Pharmacy Provider Manual

APPLICABLE TO ALL PROVINCES AND TERRITORIES (EXCLUDING QUÉBEC)

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Version 8.1

Express Scripts Canada Express Scripts Canada

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1. DEFINED TERMS

The glossary below lists terms and definitions that may be relevant as background information when reading the Pharmacy Provider Manual.

Term	Definition
Assigned Claim	means a claim submitted electronically or manually by the Provider to Express Scripts Canada with payment by Express Scripts Canada to such Provider in compliance with the Pharmacy Provider Agreement.
Coordination of Benefits or COB	means a situation in which a Member is covered under more than one public and/or private insurance plan and payment of the Member's Covered Medications must be coordinated between the plans and their respective payers to determine the amount payable under each plan.
Copayment	means that portion of the total charge for each prescription drug that a Member is required to pay to Provider or to the Pharmacy(ies) in accordance with that Member's Pharmacy Benefit Plan and the relevant provisions of the Pharmacy Provider Agreement, whether designated as a "copay", "co-insurance" or "deductible" under the applicable Pharmacy Benefit Plan.
Covered Medication(s)	means those drugs, services, supplies and other items covered and approved by a Pharmacy Benefit Plan.
CPhA	means the Canadian Pharmacists Association.
CPhA pharmacy claim standard (CPhAPCS)	means the standard rules of electronic claim transmission published and updated by the CPhA accepted and approved by Express Scripts Canada. A copy may be obtained by Provider directly from the Canadian Pharmacists Association. https://www.pharmacists.ca/ Phone: 613 523-7877 Fax: 613 523-0445
Days' Supply	means the number of days of treatment relative to the quantity dispensed for Covered Medications.
Deferred Payment Claim	means a claim submitted electronically by the Provider to Express Scripts Canada, without payment by Express Scripts Canada to such Provider; where Members are responsible for full payment of Covered Medications to the Provider and will later be reimbursed by the Sponsor pursuant to the terms of the applicable Pharmacy Benefit Plan.

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Term	Definition
DIN	means the drug identification number specific to a particular drug in Canada.
ESC	means Express Scripts Canada.
Extemporaneous Compound Code	means the code used to designate the applicable compound type (such as an injection, cream, et cetera) for an extemporaneous compound.
Formulary	means the list of certain preferred drugs, services and supplies prepared by ESC for a Sponsor and revised periodically, which prescribers are encouraged to prescribe, pharmacists are encouraged to dispense, consistent with their professional judgment and applicable medical and pharmaceutical laws and procedures, and which Members are encouraged to use.
Identification Information	means the printed identification information issued to the Member pursuant to the applicable Pharmacy Benefit Plan.
Intervention Code	means a code that is required to indicate the reason for overriding a claim rejection or a claim cutback, where applicable, in compliance with the CPhAPCS. Written documentation to support the use of an intervention code is required. This can be documented either directly on the prescription or on the hard copy of the dispensing record or electronic version of the Member's profile, at the time of dispensing.
Manual Claim	means a claim submitted by a Provider in any manner other than electronically through Express Scripts Canada's adjudication system without payment by ESC to said Provider.
Member	means an eligible person and their eligible dependents to whom Covered Medications are available pursuant to a Pharmacy Benefit Plan.
Net Reimbursement or Net Payment	means the amount payable by Express Scripts Canada for an Assigned Claim following a deduction of the Copayment(s)
OPINIONS	means the online Product Identification Number Index of Nova Scotia.
Pharmacy or Pharmacies	means the pharmacy(ies) and/or outpatient pharmacy(ies) listed in EXHIBIT B of the Pharmacy Provider Agreement, as defined in the Pharmacy Provider Agreement. "Provider" and "Pharmacy(ies)" are used interchangeably in this Pharmacy Provider Manual.

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Term	Definition
Pharmacy Benefit Plan	means a health care plan pursuant to which pharmacy benefits are available to Members as provided by a Sponsor pursuant to an agreement with ESC or an ESC client, including any Formulary.
Pharmacy Practice Management System (PPMS)	means the software used by the Provider to submit claims and capture all relevant data when dispensing medication in accordance with the CPhAPCS, the prescription and Express Scripts Canada procedures.
Pharmacy Provider Agreement	means the contract between Express Scripts Canada and a Provider.
Provider	means a Provider bound by the terms and conditions detailed in the Pharmacy Provider Agreement.
Primary Cardholder	means the Member that is the principal beneficiary of a Pharmacy Benefit Plan as indicated on the Identification Information.
Product Selection Code	means the code to indicate the reason for "no substitution" or other reason for the selection of the Covered Medication dispensed included in the CPhAPCS as it may be revised from time to time.
Rate Sheet	means the pricing exhibit(s), attached to the Pharmacy Provider Agreement and incorporated therein as EXHIBIT A, as amended from time to time, which outlines, among other things, the compensation Provider shall receive for Covered Medications provided to Members.
Remittance Advice	means the statement indicating the Assigned Claim(s) adjudicated by the Express Scripts Canada adjudication system during a particular payment cycle for the associated Provider including Net Reimbursement as well as any reversals or adjustments.
Real-Time Processing (RTP)	Has the meaning set forth in section 7.1 of this Pharmacy Provider Manual.
Service Date	means the dispensing date for the Covered Medication.
Sponsor	means any client of Express Scripts Canada (i.e., insurance company, employer or other organization) having principal financial responsibility for payment of Covered Medications provided to Members under a Pharmacy Benefit Plan.

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2. INTRODUCTION

2.1. Purpose

The Pharmacy Provider Manual is a written description of practices, policies, rules, service fees, operational requirements and procedures Providers are to follow as part of the Express Scripts Canada (ESC) provider network when dispensing Covered Medications to Members. The Pharmacy Provider Agreement sets out certain terms and conditions governing the relationship between the Provider and ESC. The obligations in this Pharmacy Provider Manual supplement and are in addition to the terms and conditions of the Pharmacy Provider Agreement. The Pharmacy Provider Manual may be revised from time to time by ESC in its sole discretion.

It is the Provider's responsibility to follow the most recent version of the Pharmacy Provider Manual. For updates to the Pharmacy Provider Manual, Provider will receive a minimum thirty (30) calendar days written advanced notice of change(s) to the Pharmacy Provider Manual. Posting of notice and documents by ESC on the Provider's account on the ESC Pharmacy Provider Website (the "Provider's Account" or "Provider Account") is deemed to meet any of the notice requirements and any requirements for sending communications under the Pharmacy Provider Agreement and this Pharmacy Provider Manual. It is therefore a requirement for the Provider to ensure it has enrolled for access to its Provider Account in order to receive important communications from ESC. Failure to enrol may result in the Provider not receiving important information that may affect its rights and obligations under the Pharmacy Provider Agreement and Pharmacy Provider Manual. The Pharmacy Provider Manual may be accessed through the Provider's Account. Provider's failure to comply with any of the provisions of the Pharmacy Provider Manual shall be considered a breach of the Pharmacy Provider Agreement. If a Provider has any amount owing to ESC for any reason, including but not limited to, unpaid Service Fees as defined in Section 2.6, or by reason of an audit, access to the ESC Pharmacy Provider Website may be limited.

Unless otherwise stated, all sections of the Pharmacy Provider Manual apply to all claim submission methods and all Providers.

2.2. Deleted

This section is intentionally left blank.

2.3. Exemptions

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

This Pharmacy Provider Manual does not apply to any claims processed through the Non-Insured Health Benefits (NIHB) Program for Indigenous Services Canada (ISC). Providers interested in submitting any eligible claims through the NIHB Program can enrol by completing and signing the NIHB Pharmacy Enrolment Package located online at NIHB (express-scripts.ca) or by calling the NIHB call centre at ESC.

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

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2.4. Express Scripts Canada (ESC)

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

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

- Pharmacy benefit management services, including consolidated claims reimbursement;
- Pharmacy network management;
- Provider enrolment services;
- Real-time electronic adjudication of claims;
- Provider communication services;
- Express Scripts Canada Provider Call Centre;
- Audits, investigations, and quality assurance services;
- Clinical programs; and
- Training and education.

2.5. Express Scripts Canada Sponsors (Clients)

ESC adjudicates claims on behalf of these Sponsors:

Client/Carrier ID	Sponsor
02	Manulife
07	Manion
11 & 73	iA Financial Group
15	Non-Insured Health Benefits (NIHB) Program (The NIHB Program is not governed by this Pharmacy Provider Manual)
16	Sun Life
31	Ministère de l'Emploi et de la Solidarité Sociale (MESS)
32	STI Technologies Ltd. (STI)
37	Cowan Insurance Group
40	RWAM
43	Manulife Affinity Markets
49 & 50	GMS - Group Medical Services
53	GPM group benefits
55	belairdirect
90	Empire Life

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2.6. ESC Services and Service Fees

As used in this Section 2.6, and as defined below, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein, except where the context makes it clear that such meaning is not intended:

Term	Definition
Billable Claim	means an accepted (i) Assigned Claim, (ii) Deferred Payment Claim, (iii) Manual Claim (iv) Member submitted claim, (v) claim adjustment made as part of audits, and (vi) any accepted claim reversal.
Billing Cycle	means the interval of time between the sixteenth (16th) calendar day of the previous month to the fifteenth (15th) of the current month where the Service Fees are calculated based on Billable Claims.
ESC Services	means the services offered by ESC to Providers, as detailed in, and pursuant to and subject to the Pharmacy Provider Agreement and this Pharmacy Provider Manual.
Express Scripts Canada Pharmacy Provider Website/ESC Pharmacy Provider Website	means ESC's website for Providers to obtain access details related to their account, ESC information, communications and notices from ESC and ESC Services. Express Scripts Canada Pharmacy Provider Website is available at https://provider.express-scripts.ca.
Reconnection Fee	means the fee of $650 (plus applicable taxes) payable by Provider to ESC to request reconnection within ESC's pharmacy provider network for the provision of ESC Services pursuant to and subject to the Pharmacy Provider Agreement and this Pharmacy Provider Manual.

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Term	Definition
Service Fees	means the monthly service fee (plus applicable taxes) payable by Provider to ESC based on the number of Billable Claims per Billing Cycle, as set out below, for the provision of the ESC Services, subject to the Service Fees Adjustment:

Total Billable Claims per Billing Cycle			Service Fees per Billing Cycle
1	-	40	$25
41	-	50	$50
51	-	60	$75
61	-	70	$100
71	-	80	$125
81	-	90	$150
91	-	100	$175
101	+		$200

As an example, should the Billable Claims volume for a given Billing Cycle be 42, the Service Fee for such period will be $50. Should the Billable Claims volume in the next Billing Cycle be 35, the Service Fee for such period will be $25.

Service Fees Adjustment	means any adjustment to the Service Fees by ESC from time to time in ESC's sole discretion related to the ESC Services provided by ESC.

Note: All prices and dollar amounts are in Canadian dollars and all applicable taxes are extra.

In consideration of the performance of the ESC Services, Provider shall pay to ESC the Service Fees. Provider acknowledges and agrees that any Service Fees payable by Provider to ESC are subject to a Service Fees Adjustment.

The ESC monthly invoices for the Service Fees and applicable taxes will be made available by ESC to Provider through posting in the Provider's Account. Payment for the invoice is due thirty (30) calendar days of the invoice date.

If, at any time, the Pharmacy Provider Agreement is terminated and the Provider is granted reconnection into the ESC pharmacy provider network, in ESC's sole discretion, the Provider shall pay to ESC a Reconnection Fee in advance of reconnection. Notwithstanding the foregoing, no Reconnection Fee shall be payable by Provider for reconnection in the following circumstances: (i) if the Pharmacy Provider Agreement has been terminated by ESC, by sending a non-renewal notice to a Provider; (ii) if the Pharmacy Provider Agreement has been terminated by ESC in its sole discretion, without cause; or (iii) if the Pharmacy Provider Agreement has been terminated by a Provider because of ESC's failure to pay the Provider in accordance with the Pharmacy Provider Agreement or ESC is insolvent, goes into receivership or bankruptcy or any other action is taken on behalf of its creditors.

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3. PHARMACY PROVIDER AGREEMENT

3.1 Pharmacy Provider Agreement

ESC approval and execution of the completed Pharmacy Provider Agreement and its exhibits are required in order to become a Provider on the ESC pharmacy provider network. ESC reserves the right to verify any information provided in the Pharmacy Provider Agreement which may include, but is not limited to, a review of information about the Provider and its personnel who are subject to the rules of a provincial regulatory body ("Regulated Personnel") and other personnel such as owners, directors, officers and shareholders (such Regulated Personnel and others collectively, "Pharmacy Personnel"). Such verification may include, but is not limited to, information available from the relevant regulatory body, which may be cross-referenced with ESC's provider watch list. Notwithstanding the foregoing, any Provider who submits a claim is required to abide by this Pharmacy Provider Manual.

3.1.1 Credentialing/Re-credentialing

ESC frequently re-credentials active Providers to ensure Provider records are accurate, through a review of relevant information, which may include the information available from the relevant provincial regulatory bodies. In cases where the provincial regulatory body information does not match what the Provider has shared with ESC, the Provider is either contacted for a follow-up and/or may be terminated if it is determined that the Provider is in violation of the Pharmacy Provider Agreement.

While credentialing and re-credentialing, ESC may confirm that Regulated Personnel remain in good standing with their applicable governing body. Concerns of professional or proprietary misconduct may be referred to ESC's Fraud Waste and Abuse team for further investigation and may result in Providers being added to ESC's provider watch list. In the event that fraud is suspected, or if the Provider's or Pharmacy's license required to dispense medications is suspended or revoked, immediate termination of the Provider or any Pharmacy's billing privileges may occur.

Failure to update the information in Exhibit B ("Pharmacy Information"), or to comply with any other credentialing/re-credentialing requirements required by ESC within ten (10) calendar days of ESC's request for information may lead to the termination of the Pharmacy Provider Agreement and/or suspension of the Provider or Pharmacy's billing privileges.

3.2 Liability Insurance and Indemnity

The Provider shall obtain and maintain, and shall cause the Pharmacies to obtain and maintain, in full force and effect and throughout the term of the Pharmacy Provider Agreement the insurance requirements described in the Pharmacy Provider Agreement.

3.3 Copayments/No Balance Billing/Same Level Playing Field

In accordance with the Pharmacy Provider Agreement, in no event shall a Provider "balance bill", i.e., charge a Member any amount in excess of the amount that is permitted to be charged under the Rate Sheet, including by charging, collecting a deposit from, or seeking any other fees, taxes/surcharges, or any other compensation other than the applicable Copayment.

In the event the payment by ESC and the applicable Copayment collected from Member for a Covered Medication results in a total reimbursement that is below the "Total Allowable Prescription Reimbursement" as that term is defined in the Pharmacy Provider Agreement, the remaining amount ("Non-Insured Portion") may be submitted by the Provider to the Member's secondary drug plan (through the COB process). If the Member does not have a secondary drug plan or other reimbursement options (i.e., the Pharmacy Benefit Plan managed by ESC is the payer of last resort), the Provider or any

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Pharmacy shall only charge and collect from the Member the "Non-Insured Portion" in accordance with the scenarios listed below. If a Provider, or any Pharmacy, is uncertain if an amount can be charged to the Member, they should contact the ESC Provider Call Centre.

i. The difference between the Pharmacy's allowable Professional Fee under the applicable Rate Sheet and the Professional Fee reimbursed by the Pharmacy Benefit Plan.
   - The CPhAPCS message returned is DH—PROFESSIONAL FEE ADJUSTED.

ii. The difference in ingredient cost and markup for a Covered Medication that is a brand product and for which the Pharmacy Benefit Plan cut back such Covered Medication to the price of the generic or biosimilar reference drug and the Member has decided to remain on the brand product (including scenarios in which the prescriber's choice is "no substitution").
   - The CPhAPCS message returned for a Covered Medication cutback to the price of the generic is D8—INGREDIENT COST REDUCED TO MAXIMUM—ALLOWED—GENERIC PLAN.
   - The CPhAPCS message returned for a "no substitution" claim when the plan is mandatory generic is LC—REDUCED TO GENERIC COST—NO EXCEPTIONS.
   - There is no CPhAPCS message returned for a price cutback due to a Biosimilar reference drug.

iii. The difference in ingredient cost and markup for a Covered Medication for which the Pharmacy Benefit Plan uses a Maximum Allowable Cost (MAC) program (also often referred to as reference-based pricing "RBP").
   - The CPhAPCS message returned is QR—MAXIMUM ALLOWABLE COST (MAC) PAID

iv. The difference in ingredient cost and markup for a Covered Medication for which the Pharmacy Benefit Plan uses a custom Sponsor ingredient cost price file.
   - The CPhAPCS message returned is DJ— DRUG COST ADJUSTED\DRUG COST PAYABLE LESS THAN SUBMITTED

v. Difference in ingredient cost and markup for a Covered Medication when the Days' Supply for the quantity dispensed to the Member is in excess of the maximum Days' Supply permitted by the Pharmacy Benefit Plan (e.g., vacation supply of 180 days but Pharmacy Benefit Plan covers no more than 100 days per claim, submitted Days' Supply is 100 but Pharmacy Benefit Plan covers no more than 34 days at a time, etc.).
   - The CPhAPCS message returned is DM—DAYS SUPPLY EXCEEDS PLAN LIMIT

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

In keeping with the principle of same level playing field, each Pharmacy Provider Agreement with ESC provides that Pharmacies cannot charge more for a Covered Medication than what they charge their cash-paying customers or ESC competitors. As such, the total reimbursement to the Provider by ESC and the Member for the provision of a Covered Medication shall not exceed the amount contracted for or accepted as payment by such Provider from any other private payer or cash-paying customer for that Covered Medication.

ESC regularly reviews claims submitted by Pharmacies to assess compliance with same level playing field obligations and the requirement that there be no balance billing. ESC may actively address any instances related to unequal treatment including, but not limited to, auditing claims for excess pricing passed on to Members, to ensure compliance with the Pharmacy Provider Agreement and this Pharmacy Provider Manual. The relevant claims could be subject to audit and could lead to reversals and/or adjustments.

Please note, preferred provider networks (PPNs) are a benefit management strategy commonly used by our Sponsors and

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set up within our adjudication system. This principle does not prevent Providers from entering into these separate, negotiated arrangements with our Sponsors.

3.4 Effect of Termination

Upon termination of the Pharmacy Provider Agreement for cause or without cause, ESC may take the following actions including but not limited to:

- Termination of other Pharmacy Provider Agreements in which Provider or Pharmacies share common ownership
- Inclusion of Provider's and/or Pharmacy(ies) name in the applicable Sponsor and/or ESC's list of terminated Providers and whether such termination was for cause or without cause
- Notifying ESC Sponsors of the termination, who may in turn notify the Members
- Offset from any amounts owing to Provider and/or Pharmacies or any amounts which the Provider and/or Pharmacies may owe to ESC
- Instill a blackout period in which the Pharmacy Personnel and Provider shall not be allowed to enrol a pharmacy with ESC for a minimum period of one (1) year from the termination of the agreement
- Instill a blackout period in which the pharmacy location, regardless of ownership, shall not be allowed to enrol with ESC for a minimum period of one (1) year from the termination of the agreement

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

4. ENROLMENT AND MODIFICATIONS TO PHARMACY PROVIDER INFORMATION

4.1. Pharmacy Provider Enrolment Process

To start the enrolment process and join the ESC pharmacy provider network, or in the event of an ownership change, please visit the ESC Pharmacy Provider Website at https://provider.express-scripts.ca. Once enrolled, ESC must be notified a minimum of twenty (20) business days in advance of any pharmacy openings or ownership changes. Failure to give ESC adequate notice of openings and/or ownership changes with the required completed documentation may lead to delays in enrolment and/or pharmacies' ability to submit claims.

Once enrolment request is submitted and determined to be in good order, Providers will be asked to complete and sign the Pharmacy Provider Agreement and submit it along with other documentation as may be required by ESC to finalize enrolment.

All pharmacies under the same ownership must be listed in the enrolment request. If the enrolment request is approved by ESC, Providers will receive a unique ESC Provider number for each pharmacy business location they own. This unique Provider number is required on all correspondence with ESC, including but not limited to claims submissions and prior authorizations.

Once finalized, ESC will send an email, advising the Provider or Pharmacy to log into their Provider Account to review their welcome letter and other important information.

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4.2. Modifications to Pharmacy Provider Information

Modifications to the information in Exhibit B/the Pharmacy Information, including changes to business information and pharmacy details, must be submitted via the Provider's Account in the ESC Pharmacy Provider Website.

It is the responsibility of the Provider to notify ESC of any and all modifications in conformity with the following timelines:

- For any modification(s) to pharmacy legal business name, change to sole proprietorship, corporate ownership or partnership, Pharmacy Personnel, or address, Providers must submit a modification to the Pharmacy Information at least twenty (20) business days in advance of the effective date of the modification(s)
- For Pharmacy closures, Providers must notify ESC by modifying their Pharmacy Information at least ten (10) business days in advance of the effective date of the closure to initiate the termination of the Provider number
- For any modification(s) to Pharmacy operating name and/or banner/chain name, Providers must submit a modification to the Pharmacy Information at least ten (10) business days in advance of the effective date of the modification(s)
- For modifications to Pharmacy direct deposit (EFT) information, Providers must submit a modification to the Pharmacy Information at least two (2) business days in advance of the effective date of the change.

For all other modification(s) to information, Providers are responsible for updating their Pharmacy Information. Failure to notify ESC of modifications promptly may impact the Provider's access to ESC Services. When the Provider submits any updates to Pharmacy Information via the ESC Pharmacy Provider Website, they must verify and confirm the accuracy of the remaining information.

For changes to the Provider's or any Pharmacy's required federal, provincial and local licenses, certificates and permits that are necessary to allow each Pharmacy to dispense to Members, Providers must notify ESC immediately.

5. DISPENSING QUANTITIES AND UNITS OF MEASURE

Where applicable to the Pharmacy Benefit Plan, Covered Medication may be classified as maintenance or non-maintenance to determine the maximum allowable Days' Supply for each medication. For a new course of treatment or for the first four (4) months of coverage (whichever criterion is specified by the Pharmacy Benefit Plan), the same maximum allowable Days' Supply generally applies to all Covered Medication regardless of their eventual classification as maintenance or non-maintenance medication.

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

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

- The quantity prescribed; or
- 34-Days' Supply, if this limit is specified by the Pharmacy Benefit Plan

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

For long-acting maintenance medications, Providers can submit a Days' Supply greater than 90 days. This will enable Providers to maintain accurate patient pharmacy records and is in alignment with provincial directives and EMR requirements. Days' Supply should be reflective of the prescribed dosing interval and in accordance with the professional

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judgement of the dispensing pharmacist. The relevant claims could be subject to audit and could lead to reversals and/or adjustments. According to the current CPhAPCS, the allowed maximum Days' Supply is 999.

Note: Maximum allowable Days' Supply specifications do not apply to compound claims.

5.1. Extended Supply—Vacation Supply

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

5.2. Lost, Stolen or Damaged Medication

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

5.3. Compliance Packaging and Frequent Dispensing

When not documented on the original prescription by the prescriber, ESC requires that a Frequency of Dispensing form (Appendix D) is completed, at least annually, and retained by the Provider for each patient requiring compliance packaging or dispensing of maintenance medications more frequently than every ninety (90) days. Unless directed by the prescriber, ESC will only reimburse one (1) fee every twenty-eight (28) days for maintenance medications.

For audit and investigation purposes, the Provider must clearly identify who is requesting the compliance packaging. General letters requesting frequent dispensing/compliance packaging will not be accepted during an audit or investigation and claims will be subject to adjustments or reversals through ESC's Fraud, Waste and Abuse Program.

5.4. Pack Sizes and Units of Measure

ESC may refer to provincial formularies or a Formulary when determining units of measure in the ESC adjudication system. In particular, certain DINs require the use of specific units of measure to avoid improperly submitting claims relative to the wrong unit of measure. Improperly submitted claims may be subject to claim adjustments, claim reversals and the recoupment of reimbursement, through ESC's Fraud, Waste and Abuse Program. A comprehensive list of units of measure updates may be accessed via the ESC Pharmacy Provider Website. Providers must be diligent when submitting claims for all medication including medication dispensed in packages (e.g., inhalers, oral contraceptives and vaccines).

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

6. PRESCRIPTION SAVINGS CARDS

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

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

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

7. ADJUDICATION SYSTEM OVERVIEW

7.1. Real-time Processing

Real-Time Processing (RTP) refers to the capacity of the Express Scripts Canada (ESC) electronic system to receive, process and return the adjudication results of Provider claims automatically

7.2. Adjudication System Functionality

The ESC adjudication system processes any electronic claim transmitted through the Provider's PPMS and returns a response indicating whether the claim was successfully adjudicated or not. The adjudication response is transmitted using the format specified by the current CPhAPCS.

7.3. Variations in Pharmacy Practice Management Systems (PPMS)

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

8. COORDINATION OF BENEFITS (COB)

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

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

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

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on the outstanding claim amount.

When the ESC adjudication system determines that a COB is required, the previously paid field CPhAPCS must be populated by the Provider with a previously paid amount even if the previously paid amount is $0.00. COB in the ESC adjudication system, whether private or provincial, only occurs when all portions of the same claim including previously paid portions are made by electronic claim submission. Improperly submitted claims with an incorrect use of DA and/or DB Intervention Codes may be subject to claim adjustments or reversals through ESC's Fraud, Waste and Abuse Program.

8.1. Provincial/Territorial and Private COB

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

Please note that claims fully covered by National Pharmacare should not be submitted to ESC for reimbursement. Claims partially covered by National Pharmacare may be coordinated with ESC. Improperly submitted claims may be subject to claim adjustments, claim reversals and the recoupment of reimbursement, through ESC's Fraud, Waste and Abuse Program.

8.2. Private and Private COB

When the ESC adjudication system sends back a CPhA code indicating that a private COB required, the DB intervention code must be included by the Provider when submitting the claim to ESC for adjudication.

If both private and provincial COB is required for a claim (i.e., a Sponsor is the third payer in a situation that already involved a provincial payer and/or private payer as first and second payers), the DB intervention code must be used by the Provider (rather than the DA intervention code) when submitting the claim to ESC.

8.2.1. COB—Coverage Termination

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

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

8.2.2. COB—Spouse or Dependent

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

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

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

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

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

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

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

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

Coordination of benefit claims are audited through ESC's Fraud, Waste and Abuse Program and subject to adjustments due to incorrect payer submissions and/or inflated prescription costs passed on to ESC and/or the Member.

9. PRIOR AUTHORIZATIONS AND LIMITATIONS

9.1. Prior Authorizations

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

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

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

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indicates the procedures for obtaining prior approval, as applicable:

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

9.2. Coverage Limitations

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

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

Member-specific Limitations

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

Limitation	Scenario
Copayment	As defined in section 1 of this Manual
Coinsurance	A percentage per prescription that the Member is responsible for paying out-of-pocket for a Covered Medication, relative to the Pharmacy Benefit Plan.

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Limitation	Scenario
Deductible	Cumulative fixed dollar amount to be paid by the Member (Primary Cardholder, spouse, or dependent[s]) before the Sponsor assumes any portion of the cost of the Covered Medication. Several classes of deductibles exist including but not limited to: • Individual—each individual in a family must satisfy a fixed amount. • Family—all individuals in a family accumulate toward the fixed amount. • Combined—each individual in a family accumulates an individual deductible, and each individual's deductible accumulates towards the family deductible.
Limited dispensing fee	The limited dispensing fee feature allows for the reimbursement of dispensing fees on claims up until the Member has met the limit on the number of paid dispensing fees as determined by the Pharmacy Benefit Plan design for a specific DIN for that Member in a defined period. Once this limit is reached, dispensing fees on all subsequent adjudicated claims will not be reimbursed by the Pharmacy Benefit Plan (For example 4 dispensing fees covered in a 12-month period for a maintenance drug). Covered Medications that may result in noncompliance issues (e.g., antipsychotics) may be exempt from limited dispensing fees feature. Covered Medications exempt from limited dispensing fees feature should not have the limited dispensing fee feature in the ESC adjudication system.
Other Member-specific limitations	Limitations can also apply to quantity, specific DIN, Days' Supply, etc., for different Members based on the Member's profile or medication history.

10. CLAIMS SUBMISSION PROCESS

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

10.1. Claims Submission Requirements—General

10.1.1. Prescription Documentation Requirements

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

- Date of authorization by the prescriber;
- Member's complete name;

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

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

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

10.1.2. Prescriptions for Diabetic Supplies

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

10.1.3. Product Selection Code Requirement

Subject to applicable laws and regulations in the province or territory of practice, the use of Product Selection Codes (see section **Error! Reference source not found.** Product Selection Codes for additional information) must be supported by appropriate documentation on the original prescription.

10.1.4. Intervention Code Requirement

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

10.1.5. Prescriber ID/Reference Number Requirement

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

10.1.6. Pharmacist Prescribing Requirement

Prescriptions must meet the documentation requirements listed in section 10.1.1 and must be prescribed by a pharmacist meeting the following conditions:

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

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10.1.7. Actual Days' Supply Requirements

The actual Days' Supply must be indicated on each claim taking into consideration Member dialogue and professional discretion when prescription directions are not specific. If exact directions are not provided by the prescriber (e.g., if the prescriber indicates "as directed" or "prn"), Pharmacy shall contact the prescriber or make a reasonable assessment and submit the Days' Supply based on:

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

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

For claims submissions exceeding $9,999.99, the Days' Supply for the total quantity dispensed, must be used for each split claim.

10.2. Real-Time Processing (RTP) Claim Submissions

RTP claims may be submitted electronically by the Provider up to ninety (90) days from the service date. The following information must be indicated when submitting an RTP claim through the ESC adjudication system:

Type of information	Description
Member information	Always refer to the Identification Information when submitting a claim. All numbers (e.g., group number, carrier number, Member ID alphanumeric number) should match the exact number of digits on the Identification Information, including leading zeros and trailing zeros.
Relationship code	Confirm that the appropriate relationship code is entered for the Primary Cardholder, spouse, or dependents respectively. Where applicable, ask the Member to verify that the spouse or dependent is covered by the Pharmacy Benefit Plan.
Drug information	Include the DIN of the submitted medication, quantity dispensed, the Days' Supply, the drug and compounding costs, the professional fee and the prescription number. ESC accepts provincial/territorial drug plan pseudo-DINs including OPINIONS pseudo-DINs.
Prescriber information	ESC requires that Pharmacies provide valid prescriber ID and prescriber ID reference information as assigned by the respective provincial/territorial regulatory authority in accordance with CPhA standards.
Claim amount	Refers to the total amount billed for a specific submitted medication in a specific quantity including the drug cost, markup and professional fee.

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

10.3. Deferred Payment Claims Submissions

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

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10.4. Claims Submissions Exceeding $9,999.99

Claims over $9,999,99 can be submitted via RTP through the ESC adjudication system. As a reminder, the following scenarios apply when submitting an electronic claim over $9,999.99:

- Split the claim amount into equal amounts such that each resulting amount is less than $9,999.99
- Split the quantity submitted the same number of times as the claim amount
- Submit each subsequent claim resulting from the split with a dispensing fee of $0.00
- Indicate a unique Rx/Tx number for each split claim
- The ESC adjudication system will automatically generate a new claim reference number for each split claim
- A claim rejection will occur for each subsequent claim because the system recognizes each subsequent claim as a duplicate claim
    - Use the following CPhA intervention code to override the duplicate claim rejection: MP—VALID CLAIM—VALUE $1,000.00 TO $9,999.99

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

10.4.1. Markup/cost upcharge on claims over $9,999.99

Claims over $9,999.99 must be submitted in accordance with the appropriate Rate Sheet(s).

For provinces where the wholesale markup is included in cost (ON, BC, MB, SK and NL):

- Markup should be submitted on the first claim up to the maximum allowed. Subsequent claims should not be submitted with a markup.

For the remaining provinces/territories (NS, NB, AB, PE, NWT, NU, YK):

- Markup #1 must be split equally per split claim and submitted with the drug cost
- Markup #2 (where applicable) should be submitted on the first claim up to the maximum allowed

10.4.2. Coordination of Benefits

A Provider must ensure that the applicable CPhA intervention codes are used on each split claim to indicate the kind of COB that applied to the service: DA—SECONDARY CLAIM—ORIG TO PROV PLAN

DB—SECONDARY CLAIM—ORIG TO OTHER CARRIERS

For all subsequent split claims in a COB scenario, the MP intervention code (MP—VALID CLAIM—VALUE $1,000.00 TO $9,999.99) is used by the Provider in addition to the applicable COB CPhA intervention code(s) (DA/DB).

For instance, if only a provincial COB applied to the claim, the first split claim is submitted by the Provider with the DA intervention code while subsequent split claims associated with the same dispensed medication are submitted with both the DA and MP intervention codes.

10.4.3. Reversals

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

- To reverse the first split claim, all subsequent claims must be reversed **prior to** reversing the first claim. For instance, if there are four split claims associated with the same dispensed medication and the first split claim needs to be reversed, all three subsequent split claims must be reversed **prior to** the first split claim. Failure to reverse claims in this order will result in a rejection of the claim reversal.

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- To reverse a subsequent split claim, the applicable claim(s) can be reversed without reversing all preceding claims.
- If an error message is received such as [E4] ADJUDICATOR TIME OUT ERROR, [D9] CALL ADJUDICATOR or any other host time out system messaging while processing a reversal, please call the ESC Provider Call Centre to ensure the claim has been properly reversed. Failure to do so may lead to a further review from ESC's Fraud Waste and Abuse Team.
- To ensure the accuracy of claims submissions and reversals, check the ESC Provider Remittance Advice and compare against the pharmacy records. If there is any discrepancy, it is the Provider's obligation to contact ESC to rectify any reconciliation issues.

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

10.4.4 Submitting Manual Claims over $9,999.99

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

For instance:

- If the total amount submitted by the Provider represents three whole units of $9,999.99 (i.e., three units or more but less than four units), the quantity submitted is split into three equal parts. One whole unit of $9,999.99 results in one unit increase in the number of quantity splits.
- The Remittance Advice displays each split quantity in the quantity column as a distinct claim associated with a distinct Rx number.

For any claim exceeding $9,999.99, Provider must submit the claim using the claim form for medications over $9,999.99 (available at https://provider.express-scripts.ca) via fax or mail.

Contact resources for claims over $9,999.99	Contact
Fax	1 844 744-8433
Mail	Express Scripts Canada Attention: Health Claims & Administration 6985 Financial Drive, Suite 300 Mississauga, ON L5N 0G3

Alternatively, the Member may pay for the claim and submit the claim information and receipts directly to the Sponsor for reimbursement, where applicable. ESC does not accept any liability for the coverage of manual claims submitted by Providers. Claims are reimbursed according to the Pharmacy Benefit Plan for that Covered Medication for that Member.

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11. CLAIM REIMBURSEMENT PROCESS

11.1. Provider Reimbursement

ESC shall pay the Provider by electronic funds transfer to a bank account designated by the Provider, within ten (10) business days of such claims.

The Provider will receive reimbursement for:

- Assigned Claims provided in relation to a Covered Medication.
- Other reimbursable claims, as detailed in the applicable Pharmacy Provider Agreement, any amendments to the same and this Pharmacy Provider Manual. Applicable Copayments and reversals and/or adjustments conducted during that payment cycle will be subtracted from such reimbursements (the resulting amount is referred to as a Net Reimbursement or a Net Payment).

11.2. Reimbursement Schedule

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

11.2.1. Reimbursement Method

Direct deposit (electronic funds transfer [EFT]) is an environmentally friendly method for depositing Provider claim reimbursements. It is the only reimbursement method for Providers. Providers must update direct deposit (EFT) information using the Pharmacy information section of the ESC Pharmacy Provider Website at least two (2) business days in advance of the desired effective date of the change. For more information on modifications to Pharmacy Information, including updates to direct deposit (EFT), please refer to section 4.2 of this manual.

11.2.2. Remittance Advice

The Remittance Advice is a statement summarizing any Assigned Claim(s) adjudicated during the associated payment cycle, including reversals and/or adjustments conducted during that payment cycle. The Remittance Advice also includes CPhA response codes associated with processed Assigned claim(s), where applicable. The Remittance Advice will be posted on the Provider's Account on the ESC Pharmacy Provider Website. The Provider must ensure they have enrolled for access to their Provider Account. A sample Remittance Advice has been provided in Appendix A.

11.2.3. Reimbursement Errors

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

11.3. Extemporaneous Preparations/Compound Claim Submissions Guidelines

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

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A list of pseudo-DINs corresponding to active ingredients used for compounding will be available for viewing on the Provider's Account on the ESC Pharmacy Provider Website. For compound claim submissions, indicate the DIN or pseudo-DIN of the highest cost eligible ingredient and the Extemporaneous Compound Code corresponding to the medication type.

All extemporaneous preparations are subject to reversals or adjustments for excessive costs, markups and/or fees through ESC's Fraud, Waste and Abuse Program. It is the Provider's responsibility to ensure all requirements noted in this section are appropriately documented at the time of dispense.

When an extemporaneous mixture is purchased from another Provider/manufacturer, the dispensing Provider is not eligible for a compounding fee. The dispensing Pharmacy charge their usual and customary fee, and eligible markup as identified in their applicable provincial rate sheet. The cost of the mixture submitted should be up to a maximum of the amount on the invoice. Invoices for purchased compounds are reviewed and are subject to reversals and/or adjustments through ESC's Fraud, Waste and Abuse Program.

11.3.1. Eligible compounds

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

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

11.3.2. Ineligible compounds

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

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

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

**Please see Appendix C—Ineligible Ingredients, Bases and Formats for Compound Preparations for a list of ineligible bases, ingredients and dosage formats. Please be advised that this list is not exhaustive and may be updated at ESC's discretion at any time.

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

11.3.3. Mixture breakdown requirements

ESC considers the following as requirements of the mixture breakdowns for eligible compounds, which are subject to full reversals through ESC's Fraud, Waste and Abuse Program:

- Name and expiry of raw material
- Source*
- Drug identification number (DIN) and lot number, as applicable*
- Name, strength and dosage of preparation*
- Date of preparation
- Quantity required and quantity actually weighed of each ingredient
- Total quantity prepared*
- Initials of compounder responsible for the preparation and pharmacist who verified the preparation
- Initials of the person who performed quality control procedures*
- Written formula used
- Cost charged for each ingredient
    - *Please note: compounding supplies/equipment are NOT acceptable ingredients and will not be reimbursed (some examples include but not limited to: gloves, glassware, lab coats, flavoring agents, etc.)*
- Assigned prescription or preparation batch number*
- Cost charged for each ingredient
- Mixing time charges (if applicable)
- Assigned prescription or preparation batch number*
- Assigned beyond use date*
- Original authorizing prescription
- Results of quality control procedures as appropriate*
- Documentation of any quality control issues and/or issues reported by the patient or caregiver*
- If preparation made by another pharmacy, name and details of pharmacy*
- Any other documentation required by provincial authority
- If purchasing in bulk, stability and expiration of compound must be appropriately documented

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

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

11.3.4. Compounding Commercially Available Products

If a compound duplicates a commercially available product, the Pharmacy Benefit Plan will not cover the compound. However, if the commercially available product is out of stock/back-ordered or not available, the Pharmacy Benefit Plan will cover compound preparations until the commercially available product becomes available again. The Provider must maintain a record of the commercial drug backorder at the time of compounding the back-ordered drug.

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

11.3.5. Unlisted Compound Codes

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

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

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

11.3.6. Reimbursement Guidelines for Compounded Covered Medications

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

Providers operating in all other provinces and territories should refer to the Rate Sheet included in their Pharmacy Provider Agreement where applicable. Copies of the current Rate Sheet(s) may be made available upon request to ESC.

Compounding ingredient costs, markups and fees should be submitted in separate fields. Additional compounding fees or charges are not accepted and subject to full reversals and/or adjustments through ESC's Fraud, Waste and Abuse Program.

11.4. Methadone and Buprenorphine/Naloxone Claim Submissions

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

- Do not include a compound code;
- Indicate the Day's Supply and the number of milligrams (mg) if using powder form or the volume in milliliters (mL) if using liquid form (e.g., Methadose™);
- Do not add an additional compounding fee above and beyond the Provider's usual and customary fee (i.e., professional fee);
- Where requested by ESC, provide documentation logs including a chain of signatures that indicate the doses were dispensed (both those witnessed and/or carried). Failure to provide all necessary documentation may lead to reversals or and/adjustments through ESC's Fraud, Waste and Abuse Program;
- Submit one usual and customary fee for any witnessed dose and one usual and customary fee for the group of carries (take-home doses). For instance, if a Member is prescribed one witnessed dose and six carries, the pharmacy must submit no more than two fees: one for the single witnessed dose and one for the six carries.

Excess fees charged directly to the Member constitutes balance billing and will warrant further investigation from ESC's

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Fraud, Waste and Abuse Program.

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

12. CLAIM REVERSALS

12.1. Electronic Claim Reversals

RTP claim reversals can be used to reverse a previously submitted electronic Assigned Claim that has already been reimbursed. RTP Assigned Claims can be reversed by the Provider via the ESC adjudication system if the reversal is made within ninety (90) calendar days of the Service Date, as per the CPhAPCS.

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

Assigned Claims which were approved for payment by ESC and not picked up by the Member, in whole or in part, must be reversed within fourteen (14) calendar days from the date of submission of the claim by the Pharmacy.

12.2. Deferred Payment Claim Reversals

RTP claim reversals can be used to reverse a previously submitted electronic Deferred Payment Claim. RTP Deferred Payment Claims can be reversed by the Provider via the ESC adjudication system if the reversal is made within two (2) calendar days of the Service Date, as per the CPhAPCS.

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

Deferred Payment Claims which were approved for payment by ESC and not picked up by the Member, in whole or in part, must be reversed within two (2) calendar days from the date of submission of the claim by the Pharmacy.

12.3. Manual Claim Reversals

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

13. PROGRAMS

Where applicable to the Pharmacy Benefit Plan design, the following programs may apply to a claim:

13.1. Provincial Integration Program

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

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

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

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

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

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

13.2. Drug Utilization Review

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

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

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

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

The two tables below describe:

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

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

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

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

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DUR CPhAPCS Intervention Code	Scenario
UA	Consulted prescriber and filled Rx as written.
UB	Consulted prescriber and changed dose.
UC	Consulted prescriber and changed instructions for use.
UD	Consulted prescriber and changed drug.
UE	Consulted prescriber and changed quantity.
UF	Patient gave adequate explanation. Rx filled as written.
UG	Cautioned patient. Rx filled as written.
UI	Consulted other source. Rx filled as written.
UJ	Consulted other sources, altered Rx and filled.
UN	Assessed patient, therapy is appropriate.

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

13.3. Step Therapy Program

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

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

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

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

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

13.3.1. Step Therapy Cognitive Fee

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

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

Providers submit their usual and customary cognitive service fees and the ESC adjudication system will adjudicate the claim according to Pharmacy Benefit Plan design. Step therapy cognitive fee reimbursements vary according to Pharmacy Benefit Plan design.

ESC may conduct a post adjudication review of the step therapy cognitive fee payment to verify the validity of the claim.

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13.4. Opioid Management Program

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

13.4.1. Opioid Management Program—Long-acting opioid module

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

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

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

13.4.2. Opioid Management Program—Short-acting opioid module

For an initial fill of a short-acting opioid, a seven (7) Days' Supply limit applies. If a claim is submitted for an initial fill of a short-acting opioid that exceeds the seven-Days' Supply limit and a Member is determined to be opioid naïve, the claim will be cut back to the seven-Days' Supply limit with the following CPhAPCS response code: OF—INITIAL RX DAY SUPPLY EXCEEDED. Provider is to dispense a seven-Days' Supply.

13.4.3. Opioid Management Program—Intervention Codes

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

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

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

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

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

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To obtain a CPhAPCS intervention code for reasons other than those indicated above or have further questions, call the ESC Provider Call Centre.

14. PRICING FUNCTIONALITIES

14.1. Maximum Allowable Cost (MAC)

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

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

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

14.2. Substituting Medication

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

14.2.1. Mandatory Generic Substitution

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

14.2.2. Standard Generic Substitution

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

14.2.3. Product Selection Codes

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

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

CPhAPCS Product Selection Code	Product Selection Rationale	Scenario
1	Prescriber's Choice	The prescriber indicated no substitution on the prescription. On verbal prescriptions: "No substitution" must be written along with the date it was authorized by the prescriber. On written or electronic prescriptions: the prescriber must indicate "No substitution" on the document.
2	Patient's Choice	The Member specified "no substitution" or has selected a specific interchangeable medication in writing or by initialing a written or printed statement.
3	Pharmacist's Choice	The dispensing pharmacist chose not to substitute the medication on a prescription or has selected a specific interchangeable medication when the prescription is written without the "no substitution" stipulation.
4	Existing Therapy (prescription renewal)	The dispensing pharmacist chose to continue the use of a brand name or generic medication where variance in the choice of medication may adversely affect treatment.
Blank	Information is not required	The product selection code is not needed.

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

15. FRAUD, WASTE AND ABUSE (FWA) PROGRAM

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

- Detect and address inappropriate billing practices
- Address billing irregularities
- Address high abuse and/or fraudulent claim submission patterns and billing practices
- Ensure compliance to the Pharmacy Provider Agreement

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- Ensure that Providers have retained appropriate documentation to support submitted claims
- Confirm paid prescriptions and/or services were received by Members and ensure that Members are not billed excessive costs from Providers
- Educate Providers on billing practices that align with ESC's policies and procedures, as outlined in our Pharmacy Provider Agreement and Pharmacy Provider Manual.

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

ESC or a third party authorized by ESC can audit and/or investigate any claim documents that a Provider is required to maintain for the document retention period required by any federal or provincial laws and/or provincial college requirements, whichever period is longer. When risk(s) are detected for a Provider's location, any new Provider enrolments associated with the same ownership group during an audit or investigation may be delayed.

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

15.1. Provider Responsibility for audits and investigations

The Provider must cooperate with ESC in all audit and investigation activities.

Upon request, Provider shall permit, and shall cause the Pharmacies to permit, ESC or a third party authorized by ESC to inspect, review, audit and reproduce, during regular business hours and without charge, any of the Provider records pertaining to ESC, Members or the Pharmacy Provider Agreement as ESC deems necessary to determine compliance with the terms of the Pharmacy Provider Agreement. Failure to comply with any ESC audit process will result in reversal of all applicable paid claims and may result in termination of the Pharmacy Provider Agreement. ESC has the right to offset against any amounts owing to Provider with any such amounts owing or potentially owed to ESC for discrepant or unsubstantiated claims or other audit-related costs. The methods used to collect amounts due hereunder to ESC as a result of audit discrepancies or unsubstantiated claims may include, but are not limited to, an offset against Provider's and/or Pharmacy(ies')' account payable.

Providers must respond to all audit and investigation requests within the defined timelines.

Failure to comply with any ESC audit and investigation processes and procedures may result in an adjustment, reversal, recovery of any impacted claim reimbursements and/or the termination of the Pharmacy Provider Agreement, as well as the suspension or termination of billing privileges on ESC's network.

15.2. Audits

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

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

- Educate Providers on expected practices/policies and monitor future claims submission to identify change in behaviours
- Recovery of funds and adjustments to claims
- Escalation to an investigation if additional abusive or fraudulent risks are identified

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- File a formal complaint with the applicable provincial College of pharmacy professionals, board or association associated with the Provider
- Suspension of billing privileges from participating in any Sponsor's Pharmacy Benefit Plan
- Termination of the Pharmacy Provider Agreement.

ESC may conduct any of the following audits described in the following sections.

15.2.1. Claim Verifications

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

For all other claims selected for audit, ESC may send an audit request form, seeking a copy of the prescription hard copy of the dispensing records, invoices and any other supporting documentation as required. Electronic prescriptions must contain all necessary information required for ESC to validate the claim. Providers have one (1) business day from the date indicated on the audit request form to provide the requested documentation. Complete, legible, unaltered, full-page view documentation is required. If the required documentation is not submitted for review by the due date indicated on the request, or if errors are detected during the audit, ESC will adjust or reverse the claim(s) in question. Accordingly, Providers must ensure that they have enrolled for access to their Provider Account, as otherwise, audit requests be missed. The amount owing will be offset against the Provider's account payable. Details of all adjustments and/or reversals will appear on the Remittance Advice. Providers can generate reports on their Provider Account on the ESC Pharmacy Provider Website that will help them understand and respond to claim adjustment and/or reversals. Providers will have ten (10) calendar days from the date of notification to appeal an adjustment or reversal. Appeals will not be accepted beyond this timeline. The ESC Pharmacy Provider Website contains an Appeal Eligibility Inquiry feature for Providers to confirm if an adjusted or reversed claim is eligible for an appeal.

The reports that may be generated through the Provider's Account on the ESC Pharmacy Provider Website include:

- Summary of ESC Claim Adjustments and Reversals: A weekly report that summarizes the claim adjustments and reversals performed by Express Scripts Canada
- Summary of Appeals: A weekly report that summarizes the appeals processed
- Monthly Claim Verification Success Rate: A monthly report that presents the number of audited claims and the percentage of claims accepted, after accounting for appeals
- Claim Adjustments due to Pack Size – Monthly Results: A monthly report that presents the number of claims adjusted due to pack size concerns
- Claim Reversals due to No Replies – Monthly Results: A monthly report that presents the percentage of claims reversed due to no replies
- Claim Adjustments or Reversals due to Insufficient Documentation – Monthly Results: A monthly report that presents the number of claims adjusted or reversed due to insufficient documentation

15.2.2. Written Desk Audit

During a written desk audit, a request for documentation for a selection of claims is sent to the Provider. Additional claims may be requested beyond the initial selection if deemed necessary by the auditor. Once the review of the documentation is complete, ESC will send the Provider a written audit report. For further information regarding audit response guidelines and timelines please refer to section 15.2.4. Desk and On-site Audit Response Guidelines and Timelines.

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15.2.3. On-site Audit

During an on-site audit, ESC or a third party authorized by ESC, will visit the Provider's location to inspect, review, and analyze the Provider's records for a selection of claims and/or additional claims as may be deemed necessary by the auditor. Mutually acceptable dates and times will be prearranged. Once ESC has completed the review of the on-site documentation, a written audit report is compiled and sent to the Provider. For further information regarding audit response guidelines and timelines please refer to section 15.2.4. Desk and On-site Audit Response Guidelines and Timelines.

15.2.4. Desk and On-site Audit Response Guidelines and Timelines

Once the written audit report has been sent:

- If ESC does not invite a response, the report is considered final and payment is due within fourteen (14) calendar days. Rather than receiving payment from the Provider, ESC may adjust or reverse any claims identified as improper within the audit report.
- Where ESC has invited the Provider to respond to the written audit report, a response must be received within fourteen (14) calendar days of the date the report was sent. ESC will assess the response and any additional documentation provided, and a final audit report will be sent to the Provider. Should there be an amount owing, payment is due within fourteen (14) calendar days from the date ESC sends the final audit report. Rather than receiving payment from the Provider, ESC may adjust or reverse any claims identified as improper in the audit report.

ESC will not accept the following additional documentation for review:

- Supporting documentation not provided by the response due date;
- Purchase invoices not provided by the response due date;
- Documentation to support claims that was not provided during the on-site audit or following the initial request for a written audit (i.e., physician/prescriber authorization, rationale for dispensing a different quantity etc.).
- Overcharges (i.e., excessive markups exceeding provincial level) are not an acceptable reason to appeal the findings of an audit.

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

15.3. Investigations

ESC may conduct an investigation if there is suspicion of high abuse or fraud from a Provider at ESC's sole discretion. ESC may suspend or terminate the Provider's ability to submit claims or immediately place a withhold on all payments to the Provider as a result of ESC's suspicion, regardless of whether or not an investigation has concluded.

At the conclusion of an investigation, if ESC determines there is evidence of high abuse and/or fraud, ESC reserves the right to immediately suspend or terminate the Provider's ability to submit claims on ESC's network, place an immediate hold on any and all Provider reimbursement, share the ongoing information or results of the investigation with its clients, law enforcement and/or other appropriate parties. At the conclusion of an investigation where withheld claim payments are deemed in excess of the claims identified for recovery in the final audit report, the excess amount is disbursed to the Provider.

If ESC determines that a Provider has: (i) refused to cooperate in an investigation; (ii) acted in an inappropriate manner; (iii) caused any claim to be submitted inaccurately under false pretenses; and/or (iv) engaged in inconsistent billing patterns, ESC reserves the right to exercise, without limitation, any and all of the following options in addition to those provided for in section 3.4 **Error! Reference source not found.** and those provided by law including:

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- Reversing the applicable claim(s) and recover the amount(s) paid.
- Requiring immediate reimbursement from the Provider.
- Withholding all future amounts payable to the Provider until sufficient funds are withheld to satisfy the amount owing.
- Filing a formal complaint with the applicable provincial College of pharmacy professionals, board or association associated with the Provider;
- Initiating collection efforts to recover any amounts payable;
- Immediately terminating the Pharmacy Provider Agreement with the Provider; and/or
- Contacting law enforcement to report ESC's investigation findings.

ESC may conduct any of the following investigations described in the following sections.

15.3.1. Written Desk Investigation

During a written desk investigation, a selection of claims are flagged and a request for documentation pertaining to those claims is sent to the Provider. Additional claims may be requested beyond the initial sample if deemed necessary by the investigator. Once the review of the documentation is complete, ESC will send the Provider a written investigation report. For further information regarding investigation response guidelines and timelines please refer to section 15.3.3. Investigation Response Guidelines and Timelines.

15.3.2. On-Site Investigation

During an on-site investigation, ESC or a third party authorized by ESC, will visit the Provider location to inspect, review, and analyze the Provider's records for a selection of flagged claims and/or additional claims as deemed necessary by the investigator. ESC may not provide advance notice. Once the review of the on-site documentation has been completed, a written investigation report is compiled and sent to the Provider. For further information regarding investigation response guidelines and timelines please refer to section 15.3.3. Investigation Response Guidelines and Timelines.

15.3.3. Investigation Response Guidelines and Timelines

Once the written investigation report has been sent:

- If ESC does not invite a response, the written investigation report is considered final and payment is due within the seven (7) calendar days. Rather than receiving payment from the Provider, ESC may adjust or reverse any claims identified as improper within the investigation report.
- In cases where ESC has invited the Provider to respond, a response must be received within seven (7) calendar days. ESC will assess the response and any further documentation provided, and a final investigation report will be sent to the Provider. Should there be an amount owing, the Provider is required to submit payment within seven (7) calendar days from the date ESC sends the final report. Rather than receiving payment from the Provider, ESC may adjust or reverse any claims identified as improper within the investigation report.

ESC will not accept the following additional documentation for review:

- Supporting documentation not provided by the response due date;
- Purchase invoices not provided by the response due date;
- Documentation to support claims that was not provided during the on-site audit or following the initial request for a written audit (i.e., physician/prescriber authorization, rationale for dispensing a different quantity etc.).
- Overcharges (i.e., excessive markups exceeding provincial level) are not an acceptable reason to appeal the findings of an investigation.

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15.4. Additional Audit and Investigation Activities

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

15.4.1. Member Verification

Member verification letters are sent to Members to validate service dates, receipt of prescriptions and/or services paid, specific claim information and any other relevant information.

15.4.2. Prescriber Verification

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

15.4.3. Purchase invoices

For audit and investigation purposes, ESC may request purchase invoices to validate claims billed to ESC. Failure to provide purchase invoices may result in claim reversals and/or adjustments.

15.4.4. Bin checks

During on-site audits and investigations, ESC may request Providers to retrieve prescriptions that were filled more than fourteen (14) days prior, or prescriptions for Deferred Payment Claims that were filled more than two (2) days prior. Any such prescriptions that are still with the Provider waiting to be picked up are required to be reversed during the on-site audit or investigation.

15.4.5. Post Assessment Ranking

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

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

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MINOR* (low to moderate risk) 1 - 54	MODERATE TO SIGNIFICANT* (moderate to high risk) 55 - 89	SEVERE* (high/fraud risk) >90
• Recover on incorrect/discrepant claims submissions • Provide education on ESC claim submission policies • No further action required	• Recover on incorrect/discrepant claims submissions • Provide education on ESC claim submission policies • Providers may be monitored for claims submission behaviours • Providers may be re-audited or subject to an investigation within twelve (12) months. • Issue letter of concern/complaint to regulatory College (if necessary) • Terminated from network if fraud or high abuse is confirmed	• Recover on incorrect/discrepant claims submissions • Issue letter of complaint to regulatory College • Contact law enforcement (if necessary) • Provider/owners are added to ESC's Do-Not-Register (DNR) list for a minimum period of one year • Terminated from network if fraud or high abuse is confirmed

*Includes but not limited to

15.5. Fraud Tip Line

Everyone pays for fraud and we all have a role to play in combatting it. If you suspect fraudulent activity is occurring, we encourage you to report it. With your help, ESC can help reduce fraud and continue our anti-fraud efforts.
Fraud Tip Hotline: 1 888 677-0111, ext. 64227

16. CONTACT US
Contact Information

Pharmacy Providers can contact ESC and access resources via the Express Scripts Canada Pharmacy Provider Website: https://provider.express-scripts.ca.

For phone, fax, and mail information, please visit: https://express-scripts.ca/contact-us

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

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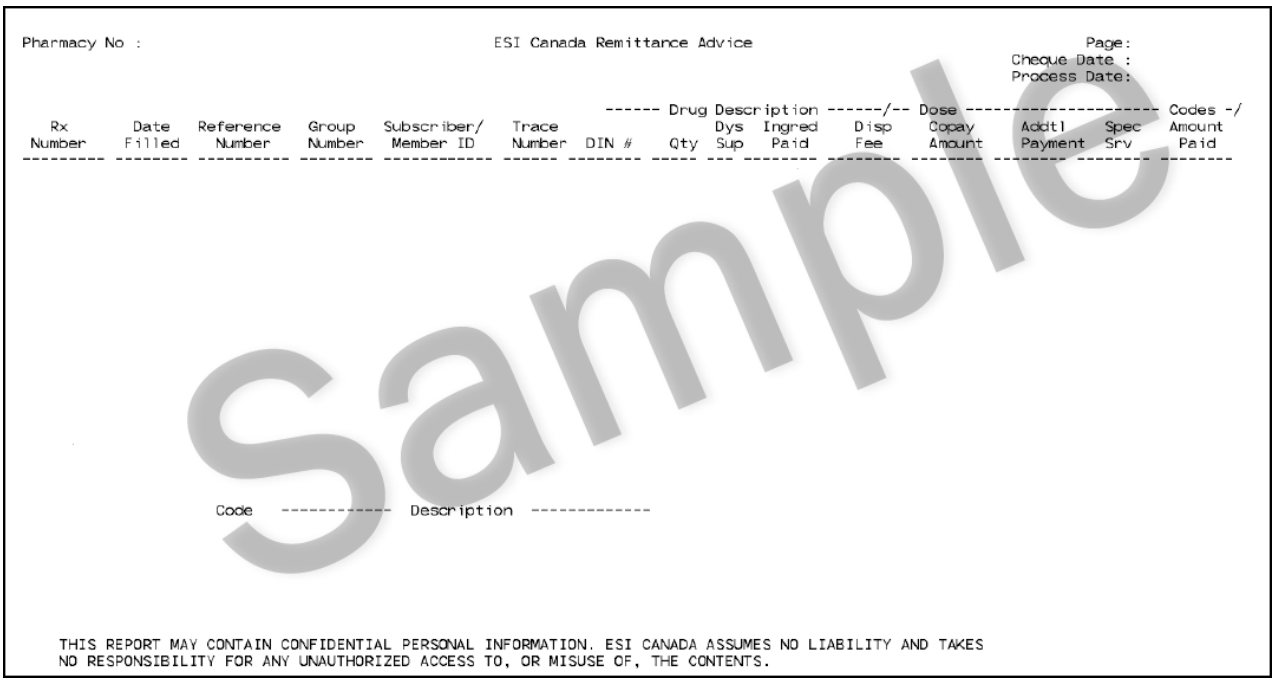
17. APPENDICES

Appendix A – Sample Remittance Advice



Pharmacy No :

ESI Canada Remittance Advice

Page:
Cheque Date :
Process Date:

Rx Number	Date Filled	Reference Number	Group Number	Subscriber/ Member ID	Trace Number	DIN #	Drug Description Qty	Dys Sup	Ingred Paid	Dose Disp Fee	Copay Amount	Addtl Payment	Spec Srv	Codes -/ Amount Paid

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

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

Sample

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

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

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

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

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

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

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Appendix C – Ineligible Ingredients, Bases and Formats for Compound Preparations

Please be advised that this list is not exhaustive and may be updated at ESC's discretion at any time.

Ineligible bases and ingredients

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

Ineligible dosage forms/formats

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

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EXPRESS SCRIPTS®

Appendix D – Frequent Dispensing Form

Patient Information		
Name:	Cardholder ID:	Date of Birth:

Pharmacist Assessment

In order to qualify for more frequent dispensing of drug(s), a patient must be unable to manage their drug therapy without additional support. It is my professional opinion that the patient above qualifies as a result of:

☐ Physical impairment Clinical description:	☐ Cognitive impairment Clinical description:	☐ Sensory impairment Clinical description:	☐ Complex medication regimen Details:

The dispensing regimen will be:

☐ every 7 days ☐ every 14 days ☐ every 28 days ☐ Other:

The rationale/reason(s) for my assessment of the clinical or safety risks to the patient if larger quantities were dispensed, is/are:

Pharmacist's name:	License #:
Signature:	Date:

Pharmacy Information

Pharmacy name:	Address:
Telephone:	Fax:

Patient Consent

I consent and authorize to have my medication(s) dispensed in reduced quantities from what was originally prescribed, as per the assessment, rationale and dispensing regimen outlined above.

Date:	Agent's Name / Relationship (if applicable):
Patient's signature:	Agent's signature (if applicable):

Prescriber Authorization (if applicable)

The above noted assessment is an accurate reflection of the patient's abilities contributing to the need of more frequent medication dispensing.

Prescriber's name:	Date (DD/MM/YYYY):

Prescriber's signature:

- ***Please complete all sections of the form***
- **It is valid for a period of 365days**
- **Should there be any discrepancies with your submitted claim(s) and the above documentation, your account will be adjusted accordingly**

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