Pharmacy Provider Manual

Claims Submission for Participating Pharmacies

Applicable to all provinces and territories (excluding Quebec and Newfoundland and Labrador)

June 2016

Version 3.0

Optimizing the Value of Health Benefits

EXPRESS SCRIPTS®

Any comments or requests for information may be transmitted to:
Express Scripts Canada
Attention: Provider Relations
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

The information contained in this document is subject to change without notice. The data used in the examples are fictitious, unless otherwise noted. In case of discrepancies between the English and French version, the English version will prevail.

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The Pharmacy Provider Manual is subject to the terms and conditions of the Express Scripts Canada Pharmacy Provider Agreement[1].

[1]The Express Scripts Canada Pharmacy Provider Agreement is the agreement governing the electronic adjudication by Express Scripts Canada of claims submitted by the pharmacy on behalf of a patient and entered into between Express Scripts Canada and the pharmacy, whether directly or through an association which the pharmacy is a member of and to which the pharmacy has assigned the authority to enter into such agreement on its behalf.

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Document Revision and History

Version	Revision Date	Details
1.0	December 2010	Revision
2.0	November 2012	Revision
3.0	April 2016	Revision

1. Defined Terms

The defined terms below lists the terms and definitions, which are relevant for background information when reading the Pharmacy Provider Manual.

Term	Definitions
Appendices	Each Appendix A, B, C and D attached hereto and incorporated herein by this reference are substantially representative of the forms detailed throughout this Manual, each of which may be updated or modified, by Express Scripts Canada, at its sole discretion, without the necessity of revising the representative form as attached hereto.
Benefits Administrator	The individual responsible for administering the drug benefit plan details with the client on behalf of the drug benefit plan members.
Carrier	The insurance company, insurer and insurance carrier. Refer to **client** below.
Claim	A claim for which the pharmacy provider or member applies for reimbursement for a portion of the cost of a dispensed covered medication.
Client	The insurance carrier, third party administrator (TPA),employer or other organization having principal financial responsibility for payment of covered medications provided to members under a drug benefit plan.
Co-ordination of Benefits (COB)	Co-ordination of benefits between two drug benefit plans, whether they are either private, or a mix of public and private coverage.
Copayment	That portion of the total charge for each covered medication that a member is required to pay to the pharmacy provider or to the pharmacies in accordance with that member's drug benefit plan, whether designated as a copayment or deductible.
Covered Medication	Those prescription drugs, supplies and other items prescribed by an authorized, licensed practitioner that are covered by a drug benefit plan.
CPhA	Canadian Pharmacists Association
CPhA Pharmacy Claim Standard	The standard rules of electronic claims transmission published by the CPhA. A copy may be obtained directly from the following address: Canadian Pharmacists Association 1785 Alta Vista Drive Ottawa, ON K1G 3Y6 Phone: 613-523-7877 Fax: 613-523-0445
Deferred Claim	An electronically submitted claim for which the member pays the pharmacy provider for the entire cost of the covered medications upon dispensing, and later receives reimbursement by the client for the portion of the cost taken on by the latter.

Term	Definitions
Direct Claim	An electronically submitted claim for which the payment of the portion of the cost of the covered medication taken on by the client is made to the pharmacy provider directly by the client.
Drug Benefit Plan or Plan	A healthcare plan pursuant to which prescription drug benefits are available to members.
Formulary	A list of covered medications prepared by Express Scripts Canada for a client and revised periodically and includes, without limitation, drugs. Physicians are encouraged to prescribe and pharmacists to dispense, consistent with their professional judgment and applicable medical and pharmaceutical laws and procedures, which members are encouraged to use.
Identification Card	The printed identification information card issued to member pursuant to the applicable drug benefit plan bearing the Express Scripts Canada logo and the third party payer's logo.
Member	A subscriber, their spouse and eligible dependents to which benefits are available pursuant to a drug benefit plan.
Ontario Drug Benefit (ODB)	Drug plan program for the province of Ontario.
Pharmacy Provider	A pharmacy provider (also referred to as the provider) is bound by the terms and conditions set forth in the Express Scripts Canada Pharmacy Provider Agreement; also referred to as the participating pharmacy.
Pharmacy Provider Manual or Manual	Written description of procedures that pharmacy providers are required to follow when dispensing covered medications to members in order to receive reimbursement for each claim (developed by Express Scripts Canada).
Pharmacy Practice Management System (PPMS)	A type of software used by a pharmacy provider to capture all relevant data when dispensing medication in accordance with a prescription and the CPhA pharmacy claim standard.
Prescription Drug Program	A prescription drug program is provided by a client pursuant to an agreement with Express Scripts Canada, including any formulary.
Product Selection Code	The code to indicate the reason for no substitution or another reason for the selection of the product dispensed at the pharmacy. The list of codes was developed by CPhA and may be revised from time to time.
Real-Time Processing (RTP)	Processing of claims in real live time.
Régie de l'assurance maladie du Québec (RAMQ)	The governing body of Québec's public health insurance plan.

Term	Definitions
Public Prescription Drug Insurance Plan	Québec's public health insurance plan administered by the Régie de l'assurance maladie du Québec.
Software Provider	The entity providing a pharmacy provider with the PPMS.
Usual and Customary (U&C) Retail Price	The lowest retail price (including ingredient cost, mark-up and professional fee) of a covered medication in a cash transaction at the pharmacy, dispensing the covered medication (in the quantity dispensed) on the date that it is dispensed, including any discounts or special promotions offered on such date.

2. Introduction

2.1 Overview

Note: Applicable to all provinces/territories, excluding Quebec (QC) and Newfoundland and Labrador (NL).

Express Scripts Canada adjudicates over 100 million claims per year across Canada.

Express Scripts Canada's activities go far beyond simple electronic adjudication of healthcare claims. Express Scripts Canada offers its clients special services such as:

- Benefit plan design and management
- Express Scripts Canada Pharmacy
- Active pharmacy benefit services
- Drug utilization review (DUR)
- Clinical programs
- Innovative and flexible claims adjudication
- Point of service (POS) claim utilization review
- Provider and member verifications
- Pharmacy provider audits
- Pharmacy network management
- Provider Call Centre
- Research
- Retrospective analysis and simplified reporting
- Training and education

2.2 Role of Express Scripts Canada

Express Scripts Canada's mission is to be a leader in progressive healthcare initiatives by employing its professional expertise, leading edge information management systems and technology to ensure high-quality, cost-effective healthcare products and services to its customers.

What does Health Care Claims Adjudication Consist of?

In the context of pharmacy benefit management, a claims adjudicator is not an insurance company, but is rather mandated by its clients to receive, analyze, audit and proceed with payment of (as applicable), all claims submitted electronically by pharmacy providers on behalf of the client's members (i.e. the patients).

As a claims adjudicator, Express Scripts Canada is a third party to the relationship between the client and it's member, and as such, does not interfere with such relationship nor interfere with the member-provider relationship, which Express Scripts Canada recognizes as a crucial element of therapy.

2.3 Express Scripts Canada Clients

Express Scripts Canada represents the following Canadian insurance carriers, third party benefits administrators, plans sponsors and public sector entities:

Client ID	Insurance/Claim Services Provider
02	Manulife Financial
07	Manion Wilkins & Associates Ltd
11	Industrial Alliance
12	Desjardins Insurance
15	NIHB**
23	U-L Mutual
25	Teamsters' National Benefit Plan
29	Humania
31	MESS
32	STI Technologies Limited (STI)
34	Symbility Health Inc.
37	Cowan Insurance Group
38	SFMM
39	Coughlin & Associates Ltd.
40	RWAM
43	Manulife Affinity Markets
47	Benecaid
49	Group Medical Services (GMS)
50	GMS Insurance Inc.
53	Groupe Premier Médical (GPM)
73	L'Excellence
90	Empire Life

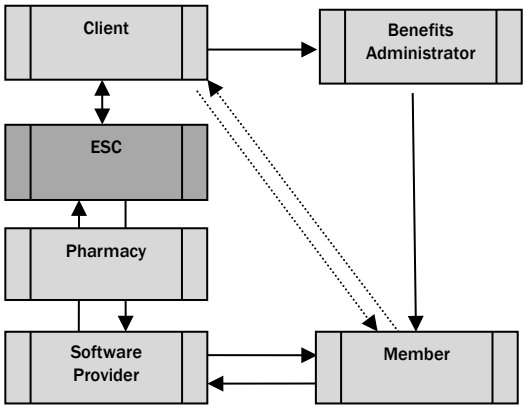
** As the claims processor for Health Canada's Non-Insured Health Benefits (NIHB) Program, Express Scripts Canada is pleased to support the pharmacy providers across Canada as they provide services to registered First Nations and recognized Inuit clients, although claims under the NIHB Program are not governed under this Express Scripts Canada Pharmacy Provider Manual.

Pharmacy providers wishing to submit claims for services eligible through the NIHB Program must first enrol in the NIHB Program by fully completing and signing the Express Scripts Canada Pharmacy Provider Agreement for NIHB, located on the NIHB Claims Services provider website at *www.provider.express-scripts.ca* or by contacting the Provider Claims Processing Call Centre to request the Express Scripts Canada Pharmacy Provider Agreement.

Provider Claims Processing Call Centre for NIHB Providers	
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 Claim Transmission Relationship

The diagram below sets forth the typical relationships between all players involved in claim transmission, as well as explanations.



The client has entered into an agreement with Express Scripts Canada, whereby Express Scripts Canada manages the client's drug benefit plans on its behalf. The client offers various drug benefit plans, covering a multitude of members through their respective employers.

The member can present an identification card at the pharmacy when requesting a prescription to be filled or send manual claims in writing directly to the client after the prescription has been filled. Upon presentation of the identification card, the pharmacy provider captures the necessary information for electronic transmission of the claim to Express Scripts Canada within the pharmacy practice management system (PPMS).

When electronically transmitted to Express Scripts Canada by the pharmacy provider, a claim is automatically assessed and a response is transmitted to the pharmacy. The pharmacy provider provides the member with an invoice detailing the electronic transmission results, as available.

2.5 General Terms

The general terms and conditions governing the relationship between the pharmacy provider and Express Scripts Canada are set forth in the Express Scripts Pharmacy Provider Agreement. This Pharmacy Provider Manual supplements and completes the terms and conditions set forth in the Express Scripts Canada Pharmacy Provider Agreement. Express Scripts Canada reserves the right to update this Pharmacy Provider

Manual as required. The Pharmacy Provider Manual is located on the Express Scripts Canada website under the health care providers tab at *www.express-scripts.ca*.

Please refer all questions and/or comments regarding the Express Scripts Canada Pharmacy Provider Manual to the Provider Call Centre. For additional details, refer to *Section 11.2 Provider Call Centre*.

2.6 Express Scripts Canada Pharmacy Provider Manual - Purpose

The Express Scripts Canada Pharmacy Provider Manual is notably designed to assist pharmacy providers in understanding how Express Scripts Canada's adjudication system works (as defined below). The following *Section 3. Adjudication System Overview*, outlines the role of the pharmacy providers, and includes the information to submit electronic claims. Please note, the information contained herein is general, and therefore does not necessarily reflect in detail the information observed by the dispensary personnel when capturing information in the PPMS. As pharmacy providers use different PPMS, some systems offer automated steps that are completed without the pharmacy providers' effort or awareness. Express Scripts Canada cannot reflect all possibilities in this Pharmacy Provider Manual.

The Pharmacy Provider Manual will be revised from time to time by Express Scripts Canada, and it is the provider's responsibility to check for any updates. When revisions have been made, providers will receive a minimum 30-days written advanced notification of the change(s). The provider will be given 30 days to terminate their agreement with Express Scripts Canada if they do not agree with the proposed change(s) to the Manual. If no notice of termination is received within 30 days, Express Scripts Canada will deem a provider's acceptance of the amendment(s)/revision(s).

3. Adjudication System Overview

3.1 Real-Time Processing System

Real-time processing (RTP) refers to the capacity of Express Scripts Canada's electronic claims adjudication system to virtually receive, process and return the adjudication results of pharmacy provider claims automatically, all within seconds.

Express Scripts Canada's RTP system (hereinafter referred to as Express Scripts Canada's adjudication system) eliminates paperwork and the risk for members to have their claim(s) rejected after initiating their treatment. Express Scripts Canada's adjudication system is available to eligible providers nation-wide.

3.2 Adjudication System Functionality

Express Scripts Canada's adjudication system captures claims sent through a personal computer (PC) based PPMS via an electronic data network, processes the claims and returns an electronic response. The data is transmitted respecting the format specified by the current CPhA Pharmacy Claim Standard[2].

[2] To obtain a copy of the CPhA pharmacy claim standard, please contact the Canadian Pharmacists Association.

4. Express Scripts Canada Pharmacy Provider Agreement

The approval and execution of a fully completed Express Scripts Canada Pharmacy Provider Agreement and applicable exhibits, (including the Pharmacy Declaration upon Registration) are required in order to become a participating pharmacy provider in Express Scripts Canada's network. Express Scripts Canada requires each pharmacy provider to fully complete and sign an Express Scripts Canada Pharmacy Provider Agreement. However, if amending any pharmacy provider information, a Modification to Pharmacy Provider Information Form must be completed and returned to Express Scripts Canada twenty (20) business days in advance of the change. Notwithstanding the foregoing, any pharmacy provider that submits a claim and is reimbursed by Express Scripts Canada is subject to the terms and conditions of this Pharmacy Provider Manual.

The Modification to Pharmacy Provider Information Form can be downloaded from the Express Scripts Canada website at *www.express-scripts.ca*. In addition, a sample copy has been included in this manual; refer to *Appendix A Sample Modification to Pharmacy Provider Information Form*.

4.1 Unique Provider Number

Upon approval of registration, Express Scripts Canada will assign a unique provider number to each pharmacy provider. The unique provider number is required on all correspondence with Express Scripts Canada, including such items as claims submissions and prior authorizations (PA).

4.2 Change in Ownership/Provider Information

It is the responsibility of the pharmacy provider to notify Express Scripts Canada in writing 20 business days in advance of any changes to their required pharmacy provider information. Express Scripts Canada must be notified in writing, by completing the Modification to Pharmacy Provider Information Form for the following requests:

- Change of operating/legal name
- Change of usual and customary (U&C) professional fee (non-QC pharmacies only)
- Pharmacy acquisition
- Pharmacy closure
- New/change of payment information
- Change of address
- Change of email address, fax or phone number

In addition, the pharmacy provider must notify Express Scripts Canada promptly of any changes with the membership in the provincial pharmacist regulatory body.

4.3 Supremacy

In the event that the terms and conditions of the Pharmacy Provider Manual contradict the terms and conditions of the Express Scripts Canada Pharmacy Provider Agreement, the provisions of the Express Scripts Canada Pharmacy Provider Agreement shall prevail.

4.4 Usual and Customary Professional Fee

Express Scripts Canada must be informed of the pharmacy provider's current U&C professional fee posted, registered or charged to customers, for transactions other than those for which the provincial or federal government is the payer. All changes to the U&C professional fee must be communicated to Express Scripts Canada immediately upon change in writing, by either fax or mail, using the Modification to Pharmacy Provider Information Form.

4.5 Liability Insurance/Indemnification

The pharmacy 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 Express Scripts Canada 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 pharmacy provider shall obtain and maintain, for itself and each pharmacy, or shall cause each pharmacy provider to obtain and maintain during the term of the Express Scripts Canada 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 outline 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 pharmacy provider's operation or the operation of the pharmacies under the Express Scripts Canada Pharmacy Provider Agreement.

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

Express Scripts Canada 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 pharmacy provider pursuant to the agreement. Regardless of the insurance coverage required, the pharmacy provider shall indemnify, defend and hold harmless Express Scripts Canada, 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.

4.6 Pharmacy Reimbursement

Express Scripts Canada will reimburse the pharmacy providers in a timely manner in accordance with the terms and conditions of the applicable Express Scripts Canada Pharmacy Provider Agreement and of the Pharmacy Provider Manual, following a specific and predetermined method of payment.

a) Net Payments

The pharmacy provider will receive payment from Express Scripts Canada for:

(i) Services provided in relation to a covered medication.

(ii) Other reimbursable services, as set forth in the applicable Express Scripts Canada Pharmacy Provider Agreement, any amendments to the same, or the Express Scripts Canada Pharmacy Provider Manual. Applicable copayments and deductibles will be subtracted from such payment (the resulting amount is herein referred to as a net payment).

b) Payment Errors

Any payments made to the pharmacy provider in excess or below of any amount properly determined to be due by Express Scripts Canada, if any, under the Express Scripts Canada Pharmacy Provider Agreement and this Express Scripts Canada Pharmacy Provider Manual, due to an error by either party, inaccurate claims submission or information submitted by the pharmacy provider or due to any other reason, including, but not limited to, any audit deficiencies may be recovered. For further details, refer to *Section 8 Audits.*

Express Scripts Canada shall notify the pharmacy provider in writing of the situation. In the event of excess payment(s), Express Scripts Canada shall, at its discretion, have the right to either offset the excess payment amount or require immediate reimbursement from the pharmacy provider. In the event of an underpayment, please contact the Provider Call Centre. For further details, refer to *Section 11.2 Provider Call Centre*.

c) Payment Schedule

Unless the applicable Express Scripts Canada Pharmacy Provider Agreement provides otherwise, pharmacy providers shall be paid on a weekly basis. For the purposes of this Express Scripts Canada Pharmacy Provider Manual, a payment cycle refers either to a period of time starting Tuesday morning at midnight and ending Monday of the next calendar week at midnight eastern time (ET). For each individual payment cycle, the corresponding payment will be issued to the pharmacy provider on the following Wednesday. If a payment issue date falls on a statutory holiday, the payment in question will be issued on the next business day.

d) Payment Method

Electronic funds transfer (EFT)/direct deposit is the required electronic payment method for pharmacy providers. Direct deposit allows the pharmacy provider's bank to deposit the claim payments directly into the designated bank account indicated on the Express Scripts Canada Pharmacy Provider Agreement, on the day the payment is issued. The pharmacy provider Remittance Advice for reconciliation is available online (*https://www.escstatement.ca*). To view a sample copy of the pharmacy provider Remittance Advice, refer to *Appendix C Sample Pharmacy Provider Remittance Advice*.

Direct deposit is a fast, secure, confidential and efficient means of payment delivery. It is the pharmacy provider's responsibility to advise Express Scripts Canada promptly of any changes to banking information, such as, bank, branch or account number.

Pharmacy providers who do not provide banking information will be paid by cheque. For timely receipt of payments, please ensure that the correct mailing address is captured in the pharmacy information. Pharmacy providers receiving payments by cheque and wishing to switch to direct deposit of payments should complete section C (Payment Information) of the Modification to Pharmacy Provider Information Form and return it to Express Scripts Canada. The Modification to Pharmacy Provider Information Form can be downloaded from the Express Scripts Canada website at *www.express-scripts.ca*. In addition, a sample copy has been included in this manual; refer to *Appendix A Sample Modification to Pharmacy Provider Information Form*.

e) **Pharmacy Provider Remittance Advice**

Any claims adjudicated during a payment cycle will be summarized on the pharmacy Provider Remittance Advice. The Pharmacy Provider Remittance Advice is available online (*https://www.escstatement.ca*).

5. Manual Claims Submission

5.1 Mandatory Information for Claims over $9,999.99

Drug claims that have a total amount greater than $9,999.99 cannot be submitted electronically to Express Scripts Canada due to a CPhA standard restriction in the dollar field. The member must therefore pay these claims and submit them manually to their benefits administrator for reimbursement; in addition, for eligibility inquiries, please contact the Provider Call Centre by referring to *Section 11.2 Provider Call Centre*.

However, if a pharmacy provider chooses direct card payment, claims can be submitted by the pharmacy provider via priority fax service or mail to Express Scripts Canada for payment to the pharmacy provider. Express Scripts Canada does not accept any liability in regards to the coverage of the claims submitted manually by pharmacies.

Priority Fax	Mail
905-712-6322 **Attention:** Health Claims & Administration 9th Floor, Mississauga	Express Scripts Canada Attention: Health Claims & Administration 5770 Hurontario Street, 10th Floor Mississauga, ON L5R 3G5

Deferred Claims

The above process for claims over $9,999.99 does not apply to deferred claims, as deferred claims must be paid by the member.

6. Electronic Claims Submission

Express Scripts Canada's adjudication system is designed to process information transmitted in accordance with the most recent version of the CPhA Pharmacy Claim Standard.

The adjudication system can automatically verify eligibility and coverage, and calculate copayment, coinsurance or annual deductibles when the member is waiting for the prescription.

A claim reference number is generated for each transaction. Rejected claims are accompanied by the appropriate CPhA message and explanation. For further details, refer to *Appendix B Response Codes/Explanations.*

6.1 Mandatory Information in Transmissions

In addition to the information that is mandatory in the creation of a member's file when submitting a claim, the pharmacy provider must ensure that the following information is provided (keyed):

- The carrier number, group number, member identification number and the relationship code.
- Prescription and professional service information and the drug identification number (DIN) of the covered medication (in the case of a compound, please indicate the DIN of the covered medication with the highest cost along with the compound code. Refer to *Section 6.4 Transmission of Claims for Compounds* or the pseudo DIN of the diabetic supply[3]). You will also need to include the metric quantity dispensed, the actual day's supply, the drug and compounding costs, the professional fee, the physician's ID number and the prescription number.

Note: Express Scripts Canada will accept the provincial drug plan pseudo DIN and the OPINIONS pseudo DINs. Please contact the Provider Call Centre to validate a pseudo DIN in your system for an Express Scripts Canada claim. For further details, refer to *Section 11.2 Provider Call Centre*.

6.2 Transmission Delays

Electronic claims or resubmissions must be transmitted within sixty (60) days of the dispensing date. Claims or resubmissions transmitted after this sixty (60) day period will be rejected.

6.3 Claim Reversal

A claim reversal transaction is used to reverse a previously submitted and paid electronic data interchange (EDI) claim.

Direct claims may only be reversed using the adjudication system within sixty (60) days of the dispensing date as per the CPhA Pharmacy Claim Standard. After this time, a reversal request must be made to the Provider Call Centre.

Please contact the Provider Call Centre before reversing any deferred claims, as the delay allotted for electronic reversal varies in accordance with the client involved.

[3] Please contact the Provider Call Centre for the current list of pseudo DINs for diabetic supplies.

Once a claim is reversed, the pharmacy provider may electronically resubmit the claim; provided this is done within sixty (60) days of the dispensing date.

Note: If a member requested a covered medication to be prepared in advance and does not pick up the prescription, the corresponding claim must be reversed within seven (7) days.

For further details, refer to *Section 11.2 Provider Claims Centre*.

6.4 Transmission of Claims for Compounds

To be covered, extemporaneous preparations (compounds) must not duplicate the formulation of a commercially manufactured drug product, and at least one of the active ingredients of the compound must be covered under the member's drug benefit plan. The list of pseudo DINs corresponding to the chemicals used for compounding can be obtained by contacting the Provider Call Centre.

Compound Codes

When submitting a claim for a compound, please use the appropriate compound code. The possible compound codes are set forth in the table below:

Compound Codes			
0	Topical cream	5	Internal powder
1	Topical ointment	6	Injection or infusion
2	External lotion	7	Ear/eye drop
3	Internal use liquid	8	Suppository
4	External powder	9	Other

Note: Compound codes are **not** applicable for methadone claims.

6.5 Drug Utilization Review

One of the options offered to the clients when creating a drug benefit plan is the Drug Utilization Review (DUR) Program.

When a transmitted claim is covered under a specific drug benefit plan for which this option is applicable, Express Scripts Canada's centralized database is accessed and the current prescription data is analyzed (both the member's prescription history and other drug data are automatically reviewed) to identify potential drug therapy problems. Depending on the option selected by the client, the claim may be rejected or adjudicated, and applicable warnings and/or information messages are sent to the pharmacy provider in accordance with the current CPhA pharmacy claim standard. Upon receipt of these messages, the pharmacist exercises professional judgment on the appropriate actions to be taken before dispensing the covered medication, if any.

Note: The pharmacy provider claim must be processed by using the date the medication is dispensed to the member and **not** the date the claim is being processed.

Following are explanations for messages which could be forwarded to the pharmacy provider where a drug therapy problem is identified by the DUR Program[4].

[4] Please note that the wording of messages may vary from one carrier to another.

Duplicate Drug (Early Refill) Same Pharmacy (MW) or Multi-Pharmacy (MY)

An identical ingredient, strength and dosage form was dispensed by the same pharmacy (MW) or multi-pharmacy (MY) and less than 67% of the day's supply of the previous dispensed covered medication has elapsed.

Duplicate Therapy Same Pharmacy (MX) or Multi-Pharmacy (MZ)

The DIN being dispensed is in the same therapeutic class (regardless of the strength and dosage form) as a covered medication currently being used by the member. Express Scripts Canada's adjudication system reviews the member history and ascertains whether the first covered medication is still active based on the quantity dispensed and standard recommended dosage schedules.

Drug to Drug Interaction (ME)

Warning messages are only being sent to the pharmacy provider for potential Level 1 drug interactions (severe or life-threatening interactions). Express Scripts Canada's adjudication system reviews the member history and ascertains whether the first covered medication is still active based on the quantity dispensed and standard recommended dosage schedules.

Pharmacists have the ability to override DUR rejections, but should only do so for a valid medical reason and when an intervention was done.

In such instances, the claim must be re-transmitted with the appropriate CPhA intervention and exception code, as set forth below:

CPhA Code	Description
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 and Rx filled as written
UG	Cautioned patient and Rx filled as written
UI	Consulted other source and Rx filled as written
UJ	Consulted other sources, altered Rx and filled
UN	Assessed patient, therapy is appropriate

Please document the reason for the intervention performed for codes, along with the intervening pharmacist's name, all other relevant information for audit purposes, and use one of the codes listed above (excluding the CPhA codes UA, UB, UC, UD and UE) when resubmitting the claim.

Note: Express Scripts Canada is aware that each pharmacy provider may have an in-house DUR program, however Express Scripts Canada's DUR Program takes into context claims that the member has had anywhere in Canada.

6.6 Prescriber Identification Numbers

Pharmacies are required to submit the appropriate prescriber identification number for each claim. The required identifier is the prescriber's unique assigned prescriber number. Failure to submit the complete and accurate prescriber identifier could result in a potential audit review and claim reversal.

Note: The pharmacy provider must submit their license number as provided and approved by their licensing body in the pharmacist code field.

6.7 Actual Day's Supply

The actual day's supply must be indicated for each claim, taking into consideration member dialogue and professional discretion when prescription directions are not specific. This is a **mandatory** field.

If exact directions are not provided by the prescribing physician (i.e. physician indicates as directed or prn), the pharmacist should call the physician or make a reasonable assessment and submit the exact day's supply based on:

i. The physician's verbal indications (which should be documented on the original prescription in accordance with applicable legislation) or the pharmacist's assessment.
ii. The quantity prescribed.

If the day's supply submitted exceeds the drug benefit plan's limitation, the message, quantity exceeds maximum day's supply is displayed. In this case, the quantity dispensed should be reduced so as to respect the drug benefit plan's day's supply limitation. This message **should not** result in a modification of the ratio of quantity dispensed to actual day's supply, unless an error was made in the original assessment of such ratio.

6.8 Dispensing Quantity

For non-maintenance medication, refer to **dynamic maintenance drugs** for an explanation on maintenance versus non-maintenance drugs. The maximum quantity dispensed per prescription will be the lesser of:

(i) The amount prescribed or
(ii) 34 day's supply, if not specified by the drug benefit plan.

Maintenance drugs may be dispensed in quantities corresponding to a maximum of one hundred (100) day's supply if ordered by the physician, unless the drug benefit plan specifically states otherwise. Again subject to drug benefit plan specifications, a prescription should not be refilled unless at least 67% of the day's supply of the previous dispensed covered medication has already elapsed.

Dynamic Maintenance Drugs

Drugs are identified in Express Scripts Canada's adjudication system as either maintenance or non-maintenance products. This classification serves as the basis for determining the maximum allowable day's supply (MADS), as elected by the client for each individual drug benefit plan. For most drug benefit plans, the MADS for a maintenance drug is greater than the MADS for a non-maintenance drug.

Upon initiation of treatment (or for the first four (4) months of coverage by a client), all drugs have the same MADS, independently of their classification. This initial MADS corresponds to the MADS applicable for a non-maintenance drug. For every claim

submitted, the adjudication system evaluates the last 135 days of claim activity for the member for the same drug and dosage to determine the applicable MADS.

If a maintenance supply of a covered medication has not been dispensed to a member eligible to receive a MADS corresponding to a maintenance drug, the following message will be sent to the pharmacy provider: **KX = Patient now eligible for maintenance supply.**

Extended Supplies (Vacation Supplies)

Extended supplies may be allowed for members traveling out of their province of residence for a greater period of time than the allowed day's supply under the member's drug benefit plan. In such instances, for the claim to be adjudicated electronically, members should seek prior authorization from the insurance company (through their benefits administrator). Otherwise, depending on the limitations of the drug benefit plan, the member may have to pay for the entire prescription or for the portion of the prescription in excess of the allowable day's supply and submit the claim and receipts manually for reimbursement. The appropriate quantity must be entered in the day's supply field as per the directions found on the prescription. These are not to be altered to bypass a rejection. The use of any intervention code to override a quantity exceeds maximum day's supply message in such instances is **not acceptable** in accordance with the CPhA standards.

6.9 Co-ordination of Benefits

Co-ordination of benefits (COB) is a mechanism used when a member is covered by more than one drug benefit plan. Co-ordination avoids duplicate payments and ensures that the total amount paid under overall coverage does not exceed 100% of the expenses incurred by the member.

The first ranking patient's insurance company (called the *first payer*) pays the claim by applying the parameters specific to its drug benefit plan. The claim is then transmitted to the second ranking patient's insurance company (called the *second payer*), who eventually completes the payment based on its own drug benefit plan.

When an amount is to be paid by the primary private or provincial plan, the previously paid field must be populated with the previous paid amount and then the claim should be transmitted to Express Scripts Canada with the appropriate intervention code (DA or DB). Consequently, real-time COB can only be performed where all previous paid claim portions are by electronic submission/direct claim.

CPhA Intervention Code	Details
DA (provincial COB)	Must be submitted to the secondary plan when first payer is a provincial plan.
DB (co-ordination between two private plans)	Must be submitted to the secondary plan when first payer is an active private plan. The amount paid by the primary private plan must be indicated in the **previously paid** field.

Provincial Co-ordination

When a member is covered by two drug benefit plans and the first payer's plan is a provincial plan, the intervention code DA must be submitted with the remaining amount to Express Scripts Canada for adjudication by the second payer.

Private Co-ordination

When the first payer's drug benefit plan is private, the intervention code DB must be submitted with the remaining amount to Express Scripts Canada for adjudication by the second payer.

There are different rules when processing claims subject to private co-ordination, which can be one of the two following:

a) COB 1

One of Express Scripts Canada's clients is the primary payer for the cardholder and their dependents. Consequently, the pharmacy provider may transmit the claim electronically to Express Scripts Canada for adjudication.

b) COB 2

One of Express Scripts Canada's clients is the primary payer for the cardholder only. With respect to claims for the spouse or the dependents, the following options are available:

(i) Request the spouse or the dependents to pay for the entire prescription and submit to the first payer for reimbursement, and then to the secondary payer.

Or

(ii) If the first payer for the spouse and the dependents adjudicates electronically as a direct claim, transmit the claim to the first payer and then to Express Scripts Canada using the intervention code DB with the remaining amount for adjudication by the second payer.

When a claim is transmitted to Express Scripts Canada as a primary payer for a spouse or dependent, the claim will be rejected with the C6 code: patient has coverage.

7. Drug Benefit Plan Limitations

7.1 General Limitations

The coverage of medications depends on the applicable drug benefit plan. However, all drug benefit plans have limitations.

The following table sets forth details concerning the most common limitations.

Limitation	Description
Fertility Drugs, Smoking Cessation Products, Anorectics and Anti-Obesity Drugs	• These medications may not be covered under certain drug benefit plans, or subject to certain limitations in terms of time and/or amount. • When unable to submit a claim electronically, please contact the Provider Call Centre to verify the status and maximum amount of coverage. *Please note that Express Scripts Canada can only verify quantities of a particular covered medication which have been processed to date.*
Member Specific Limitations	• Some limitations may apply to specific members and not to other members covered under the same drug benefit plan. Such limitations can pertain to quantity, specific drug identification number and day's supply.

Limitation	Description
Member Specific Limitations	• **Copayment** Dollar amount which the member is responsible for paying out-of-pocket per prescription. • **Coinsurance** Fixed percentage per prescription which the member is responsible for paying out-of-pocket. • **Deductibles**[5] Fixed amount to be borne entirely by the member on prescriptions for themselves, spouse or dependents before the client starts assuming a portion of the cost of covered medication. The deductible can be: (i) Individual - each individual in a family must satisfy a fixed amount. (ii) Family - all members in a family accumulate toward the fixed amount. (iii) Combined - each member in a family accumulates an individual deductible, and each individual's deductible accumulates toward the family deductible.
Closed Drug Benefit Plans	Certain drug benefit plans are closed: any drug which was not included when the plan was created will not be covered. Members should be instructed to contact their benefits administrator.
Generic Substitution	Some drug benefit plans encourage generic substitution by offering better coverage for generics. The generic substitution options can be included in a drug benefit plan when the drugs in question are considered multi-source (brand and equivalent generic drugs are available). Two options are available for generic substitution: 1) **Standard Generic Substitution**: where an equivalent generic drug is substituted for the brand drug and the claim for the prescription is paid based on the lowest cost generic drug. In this option, the plan will pay for the brand drug if the prescribing physician has indicated in writing dispense as written or no substitution on the prescription. 2) **Mandatory Generic Substitution**: this option is the same as the standard generic substitution with the exception that, regardless of the prescribing physician's written indication for dispense as written or no substitution on the prescription, the drug benefit plan will only cover an amount corresponding to the lowest cost equivalent generic drug. The product selection code is used to indicate the reason for no substitution or other reasons for the selection of the product dispensed. For further details, refer to *Appendix D Product Selection Code List*.

[5] If a Member questions the deductible, please refer them to contact their Benefits Administrator.

Limitation	Description
Therapeutic Equivalent Pricing	The price of the submitted DIN has been reduced to the price of the lowest cost equivalent DIN. Express Scripts Canada has created a table regrouping certain drugs considered to be therapeutically equivalent (similar efficacy and safety), and the lower priced drug becomes the price reference for its therapeutic group. When a claim is submitted and this functionality is applicable, only the *cost* of the reference drug will be covered. At the point of sale, the Member has a choice of whether or not to obtain what was originally prescribed and pay the difference in cost for the more expensive drug. Or, the member may choose to have the therapeutic equivalent drug choice dispensed, with the physician's approval. A response code of PE = Therapeutic equivalence DIN available and a message identifying the DIN of the lowest cost equivalent will accompany this adjudication.

7.2 Prior Authorization

For the sake of ensuring appropriate drug plan utilization and the optimal use of certain specific innovative and expensive drugs, and in order to control related costs, some clients have elected to have such drugs require a prior authorization (PA) for coverage under certain drug benefit plans.

Therefore, unless the member meets specific criteria and has obtained a PA for the drug to be covered, the claim may be rejected.

In such instances, the pharmacy provider will receive one of the following response codes:

Message Code	Message
LH	Prior authorization required – call Express Scripts Canada pharmacy helpdesk • Express Scripts Canada is responsible for the assessment of the request.
DX	Drug must be authorized • Carrier is responsible for the assessment of the request.

Note: The **response code** depends on which of Express Scripts Canada or the client is responsible for assessing the request for PA; however the message will be the same.

It may be preferable for the member to complete the PA process before filling in their prescription, as there is no guarantee that the medication will ultimately be covered.

PA for coverage of a medication can be obtained as follows:

a) **Where Express Scripts Canada is responsible for the assessment of the request**

If a PA is required for a prescription, download the appropriate Prior Authorization Request Form from the Express Scripts Canada Website www.express-scripts.ca/health-care-downloads-and-resources and have the form completed by the prescribing physician before returning it to Express Scripts Canada for assessment.

Whether the PA request is granted or denied, Express Scripts Canada will inform the client and the member of the result of its assessment, and the client will update the electronic profile of the member accordingly.

b) **Where the client is responsible for the assessment of the request**

The member can contact the client directly to obtain the appropriate Prior Authorization Request Form to be completed by the prescribing physician and returned to the client for assessment. Whether the PA is granted or denied, the client will update the electronic profile of the member accordingly and inform the member of its decision.

Note: Express Scripts Canada's drug benefit plan is to be used after coverage through the provincial program has been exhausted.

8. Audits

As a service to its clients and to ensure compliance by pharmacy providers with the terms and conditions set forth in the Express Scripts Canada Pharmacy Provider Agreement, Express Scripts Canada maintains an ongoing Provider Audit Program.

On behalf of its clients, Express Scripts Canada reviews selected claims to ensure accuracy in payment in conjunction with the applicable plan and conditions set forth in the applicable Express Scripts Canada Pharmacy Provider Agreement. The audit also ensures that claims paid are aligned with contracts and adjudication guidelines.

Express Scripts Canada can investigate claims for up to two (2) years from the last date of dispense to a member[6]. The pharmacy provider must permit a representative of Express Scripts Canada (the auditor) to inspect, review, audit and reproduce any business, financial, prescriptions and authorizations for submitted claims maintained by the pharmacy provider pertaining to the members or the Express Scripts Canada Pharmacy Provider Agreement. The auditor can be an employee of Express Scripts Canada or a third party mandated by Express Scripts Canada. Access will be granted to the auditor during regular business hours. The pharmacy provider must co-operate and participate with the auditor in all processes, audit systems and any complaint resolution procedures established by Express Scripts Canada.

Express Scripts Canada's actions can involve communicating with the pharmacy provider to discuss any areas of concern or issues, reversing claims, recovery of funds, and potential termination of the pharmacy provider's EDI submission privileges with Express Scripts Canada.

8.1 Audit Program

The Express Scripts Canada audit program includes but is not limited to the following types of audits:

a) **Member Verification**

A letter is sent to the member to validate the date of services, receipt of prescription receipts and specific claim information.

[6] The determination of the status of a member is made at the time that the medication is dispensed.

b) Physician Verifications

Physicians are contacted to confirm certain prescriptions for which they were identified as the prescribing physician.

c) Next Day Claims Verification

The next day claims verification (NDCV) program consists of a review of a defined sample of claims submitted by pharmacy providers, the day following receipt by Express Scripts Canada.

Each day, online claims from the previous day are automatically flagged by Express Scripts Canada's adjudication system in accordance with predetermined criteria. Flagged claims are analyzed pursuant to specific audit procedures. Following these procedures, Express Scripts Canada may request a copy of prescriptions and computer generated hardcopies to be faxed by the pharmacy provider for verification.

If the requested documents are not available for review, or if any errors are detected through this process, the audited claim will be reversed or adjusted.

d) Written Desk Audit

Targeted documentation is requested from the pharmacy provider and reviewed and compared with in-house pharmacy provider dispensing information by Express Scripts Canada.

e) Onsite Audit

The auditor visits the pharmacy to perform a comprehensive review of a selection of submitted claims for validation with the pharmacy provider's records. A mutually acceptable date and time may be pre-arranged.

Following the audit, if it is determined that a claim was paid by Express Scripts Canada based on incorrect data submitted by the pharmacy provider, Express Scripts Canada will recover payment for that claim. If the pharmacy provider is no longer an Express Scripts Canada participating pharmacy provider, Express Scripts Canada will send the pharmacy provider an invoice for the unduly paid amount.

8.2 Audit Guidelines

Pharmacies are to comply with the following guidelines when transmitting claims electronically in order to minimize the risk of claim reversals and compensation following an audit.

a) Compliance with Audit Procedures

Failure to comply with any Express Scripts Canada quality assurance or audit procedure will result in adjustment or reversal of and, where applicable, compensation for all concerned claims and may result in termination of the Express Scripts Canada Pharmacy Provider Agreement at Express Scripts Canada's sole determination.

b) Audit Response

Pharmacy providers are given the opportunity to respond to audit findings within thirty (30) days from receipt of the initial audit report.

If no response, including follow up documentation to support pharmacy provider's opposition to the findings is received in such thirty (30) day period, the audit is deemed final. If response is received in such time period, Express Scripts Canada will

review the follow-up documentation provided in support of disputed claims, following which a final report will be issued to the pharmacy provider, and the pharmacy provider will be informed of the final determination and of any necessary compensatory adjustment.

c) Consistency

The total amount billed for a specific covered medication in a specific quantity, including cost of drug, mark-up and professional fee must be consistent for all Express Scripts Canada drug benefit plans.

d) Quantities Dispensed

In addition to the conditions set forth in *Section 6.7 Actual Day's Supply*, the following condition must be respected: the quantity dispensed must correspond to the quantity billed (i.e. if a ninety (90) day supply is dispensed, billing cannot be in thirty (30) day increments, but all ninety (90) days must be billed at once).

e) Pack Size

Express Scripts Canada refers to the provincial formularies as a reference when establishing pack sizes and unit prices in our adjudication system. The pharmacy provider must be diligent when submitting for products that are dispensed in packages (i.e. inhalers, oral contraceptives, vaccines, etc.). Please refer back to the provincial formulary to determine what pack size to bill Express Scripts Canada.

f) No Substitution Codes

Subject to applicable laws and regulations within the pharmacy provider's province, the submission of codes must be supported by appropriate documentation on the original prescription, whether verbal or written. Express Scripts Canada will disallow payment for any claim submitted with an incorrect code or without the applicable code when such code is required. For further details, refer to *Appendix D Product Selection Code List*.

g) Formulary Compliance

Pharmacy providers should make their best effort to comply with Express Scripts Canada formularies, respond to messaging and dispense the Express Scripts Canada formulary product. Except for generic substitution or for medical necessity, never switch a member from the formulary product to the non-formulary product when filling a prescription for any Express Scripts Canada member. Should a formulary product be switched to another product other than a generic for any reason other than documented medical necessity, payment for the non-formulary product may be disallowed.

h) Express Scripts Canada Privacy Policies

Express Scripts Canada must follow all applicable privacy laws. Express Scripts Canada's privacy policy is based on applicable privacy laws in Canada, including the federal Personal Information Protection and Electronic Documents Act (PIPEDA) and the Privacy Act.

For more information regarding Express Scripts Canada's Privacy Policy, contact the Express Scripts Canada's privacy officer by one of the following methods:

- **Email:**

  ExpressScriptsCanada_Privacy@express-scripts.com

- **Website:**

  www.express-scripts.ca/privacy-policy

- **Telephone:**

  1-888-677-0111 (ask for the privacy officer)

- **Mail:**

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

8.3 Provider Responsibility

The pharmacy provider shall co-operate with Express Scripts Canada in all audit activities.

Upon request, the pharmacy provider shall grant office or clinic access to Express Scripts Canada or a third party authorized by Express Scripts Canada, to inspect, review and reproduce during regular business hours any drug prescriptions maintained by the pharmacy provider pertaining to members, or its requirements for the registration to be a pharmacy provider to members as Express Scripts Canada deems necessary to determine compliance with the terms outlined in these documents.

9. Pricing

Pricing policies differ across the country; therefore please refer to your Express Scripts Canada Pharmacy Provider Agreement which will include the payment schedules and fees that are specific to your province.

9.1 Same Level Playing Field

We are aware that a number of pharmacies are providing reduced prices to our competitors which include a lower U&C dispensing fee, lower ingredient cost and mark-up (on some products). In addition, our (insurer and TPA) clients are receiving an increasing number of complaints from their plan members (your patients) buying medications at these pharmacies, regarding unexpected out-of-pocket amounts.

Each Express Scripts Canada Pharmacy Provider Agreement with Express Scripts Canada states that pharmacies cannot charge more for cash paying customers or competitors. As such, the total reimbursement to the pharmacy provider by Express Scripts Canada and the plan member for the provision of a covered medication shall not exceed the amount contracted for, or accepted as payment by such pharmacy provider from any other private payer or cash paying customer for that covered medication.

As of June 1, 2012, Express Scripts Canada addressed all instances relating to unequal treatment including, but not limited to auditing claims, to ensure compliance with our Express Scripts Canada Pharmacy Provider Agreement and this manual.

Please note, preferred provider networks (PPNs) are a benefit management strategy commonly used by our clients and set up within our adjudication system. The same level playing field principle does not prevent pharmacy providers from entering into these separate, negotiated arrangements with our clients.

10. New Programs

10.1 Step Therapy Program

The Step Therapy Program encourages the use of lower-cost, therapeutic alternatives (Step 1 drugs) before stepping up to the more costly Step 2 or Step 3 drugs, when appropriate. If a member is already using the Step 2 or Step 3 drug, the claim will continue to be paid. If a member is starting therapy with a Step 2 drug and has not already tried a Step 1 drug, the claim will be rejected. If a member is starting therapy with a Step 3 drug and has not already tried a Step 1 and a Step 2 drug, the claim will be rejected.

The pharmacist can either contact the physician to see if a Step 1 drug is acceptable or advise the member to contact their physician directly to determine if the prescription can be changed.

Pharmacy Software Responses

Following adjudication by Express Scripts Canada, if the drug submitted is part of the step therapy program, the pharmacy provider will receive one of the below standard CPhA response codes:

Scenario	CPhA Response Code	Solution
Accepted Claim: The adjudication system finds claims for the Step 1 drug or evidence that the Member is already taking the Step 2 or Step 3 drug.	**QO:** Preference or Step drug available.	No action from the pharmacist is required at this point.

Rejected Claim: The adjudication system does not find claims for the Step 1 drug, nor the Step 2 or Step 3 drugs.	**SA:** Preferred or Step drug must be submitted and pharmacy message is provided to specify which drug is expected to be submitted first. *Please see below Table -Explanation of the Pharmacy System Message Accompanying SA Rejection Code.*	1. Refer to the system message received indicating the drug listed is the alternative which requires authorization from the prescriber for a prescription modification to an appropriate alternative Step 1 or Step 2 drug; **OR** 2. Verify that this particular member requires the prescribed drug due to lack of efficacy or intolerance of the lower cost alternatives. **Note:** If this is the case, one (1) of the CPhA intervention codes listed below is required to process the claim. Written documentation should be made on the prescription hardcopy to support the use of the intervention code. • **UP** - First line therapy ineffective • **UQ** - First line therapy not tolerated by patient

The prescriber should assess the risk/benefit ratio and make the final decision on member's drug therapy.

Note: Claims processed using these overrides may be subject to audit to ensure appropriate use of the intervention codes.

Explanation of the Pharmacy System Message Accompanying SA Rejection Code		
Module	**Pharmacy System Message**	**Description**
Met ER	Use generic metformin IR 1st	Therapy with an immediate release metformin should be attempted prior to initiating therapy with Glumetza (metformin ER).
DPP-4	Use metformin or sulfonylurea 1st	Therapy with a drug containing metformin or a sulfonylurea should be attempted prior to use of a drug containing a DPP-4 inhibitor.
Gout	Use generic allopurinol 1st	Therapy with allopurinol should be attempted prior to initiating therapy with Uloric.
RAS-BP C	*Step 2* – Use ACEI, ARB or, ACE/ARB combo 1st	Therapy with an ACE inhibitor, ARB or ACE/ARB combination should be attempted prior to initiating therapy with Rasilez or Rasilez HCT.
Cholest	Use statin or statin combo 1st	Therapy with an optimally dosed statin containing drug should be attempted prior to initiating therapy with Ezetrol.

PPI	*Step 2* – Use generic rabeprazole 1st	Therapy with rabeprazole should be attempted prior to initiating therapy with another PPI.
	Step 3 – Use rabeprazole 1st then use 2nd PPI excluding esomeprazole and dexlansoprazole	Therapy with rabeprazole followed by at least one other PPI should be attempted prior to initiating therapy with either Nexium, Dexilant or Prevacid FasTab.

Disclaimer: this information may be subject to change without notice.

Step Therapy Cognitive Fees

A step therapy cognitive fee may be eligible when the pharmacist has been successful in the switching of a prescribed drug to a drug in a lower step. The inclusion of this provision is based on the employer's drug benefit plan.

To claim the cognitive fee, the pharmacy provider will have to submit a separate EDI claim with a product identification number (PIN or pseudo-DIN) which is specific to the cognitive fee for a specific step module. Express Scripts Canada may conduct a post claim review of the cognitive fee payment to verify the validity of the claim.

The relevant PINs for the step therapy cognitive fees are as follows:

Step Module	PIN	Drug Name
PPI	98174101	STEP - PPI (ADMIN DIN)
RAS-BP C	98174102	STEP - RAS BP (ADMIN DIN)
DPP-4	98174103	STEP - DPP 4 (ADMIN DIN)
Met ER	98174104	STEP – MET ER (ADMIN DIN)
Gout	98174105	STEP - GOUT (ADMIN DIN)
Cholest	98174106	STEP - CHOLEST (ADMIN DIN)

10.2 Provincial Integration Program

The Provincial Integration Program is designed to recognize when the submitted DIN is part of a provincially funded program and may be designated as an exception drug under the provincial formulary or part of a provincial specialty/disease program. The Provincial Integration Program encourages members to first submit their request to the provincial plan for coverage. When provincial integration applies, the pharmacy provider will receive a CPhA message requesting the pharmacy provider to confirm provincial drug coverage for DIN. The pharmacy provider should ask the member to confirm whether they have applied for provincial coverage and resubmit the claim using the intervention code relevant to the member's situation (i.e. applied for provincial coverage and denied, applied for provincial coverage and accepted or not yet applied).

Intervention/Exception Codes

Where a member is covered under two drug benefit plans and the first payer is a provincial plan, the intervention code DA must be submitted with the remaining amount to Express Scripts Canada for adjudication. In addition to the DA intervention code, pharmacy providers must submit one of the following CPhA standard intervention/exception codes when the previously paid field is valued at $0.00 to identify whether the member's application for provincial coverage has been approved, rejected or if a decision is pending. Please note that if private co-ordination also applies, the DB intervention code should be used instead of DA.

Scenario	Solution
If the member advises that they have not applied to the provincial plan.	Advise the plan member to make an application to the provincial plan and that failure to do so could mean an interruption in future claim payment. To allow a first time forgiveness - Use intervention codes **DADX** – Applied to provincial plan and decision is pending. **Note:** The DX intervention code can only be submitted once, and an attempt to use this code in future claims for the same drug will result in rejection of the claim.
The pharmacy provider has received confirmation that the member has applied to the provincial plan and is waiting for a response regarding eligibility for the claimed DIN.	To allow first time forgiveness - Use intervention codes **DADX** – applied to provincial plan and decision is pending. **Note:** The DX intervention code can only be submitted once, and an attempt to use this code in future claims for the same drug will result in rejection of the claim.
The pharmacy provider has received confirmation that the member has applied to the provincial plan and was approved for coverage of the claimed DIN.	Submit claim to the provincial program and then submit any unpaid balance to the private insurer. Use Intervention Codes **DADV** – Applied to provincial plan and approved.
The pharmacy provider has received confirmation that the Member has applied to the provincial plan and was rejected for coverage of the claimed DIN.	Use Intervention Codes **DADW** – Applied to provincial plan and rejected.
The member by definition is ineligible for coverage under the provincial plan (i.e., not just for the claimed DIN).	Use Intervention Code **DY** – Not eligible for provincial plan coverage. The DA intervention code is not required in the submission.

To address the potential need to override multiple programs (i.e. Step Therapy Program) for a claim, three (3) additional CPhA standard intervention/exception codes are available.

Scenario	Solution
The pharmacy provider has received confirmation that the Member has applied to the provincial plan and was approved for coverage of the claimed DIN, plus the Step Therapy Program also needs to be overridden.	Use intervention codes **DASV** – Approved by the provincial plan. Bypass other programs.
The pharmacy provider has received confirmation that the member has applied to the provincial plan and was rejected for coverage of the claimed DIN, plus the Step Therapy Program also needs to be overridden.	Use intervention codes **DASW** – Rejected by Provincial Plan. Bypass other programs.
The pharmacy provider has received confirmation that the member has applied to the provincial plan and is waiting for a response regarding eligibility for the claimed DIN, plus the Step Therapy Program also needs to be overridden.	To allow first time forgiveness - Use intervention codes **DASX** – pending provincial plan, bypass other programs. **Note:** The SX intervention code can only be submitted once, and an attempt to use this code in future claims for the same drug will result in rejection of the claim.

If the pharmacy provider is not able to obtain the provincial plan information from the member, the claim will be rejected and the member will be advised to submit to the provincial plan.

Private COB

When there is provincial integration and private COB involved, the DB intervention code should be submitted. The DB intervention code refers to the COB with a private plan.

Adjudication System Messaging

In the event that the pharmacy provider does not submit the claim to the provincial plan and the intervention code DA is not submitted, the claim will be rejected with the CPhA message C6 – patient has other coverage. If the provincial plan is not paying any portion of the claim and it is submitted to Express Scripts Canada with intervention code DA, with no additional intervention code, the claim is rejected with the CPhA message 86 – confirm provincial drug coverage for DIN. The DA intervention code must be used in conjunction with one of the other intervention codes listed above, based on the information received from the member.

Note: If more than one program is applicable with provincial integration (i.e. provincial integration and step therapy), the intervention codes SV, SW or SX can be used to override these programs as indicated above. However, whenever the Step Therapy Program is being overridden, a note on the member's profile indicating the reason the claim was overridden is required. The use of intervention/exception codes may be subject to review through the Express Scripts Canada Audit Program.

11. Contact Us

11.1 Express Scripts Canada Website

The Express Scripts Canada website at *www.express-scripts.ca* includes the following valuable resources and contact information for pharmacy providers.

- Pharmacy Provider Manual
  - An up-to-date version of this Pharmacy Provider Manual.
- Modification to Pharmacy Provider Information Form
  - A form for providers to complete, sign and return by fax (indicated on the form) for changes to the pharmacy provider information, operating name, address, payment information (setup or change) and dispensing fee.
- NIHB Program
  - A link to the Non-Insured Health Benefits (NIHB) claims services provider website, which is main source of information for NIHB Program providers. This website is jointly maintained by Express Scripts Canada and Health Canada's First Nations and Inuit Health Branch (FNIHB).
- Audit Mission Statement
  - A detailed explanation of the mission of Express Scripts Canada's Business Integrity Department, in addition, providing a fraud tip hotline and email reporting system.
- Frequently Asked Questions (FAQs)
  - Commonly asked questions and answers about pharmacy provider registration, in addition to EDI and EFT.
- Prior Authorization Request Forms
  - Any questions on the Prior Authorization Program, please contact the Provider Claims Process Call Centre.

11.2 Provider Call Centre

The Provider Call Centre is for **providers** only.

Please do *not* refer our members (your patients) to contact the Provider Call Centre for inquiries regarding their drug benefits plan coverage or eligibility.

Inquiries regarding a specific claim, payment issues, retrieval and completion of the Express Scripts Canada Pharmacy Provider Agreement, or a change in pharmacy provider address, contact the Provider Call Centre:

Phone:	1-800-563-3274 (Press 1 (English)/2 (French), press 1 for Drug Claims) Monday to Friday: 6:30 a.m. to midnight (ET) Saturday, Sundays and statutory holidays: 8 a.m. to midnight (ET)
Fax:	1-855-622-0669
Mail:	**Express Scripts Canada** Attention: Provider Relations 5770 Hurontario Street, 10th Floor Mississauga, ON L5R 3G5

Outside of regular hours of operation, please leave a detailed message with a provider number and a customer service representative will return the call the following business day.

Please note that Express Scripts Canada cannot change any eligibility information (including, without limitation: coverage, date of birth, etc.). Therefore, in such instances where the eligibility of a member is in question, please refer the cardholder (beneficiary of the insurance) to the benefits administrator at their place of employment.

11.3 Canadian Pharmacists Association

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

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

11.4 Software Certification/Network Communications

For inquiries regarding software certification or network communication issues, contact:

Telus
Attention: Erik Noolandi
5090 Orbitor Drive
Mississauga, ON L4W 5B5
Phone: 905-629-5703

12. Appendices

Appendix A – Sample of Modification to Pharmacy Provider Information Form

Appendix B – Response Codes/Explanations

Appendix C – Sample of Pharmacy Provider Remittance Advice

Appendix D – Product Selection Code List

Appendix A Sample Modification to Pharmacy Provider Information Form

EXPRESS SCRIPTS®

MODIFICATION TO PHARMACY PROVIDER INFORMATION FORM

It is the responsibility of the Owner to notify Express Scripts Canada in writing of any changes to their Pharmacy information. Please allow 10 business days to process the modifications.

PROVIDER INFORMATION (Mandatory to Complete)

Provider No.: _____ Language Preference: ☐ English ☐ French

Operating Name: _____

Legal Name: _____

Current Address: _____

City/ Province/ Postal Code: _____

Phone No.: _____ Fax No.: _____

E-mail Address: _____

Contact Name: _____ Title: _____

☐ SECTION A – OPERATING NAME (Change)

An Operating Name change is accepted when the **Legal Name and Ownership Names** remain the same.

Effective Date: _____

Current Operating Name: _____

New Operating Name: _____

☐ **Change of Legal/ Ownership Name Required** (includes adding and/ or removing owner names)

IMPORTANT: If you check the box above, an Express Scripts Canada representative will contact you directly to complete a NEW Pharmacy Agreement, *end-date the current owner Provider Number, and assign a NEW Provider Number to the new Owner.*

☐ SECTION B – ADDRESS AND COMMUNICATIONS (Delivery Mode) (Change)

Effective Date: _____

Address: _____ Phone No.: _____

City: _____ Province: _____ Postal Code: _____

The delivery of communications will be sent by **E-mail first**, then Fax, then Mail (if required).

☐ Same E-mail Address or ☐ New E-mail Address: _____

☐ Same Fax No. or ☐ New Fax No.: _____

☐ SECTION C – PAYMENT INFORMATION (Change or Set up for Electronic Funds Transfer)

I instruct Express Scripts Canada to set up or change my direct EFT PAYMENTS. This form authorizes deposits to the account and does not authorize withdrawals or any other transactions with respect to the account. All information will be treated as PRIVATE AND CONFIDENTIAL. I will advise Express Scripts Canada promptly of any changes to bank, branch or account number.

Effective Date: _____ ☐ **NEW Banking Information** or ☐ **REPLACE Banking Information**

Complete the bank information below and ☐ Attach a **VOID Cheque** (Photocopy of VOID cheque is acceptable when faxing) or ☐ **Official Bank Letter**

Bank Name: _____ Branch Name: _____

Branch Address: _____

City: _____ Province: _____ Postal Code: _____

Bank No.: | | | | Branch/ Transit No.: | | | | | Account No.: | | | | | | | | | | |

☐ SECTION D – DISPENSING FEE (Change) *(Non-Quebec Pharmacies ONLY)*

ONTARIO Pharmacies:	**All OTHER Pharmacies:**
Eff. Date: _____ Zone Set by ODB: _____	Eff. Date: _____
CURRENT U&C Fee: _____	CURRENT U&C Fee: _____
NEW U&C Fee: _____	NEW U&C Fee: _____

_____ _____

Full Name, Owner or Director of the Business (please print) **Position/ Title** (please print)

_____ _____

Signature, Owner or Director of the Business **Date**

Return the completed, signed form (and VOID cheque or Official Bank Letter, if applicable) by fax or mail to:
Express Scripts Canada, Attention: Provider Relations, 6770 Hurontario St., 10th Floor, Mississauga, ON L5R 3G5, Fax No.: 1-866-822-0669.

EXPRESS SCRIPTS CANADA April/2014 Ver5.0

Sample

Appendix B Response Codes/Explanations

Listed in the table below are the possible response codes sent by Express Scripts Canada to the pharmacy provider following electronic submission or reversal of a claim. Please note that the wording set forth in this table may not exactly match the wording appearing on the pharmacy screen, as such wording is controlled by the individual pharmacy provider's software vendor.

A CPhA description refers to the wording established by the CPhA pharmacy claim standard. The CPhA descriptions that are bolded and underlined, signify the most common causes of claim rejection. If a message that was sent by Express Scripts Canada to the pharmacy provider is not listed in this table; please contact the Provider Call Centre for more information.

CPhA Description	Reason	Action Required
(01) – BIN ERROR	In order to submit EDI claims to Express Scripts Canada, the pharmacy provider must have its software provider register the Express Scripts Canada BIN number. This message appears if the BIN number is incorrect or missing on the claim.	Please contact your software provider.
(21) – PHARMACY ID CODE ERROR	The pharmacy provider is not registered or its contract has expired. The provider number submitted is incorrect or an expired provider number was used. The pharmacy provider's account number was temporarily suspended after five consecutive errors.	Please contact Express Scripts Canada in order to register, verify that the submitted provider number is correct, or to be re-activated.
(30) – CARRIER ID ERROR	The client must be pre-registered with Express Scripts Canada and the submitted client on the claim must be correct.	Verify the submitted carrier number. For more information, please contact Express Scripts Canada or the software provider.
(31) – GROUP NUMBER ERROR	The effective or expiry date at the group and/or subgroup levels is missing. The submitted group number on the claim is invalid. The client /group/member has a specific RAMQ code defined, and the RAMQ code does not exist in the adjudication system or the RAMQ code exists but is not valid for the claims date of service. The benefit code or the benefit override code entered (at any level) does not exist.	Please verify the group number. If the group number is correct and the claim is rejected, please contact Express Scripts Canada for verification.

(32) – CLIENT ID NUMBER ERROR	The effective date or expiry date information at the client level is missing. The submitted member on the claim is not enrolled or the client ID is incorrect.	Please contact Express Scripts Canada to verify the client ID submitted.
(34) – PATIENT DOB ERROR	The DOB at the member level is missing or the incorrect DOB was submitted on the claim. The Member is not enrolled or the submitted information does not correspond to the current member record.	Please verify the date of birth and personal information submitted with the member. If the submitted information is correct, please ask the member to contact the benefits administrator or the client in order to verify and confirm the DOB or other personal information in the adjudication system.
(36) – RELATIONSHIP ERROR	The relationship code at the member level is missing or incorrect, or the incorrect relationship code was submitted by the pharmacy provider. The member is not enrolled or the submitted information does not correspond to the current member record. The claim is submitted for the spouse, but the spouse is not covered under this plan. The claim is submitted for an underage dependent, but underage dependents are not covered under this plan. The claim is submitted for an overage dependent, but overage dependents are not covered under this plan. The claim is submitted for a disabled dependent, but disabled dependents are not covered under this plan.	Please verify the relationship code with the member. If the submitted relationship is correct, please ask the member to contact the benefits administrator or the client in order to modify the relationship code in the adjudication system or verify coverage.
(37) - PATIENT FIRST NAME ERROR	The first name at member level is missing or the incorrect first name was submitted on the claim. The member is not enrolled or the submitted information does not correspond to the current member record.	Please verify the first name submitted with the member, including any middle name. If the submitted information is correct, please ask the member to contact the benefits administrator or the client in order to modify the first name in the adjudication system.

(38) - PATIENT LAST NAME ERROR	The last name at member level is missing or the submitted last name on the claim was incorrect.	Please verify the last name submitted with the member. If the submitted information is correct, please ask the member to contact the benefits administrator or the client in order to modify the last name in the adjudication system.
(40) – PATIENT GENDER ERROR	The gender at member level is missing or the submitted gender on the claim is incorrect. The member is not enrolled or the submitted information does not correspond to the current member record.	Please verify the gender submitted with the member. If the submitted information is correct, please ask the member to contact the benefits administrator or the client in order to modify the gender in the adjudication system.
(50) – MEDICAL REASON REFERENCE ERROR	An incorrect medical reason code was submitted with the claim.	Please verify the medical reason code submitted with the claim and re-submit with the correct code.
(54) – REFILL/REPEAT AUTHORIZATION ERROR	The number of refills indicated on the claim does not correspond with the type of prescription (new/refill) indicated.	The claim must be submitted with the correct number of refills.
(56) – DIN /GP # /PIN ERROR	The submitted DIN/GP number does not exist in Express Scripts Canada's system or is no longer active. The claim was submitted with an invalid compound number, there is no DIN pricing for the province or the dispense date is not in the DIN coverage period.	Please contact Express Scripts Canada for additional information.
(58) – QUANTITY ERROR	The claim was submitted with an invalid or missing quantity.	Verify the quantity submitted on the claim. The quantity must be greater than zero (0).
(59) – DAY'S SUPPLY ERROR	The claim was submitted with an invalid or missing day's supply.	Please verify the day's supply submitted on the claim (must be greater than zero (0)).
(63) – UNLISTED COMPOUND CODE ERROR	The claim is submitted with an invalid or no ingredient cost.	The claim must be submitted with a ingredient cost greater than $0.00.
(66) – DRUG COST /PRODUCT VALUE ERROR	The claim is submitted with an invalid or no ingredient cost.	The claim must be submitted with an ingredient cost greater than $0.00.

(75) – PREVIOUSLY PAID ERROR	The claim is submitted without a previously paid amount. The claim is submitted with a previously paid amount but without an intervention code or with both intervention codes. The previously paid amount is greater than the gross amount of the claim.	The claim must be submitted with a previously paid amount equal to or greater than $0.00 and with only one of the following intervention codes: DA or DB.
(A1) – CLAIM TOO OLD	The claim was submitted with a dispense date greater than the allowed submission period. A claim was submitted too late after the dispensing date.	Please contact Express Scripts Canada.
(A3) – IDENTICAL CLAIM HAS BEEN PROCESSED	A claim with the same DIN or RX number was submitted for the member in the last three (3) days of the dispensing date; the claim is rejected because of duplicate payment.	Please verify that the dispensing date on the claim is not within three (3) days of a previous claim for the same DIN. Please contact Express Scripts Canada if this rejection code has been overridden and the claim must be reversed.
(A6) – SUBMIT MANUAL CLAIM	A claim for a drug requiring a prior authorization is submitted. A spouse already exists on file or the submitted member information does not correspond to the current member record.	Please ask the member to submit the claim manually.
(B1) – PHARMACY NOT AUTHORIZED TO SUBMIT CLAIMS	The pharmacy provider is not registered or their contract is expired with Express Scripts Canada. The province for the pharmacy provider is not valid.	Please contact Express Scripts Canada. If the submitted province code is incorrect, please contact the software vendor.
(C0) – PATIENT AGE OVER PLAN MAXIMUM	The member has reached the maximum overage dependent age (relationship code of 3).	The member must contact the benefits administrator or the client.
(C4) – COVERAGE TERMINATED BEFORE SERVICE	The claim is submitted after the expiry date at the group/subgroup level. The claim is submitted after the expiry date at the member level.	The member must contact the benefits administrator or the client.
(C5) – PLAN MAXIMUM EXCEEDED	The claim submitted has exceeded the plan's annual - member, annual - family dollar amount.	The member must contact the benefits administrator or the client.

(C6) – PATIENT HAS OTHER COVERAGE	Member has another provincial or private coverage. The submitted DIN is not covered under the Plan or is excluded by a Member or GSAS exception.	Please submit the claim to the active primary coverage, then to Express Scripts Canada with an Intervention Code of DA (provincial) or DB (private). If the Member has another private coverage, the adjudication system will not accept a DA Intervention Code. If the claim was submitted in accordance with the foregoing and this error message appears, please contact Express Scripts Canada.
(C7) – PATIENT MUST CLAIM REIMBURSEMENT	The claim must be submitted by the member. The claim is submitted with a suspend flag at any level (client, patient, GSProf or GrProf).	Please ask the member to submit the claim manually.
(C8) – NO RECORD OF THIS BENEFICIARY	A claim is submitted without the enrolment date parameter at the member coverage level being valued.	The member must contact the benefits administrator or the client.
(C9) – PATIENT NOT COVERED FOR DRUGS	This member is eligible for dental coverage only; not for drug coverage.	The member must contact the benefits administrator or the client.
(CC) – THIS SPOUSE NOT ENROLLED	A spouse already exists on file and the submitted Member information does not correspond to the current member record. A spouse is already on file and the expiry date is greater than the claim process date.	The member must contact the benefits administrator or the client.
(CN) – PATIENT HAS ATTAINED QUANTITY LIMIT/DAY'S SUPPLY EXCEEDS PLAN LIMIT, PATIENT HAS ATTAINED QUANTITY LIMIT/MAXIMUM DAY'S SUPPLY FOR REGULAR DRUG EXCEEDED – AMOUNT PAYABLE IS REDUCED	The member has reached the maximum approved quantity allowed for a specific DIN or group of DINs defined by their plan. The day's supply submitted is greater than the maximum day's supply outlined for this DIN. Therefore, the ingredient cost is reduced accordingly.	Please contact Express Scripts Canada for additional information.

(CO) – PATIENT IS OVER QUANTITY LIMIT	The claim submitted is for a DIN or a group of DINs covered by a member or GSAS exception with an accumulator ID criterion. Based on these criteria, the maximum quantity or quantity per cycle is attained.	Please contact Express Scripts Canada for additional information.
(CS) – PATIENT EXCLUSION PREVENTS PAYMENT	The submitted DIN is excluded by a member exception.	The member must contact the benefits administrator or the client.
(CX) – NO RECORD OF PATIENT DATA	The member's SAS, assigned on the dispensing date is not the same as the member's current SAS.	Please contact Express Scripts Canada.
(D1) - DIN/PIN/GP# NOT A BENEFIT	The submitted DIN is not covered under the Plan or is excluded by a member or GSAS exception.	The member must contact the benefits administrator or the client.
(D8) – REDUCED TO GENERIC COST	The DIN submitted has an interchangeable generic for the dispensing province. Therefore, the ingredient cost is reduced.	Please consider dispensing the generic DIN. If the prescribing physician has specified *no substitution* on the script, please submit the claim with a product selection code = 1.
(D9) – CALL ADJUDICATOR	The claim requires further investigation.	Please call Express Scripts Canada for resolution.
(DH) – PROFESSIONAL FEE ADJUSTED	The professional fee of the submitted claim is reduced to the maximum allowed.	Please contact Express Scripts Canada for additional information.
(DJ) – DRUG COST ADJUSTED	A claim is cut back because it reaches the provincial accumulator maximum. The drug cost submitted is cut back according to Plan details. The drug cost submitted is cut back to the DIN pricing in the DIN database. The member has reached the dollars annual - member, annual - family maximum amount with this claim. Therefore, the amount paid is reduced to the residual amount.	Please contact Express Scripts Canada for additional information.
(DM) – DAY'S SUPPLY EXCEEDS PLAN LIMIT	The day's supply submitted is greater than the maximum day's supply outlined for this DIN. Therefore, the ingredient cost is reduced. A claim is submitted for a day's supply greater than what is allowed.	Please modify the claim and resubmit according to the day's supply allowed under the coverage, or ask the member to pay for the difference.

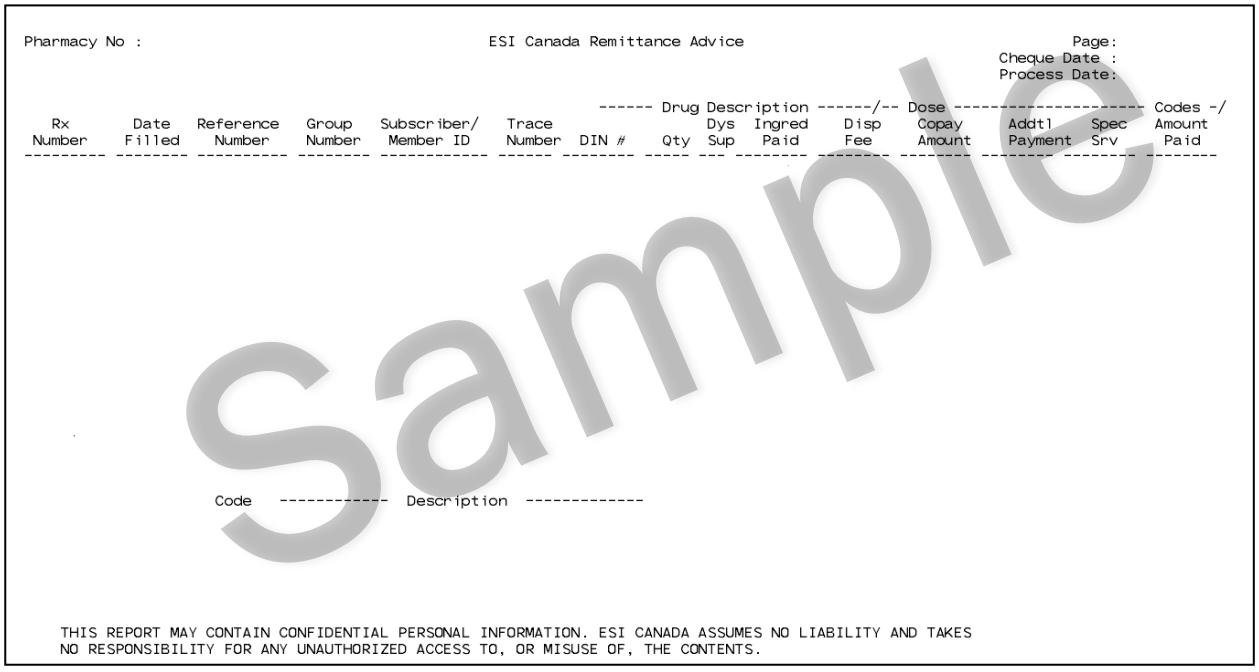
(DR) – DAY'S SUPPLY LOWER THAN MINIMUM ALLOWABLE	The day's supply submitted is less than the defined maintenance day's supply limit.	Please resubmit the claim with the intervention code MG.
(DX) – DRUG MUST BE AUTHORIZED	The claim submitted is for a DIN or group of DINs that requires a PA. A claim for a prior authorization drug is submitted and $0.00 is paid.	Please contact Express Scripts Canada for additional information.
(E1) – HOST PROCESSING ERROR	The claim was not successfully transmitted due to an adjudication error.	Please contact your software vendor for additional information.
(E2) – CLAIM COORDINATED WITH GOVT PLAN	The claim submitted is co-ordinated with a provincial coverage, with an Intervention Code of DA and is paid based on the COB rule D, E, F, G or H (provincial). The claim is cut back because it reaches the provincial accumulator maximum.	No action required.
(E3) – CLAIM COORDINATED WITH OTHER CARRIER	The claim submitted is coordinated with a provincial or private coverage, with an intervention code of DA or DB and is paid based on the COB rule (provincial or private).	No action required.
(EN) – INSURER REQUIRES PROV. PLAN ENROLLMENT	The claim was submitted for a Member with a provincial enrolment date prior to the current benefit year. The claim is accepted.	No action required.
(EO) – FAILURE TO ENROLL MAY SUSPEND PAYMENT	Generated when claims with provincial enrolment dates are dated prior to the benefit year. The provincial plan is activated and payment will be suspended if the member does not enrol with the provincial plan.	The member must enrol with the provincial plan. To notify the Plan of enrolment, please send a DA intervention code with the claim when submitting to Express Scripts Canada as the secondary payer, or ask the member to contact the client directly.
(EP) – LAST CLAIM, MUST ENROLL WITH PROV. PLAN	The current claim's maximum is reached and the enrolment date is not current. The claim is accepted, but the eligible amount will be reduced to zero. This is the last claim that will be paid unless the member enrols with the provincial plan.	The member must enrol with the provincial plan. To notify the plan of enrolment, please send a DA intervention code with the claim when submitting to Express Scripts Canada as the secondary payer, or ask the member to contact the client directly.

(EQ) - REJECT, PROV. PLAN ENROLMENT REQUIRED	The current claim's accumulator maximum is reached and the enrolment date is not current. The claim is rejected because the member is not enrolled with the provincial plan.	The member must enrol with the provincial plan. To notify of enrolment, please send a DA code with the claim when submitting to Express Scripts Canada as the secondary payer, or ask the member to contact the client directly.
(EV) – CLAIM EXCEEDS ODB LEGISLATED PRICING	The claim was subject to cut back due to ODB-eligible pricing logic.	Please contact Express Scripts Canada for additional information.
(EW) - PROF. FEE EXCEEDS ODB LEGISLATED PRICING	The claim was subject to cut back due to ODB-eligible pricing logic.	Please contact Express Scripts Canada for additional information.
(GA) – PREFERRED PROVIDER NETWORK FEE PAID	The submitted dispensing fee is cut back to the Express Scripts Canada preferred provider network (PPN) fee amount.	Please ask the member to contact the benefits administrator or the client.
(GB) - PREFERRED PROVIDER NETWORK CLAIM	The submitted dispensing fee is NOT cut back, but the Express Scripts Canada preferred provider network processing rule was applied to the claim.	No action required.
(HA) – CARDHOLDER DATE OF BIRTH IS REQUIRED	The member date of birth is missing at the client record.	The member must contact the benefits administrator or the client.
(HB) - CARDHOLDER IS OVER COVERAGE AGE LIMIT	The claim submitted is for a member who has reached the maximum age of coverage.	The member must contact the benefits administrator or the client.
(HC) - REQUIRE CARDHOLDER PROVINCE OF RESIDENCE	The claim was submitted for a plan based on the member's province of residence. Since no province is found, the claim is rejected.	The member must contact the benefits administrator or the client.
(HE) – COVERAGE SUSPENDED, REFER TO EMPLOYER	The submitted group is temporary suspended.	The member must contact the benefits administrator.
(KC) – PATIENT PRODUCT DOLLAR MAXIMUM EXCEEDED	The member has a dollar maximum for a DIN or group of DINs and this amount is exceeded.	The member must contact the benefits administrator or the client.
(KK) – NOT ELIGIBLE FOR COB	The plan is based on the provincial COB rule 2 (does not co-ordinate with the provincial plan). The claim is rejected if the DIN is a formulary drug and the claim is submitted with the intervention code of DA. The claim is accepted (but amount paid is $0.00) if the DIN is a non-formulary drug and the claim is submitted without the intervention code DA.	The member must contact the benefits administrator or the client.

(KX) – PATIENT NOW ELIGIBLE FOR MAINTENANCE SUPPLY	The DIN is considered as a maintenance drug. The member is eligible to receive a maintenance supply of this drug.	Please contact Express Scripts Canada for additional information.
(LH) – AUTHORIZATION REQUIRED – CALL ADJUDICATOR	The claim submitted is for a DIN or group of DINs that requires a prior authorization by Express Scripts Canada.	Please contact Express Scripts Canada for additional information.
(LK) – CLAIM PROCESSED - NET PAYABLE IS $ 0.00	The annual - member, annual - family deductible is not satisfied, the amount paid is $0.00. The previously paid amount is greater than the plan details based on the COB rule.	No action required.
(LP) – LIFETIME PLAN MAXIMUM EXCEEDED	The lifetime Plan maximum has been reached.	No action required.
(ME) – DRUG /DRUG INTERACTION POTENTIAL	The drug being dispensed may interact with another drug the member is currently taking.	Please refer to the DUR section of the Pharmacy Provider Manual or contact Express Scripts Canada for additional information.
(MW) – DUPLICATE DRUG	Early refill: the member received the same chemical entity and less than 2/3 of the medication supply of the original claim was used.	Please refer to the DUR section of the Pharmacy Provider Manual or contact Express Scripts Canada for additional information.
(MX) – DUPLICATE THERAPY	The member received a drug from the same therapy class and less that 2/3 of the medication supply of the original claim was used.	Please refer to the DUR section of the Pharmacy Provider Manual or contact Express Scripts Canada for additional information.
(MY) - DUPLICATE DRUG /OTHER PHARMACY	Early Refill: the member received the chemical entity and has used less than 2/3 of the medication supply of the original claim filled by another pharmacy provider.	Please refer to the DUR section of the Pharmacy Provider Manual or contact Express Scripts Canada for additional information.
(MZ) - DUPLICATE THERAPY /OTHER PHARMACY	The member received a drug from the same therapy class and has used less than 2/3 of the medication supply of the original claim which was filled by another pharmacy provider.	Please refer to the DUR section of the Pharmacy Provider Manual or contact Express Scripts Canada for additional information.
(NE) – POTENTIAL OVERUSE/ABUSE INDICATED	The member is receiving methadone and at least one other narcotic at the same time.	Please refer to the DUR section of the Pharmacy Provider Manual or contact Express Scripts Canada for additional information.
(OR) – EXCEPTION DRUG, SUBMIT TO PROVINCIAL PLAN	A claim for a limited-use drug is submitted for a plan that requires co-ordination with the provincial plan.	Please resubmit the claim as a COB claim (with a DA intervention code).

(OS) – SUBMIT FUTURE CLAIMS TO PROVINCIAL PLAN	A claim for a limited-use drug is submitted for a plan that would normally require coordination with the provincial plan. The intervention code MU must be submitted with this claim.	Please submit future claims for this limited-use drug with a DA intervention code to indicate it has first been submitted to ODB.
(QJ) – DEFERRED PAYMENT – PATIENT TO PAY PHARMACIST	The claim is submitted electronically. However, the member is requested to pay the full amount of the prescription to the pharmacy provider. Automatically, a reimbursement cheque is generated to the member.	No action required.
(QP) – DRUG INELIGIBLE - FUNDED BY HOSPITAL BUDGET	The claim is rejected because the drug is classified as a hospital drug.	The member must contact the benefits administrator or the client.
(QQ) – DRUG INELIGIBLE - SPECIALTY PROGRAM DRUG	The claim is rejected because the drug is classified as a specialty drug.	The member must contact the benefits administrator or the client.
(QR) – MAXIMUM ALLOWABLE COST (MAC) PAID	The claim is adjusted to pay the lower cost equivalent drug in the same class.	Please ask the member to contact the benefits administrator or the client.
(QU) – REDUCED TO $ LIMIT MAXIMUM	The dollar maximum for a DIN or grouping of DINs is exceeded.	The member must contact the benefits administrator or the client.
(RC) – TRANSMITTED TO INSURER	Sent for claims adjudicated with the deferred payment logic.	No action required.
(RS) – ANNUAL LIMIT REACHED WITH CURRENT CLAIM	The annual plan maximum (member or family) has been reached.	The member must contact the benefits administrator or the client.
(RU) - SPECIAL COB, REFERS TO PLAN PAYS AMOUNT ONLY	Special COB processing rules have been applied to the claim, and the pharmacy provider software may adjust the claim response accordingly.	No action required.

Appendix C Sample Pharmacy Provider 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 Qty	Dys Sup	Ingred Paid	Dose Disp Fee	Copay Amount	Addtl Payment	Codes -/ Spec Srv	Amount Paid

Code ---------- Description ----------

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Sample

Appendix D Product Selection Code List

Code Values	Reason	Description
1	Prescriber's Choice	The prescriber indicated no substitution in compliance with any plan or regulatory requirements.
2	Patient's Choice	The patient has specified no substitution or has selected a specific interchangeable product in writing or by initialing a written or printed statement.
3	Pharmacist's Choice	The pharmacist has chosen not to substitute the drug on a prescription or has selected a specific interchangeable product when the prescription is written without the *no substitution* instruction.
4	Existing Therapy	The pharmacist has chosen to continue the use of a brand name or generic product where variance of a product source may be adversely affect treatment.
Blank		Information is not required.