, and could lead to reversals and/or adjustments.

In the event the payment by ESC and the applicable Copayment collected from Member for a Covered Medication results in a total reimbursement that is below the “Total Allowable Prescription Reimbursement” as that term is defined in the Provider Agreement, the remaining amount (“Non-Insured Portion”) may be submitted to the Member’s secondary drug plan (CoB) by the Provider. If the Member does not have a secondary drug plan or other reimbursement options (the Pharmacy Benefit Plan managed by ESC is the payer of last resort), the Provider or any Pharmacy shall only charge and collect from the Member the “Non-Insured Portion” in accordance with the scenarios listed below. If a Provider, or any Pharmacy, is uncertain if an amount can be charged to the Member, they should contact the ESC Provider Call Center.

- i. The difference between the Pharmacy’s allowable Professional Fee under the applicable Rate Sheet and the Professional Fee reimbursed by the Pharmacy Benefit Plan.
 - o The Claims Transmission Standard message returned is DH – PROFESSIONAL FEE ADJUSTED.
- ii. The difference in ingredient cost and mark-up for a Covered Medication that is a brand product and for which the Pharmacy Benefit Plan cutback such Covered Medication to the price of the generic or biosimilar reference drug and the Member has decided to remain on the brand product (including scenarios in which the prescriber’s choice is “no substitution”).
 - o The Claims Transmission Standard message returned for a covered Medication cutback to the price of the generic is D8 - INGREDIENT COST REDUCED TO MAXIMUM - ALLOWED - GENERIC PLAN.
 - o The Claims Transmission Standard message returned for a “no substitution” claim when the plan is mandatory generic is LC - - REDUCED TO GENERIC COST - NO EXCEPTIONS.
 - o There is no Claims Transmission Standard message returned for a price cutback due to a Biosimilar reference drug.
- iii. The difference in ingredient cost and mark-up for a Covered Medication for which the Pharmacy Benefit Plan uses a Maximum Allowable Cost (MAC) program (also often referred to as reference based pricing “RBP”).
 - o The Claims Transmission Standard message returned is QR- MAXIMUM ALLOWABLE COST (MAC) PAID
- iv. The difference in ingredient cost and mark-up for a Covered Medication for which the Pharmacy Benefit Plan uses a custom Sponsor ingredient cost price file.
 - o The Claims Transmission Standard message returned is DJ- DRUG COST ADJUSTED\DRUG COST PAYABLE LESS THAN SUBMITTED
- v. Difference in ingredient cost and mark-up for a Covered Medication when the days supply for the quantity dispensed to the Member is in excess of the maximum days supply permitted by the Pharmacy Benefit

Plan (e.g. vacation supply of 180 days but Pharmacy Benefit Plan covers no more than 100 day per claim, submitted days supply is 100 but Pharmacy Benefit Plan covers no more than 34 days at a time, etc.).

- The Claims Transmission Standard message returned is DM – DAYS SUPPLY EXCEEDS PLAN LIMIT

vi. and other Pharmacy Benefit Plan controls and limits applied to the claim and indicated by the ESC system in accordance with the Claims Transmission Standard.

Please note, preferred provider networks (PPNs) are a benefit management strategy commonly used by our Sponsors and set up within our adjudication system. This principle does not prevent Providers from entering into these separate, negotiated arrangements with our Sponsors.

4.4. Effect of Termination

- Upon termination of the Pharmacy Provider Agreement for cause or without cause, ESC may take the following actions including but not limited to:
 - Termination of other Pharmacy Provider Agreements in which Provider or Pharmacies share common ownership
 - Inclusion of Provider's and/or Pharmacy(ies) name in the applicable Sponsor and/or ESC's published list of terminated Providers
 - Notifying ESC Sponsors, who may in turn notify the Members
 - Offset from any amounts owing to Provider or any amounts which the Provider may owe to ESC.
 - Instill a blackout period in which the pharmacy owner shall not be allowed to register a pharmacy with ESC for a minimum period of one (1) year from the termination of the agreement.
 - Instill a blackout period in which the pharmacy location, regardless of ownership, shall not be allowed to register with ESC for a minimum period of one (1) year from the termination of the agreement.

Please note, Sponsors may not utilize Provider and/or all or any Pharmacies in a network for their respective Pharmacy Benefit Plans. Accordingly, without terminating the Pharmacy Provider Agreement, ESC may terminate a Provider (or any Pharmacy) from participating in any Sponsor's Pharmacy Benefit Plan in accordance with Sponsor's timing and at such Sponsor's discretion.

5. DISPENSING QUANTITIES AND UNITS OF MEASURE

Where applicable to the Pharmacy Benefit Plan, Covered Medication may be classified as maintenance or non-maintenance to determine the maximum allowable Day Supply for each medication. For a new course of treatment or for the first four months of coverage (whichever criterion is specified by the Pharmacy Benefit Plan), the same maximum allowable Day Supply generally applies to all Covered Medication regardless of their eventual classification as maintenance or non-maintenance medication.

Maintenance medication, other than long-acting medications, may be dispensed in quantities corresponding to a maximum allowable days supply of 90 days, if authorized by the prescriber, unless the Pharmacy Benefit Plan states otherwise.

For non-maintenance medications, the maximum quantity dispensed per Covered Drug will be the lesser of:

- The quantity prescribed; or a
- 34-day supply, if this limit is specified by the Pharmacy Benefit Plan.

If a maintenance supply of a Covered Medication has not been dispensed to a Member eligible to receive a maximum allowable day supply, the following CPhA response code will be generated: KX – PATIENT IS NOW ELIGIBLE FOR MAINTENANCE SUPPLY.

For long-acting maintenance medications, Providers can submit a days' supply greater than 90 days. This will enable Providers to maintain accurate patient pharmacy records and is in alignment with provincial directives and EMR requirements. Days' supply should be reflective of the prescribed dosing interval and in accordance with professional judgement of the dispensing pharmacist. The relevant claims could be subject to audit, and could lead to reversals and/or adjustments.

Note: Maximum allowable day supply specifications do not apply to compound claims.

5.1. Extended Supply – Vacation Supply

An extended supply (i.e., a medication supply exceeding the Pharmacy Benefit Plan Day Supply for that Member for the applicable DIN) may be permitted for Members travelling out of their province of residence, if prior authorization has been obtained where applicable to Pharmacy Benefit Plan. Members seek prior authorization from the Sponsor to allow for a vacation supply of the applicable DIN in advance of the claim submission by the Provider. If the Pharmacy Benefit Plan prevents an extended supply, the Member may pay for the Covered Medication or for the portion of the Covered Medication in excess of the allowable Day Supply and submit the Claim information and receipts to the Sponsor for reimbursement of the outstanding amount, as applicable.

5.2. Lost, Stolen or Damaged Medication

In the event that a Covered Medication is lost, stolen or damaged, the Member must pay for the replacement prescription and submit the required documentation to their Sponsor with supporting documentation for manual Claim processing. The Provider shall not submit the claim electronically as an early refill.

5.3. Compliance Packaging and Frequent Dispensing

ESC requires that the prescriber authorize the request for compliance packaging, or frequent dispensing less than 90 days for maintenance medications, in order to be reimbursed for additional dispensing fees. The authorization must be documented directly on the prescription by the prescriber. Note that prescriber notification will not be accepted as authorization. Documentation for reduced Days Supply must be clearly written on each new prescription by the prescriber. Unless directed or agreed upon by the prescriber, ESC will reimburse one (1) fee every 28 days for maintenance medications.

For audit and investigation purposes, please ensure that it is clearly documented who is requesting the compliance packaging on every new prescription. General letters requesting frequent dispensing/compliance packaging will not be accepted during an audit or investigation and Claims will be subject to adjustments or reversals through ESC's Fraud, Waste and Abuse Program.

5.4. Pack Sizes and Units of Measure

ESC may refer to provincial formularies or a Formulary when determining units of measure in the ESC adjudication system. In particular, certain DINs require the use of specific units of measure to avoid improperly submitting Claims relative to the wrong unit of measure. Improperly submitted Claims may be subject to Claim adjustments, Claim reversals and the recoupment of reimbursement, through ESC's Fraud, Waste and Abuse Program. For a comprehensive list of units of measure updates, please see: express-scripts.ca/health-care-downloads-and-resources. Providers must be diligent when submitting claims for all medication including medication dispensed in packages (e.g., inhalers, oral contraceptives and vaccines).

Providers must ensure they are submitting the smallest pack size combinations needed to fill the prescription, in order to reduce waste of medication and excessive amounts billed to Pharmacy Benefit Plans. Claims where the smallest pack size combinations are not used should have rationale clearly documented. Improperly submitted claims without complete documentation may be subject to claim adjustments or reversals, through ESC's Fraud, Waste and Abuse Program.

6. PRESCRIPTION SAVINGS CARDS

ESC adjudicates claims related to prescription savings cards, on behalf of certain Sponsors. Prescription savings cards offer financial assistance on brand name medication prescriptions and include the following card types but not limited to:

- **Sample cards** – the program pays the usual and customary costs for the DIN specified on the card **and** the drug benefit plan does not cover any costs associated with the dispensed DIN (primary payer).
- **Patient benefit and patient assistance cards** – the program pays a portion of the prescription price (payer of last resort).
- **Patient choice cards** – the program pays the difference between the brand name DIN list price and the generic DIN list price (secondary payer).

Prescription savings cards may be coordinated with a Member's insurance coverage, whether public or private. Providers must follow the recommendations indicated on the reverse of each card, for Co-ordination of benefits. Co-ordination with additional prescription savings cards is prohibited by Sponsors and/or by the issuer of a prescription savings card. ESC will reverse claims used with a prescription savings card(s) where the prescription savings card(s) is coordinated with one or more additional prescription savings cards, through ESC's Fraud, Waste and Abuse Program.

7. ADJUDICATION SYSTEM OVERVIEW

7.1. Real-time Processing

Real-time processing (RTP) refers to the capacity of the Express Scripts Canada (ESC) electronic system to receive, process and return the adjudication results of Provider Claims automatically.

7.2. Adjudication System Functionality

The ESC adjudication system processes any electronic Claim transmitted through the Provider's PPMS (pharmacy practice management system) and returns a response indicating whether the claim was successfully adjudicated or not. The adjudication response is transmitted using the format specified by the current CPhA Pharmacy Claim Standard.

7.3. Variations in Pharmacy Practice Management Systems (PPMS)

Exact messaging and options displayed to Providers may vary from those indicated in this Pharmacy Provider Manual depending on the PPMS implemented by the Provider. Each Provider is responsible to determine if the PPMS aligns with ESC's terms to facilitate all claim submissions including methadone claim submissions.

8. COORDINATION OF BENEFITS (CoB)

ESC adjudication system indicates that a CoB is required when a combination of Pharmacy Benefit Plan coverages (i.e., provincial and private or private and private) may apply to the Claim. Co-ordinating benefits reduces duplications in Claim processing and ensures that the total amount paid in coverage for a claim does not exceed 100 per cent of the expenses incurred by the Sponsor and or Member.

Where Members are eligible for provincial drug coverage, Providers must coordinate claims with the province as the first payer unless the province specifically states otherwise.

The first ranking insurer (i.e., the first payer or the primary payer) reimburses the Claim according to its reimbursement guidelines. Subsequently, the Claim is transmitted by the Provider to the second-ranking insurer (i.e., the second payer or the secondary payer) for reimbursement on the outstanding Claim amount according to its own reimbursement guidelines. Finally, if applicable, the Claim is transmitted to the payer of last resort for reimbursement on the outstanding Claim amount.

When the ESC adjudication system determines that a CoB is required, the previously paid field must be populated by the Provider with a previously paid amount even if the previously paid amount is \$0. CoB in the ESC adjudication system, whether private or provincial, only occurs when all portions of the same Claim including previously paid portions are made by electronic claim submission.

8.1. Provincial and Private CoB

When the ESC adjudication system sends back a CPhA code indicating that a provincial CoB is required, the DA intervention code must be included when submitting the claim to ESC for adjudication. The DA intervention code is used by the Provider to indicate that the claim has been coordinated with the provincial plan.

8.2. Private and Private CoB

When the ESC adjudication system sends back a CPhA code indicating that a private CoB required, the DB intervention code is used by the Provider to co-ordinate the Claim with the ESC adjudication system. This co-ordination is required regardless of whether the first payer Pharmacy Benefit Plan is provided by Sponsor. If both private and provincial CoB is required (i.e., a Sponsor is the third payer in a situation that already involved a public payer or private payer as first and second payers), the DB intervention code must be used by the Provider (rather than the DA intervention code) when submitting the claim to ESC.

8.2.1. CoB – Coverage Termination

If the ESC adjudication system indicates that the first payer coverage is terminated (i.e., CPhA response codes C4 and CJ), the DB intervention code cannot be used to submit the claim.

- If different valid Identification information applies, the Provider must resubmit the claim using the updated information.
- If coverage is terminated, the Member will have to pay for the claim, notify their Sponsor and submit the claim and receipts manually directly to the first payer (plan). The outstanding amount is sent by the member directly to the second payer (i.e., the ESC client) for reimbursement – not to ESC.

8.2.2. CoB – Spouse or Dependent

Several situations may apply when submitting claims to ESC that involve CoB scenarios for spouses and dependents.

When a claim is transmitted to ESC as the primary payer for a spouse or dependent(s) and a different pharmacy benefit plan should be the primary payer:

- The claim will be rejected by ESC with the following CphA response code: C6 – PATIENT HAS OTHER COVERAGE.
- In such a scenario, Provider must process the claim through the appropriate primary payer first and transmit the outstanding amount to ESC using the DB intervention code (to indicate that a different private coverage also applies).

When a Sponsor is the primary payer for the cardholder, spouse and dependent(s) and the CoB information for the spouse and/or dependents is not updated:

- The following CphA response code is generated by the ESC adjudication system: C6 – PATIENT HAS OTHER COVERAGE.
- In such a scenario, the claim cannot be submitted electronically.
- The Claim and receipts are submitted manually by the Member to the Sponsor for manual reimbursement.
- Please ask the Member to contact the Sponsor to change or update the CoB information for the spouse and/dependents.

When the primary payer for the spouse or dependent(s) is a non-ESC Sponsor and ESC Sponsor is the primary payer for the primary cardholder only:

- If the first payer for the spouse or dependent(s) adjudicates electronically, transmit the Claim to the primary payer first and then to ESC using the DB intervention code with the outstanding Claim amount.
- If the first payer for the spouse or dependent(s) does not adjudicate electronically, request the spouse and/or dependent(s) pay for the cost of the claim upon dispensing. The claim and receipts are submitted in manually by the Member directly to the first payer (pharmacy benefit plan) and then the outstanding claim amount is sent manually by the Member to the second payer (plan) for reimbursement.

Note: The total cost paid by a Sponsor and Member as a secondary payer should not exceed the total allowable prescription reimbursement by ESC including the amount covered by the primary payer.

Co-ordination of benefit Claims are audited through ESC's Fraud, Waste and Abuse Program and subject to adjustments due to incorrect payer submissions and/or inflated prescription costs passed on to ESC as a secondary payer.

9. PRIOR AUTHORIZATIONS AND LIMITATIONS

9.1. Prior Authorizations

Covered Medications may require prior authorizations (PAs) to ensure appropriate Pharmacy benefit plan utilization and the optimal use of certain innovative costly medications. Unless the Member has obtained a prior authorization approval for a DIN that requires a prior authorization, the Claim will be rejected by the ESC adjudication system. When a prior authorization is required, the Provider will receive one of the following CPhA response codes:

Prior Authorization CPhA Response Code	Scenario	Action Required
LH	The submitted DIN cannot be processed for this Member without a prior authorization approved by ESC and attached to the Member's profile	ESC is responsible for the assessment of the prior authorization request. See the procedures below (LH).
DX	The submitted DIN cannot be processed for this Member without a prior authorization, approved by a Sponsor and attached to the Member's profile	The Sponsor is responsible for the assessment of the request. See the procedures below (DX).

The CPhA response code (LH versus DX) differs depending on whether ESC or the Sponsor (e.g., the insurer) is responsible for assessing the prior authorization request. The message generated by the ESC adjudication system to the Provider, accompanying both CPhA response codes (LH and DX), remains the same regardless of who is responsible for assessing the request. It may be preferable for the Member to complete the prior authorization process to confirm coverage for the medication, prior to getting the Provider to submit the Claims for adjudication by ESC. The table below indicates the procedures for obtaining prior approval, as applicable:

Prior Authorization CPhA Response Code	Scenario
LH	<p>ESC is responsible for the assessment of the prior authorization request. A prior authorization form is to be completed by the Member and the authorizing prescriber before it is returned to ESC in writing for assessment.</p> <p>Whether the prior authorization request is granted or denied, ESC will inform the Member accordingly in writing. If the request is granted, ESC will also update the electronic profile of the Member.</p> <p>The prior authorization form required when ESC is responsible for the assessment of the request and the ESC prior authorization drug list are both available at express-scripts.ca/health-care-downloads-and-resources.</p>
DX	<p>The ESC Sponsor is responsible for the assessment of the request prior authorization. The Member contacts the Sponsor directly to obtain the appropriate prior authorization form. The prior authorization form is to be completed in full and returned to the Sponsor for assessment.</p> <p>Whether the prior authorization request is granted or denied, the ESC Sponsor will inform the Member. If the prior authorization request is granted, the ESC Sponsor will also update the electronic profile of the member in the ESC adjudication system.</p>

9.2. Coverage Limitations

Benefit plans have limitations on Covered Medication. The table below details some of these limitations:

Limitation	Scenario
Fertility Medications, Smoking Cessation Products, Anorectics and Anti-Obesity Medications	Coverage for these medications varies by Pharmacy Benefit Plan, Day Supply, quantity, et cetera. Some Pharmacy Benefit Plans may not cover some or all of these medications.
Other limitations	Limitations can also apply to quantity, specific DIN, Day supply, et cetera.

Member-specific Limitations

Limitations may apply to specific Members and not to other Members covered by the same Pharmacy Benefit Plan and include the following:

Limitation	Scenario
Copayment	That portion of the total charge for each prescription drug that a Member is required to pay to Provider or to the Pharmacy(ies) in accordance with that Member's Pharmacy Benefit Plan and the relevant provisions the Provider Agreement, whether designated as a "copay," "co-insurance" or "deductible" under the applicable Pharmacy Benefit Plan.
Coinsurance	A percentage per prescription that the Member is responsible for paying out-of-pocket for a Covered Medication, relative to the Pharmacy benefit plan.
Deductible	<p>Cumulative fixed dollar amount to be paid by the Member (primary cardholder, spouse, or dependent(s)) before the Sponsor assumes any portion of the cost of the Covered Medication. Several classes of deductibles exist including but not limited to:</p> <ul style="list-style-type: none"> • Individual – each individual in a family must satisfy a fixed amount. • Family – all individuals in a family accumulate toward the fixed amount. • Combined – each individual in a family accumulates an individual deductible, and each individual's deductible accumulates towards the family deductible.
Limited dispensing fee	<p>The limited dispensing fee feature allows for the reimbursement of dispensing fees on adjudicated claims up until the member has met the limit on the number of paid dispensing fees as determined by the Pharmacy benefit plan design for a specific DIN for that member in a 12-month period. Once this limit is reached, dispensing fees on all subsequent adjudicated claims will not be reimbursed (For example 4 dispensing fees in a 12-month period for a maintenance drug).</p> <p>Covered Medications that may result in noncompliance issues (e.g., antipsychotics) may be exempt from limited dispensing fees feature. Covered Medications exempt from limited dispensing fees feature should not have the limited dispensing fee feature in the ESC adjudication system.</p>
Other member-specific limitations	Limitations can also apply to quantity, specific DIN, Day supply, et cetera, for different Members based on the Member's profile or medication history.

10. CLAIM SUBMISSION PROCESS

Claims may be submitted electronically through the ESC adjudication system or in writing (i.e. as manual Claims). Failure to comply with the claim submission requirements outlined below may result in an audit and potential claim recovery through ESC's Fraud, Waste and Abuse Program.

10.1. Claim Submission Requirements – General

10.1.1. Prescription Documentation Requirements

ESC requires an authorized prescription for any Claim submitted by the Provider for reimbursement. All claims for items covered by the ESC Sponsor (including medication that typically requires a prescription, over-the-counter medication and behind-the-counter medication) must be accompanied by a valid prescription. Each prescription, including those initiated by a pharmacist as governed by provincial or territorial legislation and/or governing bodies, must include at a minimum the following information:

- Date of authorization by the prescriber;
- Member's complete name;
- Drug name, quantity and direction for use;
- Prescriber's name and signature;
- Number of refills and the interval between fills (if applicable); and the
- Date that the authorization was received/signature of the receiving pharmacist* (for verbal prescriptions**).

Note: Any changes to the authorized prescriptions must be recorded directly on the prescriptions prior to processing the claim. Data entry for all claim information must be consistent with the data on the prescription documentation.

**Pharmacist and/or designated personnel authorized by the respective provincial or federal regulatory authority.*

***Verbal prescriptions are only valid for the duration of the prescription (including all refills).*

10.1.2. Prescriptions for Diabetic Supplies

Claims for diabetic supplies have the same requirements as any other prescription submitted to ESC ([Section 10.1- Claim Submission Requirements – General](#)). If the prescriber has only written “diabetic supplies” this will not be accepted as a valid prescription. Prescriptions for diabetic supplies must be itemized with descriptions and quantities clearly decipherable and/or calculable.

10.1.3. Product Selection Code Requirement

Subject to applicable laws and regulations in the applicable province or territory of practice, the use of Product Selection Codes (see section 14.2.3 for additional information) must be supported by appropriate documentation on the original prescription.

10.1.4. Intervention Code Requirement

When a claim is submitted with an Intervention code, written documentation to support the use of an Intervention code is required. The supporting information can be documented directly on the prescription, on the hard copy of the dispensing record, or on the electronic version of the Member's profile in the PPMS, at the time of dispensing.

10.1.5. Prescriber ID Reference Number Requirement

The Prescriber ID is the number assigned by the respective provincial or federal regulatory authority that is used to identify the prescriber. The Prescriber ID Reference number is the prescriber's valid two (2) character alphanumeric code, which identifies the prescriber type. ESC requires that claims are submitted by Provider with adherence to the most current CphA Claims Transmission Standard for processing and payment, which includes a valid Prescriber ID number and Prescriber ID Reference number.

10.1.6. Pharmacist Prescribing Requirement

These conditions must be satisfied by a pharmacist prescribing:

- The pharmacist prescribing is licensed by and in good standing with the respective governing body and province or territory of practice.
- The prescription is written within the context of the authorized prescriber’s scope of practice as determined by the applicable provincial legislation.
- The pharmacist code field is populated with the license number of the pharmacist prescribing as approved by their licensing body and the applicable CphA prescriber reference ID number is indicated on each claim.

10.1.7. Actual Day Supply Requirements

The actual Day supply must be indicated on each Claim taking into consideration Member dialogue and professional discretion when prescription directions are not specific. If exact directions are not provided by the prescriber (e.g., if the prescriber indicates “as directed” or “prn”), Providers shall contact the prescriber or make a reasonable assessment and submit the day supply based on:

- The prescriber’s verbal indications or the pharmacist’s assessment (which should be documented on the original prescription in accordance with applicable legislation); and
- The quantity prescribed.

For all medication, the quantity dispensed must correspond to the quantity billed. For instance, if a 90-day supply is dispensed, billing cannot be made in 30-day increments. All ninety (90) days must be billed at once.

10.2. Direct Electronic Claim Submissions

Direct electronic claims may be submitted and reversed electronically by the Provider up to ninety (90) days from the Service date. The following information must be indicated when submitting a direct electronic claim through the ESC adjudication system:

Type of information	Description
Member information	Always refer to the member ID card when submitting a claim. All numbers (e.g., group number, carrier number, member ID alphanumeric number) should match the exact number of digits on the identification card, including leading zeros and trailing zeros.
Relationship code	Confirm that the appropriate relationship code is entered for the primary cardholder, spouse, or dependents respectively. Where applicable, ask the Member to verify that the spouse or dependent is covered by the benefit plan.
Drug information	Include the DIN of the covered medication, quantity dispensed, the day supply, the drug and compounding costs, the usual and customary fee and the prescription number. ESC accepts provincial drug plan pseudo-DINs including OPINIONS pseudo-DINs.
Prescriber information	ESC requires that pharmacists provide valid prescriber ID and prescriber ID reference information as assigned by the respective provincial or federal regulatory authority.
Claim amount	Refers to the total amount billed for a specific covered medication in a specific quantity including the drug cost, markup and professional fee.

For claims older than ninety (90) days but less than 365 days, please call the ESC Provider Contact Centre. Please note that claims older than 365 days cannot be processed via real-time processing (RTP).

10.3. Deferred Claim Submissions

The Provider submits claim information electronically via real-time processing (RTP) to ESC and the information received from the Provider is communicated to the Sponsor by ESC. Deferred claims are paid in full to the Provider by the Member at the time of dispensing, as per the adjudication result provided by ESC.

10.4. Claim Submissions Exceeding \$9,999.99

Claims over \$9,999.99 are able to be submitted electronically through the ESC adjudication system. As a reminder, the following scenarios apply when submitting an EDI Claim over \$9,999.99:

- Split the Claim amount into equal amounts such that each resulting amount is less than \$9,999.99.
 - Split Claim amounts as efficiently as possible. For instance, a Claim amount of \$15,000 can be split into 2 claims, 3 claims, et cetera to bill for the quantity prescribed but the minimum it needs to be split into to ensure that each claim amount is less than \$9,999.99 is two Claims.
Ex. Splitting \$12,000 into two Claims results in \$6,000 per Claim. Additional splits are unnecessary.
- Split the quantity submitted the same number of times as the Claim amount:
 - If the Claim amount is split into two equal amounts, the quantity submitted should be split into two equal amounts; if the Claim amount is split into three equal amounts, the quantity submitted should be split into three equal amounts.
For instance, for a Claim amount of \$12,000 and a quantity submitted value of 6, splitting the Claim amount into two equal amounts (\$6,000 and \$6,000) will ensure that each split amount is less than \$9,999.99. The quantity submitted (6) needs to also be split into two equal quantities (3 and 3).
Additional splits are unnecessary.
- Submit each subsequent claim resulting from the split with a dispensing fee of \$0.00.
- Indicate a unique Rx number for each split claim.
- The ESC adjudication system will automatically generate a new claim reference number for each split Claim.
- A claim rejection will occur for each subsequent claim because the system recognizes each subsequent Claim as a duplicate Claim.
 - Use the following CphA intervention code to override the duplicate claim rejection: MP – VALID CLAIM – VALUE \$1,000.00 TO \$9,999.99

For your reference, information related to claim submission values, CoB and claim reversals when submitting EDI claims over \$9,999.99 are included below:

10.4.1. Claim submission field values

Un-split values on all split claims associated with the same dispensed medication	Split values on all split claims associated with the same dispensed medication
<ul style="list-style-type: none"> • Day supply (indicate the same day supply i.e. the total day supply on each split claim) • Price per unit (remains the same on each split claim) 	<ul style="list-style-type: none"> • Quantity submitted (split equally per split claim) • Drug cost (split equally per split claim) • Markup/cost upcharge (split equally per split claim) • Previously paid amount (split equally per split claim)

10.4.2. Coordination of benefits

For Claim submissions over \$9,999.99, the previously paid amount is split equally such that the same previously paid amount is indicated on each split Claim. The applicable CphA intervention codes are used on each split claim to indicate the kind of CoB that applied to the service:

DA – SECONDARY CLAIM – ORIG TO PROV PLAN

DB – SECONDARY CLAIM – ORIG TO OTHER CARRIERS

For all subsequent split claims in a CoB scenario, the MP intervention code (MP – VALID CLAIM – VALUE \$1,000.00 TO \$9,999.99) is used by the Provider in addition to the applicable CoB CphA intervention code(s) (DA/DB). For instance, if only a provincial CoB applied to the claim, the first split claim is submitted by the Provider with the DA intervention code while subsequent split claims associated with the same dispensed medication are submitted with both the DA and MP intervention codes.

10.4.3. Reversals

The claim reversal process differs if the first split claim needs to be reversed versus a subsequent claim (i.e. not the first claim) for the same dispensed Covered Medication.

- To reverse the first split claim, all subsequent claims must be reversed **prior to** reversing the first claim. For instance, if there are four split claims associated with the same dispensed medication and the first split claim needs to be reversed, all three subsequent split claims must be reversed **prior to** the first split claim. Failure to reverse claims in this order will result in a rejection of the claim reversal.
- To reverse a subsequent split claim, the applicable claim(s) can be reversed without reversing all preceding claims.
- If an error message is received such as [E4] ADJUDICATOR TIME OUT ERROR, [D9] CALL ADJUDICATOR or any other host time out system messaging while processing a reversal, please call the ESC Provider Call Centre to ensure the claim has been properly reversed. Failure to do may lead to a further review from ESC's Fraud Waste and Abuse Team.
- To ensure the accuracy of claims submissions and reversals, please check the ESC provider Remittance advice and compare against your pharmacy records. If there is any discrepancy, it is your obligation to contact ESC to rectify any reconciliation issues.

If you require further information, please contact the ESC Provider Call Centre at 1 800 563-3274, Monday to Friday from 6:30 a.m. to midnight (ET). The ESC Provider Call Centre is also open Saturdays, Sundays and statutory holidays from 8 a.m. to midnight (ET).

Claims with a total amount submitted value that exceeds \$9,999.99 can also be submitted manually if Real Time Processing is not available or possible. Manual claims submitted by Provider to ESC as an Assigned Claim with a total amount submitted value that exceeds \$9,999.99 are processed by dividing the total quantity submitted into a number of equally split quantities. The number of quantity splits is determined by the number of units of \$9,999.99 in the total amount submitted.

For instance:

- If the total amount submitted by the Provider represents three whole units of \$9,999.99 (i.e., three units or more but less than four units), the quantity submitted is split into three equal parts. One whole unit of \$9,999.99 results in one unit increase in the number of quantity splits.

- The Remittance advice displays each split quantity in the quantity column as a distinct claim associated with a distinct Rx number.
- For any claim exceeding \$9,999.99, Provider must submit the claim using the claim form for medications over \$9,999.99 (available at express-scripts.ca/health-care-downloads-and-resources) via fax or mail:

Contact resources for claims over \$9,999.99	Contact
Fax	1 844 744-8433
Mail	Express Scripts Canada Attention: Health Claims & Administration 10 th Floor 5770 Hurontario Street Mississauga, ON L5R 3G5

ESC is committed to processing claims over \$9,999.99 submitted on a duly filled out claim form for medications over \$9,999.99 within one (1) business day. Claim forms received before 3 p.m. (ET) should be processed on the same day. Claims received after 3 p.m. (ET) will be processed the next business day. Some claims may require additional validation and may not fall within the standard turnaround time. Alternatively, the Member may pay for the claim and submit the claim information and receipts directly to the ESC Sponsor for reimbursement, where applicable. ESC does not accept any liability for the coverage of manual claims submitted by Providers. Claims are reimbursed according to the Pharmacy benefit plan for that Covered Medication for that Member.

11. CLAIM REIMBURSEMENT PROCESS

11.1. Provider Reimbursement

ESC shall pay the Provider by electronic funds transfer to a bank account designated by the Provider, within ten (10) business days of such claims. or as provided in the Pharmacy Provider Manual if it differs

Net Reimbursement

The Provider will receive reimbursement for:

- Assigned Claims provided in relation to a Covered Medication.
- Other reimbursable Assigned Claims, as detailed in the applicable Pharmacy Provider Agreement, any amendments to the same and this Pharmacy provider manual. Applicable Copayments will be subtracted from such reimbursements (the resulting amount is referred to as a Net reimbursement or a Net payment).

11.2. Reimbursement Schedule

Pharmacy providers are reimbursed on a weekly basis, except Quebec Providers. If a reimbursement issue date falls on a statutory holiday, the reimbursement is issued on the following business day.

11.2.1. Reimbursement Method

Direct deposit (electronic funds transfer (EFT)) is an environmentally friendly method for depositing Provider claim reimbursements. It is the preferred reimbursement method for Providers. Providers must notify ESC immediately in writing of any changes to the direct deposit information.

11.2.2. Remittance Advice

The Remittance advice is a statement summarizing any Assigned Claim(s) adjudicated during the associated payment cycle, including reversals and/or adjustments conducted during that payment cycle. The Remittance advice also includes CPhA response codes associated with processed Assigned Claim(s), where applicable. The Remittance advice can be accessed electronically, where the Provider is not associated with a chain/banner that has designated centralized access for its chain/banner Providers. Available Remittance advice can be accessed via [ESCstatement.ca](https://www.escstatement.ca). A sample remittance advice has been provided in Appendix A.

Login credentials to access available Remittance advice are issued after Providers become eligible to submit claims (i.e., following the completion of the enrolment process). For security reasons, login credentials cannot be sent by email. If a new Provider has still not received login credentials after the standard mailing time determined by Canada Post™ for your address, please call the ESC Provider Call Centre to initiate an inquiry. Where applicable, additional validation may be required and may impact the turnaround time for processing login credentials.

11.2.3. Reimbursement errors

Any payments made to Provider (or any Pharmacy) in excess or below of any amount properly determined to be due by ESC, if any, under the Provider Agreement, due to an error by either party, inaccurate claims submission or information submitted by Provider (or any Pharmacy) or due to any other reason, including, but not limited to, any audit deficiencies (may be recovered by ESC from Provider (or any individual Pharmacy)). ESC shall notify the Provider (and Pharmacy, if applicable) in writing of the situation. In the event of excess payment(s), ESC shall, at its discretion, have the right to either offset the excess payment amount as provided or require immediate reimbursement from Provider (or any individual Pharmacy)

11.3. Extemporaneous Preparations /Compound Claim Submissions Guidelines

Extemporaneous preparations (compounds) must not duplicate the formulation of a commercially manufactured drug product and at least one of the active ingredients in the compound must be covered by the Member's Pharmacy benefit plan when submitting a compound claim through the ESC adjudication system.

For a list of pseudo-DINs corresponding to active ingredients used for compounding, please see: [express-scripts.ca/health-care-downloads-and-resources](https://www.express-scripts.ca/health-care-downloads-and-resources). For compound claim submissions, indicate the DIN or pseudo-DIN of the **highest** cost eligible ingredient and the Extemporaneous compound code corresponding to the medication type.

11.3.1. Eligible compounds

Compound preparations are eligible if the main/active medicinal ingredient is covered by the Member's Pharmacy Benefit plan.

Note: If an eligible ingredient is added to a compound with an ineligible base, ingredient, and/or dosage format, then the compound becomes ineligible and subject to full reversals through ESC's Fraud, Waste and Abuse Program.

11.3.2. Ineligible compounds

ESC considers the following as ineligible compounds and are subject to full reversals through ESC's Fraud, Waste and Abuse Program:

- A compound that duplicates a commercially available product
- Compounds where the primary/active ingredient is not covered by the plan member's coverage
- Natural products including herbal and homeopathic remedies
- OTC's including vitamins and minerals
- Investigational products
- Compounds for cosmetic use
- Compounded allergy serums and extracts
- Hair growth
- Smoking cessation medications*
- Fertility medications*
- Anti-obesity or anorexiant medications*
- Sunscreens
- Compounds prepared that contain an ineligible base/ingredient or dosage format**

*These types of compounds are not covered under standard plan designs. However, plan sponsors may choose to cover these medications as a modified benefit. If they are covered under the plan design, then these medications will be considered an eligible drug/ingredient.

**Please see [Appendix C – Ineligible Ingredients, Bases and Formats for Compound Preparations](#) for a list of ineligible bases, ingredients and dosage formats

For any questions regarding the eligibility of compounds, please contact ESC Provider Call Centre at 1 800 563-3274.

11.3.3. Mixture breakdown requirements

- Name and expiry of raw material
- Source*
- Drug identification number (DIN) and lot number, as applicable*
- Name, strength and dosage of preparation*
- Date of preparation
- Quantity required and quantity actually weighed of each ingredient
- Total quantity prepared*
- Initials of compounder responsible for the preparation and pharmacist who verified the preparation
- Initials of the person who performed quality control procedures*
- Written formula used

- Cost charged for each ingredient
 - *Please note: compounding supplies/equipment are NOT acceptable ingredients and will not be reimbursed (some examples include but not limited to: gloves, glassware, lab coats, flavoring agents, etc.)*
- Assigned prescription or preparation batch number*
- Cost charged for each ingredient
- Mixing time charges (if applicable)
- Assigned prescription or preparation batch number*
- Assigned beyond use date*
- Original authorizing prescription
- Results of quality control procedures as appropriate*
- Documentation of any quality control issues and/or issues reported by the patient or caregiver*
- If preparation made by another pharmacy, name and details of pharmacy*
- Any other documentation required by provincial authority

* These requirements are effective when the applicable provincial regulatory authority that governs the dispensing pharmacy requires complete implementation of the National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards for Pharmacy Compounding of Non-Sterile Preparation, NAPRA Model Standards for Pharmacy Compounding of Non-hazardous Sterile Preparations and/or NAPRA Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.

Note: Hand-written mixture breakdowns will **NOT** be accepted for audit or investigation purposes.

11.3.4. Compounding Commercially Available Products

If a compound duplicates a commercially available product, the Pharmacy Benefit Plan will not cover the compound. However, if the commercially available product is out of stock/back-ordered or not available, the Pharmacy Benefit Plan will cover compound preparations until the commercially available product becomes available again.

Please note, any compound preparations made for a commercially available product after the product is available, will be subject to full reversals through ESC's Fraud, Waste and Abuse Program.

11.3.5. Unlisted Compound Codes

To help generate the correct compound code for unlisted compounds (there are no pseudo-DINs corresponding to active ingredients used for compounding), select the appropriate CPhA pharmacy claim standard (CPhACS) compound code value as indicated in the table below:

Code	Description	Code	Description
0	Compounded topical cream	5	Compounded internal powder
1	Compounded topical ointment	6	Compounded injection or infusion
2	Compounded external lotion	7	Compounded eye/ear drop
3	Compounded internal use liquid	8	Compounded suppository
4	Compounded external powder	9	Other compound

Note: The step therapy program and the drug utilization review (DUR) does not apply to compound claims.

11.3.6. Reimbursement Guidelines for Compounded Covered Medications

For the provinces of British Columbia, Manitoba, Ontario and Saskatchewan, Providers must submit all claims related to compounded medications using the ESC reimbursement guidelines available in [Appendix B](#). These guidelines determine the maximum time charge allowed to be submitted by the Provider for each compounded drug type.

For all other provinces and territories, a flat fee (1.5 times the allowable dispensing fee) applies to compounded medications. Additional compounding fees or charges are not accepted and subject to full reversals and/or adjustments through ESC's Fraud, Waste and Abuse Program.

11.3.7. Purchased compounds

When the provider does not make the extemporaneous mixture and instead purchases the compound from another provider/manufacture, the dispensing provider is not eligible for a compounding fee. The dispensing provider can only charge their usual and customary fee and eligible markup identified in the rate sheet. The cost of the mixture should be the amount on the invoice charged by the provider from whom the compound was purchased. Purchased compounds invoices are reviewed and will be subject to reversals or adjustments through ESC's Fraud, Waste and Abuse Program. It is the responsibility of the Provider that additional information such as lot number, date of preparation, Beyond Use Date etc. are appropriately documented at the time of dispensing.

11.4. Methadone and Buprenorphine/Naloxone Claim Submissions

Methadone and buprenorphine/naloxone claims may be eligible for reimbursement where applicable to the Pharmacy benefit plan design. When submitting methadone or buprenorphine/naloxone claims, Provider must adhere to the following:

- Do not include a compound code;
- Indicate the Days supply and the number of milligrams (mg) if using powder form or the volume in milliliters (mL) if using liquid form (e.g., Methadose™);
- Do not add an additional compounding fee above and beyond the pharmacy provider's usual and customary fee (i.e., professional fee);
- Submit one usual and customary fee for any witnessed dose and one usual and customary fee for the group of carries (take-home doses). For instance, if a Member is prescribed one witnessed dose and six carries, the pharmacy must submit no more than two fees: one for the single witnessed dose and one for the six carries.

If through an ESC audit or investigation additional fees are identified as being in excess, reversals and/or adjustments will be made through ESC's Fraud, Waste and Abuse Program.

11.5. Medical Cannabis Claim Submissions

Medical cannabis claims may be eligible for reimbursement under certain prescription drug programs or Pharmacy benefit plans. For a medical cannabis claim to be eligible for reimbursement, the medical cannabis must be prescribed by an authorized health care practitioner and dispensed by a licensed cannabis producer or distributor in accordance with all applicable cannabis laws and regulations. For medical cannabis claim submissions, the quantity dispensed must be expressed in equivalent grams of dried cannabis.

12. CLAIM REVERSALS

12.1. Electronic Claim Reversals

Electronic claim reversals can be used to reverse a previously submitted electronic claim that has already been reimbursed. Electronic claims can be reversed by the pharmacy provider via the Express Scripts Canada (ESC) adjudication system if the reversal is made within ninety (90) calendar days of the Service date, as per the CPhA Pharmacy Claim Standard (CPhACS).

A successfully reversed claim can be resubmitted by the Provider as long as both the reversal and resubmission occur within ninety (90) days of the service date.

12.2. Deferred Claim Reversals

Deferred electronic claims can only be reversed within two (2) calendar days from submission of the claim by the Pharmacy. Once this period has elapsed, deferred claims cannot be reversed by ESC. To determine if a deferred claim can be reversed, please call the ESC Provider Call Centre.

12.3. Manual Claim Reversals

For reversals of a manually submitted Assigned Claim (i.e., for reversing a claim submitted by the Provider in writing for claims above \$9,999.99), please call the ESC Provider Call Centre.

13. PROGRAMS

Where applicable to the Pharmacy benefit plan design, the following programs may apply to a claim:

13.1. Provincial Integration Program

The Provincial Integration Program is designed to recognize two scenarios: when the submitted DIN is part of a provincially funded program and may be designated as an exception drug by the provincial formulary or when the submitted DIN is part of a provincial specialty or provincial disease program. The Provincial Integration Program recognizes provincial coverage of the DIN, not the Member.

In Ontario, the Provincial Integration Program can be combined with the Ontario Drug Benefit (ODB) including Limited Use drug products, Ontario Vacation Supply or the step therapy program, when submitting claims.

The DA intervention code must be submitted by the Provider to indicate that the Claim has been coordinated with the provincial plan in general even if the previously paid amount (the amount covered by the province) for that particular Claim is \$0.

- If a Provider does not coordinate the Claim with the provincial plan and does not indicate the DA intervention code, the Claim will be rejected with the following CPhA response code: C6 – PATIENT HAS OTHER COVERAGE.
- If the provincial plan is not paying any portion of the Claim and it is submitted to ESC with the DA intervention code and no additional intervention code, the Claim will be rejected with the following CPhA response code: 86 – CONFIRM PROVINCIAL DRUG COVERAGE FOR DIN. The DA intervention code must be used in conjunction with the appropriate secondary intervention code as outlined in the table below. If the Provincial Integration Program is combined with ODB limited use, Ontario vacation supply or the step therapy program, replace DV, DW and DX respectively (in the table below) with SV, SW and SX when coordinating claims.

Provincial Integration Intervention Code as per the CPhACS)	Scenario	Action Required by Provider
DV–APPLIED TO THE PROVINCIAL PLAN AND WAS APPROVED	Member applied to provincial plan for coverage on this DIN and was <u>approved</u> .	Indicate the DA intervention code with the DV intervention code to allow processing.
DW–APPLIED TO THE PROVINCIAL PLAN AND WAS REJECTED	Member applied to provincial plan for coverage on this DIN and was <u>rejected</u> .	Indicate the DA intervention code with the DW intervention code to allow processing.
DX–APPLIED TO PROVINCIAL PLAN AND THE DECISION IS PENDING	Member applied to provincial plan for coverage on this DIN and is <u>awaiting decision</u> .	Indicate the DA intervention code with the DX intervention code to allow processing. The DX and SX intervention codes can only be used once. Attempts to use this code in future Claims for the same DIN for the same member will result in the rejection of the Claim.
DY–PATIENT IS NOT ELIGIBLE FOR PROVINCIAL PLAN COVERAGE	Member is not eligible for provincial plan coverage in general, not just for the submitted DIN.	The Provincial Integration Program recognizes provincial coverage of the DIN, not the Member. Indicate the DY intervention code to show that provincial plan coverage does not apply to this Member. The DA intervention code is not required.

For all Claims related to the Provincial Integration Program, all audit requirements apply including intervention code documentation requirements, where applicable. Claims where there is missing documentation are subject to adjustments through ESC’s Fraud, Waste and Abuse Program.

13.2. Drug Utilization Review

The Drug Utilization Review (DUR) analyzes a Member’s history to determine if a previously dispensed Covered Medication in the same therapeutic class or identical to the medication indicated on the Claim is still active, based on the quantity dispensed and standard recommended dosage schedule for the previously dispensed medication.

A Drug Utilization Review (DUR) edit occurs when the ESC adjudication system identifies a drug therapy conflict and informs the Provider using the applicable CPhACS response codes.

ESC is aware that the dispensing pharmacist may conduct its own Drug Utilization Review (DUR). The ESC Drug Utilization Review (DUR), however, analyzes any Claim transmitted via the ESC pharmacy provider network for a Member from anywhere in Canada.

Where applicable, Provider’s dispensing pharmacists are to exercise professional judgment in applying an intervention code to override DUR edits prior to dispensing Covered Medication. Provider’s dispensing pharmacists can apply a CPhACS intervention code but should only do so for a valid medical reason when an intervention has been conducted. ESC’s DUR processes are not intended to substitute for the professional judgment of the prescriber, the dispensing pharmacist or any other health care professional providing services to the Member.

The two tables below describe:

- The CPhACS response codes generated when a DUR identifies a drug therapy conflict; and
- The CPhACS intervention codes that may be applied by the dispensing pharmacist in these scenarios to override CPhACS response codes, where applicable.

DUR CPhACS Response Code	Scenario
MW or MY	The dispensed DIN is the same drug (same chemical entity) as a drug dispensed by the same Provider (MW) or another pharmacy provider (MY) and less than 67 per cent of the day supply of the previous dispensed Covered Medication has elapsed on the original Claim.
MX or MZ	The dispensed DIN is in the same therapeutic class as a drug dispensed by the same Provider (MX) or another pharmacy provider (MZ) and less than 67 per cent of the day supply of the previously-dispensed Covered Medication has elapsed according to the day supply on the original Claim.
ME	Member’s prescription history reveals that there may be potentially severe or life-threatening drug interactions with another drug on the Member’s profile and the day supply of the previously-dispensed drug has not elapsed according to the day supply indicated on the previous Claim.

Dispensing pharmacist is to exercise professional judgment in applying an intervention code to override DUR edits prior to dispensing a Covered Medication (i.e., a medication indicated as a benefit item in the Pharmacy Benefit Plan). Dispensing pharmacists can apply an intervention code but should only do so for a valid medical reason when an intervention has been conducted. Procedures for documenting intervention codes as indicated in the claim submission requirements are required ([Section 10.1- Claim Submission Requirements – General](#)).

The table below details CPhACS intervention codes applicable to a DUR:

DUR CPhACS Intervention Code	Scenario
UA	Consulted prescriber and filled Rx as written.
UB	Consulted prescriber and changed dose.
UC	Consulted prescriber and changed instructions for use.
UD	Consulted prescriber and changed drug.
UE	Consulted prescriber and changed quantity.
UF	Patient gave adequate explanation. Rx filled as written.

DUR CPhACS Intervention Code	Scenario
UG	Cautioned patient. Rx filled as written.
UI	Consulted other source. Rx filled as written.
UJ	Consulted other sources, altered Rx and filled.
UN	Assessed patient, therapy is appropriate.

For all claims related to DUR responses, all audit requirements apply including intervention code documentation requirements, where applicable, refer to Drug Utilization Review. Claims where there is missing documentation are subject to adjustments through ESC's Fraud, Waste and Abuse Program.

13.3. Step Therapy Program

The Step Therapy Program encourages the use of proven and cost-effective therapeutic alternatives (step one (1) medications) before stepping up to less cost-effective medications (step two [2] or step three [3] medications), where appropriate. Following adjudication by ESC, if the Step Therapy Program applies to the Claim, the following CPhACS response codes are generated by the ESC adjudication system:

In both cases, a Provider can verify that the Member requires the prescribed drug due to lack of efficacy or intolerance of the lower-cost alternatives. If it is determined that a Member cannot use the step 1 drug, a CPhACS intervention code is required to override the rejection and process the Claim:

Step Therapy CPhACS Response Code	Scenario	Action Required by Provider
QO—PREFERENCE OR STEP DRUG IS AVAILABLE	The ESC adjudication system finds Claims for the first step (1) drug or evidence that the Member is already taking a step two (2) drug (in a Pharmacy Benefit Plan where grandfathering applies). The Claim is accepted.	No action required.
SA—PREFERRED OR STEP DRUG MUST BE SUBMITTED	If a Member is starting therapy with a step two (2) drug and has not already tried a step one (1) drug or the Member is starting therapy with a step three (3) drug and has not already tried a step one (1) and a step two (2) drug, the following CPhACS response code is generated: <i>SA – PREFERRED OR STEP DRUG MUST BE SUBMITTED</i> . The Claim will be rejected.	The Provider can contact the prescriber to determine if a step one (1) drug is acceptable or advise the Member to contact their prescriber directly to determine if the prescription can be changed.

Step Therapy CPhACS Intervention Code	Scenario
UP - FIRST-LINE THERAPY INEFFECTIVE	First-line therapy was ineffective
UQ - FIRST-LINE THERAPY NOT TOLERATED BY PATIENT	First-line therapy not tolerated by Member. This intervention code should not be used for Members under the age of 18 if the drug is inappropriate for that age demographic.

For all Claims related to the Step Therapy Program, all audit requirements apply including intervention code documentation requirements, where applicable. Refer to Step Therapy Program). Claims where there is missing documentation are subject to adjustments through ESC's Fraud, Waste and Abuse Program.

13.3.1. Step Therapy Cognitive Fee

A Provider may be eligible for a step therapy cognitive fee when the Provider is successful in switching a Member to a lower step drug (ex. Step two (2) drug to a step one (1) drug). The inclusion of this provision (i.e., a step therapy cognitive fee) is contingent on the Pharmacy Benefit Plan.

To claim the step therapy cognitive fee, the Provider must submit a separate electronic Claim indicating the PIN applicable to the specific step therapy module in the DIN field and the pharmacy provider's usual and customary cognitive service fee in the CPhACS drug cost field. A comprehensive list of step therapy modules and the PINs associated with step therapy cognitive fee is available at express-scripts.ca/health-care-downloads-and-resources.

Step therapy cognitive fee reimbursements vary according to Pharmacy Benefit Plan design. Providers submit their usual and customary cognitive service fees and the ESC adjudication system will adjudicate the claim according to Pharmacy Benefit Plan design. ESC may conduct a post-claim review of the Step therapy cognitive fee payment to verify the validity of the Claim.

13.4. Opioid Management Program

Where implemented by the Pharmacy Benefit Plan, the Opioid Management Program aims to reduce opioid over-dependency for Members identified as opioid naïve by encouraging initial fill evaluations. Opioid naïve Members are Members for whom a drug history review determines that a direct electronic (i.e., EDI) opioid claim has **not** been submitted in the last 180 days through the Sponsor (i.e., carrier) associated with the Member's current Claim.

13.4.1. Opioid Management Program – Long-acting opioid module

For an initial fill of a long-acting opioid, a short-acting opioid is to be tried first before stepping up to a long-acting opioid. If a Claim is submitted for an initial fill of a long-acting opioid and a Member is determined to be opioid naïve, the Claim will be rejected with the following CPhACS response code: *SA – PREFERRED OR STEP DRUG MUST BE SUBMITTED*. Provider is to dispense a short-acting opioid first.

Providers may be eligible for an Opioid Management Program cognitive service fee (PIN – 92000042) when they are successful in switching an opioid naïve Member from a prescribed long-acting opioid to a prescribed short-acting opioid during an initial fill. On a separate electronic Claim, please indicate your usual and customary cognitive service fee in the CPhACS drug cost field and indicate the cognitive service fee PIN in the DIN field. The ESC adjudication system will adjudicate the claim according to the Pharmacy Benefit Plan. Opioid Management Program Cognitive fee reimbursements vary according to Pharmacy Benefit Plan design.

ESC may conduct a post adjudication review of the Opioid Management Program cognitive service fee Claim to validate the Claim.

13.4.2. Opioid Management Program – Short-acting opioid module

For an initial fill of a short-acting opioid, a seven (7) day supply limit applies. If a Claim is submitted for an initial fill of a short-acting opioid that exceeds the seven-day supply limit and a Member is determined to be opioid naïve, the Claim will be cut back to the seven-day supply limit with the following CPhACS response code: *OF – INITIAL RX DAY SUPPLY EXCEEDED*. Provider is to dispense a seven-day supply.

13.4.3. Opioid Management Program – Intervention codes

CPhACS Intervention codes may be used by the dispensing pharmacist to override a short-acting opioid Claim cutback or a long-acting opioid Claim rejection when:

Opioid Management Program CPhACS Intervention Code	Scenario
UP	First line therapy ineffective
UQ	First line therapy not tolerated by patient

In the following cases, please contact the ESC Provider Call Centre to obtain an approved intervention code:

- Members live in rural areas or have transportation difficulties accessing pharmacy services;
- Members have an opioid claim that was processed in the last 180 days, but not through a direct electronic claim submission specific to the ESC client associated with the member's current claim; and
- Members who require a vacation supply.

For all Claims related to the Opioid Management Program, all audit requirements apply including intervention code documentation requirements, where applicable. Refer to Opioid Management Program. Claims where there is missing documentation are subject to adjustments through ESC's Fraud, Waste and Abuse Program.

If you require a CPhACS intervention code for reasons other than those indicated above or have further questions, please call the ESC Provider Call Centre.

14. PRICING FUNCTIONALITIES

14.1. Maximum Allowable Cost (MAC)

The Maximum Allowable Cost program encourages the use of cost-effective DINs of similar efficacy and safety (i.e., therapeutic equivalents). For the Maximum Allowable Cost program, the lowest cost DIN in a group of DINs classified as therapeutic equivalents becomes the price reference for its group of DINs.

When a Claim is submitted and the Maximum Allowable Cost program is applicable, the cost of the lowest cost equivalent DIN (i.e., the lowest cost therapeutic equivalent in a group of DINs) will be covered for the Claim. The following scenario may apply:

Maximum Allowable Cost Module CPhACS Response Code	Scenario
QR – MAXIMUM ALLOWABLE COST (MAC) PAID	<p>The Claim is cut back to reflect the cost of the reference drug.</p> <p>At the point of sale, the Member has a choice to either (i) obtain the originally prescribed drug and pay the difference in cost for the more expensive originally prescribed drug or (ii) have the lowest cost therapeutic equivalent drug dispensed with the approval of the prescriber's and/or dispensing pharmacist, as the case may be.</p>

14.2. Substituting Medication

Pharmacy Benefit Plans may encourage generic substitution by offering better coverage for the equivalent generic medication when compared to the brand name medication through mandatory generic substitution or standard generic substitution.

14.2.1. Mandatory Generic Substitution

The Pharmacy Benefit Plan will only cover an amount corresponding to the lowest cost equivalent generic drug, even if the authorized prescriber has indicated “dispense as written” or “no substitution” on the prescription. Members may contact their Sponsor to obtain an exception for a mandatory generic substitution, if applicable.

14.2.2. Standard Generic Substitution

An equivalent generic drug is substituted for the brand name drug and a claim reimbursement amount is generated based on the lowest cost equivalent generic DIN. Product selection codes, as detailed below, may apply to the claim.

14.2.3. Product Selection Codes

Product selection codes are used to indicate the reason for selecting a different DIN from the DIN generated by the ESC adjudication system when a standard generic substitution applies to the DIN according to the Pharmacy Benefit Plan. Product selection codes do not apply if a Sponsor has indicated that the Pharmacy Benefit Plan is a mandatory generic substitution plan (i.e., mandatory generic substitution applies).

If a different DIN from the DIN recommended by the ESC adjudication system is selected for a reason other than a generic product substitution or a documented medical necessity, reimbursement for the substituted medication may be disallowed. The table below details the CPhACS product selection codes that must be submitted to describe scenarios where a product selection code applies:

CPhACS Product Selection Code	Product Selection Rationale	Scenario
1	Prescriber’s Choice	The prescriber indicated no substitution on the prescription. On verbal prescriptions: “No substitution” must be written along with the date it was authorized by the prescriber. On written or electronic prescriptions: the prescriber must indicate “No substitution” on the document.
2	Patient’s Choice	The Member specified “no substitution” or has selected a specific interchangeable medication in writing or by initialing a written or printed statement.
3	Pharmacist’s Choice	The dispensing pharmacist chose not to substitute the medication on a prescription or has selected a specific interchangeable medication when the prescription is written without the “no substitution” stipulation.

CPhACS Product Selection Code	Product Selection Rationale	Scenario
4	Existing Therapy (prescription renewal)	The dispensing pharmacist chose to continue the use of a brand name or generic medication where variance in the choice of medication may adversely affect treatment.
Blank	Information is not required	The product selection code is not needed.

For audit purposes, the use of product selection codes (section 14.2.3) must be supported by appropriate documentation on the original prescription. Claims where there is missing documentation are subject to adjustments through ESC's Fraud, Waste and Abuse Program.

15. FRAUD, WASTE AND ABUSE (FWA) PROGRAM

ESC's Fraud, Waste, and Abuse (FWA) Program protects the integrity of Claim submissions for all ESC Sponsors while mitigating risks. The key objective of ESC's FWA Program is to provide services to our Sponsors by proactively detecting and addressing risks in a timely manner to minimize the financial risk and maintain the reputation of our Sponsors, and their Members. ESC's FWA program is designed to:

- Detect and address inappropriate billing practices
- Address billing irregularities
- Address high abuse and/or fraudulent Claim submission patterns and billing practices
- Ensure compliance to the Pharmacy provider agreement
- Ensure that providers have retained appropriate documentation to support submitted Claims
- Confirm paid prescriptions and/or services were received by Members and ensure that Members are not billed excessive costs from Providers
- Educate Providers on billing practices that align with ESC's policies and procedures, as outlined in our Pharmacy provider agreement and Pharmacy provider manual.

ESC maintains an ongoing Fraud, Waste and Abuse Program as a service to its Sponsors. As such, information surrounding an ongoing audit or investigation and the final results thereof may be shared with ESC's Sponsors at any time during the audit or investigation. Providers are to comply with the Pharmacy provider agreement, the Pharmacy provider manual, ESC newsletters and any communication distributed or published by ESC when submitting a Claim, to minimize the risk of Claim adjustments and/or Claim reversals.

ESC or a third party authorized by ESC can audit and/or investigate any Claim up to two (2) years from the last Service date or for as long as the applicable statute(s) of limitation allow. When risk(s) are detected for a Provider's location, any new Provider enrolments associated with the same ownership group during an audit or investigation may be delayed.

All Claims adjudicated by ESC are subject to post adjudication audits which may result in the adjustment or reversal of the Claim, if necessary. Claim adjustments and/or reversals can be viewed on the Remittance advice.

15.1. Provider Responsibility for audits and investigations

- The Provider must cooperate with ESC in all audit and investigation activities.
- Providers must permit ESC or a third party authorized by ESC to inspect, review and reproduce, during regular business hours and without charge, any business documentation, financial documentation, prescriptions and authorizations for any submitted Claim. The original details on all documentation retained by the Provider should be visible, legible and unaltered. This documentation can relate to dispensing medication to Members or to the registration requirements to be a Provider as ESC deems necessary to determine compliance as outlined in the ESC Pharmacy provider agreement, this Pharmacy provider manual, ESC newsletters and any communication distributed or published by ESC.
- Providers must respond to all audit and investigation requests within the defined timelines.
- Failure to comply with any ESC audit and investigation processes and procedures may result in an adjustment, reversal, recovery of any impacted Claim reimbursements and/or the termination of the Pharmacy provider agreement, including the suspension or termination of billing privileges on ESC's network.

15.2. Audits

Pharmacy audits are conducted to ensure Providers are compliant with the provisions of the Pharmacy provider agreement, the Pharmacy provider manual, and all other communication issued by ESC. Audits include but are not limited to the validation that the services paid were delivered to the Member, the services paid match the services delivered and that the fee(s) paid are appropriate.

Some of the possible outcomes of an audit include, but are not limited to:

- Recovery of funds and adjustments to Claims
- Educate providers on expected practices/policies and monitor future claims submission to identify change in behaviours
- Escalation to an investigation if additional abusive or fraudulent risks are identified
- File a formal complaint with the applicable provincial College of pharmacy professionals, board or association associated with the Provider;
- Suspension or termination of billing privileges on ESC's network
- Termination of the Pharmacy provider agreement

ESC may conduct any of the following audits:

15.2.1. Claim Verifications

During a claim verification, Claims are selected based on risks established by ESC and subject to audit procedures. Claims that were submitted with incorrect pricing and subsequently identified by ESC will be adjusted automatically. The adjusted Claim will appear on the Provider's next Remittance advice.

For all other Claims selected for audit, ESC may request a copy of the prescription hard copy of the dispensing records, invoices and any other supporting documentation as required. Providers have one (1) business day from the date indicated on the audit request form to provide the requested documentation. Complete, legible, unaltered, full-page view documentation is required. If the required documentation is not submitted for review by the due date indicated on the request, or if errors are detected during the audit, ESC will adjust or reverse the

Claim(s) in question. The amount owing will be offset against the Provider's account payable. Details of all adjustments and/or reversals will appear on the Remittance advice. Providers will have ten (10) calendar days from the date of notification to appeal an adjustment or reversal. Appeals will not be accepted beyond this timeline.

15.2.2. Written Desk Audit

During a written desk audit, a selection of Claims is selected and documentation pertaining to those Claims are requested from the Provider for review. Additional Claims may be requested beyond the initial sample if deemed necessary by the auditor. Once the review of the documentation is complete, ESC will send the Provider a written audit report and the Provider will have an opportunity to respond to the findings. Following the review of the Provider's response, a final audit report is compiled and sent to the Provider at which point the audit is considered final. If no response is provided within the required timeline the audit will be deemed final. For further information regarding audit response guidelines and timelines please refer to section [15.2.4. Audit Response Guidelines and Timelines](#).

15.2.3. On-site Audit

During an on-site audit, ESC or a third party authorized by ESC, will visit the Provider's location to inspect, review, and analyze the provider's records for a selection of flagged Claims and/or additional Claims as deemed necessary by the Auditor. Mutually acceptable dates and times will be prearranged. Once ESC has completed the review of the on-site documentation, a written audit report is compiled and sent to the Provider and the Provider will have an opportunity to respond. Following the review of the Provider's response, a final audit report is compiled and sent to the Provider at which time the audit is considered final. If no response is provided within the required timeline the audit will be deemed final. For further information regarding audit response and timelines please refer to section [15.2.4. Audit Response Guidelines and Timelines](#).

15.2.4. Audit Response Guidelines and Timelines

Following the review of the documentation pertaining to a selection of flagged Claims, Providers will be sent a written audit report detailing the outcome of ESC's review. Providers will have fourteen (14) calendar days to review the findings and submit a response, if applicable.

- If a response is not applicable, payment is due within the fourteen (14) calendar days. Alternatively, ESC may adjust or reverse any Claims identified in error within the audit report.
- If there is no reply within fourteen (14) calendar days the audit will be deemed final and payment is due, there will not be another opportunity to respond to the audit. Alternatively, ESC may adjust or reverse any Claims identified in error within the audit report.
- If a response is received within the fourteen (14) calendar days, ESC will assess the documentation provided to support the Claim(s) in question. A final audit report will be sent to the Provider. Should there be an amount owing, the Provider is required to submit payment within fourteen (14) calendar days. Alternatively, ESC may adjust or reverse any Claims identified in error within the audit report.

During the course of the audit if high abuse and/or fraudulent risk(s) are identified, the audit will turn into an investigation and will follow the timelines associated with an investigation. For further information regarding investigation response guidelines and timelines please refer to section [15.3.3. Investigation Response Guidelines and Timelines](#).

ESC **will not** accept additional documentation for any of the following reasons:

- A failure to provide supporting documentation by the response due date;

- A failure to provide purchase invoices by the response due date;
- Documentation to support claims that was not provided during the on-site audit or following the initial request for a written audit (i.e. physician/prescriber authorization, rationale for dispensing a different quantity etc.).
- Overcharges (i.e. excessive markups exceeding provincial level).

15.3. Investigations

ESC may conduct an investigation if there is suspicion of high abuse, fraud or from a Provider at ESC's sole discretion. ESC may suspend or terminate the ability to submit Claims or immediately place a withhold on all payment to the Provider as a result of ESC's suspicion; regardless of whether or not an investigation has concluded. At the conclusion of an investigation, if ESC determines there is evidence of high abuse and/or fraud, ESC reserves the right to immediately terminate the Provider from ESC's network, share the ongoing information or results of the investigation to its clients, law enforcement and/or other appropriate parties. At the conclusion of an investigation where withheld Claim payments are deemed in excess of the Claims identified for recovery in the final audit report, the excess amount is disbursed to the Provider.

If ESC determines that a Provider has: (i) refused to cooperate in an investigation; (ii) acted in an inappropriate manner; (iii) caused any Claim to be submitted inaccurately under false pretenses; and/or (iv) inconsistent billing patterns are identified, ESC reserves the right to exercise any and all of the following options in addition to those already provided for in [Effect of Termination](#):

- Reverse the applicable claim(s) and recover the amount(s) paid;
- Require immediate reimbursement from the Provider;
- Withhold all future amounts payable to the Provider until sufficient funds are withheld to satisfy the amount owing;
- File a formal complaint with the applicable provincial College of pharmacy professionals, board or association associated with the Provider;
- Initiate collection efforts to recover any amounts payable;
- Immediately terminate the Pharmacy provider agreement with the Provider; and/or
- Contact law enforcement to report ESC's investigation findings.

ESC may conduct any of the following investigations:

15.3.1. Written Desk Investigation

During a written desk investigation, a selection of Claims are flagged and documentation pertaining to those Claims are requested from the Provider for review. Additional Claims may be requested beyond the initial sample if deemed necessary by the investigator. Once the review of the documentation is complete, ESC will send the Provider a written investigation report and the provider will have an opportunity to respond. Following a review of the Provider's response, a final investigation report is compiled and sent to the Provider at which time the investigation is considered final. For further information regarding investigation response guidelines and timelines please refer to section [15.3.3. Investigation Response Guidelines and Timelines](#).

15.3.2. On-Site Investigation

During an on-site investigation, ESC or a third party authorized by ESC, will visit the Provider location to inspect, review, and analyze the provider's records for a selection of flagged Claims and/or additional Claims as deemed necessary by the investigator. ESC may not provide advanced notice. Once ESC has completed the review of the on-site documentation, a written investigation report is compiled and sent to the Provider and the Provider will have an opportunity to respond. Following a review of the Provider's response, a final investigation report is compiled and sent to the Provider at which time the investigation is considered final. For further information regarding investigation response and timelines please refer to section [15.3.3. Investigation Response Guidelines and Timelines](#).

15.3.3. Investigation Response Guidelines and Timelines

Following the review of the documentation pertaining to a selection of flagged Claims, providers will be sent a written investigation report detailing the outcome of ESC's review. Providers will have seven (7) calendar days to review the findings and submit a response, if applicable.

- If a response is not applicable, payment is due within the seven (7) calendar days. Alternatively, ESC may adjust or reverse any Claims identified in error within the investigation report.
- If there is no reply within seven (7) calendar days the investigation will be deemed final and payment is due, there will not be another opportunity to respond to the investigation. Alternatively, ESC may adjust or reverse any Claims identified in error within the investigation report.
- If a response is received within the seven (7) calendar days, ESC will assess the documentation provided to support the Claim(s) in question. A final investigation report will be sent to the Provider. Should there be an amount owing, the Provider is required to submit payment within seven (7) calendar days. Alternatively, ESC may adjust or reverse any Claims identified in error within the investigation report.

ESC **will not** accept additional documentation for any of the following reasons:

- A failure to provide supporting documentation by the response due date;
- A failure to provide purchase invoices by the response due date;
- Documentation that was not provided during the on-site investigation or following the initial request for a written investigation (i.e. physician/prescriber authorization, rationale for dispensing a different quantity, etc.).
- Overcharges (i.e. excessive markups exceeding provincial level).

15.4. Additional Audit and Investigation Activities

ESC may conduct any of the following activities in addition to those listed above:

15.4.1. Member Verification

Member verification letters are sent to plan members to validate service dates, receipt of prescriptions and/or services paid and specific claim information.

15.4.2. Prescriber Verification

Prescriber verification letters are sent to validate prescription authorizations. Prescribers are contacted to confirm selected prescriptions for which they were identified as the authorizing prescriber.

15.4.3. Purchase invoices

For audit and investigation purposes, ESC may request purchase invoices to validate Claims billed to ESC. Failure to provide purchase invoices may result in Claim reversals.

15.4.4. Bin checks

During on-site audits and investigations, ESC may request Providers to retrieve prescriptions that were filled more than fourteen (14) days prior. Any such prescriptions that are still with the Provider waiting to be picked up are required to be reversed during the on-site audit or investigation.

15.4.5. Post Assessment Ranking

Following the completion of pharmacy audits and investigations, Providers are ranked. Based on the ranking, pharmacy providers are placed into one of three different categories: minor, moderate to significant and severe. The methodology to determine this ranking is based on a scoring process by applying a weighted average to the criteria below including but not limited to:

- The results of the audit or investigation
 - Confirmed risk and recovery details
 - Observations and behaviour during audit or investigation
- Regulatory standing

MINOR* (low to moderate risk) 1 - 54	MODERATE TO SIGNIFICANT* (moderate to high risk) 55 - 89	SEVERE* (high/fraud risk) >90
<ul style="list-style-type: none"> • Recover on incorrect Claims submissions • Provide education on ESC Claim submission policies • No further action required 	<ul style="list-style-type: none"> • Recover on incorrect/discrepant Claims • Provide education on ESC Claim submission policies • Providers are monitored for Claims submission behaviours • Providers may be re-audited or subject to an investigation within twelve (12) months. • Issue letter of concern/complaint to regulatory College (if necessary) • Terminated from network if fraud or high abuse is confirmed 	<ul style="list-style-type: none"> • Recover on discrepant/fraudulent Claims • Issue letter of complaint to regulatory College • Contact law enforcement (if necessary) • Provider/owners are added to ESC's Do-Not-Register (DNR) list for a minimum period of one year • Terminated from network if fraud or high abuse is confirmed

*Includes but not limited to

15.5. Fraud Tip Line

Everyone pays for fraud and we all have a role to play in combatting it. If you suspect fraudulent activity is occurring, we encourage you to report it. With your help, ESC can help reduce fraud and continue our anti-fraud efforts.

Fraud Tip Hotline: [1 888 677-0111](tel:18886770111), ext. 642273

Email reporting system: investigation@express-scripts.com

16. CONTACT US

16.1. Express Scripts Canada Website for Health Care Providers

The *downloads and resources* portal of the Express Scripts Canada website contains several resources for providers: express-scripts.ca/health-care-downloads-and-resources.

16.2. Express Scripts Canada Provider Call Centre

The Express Scripts Canada Provider Call Centre is for Providers only. Member inquiries regarding benefit plan coverage or eligibility (e.g., date of birth, coverage, et cetera) may be addressed to the Sponsor affiliated with the Member.

When contacting the Express Scripts Canada Provider Call Centre outside of regular hours of operation, leave a clear detailed voicemail message including the associated provider number. Generally, a customer service representative will respond to the call within one business day.

Provider Resource	Contact
Website	express-scripts.ca/providers
Provider Call Centre	1 800 563-3274 Monday to Friday: 6:30 a.m. to midnight (ET) Saturday, Sunday and statutory holidays: 8 a.m. to midnight (ET)
Fax	1 855 844-4421
Mail	Express Scripts Canada Attention: Provider Relations 10th Floor 5770 Hurontario Street Mississauga, ON L5R 3G5

17. OTHER CONTACTS

17.1. Canadian Pharmacists Association

For a copy of the current CPhA Pharmacy Claim Standard, please contact:

Canadian Pharmacists Association	Contact
Email	service@pharmacists.ca
Phone	613 523-7877
Fax	613 523-0445
Mail	1785 Alta Vista Drive Ottawa, ON K1G 3Y6

18. APPENDICES

Appendix A Sample Remittance Advice

Pharmacy No :		ESI Canada Remittance Advice										Page :			
												Cheque Date :			
												Process Date:			
Rx Number	Date Filled	Reference Number	Group Number	Subscriber/Member ID	Trace Number	DIN #	Drug Description			Disp Fee	Dose	Co-pay Amount	Addtl Payment	Spec Srv	Codes -/Amount Paid
							Qty	Sup	Ingred	Paid					
<div style="font-size: 48px; opacity: 0.3; transform: rotate(-15deg); pointer-events: none;">Sample</div>															
		Code	Description												

THIS REPORT MAY CONTAIN CONFIDENTIAL PERSONAL INFORMATION. ESI CANADA ASSUMES NO LIABILITY AND TAKES NO RESPONSIBILITY FOR ANY UNAUTHORIZED ACCESS TO, OR MISUSE OF, THE CONTENTS.

Appendix B Reimbursement Guidelines for Compounded Medications in BC, MB, ON and SK

Express Scripts Canada reimburses at \$1.50/min when calculating the eligible compounding fee. Listed below are the allowable charges Express Scripts Canada will reimburse for eligible compounds. Please refer to the appropriate chart below when submitting claims for compound mixtures.

*Note: some plan designs have a compounding fee cap. In these situations, the compounding fee will be calculated up to the eligible cap set by plan design.

- *Ex.#1: Fee cap is \$25 but calculated fee by Audit is \$35, Express Scripts Canada will pay only \$25*
- *Ex.#2: Fee cap is \$25 but calculated fee by Audit is \$20, Express Scripts Canada will adjust claim to \$20*

Quantity	Number of ingredients	Time allowed (in minutes)
I. Creams, Ointments, Lotions		
1-15 g	2	4
	3	6
	4 or more	8
16-25 g	2	6
	3	8
	4 or more	10
26-50 g	2	8
	3	10
	4 or more	12
51-100 g	2	10
	3	12
	4 or more	14
101 g or greater or more than 4 ingredients	2	14
	3	16
	4	18
	5	20
	6	22
	7	24
	8	26
	9	28
	10 or more	30
	II. Capsules, Tablets, Suppositories	
1-10	2	26
	3	28
	4 or more	30
11-25	2	30
	3	32
	4 or more	34
26-40	2	32
	3	34
	4 or more	36
41-65	2	34
	3	36
	4	38
66-80	2	36
	3	38
	4	40
81 or greater	2	38
	3	40

Quantity	Number of ingredients	Time allowed (in minutes)
	4 or more	42
III. Powder/Liquid to Liquid <i>(up to an extra 5 minutes may be permitted for compounds dispensed in vials)</i>		
Quantity	Number of ingredients	Time allowed (in minutes)
0-500 ml	2	2
	3	3
	4 or more	4
501-1000 ml	2	4
	3	5
	4 or more	6
1001 ml or greater	2	6
	3	7
	4 or more	8
IV. Capsules/Tablets to Liquid		
17.1.1.1.		
Quantity	Number of ingredients	Time allowed (in minutes)
1-10 caps/tabs	N/A	10
11-25 caps/tabs	N/A	15
26-40 caps/tabs	N/A	20
41-65 caps/tabs	N/A	25
66 caps/tabs or greater	N/A	30
V. IV Bags		
Quantity	Number of ingredients	Time allowed (in minutes)
1 (any size IV bag)	2	10
1 (any size IV bag)	3	15
1 (any size IV bag)	4	20
1 (any size IV bag)	5 or more	25
VI. Triple Mix (alprostadil, papaverine and phentolamine)		
17.1.1.2.		
Quantity	Number of ingredients	Time allowed (in minutes)
25 ml or less	N/A	30
25-100 ml	N/A	45
101 ml or greater	N/A	60

Appendix C Ineligible Ingredients, Bases and Formats for Compound Preparations

Ineligible bases and ingredients

- Ammoniated mercury
- Arsenic
- Azelaic acid
- Avene product line
- Benzoin tincture/Friar's Balsam
- Bichloroacetic acid or dichloroacetate sodium
- Biobase G
- Boric acid
- Cold cream
- Coumarin
- Crystal/Gentian violet
- Daptomycin
- DHEA
- DMAE
- DMPS
- DMSA
- DNCB
- DPCP (Diphencyprone/diphencyclopropenone)
- Duonalc solution
- Evening primrose oil
- Finasteride
- Glutaraldehyde
- Glycolic acid
- Hydroquinone
- Kojic acid
- La Roche-Posay product line
- Mandelic acid
- Mequinol
- Mercurochrome
- Minoxidil
- Monobenzone
- Neostrata product line
- Neutrogena product line
- Nipasept
- Peru Balsam
- Pregnenolone
- Resorcinol
- Reversa product line
- Rosacure
- Sunscreens (any base with an SPF rating)
- Triamcinolone
- Trichloroacetic acid
- Titanium dioxide
- Vitamin E cream or ointment
- Vitamin K
- Yohimbine

Ineligible dosage forms/formats

- Extended release products
- Gummies
- Lollipops
- Lozenges
- Modified release products (ex. slow release, rapid dissolve tablets/capsules, etc.)
- Troches