

Announcement of Selected Vendor

Alabama Medicaid Agency Pharmacy Administrative Services

Request for Proposal (RFP) Number 2018-PAS-01

Alabama Medicaid Agency

On July 6, 2018, the Alabama Medicaid Agency issued an Intent to Award Notice to Health Information Designs, LLC for the Alabama Medicaid Agency Pharmacy Administrative Services RFP (RFP Number 2018-PAS-01).

The final award of this contract is subject to review by the Legislative Oversight Committee and signature by the Governor.



ALABAMA MEDICAID AGENCY REQUEST FOR PROPOSALS

RFP Number: 2018-PAS-01	RFP Title: Pharmacy Administrative Services	
RFP Due Date and Time: May 16, 2018 by 5:00 pm Central Time		Number of Pages: 89
PROCUREMENT INFORMATION		
Project Director: Tiffany Minnifield		Issue Date: April 17, 2018
E-mail Address: PASRFP@medicaid.alabama.gov Website: http://www.medicaid.alabama.gov		Issuing Division: Clinical Services and Support Division
INSTRUCTIONS TO CONTRACTORS		
Return Proposal to: Alabama Medicaid Agency Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624		Mark Face of Envelope/Package: RFP Number: 2018-PAS-01 RFP Due Date: May 16, 2018 by 5:00 pm Central Time Total Evaluated Price from Appendix C:
CONTRACTOR INFORMATION <i>(Contractor must complete the following and return with RFP response)</i>		
Contractor Name/Address:	Authorized Contractor Signatory: (Please print name and sign in ink)	
Contractor Phone Number:	Contractor FAX Number:	
Contractor Federal I.D. Number:	Contractor E-mail Address:	

Section A. RFP Checklist

1. ____ **Read the *entire* document.** Note critical items such as: mandatory requirements; supplies/services required; submittal dates; number of copies required for submittal; licensing requirements; contract requirements (i.e., contract performance security, insurance requirements, performance and/or reporting requirements).
2. ____ **Note the project director's name, address, phone numbers and e-mail address.** This is the only person you are allowed to communicate with regarding the RFP and is an excellent source of information for any questions you may have.
3. ____ **Take advantage of the "question and answer" period.** Submit your questions to the project director by the due date(s) listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the State's website and will include all questions asked and answered concerning the RFP.
4. ____ **Use the forms provided,** i.e., cover page, and disclosure statement.
5. ____ **Check the State's website for RFP addenda.** It is the Contractor's responsibility to check the State's website at http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx for any addenda issued for this RFP, no further notification will be provided. Contractors must submit a signed cover sheet for each addendum issued along with your RFP response.
6. ____ **Review and read the RFP document again** to make sure that you have addressed all requirements. Your original response and the requested copies must be identical and be complete. The copies are provided to the evaluation committee members and will be used to score your response.
7. ____ **Submit your response on time.** Note all the dates and times listed in the Schedule of Events and within the document, and be sure to submit all required items on time. Late proposal responses are *never* accepted.
8. ____ **Prepare to sign and return the Contract, Contract Review Report, Business Associate Agreement and other documents** to expedite the contract approval process. The selected Contractor's contract will have to be reviewed by the State's Contract Review Committee which has strict deadlines for document submission. Failure to submit the signed contract can delay the project start date but will not affect the deliverable date.

This checklist is provided for assistance only and should not be submitted with Contractor's Response.

Section B. Schedule of Events

The following RFP Schedule of Events represents Medicaid's best estimate of the schedule that shall be followed. Except for the deadlines associated with the Contractor question and answer periods and the proposal due date, the other dates provided in the schedule are estimates and will be impacted by the number of proposals received. Medicaid reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. Notification of any adjustment to the Schedule of Events shall be posted on the RFP website

at http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx.

EVENT	DATE
RFP Issued	April 17, 2018
Questions Due by 5 pm CST	April 23, 2018
Final Posting of Questions and Answers	May 7, 2018
Proposals Due by 5 pm CST	May 16, 2018
Evaluation Period	May 24, 2018-June 15, 2018
Contract Award Notification	June 28, 2018
**Contract Review Committee	October 4, 2018
Official Contract Award/Begin Work	November 1, 2018**

* *By State law, this contract must be reviewed by the Legislative Contract Review Oversight Committee. The Committee meets monthly and can, at its discretion, hold a contract for up to forty-five (45) days. The "Contractor Begins Work" date above may be impacted by the timing of the contract submission to the Committee for review and/or by action of the Committee itself.

Table of Contents

Section A. RFP Checklist	2
Section B. Schedule of Events	3
I. Introduction	8
II. Scope of Work	8
A. Program components	8
B. Perform Quality assurance monitoring	9
C. Reporting Requirements	9
D. Additional Contractor Responsibilities	10
E. Additional Medicaid Responsibilities	10
F. Informal Review and Fair Hearing	10
G. Monitoring, Performance Standards and Corrective Action Plans	11
H. Operational Requirements	11
I. Key Personnel	12
J. Other Personnel	22
K. Organizational Plan	22
L. Work Plan and Implementation Schedule	23
M. Transmittal Letter	24
N. Drug Utilization Review	25
O. Prior Authorization (PA)	31
P. Electronic Prior Authorization	33
Q. Online Prior Authorization	34
R. Incentive Program	35
S. Overrides	36
T. Clinical Appeal	39
U. Specialty Drugs-Synagis®	40
V. Help Desk	42
W. Pharmacy Lock-In (PLI)	44
X. Performance Standards	46
Y. Academic Detailing	46
Z. Drug Interface Capability	49
AA. Transition Period (July 1, 2018 – November 1, 2018)	51
BB. Scope of Work Strategies	52
CC. Breach of Contract	52

III.	Pricing	54
IV.	General Medicaid Information	54
V.	General	55
VI.	Corporate Background and References	55
VII.	Submission Requirements	56
A.	Authority	56
B.	Single Point of Contact	56
C.	RFP Documentation	57
D.	Questions Regarding the RFP	57
E.	Acceptance of Standard Terms and Conditions	57
F.	Adherence to Specifications and Requirements	57
G.	Order of Precedence	57
H.	Contractor’s Signature	57
I.	Offer in Effect for 90 Days	57
J.	State Not Responsible for Preparation Costs	58
K.	State’s Rights Reserved	58
L.	Price	58
M.	Submission of Proposals	58
N.	Copies Required	58
O.	Late Proposals	59
P.	Proposal Format	59
Q.	Proposal Withdrawal	59
R.	Proposal Amendment	59
S.	Proposal Errors	59
T.	Proposal Clarifications	60
U.	Disclosure of Proposal Contents	60
VIII.	Evaluation and Selection Process	60
A.	Initial Classification of Proposals as Responsive or Non-responsive	60
B.	Determination of Responsibility	60
C.	Opportunity for Additional Information	61
D.	Evaluation Committee	61
E.	Scoring	61
F.	Determination of Successful Proposal	61
IX.	General Terms and Conditions	61

A.	General	61
B.	Compliance with State and Federal Regulations	62
C.	Term of Contract	62
D.	Contract Amendments	62
E.	Confidentiality	63
F.	Security and Release of Information	63
G.	Federal Nondisclosure Requirements	63
H.	Contract a Public Record	64
I.	Termination for Bankruptcy	64
J.	Termination for Default	64
K.	Termination for Unavailability of Funds	64
L.	Proration of Funds	64
M.	Termination for Convenience	64
N.	Force Majeure	65
O.	Nondiscriminatory Compliance	65
P.	Conflict of Interest	65
Q.	Open Trade	65
R.	Small and Minority Business Enterprise Utilization	65
S.	Worker’s Compensation	65
T.	Employment of State Staff	66
U.	Immigration Compliance	66
V.	Share of Contract	66
W.	Waivers	66
X.	Warranties Against Broker’s Fees	66
Y.	Novation	67
Z.	Employment Basis	67
AA.	Disputes and Litigation	67
BB.	Records Retention and Storage	67
CC.	Inspection of Records	67
DD.	Use of Federal Cost Principles	68
EE.	Payment	68
FF.	Notice to Parties	68
GG.	Disclosure Statement	68
HH.	Debarment	68

II.	Not to Constitute a Debt of the State	68
JJ.	Qualification to do Business in Alabama	69
KK.	Choice of Law	69
LL.	Alabama interChange Interface Standards	69
MM.	Attorney Fees	69
NN.	Procedure for Termination	69
OO.	Contractor's Duties Upon Expiration/Termination	70
PP.	Indemnification	70
QQ.	Performance Guarantee	71
RR.	Provision of Gratuities	72
SS.	Method of Payment and Invoices	72
Appendix A:	Proposal Compliance Checklist	73
Appendix B:	Contract and Attachments	74
Appendix C:	Pricing Form	89

I. Introduction

Background

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, hereby solicits bids for the procurement of services with a Contractor to administer certain components of the retrospective and prospective drug utilization review program, prior authorization and override process, as well as education activities. Services required are outlined through this RFP. Medicaid will maintain administration responsibilities of the pharmacy program. Additionally, Contractor will not be allowed to restrict the provider network or mandate mail-order services. The program design reflects the components of the programs that are currently operational. Contractor will be required by the State to operate under all provisions of the Omnibus Budget Reconciliation Act (OBRA), 1990. State regulatory authority is derived from the Code of Alabama 1975, Alabama Administrative Code and the Social Security Act.

The Contractor to whom the RFP is awarded shall be responsible for the performance of all duties contained within this RFP for the firm and fixed price quoted in Contractor's bid to this RFP. All bids must state a firm and fixed price for the services described.

II. Scope of Work

AS PART OF THE PROPOSAL, CONTRACTORS MUST PROVIDE A BLANKET ACKNOWLEDGE AND COMPLY STATEMENT FOR ALL REQUIREMENTS LISTED IN THE RFP.

AS PART OF THE PROPOSAL, CONTRACTORS MUST PROVIDE DETAILED DESCRIPTIONS OF ALL REQUIREMENTS LISTED IN THE RFP WHERE APPROPRIATE.

Scope of Work Overview

A. Program components

Contractor will be responsible for:

- a. Prior Authorization and Override program for outpatient pharmacy and certain J codes and physician administered drugs as per established medical criteria.
- b. Electronic Prior Authorization program.
- c. Drug Utilization Review Program to include reporting on Prospective DUR and Retrospective DUR.
- d. Staff Pharmacist and Staff Certified Technician/Drug File Coordinator on site at Medicaid;
- e. Provider Academic Detailing/Education Program.
- f. Help Desk Program, including recipient liaisons.
- g. Drug Interface System.
- h. Pharmacy Lock In Program.

Prior Authorization and utilization statistics and additional program information are included on the Alabama Medicaid Agency website located at:

http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx

B. Perform Quality assurance monitoring

Contractor must monitor the quality of its utilization operations, including performing reliability testing of review decisions by reviewer staff and physician reviewers and call center staff. Reports must be generated as described in this RFP. Medicaid staff will monitor the quality of the Contractor's utilization operations through rigorous retrospective audits. Breach of contract will be applied as described in this RFP, if applicable.

C. Reporting Requirements

Contractor shall produce and submit to the Medicaid Pharmacy program, in formats approved by Medicaid, monthly reports as described below. Unless otherwise stated, reports should be delivered to Medicaid by the tenth of each month. Reports shall be provided in hard copy and electronic format to Medicaid.

Contractor shall also produce and submit an annual status report that summarizes all information for the current monthly reporting period and annually and provide analysis on the numerical figures presented in the reports.

These status reports must include:

Prior authorization and Override activity by drug, including, but not limited to, the number of denied and approved requests by drug classification, number of appeals referred to consulting physician, number of requests received by fax, mail, electronic or telephone, number of requests by source such as pharmacy or physician, and number of requests received daily. Contractor shall submit a monthly ranking report of the 25 physicians submitting the most PA Requests and Override Requests. Contractor shall produce statistical reports as reasonably requested and approved by Medicaid.

a. Prior Authorization statistics:

1. Number of prior authorization requests.
2. Number of prior authorization requests by month and in total.
3. Number of prior authorization requests by procedure code.
4. Number of requests requiring a physician review.
5. Number of prior authorization approvals.
6. Number of prior authorization denials categorized by reason for denial.
7. Number of appeals and appeal outcomes.

b. Help Desk Call center performance statistics and weekly toll free phone line usage to determine the capability of all lines and potential need for additional lines. Results of these studies shall be provided to Medicaid's Contract Administrator. Reports shall include but not be limited to:

1. Call abandonment rate.
2. Call waiting time.
3. Average speed for answering calls.
4. Total Number of Calls received.
5. Percentage of calls answered in 60 seconds or less.

c. Dollar and Claim Analysis Reports

1. Top 30 non-preferred drugs (single source brand) by dollar and claims.
2. Top 30 non-preferred drugs (multi-source brand and generic) by dollar and claims.

3. Physician analysis report (Top 200 prescribers) by dollar and claims.
4. Top 200 pharmacies report by dollar and claims.
5. Claims analysis by major therapeutic class.

d. Monthly Cost Savings

1. Provide a summary of cost savings for Prior Authorization, DUR, Academic Detailing, and Pharmacy Lock In programs.

D. Additional Contractor Responsibilities

- a. Contractor shall be expected to perform all responsibilities and deliverables within this RFP. Additional Contractor responsibilities are listed below. Contractor shall coordinate with the Medicaid Project Manager throughout the term of this contract for any questions and further direction as it relates to the functions of this RFP.
- b. Make recommendations for changes to existing criteria across all programs. Recommendations shall also include the addition of new procedures, services or equipment for approval to increase efficiency, program effectiveness, and appropriate utilization as it relates to this RFP.
- c. Make Contractor physician(s) available to participate in informal reviews and hearings resulting from appeals of denied requests.
- d. Make presentations to groups/associations or others regarding this contract and work hereunder only with request or prior approval of Medicaid.

E. Additional Medicaid Responsibilities

- a. Medicaid shall be expected to follow the additional Medicaid responsibilities below. Medicaid agrees to correspond to inquiries from the Contractor in a timely and accurate manner interpreting Medicaid policy so that Contractor is able to respond and provide deliverables as indicated throughout this RFP.
- b. Medicaid shall retrospectively review a random sample of a minimum of 25 prior authorization and override requests quarterly of pharmacy PAs reviewed by Contractor.
- c. Medicaid shall review and approve any changes in the form of communication to the Provider by the Contractor which may include, but is not limited to, changes in form letters, report formats, new forms or new reports, audit or review tools to be used by the Contractor.
- d. Medicaid shall review Pharmacy Program criteria based upon clinical review or recommendations made by the Medicaid Medical or Clinical Services Director(s) or Contractor.
- e. Medicaid shall initiate and distribute public notice of policy changes in the PA program to include recipient and provider notices and alerts.
- f. Medicaid shall notify Contractor in writing of any additional review requirements or changes within 14 calendar days.

F. Informal Review and Fair Hearing

All adverse review decisions made by the Contractor may be subject to an appeal by the requesting provider or recipient (Aggrieved Party). An Aggrieved Party may request an informal review and a fair hearing for denied Medicaid benefits.

a. **Informal Review**

An Aggrieved Party may request reconsideration of an adverse decision through the informal review process by filing a written request with Contractor within 30 days for Prior Authorization Requests. Upon receipt of a reconsideration request, the Contractor's consulting physician shall review the documentation and render a decision based on Medicaid-approved criteria within five working days of receipt of a complete reconsideration request. Contractor shall mail notice of the reconsideration decision to the Aggrieved Party and enter the decision into the system for Prior Authorizations and must generate and mail notices to providers.

b. **Fair Hearing**

An Aggrieved Party may request a Fair Hearing by filing a written request with the Medicaid Administrative Hearings Office within 60 calendar days of the date of the reconsideration denial notice by the Contractor. The Contractor's consulting physician and other appropriate personnel who were involved in the denial shall be available at Medicaid's request to provide justification for the denial and participate in any Fair Hearings.

G. Monitoring, Performance Standards and Corrective Action Plans

Medicaid will monitor the Contractor's performance according to the requirements contained within this RFP.

Medicaid will inform Contractor when performance does not comply with the contract requirements and of any liquidated damage assessments. Contractor must prepare and submit for approval a corrective action plan for each identified problem within the timeframe determined by Medicaid. The corrective action plan must include, but is not limited to:

- a. Brief description of the findings.
- b. Specific steps the Contractor will take to correct the situation or reasons why the Contractor believes corrective action is not necessary.
- c. Name(s) and title(s) of responsible staff person(s).
- d. Timetable for performance of each corrective action step.

Contractor must implement the corrective action plan within the timeframe specified by Medicaid. Failure by the selected Contractor to implement corrective action plans, as required by Medicaid, may result in further action by Medicaid.

H. Operational Requirements

Contractor will be responsible for entering and/or interfacing with Medicaid's on-line PA system for the inclusion of approved procedures.

Contractor shall install and maintain the necessary hardware, software, and secure, encrypted data connections necessary to access the Medicaid system. A high-speed virtual private network (VPN) connection to the Medicaid Agency Fiscal Agent's Orlando Data Center (ODC) is recommended. Charges for site to site VPN to the ODC include a setup fee of \$1,600 and quarterly maintenance of \$1,350. The minimum requirements for configuration of a desktop to be used to access the Medicaid system are as follows:

CPU- 3.0GHz, P4, 800FSB
Cache- IMB 1.2 Cache

Connectivity- 10/100/1000 NIC
Microsoft Windows XP
Microsoft Internet Explorer for access to InterChange MMIS

Contractor shall also provide an appropriate backup/emergency plan in the event of power outage or natural disaster.

Contractor must have a HIPAA-compliant system with effective security measures to prevent the unauthorized use of, or access to, data. The selected Contractor must maintain confidentiality and only use information from Medicaid to fulfill its contractual obligations.

Contractor system responsibilities include:

- a. Submission of requests for employee passwords for the Medicaid system.
- b. Notifying Medicaid when an issued password is no longer needed due to termination of employment or change in duties within five days.
- c. Ensuring that its employees are informed of importance of system security and confidentiality.
- d. Documenting and notifying Medicaid of system problems to include type of problem, action(s) taken by Contractor to resolve problem and length of system down-time within eight hours of problem identification. Contractor shall ensure that the problem is resolved within 24 hours of system down time.

Medicaid system responsibilities include:

- a. Obtain security passwords from the Fiscal Agent upon Contractor request.
- b. Serve as liaison between Contractor and Fiscal Agent.

I. Key Personnel

Contractor must maintain sufficient staffing levels to meet program requirements. Key personnel must be located within the State of Alabama and denoted in the respective section below. At a minimum, Contractor's key personnel must include the following positions:

a. Project Manager (PM)

Contractor shall propose a PM with a minimum of an undergraduate degree who shall have day-to-day responsibility for supervising the performance and obligations under this Contract, as well as receive policy direction from the Medicaid Contract Administrator. The PM must be located within Alabama. The PM shall be the person assigned under this contract who is responsible for operation of contract duties including the PA review process, help desk functions, Prospective and Retrospective DUR, Academic Detailing and correspondence. In the event the PM does not meet the requirements of Medicaid before or after implementation, Contractor shall recommend a candidate to Medicaid who is capable of performing contract obligations. Contractor shall not change its PM without prior written approval from Medicaid, and such approval shall not be unreasonably delayed or withheld. Contractor shall use the PM for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Project Manager at least 30 days prior to change. Contractor shall furnish with its bid response to the RFP a resume/curriculum vitae (CV) for the proposed PM which shall include the individual's name, current address, current title and position, experience with Contractor, experience in implementation or performing PA functions, experience with provider relations, experience with drug utilization review,

relevant education and training and management experience. Contractor shall provide a minimum of two work references for the PM.

Contractor's PM shall serve as liaison between Medicaid and Contractor and shall be available and responsible for consultation and assistance with issues arising out of the scope of the Contract. PM shall attend, upon request, Medicaid meetings, fair hearings, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. PM shall provide timely and informed responses when operational and administrative issues arise in relations to obligations under this contract. Whenever the PM is not available, Contractor shall provide a designated alternate fully capable of meeting the requirements of this RFP.

Additional responsibilities of the PM include but are not limited to:

1. Assure timely compliance with all contract responsibilities and deliverables.
2. Attend monthly contract status meetings and other meetings upon Medicaid request.
3. Notify Medicaid's Contract Administrator of any proposed changes in personnel; organizational changes; any system problems; within time period specified within this RFP.

b. Account Pharmacist

The Contractor shall assign a Full Time Equivalent (FTE) Account Pharmacist to work with the program. The Account Pharmacist must be located within Alabama. The Account Pharmacist assigned to work with Alabama Medicaid shall possess superior clinical competence and demonstrate proficiency in drug therapy management, hold a minimum of a Doctor of Pharmacy degree, must be licensed in the state of Alabama and must be in good standing with the Alabama Board of Pharmacy. Contractor shall furnish with its response to the RFP a CV/resume for the proposed Account Pharmacist which shall include the individual's name, current address, current title and position, and minimum of 3 years' experience with the following: experience with the Contractor, experience in implementing or performing prior authorization oversight, experience with provider relations, experience with drug utilization review functions, relevant education and training, and management experience. Contractor shall provide a minimum of three work references for the Account Pharmacist. At minimum one month before beginning work for the contract, the Account Pharmacist will interview with the Director of Clinical Services/Pharmacy program and any additional Agency staff necessary, and must be pre-approved by Medicaid. Medicaid has the right to refuse the Account Pharmacist after interview; Contractor will respond with another applicant meeting all requirements within 10 business days. The Account Pharmacist assigned under this contract shall be responsible for clinical functions and contract duties including the PA review process, Preferred Drug List management, help desk functions, Prospective and Retrospective DUR, Pharmacy Audit, and correspondence. Contractor shall use the Account Pharmacist for not less than 12 months to ensure successful contract performance and consistency. The Account Pharmacist will be responsible for (at a minimum) biweekly quality assurance checks and report findings during monthly meetings. Contractor shall notify Medicaid in writing of any proposed change in Account Pharmacist at least 30 calendar days prior to the change, if possible. Whenever Account Pharmacist is not reasonably available, Contractor shall provide a designated alternate fully capable of meeting the requirements of this RFP.

Responsibilities of the Account Pharmacist shall include, but are not limited to:

1. Conduct clinical research and development, with the DUR Board, of the therapeutically based criteria by which patient and provider profiles for the program will be generated.
2. Provide clinical support and administrative oversight to the Help Desk.

3. Coordinate review of prior authorization and override appeal requests with Account Physician.
4. Coordinate DUR Board meetings to update therapeutic criteria, provider education and interventions for retrospective and prospective DUR.
5. Perform drug utilization reviews. A drug utilization review shall be performed by an analysis of claims paid and/or denied to providers on behalf of Medicaid recipients.
6. Conduct research relating to drug therapy and advising providers of the significance of information obtained from the DUR program.
7. Provide recommendations on additional areas of improvement and/or disease management.
8. Attend DUR Board meetings and P&T meetings.
9. Attend monthly contract status meetings with Medicaid.
10. Attend Medicaid meetings upon request.
11. Attend and participate in programs/seminars required through the academic detailing component upon request.
12. Coordinate, oversee and present DUR Board meeting materials at such meetings.
13. Provide ongoing support and research for legislative and budgetary requests from Medicaid.

c. Medicaid Clinical Staff Pharmacist

Contractor shall assign a FTE Staff Pharmacist to work with the program. The Clinical Staff Pharmacist must be located within Alabama, and reside within driving distance of the Alabama Medicaid home office in Montgomery, Alabama. The Staff Pharmacist assigned to work with Alabama Medicaid must possess superior clinical competence, demonstrate proficiency in drug therapy management, have at minimum 3 years of experience in outpatient/community pharmacy, must be licensed in the State of Alabama, hold a current preceptor license, and must be in good standing with the Alabama Board of Pharmacy.

Upon award of the contract, the Contractor shall furnish a CV/resume for the proposed Staff Pharmacist which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. Three work references shall also be included. At a minimum of one month before beginning work for the contract, the Staff Pharmacist will interview with the Director of Clinical Services/Pharmacy program and any additional Agency staff necessary, and must be pre-approved by Medicaid. Medicaid has the right to refuse staff pharmacist after interview; Contractor will respond with another applicant meeting all requirements within 10 business days. Contractor shall, in its bid response, demonstrate an understanding of this section's requirements.

Contractor shall use the Staff Pharmacist for the entire length of the contract to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Staff Pharmacist at least 30 days prior to the change, if possible. Any replacements made will be subject to Medicaid approval.

The Staff Pharmacist will be physically located and work at the Medicaid central office in Montgomery, Alabama on a full-time basis (i.e. fully dedicated to Alabama); work schedule will be at the discretion of the Alabama Medicaid Agency Director of Clinical Services/Pharmacy to best serve Medicaid. The majority of his/her time will be spent providing clinical support to Medicaid's Pharmacy Program staff. He/she will report to the Pharmacy Program/Clinical Services Director for work assignments and scheduling requests.

It will be at Contractor's discretion as to work requirements for this individual on State holidays that are not Contractor holidays since the Medicaid office will be closed. The Staff Pharmacist will be required to attend various off-site meetings; at the time of the writing of this RFP it is common to

have the Staff Pharmacist to attend pharmacy associations' yearly conferences (1-4 in/out of state meeting(s)/year), the Annual Drug Utilization Review meeting (1 out of state meeting/year), various state and national meetings (1-4 per year), and the quarterly academic detailing in-house meeting (4 meetings/year to be held at a location determined by the Contractor). The Contractor will be responsible for the Staff Pharmacist travel costs if not covered by the meeting group.

Medicaid will not be responsible for costs that result from Staff Pharmacist's work on other Contractor projects outside of this RFP such as travel costs, costs for long-distance telephone calls; postage and copying/printing.

Medicaid will provide a suitable work-station for this individual at the Medicaid office to include a desktop computer. Reference materials and software needed to perform the responsibilities outlined below will be at the cost of Contractor unless already maintained by Medicaid such as Redbook, AHFS, Interchange, DSS (Decision Support System), and PDR (Physician Desk Reference). The Staff Pharmacist's current membership with the appropriate state/national pharmacy association(s) is required. The use of personal notebook computer, or smart phone, (to be supplied by Contractor) is required; the Contractor shall supply the Staff Pharmacist with any additional technology/membership(s) to support the pharmacist to ensure successful contract performance. Prior to beginning at the Medicaid Agency, the Staff Pharmacist shall be experienced in Microsoft Office (to include Outlook, Excel, and PowerPoint) Staff Pharmacist shall be available to begin work at Medicaid no later than November 1, 2018.

Responsibilities of the staff pharmacist include, but are not limited to:

1. Provide recommendations on additional areas of program improvement such as disease management, and DUR interventions.
2. Attend and participate in DUR Board meetings and P&T Committee meetings.
3. Assist PDL coordinator by review and revision of drug lists for P&T meetings, review of clinical packet for meetings, and coordination of appropriate lists once clinical review is complete.
4. Run, review, and coordinate clinical data for financial reports related to Drug Rebate/PDL quarterly reviews.
5. Attend weekly teleconferences and any additional meetings between Medicaid and Clinical Contractor.
6. Must hold a current preceptor license in the state of Alabama. Accept pharmacy students from one or more school(s) of pharmacy in the state of Alabama. Coordinate and oversee all student activities, prepare and grade assignments in accordance with School of Pharmacy guidelines, and ensure student receives well-rounded rotation that reflects all aspects of Medicaid pharmacy, school requirements, and current policies.
7. Conduct product research for weekly drug file reviews and provide recommendations for coverage and restrictions by applying Medicaid guidelines.
8. Conduct clinical reviews on drug classes and/or individual products upon Medicaid's request.
9. Attend and participate in Medicaid related meetings upon request.
10. Provide clinical support to Medicaid's Pharmacy Program.
11. Provide clinical support to Medicaid's Medical Director and Associate Medical Director.
12. Review, maintain, and revise internal/external criteria for use in the prior authorization process, and coordinate any updates/changes with pertinent personnel.
13. Make recommendations and maintain maximum units list for providers.
14. Review, maintain, and revise information for classes pertaining to electronic prior authorization.
15. Attend weekly teleconferences and monthly contract status meetings with Medicaid and Contractor.

16. Attend programs/seminars required through the academic detailing component.
17. Respond to provider/recipient inquiries via written, verbal, or electronic means upon Medicaid's request.
18. Review and make recommendations as it relates to information regarding the drug reference file, pharmacy billing, and other aspects of the program for Medicaid MMIS system.
19. Oversee the Pharmacy Lock In program if so designated by the Contractor.

d. Staff Certified Pharmacy Technician/Staff Drug File Coordinator

Contractor shall assign a full time equivalent (FTE) Certified Pharmacy Technician to work with the program and serve as the drug file coordinator. The staff drug File Coordinator must be located in Alabama, and reside within driving distance of the Alabama Medicaid home office in Montgomery, Alabama. The coordinator shall possess a minimum of a bachelor's degree. The coordinator shall be nationally certified as a pharmacy technician, registered and in good standing with the Alabama Board of Pharmacy, and possess a minimum of 3 years of experience in outpatient/community pharmacy.

Upon award of the contract, the Contractor shall furnish a CV/resume for the proposed Staff Drug File Coordinator which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. Three work references shall also be included. At minimum of one month before the Drug File Coordinator begins work for the contract, he/she will interview with the Director of Clinical Services/Pharmacy program, and any additional Agency staff necessary, and must be pre-approved by Medicaid. Medicaid has the right to refuse staff drug file coordinator after interview; Contractor will respond with another applicant meeting all requirements within 10 business days. Contractor shall, in its bid response, demonstrate an understanding of this section's requirements.

Contractor shall use the Staff Drug File Coordinator for the entire length of the contract to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Staff Drug File Coordinator at least 30 calendar days prior to the change, if possible. Any replacements made will be subject to Medicaid approval.

The Staff Drug File Coordinator will be physically located and work at the Medicaid central office in Montgomery, Alabama on a full time basis; work schedule will be at the discretion of the Pharmacy/Clinical Services Director to best serve Medicaid. The majority of his/her time will be spent maintaining the Alabama Medicaid drug file and providing administrative support to the Pharmacy program.

It will be at contractor's discretion as to work requirements for this individual on State holidays that are not Contractor holidays since the Medicaid office will be closed. The Drug File coordinator will be required to maintain any certifications required of the position. The Drug File Coordinator's current membership with the appropriate state/national pharmacy association(s) is required. Contractor shall be responsible for Drug File Coordinator's travel costs.

Medicaid will provide a suitable work station for this individual at the Medicaid office to include a desktop computer. Reference materials and software needed to perform the responsibilities outlined below will be at the cost of the Contractor unless already maintained by Medicaid. The contractor shall supply the Staff Drug File Coordinator with any additional technology to support the technician to ensure successful contract performance. Prior to beginning at the Medicaid Agency, the Staff Drug File Coordinator shall be experienced in Microsoft Office (to include Outlook, Excel, PowerPoint) The Staff Drug File Coordinator shall be available to begin work at Medicaid no later than November 1, 2018.

Responsibilities of the staff drug file coordinator include, but are not limited to:

1. Monitor the drug pricing file, including but not limited to receiving and disseminating weekly drug file, making system updates based on weekly file updates, communicating both orally and in written form with providers and outside contractors.
2. Monitor, oversee, and update the HCPCS/JCode drug file/program to include but not limited to routine pricing updates, fee schedule review, file maintenance, annual review of new HCPCS, utilization audits, administrative reviews/appeals, and assist providers, agency staff, drug manufacturers, and outside contractors with claim adjudication issues.
3. Provide administrative support to pharmacy administrative services as needed.
4. Attend weekly teleconferences and any additional meetings between Medicaid and Administrative Services Contractor.
5. Conduct pricing reviews on individual products.
6. Attend and participate in Medicaid related meetings upon request.
7. Provide backup for updates to various drug lists (i.e., cough and cold list) and post on the web for providers.
8. Respond to provider/recipient inquiries via written, verbal, or electronic means.
9. Conduct various decision support system queries and system testing.
10. Provide clinical support to the staff pharmacist as needed.
11. Represent Pharmacy in weekly coverage and procedures (COPS) meeting. Present HCPCS coverage issues/requests in COPS meeting as needed.
12. Research proposed cost savings as needed.
13. Review monthly contractor status report.
14. Assist with drug utilization review projects.
15. Assist with program audits and pharmacy lock-in updates as needed.
16. Update hemophilia factor product prices and conduct hemophilia utilization query, cost savings report, and audits quarterly.
17. Provide backup phone support to the Pharmacy Administrative Support Assistant.
18. Conduct monthly claim corrections as requested.
19. Review the semi-annual average acquisition rebase and provide feedback as needed.
20. Review system change orders and provide feedback as needed.
21. Review monthly Medicare newsletters and provide feedback as needed.
22. Monitor weekly data warehouse newsletters and editorial highlights and recommend drug file/policy changes as needed.
23. Maintain drug file/HCPCS policies and procedures.
24. Additional ad-hoc projects as requested by Medicaid.

e. Consulting Physician(s)

Contractor shall furnish with its response to the RFP a Consulting Physician. The Consulting Physician shall be FACP certified and licensed to practice medicine in Alabama. A resume for the proposed Consulting Physician(s) shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. A minimum of three work references shall also be included. Consulting Physician(s) shall be available to meet all requirements under this contract. The Consulting Physician duties do not constitute an FTE. Contractor shall use Consulting Physician(s) for not less than 12 months to ensure successful contract performance and consistency. Contractor shall notify Medicaid in writing of any proposed change in Consulting Physician(s) at least 30 calendar days prior to the change, if possible.

Responsibilities of the consulting physician shall include, but are not limited to:

1. Work with Account Pharmacist to conduct clinical research and development, with the DUR Board, with the DUR Board, of the therapeutically based criteria by which patient and provider profiles for the program will be generated.
2. Provide recommendations on additional areas of program improvement such as disease management, and DUR interventions.
3. Review prior authorization and override appeal requests and make a decision for approval or denial based on Medicaid approved criteria and supporting evidenced-based medicine documentation. All reviews must follow the pre-determined timeline.
4. Provide clinical support to Help Desk and Account Pharmacist when needed.
5. Meet with Medicaid staff upon request.
6. Attend programs/meetings required through the academic detailing component.

f. Help Desk Supervisor

Contractor shall furnish with its response to the RFP a Help Desk Supervisor. Upon award of the contract, a resume shall be submitted to Medicaid including the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. A minimum of three work references shall also be included. The Help Desk Supervisor shall be a certified pharmacy technician, nurse (minimum BS/RN), pharmacist, or physician. The Help Desk Supervisor shall be located 100% of the time at the physical address of the help desk/call center.

Contractor shall use the Help Desk Supervisor for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Help Desk Supervisor at least 30 calendar days prior to the change, if possible.

Responsibilities of the Help Desk Supervisor shall include, but are not limited to:

1. Oversee the Help Desk to ensure criteria is followed appropriately and Help Desk staff are responding timely and professionally to providers and recipients.
2. Provide clinical support and administrative oversight to the Help Desk.
3. Coordinate review of prior authorization and override appeal requests with account physician.
4. Review prior authorization and override appeal requests and make a decision for approval or denial based on Medicaid approved criteria and supporting evidence-based medicine documentation from provider.
5. Provide clinical support to Help Desk and Account Pharmacist when needed.
6. Meet with Medicaid staff upon request.
7. Attend programs/meetings.

g. Recipient Liaison

Contractor shall provide a Recipient Liaison. Upon award of the contract, a resume shall be submitted to Medicaid including the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. A minimum of three work references shall also be included. The Recipient Liaison shall be a certified pharmacy technician, nurse, pharmacist, or social worker. The Recipient Liaison shall demonstrate the utmost professionalism, patience, and respect while conducting duties listed in this section. Before beginning work for the contract, the Recipient Liaison will interview with the Director of Clinical Services/Pharmacy program and any additional Agency staff necessary, and must be pre-approved by Medicaid. Medicaid has the right to refuse Recipient Liaison after interview; Contractor will respond with another applicant meeting all requirements within 10 business days. Contractor shall, in its bid response, demonstrate an understanding of this section's

requirements. Contractor shall use the Recipient Liaison for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Recipient Liaison at least 30 calendar days prior to the change, if possible.

As the Help Desk focuses primarily on calls, requests, and issues with providers, the Recipient Liaison will accept calls from recipients with questions regarding PA and Override requests, approvals, and denials. The Recipient Liaison shall be given his/her own extension of the toll-free help desk number, and will take recipient calls referred from Medicaid and the help desk. The Recipient Liaison will assist recipients with PA and Override issues, and will coordinate with providers to ensure recipients receive medically necessary medication covered by Medicaid. The Recipient Liaison may be a Help Desk Staff and review requests/data entry while not taking recipient calls, but recipient assistance shall be his/her first priority. Base hours the Recipient Liaison shall be available are 8:30am – 5:30pm Central Time Monday – Friday. Other times the Help Desk is open, the Help Desk Supervisor (or designated representative) shall take recipient calls as described above.

Responsibilities of the Recipient Liaison shall include, but are not limited to:

1. Assist recipients with prior authorization and override issues, and coordinate with providers to ensure recipients receive medically necessary medication covered by Medicaid.
2. Return messages left by providers and/or recipients within two hours.
3. Review prior authorization and override appeal requests and make a decision for approval or denial based on Medicaid approved criteria and supporting evidence-based medicine documentation from provider.
4. Provide support to Help Desk and Account Pharmacist when needed.
5. Meet with Medicaid staff upon request.

h. Consulting Child Psychiatrist

Contractor shall provide services of a Child/Adolescent Psychiatrist for necessary oversight and review of prior authorizations for appropriate drug classes. The consulting Child Psychiatrist shall be a Board Certified Child/Adolescent Psychiatrist licensed to practice medicine in the state of Alabama.

1. Review prior authorization and override appeal requests for appropriate drug classes and make a decision for approval or denial based on Medicaid approved criteria and supporting documentation.
2. Provide clinical support to Account Pharmacist when needed for appropriate drug classes.

i. Pharmacy Lock In (PLI) Pharmacist

Contractor shall assign a PLI Pharmacist to manage the PLI program. The PLI must be located within Alabama. The PLI Pharmacist must possess superior clinical competence, demonstrate proficiency in drug utilization review, hold a minimum of a Bachelor of Science Pharmacy degree, must be licensed in the State of Alabama, have at minimum two years' experience in outpatient/community pharmacy, and must be in good standing with the Alabama Board of Pharmacy. Contractor shall furnish with its response to the RFP a CV or resume for the proposed PLI Pharmacist which shall include the individual's name, current address, current title and position, experience with the Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. Three work references shall also be included. The PLI Pharmacist may be the Staff Audit Pharmacist.

j. PLI Nurse or Certified Pharmacy Technician

Contractor shall assign a FTE PLI Nurse or Certified Pharmacy Technician to administer the PLI program. The PLI Nurse or Certified Pharmacy Technician must possess superior clinical competence, demonstrate proficiency in drug utilization review, hold a minimum of a Bachelor of Science degree, must be licensed in the State of Alabama, have at minimum two years' experience in outpatient/community pharmacy (certified pharmacy technician) or outpatient/community clinical setting (nurse), and must be in good standing with the respective authoritative Board of Alabama. Contractor shall furnish with its response to the RFP a CV or resume for the proposed PLI Nurse or Certified Pharmacy Technician which shall include the individual's name, current address, current title and position, experience with the Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. Three work references shall also be included.

k. Audit Pharmacist

Contractor shall assign a FTE Audit Pharmacist to work with the program to conduct audits related to Pharmacy and Durable Medical Equipment (DME). The Audit Pharmacist must be located in Alabama, and reside within driving distance of the Alabama Medicaid home office in Montgomery, Alabama. The Audit Pharmacist assigned to work with Alabama Medicaid must possess superior clinical competence, demonstrate proficiency in claims processing, policy, pharmacy operations, and have superior computer, communication, analytical thinking and problem solving skills, and be willing to travel if needed. Audit experience is preferred. The Audit Pharmacist shall have at minimum 3 years of experience in outpatient/community pharmacy within the past 5 years, must be licensed in the State of Alabama, and must be in good standing with the Alabama Board of Pharmacy.

Upon award of the contract, the Contractor shall furnish a CV/resume for the proposed Audit Pharmacist which shall include the individual's name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. Three work references shall also be included. At minimum one month before beginning work for the contract, the Audit Pharmacist will interview with the Director of Clinical Services/Pharmacy program and any additional Agency staff necessary, and must be pre-approved by Medicaid. Medicaid has the right to refuse audit pharmacist after interview; Contractor will respond with another applicant meeting all requirements within 10 business days. Contractor shall, in its bid response, demonstrate an understanding of this section's requirements.

Contractor shall use the Audit Pharmacist for the entire length of the contract to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in audit pharmacist at least 30 days prior to the change, if possible. Any replacements made will be subject to Medicaid approval.

The audit pharmacist will be physically located and work at the Medicaid central office in Montgomery, Alabama on a full-time basis (i.e. fully dedicated to Alabama); work schedule will be at the discretion of the Alabama Medicaid Agency Director of Clinical Services/Pharmacy to best serve Medicaid. The majority of his/her time will be spent reviewing claims, policy, auditing, and making recommendations to Medicaid's Pharmacy and DME Program staff. He/she will report to the Pharmacy Program/Clinical Services Director for work assignments and scheduling requests.

It will be at Contractor's discretion as to work requirements for this individual on State holidays that are not Contractor holidays since the Medicaid office will be closed. The Audit Pharmacist will be required to attend various off-site meetings; at the time of the writing of this RFP it may be expected to have the Audit Pharmacist to attend pharmacy associations' yearly conferences (1-4 in/out of state meeting(s)/year), the Annual Drug Utilization Review meeting (1 out of state meeting/year), various state and national meetings (1-4 per year), and the quarterly academic detailing in-house meeting (4

meetings/year to be held at a location determined by the Contractor). The Contractor will be responsible for the Audit Pharmacist's travel costs if not covered by the meeting group.

Medicaid will not be responsible for costs that result from audit pharmacist's work on other Contractor projects outside of this RFP such as travel costs, costs for long-distance telephone calls; postage and copying/printing.

Medicaid will provide a suitable work-station for this individual at the Medicaid office to include a desktop computer. Reference materials and software needed to perform the responsibilities outlined below will be at the cost of Contractor unless already maintained by Medicaid such as Redbook, AHFS, Interchange, DSS (Decision Support System), and PDR (Physician Desk Reference). The Audit Pharmacist's current membership with the appropriate state/national pharmacy association(s) is required. The use of a personal notebook computer, or smart phone, (to be supplied by Contractor) is required; the Contractor shall supply the audit pharmacist with any additional technology/membership(s) to support the pharmacist to ensure successful contract performance. Prior to beginning at the Medicaid Agency, the audit pharmacist shall be experienced in Microsoft Office (to include Outlook, Excel, PowerPoint) Audit pharmacist shall be available to begin work at Medicaid no later than November 1, 2018.

Responsibilities of the Audit Pharmacist include, but are not limited to:

1. Review claims to certify that filled prescriptions are paid for appropriate recipients, by appropriate prescribers, according to appropriate rates in accordance with state and federal rules and regulations.
2. Attend and participate in Medicaid and Provider meetings.
3. Run, review, and make recommendations on data for financial reports to minimize waste and abuse.
4. Attend weekly teleconferences and any additional meetings between Medicaid and Clinical Contractor.
5. Assist providers with claim issues to minimize waste and abuse.
6. Conduct desk audits on all aspects related to Medicaid Pharmacy and DME claims and policy, and other areas as requested.
7. Perform on-site audits as needed/requested by Medicaid, and schedule audit travel in a cost and time effective manner. The Contractor will be responsible for the audit pharmacist travel costs if travel is warranted.
8. Manage the Hemophilia Standard of Care (SOC) and all hemophilia annual clinical audits and annual SOC agreements.
9. Run monthly reports and review claims over \$1000 for potential billing errors.
10. Must have a proven ability to effectively handle cases of potential abuse in a discreet, confidential, and professional manner.
11. Must work independently with minimal guidance.
12. Report any audit concerns in a timely manner without delay.
13. Comply with HIPAA and all federal/state regulations regarding privacy and confidentiality of patient information.
14. Coordinate with appropriate Agency staff outside of Clinical Services (Medical Directors, Program Integrity).
15. Represent the primary point of contact for all audits conducted.
16. Provide education to providers and Agency staff when needed.
17. Provide recommendations on potential new audits/edits.
18. Provide recommendations on potential new policy, and provide assistance on implementation when needed.

19. Attend and participate in a professional manner with any fair hearings, informal conferences, or litigation that shall arise.
20. Provide clinical or administrative support to Medicaid's Pharmacy Program.
21. Review, maintain, and revise internal/external policy and coordinate any updates/changes with pertinent personnel.
22. Attend weekly teleconferences and monthly contract status meetings with Medicaid and Contractor.
23. Attend programs/seminars required through the academic detailing component.
24. Respond to provider/recipient inquiries via written, verbal, or electronic means upon Medicaid's request.
25. Review and make recommendations as it relates to information regarding the drug reference file, pharmacy billing, and other aspects of the program for Medicaid MMIS system.

J. Other Personnel

Contractor shall demonstrate the ability to secure and retain professional staff to meet contract requirements. This shall include staff member with financial based education (accounting, statistics, business degree) for projected cost savings data and other clinical and administrative personnel, pharmacists, physicians, specialists (pain management specialists, dentists) and provider representatives.

Medicaid shall have the absolute right to approve or disapprove Contractor's and any subcontractor's staff assigned to the contract, to approve or disapprove any proposed changes in this personnel, or to require the removal or reassignment of any personnel found by Medicaid to be unwilling or unable to perform under the terms of the contract. Contractor shall, upon request, provide Medicaid with a resume of any members of its staff or a subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this contract. Personnel commitments made on Contractor's response shall not be changed except as herein above provided or due to the resignation of any named individual.

K. Organizational Plan

Contractor shall submit an organizational chart to Medicaid with proposal. Contractor does not have to have all position resources named at this time but must list the position in the organization chart and include in any write up that contractor understands that this position must be filled and resume submitted to Medicaid for approval prior to contract implementation. This plan shall include a breakdown of job duties and responsibilities of management staff. Any subsequent changes to the organizational plan shall be approved by Medicaid.

It is permitted by Medicaid to have one individual assigned by Contractor for Project Manager and Account Pharmacist as long as the individual is qualified to perform duties outlined for these positions. It is permitted to have one individual assigned by Contractor for Account Pharmacist and Help Desk Supervisor as long as the individual is qualified to perform duties outlined for these positions. It is not permitted to have the same individual as Project Manager, Account Pharmacist, and Help Desk Supervisor.

It will not be permitted by Medicaid to have one individual assigned to perform the duties of Account Pharmacist and Staff Pharmacist or Audit Pharmacist. It is permitted by Medicaid to have one individual assigned to Staff Pharmacist and Pharmacy Lock-In Pharmacist. It is permitted to have the Audit Pharmacist serve as the Lock-In Pharmacist should the Audit Pharmacist option be chosen (however, a Lock-In Pharmacist must be named even if the Audit Pharmacist option is not chosen).

It will not be permitted by Medicaid to have one individual assigned to perform the duties of Staff Certified Pharmacy Technician and have that person serve on the Help Desk or any other areas other than described in the duties of Staff Certified Pharmacy Technician section.

Contractor may not combine the FTE provider representatives required for the academic detailing component with other required positions.

Any subsequent changes to the organizational plan must be approved by Medicaid.

L. Work Plan and Implementation Schedule

Contractor must provide a proposed work plan and implementation schedule as a part of this RFP response submission. A revised work plan and implementation schedule must be provided to Medicaid in electronic format within 30 business days of contract award.

The work plan must identify major tasks, the work elements of each task, the resources assigned to the task, the time allotted to each element and the deliverable items the selected Contractor will produce.

The contract support has been described in this RFP in key personnel. Additional staff shall be available to provide whatever clinical, administrative and technical support personnel Contractor deems necessary to accomplish the scope of work described herein. Unless otherwise indicated, the Contractor shall submit a resume for each position listed.

Required components of the program are:

- Implement and maintain a pharmacy prior authorization/override provider and Recipient Help Desk. The Help Desk shall be staffed with appropriate personnel certified as required by the contract. The administration of retrospective DUR for outpatient pharmacy services will be provided through a single Contractor who will work with Medicaid to ensure that quality, accessible pharmaceutical products are provided to Medicaid beneficiaries.
- Contractor will be required to execute Medicaid directives for program and/or policy changes to ensure that quality standards are maintained, services provided are accessible and are appropriate. Areas involved include, but are not limited to, Preferred Drug List product education, Prior Authorization (PA) criteria, Override criteria for Prospective Drug Utilization Review (DUR) hard editing, Academic Detailing and Retrospective DUR criteria.
- The Medicaid Fiscal Agent will remain responsible for processing pharmacy claims using an electronic format. Contractor shall be responsible for all costs associated with installing and maintaining system interfaces with the Alabama Medicaid Management Information System (AMMIS). On-line interfaces will be required for prior authorizations to include eligibility and claims information, and prospective DUR edit overrides. Additional information and data transfers can be accomplished through tape transfers/coordination with our fiscal agent.
- Expansion and maintenance of the current Prior Authorization (PA) Program and selection of high-risk drugs is permitted through recommendations to Medicaid's Pharmacy and Therapeutics (P&T) Committee, DUR Board, and approval of Medicaid. Contractor will not have authority over what drugs require prior authorization. All additional drugs to require

prior authorization may be recommended to the P&T Committee or Agency for inclusion on the Medicaid Prior Authorization List. The PA Program must include a mechanism to allow for a 72 hour emergency supply, 8 hour response time with a mandated 24 hour turnaround and a Help Desk staffed with appropriate professionals. The turnaround process does not start until all information is received.

- Promotion of the Medicaid Preferred Drug List (PDL) as approved by the Medicaid P&T Committee and Medicaid.
- Provider education through academic detailing and other Medicaid approved mechanisms such as distribution of educational materials through notices or newsletters and targeted intervention to selected providers.
- Provider summary reporting of prescribing and dispensing patterns through claims data analysis.
- Contractor shall refer to Medicaid's Program Integrity Division Director and Director of Clinical Services/Pharmacy any instances of suspected fraud or abuse. In this regard, Contractor shall provide all of its employees with specific, written instructions approved by Medicaid on the identification and referral of suspected fraud and abuse.
- For reviews and recommendations to Medicaid and the DUR Board, Contractor must utilize the most current pharmacological data from the following: AHFS (American Hospital Formulary Services), Hanson's Adverse Drug Reactions, Physician's Desk Reference (PDR), USP DI Pharmacopoeia, ASHP DI, American Medical Association Drug Evaluations, Facts and Comparison, Redbook, Orangebook, and National Formulary, OVID, and Up-to-Date.
- Contractor shall coordinate DUR Board Meetings to update therapeutic criteria, provider education and interventions for retrospective and prospective DUR.
- Contractor shall maintain an academic detailing program based upon on-going reviews and analysis by Medicaid and Contractor.
- Contractor shall provide access to Medicaid PA and Override request forms, Medicaid Preferred Drug List (PDL) and a link to the Medicaid web-site through Contractor web-site.
- Provide clinical information and respond to questions from Medicaid designated Pharmacy staff within one business day.

M. Transmittal Letter

The Transmittal Letter is a cover letter addressed to Medicaid. It must include the following information:

- a. Identification of all materials and enclosures being submitted collectively as the bid in response to this RFP.
- b. A statement identifying each amendment or addendum to this RFP that has been received; if no amendments or addenda have been received, a statement to that effect must be included. The bidder must list each RFP amendment or addendum acknowledged and received, by amendment or addendum number.

- c. Identification of the bidder that will be the Contractor and the name of the corporation or other legal entity submitting the bid. The bidder must assume sole and exclusive responsibility for all of the contract responsibilities and work indicated in the RFP (including any and all addenda). Any effort to limit or qualify this responsibility, or assign any responsibility to a subcontractor will result in the bid being rejected as non-responsive to the bid requirements. Bidder must use this section to state whether it is a: partnership, non-profit corporation, Alabama corporation, non-Alabama corporation or some other structure.
- d. A statement of compliance with Affirmative Action and Equal Employment Opportunity regulations that confirms that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, developmental disability, political affiliation, national origin, or handicap, and complies with all applicable provisions of Public Law 101-336, Americans with Disabilities Act of 1990.
- e. A statement acknowledging and agreeing to all of the rights of Medicaid contained in the provisions of this RFP.
- f. A statement that the bidder understands and will comply with all of the provisions of the RFP.
- g. A statement that the prices proposed have been arrived at independently without consultation, communication, or agreement with any other bidder or competitor involved in the procurement for this contract.
- h. A statement that the bidder, through its duly authorized representatives, has in no way entered into any arrangement or agreement with any other bidder or competitor which could lessen or destroy free competition in awarding the contract sought by the attached bid.
- i. A statement that, unless otherwise required by law, the prices quoted must not be knowingly disclosed by the bidder, directly or indirectly, prior to award of the contract, to any other bidder, competitor or any other person or entity.
- j. A statement that the bidder has not and will not make any attempt to induce any other person or firm to withhold or submit a bid for the purposes of restricting competition.
- k. A statement that the person signing this bid is authorized to make decisions on behalf of the bidder's organization as to the prices quoted.
- l. A statement that no person or agency has been employed or retained to solicit or secure the proposed contract based on an agreement or understanding for a commission, percentage, brokerage, or contingent fee.
- m. A statement that the bidder and its subcontractors will maintain a drug-free workplace.
- n. A statement that the successful bidder will be required to complete a financial disclosure statement, Health Insurance Portability and Accountability Act (HIPAA) agreement, and business associate agreement with the executed contract.

N. Drug Utilization Review

a. Prospective DUR (ProDUR) Edits Monitoring

Prospective Drug Utilization Review (DUR) is a structured program required by the CFR that screens drug claims on-line against predetermined medical standards and criteria, and promotes clinical safety, therapeutic efficacy and appropriate drug use. Only through the identification of potential drug therapy problems can appropriate interventions be initiated. Contractor will be responsible for monitoring the Prospective DUR program. Additionally, Contractor shall make recommendations to Medicaid and the DUR Board for additions and/or deletions of established prospective DUR criteria.

Contractor is not responsible for adjudicating claims and maintaining the on-line Prospective DUR system. Contractor is responsible for monitoring the prospective DUR program as well as staffing a provider help desk to consider and grant appropriate overrides to hard edits through the prospective DUR system maintained by the fiscal agent. Contractor shall respond to all requests for on-line editing overrides within 24 hours of receipt of the request. Claims will be flagged by the fiscal agent for prospective DUR including high-dose, drug/drug interaction, early refill, and excessive quantity. Currently, early refill, maximum units, maximum cost and therapeutic duplication are hard edits that require an override from the Pharmacy Contractor for claims submission. Drug/drug interaction and High Dose are soft edits and can be overridden by the provider at the pharmacy level. Recommendations for other edits may be made by the Contractor to Medicaid for consideration.

General Requirements

1. Monitor frequency of alerts/overrides by pharmacists; determine the average override percentage for the majority of Medicaid pharmacies based on research of Medicaid provider data.
2. Monitor and target through Medicaid approved educational plans, pharmacies that consistently override alerts above standards established by Medicaid.
3. Provide Medicaid drug utilization information and data, as required to the Alabama Medicaid DUR Board and/or to Alabama Medicaid Agency to support Pro-DUR criteria enhancements.
4. Evaluate effectiveness of specific alerts and recommend modifications as needed.
5. Recommend use of additional hard, soft, or informational edits to Medicaid for approval.
6. Provide ongoing support to providers by maintaining and staffing a help desk.
7. Assist Medicaid in the evaluation of overall on-line system effectiveness.
8. Develop in conjunction with the ProDUR contractor, additional Pro-DUR criteria and present to the DUR Board for approval.
9. Coordinate with the DUR Board on specific therapeutic classes to include/exclude in Pro-DUR editing.
10. Identify additional reporting needs; assist Medicaid in development of additional reports.
11. Refer cases to Medicaid's Program Integrity Division including Pharmacy Audit Unit as appropriate via the contract administrator.
12. Monitor Monthly Provider Summary Reports to identify problem providers; inappropriate prescribing and dispensing patterns.
13. Recommend changes to the Alabama Medicaid Provider Manual as appropriate.

Specific Requirements

1. Monthly reports that identify pharmacists exceeding the established standard for overrides. These reports shall include, but not limited to, top pharmacies requesting an early refill, total number of early refills, therapeutic duplications, max unit requests and the source of these requests. These reports shall include but not limited to top pharmacies and providers by claim cost.
2. Monthly provider summary reports which identify pharmacists to target through retrospective DUR and education initiatives.

3. Quarterly presentations to the Medicaid DUR Board as to the effectiveness of the current prospective DUR system as well as any enhancements that should be considered.
4. Pro-DUR training to Medicaid staff and providers as requested by Medicaid.

Medicaid Responsibilities

1. Establish policies and guidelines to be followed by providers and Contractor in using Pro-DUR.
2. Determine the modules and criteria to use for the Pro-DUR functions.
3. Specify the Pro-DUR training needs of both State staff and providers.
4. Serve as the liaison between the DUR Board, Fiscal Agent and Contractor.
5. Coordinate the development of additional prospective DUR editing with the Fiscal Agent.

b. Retrospective DUR (RDUR) Edits Monitoring

Contractor will be responsible for performing retrospective DUR functions as outlined in 42 CFR 456.709. Paid claims data will be used to develop reports which identify patterns of fraud, abuse, overuse, or inappropriate medically unnecessary care among physicians, pharmacists, and Medicaid recipients, associated with specific drugs or groups of drugs. This examination must involve pattern analysis using predetermined standards of physician prescribing practices, drug use by individual patients, and where appropriate, dispensing pharmacies. Retrospective DUR includes, but is not limited to, using predetermined standards to monitor the following: therapeutic appropriateness, over-utilization and under-utilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug/drug interaction, incorrect drug dosage, incorrect duration of drug treatment, and clinical abuse and misuse.

Contractor will be responsible for the development and distribution of DUR Board meeting agendas and meeting packets. Contractor pharmacist will present appropriate materials to the DUR Board at quarterly meetings. Contractor will also be responsible for drafting and finalizing minutes of the DUR Board meetings to include discussions held, and motions and recommendations made.

General Requirements

1. Coordinating with Medicaid provider education activities.
2. Marketing of the Medicaid PDL and instructing in its usage.
3. Generating provider specific prescribing data of Medicaid's top 200 prescribing physicians and top 200 dispensing pharmacists on a quarterly basis to Medicaid.
4. Generating and distributing educational letters on specific intervention criteria as directed by the DUR Board and Medicaid. A minimum of 500 recipients (some recipients may hit more than one criteria and result in more than one letter) are to be targeted each quarter and all involved providers for each recipient must be contacted for intervention. Letters shall be reviewed by a licensed pharmacist and should offer the provider an opportunity for feedback. Any such feedback should be summarized and provided to Medicaid and the DUR Board. Medicaid shall have the option of increasing the quarterly target recipient number through contract amendments if the Contractor can demonstrate increased letters are cost-effective.
5. Referring provider concerns regarding inappropriate prescribing and dispensing patterns to Medicaid.
6. Maintain a database to support retrospective DUR.

7. Develop, in conjunction with the DUR Board, therapeutically based criteria by which patient specific profiles, physician and pharmacy profiles will be generated.
8. Input into the retrospective DUR database the therapeutic criteria, approved by the DUR Board, within four weeks of DUR Board and Medicaid approval to ensure that the most current criteria have been used to generate profiles.
9. Provide within seven business days, upon request of Medicaid, a hard copy listing of all DUR criteria in computer system.
10. Develop and monitor the retrospective DUR program according to Federal guidelines to ensure compliance.
11. Annually review current criteria for recommended DUR Board revision and approval.
12. Provide ongoing evaluation of appropriateness of dispensing and prescribing patterns for DUR Board review.
13. Compile analysis from DUR annually to meet Centers for Medicaid and Medicare Services (CMS) requirements for annual DUR reporting. Prepare and submit to Medicaid for approval the CMS DUR Report a minimum of four weeks prior to CMS due date. Submit the final approved DUR Annual Report to CMS per CMS guidelines.
14. Provide professional guidance on DUR issues upon request.
15. Develop and distribute Medicaid approved DUR Board agenda and meeting packets to include ballots to board members for DUR Board meetings. Packets must be received by DUR Board members a minimum of two weeks prior to scheduled meetings. Seven copies of the finalized packets should be sent to Medicaid Contract Administrator two weeks prior to meeting.
16. Act as the recording secretary of all DUR Board meetings and provide formal record of DUR Board meeting in the form of minutes to be approved by Medicaid. Proposed draft of minutes shall be provided to Medicaid within two weeks of DUR Board meetings. Once approved by Medicaid, the finalized version shall be provided to Medicaid within one week for posting to the web.
17. Notify members of DUR Board of meetings in coordination with Medicaid.
18. Send written notification to DUR members whose terms are expiring.
19. Maintain a listing of committee members and send an electronic version to Medicaid annually or upon update to include contact information.
20. Maintain an operational procedures manual for DUR Board to include meeting policies, election of officers, conflict of interest policy.
21. Conduct a meeting with all new members prior to first meeting to provide an orientation to the committee. These meetings are to be conducted with a designated staff member from Medicaid.
22. Make recommendations to Medicaid regarding operational policy and procedures for the DUR and pharmacy program policy and procedures as they relate to the scope of work of this RFP. Contractor is expected to utilize its expertise in the scope of this RFP to identify procedures that may improve current Medicaid policy.

Specific Requirements

1. Quarterly DUR letters sent to providers.
2. Quarterly report of providers targeted through retro DUR initiatives to include the total number of letters sent, number of recipients and providers targeted, DUR criteria used for interventions, and summary of feedback received.
3. Quarterly report of PDL usage to monitor effectiveness of program and program dollars saved as a result of PDL usage.
4. Quarterly report consisting of, at a minimum, tabulation by percent of generic, single source and multi-source prescriptions by dollars, claim count, unduplicated count of recipients and number of prescribing physicians.
5. Annual CMS DUR Report for Medicaid approval as specified in 42 CFR 456.712.
6. Formal minutes of DUR Board meetings.
7. Finalized DUR Board meeting agendas, ballots and meeting packets.
8. Formal internal timeline of each quarterly DUR meeting action items to be pre-approved by Medicaid.
9. Submit DUR Annual Report to CMS.

Medicaid Responsibilities

1. Approve retro DUR educational activities of Contractor.
2. Provide Contractor with a current Medicaid Preferred Drug List and notify timely of updates.
3. Schedule P&T Committee and DUR Board meetings.
4. Review and approve DUR Board meeting agendas and packets and annual reports.
5. Review and approve DUR Board meeting minutes and notify Contractor of recommendation decisions.
6. Maintain responsibility for nominations and approval of DUR Board member positions.
7. Notify Contractor of any changes in DUR Board membership in a timely manner.
8. Provide Contractor with monthly eligibility and claims extract tapes.

c. Preferred Drug List (PDL)

In accordance with Alabama Act No. 2003-297, Alabama Medicaid implemented a mandatory Preferred Drug Program in November 2003. Prior to November 2003, the Preferred Drug Program was voluntary.

The Preferred Drug Program operates with three basic goals. The primary goal of the program is to foster safe, appropriate and effective drug therapy. Clinical considerations and patient care and safety take precedence over all other deliberations and decisions. The program provides Medicaid with a fundamental and foundational drug management system through a quality of care supported by evidence-based medicine driven approach.

Secondly, the Preferred Drug Program is designed to serve as an educational system for both prescribing physicians and dispensing pharmacies. The Preferred Drug Program does not override the prescribing prerogatives of physicians. A physician has and maintains the ability to prescribe any medically necessary medication. Use of a preferred drug is required unless the prescriber obtains prior approval.

Additionally, the Preferred Drug Program offers a mechanism to control the increasing costs associated with medical care. Properly employed drug therapy in managing disease contributes substantially to improved health outcomes and lower overall health care costs. Also, the Preferred Drug Program fosters appropriate generic and over-the-counter (OTC) drug utilization.

The pertinent components of the Preferred Drug Program include the Preferred Drug List (PDL) and the Pharmacy and Therapeutics (P&T) Committee. These components are outlined in the following sections.

Alabama Medicaid utilizes a Preferred Drug List (PDL) for determination of drugs available for reimbursement under the Medicaid Program without prior authorization. The PDL is composed of preferred brands, generics and covered over-the-counter (OTC) products of targeted and reviewed classes of drugs. Non-preferred agents for the classes reviewed remain covered but require prior authorization. For reimbursement under the Medicaid Program, use of the Preferred Drug list is mandatory. Drugs will be considered for the preferred drug list based on the following:

- (a) clinical efficacy
- (b) side effect profiles
- (c) appropriate usage
- (d) cost

OTC drugs covered by Medicaid will be considered preferred drugs for Alabama Medicaid's Preferred Drug Program. However, OTC drugs will not appear on the Preferred Drug Lists.

Also, brand name drugs not included on the Preferred Drug Lists may be available through the prior authorization process. Medicaid shall strive to ensure any restriction on pharmaceutical use does not increase overall health care costs to Medicaid.

As of the writing of this RFP, the following drug classes have been implemented into the PDL: Alzheimers Agents, Androgens, Antidepressant Agents, Antidiabetic Agents, Antiemetic Agents, Antihistamines (First Generation), Antihypertensive Agents, Anti-infective agents, Antilipemic Agents, Anxiolytics/Sedatives/Hypnotics, Cardiac Agents, Cerebral Stimulants, ADHD Agents, Disease-Modifying Antirheumatic Drugs (DMARDs), EENT Antiallergic Agents, EENT Antibacterial Agents, EENT Vasoconstrictor Agents, Estrogens, Genitourinary Smooth Muscle Relaxants, Intranasal Corticosteroids, Multiple Sclerosis (MS) Agents, Narcotic Analgesic Agents, Opioid Dependence Agents, Oral Anticoagulants, Platelet-Aggregation Inhibitor Agents, Prenatal Vitamins, Proton Pump Inhibitors, Respiratory Agents, Selective Serotonin Agonists, Skeletal Muscle Relaxants, Skin and Mucous Membrane Agents, and Wakefulness Promoting Agents. Other drug classes may be added as they are reviewed and approved.

d. Pharmacy and Therapeutics (P&T) Committee

Alabama Legislation mandates that Medicaid is to develop the PDL in coordination with the Pharmacy and Therapeutics (P&T) Committee. The P&T Committee functions include advising Medicaid on prior authorization, PDL reviews and coverage determinations. For purposes of the PDL, the Committee performs in-depth clinical reviews of targeted classes of drugs. The P&T Committee serves as an advisory panel and makes recommendations to Medicaid utilizing reviews provided by a Clinical (not the Administrative) Contractor.

The Alabama Medicaid Agency will utilize the P&T Committee to review and recommend drugs for the Preferred Drug List. The Committee will consist of three clinical pharmacists licensed to practice in the state of Alabama including at least one independent pharmacist and one long term care pharmacist, and at least five physicians licensed to practice medicine in the state of Alabama. More information regarding our Preferred Drug Program can be found on the Medicaid website, http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx.

Drugs may be added from time to time upon request to P&T, however Contractor shall not have authority over drugs that go on the Prior Authorization List, nor shall Contractor be responsible for selecting products for the PDL. Contractor may make recommendations for additional drugs to be added.

Contractor Account Pharmacist and Staff Pharmacist will be required to attend all P&T Committee meetings.

General Requirements

1. Account and Staff Pharmacists shall attend all P&T Committee meetings.
2. Review, implement, and recommend modifications regarding any criteria related to prior authorization, override, and/or DUR as outlined in this RFP.

Medicaid Responsibilities

1. Provide needed support and coordination efforts between Contractor, Clinical Contractor, Fiscal Agent, and any other needed parties.

O. PRIOR AUTHORIZATION (PA)

The primary goal of the PA program is to promote the most appropriate utilization of select drugs. Medicaid and the P&T Committee will approve prior authorization requirements to target a chosen drug or group of drugs. Additional drugs to require prior authorization may be presented for review by the Medicaid P&T Committee and approved by Medicaid in accordance with State of Alabama Administrative Code Rule No. 560-X-16-.09.

Contractor shall review proposed prior authorization criteria and make recommendations for change to Medicaid based on clinical review of current medical literature. Medicaid will provide Contractor with approved PA criteria and forms in hard copy and electronic format. In FY 2017, there were a total of 389,956 manual and electronic prior authorizations by the PA contractor. Of those requests, there were 295 appeals completed.

a. Prior Authorization Requirements

Contractor shall receive requests, hereinafter referred to as PA Requests, from physicians or pharmacies for Medicaid coverage of drugs that require prior authorization. Drugs requiring prior authorization outside the scope of the PDL include Antihistamines (Second Generation), Antipsychotic Agents, Growth Failure Agents including Adults, AIDS Wasting and Children, H2 Antagonists, NSAIDs, Phosphodiesterase Inhibitors, Smoking Cessation, Specialized Nutritionals, Sustained Release Oral Opioid Agonists, Xenical, and Xolair. Non-preferred agents for the classes reviewed under the PDL are covered but require prior authorization as well. For medications currently requiring prior authorization, please visit the applicable RFP posting on the Alabama Medicaid website at http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx. Other requirements may be added by Medicaid at any point in the future. Medicaid shall give at least two weeks written notice to Contractor before implementing a new prior authorization requirement.

Contractor shall accept written, electronic or telephone requests from either the prescribing physician or their authorized representative, or the dispensing pharmacy. Written requests may be submitted by mail, fax, or online. Toll free phones shall be provided 24 hours a day, 7 days a week with an automated voice message system to record calls after hours and give on-call contact information. Toll-free FAX lines shall be provided 24 hours a day, seven days a week. A help desk shall be available to providers 8:00 a.m. - 7:00 p.m. Monday through Friday with Saturday coverage from 10:00 a.m. until 4:00 p.m. Contractor will provide a clinical representative on call to accept prior authorization and issue prior authorization numbers on Sundays, after hours and on help-desk holidays.

Contractor shall respond to a minimum of 75 percent of total prior authorization requests each month within 8 hours of receipt of completed request but in no event shall response time exceed 24 hours. Responses to requests must be issued within 24 hours of receipt of the completed request. Upon receipt of an incomplete request, Contractor is obtain missing information. This may be accomplished through system inquiry, calling or faxing form to provider for completion of required information.

Additionally, a mechanism must be in place to provide a 72 hour supply of medication in emergency situations. Medicaid has established a generic PA number to be used in these situations. Utilization of this generic PA number will be monitored closely by Medicaid.

Contractor shall respond to the requesting practitioner by telephone or other telecommunications device with approval/denial within twenty-four hours of receipt of a phoned, faxed, electronic or mailed complete PA. Telephone responses shall be during the normal business hours of the providers. Contractor shall document unsuccessful attempts to respond which occur more than fifteen minutes apart. Attempts made more frequently than these fifteen minute intervals are at Contractor's discretion. Documentation must include the date, time, method used, and the result of each attempt. Contractor shall respond by mail to a request only when the documentation on the Drug Prior Authorization Response establishes that three unsuccessful attempts were made no closer than fifteen minutes apart. Contractor shall receive and respond to electronic requests in the National Council for Prescription Drug Programs (NCPDP) HIPAA Standard format. Additional responses to electronic requests by telephone, fax and mail are allowed but are not required.

Contractor shall utilize drug usage criteria approved by Medicaid to approve/deny PA requests. Current criteria to be applied to specific drugs requiring prior authorization can be found on Medicaid's website at http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx. Medicaid will provide Contractor with more detailed criteria during implementation phase. Criteria may be added or revised by Medicaid based on clinical review or recommendation of the P&T Committee. Contractor shall ensure that review criteria are applied in a uniform manner to all requests. If staff cannot determine whether to approve or deny a request, it shall be referred to a pharmacist or physician consultant for approval/denial. If Contractor has questions regarding criteria, clarification should be requested from Medicaid. (See Attachments for a workflow diagram of the review process). Contractor shall implement daily quality control checks on prior authorization and override requests and monthly prior authorization and override audits shall be conducted to ensure requests are being reviewed approved accurately. Prior authorization denials that contain additional medical justification shall be reviewed by clinical personnel before a denial letter is sent to a provider.

Additionally, Contractor shall review the Alabama Drug Information Reference subsystem panels to ensure that the drug being prior authorized is covered by Medicaid and the Alabama Recipient panels to ensure that the recipient is eligible for Medicaid drug coverage at the time of the PA request. Requests for QMB-only, otherwise ineligible recipients, and recipients covered under Part D (for Part D covered drugs) shall be denied. Contractor shall verify that the designated pharmacy is currently enrolled in the Medicaid program. Contractor shall also ensure that the appropriate pharmacy or prescriber is indicated when the recipient is locked-in to a certain provider. This information is provided through the Recipient Lock-in File.

Contractor shall assign a ten digit numeric PA number for approved PA requests which meet the approval criteria for Medicaid coverage. Contractor shall document the assigned PA number and supporting documentation on the request form. Contractor shall update Medicaid's on-line Prior Authorization File within twenty-four hours of receipt of request.

Contractor shall deny PA requests that fail to meet Medicaid approved guidelines. Contractor shall notify the prescribing physician and dispensing pharmacy in writing and include the denial reason using codes

established by Contractor and approved by Medicaid. This information shall be faxed to the prescribing physician and dispensing pharmacist within 24 hours of receipt. Contractor must respond to electronic requests via NCPDP HIPAA Standard format.

Contractor shall establish and maintain a database of PA requests. Data shall include, but is not limited to, date and time of receipt; name of recipient; Medicaid number; pharmacy name and provider number; date of PA approval or denial, drug name, NDC number, requester, whether medical justification was submitted and prescribing physician license number. Provider may appeal a PA decision and supply additional medical justification for consideration. (See Clinical Appeals and PA workflow diagram on Medicaid's website at

http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx)

General Requirements

1. Make presentations including documentation to Medicaid regarding recommendations for additions/deletions of prior authorization requirements.
2. Provide monthly and annual prior authorization report by drug group to include number of requests, approvals, denials; number of requests initiated by pharmacists and physicians; number of requests by fax, phone, mail, electronic and online; percentage of total requests responded to within eight hours of receipt of completed request.
3. Provide weekly toll-free phone line usage studies to include number of calls per day, average wait time, average response time, longest wait time, longest response time, number of aborted calls, number of Help Desk personnel for each day.
4. Provide monthly reports identifying cost savings associated with prior authorization requirements.
5. Establish and maintain a database for prior authorization requests.
6. Provide a clinical representative on call to accept prior authorization and issue prior authorization numbers on Sundays, after hours and on help-desk holidays.

P. Electronic Prior Authorization

Contractor shall be knowledgeable in the development and maintenance of automated clinical criteria. Contractor shall develop and maintain a system for the electronic prior authorization (EPA) of pharmacy claims that require PA. The EPA system shall check Medicaid pharmacy and medical claims history to determine if prior authorization requirements are met when a pharmacy claim is submitted. If it is determined that all criteria are met, the request is approved, the claim will pay and no manual PA request will be required. EPA criteria must exactly match manual PA criteria. Currently, the vendor, using criteria approved by Medicaid and interfacing with the fiscal agent, provides an electronic PA process where the system electronically checks the medical claims history to identify prior drug history, diagnosis and other aspects. If the prior history is not found electronically, the prior authorization is rejected electronically, with a message sent to the provider by the fiscal agent that a manual prior authorization is required, meaning, a paper PA must be completed by the provider and the help desk personnel must physically review the PA for approval or denial. Once the manual request is approved or denied, a response is then sent to the provider, (both prescriber and pharmacy) via fax by the contractor. Contractor must have capability in place to monitor the EPA system for rejected claims that do not meet criteria and will need to be completed manually. Contractor must be able to accept batch transactions. Contractor shall establish a dedicated VPN communication line from Medicaid's fiscal agent to the contractor's facility and maintain interface capabilities between contractor and Medicaid's fiscal agent to ensure a less than 3 second response time to the provider. Contractor shall establish any VAN lines needed to complete the EPA process. Contractor shall respond to provider regarding the outcome of prior authorization request (if the EPA is denied, the provider must be guided that a manual PA is needed).

Contractor must be able to accept and respond to requests in NCPDP P4 format. At the time of the writing of this RFP, there are 28 drug classes implemented into EPA. Other classes may be phased in as needed. The electronic PA process must be automated and check the system electronically within seconds of the PA submission. For all PA requests, including electronic, contractor shall send approval letters to physician and pharmacists. Contractor will be responsible for ensuring computer connections are compatible with fiscal agent connectivity requirements already in place. Contractor shall be responsible for providing a technical position that can understand and function on behalf of the contractor to answer questions and understand communication for programming and development of the electronic prior authorization system. Contractor shall be responsible for developing a system for the checking of diagnosis, therapy data and must develop a system that is able to look back into claims history. Contractor shall be responsible for providing operability and status updates to Medicaid when new classes are implemented to the electronic PA system. Any additional lines needed by contractor will be at the expense of the contractor to ensure that system is operational from the contractor's end of the connectivity lines.

General Requirements

1. A monthly and annual report of electronic prior authorization submission, totals of EPA implemented drug classes, to include number of denials, total rejected for manual completion, total unique approvals.
2. Contractor will provide plans and procedures on development and maintenance of EPA system to Medicaid for approval.
3. Make presentations including documentation to Medicaid regarding recommendations for additions/deletions of prior authorization requirements.
4. Provide monthly electronic prior authorization report by drug group to include number of requests, approvals, denials; number of requests initiated by pharmacists and physicians; number of requests by fax, phone, mail, electronic and online; percentage of total requests responded to within eight hours of receipt of completed request.
5. Provide monthly reports identifying cost savings associated with prior authorization requirements.

Q. Online Prior Authorization

Contractor shall develop, and maintain an online submission system for prior authorizations. The online system shall meet minimum standards of what is currently in place. Currently, this is done via an email request utilizing HTML and SSL encryption to provide a secure interface. The online submission of prior authorization will allow a provider to complete the prior authorization form via a fillable form online and send it directly to the pharmacy PA help desk via an email account for review by the PA contractor. The prescribing physician and the dispensing pharmacy will receive a faxed approval or denial response for documenting purposes. Contractor shall establish a link from its website for online PA submission and make available a link to Medicaid's website. Contractor plans and procedures shall be submitted to Medicaid for approval. Contractor shall establish and maintain an HTML page for data entry of EPA claim. Online html page must maintain a fillable form and programming to require certain fields before submission. Online system shall prompt provider to enter required fields before submission will occur. Creating the online fillable version of the form will be the responsibility of the contractor.

General Requirements

1. Make recommendations for prior authorization to Medicaid based on clinical data.
2. Make recommendations for and conduct provider education.
3. Monitor effectiveness of prior authorization requirements for specified drug; dollars saved and clinical outcome cost savings.
4. Identify and monitor areas where cost shifting could occur as a result of a prior authorization requirement.
5. Contractor shall maintain a turnaround time not to exceed three seconds on electronic PA claims.

Specific Requirements

1. Make presentations including documentation to Medicaid regarding recommendations for additions/deletions of prior authorization requirements.
2. Provide monthly prior authorization report by drug group to include number of requests, approvals, denials; number of requests initiated by pharmacists and physicians; number of requests by fax, phone, mail, electronic and online; percentage of total requests responded to within eight hours of receipt of completed request.
3. Provide monthly reports identifying cost savings associated with prior authorization requirements.
4. Contractor shall monitor and report monthly on statistics of online submissions.

Medicaid Responsibilities

1. Ensure that the P&T Committee reviews drugs recommended for PA inclusion by the Contractor. Medicaid shall consider recommendations for additional review categories for approval.
2. Supply Contractor with PA number range for assignment of approved PA Requests.
3. Review and approve any changes in form letters, report formats and new forms or reports prior to use by Contractor.
4. Provide for administrative review by a licensed physician for requests when medical documentation has been submitted and denied after administrative and clinical remedies have been exhausted at Contractor level. Requests for review must be made by the prescribing physician or dispensing pharmacist and be received within sixty days of the date of the adverse decision. Medicaid shall obtain the necessary documentation required from Contractor for the Medicaid physician to determine whether or not Contractor's denial was justified. Medicaid will review samples of prior authorizations approved by Contractor on appeal.
5. Provide for administrative hearings. All adverse administrative review decisions made by Medicaid shall be subject to a formal administrative hearing. The prescribing physician, dispensing pharmacist, or recipient may request such a hearing. Requests must be in writing and received by Medicaid within sixty days of the date of the denial and shall be addressed to the Pharmacy Program, Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624. After receipt of a request for a hearing, Medicaid shall notify Contractor of the time, date and place of the hearing.
6. Initiate and distribute public notice of drugs requiring prior authorization, to include recipient and provider notices.
7. Notify Contractor in writing in advance of any additional prior authorization requirements.
8. Review samples of prior authorization requests and determinations made by the Contractor for accuracy and timeliness.

R. Incentive Program

Contractor shall develop, implement and maintain an incentive program for Medicaid providers. Currently this program is called the “Gold Standard Program”. The program shall be an incentive program for providers with high compliance with PDL utilization. The Incentive program shall exempt the number of prior authorizations that a provider has to obtain over a certain timeframe. Contractor must be able to track prescribing habits, reevaluate prescribing habits quarterly and implement and maintain a system that allows for exemption from the prior authorization process. Criteria for this program shall be approved by Medicaid.

General Requirements

1. Develop and maintain an incentive program for high compliance with the PDL.
2. Make recommendations for changes or updates to the Incentive program.
3. Work with Medicaid to define a standard and establish program criteria for the Incentive program.
4. Distribute Incentive program letters to providers.
5. Provide data analysis of selected providers to determine which providers meet the established Incentive program.
6. Provide assistance to providers and agency staff regarding Incentive program.

Specific Requirements

1. Provide standard provider compliance and adherence reports to determine which providers are selected and continue to meet criteria for the program each quarter.
2. Provide provider notification letters to Medicaid for approval before distributing to providers.

Medicaid Responsibilities

1. Provide approval for quarterly list of providers selected for the Incentive Program.
2. Provide contractor with approval and signatures for quarterly correspondence/letters sent out to providers.
3. Provide approval for quarterly Incentive provider list.
4. Review and approve any reports/correspondence provided to providers regarding the Incentive program.

S. Overrides

The primary goal of an override is to encourage appropriate dosing, prescribing, and dispensing as indicated by the Food and Drug Administration (FDA). For claims requesting more units than recommended by the FDA or requesting to be filled for amounts outside of required Medicaid criteria, an override will be required. Currently Medicaid has the following overrides/hard edits available: Early Refill, Maximum Allowable Cost, Maximum Unit, Brand Limit Switchover and Therapeutic Duplication. These are hard edits that must be overridden/approved by the Contractor. Medicaid shall give at least two weeks written notice to Contractor before implementing a new override requirement. Contractor shall utilize drug usage criteria and appropriate medical justification approved by Medicaid to approve/deny Override requests. Medicaid may review contractor’s overrides for appropriate accepted medical justification upon request.

a. Override Requirements

Contractor shall receive requests, hereinafter referred to as Override Requests. These requests shall be initiated from pharmacists, physicians or their authorized representative for Medicaid coverage of claims

that require an override. Currently, Medicaid has the following edits that require an override: Early Refill, Maximum Unit, Maximum Cost, Therapeutic Duplication, Brand Limit Switchover and DAW 1. Other requirements may be added by Medicaid at any point in the future. Medicaid shall give at least two weeks written notice to Contractor before implementing a new edit/override requirement.

Contractor shall accept written, electronic, telephone and some verbal requests from either the prescribing physician or the dispensing pharmacist. Written requests may be submitted by mail, fax, or online. Toll free phones shall be provided 24 hours a day, 7 days a week with an automated voice message system to record calls after hours and give on-call contact information. Toll-free FAX lines shall be provided 24 hours a day, seven days a week. A help desk shall be available to providers 8:00 a.m. - 7:00 p.m. Monday through Friday with Saturday coverage from 10:00 a.m. until 4:00 p.m. Contractor will provide a clinical representative on call to accept override and issue override numbers on Sundays, after hours and on help-desk holidays mentioned in Section 3.9.

Contractor shall respond to a minimum of 75 percent of total override requests each month within eight hours of receipt of completed request but in no event shall response time exceed 24 hours. Responses to requests must be issued within 24 hours of receipt of the completed request. Upon receipt of an incomplete request, Contractor is to obtain missing information. This may be accomplished through system inquiry or by faxing form to provider for completion of required information.

Contractor shall respond to the requesting practitioner by telephone or other telecommunications device with approval/denial within twenty-four hours of receipt of a phoned, faxed, electronic or mailed complete override request. Telephone responses shall be during the normal business hours of the providers. Contractor shall document unsuccessful attempts to respond which occur more than fifteen minutes apart. Attempts made more frequently than these fifteen minute intervals are at Contractor's discretion. Documentation must include the date, time, method used, and the result of each attempt. Contractor shall respond by mail to a request only when the documentation on the Override Response establishes that three unsuccessful attempts were made no closer than fifteen minutes apart. Contractor shall receive and respond to electronic requests in the NCPDP HIPAA Standard format. Additional responses to electronic requests by telephone, fax and mail are allowed but are not required.

Contractor shall utilize drug usage criteria approved by Medicaid to approve/deny Override requests. Current criteria to be applied to claims requesting an override can be located on Medicaid's website at http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx. Medicaid will provide Contractor with more detailed criteria during implementation phase. Criteria may be added or revised by Medicaid based on clinical review or recommendation of the P&T Committee. Contractor shall ensure that review criteria are applied in a uniform manner to all requests. If contractor staff cannot determine whether to approve or deny a request, it shall be referred to a pharmacist or physician consultant for approval/denial. If Contractor has questions regarding criteria, clarification should be requested from Medicaid.

Additionally, Contractor shall review claim history to check prior therapy information. Contractor shall review the Alabama Drug Reference panels to ensure that the drug being prior authorized is covered by Medicaid and the Alabama Recipient panels to ensure that the recipient is eligible for Medicaid drug coverage at the time of the override request. Requests for ineligible recipients shall be denied. Contractor shall verify that the designated pharmacy is currently enrolled in the Medicaid program. Contractor shall also ensure that the appropriate pharmacy or prescriber is indicated when the recipient is locked-in to a certain provider. This information is provided through the Recipient Lock-in File.

Contractor shall assign a ten digit numeric number for approved override requests which meet the approval criteria for Medicaid coverage. Contractor shall document the assigned number and supporting documentation on the request form. Contractor shall update Medicaid's on-line override file within

twenty-four hours of receipt of request. This applies to updating/transferring data for claims processing to the fiscal agent system with approved prior authorizations and overrides information.

Contractor shall deny override requests that fail to meet Medicaid approved guidelines. Contractor shall notify the prescribing physician and dispensing pharmacy in writing and include the denial reason using codes established by Contractor and approved by Medicaid. This information shall be faxed to the prescribing physician and dispensing pharmacist within twenty-four hours of receipt. Contractor must respond to electronic requests via NCPDP HIPAA Standard format.

Contractor shall establish and maintain a database of override requests. Data shall include, but is not limited to, date and time of receipt, name of recipient, Medicaid number, pharmacy name and provider number, date of override approval or denial, drug name, NDC number, requester, whether medical justification was submitted and prescribing physician license number.

General Requirements

1. Make recommendations for overrides to Medicaid.
2. Make recommendations for and conduct provider education.
3. Monitor effectiveness of override requirements for specified drug; dollars saved and clinical outcome cost savings.
4. Identify and monitor areas where cost shifting could occur as a result of an override requirement.

Specific Requirements

1. Make presentations including documentation to Medicaid regarding recommendations for additions/deletions of override requirements.
2. Provide monthly override report by drug group to include number of requests, approvals, denials; number of requests initiated by pharmacists and physicians; number of requests by fax, phone, mail, electronic and online; percentage of total requests responded to within 8 hours of receipt of completed request.
3. Provide weekly toll-free phone line usage studies to include number of calls per day, average wait time, average response time, longest wait time, longest response time, number of aborted calls, number of Help Desk personnel for each day.
4. Provide monthly reports identifying cost savings associated with override requirements.
5. Provide monthly reports to include number of requests, approvals, denials associated with override requirements.

Medicaid Responsibilities

1. Medicaid shall consider recommendations for additional review categories for approval.
2. Review and approve any changes in form letters, report formats and new forms or reports prior to use by Contractor.
3. Provide for administrative review by a licensed physician for requests when medical documentation has been submitted and denied after administrative remedies have been exhausted at Contractor level. Requests for review must be made by the prescribing physician or dispensing pharmacist and be received within sixty days of the date of the adverse decision. Medicaid shall obtain the necessary documentation required from Contractor for the Medicaid physician to determine whether or not Contractor's denial was justified. Medicaid will review samples of prior authorizations, overrides and appeals approved by Contractor.
4. Provide for administrative hearings. All adverse administrative review decisions made by Medicaid shall be subject to a formal administrative hearing. The prescribing physician, dispensing pharmacist, or recipient may request such a hearing. Requests must be in writing and

received by Medicaid within sixty days of the date of the denial and shall be addressed to the Pharmacy Program, Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624. After receipt of a request for a hearing, Medicaid shall notify Contractor of the time, date and place of the hearing.

5. Initiate and distribute public notice of drugs requiring an override, to include recipient and provider notices.
6. Notify Contractor in writing in advance of any additional override requirements.
7. Review samples of override requests and determinations made by the Contractor for accuracy and timeliness.

T. Clinical Appeal

Providers may request to appeal a PA denial or Override denial and supply additional medical justification for consideration to the Contractor. Upon receipt of an appeal, Contractor's consulting physician shall review the documentation and render a decision based on Medicaid approved PA or Override criteria or medical justification within one business day of receipt of complete appeal request. If Contractor's physician denies the appeal, the request and supporting documentation and Contractor's physician's notes are to be sent to Medicaid for review and final determination within one business day of receipt of complete appeal request. Medicaid will review the documentation and will send written notification to Contractor of final appeal decision within one Medicaid business day of receipt of appeal request from Contractor. Contractor is responsible for notifying the requesting provider of the outcome within four hours of receipt of response from Medicaid. If Contractor's physician approves the appeal, the requesting provider is to be notified within four hours.

Contractor shall also be responsible for receiving appeals related to the Early Periodic Screening Diagnostic Treatment (EPSDT) screenings. Providers may request to appeal a denial for a noncovered product when the drug has been shown to be medically necessary through the clinical appeal process using an EPSDT referral form and additional peer reviewed literature. This request shall be called EPSDT Requests for Medical Necessity.

General Requirements

1. Provide consulting physician and additional clinically appropriate staff to review the clinical appeal documentation and render a decision based on Medicaid approved criteria or medical justification within one business day of receipt of complete appeal request.
2. Provide for and transmit appeal documentation communication to Medicaid in a secure format so that information is encrypted and transmitted in a secure way.

Specific Requirements

1. Provide monthly and annual report of all appeals to include recipient name, drug name, request date and result of appeal.
2. Contractor shall send any denied clinical appeal claims to Medicaid for review.
3. Contractor shall submit a monthly report of all Clinical Appeals to include decision rendered and drug.
4. Contractor shall send all Medical Necessity requests directly to agency for Medical Director Review.

Medicaid Responsibilities

1. Coordinate with contractor for review of documentation or appeal sent directly to medical director.
2. Send written notification to Contractor of final appeal decision.

U. Specialty Drugs-Synagis®

Synagis® (palivizumab) is FDA approved for the prevention of respiratory syncytial virus (RSV) in selected infants and children. Palivizumab requires prior authorization (PA) for reimbursement through the Alabama Medicaid Agency. Prior authorization criteria are based on manufacturer labeling and current American Academy of Pediatrics (AAP) recommendations. Currently the RSV season for Alabama Medicaid runs October 1- March 31. Synagis PA requests are accepted beginning September 1 for an October 1 start date. Criteria are reviewed and evaluated annually. The contractor shall provide the following for the prior authorization and review of this specialty drug.

General Requirements

1. Provide one dedicated RN to review Synagis requests, update Synagis approvals, and serve as a liaison for provider calls. In the event, the dedicated RN is absent or not available, an equivalent back up shall be made available.
2. Provide one dedicated Data Entry staff/certified pharmacy technician responsible for entering Synagis approvals, denials, or updates.
3. Provide for troubleshooting Synagis PA issues with pharmacy provider(s).
4. Provide for phone call to providers (prescribers and/or pharmacy) to explain denials.
5. Provide for Synagis Tracking system.
 - a. Electronic system to track the number of approved doses and injection dates for each recipient.
 - b. Each recipients' Medicaid number, name, DOB, gestational age, and weight are entered.
 - c. The approval number is entered along with the number of approved doses.
 - d. The date of the patient's first injection is entered and subsequent injections are entered as the updates are received.
 - e. The criteria number for the approval can be entered (This is based on the actual internal criteria; ex. Criteria 3 = infants 32-35 weeks).
6. Provide for Synagis Appeals support (clinical pharmacist, medical director).
7. Provide for secure storage of Synagis Prior Authorizations at season's end.
8. Provide Synagis Monthly Synagis report (included in the standard monthly report).
 - a. Total number of Synagis approvals and denials
 1. Reasons for denials.
 2. Total % approved and total % denied.
 - b. Total number of Synagis 32-35 week approvals and denials
 1. Reasons for denials.
 2. Total % approved and total % denied.
 3. Percent of 32-35 week requests out of total.
9. Provide a Synagis mid-season report to Medicaid (due in February each year).
 - a. Overall utilization and cost
 1. Comparison of claims billed during the same timeframe of the previous year.

- b. Denials
 - 1. Reasons and counts for current timeframe and previous year.
 - c. Changes for the Season
10. Provide a Synagis end of season report to Medicaid (due May 1 each year).
- a. Background information on Synagis and RSV
 - b. Changes for the season
 - c. Overall utilization and cost
 - d. Post season analysis
 - 1. Number of claims per month.
 - 2. Top ten denial reasons.
 - 3. Top ten Synagis pharmacy providers.
 - e. Trending
 - 1. Utilization for current season and previous seasons.
 - A. Number of recipients;
 - B. Number of claims;
 - C. Cost/vial;
 - D. Average cost/claim;
 - E. Total cost;
 - F. Average cost/recipient;
 - G. Total PAs requested;
 - H. Number of PAs approved/denied;
 - I. % of PAs approved.
 - 2. Estimated number of doses per recipient for current season and previous 5 seasons.
 - 3. Comparison of Synagis cost versus total cost all drugs.
 - 4. RSV data for Alabama (CDC).
 - 5. RSV data for the Southern US Census Region (CDC).
 - 6. CDC's summary of the RSV season (comparing different HHS Regions or state).
11. Tracking of infants that were not dosed in the hospital setting (updated monthly).
- a. RN keeps a running spreadsheet of those recipients who did not receive a dose in the hospital:
 - 1. Contains patient's information.
 - 2. Discharging hospital.
 - 3. Date of discharge.
 - 4. Discharging provider.
 - 5. Requesting provider.
 - 6. Date of request.
 - b. Emailed to Medicaid monthly
12. Academic Detailing support.
13. Pre-Season meetings/support to include dedicated RN, Account Pharmacist, and Help Desk Supervisor.

Current Synagis criteria and an example of the mid-season and year-end report can be found on Medicaid's website at http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx. Currently, Synagis PA reviews are manual. Contractor may submit a plan to automate portions of the Synagis PA review process. Any automated processes must be approved by Medicaid.

Specific Requirements

1. Provide monthly Synagis report to include percent approved and percent denied.
2. Provide Synagis mid-season report (due in February each year).
3. Provide Synagis end of season report (due May 1 each year).
4. Report tracking infants that were not dosed in the hospital setting (updated monthly).

Medicaid Responsibilities

1. Review and approve any criteria, letters and reports used by contractor.
2. Provide agency approved criteria to contractor.
3. Review samples of requests and determinations made by the contractor for accuracy.

V. Help Desk

Contractor shall staff and maintain a Help Desk. Contractor Help Desk staff shall answer inquiries, written, electronic and telephonic from providers and Medicaid. Help desk hours of operation are 8:00 a.m. through 7:00 p.m. Central Time, Monday through Friday, and 10:00 a.m. - 4:00 p.m. Saturday. Contractor holidays are Easter, Independence Day, Thanksgiving, Christmas, and New Year. Contractor hours shall also be reduced on Christmas Eve dependent upon the call volume for that day on the previous year. Contractor shall provide a clinical representative on call on Sundays, holidays and after hours, to respond to prior authorization and override requests within the federally mandated 24 hour response period. Help Desk Staff must be capable of reviewing requests and making a determination based on medical criteria within a 24 hour time frame. All staff mentioned in this RFP must be approved by Medicaid. Contractor is responsible for 24 hour response to all requests regardless of holidays and weekends.

Contractor shall utilize clerical and administrative personnel, licensed pharmacists, pharmacy technicians, nurses, and physicians to perform the duties outlined in this RFP. Contractor shall ensure that staff is trained in current Alabama Medicaid policy relevant to drug prior authorization activity, contract requirements, telephone etiquette, and professional conduct. Contractor shall respond in writing, with identity of responding staff person, to written provider inquiries within one working day of the date of receipt. Date and time of receipt shall be stamped on all correspondence and requests. Contractor shall retain copies of written inquiries and responses and make such correspondence available to Medicaid upon request. All form letters must be approved by Medicaid prior to use.

Contractor shall provide the services of a toll free help desk for Alabama Medicaid physicians and pharmacy providers, as well as a recipient liaison. The Help Desk and staff shall be physically located in Alabama. The Help Desk shall function as the first resort for providers inquiring into matters of drug prior authorization, prospective DUR overrides and Pharmacy Lock In. 100% of Help Desk staff shall be physically located at the Help Desk. Help Desk staff shall not subcontract out services of the help desk nor transfer calls out of the help desk physical location. Help Desk staff shall consist of pharmacists, nurses, pharmacy technicians, physician and/or data entry staff. Data Entry Staff must have a minimum of a high school diploma/GED equivalent. Help Desk reviewers shall consist of certified pharmacy technician reviewers, nurses, and/or pharmacists. Currently, thirty-one representatives make up the total of help desk representatives. During peak times, the help desk can consist of a combination of 5 data entry staff, 6 CPhT, 1 LPN and 2 RN's. During non-peak times, help desk staff can consist of a combination of 5 personnel including 2 CPhT and 3 data entry personnel Contractor shall conduct weekly training meetings with pharmacy technician reviewers and data entry personnel for educational purposes, discussion of audits, quality control and feedback. Contractor shall keep record of these meetings and provide to agency staff as requested.

Contractor shall provide a minimum of twenty dedicated toll free phone lines for instate calls and bordering states, eight dedicated toll-free FAX lines to Medicaid providers, and computer stations sufficient for the requirements of the Help Desk. These are the minimum requirements of this RFP. Please refer to current call center specifications in the attachments section for the number of phone and FAX lines utilized in the current contract. Average wait time for Help Desk calls is not to exceed twenty seconds. Consideration will be given for circumstances outside of Contractor's control such as system failure or natural disaster. Medicaid will monitor this requirement through the weekly toll-free phone line studies. If as a result of weekly toll-free phone line studies, additional lines and staff are necessary, the costs associated with additional lines and staff shall be considered extra contractual services to Medicaid. Medicaid shall have approval for additional lines and staffing to include number of lines and qualifications of additional staff. Extra contractual services will only be considered if Medicaid has imposed one of the following policy changes that have resulted in the increased workload:

1. Prospective DUR overrides: Overrides are necessary for excessive quantities and early refills (Early refills are defined as prescriptions with greater than 25% of the prescription remaining).
2. Prior authorization requests.
3. Substantial system changes by Medicaid or the Fiscal Agent.

General Requirements

1. Staff help desk with appropriate personnel capable of responding to programmatic questions, prior authorization requests, and Pharmacy Lock In calls within 24 hours Help desk staff must be trained to recognize basic medical terminology as it relates to their duties. Help Desk Staff shall demonstrate the professionalism, patience, and respect while coordinating with providers, recipients, and Agency staff.
2. Provide a licensed pharmacist and licensed physician for consultation and review of prospective DUR, Pharmacy Lock In, and prior authorization requests.
3. Provide toll-free FAX lines and toll free phones to be available to providers and Medicaid staff 24 hours a day, seven days a week.
4. Staff toll-free phones from 8:00 a.m. - 7:00 p.m. Monday - Friday with an automated voice message system to record calls after 7:00 p.m. Phones shall be staffed from 10:00 a.m. - 4:00 p.m. Saturdays. Sundays, help desk holidays and after hours, a clinical representative must be available to respond to requests to comply with the twenty-four hour prior authorization response requirement.
5. Maintain average weekly call wait times of 20 seconds or less for Help Desk phone lines.
6. Provide a separate toll-free number dedicated for the Pharmacy Lock-In program.

Specific Requirements

1. Provide weekly toll-free phone and fax line usage study to Medicaid.
2. Monthly summary report of number of calls by call type, to include referrals.

Medicaid Responsibilities

1. Communicate to the Contractor help desk any changes in State policy regarding prior authorization and prospective DUR overrides.
2. Develop policy protocol to be utilized by the Contractor's help desk concerning prospective DUR overrides, Pharmacy Lock In, prior authorization requests.
3. Monitor toll-free phone line usage studies and Help Desk reports.
4. Audit Help Desk through physical onsite audits and desk audit.

W. Pharmacy Lock-In (PLI)

The contractor will review pharmacy and medical utilization of recipients to identify overutilization, duplication of services, drug abuse, and possible drug interaction. The contractor will recommend restricting recipients found to be misusing services to one physician, pharmacy, or combination of these providers. The contractor will also identify providers potentially overprescribing or overdispensing drugs.

General Requirements

- a. Contractor shall meet the following objectives:
 1. Improve care and health of recipients.
 2. Reduce wasteful and duplicative services and therapies.
 3. Project and identify program savings.
- b. Review recipient utilization of pharmacy and medical services to identify misuse, drug abuse and duplicative services and secure medical providers to provide services to restricted recipients. Items to be reviewed will include, but are not limited to:
 1. Multiple prescribers of controlled drugs.
 2. Early refills of controlled drugs.
 3. High dose of controlled drugs.
 4. Excessive use of controlled drugs.
 5. Chronic use of controlled drugs with no diagnosis.
 6. Duplication of therapy.
- c. Provide supportive professional and administrative services for appeals, prepare case summaries, and provide testimony regarding the review process during the administrative hearing.
- d. Using all available claims, enrollment and eligibility data in the MMIS, identify recipients for the PLI program. The criteria for identifying candidates for the PLI program will include, at a minimum:
 1. Number of physicians.
 2. Number of pharmacies.
 3. Number of prescriptions.
 4. Controlled drugs.
 5. Diagnoses.
 6. Total cost.

The minimum number of recipient reviews conducted per month shall be 200. Medicaid will determine a minimum number of lock-in recipient per month after the first month of reviews to determine an appropriate goal. Criteria must be reviewed at a minimum on a quarterly basis for any needed updates. Contractor shall include in the RFP response a unit price per PLI review beyond the minimum 200 reviews/month.

- e. For recipients identified for PLI, set up a case in the workflow process and send a lock-in letter to the recipient, asking them to select a lock-in provider. The recipient must choose a lock-in provider (Primary Care Providers as well as pharmacies).
- g. If the recipient chooses a lock-in provider, prepare and send a letter to the chosen provider requesting the provider to become the primary care provider for the recipient. Contact the provider by telephone as a follow-up to the letter.
- h. If the recipient does not choose a lock-in provider, identify a provider who is willing to serve as the primary care provider. Recipients in the Patient 1st program should default to their Patient 1st PMP.

- i. Recruit providers (PCPs and pharmacies) who are willing to serve as lock-in providers in all geographical areas of the state. If no providers in a specific area are willing to serve, notify Medicaid of the problem area.
- j. On approval of the provider, prepare and send a letter to the recipient notifying the recipient of the lock-in provider and report to Medicaid. The recipient must have 30 days' notice prior to the effective date of the lock-in. The lock-in must take place on the first of the month.
- k. Set the PLI indicator on the MMIS recipient database for each lock-in provider for one year.
- l. No less frequently than every year, review the recipient's utilization to determine if the problems have been corrected. If inappropriate utilization still exists during the fourth consecutive quarter, recommend a course of action and extend the restriction for one additional year. If the problems have been corrected during the fourth consecutive quarter, release the recipient from restriction. Prepare and send notification letters to the recipient, prescriber, and pharmacy as approved by Medicaid and report to Medicaid.
- m. After a recipient has been released from the PLI program restriction, review the recipient's utilization after two quarters to determine whether to reapply the PLI, and notify Medicaid of the results of the review. If the recipient is to rejoin the PLI, prepare and send letters to the recipient, prescriber(s), and pharmacy (ies) as approved by Medicaid and report to Medicaid.
- n. Reassign a recipient to a lock-in provider if a selected lock-in provider requests the reassignment or can no longer serve as the lock-in provider.
- o. Log all PLI program activity in the workflow process, including the type of activity and the date the activity occurred.
- p. Provide information to Medicaid on PLI activities when requested for use in appeals and fair hearings, including preparing case summaries and providing testimony regarding the review process during the administrative hearing.
- q. Provide Medicaid Pharmacy and Program Integrity staff with a monthly list of recipients under review.
- r. Hold weekly conference calls with Medicaid Pharmacy and Program Integrity staff to review restricted recipients, problems, and changes in review processes. Meet quarterly face-to-face if needed.
- s. Assist Medicaid with communications to provider and recipient who have health care quality issues.
- t. Identify prescribers and pharmacies with inappropriate prescribing and dispensing patterns of controlled substances. Send letters to the top 100 prescribers and top 25 pharmacies notifying them of the inappropriate utilization, and their peer rankings. Also, identify the providers to Medicaid Pharmacy and Program Integrity staff for further action.
- u. No less frequently than every quarter, review the top 10% prescribers' and top 5% pharmacies' utilization to determine if the problems have been corrected. If inappropriate utilization still exists during the fourth quarter, identify the providers to Medicaid for further action.
- v. Provide monthly reports to include, but not limited to, the number of recipients reviewed, placed in the PLI program, released from the PLI program, and prescribers and pharmacies with inappropriate

utilization of controlled substances. Reports shall be provided to Medicaid within 20 business days of the end of each quarter.

- w. Provide professional medical and administrative staff as described in the staffing section of this RFP.
- x. Provide call center support to answer recipient and provider calls/issues related to PLI activities. A separate toll free number must be provided for recipient calls related to PLI.

X. Performance Standards

General Requirements

1. On a monthly basis, report PLI program savings and a monthly measurable growth rate from preenrollment to postenrollment for PLI recipients. Outline the methodology for this analysis based on claims data to a level of detail that enables Medicaid staff to substantiate the report's content.

Specific Requirements

1. Provide report of PLI program savings and a monthly measurable growth rate from preenrollment to postenrollment for PLI recipients.
2. Provide monthly reports to include, but not limited to, the number of recipients reviewed, placed in the PLI program, released from the PLI program, and prescribers and pharmacies with inappropriate utilization of controlled substances.

Medicaid Responsibilities

1. Determine compliance with overall federal regulations and state laws.
2. Establish policy regarding the administration of the PLI program.
3. Define all parameters regarding utilization to be used by the contractor in administering the PLI program.
4. Approve the contractor's procedures and outgoing correspondence for PLI program administration.
5. Monitor the contractor's performance of PLI program activities.
6. Conduct appeals and fair hearings related to PLI decisions as needed.
7. Respond to recipient inquiries regarding PLI status and PLI processes.

Y. Academic Detailing

Contractor shall provide, at a minimum, five full time equivalent (FTE) provider representatives and one scheduler dedicated to Medicaid to educate providers on appropriate and cost-effective utilization of medications, Pharmacy ALERTS and other Medicaid-approved topics through academic detailing. Provider representatives must possess, at a minimum, an undergraduate degree and excellent communication and organizational skills. The detailers must be capable of developing an in-depth understanding of Medicaid prescribing patterns and working closely with Medicaid staff to educate providers on appropriate prescribing and dispensing patterns. They must live and work in designated regions throughout the state in order to be able to quickly and efficiently respond to requests for academic detailing visits. Medicaid shall approve the Contractors proposed five regions across the State of Alabama. The Contractor shall provide each representative with the following: laptop PC; color copier/scanner/printer with paper; ink and other supplies; and document shredder to be located at home

site of each representative. Contractor shall also furnish internet connection/service; hand-held electronic device/smartphone capable of ePocrates, Medicaid website, for demonstration purposes; dependable, late modeled vehicle equipped with GPS for location tracking; and access to detailed scheduling database. In addition, the Contractor shall also provide for a scheduler to schedule the visits for the provider representatives. Contractor must also provide for one manager to supervise provider representatives. The Academic Detailing Manager may also serve as the Project Manager. Contractor shall include in the RFP response a unit price per Academic Detailer beyond the minimum five detailers.

Contractor must conduct a minimum of 1,800 interventions/visits to targeted providers per quarter. Interventions/visits are to be completed by well-trained provider representatives and must meet the following minimum requirements:

- a. Must be pre-scheduled. No cold-calls are permitted.
- b. Must include a face-to-face meeting with the physician, prescribing nurse/physician assistant, or pharmacist (preferably the Supervising Pharmacist).
- c. The makeup of the 1800 visits should be approximately 1000 prescribers and 800 pharmacy providers each quarter.
- d. An intervention contact form must be completed by provider representative.
- e. Provider representative should supply PDL Reference Tool, and any recent Pharmacy Alerts or Notices to provider at intervention/visit.

Contractor shall provide quarterly meetings/trainings for provider representatives and Medicaid staff and others as requested by Medicaid. Contractor will be responsible for developing and recommending educational materials to promote appropriate utilization of drugs and use of the PDL and shall incorporate, telephone interventions, targeted mailings, and quarterly newsletters. Emphasis shall be placed on appropriate generic and OTC utilization. Educational materials shall include:

- a. Current and appropriate Medicaid Alerts.
- b. Prior Authorization forms and Override forms and instructions for the proper use of each.
- c. Coordination with the Health Home/Pivot Plan pharmacists in the Academic Detailing region.
- d. On an as needed basis – Maximum Unit list, PDL (in color), PDL reference tools, cough and cold list, OTC list and Nutritional list, and current newsletters.
- e. Payor and manufacturer information– information on how to obtain and use such information on a Palm PDA, and
- f. Any other documents or educational emphasis that Medicaid requests to be provided during Academic Detailing visits.

Physician provider summary reports shall be utilized to compare individual physicians to peers in their specialty, geographic area, and state-wide. The reports shall utilize graphics and charts as well as verbiage to provide the following information:

- a. Overall Utilization Rate – generic, preferred brand, and non-preferred brand.
- b. Prior Authorization Analysis – count per MD, approval and denial percentage rates.
- c. Recipients and Claims – recipients per MD per month, claims per MD per month, and claims per recipient per month.
- d. Data in chart format regarding Claims for Providers - top drugs prescribed, top most costly drugs, top denial classes, and top denial reasons.
- e. Total amount of Medicaid dollars spent as a result of their prescribing, and
- f. Suggestions on how they could assist in saving Medicaid dollars while maintaining quality of care by more aggressively utilizing the PDL.

Pharmacy provider summary reports shall be utilized to compare individual pharmacies to peers state-wide. The reports shall utilize graphics and charts as well as verbiage to provide the following information:

- a. Prior Authorization Analysis – count per pharmacy (store), approval and denial percentage rates.
- b. Overall Utilization Rate – generic, preferred brand, and non-preferred brand.
- c. Recipients and Claims – recipients per pharmacy (store) per month, claims per pharmacy (store) per month, and claims per recipient per month.
- d. Early Refill Analysis.
- e. DAW-1 Analysis.
- f. Pharmacy Originated PA Requests as a percentage of total manually processed requests for the pharmacy (store), and;
- g. PAs processed by electronic versus manual requests as a percentage of total PAs originated by the pharmacy (store).

For an example of a current pharmacy provider summary report, please see Medicaid's website at http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx.

Contractor shall host quarterly meetings for all detailing staff, interested Medicaid staff and others as requested by Medicaid. Such meetings will begin mid-morning (to allow for travel) and last at least one-half day with a working lunch provided by the Contractor to all attendees.

Contractor shall provide the following evaluations and reports to Medicaid quarterly and annually:

- a. Total visits made and total visits attempted but not completed (detailer is not allowed to see the prescriber or pharmacy representative).
- b. Visits made and visits attempted but not completed to prescribers or pharmacies (stores) with high PA denial rates.
- c. List of Providers that are unresponsive to visit requests, including providers with high denial rates and other requested by Medicaid and documentation of attempts to perform visits.
- d. Visit summary report by
 - Specialist
 - Geographical area
 - City
 - Title of entity visited – MD, DO, Nurse Practitioner, Physician Assistant, Nursing Home, and Pharmacy Store)
- e. Visit detail report by provider.
- f. Specialist Survey Response Report.
- g. Provider Survey Response Report.
- h. Provider Survey Response Comment Report.
- i. Seminar evaluation results and attendance by title of attendee.

Detailing Effectiveness Report – statistically valid analysis of PA denial rates pre and post visit for prescribers and pharmacies (based only on PAs initiated by the pharmacy) with comparisons against state averages.

General Requirements

1. Conducting a minimum of 1,800 academic detailing interventions/visits per quarter.
2. Supplying necessary staff outlined in this section.
3. Completing an intervention summary report of all provider contacts.
4. Make recommendations to Medicaid for improvements to the academic detailing initiative.
5. Develop an intervention contact form for Medicaid approval to be used by provider representatives to record interventions/visits.

6. Identify providers to be targeted for intervention based on Medicaid approved criteria.
7. Make available completed intervention contact forms for Medicaid review upon request.
8. Make recommendations to Medicaid for program/seminar presentation topics and develop program materials.

Specific Requirements

1. Quarterly reports separated by provider representative of academic detailing interventions/visits conducted to include name of provider, location of provider, title of individual(s) involved in intervention/visit, and date of intervention/visit.
2. Annual summary reports of total number of interventions/visits and programs conducted by Contractor and any cost savings accredited to interventions.
3. Quarterly reports of academic detailing seminars/programs conducted to include number of physicians and pharmacists in attendance, total number invited, location and date of programs, names of speakers and topic of presentations.
4. Supply provider representatives with color copies of the Medicaid Preferred Drug Quicklists and Medicaid notices for interventions/visits.

Medicaid Responsibilities

1. Work with Contractor to identify providers for intervention.
2. Facilitate Health Home/Pivot initial meeting and educational goals.
3. Review and approve education materials to be used by provider representatives.
4. Provide Contractor with quarterly updates to Preferred Drug List and Quicklists.
5. Conduct periodic follow-up with targeted providers to verify program requirements are being met.
6. Coordinate all education activities with the Communications Director.

Z. Drug Interface Capability

The following section details Contractor responsibilities for On-Line Inquiry, Reporting Requirements and Data Entry.

On-Line Inquiry

Contractor will be responsible for having direct interfacing capabilities with Medicaid and the Medicaid fiscal agent for on-line access. Contractor shall utilize for eligibility verification, prior authorizations and prospective DUR overrides, the following AMMIS on-line files:

- a. Prior Authorization File;
- b. Drug Pricing File;
- c. Recipient Lock-in File;
- d. Physician License File;
- e. Provider File;
- f. Recipient Eligibility File.

These files are currently maintained by Medicaid's fiscal agent and access will be allowed for inquiry and updating purposed only as required by this RFP using existing Interchange web portal software. Contractor will not be subject to transaction user fees, but will be responsible for the telecommunication charges. Contractor is responsible for supplying a software license for adequate or comparable hardware to support the scope of work. Phone lines shall have the capacity for a supervisor to routinely monitor calls, record calls, and to monitor incoming and outgoing calls.

Contractor shall have installed and provide for maintenance of a minimum of a dedicated VPN communication line from Medicaid's fiscal agent to the Contractor's facility. Contractor shall be financially responsible for all cabling within their facilities. In addition, Contractor shall be financially responsible for a CSU/DSU and IP router that will be required at each end of the line. Contractor will be financially responsible for all cabling, setup, purchase and maintenance charges for all equipment required at the Medicaid's fiscal agent facility. The circuit/router configuration must include (QOS) Quality of Service to prioritize pharmacy prior authorization traffic above all other traffic and must encrypt all traffic to a minimum of 3DES. Contractor shall be required to have workstations and adapter cards to support TCP/IP protocol. Contractor shall have IE 6.0 and TCP/IP stack for each work-station accessing the Medicaid fiscal agent network.

Contractor shall purchase or develop and install the software necessary to receive and reply to drug prior authorization and override requests in the NCPDP HIPAA Standard Format.

Contractor shall provide Medicaid, for approval, prior to contract start date, a written implementation plan addressing satisfactory back-up arrangements for data processing equipment and files to provide continued contract performance in the event of machine failure or loss of records.

Contractor shall be responsible for maintaining a minimum of twenty toll-free lines for direct access by callers for telephone inquiry and a minimum of eight dedicated FAX lines for written provider inquiries. A telephone message shall be provided for physicians and pharmacists to leave messages. It must also notify callers during off-hours of the established business hours along with the number for on-call staff.

The AMMIS system is a web-based system and is called *interChange*. AMMIS System passwords will be made available by Medicaid's fiscal agent prior to implementation for Contractor employees. Passwords are not to be shared among employees. Additional passwords for contractor are to be requested via the contract administrator.

Data Entry

Contractor shall perform on-line updates using CICS transactions to Medicaid's Prior Authorization Panel for use by the claims processing system to edit drug claims requiring a PA number. Contractor shall key the following data fields for updating:

- a. 13-digit Medicaid number.
- b. 10 digit pharmacy NPI number.
- c. 9-digit pharmacy provider license number.
- d. Date and length of approval.
- e. 11-digit National Drug Code (NDC number).
- f. 10-character prior authorization number.
- g. Authorized number of units.

Contractor will have access to panels needed to perform duties in Interchange system after clearing network security and entering appropriate password.

Medicaid will work with Fiscal Agent to provide training to Contractor staff on the use of system panels and fields during implementation phase and prior to contract begin date.

General Requirements

1. Submission of requests for employee passwords for the AMMIS Interchange system to Medicaid.

2. Notifying Medicaid when an issued password is no longer needed due to termination of employment or change in duties.
3. Ensuring that its employees are informed of importance of system security and confidentiality.
4. Documenting and notifying Medicaid of system problems to include type of problem, action(s) taken by Contractor to resolve problem and length of system down-time.
5. Coordinate with Fiscal Agent and take action as necessary to ensure all aspects of the contract are carried out timely and appropriately. All coordination with fiscal agent shall include a courtesy copy to Medicaid.

Medicaid Responsibilities

1. Obtain security passwords from the Fiscal Agent upon Contractor request.
2. Serve as liaison between Contractor and Fiscal Agent.
3. Update password information when an issued password is no longer needed due to change in employment status or duties.

AA. Transition Period (July 1, 2018 – November 1, 2018)

The Contractor will appoint an individual to work with the Incumbent Vendor and Medicaid to ensure the integrity of the proposed solution is maintained and is viable through the switchover period. The Contractor's build up will include, but are not limited to:

- Coding and testing for claims and prior authorization/override processing.
- Electronic PA.
- Technical coordination with the fiscal agent.
- Academic Detailing Program training/preparation to begin on implementation date.
- Training of the staff to be located in the Montgomery office at least one month prior to implementation.

The Medicaid appointed individual will be available to assist in communication and coordination involving the Incumbent Vendor and the incoming Contractor.

The Contractor must have adequate staff, as determined by Medicaid, available during the uncompensated transition period in order to support Medicaid under the required timeline. The following key positions are to be available during the transition period:

- Technical Liaison.
- Clinical Pharmacist.
- Certified Pharmacy Technician/Drug File Coordinator.
- Audit Pharmacist.
- Academic Detailers.

The Contractor will provide reports as required reflecting progress being made to initiate delivery of all services, effective November 1, 2018. The incoming Contractor will not be compensated for any preparation activity conducted in advance of the operations switchover to the new service which will occur effective November 1, 2018.

BB. Scope of Work Strategies

The Contractor shall provide detailed descriptions of the following sections using the questions provided below.

Questions

- *How will the task be performed?*
- *What problems need to be overcome?*
- *What functions will be performed by Contractor's staff?*
- *What assistance will be needed from the Agency staff, if any?*
- *How will the staffing proposed be adequate to fully perform each task?*

- a. **II.H. Operational Requirements**
- b. **II.I. Key Personnel**
- c. **II.K. Organizational Plan**
- d. **II.L. Work Plan and Implementation Schedule**
- e. **II.M. Transmittal Letter**
- f. **II.N.a. Prospective DUR (ProDUR) Edits Monitoring**
- g. **II.N.b. Retrospective DUR (ProDUR) Edits Monitoring**
- h. **II.N.c. Preferred Drug List**
- i. **II.N.d. Pharmacy and Therapeutics (P&T) Committee**
- j. **II.O. Prior Authorization (PA)**
- k. **II.P. Electronic Prior Authorization**
- l. **II.Q. Online Prior Authorization**
- m. **II.R. Incentive Program**
- n. **II.S. Overrides**
- o. **II.T. Clinical Appeal**
- p. **II.U. Specialty Drugs-Synagis ®**
- q. **II.V. Help Desk**
- r. **II.W. Pharmacy Lock-In (PLI)**
- s. **II.X. Performance Standards**
- t. **II.Y. Academic Detailing**
- u. **II.Z. Drug Interface Capability**
- v. **II.AA. Transition Period**

CC. Breach of Contract

In the event that Contractor fails to meet the RFP and contract requirements, and damages are sustained by Medicaid; Contractor agrees to pay Medicaid the sums set forth below as a breach of contract unless these damages are waived by Medicaid.

Contractor shall be liable for any penalties and late deliverables or disallowance of Federal Financial Participation incurred by Medicaid due to Contractor's failure to comply with the terms of the contract. Imposition of breach of contract may be in addition to other contract remedies, and does not waive Medicaid's right to terminate the contract. Any breach of contract imposed on the contractor shall not

include rebate amounts. The amount imposed to contractor for any breach of contract shall be imposed to contractor at a net cost to Medicaid.

The following breach of contract shall be assessed against contractor for:

- Failure to produce required report or any contractor deliverable - \$100 per day per report.
- Failure to respond to a prior authorization request within twenty-four hours - \$1,000 per hour for each request up to time request is complete. Penalty assessed in full hour increments. No partial penalties will be allowed.
- Use of educational materials and newsletter without prior review and approval by Medicaid - \$1,000 per instance.
- Failure to follow Medicaid criteria and/or directives in approval/denial of PA requests or Override requests - \$500 per instance or net cost to Medicaid, whichever is greater.
- Failure to include Medicaid requested changes/corrections/revisions in reports, minutes of DUR Board meetings, newsletters or any other contractor deliverable - \$100 per change/correction/revision per document.
- Failure of designated contractor staff to be punctual for DUR Board meetings - \$100 per minute past scheduled start time.
- Presentations to groups/associations or others regarding this contract and work thereunder without prior approval of Medicaid - \$1,000 per instance.
- Failure to safeguard confidential information of providers, recipients or the Medicaid program - \$2,500 per instance plus any penalties incurred by Medicaid for said infractions.
- Failure to maintain average call wait times of 20 seconds or less for Help Desk phone lines - \$500 per week that performance standard is exceeded.
- Failure to make required academic detailing provider visits per quarter - \$100 per visit under requirement.
- Failure to meet equipment, technical or personnel requirements - \$100 per day that requirement is not met.
- Failure to input DUR criteria into the retrospective DUR database within 4 weeks of DUR Board and Medicaid approval - \$100 per business day until criteria have been implemented to the satisfaction of Medicaid.
- Failure to respond to an appeal request within 12 hours of receipt of completed appeal or failure to respond to provider within four hours of receipt of response from Medicaid - \$1,000 per hour for each appeal request up to time appeal request is complete. Penalty/ assessed in full hour increments. No partial penalties allowed.
- Failure to respond to 75% of monthly total of prior authorization and override requests within 8 hours of receipt of completed requests will result in penalty of \$1,000 per percentage point below 75%. In no event shall response time exceed 24 hours.
- Failure to respond to recipient within three hours of message: \$100 per instance
- Failure of Help Desk staff to provide correct information to a provider: (Information shall include Medicare directives, criteria, or any information that has been provided during an education training or in writing to help desk staff) \$100 per instance/day, not to exceed \$500 per month.
- Failure to send Pharmacy Lock In letters out in a timely manner. \$100 per instance/day, not to exceed \$500 per month.
- Failure to meet the minimum (500) number of recipient reviews per month; \$500 per instance
- Failure to notify recipient of lock in status prior to lock in \$100 per instance/day, not to exceed \$500 per month

Contractor shall receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding. Contractor shall be allowed to submit rebuttal information or testimony in opposition to such findings. Medicaid shall make a final decision regarding implementation of breach of contract.

III. Pricing

Contractor's response must specify a Total Evaluated Price on the first page of this document and in Appendix C. A Total Evaluated price and an Annual Rate price. The proposal will be evaluated based on the total evaluated bid price, however the annual unit rate will be the annual contract price when paying invoices. Schedule A will provide the bidder with the annual reimbursement rate they will receive for the contract. Schedule B will provide the per unit rate that the contractor will use should the scope of work increase or if additional services are needed. Price for personnel by using the RFP Cover Sheet on the first page of this document and Appendix C.

IV. General Medicaid Information

The Alabama Medicaid Agency is responsible for the administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. Through teamwork, Medicaid strives to enhance and operate a cost efficient system of payment for health care services rendered to low income individuals through a partnership with health care providers and other health care insurers both public and private.

Medicaid's central office is located at 501 Dexter Avenue in Montgomery, Alabama. Central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and recipient eligibility services. For certain recipient categories, eligibility determination is made by Agency personnel located in eleven (11) district offices throughout the state and by one hundred forty (140) out-stationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined through established policies by the Alabama Department of Human Resources and the Social Security Administration. In 2015, an average of 1,049,787 Alabama citizens were eligible for Medicaid benefits through a variety of programs. Services covered by Medicaid include, but are not limited to, the following:

- Physician Services
- Inpatient and Outpatient Hospital Services
- Rural Health Clinic Services
- Laboratory and X-ray Services
- Nursing Home Services
- Early and Periodic Screening, Diagnosis and Treatment
- Dental for children ages zero (0) to twenty (20)
- Home Health Care Services and Durable Medical Equipment
- Family Planning Services
- Nurse-Midwife Services
- Federally Qualified Health Center Services
- Hospice Services
- Prescription Drugs
- Optometric Services
- Transportation Services
- Hearing Aids
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Prosthetic Devices
- Outpatient Surgical Services

- Renal Dialysis Services
- Home and Community Based Waiver Services
- Prenatal Clinic Services
- Mental Health Services

Additional program information can be found at http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx.

V. General

This document outlines the qualifications which must be met in order for an entity to serve as Contractor. It is imperative that potential Contractors describe, **in detail**, how they intend to approach the Scope of Work specified in Section II of the RFP. The ability to perform these services must be carefully documented, even if the Contractor has been or is currently participating in a Medicaid Program. Proposals will be evaluated based on the written information that is presented in the response. This requirement underscores the importance and the necessity of providing in-depth information in the proposal with all supporting documentation necessary.

The Contractor must demonstrate in the proposal a thorough working knowledge of program policy requirements as described, herein, including but not limited to the applicable Operational Manuals, State Plan for Medical Assistance, Administrative Code and Code of Federal Regulations (CFR) requirements.

Entities that are currently excluded under federal and/or state laws from participation in Medicare/Medicaid or any State's health care programs are prohibited from submitting bids.

VI. Corporate Background and References

Entities submitting proposals and all subcontractors must:

- a. Provide evidence that the Contractor possesses the qualifications required in this RFP.
- b. Provide a description of the Contractor's organization, including:
 1. Date established;
 2. Ownership (public company, partnership, subsidiary,). Include an organizational chart depicting the Contractor's organization in relation to any parent, subsidiary or related organization;
 3. Number of employees and resources;
 4. A list of all similar projects the Contractor has completed within the last 10 years;
 5. A detailed breakdown of proposed staffing for this project, including names and education background of all key employees that will be assigned to this project;
 6. A list of all Medicaid agencies or other entities for which the Contractor currently performs similar work;
 7. Contractor's acknowledgment that the State will not reimburse the Contractor until: (a) the Project Director has approved the invoice; and (b) Medicaid has received and approved all deliverables covered by the invoice;
 8. Details of any pertinent judgment, criminal conviction, investigation or litigation pending against the Contractor or any of its officers, directors, employees, agents or subcontractors of which the Contractor has knowledge, or a statement that there are

none. Medicaid reserves the right to reject a proposal solely on the basis of this information.

- c. Have all necessary business licenses, registrations and professional certifications at the time of the contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (a business corporation incorporated under a law other than the law of this state) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State. To obtain forms for a Certificate of Authority, contact the Secretary of State, (334) 242-5324, www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the bid;
- d. Have operated within the last three years and be currently operating drug utilization review and prior authorization program;
- e. Furnish a minimum of four performance references of similar size and scope to include contact name, title, telephone number, and address. Performance references should also include contract type, size, and duration;
- f. Document the resources and capability for completing the work necessary to implement the Pharmacy Administrative Services. The Contractor proposal must include a chart outlining the proposed tasks needed to complete the implementation by the implementation deadline, as well as outline follow-up and routine reporting deliverables and staff needed to complete the proposed tasks.

The State reserves the right to use any information or additional references deemed necessary to establish the ability of the Contractor to perform the conditions of the contract.

VII. Submission Requirements

A. Authority

This RFP is issued under the authority of Section 41-16-72 of the Alabama Code and 45 CFR 74.40 through 74.48. The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. No other evaluation criteria, other than as outlined in the RFP, will be used.

In accordance with 45 CFR 74.43, the State encourages free and open competition among Contractors. Whenever possible, the State will design specifications, proposal requests, and conditions to accomplish this objective, consistent with the necessity to satisfy the State's need to procure technically sound, cost-effective services and supplies.

B. Single Point of Contact

From the date this RFP is issued until a Contractor is selected and the selection is announced by the Project Director, all communication must be directed to the Project Director in charge of this solicitation. **Contractors or their representatives must not communicate with any State staff or officials regarding this procurement with the exception of the Project Director.** Any unauthorized contact may disqualify the Contractor from further consideration. Contact information for the single point of contact is as follows:

Project Director:

Tiffany Minnifield

Address: **Alabama Medicaid Agency
Lurleen B. Wallace Bldg.
501 Dexter Avenue
PO Box 5624
Montgomery, Alabama 36103-5624**

E-Mail Address: **PASRFP@medicaid.alabama.gov**

C. RFP Documentation

All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, and addenda will be posted to Medicaid's website
http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx.

D. Questions Regarding the RFP

Contractors with questions requiring clarification or interpretation of any section within this RFP must submit questions and receive formal, written replies from the State. Each question must be submitted to the Project Director via email. Questions and answers will be posted on the Medicaid website as described in the Schedule of Events.

E. Acceptance of Standard Terms and Conditions

Contractor must submit a statement stating that the Contractor has an understanding of and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Contractor's proposal being deemed non-responsive.

F. Adherence to Specifications and Requirements

Contractor must submit a statement stating that the Contractor has an understanding of and will comply with the specifications and requirements described in this RFP.

G. Order of Precedence

In the event of inconsistencies or contradictions between language contained in the RFP and a Contractor's response, the language contained in the RFP will prevail. Should the State issue addenda to the original RFP, then said addenda, being more recently issued, would prevail against both the original RFP and the Contractor's proposal in the event of an inconsistency, ambiguity, or conflict.

H. Contractor's Signature

The proposal must be accompanied by the RFP Cover Sheet signed in ink by an individual authorized to legally bind the Contractor. The Contractor's signature on a proposal in response to this RFP guarantees that the offer has been established without collusion and without effort to preclude the State from obtaining the best possible supply or service. Proof of authority of the person signing the RFP response must be furnished upon request.

I. Offer in Effect for 90 Days

A proposal may not be modified, withdrawn or canceled by the Contractor for a 90-day period following the deadline for proposal submission as defined in the Schedule of Events, or receipt of best and final offer, if required, and Contractor so agrees in submitting the proposal.

J. State Not Responsible for Preparation Costs

The costs for developing and delivering responses to this RFP and any subsequent presentations of the proposal as requested by the State are entirely the responsibility of the Contractor. The State is not liable for any expense incurred by the Contractor in the preparation and presentation of their proposal or any other costs incurred by the Contractor prior to execution of a contract.

K. State's Rights Reserved

While the State has every intention to award a contract as a result of this RFP, issuance of the RFP in no way constitutes a commitment by the State to award and execute a contract. Upon a determination such actions would be in its best interest, the State, in its sole discretion, reserves the right to:

- Cancel or terminate this RFP;
- Reject any or all of the proposals submitted in response to this RFP;
- Change its decision with respect to the selection and to select another proposal;
- Waive any minor irregularity in an otherwise valid proposal which would not jeopardize the overall program and to award a contract on the basis of such a waiver (minor irregularities are those which will not have a significant adverse effect on overall project cost or performance);
- Negotiate with any Contractor whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of a Contractor's proposal and to use any idea or all ideas presented in a proposal;
- Amend the RFP (amendments to the RFP will be made by written addendum issued by the State and will be posted on the RFP website);
- Not award any contract.

L. Price

Contractors must respond to this RFP by utilizing the RFP Cover Sheet to indicate the contractor name and contact information as well as an authorized contractor signature. Address must be a physical address and cannot be a post office box. Contractor must include a telephone number. The Contractor's Federal ID number must be listed. Contractors must also list a total evaluated price that will be used to evaluate the RFP.

M. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to 2018-PAS-01. Proposals must be sent to the attention of the Project Director and received at Medicaid as specified in the Schedule of Events. It is the responsibility of the Contractor to ensure receipt of the Proposal by the deadline specified in the Schedule of Events.

N. Copies Required

Contractors must submit one original Proposal with original signatures in ink, one additional hard copy in binder form, plus two electronic copies of the Proposal on CD/DVD or jump drive clearly labeled with the Contractor name. One electronic copy (Word and searchable PDF format) MUST be a complete version of the Contractor's response and the second electronic (searchable PDF format) copy MUST have any information asserted as confidential or proprietary removed. Contractor must identify the original hard copy clearly on the outside of the proposal.

O. Late Proposals

Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It shall be the Contractor's sole risk to assure delivery at Medicaid by the designated deadline. Late proposals will not be opened and may be returned to the Contractor at the expense of the Contractor or destroyed if requested.

P. Proposal Format

Proposals must be prepared on standard 8 ½" x 11" paper and must be bound. All proposal pages must be numbered unless specified otherwise. All responses, as well as, any reference material presented, must be written in English.

The Contractor must structure its response in the same sequence, using the same labeling and numbering that appears in the RFP section in question. For example, the proposal would have a major section entitled "Scope of Work." Within this section, the Contractor would include their response, addressing each of the numbered sections in sequence, as they appear in the RFP: i.e. II.A, II.B, and so on. The response to each section must be preceded by the section text of the RFP followed by the Contractor's response.

Proposals must not include references to information located elsewhere, such as Internet websites. Information or materials presented by the Contractor outside the formal response or subsequent discussion/negotiation, if requested, will not be considered, and will have no bearing on any award.

This RFP and its attachments are available on Medicaid's website. The Contractor acknowledges and accepts full responsibility to ensure that no changes are made to the RFP. In the event of inconsistencies or contradictions between language contained in the RFP and a Contractor's response, the language contained in the RFP will prevail. Should Medicaid issue addenda to the original RFP, then said addenda, being more recently issued, would prevail against both the original RFP and the Contractor's proposal.

Q. Proposal Withdrawal

The Contractor may withdraw a submitted proposal at any time before the deadline for submission. To withdraw a proposal, the Contractor must submit a written request, signed by a Contractor's representative authorized to sign the resulting contract, to the RFP Project Director. After withdrawing a previously submitted proposal, the Contractor may submit another proposal at any time up to the deadline for submitting proposals.

R. Proposal Amendment

Medicaid will not accept any amendments, revisions, or alterations to proposals after the deadline for submitting proposals unless Medicaid formally requested in writing.

S. Proposal Errors

The Contractor is liable for all errors or omissions contained in their proposals. The Contractor will not be allowed to alter proposal documents after the deadline for submitting proposals. If the Contractor needs to change a previously submitted proposal, the Contractor must withdraw the entire proposal and may submit the corrected proposal before the deadline for submitting proposals.

T. Proposal Clarifications

Medicaid reserves the right to request clarifications with any or all Contractors if they are necessary to properly clarify compliance with the requirements of this RFP. Medicaid will not be liable for any costs associated with such clarifications. The purpose of any such clarifications will be to ensure full understanding of the proposal. Clarifications will be limited to specific sections of the proposal identified by Medicaid. If clarifications are requested, the Contractor must put such clarifications in writing within the specified time frame.

U. Disclosure of Proposal Contents

Proposals and supporting documents are kept confidential until the evaluation process is complete, a Contractor has been selected, and the Contract has been fully executed. The Contractor should be aware that any information in a proposal may be subject to disclosure and/or reproduction under Alabama law. Designation as proprietary or confidential may not protect any materials included within the proposal from disclosure if required by law. The Contractor should mark or otherwise designate any material that it feels is proprietary or otherwise confidential by labeling the page as "CONFIDENTIAL". The Contractor must also state any legal authority as to why that material should not be subject to public disclosure under Alabama open records law and is marked as Proprietary Information. By way of illustration but not limitation, "Proprietary Information" may include trade secrets, inventions, mask works, ideas, processes, formulas, source and object codes, data, programs, other works of authorship, know-how, improvements, discoveries, developments, designs and techniques.

Information contained in the Pricing Section may not be marked confidential. It is the sole responsibility of the Contractor to indicate information that is to remain confidential. Medicaid assumes no liability for the disclosure of information not identified by the Contractor as confidential. If the Contractor identifies its entire proposal as confidential, Medicaid may deem the proposal as non-compliant and may reject it.

VIII. Evaluation and Selection Process

A. Initial Classification of Proposals as Responsive or Non-responsive

All proposals will initially be classified as either "responsive" or "non-responsive." Proposals may be found non-responsive at any time during the evaluation process or contract negotiation if any of the required information is not provided; or the proposal is not within the plans and specifications described and required in the RFP. If a proposal is found to be non-responsive, it will not be considered further.

Proposals failing to demonstrate that the Contractor meets the mandatory requirements listed in Appendix A will be deemed non-responsive and not considered further in the evaluation process (and thereby rejected).

B. Determination of Responsibility

The Project Director will determine whether a Contractor has met the standards of responsibility. In determining responsibility, the Project Director may consider factors such as, but not limited to, the Contractor's specialized expertise, ability to perform the work, experience and past performance. Such a determination may be made at any time during the evaluation process and through contract negotiation if information surfaces that would result in a determination of non-responsibility. If a Contractor is found non-responsible, a written determination will be made a part of the procurement file and mailed to the affected Contractor.

C. Opportunity for Additional Information

The State reserves the right to contact any Contractor submitting a proposal for the purpose of clarifying issues in that Contractor's proposal. Contractors should clearly designate in their proposal a point-of-contact for questions or issues that arise in the State's review of a Contractor's proposal.

D. Evaluation Committee

An Evaluation Committee appointed by the Project Director will read the proposals, conduct corporate and personal reference checks, score the proposals, and make a written recommendation to the Commissioner of the Alabama Medicaid Agency. The State may change the size or composition of the committee during the review in response to exigent circumstances.

E. Scoring

The Evaluation Committee will score the proposals using the scoring system shown in the table below. The highest score that can be awarded to any proposal is 100 points.

Evaluation Factor	Highest Possible Score
Corporate Background	15
References	5
Scope of Work	40
Price	40
Total	100

F. Determination of Successful Proposal

The Contractor whose proposal is determined to be in the best interest of the State will be recommended as the successful Contractor. The Project Director will forward this Contractor's proposal through the supervisory chain to the Commissioner, with documentation to justify the Committee's recommendation.

When the final approval is received, the State will notify the selected Contractor. If the State rejects all proposals, it will notify all Contractors. The State will post the award on Medicaid website at http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx. The award will be posted under the applicable RFP number.

IX. General Terms and Conditions

A. General

This RFP and Contractor's response thereto shall be incorporated into a contract by the execution of a formal agreement. The contract and amendments, if any, are subject to approval by the Governor of the State of Alabama.

The contract shall include the following:

1. Executed contract;
2. RFP, attachments, and any amendments thereto;
3. Contractor's response to the RFP, and shall be construed in accordance with and in the order of the applicable provisions of:
 - Title XIX of the Social Security Act, as amended and regulations promulgated hereunder by HHS and any other applicable federal statutes and regulations;
 - The statutory and case law of the State of Alabama;
 - The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended;
 - The Medicaid Administrative Code;
 - Medicaid's written response to prospective Contractor questions.

B. Compliance with State and Federal Regulations

Contractor shall perform all services under the contract in accordance with applicable federal and state statutes and regulations. Medicaid retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal statutes and regulations as the same may be amended from time to time.

C. Term of Contract

The initial contract term shall be for 2 years effective November 1, 2018, through October 31, 2020. Alabama Medicaid shall have the option of unilaterally extending the contract for three one year options, after review by the Legislative Contract Review Oversight Committee. At the end of the contract period Alabama Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Contractor will provide pricing for each year of the contract, including any extensions.

Contractor acknowledges and understands that this contract is not effective until it has received all requisite state government approvals and Contractor shall not begin performing work under this contract until notified to do so by Medicaid. Contractor is entitled to no compensation for work performed prior to the effective date of this contract.

D. Contract Amendments

No alteration or variation of the terms of the contract shall be valid unless made in writing and duly signed by the parties thereto. The contract may be amended by written agreement duly executed by the parties. Every such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

The contract shall be deemed to include all applicable provisions of the State Plan and of all state and federal laws and regulations applicable to the Alabama Medicaid Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, that materially affects the operation of the Alabama Medicaid Program or the costs of administering such Program, either party, after written

notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such substantial change.

E. Confidentiality

Contractor shall treat all information, and in particular information relating to individuals that is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under State and Federal laws including 45 CFR §160.101 – 164.534. Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this contract.

Contractor shall ensure safeguards that restrict the use or disclosure of information concerning individuals to purposes directly connected with the administration of the Plan in accordance with 42 CFR Part 431, Subpart F, as specified in 42 CFR § 434.6(a)(8). Purposes directly related to the Plan administration include:

1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services for recipients; and
4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan.

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), the successful Contractor shall sign and comply with the terms of a Business Associate agreement with Medicaid (Appendix B).

F. Security and Release of Information

Contractor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved. Contractor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of Medicaid. This provision covers both general summary data as well as detailed, specific data. Contractor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of Medicaid. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

G. Federal Nondisclosure Requirements

Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as \$5,000 or imprisonment for as long as five years, or both, together with the cost of prosecution. Such person shall also notify each such officer or employee that any such unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than \$1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n).

Additionally, it is incumbent upon the contractor to inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC 552a. Specifically, 5 USC 552a (i) (1), which is made applicable to contractors by 5 USC 552a (m) (1), provides that any officer or employee of

a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of the specific material is prohibited, willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000.

H. Contract a Public Record

Upon signing of this contract by all parties, the terms of the contract become available to the public pursuant to Alabama law. Contractor agrees to allow public access to all documents, papers, letters, or other materials subject to the current Alabama law on disclosure. It is expressly understood that substantial evidence of Contractor's refusal to comply with this provision shall constitute a material breach of contract.

I. Termination for Bankruptcy

The filing of a petition for voluntary or involuntary bankruptcy of a company or corporate reorganization pursuant to the Bankruptcy Act shall, at the option of Medicaid, constitute default by Contractor effective the date of such filing. Contractor shall inform Medicaid in writing of any such action(s) immediately upon occurrence by the most expeditious means possible. Medicaid may, at its option, declare default and notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor.

J. Termination for Default

Medicaid may, by written notice, terminate performance under the contract, in whole or in part, for failure of Contractor to perform any of the contract provisions. In the event Contractor defaults in the performance of any of Contractor's material duties and obligations, written notice shall be given to Contractor specifying default. Contractor shall have 10 calendar days, or such additional time as agreed to in writing by Medicaid, after the mailing of such notice to cure any default. In the event Contractor does not cure a default within 10 calendar days, or such additional time allowed by Medicaid, Medicaid may, at its option, notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor.

K. Termination for Unavailability of Funds

Performance by the State of Alabama of any of its obligations under the contract is subject to and contingent upon the availability of state and federal monies lawfully applicable for such purposes. If Medicaid, in its sole discretion, deems at any time during the term of the contract that monies lawfully applicable to this agreement shall not be available for the remainder of the term, Medicaid shall promptly notify Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be cancelled without penalty to Medicaid, State or Federal Government.

L. Proration of Funds

In the event of proration of the funds from which payment under this contract is to be made, this contract will be subject to termination.

M. Termination for Convenience

Medicaid may terminate performance of work under the Contract in whole or in part whenever, for any reason, Medicaid, in its sole discretion determines that such termination is in the best interest of the State. In the event that Medicaid elects to terminate the contract pursuant to this provision, it shall so notify the Contractor by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice. In such event, Contractor will be entitled only to payment for all work satisfactorily completed and for reasonable, documented costs incurred in good faith for work in progress. The Contractor will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

N. Force Majeure

Contractor shall be excused from performance hereunder for any period Contractor is prevented from performing any services pursuant hereto in whole or in part as a result of an act of God, war, civil disturbance, epidemic, or court order; such nonperformance shall not be a ground for termination for default.

O. Nondiscriminatory Compliance

Contractor shall comply with Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment.

P. Conflict of Interest

The parties acknowledge and agree that the Contractor must be free of conflicts of interest in accordance with all federal and state regulations while performing the duties within the contract and this amendment. The Contractor and Medicaid agree that each has no conflict of interest preventing the execution of this Contract amendment or the requirements of the original contract, and said parties will abide by applicable state and federal regulations, specifically those requirements found in the Office of Federal Procurement Policy Act. 42 U.S.C.A. 2101 through 2107.

Q. Open Trade

In compliance with Section 41-16-5 Code of Alabama (1975), the contractor hereby certifies that it is not currently engaged in, and will not engage in, the boycott of a person or an entity based in or doing business with a jurisdiction with which this state can enjoy open trade.

R. Small and Minority Business Enterprise Utilization

In accordance with the provisions of 45 CFR Part 74 and paragraph 9 of OMB Circular A-102, affirmative steps shall be taken to assure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

S. Worker's Compensation

Contractor shall take out and maintain, during the life of this contract, Worker's Compensation Insurance for all of its employees under the contract or any subcontract thereof, if required by state law.

T. Employment of State Staff

Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract any professional or technical personnel, who are or have been in the employment of Medicaid during the previous twelve (12) months, except retired employees or contractual consultants, without the written consent of Medicaid. Certain Medicaid employees may be subject to more stringent employment restrictions under the Alabama Code of Ethics, §36-25-1 et seq., Code of Alabama 1975.

U. Immigration Compliance

Contractor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Contractor shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Beason-Hammon Alabama Taxpayer and Citizen Protection Act (Ala. Act 2012-491 and any amendments thereto) and certify its compliance by executing Attachment G. Contractor will document that the Contractor is enrolled in the E-Verify Program operated by the US Department of Homeland Security as required by Section 9 of Act 2012-491. During the performance of the contract, the contractor shall participate in the E-Verify program and shall verify every employee that is required to be verified according to the applicable federal rules and regulations. Contractor further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of the services pursuant to this contract, that the Contractor will secure from such subcontractor(s) documentation that subcontractor is enrolled in the E-Verify program prior to performing any work on the project. The subcontractor shall verify every employee that is required to be verified according to the applicable federal rules and regulations. This subsection shall only apply to subcontractors performing work on a project subject to the provisions of this section and not to collateral persons or business entities hired by the subcontractor. Contractor shall maintain the subcontractor documentation that shall be available upon request by the Alabama Medicaid Agency.

Pursuant to Ala. Code §31-13-9(k), by signing this contract, the contracting parties affirm, for the duration of the agreement, that they will not violate federal immigration law or knowingly employ, hire for employment, or continue to employ an unauthorized alien within the state of Alabama. Furthermore, a contracting party found to be in violation of this provision shall be deemed in breach of the agreement and shall be responsible for all damages resulting therefrom.

Failure to comply with these requirements may result in termination of the agreement or subcontract.

V. Share of Contract

No official or employee of the State of Alabama shall be admitted to any share of the contract or to any benefit that may arise there from.

W. Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties.

X. Warranties Against Broker's Fees

Contractor warrants that no person or selling agent has been employed or retained to solicit or secure the contract upon an agreement or understanding for a commission percentage, brokerage, or contingency fee excepting bona fide employees. For breach of this warranty, Medicaid shall have the right to terminate the contract without liability.

Y. Novation

In the event of a change in the corporate or company ownership of Contractor, Medicaid shall retain the right to continue the contract with the new owner or terminate the contract. The new corporate or company entity must agree to the terms of the original contract and any amendments thereto. During the interim between legal recognition of the new entity and Medicaid execution of the novation agreement, a valid contract shall continue to exist between Medicaid and the original Contractor. When, to Medicaid's satisfaction, sufficient evidence has been presented of the new owner's ability to perform under the terms of the contract, Medicaid may approve the new owner and a novation agreement shall be executed.

Z. Employment Basis

It is expressly understood and agreed that Medicaid enters into this agreement with Contractor and any subcontractor as authorized under the provisions of this contract as an independent contractor on a purchase of service basis and not on an employer-employee basis and not subject to State Merit System law.

AA. Disputes and Litigation

Except in those cases where the proposal response exceeds the requirements of the RFP, any conflict between the response of Contractor and the RFP shall be controlled by the provisions of the RFP. Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Commissioner of Medicaid.

The Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this contract shall be limited to the filing of a claim with the board of Adjustment for the State of Alabama. Pending a final decision of a dispute hereunder, the Contractor must proceed diligently with the performance of the contract in accordance with the disputed decision.

For any and all disputes arising under the terms of this contract, the parties hereto agree, in compliance with the recommendations of the Governor and Attorney General, when considering settlement of such disputes, to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation by and through private mediators.

Any litigation brought by Medicaid or Contractor regarding any provision of the contract shall be brought in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdictions of these courts. This provision shall not be deemed an attempt to confer any jurisdiction on these courts which they do not by law have, but is a stipulation and agreement as to forum and venue only.

BB. Records Retention and Storage

Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the three- year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution.

CC. Inspection of Records

Contractor agrees that representatives of the Comptroller General, HHS, the General Accounting Office, the Alabama Department of Examiners of Public Accounts, and Medicaid and their authorized representatives shall have the right during business hours to inspect and copy Contractor's books and records pertaining to contract performance and costs thereof. Contractor shall cooperate fully with requests from any of the agencies listed above and shall furnish free of charge copies of all requested records. Contractor may require that a receipt be given for any original record removed from Contractor's premises.

DD. Use of Federal Cost Principles

For any terms of the contract which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the contract shall be in accordance with 48 CFR, Chapter 1, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

EE. Payment

Contractor shall submit to Medicaid a detailed monthly invoice for compensation for the deliverable and/or work performed. Invoices should be submitted to the Project Director. Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation.

FF. Notice to Parties

Any notice to Medicaid under the contract shall be sufficient when mailed to the Project Director. Any notice to Contractor shall be sufficient when mailed to Contractor at the address given on the return receipt from this RFP or on the contract after signing. Notice shall be given by certified mail, return receipt requested.

GG. Disclosure Statement

The successful Contractor shall be required to complete a financial disclosure statement with the executed contract.

HH. Debarment

Contractor hereby certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any Federal department or agency.

II. Not to Constitute a Debt of the State

Under no circumstances shall any commitments by Medicaid constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this contract shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of this Contract, be enacted, then that conflicting provision in the contract shall be deemed null and void. The Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

JJ. Qualification to do Business in Alabama

Should a foreign corporation (a business corporation incorporated under a law other than the law of this state) be selected to provide professional services in accordance with this RFP, it must be qualified to transact business in the State of Alabama and possess a Certificate of Authority issued by the Secretary of State at the time a professional services contract is executed. To obtain forms for a Certificate of Authority, contact the Secretary of State at (334) 242-5324 or www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the proposal.

KK. Choice of Law

The construction, interpretation, and enforcement of this contract shall be governed by the substantive contract law of the State of Alabama without regard to its conflict of laws provisions. In the event any provision of this contract is unenforceable as a matter of law, the remaining provisions will remain in full force and effect.

LL. Alabama interChange Interface Standards

Contractor hereby certifies that any exchange of MMIS data with Medicaid's fiscal agent will be accomplished by following the Alabama interChange Interface Standards Document, which will be posted on the Medicaid website.

MM. Attorney Fees

In the event that the State shall prevail in any legal action arising out of the performance or non-performance of this contract, Contractor must pay, in addition to any damages, all expenses of such action including reasonable attorneys' fees and costs. This requirement applies regardless of whether Medicaid is represented by staff counsel or outside counsel. Fees and costs of defense shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

NN. Procedure for Termination

Contractor must:

- a. Stop work under the contract on the date and to the extent specified in the notice of termination;
- b. Place no further orders or subcontracts for materials, services, except as may be necessary for completion of such portion of work under the contract as is not terminated;
- c. Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
- d. Assign to Medicaid in the manner and to the extent directed by Medicaid all of the rights, title, and interest of the Contractor under the orders or subcontracts so terminated, in which case Medicaid shall have the right, in its discretion, to settle or pay any and all claims arising out of termination of such orders and subcontracts;
- e. With the approval or ratification of Medicaid, settle all outstanding liabilities and all claims arising out of such termination or orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of contract;
- f. Complete the performance of such part of the work as shall not have been terminated by the notice of termination; and
- g. Take such action as may be necessary, or as Medicaid may direct for the protection and preservation of any and all property or information related to the contract which is in the

possession of the Contractor and in which Medicaid has or may acquire an interest.

OO. Contractor's Duties Upon Expiration/Termination

a. Transfer of Documents

At Medicaid's discretion, but no later than three working days following the expiration or termination of the contract, Contractor at its own expense, shall box, label, and deliver to Medicaid the following:

- All unprocessed and pending Prior Authorization requests
- All supporting documentation and correspondence regarding prior authorizations and clinical appeals
- Any information, data, manuals, records, claims or other documentation which shall permit Medicaid to continue contract performance or contract for further performance with another Contractor. Contractor shall organize and label this documentation by contract component.

b. Dialogue

Contractor shall at any time during the transition period and up to 90 calendar days after expiration of the contract answer all questions and provide all dialogue and training that Medicaid deems necessary to enable the successor Contractor to take over the provision of independent assessment services. All such communications shall be with or through the Project Manager.

PP. Indemnification

Contractor shall hold harmless, defend and indemnify Medicaid as to any penalties or federal recoupment and any interest incurred by reason of any Title XIX noncompliance due to the fault of Contractor and/or any subcontractors. The term "Title XIX noncompliance" shall be construed to mean any failure or inability of Medicaid to meet the requirements of Title XIX of the Social Security Act-and/or any regulations promulgated by the federal government therewith due to an act or omission of Contractor or subcontractor.

Contractor shall be liable and agrees to be liable for and shall indemnify, defend, and hold the State and Medicaid and their officers, employees and agents harmless from all claims, suits, judgments or damages, including court costs and attorney fees, arising out of or in connection with this contract due to negligent or intentional acts of omissions of the Contractor and/or any subcontractors. Contractor shall hold the State and Medicaid harmless from all subcontractor liabilities under the terms of this contract.

Contractor agrees to indemnify, defend, and hold harmless Medicaid, its officers, agents, and employees from:

Any claims or losses attributable to a service rendered by Contractor or any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract regardless of whether Medicaid knew or should have known of such improper service, performance, materials or supplies unless otherwise specifically approved by Medicaid in writing in advance;

Any claims or losses attributable to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid regulations or statutes, of Contractor, its officers, employees, or subcontractors in the

performance of the contract, regardless of whether Medicaid knew or should have known of such erroneous or negligent acts;

Any failure of Contractor, its officers, employees, or subcontractors to observe Alabama laws, including, but not limited to, labor laws and minimum wage laws, regardless of whether Medicaid knew or should have known of such failure.

If at any time during the operation of this contract, Medicaid gains actual knowledge of any erroneous, negligent, or otherwise wrongful acts by Contractor, its officers, employees, or subcontractors, Medicaid agrees to give Contractor written notice thereof. Failure by Medicaid to give said notice does not operate as a waiver of the Contractor's obligations to Medicaid, or as a release of any claims Medicaid may have against Contractor.

QQ. Performance Guarantee

In order to assure full performance of all obligations imposed on a Contractor contracting with the State of Alabama, the Contractor will be required to provide a performance guarantee in the amount equal to six months payments. The performance guarantee must be submitted by Contractor at least ten calendar days prior to the contract start date. The form of performance guarantee shall be one of the following:

1. Cashier's check (personal or company checks are not acceptable);
2. Other type of bank certified check;
3. Money order;
4. An irrevocable letter of credit;
5. Surety bond issued by a company authorized to do business within the State of Alabama.

The Alabama Medicaid Agency's Chief Financial Officer shall be the custodian of the performance guarantee. The performance guarantee shall reference this RFP and it shall be made payable to the State of Alabama.

If Contractor fails to deliver the required performance guarantee, the proposal shall be rejected and the contract may be awarded to the provider of the next ranked proposal.

In the event of a breach of contract, Medicaid will notify Contractor in writing of the default and may assess reasonable charges against the Contractor's performance guarantee. If after notification of default, the Contractor fails to remedy the State's damages within 30 calendar days, Medicaid may initiate procedures for collection against Contractor's performance guarantee.

Failure of the Contractor to perform satisfactorily, a breach of contract, or termination of contract shall cause the performance guarantee to become due and payable to the state of Alabama to the extent necessary to cover the costs incurred by Medicaid as a result of the Contractor's failure to perform its contractual obligations.

These costs include, but are not limited to, costs to correct any Medicaid errors caused by the Contractor's default and costs incurred by Medicaid for completion of contracted work including any costs associated with preparation, solicitation, and award of a competitive bid for these contract services and any federal, state or other penalties, sanctions, disallowances, or any other costs incurred by Medicaid as a result of the Contractor's default and any breach of contract necessary as a result of the Contractor's default.

In order to achieve the greatest economy for the State, Medicaid may choose the next responsive bidder, re-release the RFP, or complete any other action consistent with state purchasing laws. The performance guarantee will be released within 60 days of the end of the contract term.

RR. Provision of Gratuities

Neither the Contractor nor any person, firm or corporation employed by the Contractor in the performance of this contract shall offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation or contract for future reward or compensation at any time during the term of this contract.

SS. Method of Payment and Invoices

For any terms of the contract which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the contract shall be in accordance with 48 CFR, Chapter 1, Subchapter E, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

Appendix A: Proposal Compliance Checklist

NOTICE TO CONTRACTOR:

It is highly encouraged that the following checklist be used to verify completeness of Proposal content. It is not required to submit this checklist with your proposal.

Contractor Name

Project Director Review Date

Proposals for which ALL applicable items are marked by the Project Director are determined to be compliant for responsive proposals.

<input checked="" type="checkbox"/> IF CORRECT	BASIC PROPOSAL REQUIREMENTS
<input type="checkbox"/>	1. Contractor’s original proposal received on time at correct location.
<input type="checkbox"/>	2. Contractor submitted the specified copies of proposal and in electronic format.
<input type="checkbox"/>	3. The Proposal includes a completed and signed RFP Cover Sheet.
<input type="checkbox"/>	4. The Proposal is a complete and independent document, with no references to external documents or resources.
<input type="checkbox"/>	5. Contractor submitted signed acknowledgement of any and all addenda to RFP.
<input type="checkbox"/>	6. The Proposal includes written confirmation that the Contractor understands and shall comply with all of the provisions of the RFP.
<input type="checkbox"/>	7. The Proposal includes required client references (with all identifying information in specified format and order).
<input type="checkbox"/>	8. The Proposal includes a corporate background.
<input type="checkbox"/>	9. The Proposal includes a detailed description of the plan to design, implement, monitor, address special situations related to new Pharmacy Administrative Services as outlined in the request for proposal regarding each element listed in the scope of work.
<input type="checkbox"/>	10. Contractor must submit a statement stating that the Contractor has an understanding of and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Contractor’s proposal being deemed non-responsive.
<input type="checkbox"/>	11. The response includes (if applicable) a Certificate of Authority or letter/form showing application has been made with the Secretary of State for a Certificate of Authority.
<input type="checkbox"/>	12. The response must include an E-Verify Memorandum of Understanding with the Department of Homeland Security.

Appendix B: Contract and Attachments

The following are the documents that must be signed **AFTER** contract award and prior to the meeting of the Legislative Contract Oversight Committee Meeting.

Sample Contract

Attachment A: Business Associate Addendum

Attachment B: Contract Review Report for Submission to Oversight Committee

Attachment C: Immigration Status

Attachment D: Disclosure Statement

Attachment E: Letter Regarding Reporting to Ethics Commission

Attachment F: Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

Attachment G: Beason-Hammon Certificate of Compliance

CONTRACT

BETWEEN
THE ALABAMA MEDICAID AGENCY
AND

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and _____, Contractor, agree as follows:

Contractor shall furnish all labor, equipment, and materials and perform all of the work required under the Request for Proposal (RFP Number _____, dated _____, strictly in accordance with the requirements thereof and Contractor’s response thereto.

Contractor shall be compensated for performance under this contract in accordance with the provisions of the RFP and the price provided on the RFP Cover Sheet response, in an amount not to exceed _____.

Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is ____to ____.

This contract specifically incorporates by reference the RFP, any attachments and amendments thereto, and Contractor’s response.

CONTRACTOR

ALABAMA MEDICAID AGENCY
This contract has been reviewed for and is approved as to content.

Contractor’s name here

Stephanie McGee Azar
Commissioner

Date signed

Date signed

Printed Name

This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.

Tax ID: _____

APPROVED:

General Counsel

Governor, State of Alabama

**ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM**

This Business Associate Addendum (this “Agreement”) is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency (“Covered Entity”), an agency of the State of Alabama, and _____ (“Business Associate”) (collectively the “Parties”).

1. BACKGROUND

- 1.1. Covered Entity and Business Associate are parties to a contract entitled _____ (the “Contract”), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.
- 1.2. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a “business associate” within the meaning of the HIPAA Rules (as defined below).
- 1.3. The Parties enter into this Business Associate Addendum with the intention of complying with the HIPAA Rules allowing a covered entity to disclose protected health information to a business associate, and allowing a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

2.1 General Definitions

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic Protected Health Information, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

2.2 Specific Definitions

- 2.2.1. Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 C.F.R. § 160.103
- 2.2.2. Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 C.F.R. § 160.103.
- 2.2.3. HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

Business Associate agrees to the following:

- 3.1 Use or disclose PHI only as permitted or required by this Agreement or as Required by Law.

- 3.2** Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. Further, Business Associate will implement administrative, physical and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by Subpart C of 45 C.F.R. Part 164.
- 3.3** Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
- 3.4** Report to Covered Entity within five (5) business days any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.
- 3.5** Ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and § 164.308(b)(2), if applicable.
- 3.6** Provide Covered Entity with access to PHI within thirty (30) business days of a written request from Covered Entity, in order to allow Covered Entity to meet its requirements under 45 C.F.R. § 164.524, access to PHI maintained by Business Associate in a Designated Record Set.
- 3.7** Make amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 C.F.R. § 164.526 at the written request of Covered Entity, within thirty (30) calendar days after receiving the request.
- 3.8** Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary within five (5) business days after receipt of written notice or as designated by the Secretary for purposes of determining compliance with the HIPAA Rules.
- 3.9** Maintain and make available the information required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI as necessary to satisfy the Covered Entity's obligations under 45 C.F.R. § 164.528.
- 3.10** Provide to the Covered Entity, within thirty (30) days of receipt of a written request from Covered Entity, the information required for Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
- 3.11** Maintain a comprehensive security program appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities as defined in the Security Rule.
- 3.12** Notify the Covered Entity within five (5) business days following the discovery of a breach of unsecured PHI on the part of the Contractor or any of its sub-contractors, and
 - 3.12.1.** Provide the Covered Entity the following information:
 - 3.12.1.a** The number of recipient records involved in the breach.

- 3.12.1.b A description of what happened, including the date of the breach and the date of the discovery of the breach if known.
 - 3.12.1.c A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).
 - 3.12.1.d Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
 - 3.12.1.e A description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches.
 - 3.12.1.f Contact procedures for individuals to ask questions or learn additional information, which shall include the Business Associate's toll-free number, email address, Web site, or postal address.
 - 3.12.1.g A proposed media release developed by the Business Associate.
- 3.12.2. Work with Covered Entity to ensure the necessary notices are provided to the recipient, prominent media outlet, or to report the breach to the Secretary of Health and Human Services (HHS) as required by 45 C.F.R. Part 164, Subpart D.;
- 3.12.3. Pay the costs of the notification for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate;
- 3.12.4. Pay all fines or penalties imposed by HHS under 45 C.F.R. Part 160, "HIPAA Administrative Simplification: Enforcement Rule" for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate.
- 3.12.5. Co-ordinate with the Covered Entity in determining additional specific actions that will be required of the Business Associate for mitigation of the breach.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may:

- 4.1** Use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Subpart E of 45 C.F.R. Part 164 if done by Covered Entity;
- 4.2** Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- 4.3** Disclose PHI for the proper management and administration of the Business Associate, provided that:
 - 4.3.1. Disclosures are Required By Law; or
 - 4.3.2. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of

which it is aware in which the confidentiality of the information has been breached.

- 4.4 Use PHI to provide data aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

5. REPORTING IMPROPER USE OR DISCLOSURE

The Business Associate shall report to the Covered Entity within five (5) business days from the date the Business Associate becomes aware of:

- 5.1 Any use or disclosure of PHI not provided for by this agreement
5.2 Any Security Incident and/or breach of unsecured PHI

6. OBLIGATIONS OF COVERED ENTITY

The Covered Entity agrees to the following:

- 6.1 Notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.
6.2 Notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.
6.3 Notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.
6.4 Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.
6.5 Provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services to which this agreement pertains.

7. TERM AND TERMINATION

- 7.1 **Term.** The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.
7.2 **Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:
7.2.1. Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
7.2.2. Immediately terminate this Agreement; or
7.2.3. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.
7.3 **Effect of Termination.**
7.3.1 Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in

the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2 In the event that Business Associate determines that the PHI is needed for its own management and administration or to carry out legal responsibilities, and returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall:

7.3.2.a Retain only that PHI which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

7.3.2.b Return to covered entity or, if agreed to by covered entity, destroy the remaining PHI that the business associate still maintains in any form;

7.3.2.c Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the PHI;

7.3.2.d Not use or disclose the PHI retained by business associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 4, "Permitted Uses and Disclosures" which applied prior to termination; and

7.3.2.e Return to covered entity or, if agreed to by covered entity, destroy the PHI retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

7.4 Survival

The obligations of business associate under this Section shall survive the termination of this Agreement.

8. GENERAL TERMS AND CONDITIONS

8.1 This Agreement amends and is part of the Contract.

8.2 Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

8.3 In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the HIPAA Rules shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Rules.

8.4 A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

8.5 The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the HIPAA Rules.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: Clay Gaddis

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Contract Review Permanent Legislative Oversight Committee
Alabama State House
Montgomery, Alabama 36130

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor:

Contractor's Physical Street Address (No. P.O. Box) City State

* Is Contractor organized as an Alabama Entity in Alabama? YES NO

* If not, has it qualified with the Alabama Secretary of State to do business in Alabama? YES NO

Is Act 2001-955 Disclosure Form Included with this Contract? YES X NO

Does Contractor have current member of Legislature or family member of Legislator employed? YES NO

Was a lobbyist/consultant used to secure this contract OR affiliated with this contractor? YES NO

If Yes, Give Name:

Contract Number:

Contract/Amendment Total: \$ (estimate if necessary)

% of State Funds: % of Federal Funds: % Other Funds:

**Please Specify source of Other Funds (Fees, Grants, etc.)

Date Contract Effective: Date Contract Ends:

Type of Contract: NEW: RENEWAL: AMENDMENT:

If renewal, was it originally Bid? Yes No

If AMENDMENT, Complete A through C:

(A) Original contract total \$

(B) Amended total prior to this amendment \$

(C) Amended total after this amendment \$

Was Contract secured through Bid Process? Yes No Was lowest Bid accepted? Yes No

Was Contract secured through RFP Process? Yes No Date RFP was awarded

Posted to Statewide RFP Database at http://rfp.alabama.gov/Login.aspx YES No

If no, please give a brief explanation:

Summary of Contract Services to be Provided:

Why Contract Necessary AND why this service cannot be performed by merit employee:

I certify that the above information is correct.

Signature of Agency Head

Signature of Contractor

Printed Name

Printed Name

Agency Contact: Stephanie Lindsay Phone: (334) 242-5833

IMMIGRATION STATUS

I hereby attest that all workers on this project are either citizens of the United States or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States.

Signature of Contractor

Witness



State of Alabama Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP NUMBER TELEPHONE NUMBER

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

Alabama Medicaid Agency
ADDRESS
501 Dexter Avenue, Post Office Box 5624
CITY, STATE, ZIP TELEPHONE NUMBER
Montgomery, Alabama 36103-5624 (334) 242-5833

This form is provided with:
 Contract Proposal Request for Proposal Invitation to Bid Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

Yes No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT RECEIVED	TYPE OF GOODS/SERVICES	AMOUNT

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

Yes No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT OF GRANT	DATE GRANT AWARDED	AMOUNT

STATE AGENCY

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit

financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE
DEPARTMENT/AGENCY

ADDRESS

STATE

DEPARTMENT/AGENCY

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF
FAMILY MEMBER

ADDRESS

NAME OF PUBLIC OFFICIAL/
PUBLIC EMPLOYEE

STATE DEPARTMENT/
AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST

ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed \$10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature

Date

Notary's Signature

Date

Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of \$5,000.



KAY IVEY
Governor

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.alabama.gov
e-mail:
almedicaid@medicaid.alabama.gov

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504



STEPHANIE MCGEE AZAR
Commissioner

MEMORANDUM

SUBJECT: Reporting to Ethics Commission by Persons Related to Agency Employees

Section 36-25-16(b) Code of Alabama (1975) provides that anyone who enters into a contract with a state agency for the sale of goods or services exceeding \$7500 shall report to the State Ethics Commission the names of any adult child, parent, spouse, brother or sister employed by the agency.

Please review your situation for applicability of this statute. The address of the Alabama Ethics Commission is:

100 North Union Street
RSA Union Bldg.
Montgomery, Alabama 36104

A copy of the statute is reproduced below for your information. If you have any questions, please feel free to contact the Agency Office of General Counsel, at 242-5741.

Section 36-25-16. Reports by persons who are related to public officials or public employees and who represent persons before regulatory body or contract with state.

- (a) When any citizen of the state or business with which he or she is associated represents for a fee any person before a regulatory body of the executive branch, he or she shall report to the commission the name of any adult child, parent, spouse, brother, or sister who is a public official or a public employee of that regulatory body of the executive branch.
- (b) When any citizen of the State or business with which the person is associated enters into a contract for the sale of goods or services to the State of Alabama or any of its agencies or any county or municipality and any of their respective agencies in amounts exceeding seven thousand five hundred dollars (\$7500) he or she shall report to the commission the names of any adult child, parent, spouse, brother, or sister who is a public official or public employee of the agency or department with whom the contract is made.
- (c) This section shall not apply to any contract for the sale of goods or services awarded through a process of public notice and competitive bidding.
- (d) Each regulatory body of the executive branch, or any agency of the State of Alabama shall be responsible for notifying citizens affected by this chapter of the requirements of this section. (Acts 1973, No. 1056, p. 1699, §15; Acts 1975, No. 130, §1; Acts 1995, No. 95-194, p. 269, §1.)

**Instructions for Certification Regarding Debarment, Suspension,
Ineligibility and Voluntary Exclusion**

(Derived from Appendix B to 45 CFR Part 76--Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions)

1. By signing and submitting this contract, the prospective lower tier participant is providing the certification set out therein.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Alabama Medicaid Agency (the Agency) may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the Agency if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, and voluntarily excluded, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this contract is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this contract that, should the contract be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this contract that it will include this certification clause without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the Agency may pursue available remedies, including suspension and/or debarment.

State of _____)

County of _____)

CERTIFICATE OF COMPLIANCE WITH THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535, as amended by Act 2012-491)

DATE: _____

RE Contract/Grant/Incentive (describe by number or subject): _____ by and between _____ (Contractor/Grantee) and Alabama Medicaid Agency (State Agency or Department or other Public Entity)

The undersigned hereby certifies to the State of Alabama as follows:

1. The undersigned holds the position of _____ with the Contractor/Grantee named above, and is authorized to provide representations set out in this Certificate as the official and binding act of that entity, and has knowledge of the provisions of THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535 of the Alabama Legislature, as amended by Act 2012-491) which is described herein as "the Act".
2. Using the following definitions from Section 3 of the Act, select and initial either (a) or (b), below, to describe the Contractor/Grantee's business structure.
BUSINESS ENTITY. Any person or group of persons employing one or more persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood, whether for profit or not for profit. "Business entity" shall include, but not be limited to the following:
 - a. Self-employed individuals, business entities filing articles of incorporation, partnerships, limited partnerships, limited liability companies, foreign corporations, foreign limited partnerships, foreign limited liability companies authorized to transact business in this state, business trusts, and any business entity that registers with the Secretary of State.
 - b. Any business entity that possesses a business license, permit, certificate, approval, registration, charter, or similar form of authorization issued by the state, any business entity that is exempt by law from obtaining such a business license, and any business entity that is operating unlawfully without a business license.

EMPLOYER. Any person, firm, corporation, partnership, joint stock association, agent, manager, representative, foreman, or other person having control or custody of any employment, place of employment, or of any employee, including any person or entity employing any person for hire within the State of Alabama, including a public employer. This term shall not include the occupant of a household contracting with another person to perform casual domestic labor within the household.

- _____(a)The Contractor/Grantee is a business entity or employer as those terms are defined in Section 3 of the Act.
 _____(b)The Contractor/Grantee is not a business entity or employer as those terms are defined in Section 3 of the Act.

3. As of the date of this Certificate, Contractor/Grantee does not knowingly employ an unauthorized alien within the State of Alabama and hereafter it will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama;
4. Contractor/Grantee is enrolled in E-Verify unless it is not eligible to enroll because of the rules of that program or other factors beyond its control.

Certified this _____ day of _____ 20____.

Name of Contractor/Grantee/Recipient

By: _____

Its _____

The above Certification was signed in my presence by the person whose name appears above, on this _____ day of _____ 20____.

WITNESS: _____

Print Name of Witness

Appendix C: Pricing Form

Pricing Schedule A Service Components- Annual Rate

Contract Item	Price
Prospective DUR Edits Monitoring (including letters)	\$
Retrospective DUR (RDUR)	\$
Prior Authorization	\$
Override Requirements	\$
Electronic Prior Authorization	\$
Online Prior Authorization	\$
Incentive Program	\$
Clinical Appeals	\$
Specialty Drugs-Synagis	\$
Help Desk (to include key personnel other than listed below)	\$
Pharmacy Lock In	\$
Academic Detailing	\$
Drug Interface Capability	\$
Staff Pharmacist	\$
Staff Drug File Coordinator/Certified Pharmacy Tech	\$
Audit Pharmacist	\$
Total- Annual Rate	\$

Pricing Schedule B Extra Contractual Services

Contract Item	Unit/Monthly Rate	Price
Help Desk Clerk Salary and Benefits	\$Unit/monthly rate	\$
Help Desk Phone Line	\$Unit/monthly rate	\$
FAX Line	\$ per fax line	\$
Help Desk Furniture and Equipment	\$ per workstation	\$
DUR Letters (above contracted amount)	\$Per Unit rate above min 500 rec/month	\$
PLI	\$Per review Unit rate above min 200/month	\$
Academic Detailer	\$Unit price per position	\$
Total		\$

Pricing Schedule C Evaluated Price

Contract Item	Price
Firm and Fixed Annual Base Price (from Schedule A)	\$
Extra Contractual Services Total (from Schedule B)	\$
Total Evaluated Price	\$

1800000060	Document Phase Final	Document Description Alabama Medicaid Agency Pharmacy Administrative Services RFP	Page 2 of 4
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GENERAL TERMS AND CONDITIONS FOR RFP FOR SERVICES v 7-9-15 rhc edit 7-28-15

GENERAL TERMS AND CONDITIONS FOR THIS REQUEST FOR PROPOSALS - All proposals are subject to these Terms and Conditions.

1. PROHIBITED CONTACTS; INQUIRIES REGARDING THIS RFP – *From the Release Date of this RFP until a contract is awarded, parties that intend to submit, or have submitted, a Proposal are prohibited from communicating with any members of the Soliciting Party’s Team for this transaction who may be identified herein or subsequent to the Release Date, or other employees or representatives of the Soliciting Party regarding this RFP or the underlying transaction except the designated contact(s) identified in {insert location in RFP where contacts are identified, such as Section S or Item 2.}*

Questions relating only to the RFP process may be submitted by telephone or by mail or hand delivery to: the designated contact. Questions on other subjects, seeking additional information and clarification, must be made in writing and submitted via email to the designated contact, sufficiently in advance of the deadline for delivery of Proposals to provide time to develop and publish an answer. A question received less than two full business days prior to the deadline may not be acknowledged. Questions and answers will be published to those parties submitting responsive proposals.

2. NONRESPONSIVE PROPOSALS - Any Proposal that does not satisfy requirements of the RFP may be deemed non-responsive and may be disregarded without evaluation. Clarification or supplemental information may be required from any Proposer.

3. CHANGES TO THE RFP; CHANGES TO THE SCHEDULE - The Soliciting Party reserves the right to change or interpret the RFP prior to the Proposal Due Date. Changes will be communicated to those parties receiving the RFP who have not informed the Soliciting Party’s designated contact that a Proposal will not be submitted. Changes to the deadline or other scheduled events may be made by the Soliciting Party as it deems to be in its best interest.

4. EXPENSES - Unless otherwise specified, the reimbursable expenses incurred by the service provider in the providing the solicited services, shall be charged at actual cost without mark-up, profit or administrative fee or charge. Only customary, necessary expenses in reasonable amounts will be reimbursable, to include copying (not to exceed 15 cents per page), printing, postage in excess of first class for the first one and one-half ounces, travel and preapproved consulting services. Cost of electronic legal research, cellular phone service, fax machines, long-distance telephone tolls, courier, food or beverages are not reimbursable expenses without prior authorization, which will not be granted in the absence of compelling facts that demonstrate a negative effect on the issuance of the bonds, if not authorized.

If pre-approved, in-state travel shall be reimbursed at the rate being paid to state employees on the date incurred. Necessary lodging expenses will be paid on the same per-diem basis as state employees are paid. Any other pre-approved travel expenses will be reimbursed on conditions and in amounts that will be declared by the Issuer when granting approval to travel. Issuer may require such documentation of expenses as it deems necessary.

5. REJECTION OF PROPOSALS - The Soliciting Party reserves the right to reject any and all proposals and cancel this Request if, in the exercise its sole discretion, it deems such action to be in its best interest.

6. EXPENSES OF PROPOSAL – The Soliciting Party will not compensate a Proposer for any expenses incurred in the preparation of a Proposal.

7. DISCLOSURE STATEMENT - A Proposal must include one original Disclosure Statement as required by Code Section 41-16-82, et seq., Code of Alabama 1975. Copies of

1800000060	Document Phase Final	Document Description Alabama Medicaid Agency Pharmacy Administrative Services RFP	Page 3 of 4
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the Disclosure Statement, and information, may be downloaded from the State of Alabama Attorney General's web site at <http://ago.alabama.gov/Page-Vendor-Disclosure-Statement-Information-and-Instructions>.

8. LEGISLATIVE CONTRACT REVIEW - Personal and professional services contracts with the State may be subject to review by the Contract Review Permanent Legislative Oversight Committee in accordance with Section 29-2-40, et seq., *Code of Alabama 1975*. The vendor is required to be knowledgeable of the provisions of that statute and the rules of the committee. These rules can be found at <http://www.legislature.state.al.us/aliswww/AlaLegJointIntCommContracReview.aspx>. If a

contract resulting from this RFP is to be submitted for review the service provider must provide the forms and documentation required for that process.

9. THE FINAL TERMS OF THE ENGAGEMENT - Issuance of this Request For Proposals in no way constitutes a commitment by the Soliciting Party to award a contract. The final terms of engagement for the service provider will be set out in a contract which will be effective upon its acceptance by the Soliciting Party as evidenced by the signature thereon of its authorized representative. Provisions of this Request For Proposals and the accepted Proposal may be incorporated into the terms of the engagement should the Issuer so dictate. Notice is hereby given that there are certain terms standard to commercial contracts in private sector use which the State is prevented by law or policy from accepting, including indemnification and holding harmless a party to a contract or third parties, consent to choice of law and venue other than the State of Alabama, methods of dispute resolution other than negotiation and mediation, waivers of subrogation and other rights against third parties, agreement to pay attorney's fees and expenses of litigation, and some provisions limiting damages payable by a vendor, including those limiting damages to the cost of goods or services.

10. BEASON-HAMMON ACT COMPLIANCE. A contract resulting from this RFP will include provisions for compliance with certain requirements of the *Beason-Hammon Alabama taxpayer and Citizen Protection Act* (Act 2011-535, as amended by Act 2012-491 and codified as Sections 31-13-1 through 35, Code of Alabama, 1975, as amended), as follows:

E- VERIFY ENROLLMENT DOCUMENTATION AND PARTICIPATION. As required by Section 31-13-9(b), Code of Alabama, 1975, as amended, Contractor that is a "business entity" or "employer" as defined in Code Section 31-13-3, will enroll in the E-Verify Program administered by the United States Department of Homeland Security, will provide a copy of its Memorandum of Agreement with the United States Department of Homeland Security that program and will use that program for the duration of this contract.

CONTRACT PROVISION MANDATED BY SECTION 31-13-9(k):

By signing this contract, the contracting parties affirm, for the duration of the agreement, that they will not violate federal immigration law or knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Furthermore, a contracting party found to be in violation of this provision shall be deemed in breach of the agreement and shall be responsible for all damages resulting therefrom.

18000000060	Document Phase Final	Document Description Alabama Medicaid Agency Pharmacy Administrative Services RFP	Page 4 of 4
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ATTENTION: Alabama Medicaid intends to post the Alabama Medicaid Agency Pharmacy Administrative Services RFP specifications document by the close of business on 04/17/2018, to the Alabama Medicaid website at:

http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx.

All questions concerning this RFP must be directed to:

PASRFP@medicaid.alabama.gov

THE INFORMATION IN THIS DOCUMENT IS SUBJECT TO CHANGE.

ALABAMA MEDICAID SPECIFICATIONS



NCPDP VERSION D. Ø

ALABAMA SPECIFICS FOR PHARMACY

Note: The information in this document is subject to change. Please refer to the effective date located in the footer of this document for the latest information available.

Table of Contents

General Information and Requirements 1

 Testing Procedures..... 1

 Help Desk 1

Issues 1

 Field Justification..... 1

 Data Element Usage..... 1

 Co-Pay Exemption 2

 Other Insurance..... 2

 Compound Drugs..... 3

 Basis of Reimbursement Determination 3

 Rejection Codes 4

 Reversal Request Format Changes 4

 Changes to the handling of Usual & Customary / Gross Amount Due fields 4

Billing Request Transaction (B1 Request)..... 5

 Transaction Header Segment: Transmission Level..... 5

 Patient Segment: Transmission Level..... 6

 Insurance Segment: Transmission Level 7

 Claim Segment: Transaction Level..... 8

 Claim Segment: Transaction Level..... 10

 Prescriber Segment: Transaction Level 14

 COB / Other Payments Segment: Transaction Level..... 15

 Worker’s Compensation Segment: Not Used 17

 DUR / PPS Segment: Transaction Level 18

 Pricing Segment: Transaction Level 19

 Coupon Segment: Not Used..... 20

 Compound Segment: Transaction Level..... 21

 Compound Segment: Transaction Level..... 22

 Clinical Segment: Transaction Level..... 23

Billing Paid Response (B1 Response) 25

 Response Header Segment: Transmission Level 25

 Response Insurance Segment: Not Used..... 25

 Response Patient Segment: Not Used..... 25

 Response Message Segment: Transmission Level..... 26

 Response Status Segment: Transaction Level..... 27

 Response Claim Segment: Transaction Level..... 28

 Response Pricing Segment: Transaction Level..... 29

 Response Coordination of Benefits/Other Payers Segment: Not Used..... 31

Billing Rejected Response (B1 Response) 32

 Response Header Segment: Transmission Level 32

 Response Message Segment: Transmission Level..... 33

 Response Insurance Segment: Not Used..... 33

 Response Patient Segment: Not Used 33

 Response Status Segment: Transaction Level..... 34

 Response Claim Segment: Transaction Level..... 35

 Response DUR / PPS Segment: Transaction Level 36

 Response DUR / PPS Segment: Transaction Level 37

 Response Coordination of Benefits/Other Payers Segment: Not Used..... 37

Billing Duplicate Response (B1 Response) 38

 Response Header Segment: Transmission Level 38

 Response Message Segment: Transmission Level..... 39

 Response Insurance Segment: Not Used..... 39

 Response Patient Segment: Not Used 39

 Response Status Segment: Transaction Level..... 40

 Response Claim Segment: Transaction Level..... 41

 Response Pricing Segment: Transaction Level..... 42

 Response DUR / PPS Segment: Transaction Level 44

General Information and Requirements

Response Coordination of Benefits/Other Payers Segment: Not Used.....	44
Reversal Transaction (B2 Request).....	45
Transaction Header Segment: Transmission Level.....	45
Insurance Segment: Not Used.....	45
Claim Segment: Transaction Level.....	46
DUR/PPS Segment: Not Used.....	46
Pricing Segment: Not Used.....	46
Coordination of Benefits/Other Payments Segment: Not Used.....	46
Reversal Approval Response (B2 Response).....	47
Response Header Segment: Transmission Level.....	47
Response Message Segment: Transmission Level.....	48
Response Status Segment: Transaction Level.....	49
Claim Response Segment: Transaction Level.....	50
Reversal Rejection Response (B2 Response).....	51
Response Header Segment: Transmission Level.....	51
Response Message Segment: Transmission Level.....	52
Response Status Segment: Transaction Level.....	53
Response Claim Segment: Transaction Level.....	54
Eligibility Request Transaction (E1 Request).....	55
Transaction Header Segment: Transmission Level.....	55
Insurance Segment: Transmission Level.....	56
Patient Segment: Not Used.....	56
Pharmacy Provider Segment: Not Used.....	56
Prescriber Segment: Not Used.....	56
Additional Documentation Segment: Not Used.....	56
Eligibility Response Approved Transaction (E1 Response).....	57
Response Header Segment– Transmission Level.....	57
Response Message Segment: Not Used.....	57
Response Insurance Segment– Transaction Level.....	58
Response Insurance Additional Information Segment: Not Used.....	58
Response Patient Segment – Transaction Level.....	59
Response Status Segment: Transaction Level.....	60
Response Coordination of Benefits/Other Payers Segment: Not Used.....	60
Eligibility Response Rejected Transaction (E1 Response).....	61
Response Header Segment – Transmission Level.....	61
Response Status Segment: Transaction Level.....	62

General Information and Requirements

Testing Procedures

Once a vendor has developed a program following the guidelines stated in this manual, they must test the program for approval. Test claims will be issued along with other necessary information for testing. The test claim results should be returned to HPES for review. Upon approval, instructions will be given for the submission of production claims. For more information, please call (334) 215-0111 or 1-800-456-1242.

Help Desk

The EMC Helpdesk is available to providers and vendors to answer questions, concerns, or to address any problems which may occur during transmission. The help desk can be reached at the following:

Phone

(800) 456-1242
(334) 215-0111
(334) 215-4272 (fax)

Writing

Hewlett-Packard Enterprise Services
Attn: EMC Helpdesk
301 Technacenter Drive
Montgomery, AL 36117

E-mail

AlabamaSystemsEMC@hp.com

Issues

The following paragraphs give specific information regarding the implementation of NCPDP Version D.Ø. Each of the following paragraphs gives information on specific issues regarding Alabama Medicaid transmissions.

Field Justification

Due to the variable format, field justification is not applicable. However, if you choose to pad each field, all alpha-numeric fields should be left justified and numeric fields should be right justified.

Data Element Usage

In NCPDP Version D.Ø, the field/data element usage is defined as:

M = Mandatory
R = Required
Q = Qualified Requirement
I = Informational Only
O = Optional

The Data Element Usage column listed per request/response segment is from the Telecommunication Standard Implementation Guide. Please reference the AL Requirements columns for any specific requirements for the selected field/data element.

Within a segment, situational or optional fields are submitted after the mandatory and required fields/data elements.

Some fields may be repeated or sent more than once. These fields are denoted with ***R***, in the Data Element Usage column. The number inside the () represents the number of times the field can be repeated.

If the AL Requirements column is N/A, the value sent for the data element isn't used in processing the request. For example, the Processor Control Number (1Ø4-A4) in the Transaction Segment can be sent as all spaces to meet the mandatory requirement.

Co-Pay Exemption

The patient segment is an optional segment. There are two fields, also optional, that we will capture from this segment, if the segment is sent. Below is a table of these fields and the values we will default to if the segment and/or fields are not sent.

When the Place of Service indicates Long Term Care (LTC), the recipient will be considered exempt from co-pay. In version 5.1 the field was named Patient Location. For D.Ø, the field was renamed to Place of Service.

Field	Segment	NCPDP Field #	Valid Values (Valid values appear in bold .)	Default Value	AL Requirements
PLACE OF SERVICE	Patient	3Ø7-C7	Refer to External Code List for values.	Blank	It will be assumed that the recipient is not in an LTC facility. Values of 31, 32, or 54 will indicate LTC.

A pregnancy indicator field (335-2C) exists in NCPDP D.Ø on the patient segment. A value of '2' in this field will indicate that the recipient is pregnant. When the Pregnancy Indicator is '2', the recipient will be considered exempt from co-pay. The table below shows the basic data for this field.

Field	Segment	NCPDP Field #	Valid Values	Default Value	AL Requirements
PREGNANCY INDICATOR	Patient	335-2C	Blank=Not Specified 1=Not pregnant 2=Pregnant	Blank	It will be assumed that the recipient is not pregnant.

The claim segment is mandatory for a B1 Billing request. A prior authorization field (461-EU) exists in NCPDP D.Ø on the claim segment. This field (461-EU) is optional. A value of '1' in this field will indicate a prior authorization number is contained in the 462-EV field. A value of '4' in 461-EU will indicate the client is exempt from co-payment. For additional information on exemption from copay, please reference the current Provider Manual for Pharmacy found at http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx.

Field	Segment	NCPDP Field #	Valid Values	Default Value	AL Requirements
PRIOR AUTHORIZATION TYPE CODE	Claim	461-EU	Blank=Not Specified 1=Prior Authorization 4= Exemption from Copay	Blank	It will be assumed that the recipient is not exempt from co-payment.

Other Insurance

NCPDP D.Ø allows the submission of up to 9 instances of other insurance information. We will sum those values up and the value will become the TPL amount. Due to the very rare nature of more than one insurance on a pharmacy claim, we will continue to accept only one other insurance amount. In the Other Payer Amount

Paid Qualifier (342-HC) field, a value of “Ø7” (Drug Benefit) should be specified to denote the total amount paid by all other payers.

Compound Drugs

Compound drug billing is enhanced with version D.Ø to allow all NDC’s that are part of a compound to be billed on the same transaction. As a reminder, a compound drug is identified when data element 4Ø6-D6 Compound Code is equal to “2”.

- Alabama Medicaid will allow up to 25 NDC’s/ingredients to be sent per claim.
- Alabama Medicaid will reject compound claims if one or more NDC’s is “non-covered”.
- For compound claims with one or more non-covered ingredients, a value of “8” should be submitted in field 42Ø -DK (Submission Clarification Code) to allow for payment on the remaining covered NDC’s. Version 5.1 only allowed one occurrence for Submission Clarification Code. Version D.Ø allows a maximum of 3 occurrences. All three occurrences will be reviewed during processing of the claim. When at least one of the occurrences is “8” or “Ø8”, the claim will be processed for the approved ingredient(s).

Basis of Reimbursement Determination

Field 522-FM, *Basis of Reimbursement Determination* is an optional field that can be returned on a paid or duplicate billing transaction. This field explains how the drug ingredient cost was derived; whether DOJ, FUL, AWP (As of October 1, 2011, AWP pricing will no longer be available.), SMAC, WAC, or AAC. The table below shows how the basis of reimbursement values will be set in relation to the rate used in calculating the paid amount for the claim.

Value*	Price Type Used	Description
0		Not specified
1	NA – this value will be returned when the billed amount is less than the calculated allowed amount	Ingredient Cost Paid as Submitted
2		Ingredient Cost Reduced to AWP Pricing
3	AWP	Ingredient Cost Reduced to AWP Less X% Pricing
4		Usual & Customary Paid as Submitted
5		Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary
6	SMAC or FUL	MAC Pricing Ingredient Cost Paid
7		MAC Pricing Ingredient Cost Reduced to MAC
8		Contract Pricing
9	DOJ, AAC	Acquisition Pricing
1Ø		ASP (Average Sales Price)
11		AMP (Average Manufacturer Price)
12		34ØB/Disproportionate Share/Public Health Service Pricing
13	WAC	WAC (Wholesale Acquisition Cost)
14		Other Payer-Patient Responsibility Amount
15		Patient Pay Amount
16		Coupon Payment
17		Special Patient Reimbursement

*Valid values for Alabama appear in **Bold**.

Rejection Codes

A billing transaction (B1) can potentially be responded to with a rejected response, a duplicate response, or a paid response. The format of these response transactions will follow the variable requirements of the version D.Ø standard. For reject responses, Medicaid will return the corresponding four-digit internal error code for the NCPDP reject code in the Response Message Segment, field 5Ø4-F4 (Message). The error codes will be preceded by two digits indicating how many error codes are being returned. In addition, text descriptions for these error codes will be placed in the Response Status segment, field 526-FQ (Additional message information). These text descriptions will be separated by a semi-colon.

Reversal Request Format Changes

The claim reversal transaction, or B2 (value of field 1Ø3-A3 Transaction Code in NCPDP specs), is the transaction by which a provider will submit a reversal transaction. A maximum of four reversals on a single transmission can occur in version D.Ø, but is not mandated. However, Medicaid will continue to support only one reversal transaction per transmission to maintain the current billing practices supported.

The service provider ID, date of service, RX number and NDC (product/service ID) are also required to be sent on a reversal to further clarify that we have found the correct ICN to reverse. If the service provider ID, date of service, RX number and NDC do not match the paid claim exactly, the claim reversal request will be rejected accordingly.

Providers should contact their software vendor for issue(s) on processing a claim reversal.

Changes to the handling of Usual & Customary / Gross Amount Due fields

Effective April 13, 2010, for B1 transactions, the usual and customary (field 426-DQ) will be captured and compared to the amount submitted in the gross amount due (field 43Ø-DU). The lower of these fields will be used by the system to determine the final price to be paid by comparing the lowest submitted amount to the calculated price based on the Alabama Medicaid drug pricing file for the NDC submitted.

Claim Billing Request (B1)

Billing Request Transaction (B1 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card Issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	x(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		1Ø digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	x(1Ø)	1Ø		N/A

Claim Billing Request (B1)

Patient Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø1 = Patient	Ø1 = Patient ID Segment is situational.
3Ø4-C4	DATE OF BIRTH	R	Date of birth of patient.	9(8)	8		
3Ø5-C5	PATIENT GENDER CODE	R	Code indicating the gender of the individual.	9(1)	1	Ø= Not Specified 1 = Male 2 = Female	
311-CB	PATIENT LAST NAME	R	Individual last name.	x(15)	15		
3Ø7-C7	PLACE OF SERVICE	Q	Code identifying the place where a drug or service is dispensed or administered.	9(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	31 = Skilled Nursing Facility 32 = Nursing Facility 54 = Intermediate Care Facility/Mentally Retarded 31, 32 and 54 will set LTC (long term care). If field not sent, default will be space.
335-2C	PREGNANCY INDICATOR	Q	Code indicating the patient as pregnant or non-pregnant.	x(1)	1	Blank=Not Specified 1= Not pregnant 2= Pregnant	If field not sent, default will be blank.
35Ø-HN	PATIENT E-MAIL ADDRESS	I	The E-Mail address of the patient (member).	x(8Ø)	8Ø		
384-4X	PATIENT RESIDENCE	Q	Code identifying the patient's place of residence.	9(2)	2	Ø = Not Specified. 1 = Home 2 = Skilled Nursing Facility 3 = Nursing Facility. 4 = Assisted Living Facility 5 = Custodial Care Facility 6 = Group Home 7 = Inpatient Psychiatric Facility 8 = Psychiatric Facility – Partial Hospitalization 9 = Intermediate Care Facility/Mentally Retarded 1Ø = Residential Substance Abuse Treatment Facility 11 = Hospice 12 = Psychiatric Residential Treatment Facility 13 = Comprehensive Inpatient Rehabilitation Facility 14 = Homeless Shelter 15 = Correctional Institution	

Claim Billing Request (B1)

Insurance Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	04 = Insurance	04 = Insurance Segment is mandatory.
302-C2	CARDHOLDER ID	M	Insurance ID assigned to the cardholder.	x(20)	20		13 digit Medicaid ID number.
312-CC	CARDHOLDER FIRST NAME	Q	Individual first name.	x(12)	12		Required. Enter the recipient's first name. Alpha only.
313-CD	CARDHOLDER LAST NAME	Q	Individual last name.	x(15)	15		Required. Enter the recipient's last name. Alpha only.
359-2A	MEDIGAP ID	Q	Required, if known, when patient has Medigap coverage.	x(20)	20		
360-2B	MEDICAID INDICATOR	Q	Required, if known, when patient has Medigap coverage.	X(2)	2	See Section II, Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	
361-2D	PROVIDER ACCEPT ASSIGNMENT INDICATOR	Q	Required if necessary for state/federal/regulatory agency programs.	X(1)	1	Y = Assigned – Provider accepts assignment N = Not Assigned – Provider does not accept assignment	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Q	Required if specified in trading partner agreement.	X(1)	1	Y = Yes=CMS qualified facility N = No=Not a CMS qualified facility	

Claim Billing Request (B1)

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	07 = Claim	07 = Claim Segment is mandatory.
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Twelve digit numeric prescription number.
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	Code qualifying the value in 'Product/Service ID' (407-D7).	x(2)	2	See Appendix K - Product/Service Qualifier	03=National Drug Code (NDC)
407-D7	PRODUCT/SERVICE ID	M	ID of the product dispensed or service provided.	x(19)	19		The 11-digit national drug code for the drug dispensed.
442-E7	QUANTITY DISPENSED	R	Quantity dispensed expressed in metric decimal units.	9(7)v999	10		Required. Enter the ten digit metric decimal quantity of the drug dispensed in this field
403-D3	FILL NUMBER	R	The code indicating whether the prescription is an original or a refill.	9(2)	2	0 = Original dispensing 1 to 99 = Refill number	Required. Alabama only allows value of 00 thru 11 based on the NDC.
405-D5	DAYS SUPPLY	R	Estimated number of days the prescription will last.	9(3)	3		Required. Enter the estimated days supply of the drug dispensed. Alabama only allows value of <= 34.
406-D6	COMPOUND CODE	R	Code indicating whether or not the prescription is a compound.	9(1)	1	1 = Not a Compound 2 = Compound	Required.

Claim Billing Request (B1)

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	x(1)	1	Ø = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed-Patient Requested Product Dispensed 3 = Substitution Allowed-Pharmacist Selected Product Dispensed 4 = Substitution Allowed-Generic Drug Not in Stock 5 = Substitution Allowed-Brand Drug Dispensed as a Generic 6 = Override 7 = Substitution Not Allowed-Brand Drug Mandated by Law 8 = Substitution Allowed-Generic Drug Not Available in Marketplace 9 = Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed	Values Ø, 1, 3, 4, 5, 7, 8 and 9 are allowed. Values 2 and 6 are not allowed per state policy.
414-DE	DATE PRESCRIPTION WRITTEN	R	Date prescription was written.	9(8)	8		Required. Prescribe date in CCYYMMDD format.
419-DJ	PRESCRIPTION ORIGIN CODE	Q	Code indicating the origin of the prescription.	9(1)	1	Ø = Not Known 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Q	Count of the 'Submission Clarification Code' (42Ø-DK) occurrences.	9(1)	1		Maximum count of 3.

Claim Billing Request (B1)

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
42Ø-DK	SUBMISSION CLARIFICATION CODE	Q***R***	Code indicating that the pharmacist is clarifying the submission.	9(2)	2	1 = No Override 2 = Other Override 3 = Vacation Supply 4 = Lost Prescription 5 = Therapy Change 6 = Starter Dose 7 = Medically Necessary 8 = Process Compound For Approved Ingredients 9 = Encounters 1Ø = Meets Plan Limitations 11 = Certification on File 12 = DME Replacement Indicator 13 = Payer-Recognized Emergency/Disaster Assistance Request 14 = Long Term Care Leave of Absence 15 = Long Term Care Replacement Medication 16 = Long Term Care Replacement box (kit) or automated dispensing machine 17 = Long Term Care Emergency supply reminder 18 = Long Term Care Patient Admit/Readmit Indicator 19 = Split Billing 99 = Other	8 or Ø8 as necessary to process approved compound ingredients. Otherwise N/A.
3Ø8-C8	OTHER COVERAGE CODE	Q	Code indicating whether or not the patient has other insurance coverage.	9(2)	2	ØØ = Not Specified Ø1 = No other coverage Ø2 = Other coverage exists-payment collected Ø3 = Other coverage exists- claim not covered Ø4 = Other coverage exists-payment not collected Ø8 = Claim is billing for copay	Optional. Default to Ø1 if nothing entered. Ø1 = No other coverage Ø2 = Other coverage exists-payment collected Ø3 = Other coverage exists-claim not covered Ø4 = Other coverage exists-payment not collected Ø8 = Claim is billing for copay
418-DI	LEVEL OF SERVICE	Q	Coding indicating the type of service the provider rendered.	9(2)	2	Ø = Not Specified 1 = Patient consultation 2 = Home delivery 3 = Emergency 4 = 24 hour service 5 = Patient consultation regarding generic product selection 6 = In-Home Service	

Claim Billing Request (B1)

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
461-EU	PRIOR AUTHORIZATION TYPE CODE	Q	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.	9(2)	2	Ø=Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from Copay and/or Coinsurance 5 = Exemption from RX 6 = Family Planning Indicator 7 = TANF (Temporary Assistance for Needy Families) 8 = Payer Defined Exemption 9 = Emergency Preparedness	Value of '1' or 'Ø1' when applicable, to indicate Prior Authorization. Value of '4' or 'Ø4' when applicable, to indicate co-pay exemption.
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Q	Number submitted by the provider to identify the prior authorization.	9(11)	11		Prior Authorization number when (461-EU) equals '1' or 'Ø1'
343-HD	DISPENSING STATUS	Q	Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.	x(1)	1	P = Partial Fill C = Completion of Partial Fill	
344-HF	QUANTITY INTENDED TO BE DISPENSED	Q	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	9(7)V999	1Ø		
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Q	Days supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	9(3)	3		

Claim Billing Request (B1)

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
357-NV	DELAY REASON CODE	Q	Code to specify the reason that submission of the transactions has been delayed.	9(2)	2	1 = Proof of eligibility unknown or unavailable 2 = Litigation 3 = Authorization delays 4 = Delay in certifying provider 5 = Delay in supplying billing forms 6 = Delay in delivery of custom-made appliances 7 = Third party processing delay 8 = Delay in eligibility determination 9 = Original claims rejected or denied due to a reason unrelated to the billing limitation rules 10 = Administration delay in the prior approval process 11 = Other 12 = Received late with no exceptions 13 = Substantial damage by fire, etc to provide records 14 = Theft, sabotage/other willful acts by employee	
391-MT	PATIENT ASSIGNMENT INDICATOR (DIRECT MEMBER REIMBURSEMENT INDICATOR)	Q	Code to indicate a patient's choice on assignment of benefits.	X(1)	1	Y = Patient assigns benefits – Patient has assigned benefits to another party N = Patient does not assign benefits – Patient has not assigned benefits to another party	
995-E2	ROUTE OF ADMINISTRATION	Q	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.	x(11)	11	Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/	

Claim Billing Request (B1)

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
996-G1	COMPOUND TYPE	Q	Clarifies the type of compound.	X(2)	2	Ø1=Anti-infective Ø2= Ionotropic Ø3 =Chemotherapy Ø4= Pain management Ø5=TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition Ø6=Hydration Ø7=Ophthalmic 99=Other	
147-U7	PHARMACY SERVICE TYPE	Q	The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed.	9(2)	2	1 = Community/Retail Pharmacy Services 2 = Compounding Pharmacy Services 3 = Home Infusion Therapy Provider Services 4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99 = Other	

Claim Billing Request (B1)

Prescriber Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø3 = Prescriber	Ø3 = Prescriber Segment is mandatory.
466-EZ	PRESCRIBER ID QUALIFIER	Q	Code qualifying the 'Prescriber ID' (411-DB).	x(2)	2	Ø1 = National Provider Identifier (NPI) Ø2 = Blue Cross Ø3 = Blue Shield Ø4 = Medicare Ø5 = Medicaid Ø6 = UPIN Ø8 = State License Ø9 = CHAMPUS 1Ø = Health Industry Number (HIN) 11 = Federal Tax ID 12 = Drug Enforcement Administration (DEA) Number 13 = State Issued 14 = Plan Specific 15 = HC ID (HC IDEa) 99 = Other	Required. Ø1 = National Provider Identifier (NPI) or Ø8 = State license number – Will continue to be accepted in place of the NPI number.
411-DB	PRESCRIBER ID	Q	ID assigned to the prescriber.	x(15)	15		Required. Based on the Prescriber ID Qualifier field, this reports either the 1Ø digit NPI Number or the state license number of the prescribing practitioner.
364-2J	PRESCRIBER FIRST NAME	Q	Individual first name.	x(12)	12		
365-2K	PRESCRIBER STREET ADDRESS	Q	Free form text for prescriber address information.	x(3Ø)	3Ø		
366-2M	PRESCRIBER CITY ADDRESS	Q	Free form text for prescriber city name.	x(2Ø)	2Ø		
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS	Q	Standard state /province code as defined by appropriate government agency.	X(2)	2		
368-2P	PRESCRIBER ZIP/POSTAL ZONE	Q	Code defining international postal zone excluding punctuation and blanks.	x(15)	15		

Claim Billing Request (B1)

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø5 = Coordination of Benefits/Other Payments	Ø5 = Coordination of Benefits/Other Payments Segment is situational.
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M	Count of other payment occurrences.	9(1)	1		Only first occurrence will be used.
338-5C	OTHER PAYER COVERAGE TYPE	M***R***	Code identifying the type of 'Other Payer ID' (34Ø-7C).	x(2)	2	Blank=Not Specified Ø1 = Primary Ø2 = Secondary Ø3 = Tertiary Ø4 = Quaternary Ø5 = Quinary Ø6 = Senary Ø7 = Septenary Ø8 = Octonary Ø9 = Nonary	
339-6C	OTHER PAYER ID QUALIFIER	Q***R***	Code qualifying the 'Other Payer ID' (34Ø-7C).	x(2)	2	Ø1 = National Payer ID 1C = Medicare Number 1D = Medicaid Number Ø2 = Health Industry Number (HIN) Ø3 = Bank Information Number (BIN) Ø4 = National Association of Insurance Commissioners (NAIC) Ø5 = Medicare Carrier Number 99=Other	
34Ø-7C	OTHER PAYER ID	Q***R***	ID assigned to the payer.	x(1Ø)	1Ø		
443-E8	OTHER PAYER DATE	Q***R***	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	9(8)	8		Format = CCYYMMDD. Optional, will capture if sent.
993-A7	INTERNAL CONTROL NUMBER	Q***R***	Number assigned by the processor to identify an adjudicated claim when supplied in payer-to-payer coordination of benefits only.	X(3Ø)	3Ø		
341-HB	OTHER PAYER AMOUNT PAID COUNT	Q	Count of the payer amount paid occurrences.	9(1)	1		Only first occurrence will be used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Q***R***	Code qualifying the 'Other Payer Amount Paid' (431-DV).	x(2)	2	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit	

Claim Billing Request (B1)

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
431-DV	OTHER PAYER AMOUNT PAID	Q***R***	Amount of any payment known by the pharmacy from other sources (including coupons).	s9(6)v99	8		Enter the total amount paid by all other insurers.
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Q	Count of "Other Payer-Patient Responsibility Amount" (352-NQ) and "Other Payer-Patient Responsibility Amount Qualifier" (351-NP) occurrences.	9(2)	2	Max of 25.	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Q***R***	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	X(2)	2	Blank=Not Specified Ø1 = Amount Applied to Periodic Deductible Ø2 = Amount Attributed to Product Selection/Brand Drug Ø3 = Amount Attributed to Sales Tax Ø4 = Amount Exceeding Periodic Benefit Maximum Ø5 = Amount of Copay Ø6 = Patient Pay Amount Ø7 = Amount of Coinsurance Ø8 = Amount Attributed to Product Selection/Non-Preferred Formulary Selection Ø9 = Amount Attributed to Health Plan Assistance Amount 1Ø = Amount Attributed to Provider Network Selection 11 = Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection 12 = Amount Attributed to Coverage Gap 13 = Amount Attributed to Processor Fee	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	Q***R***	The patient's cost share from a previous payer.	s9(8)v99	1Ø		
392-MU	BENEFIT STAGE COUNT	Q	Count of 'Benefit Stage Amount' (394-MW) occurrences.	9(1)	1	Max count of 4.	

Claim Billing Request (B1)

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
393-MV	BENEFIT STAGE QUALIFIER	Q***R**	Code qualifying the 'Benefit Stage Amount' (394-MW).	x(2)	2	Ø1 = Deductible Ø2 = Initial Benefit Ø3 = Coverage Gap (donut hole) Ø4 = Catastrophic Coverage	
394-MW	BENEFIT STAGE AMOUNT	Q***R**	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	s9(6)v99	8		

Worker's Compensation Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Request (B1)

DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø8 = DUR/PPS	Ø8 = DUR/PPS Segment is situational.
473-7E	DUR/PPS CODE COUNTER	Q***R***	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		Only first occurrence of 439-E4, 44Ø-E5 and 441-E6 will be used in processing the claim.
439-E4	REASON FOR SERVICE CODE	Q***R***	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse PA = Drug-Age PS = Product Selection TD = Therapeutic Duplication
44Ø-E5	PROFESSIONAL SERVICE CODE	Q***R***	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	ØØ = No intervention MØ = Prescriber consulted PØ = Patient consulted RØ = Pharmacist consulted other source
441-E6	RESULT OF SERVICE CODE	Q***R***	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	1A = Filled As is, False Positive 1B = Filled Prescription As is 1C = Filled, With Different Dose 1D = Filled, With Different Directions 1E = Filled, With Different Drug 1F = Filled, With Different Quantity 1G = Filled, With Prescriber Approval 1H = Brand-to-Generic Change 1K = Filled with Different Dosage Form 2A = Prescription Not Filled 2B = Not Filled, Directions Clarified

Claim Billing Request (B1)

Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	11 = Pricing	11 = Pricing Segment is mandatory.
409-D9	INGREDIENT COST SUBMITTED	R	Submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due' (43Ø-DU).	s9(6)v99	8		
438-E3	INCENTIVE AMOUNT SUBMITTED	Q	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due' (43Ø-DU).	s9(6)v99	8		
426-DQ	USUAL AND CUSTOMARY CHARGE	Q	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	s9(6)v99	8		Required. Format = \$\$\$\$\$cc If field 426-DQ is submitted, the lower of this field and the amount sent in 43Ø -DU (gross amt due) will be used as the amount billed by the submitter.

Claim Billing Request (B1)

Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
43Ø-DU	GROSS AMOUNT DUE	R	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (48Ø-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Other Amount Claimed' (48Ø-H9).	s9(6)v99	8		Required. Format = \$\$\$\$\$cc.
423-DN	BASIS OF COST DETERMINATION	Q	Code indicating the method by which 'Ingredient Cost Submitted' (Field 4Ø9-D9) was calculated.	x(2)	2	ØØ = Default Ø1 = AWP (Average Wholesale Price) Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB /Disproportionate Share Pricing/Public Health Service Ø9=Other 1Ø=ASP (Average Sales Price) 11=AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	

Coupon Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Request (B1)

Compound Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	1Ø = Compound	1Ø = Compound Segment is situational.
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	Dosage form of the complete compound mixture.	x(2)	2	Blank=Not Specified Ø1 = Capsule Ø2 = Ointment Ø3 = Cream Ø4 = Suppository Ø5 = Powder Ø6 = Emulsion Ø7 = Liquid 1Ø = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	NCPDP standard product billing codes.	9(1)	1	1 = Each 2 = Grams 3 = Milliliters	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	Count of compound product IDs (both active and inactive) in the compound mixture submitted.	9(2)	2		A count of 1 to 25 allowed.
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R***	Code qualifying the type of product dispensed.	x(2)	2	See Appendix K - Product/Service Qualifier	Ø3 One to twenty-five occurrences allowed.
489-TE	COMPOUND PRODUCT ID	M***R***	Product identification of an ingredient used in a compound.	x(19)	19		Enter the 11 digit NDC number. One to twenty-five occurrences allowed. Note: Prior Authorizations must be acquired prior to billing for compound.
448-ED	COMPOUND INGREDIENT QUANTITY	M***R***	Amount expressed in metric decimal units of the product included in the compound mixture.	9(7)v999	1Ø		Enter the metric decimal quantity of the drug dispensed. Field length of 1Ø One to twenty-five occurrences allowed.
449-EE	COMPOUND INGREDIENT DRUG COST	Q***R***	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	s9(6)v99	8		Enter the ingredient cost. One to twenty-five occurrences allowed.

Claim Billing Request (B1)

Compound Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Q***R***	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	x(2)	2	ØØ = Default Ø1 = AWP (Average Wholesale Price) Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB /Disproportionate Share Pricing/Public Health Service Ø9 = Other 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Q	Code indicating the number of Compound Ingredient Modifier Code (363-2H)	9(2)	2		
363-2H	COMPOUND INGREDIENT MODIFIER CODE	Q***R***	Identifies special circumstances related to the dispensing/payment of the product as identified in the Compound Product ID (498-TE).	X(2)	2	Reference: Healthcare Common Procedure Coding System (HCPCS) available at www.cms.hhs.gov/medicare/hcpcs/	

Claim Billing Request (B1)

Clinical Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	13 = Clinical	13 = Clinical Segment is situational.
491-VE	DIAGNOSIS CODE COUNT	Q	Count of diagnosis occurrences.	9(1)	1		Max count of 5.
492-WE	DIAGNOSIS CODE QUALIFIER	Q***R***	Code qualifying the 'Diagnosis Code' (424-DO).	x(2)	2	ØØ = Not Specified Ø1 = International Classification of Diseases (ICD9) Ø2 = International Classification of Diseases (ICD1Ø) Ø3 = National Criteria Care Institute (NCCI) Ø4 = The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) Ø5 = Common Dental Terminology (CDT) Ø6 = Medi-Span Product Line Diagnosis Code Ø7 = American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders(DSM IV) Ø8 = First DataBank Disease Code (FDBDX) Ø9 = First DataBank FML Disease Identifier (FDB DxID) 99 = Other	
424-DO	DIAGNOSIS CODE	Q***R***	Code identifying the diagnosis of the patient.	x(15)	15		1 occurrence allowed. Three to seven digit alpha/numeric code
493-XE	CLINICAL INFORMATION COUNTER	Q***R***	Counter number of clinical information measurement set/logical grouping.	9(1)	1		
494-ZE	MEASUREMENT DATE	Q***R***	Date clinical information was collected or measured.	9(8)	8		Format = CCYYMMDD
495-H1	MEASUREMENT TIME	Q***R***	Time clinical information was collected or measured.	9(4)	4		Format = HHMM

Claim Billing Request (B1)

Clinical Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
496-H2	MEASUREMENT DIMENSION	Q***R***	Code indicating the clinical domain of the observed value in 'Measurement Value' (499-H4).	x(2)	2	Refer to the NCPDP External Code List dated June 2008 Appendix A.	
497-H3	MEASUREMENT UNIT	Q***R***	Code indicating the metric or English units used with the clinical information.	x(2)	2	Refer to the NCPDP External Code List dated June 2008 Appendix A.	
499-H4	MEASUREMENT VALUE	Q***R***	Actual value of clinical information.	x(15)	15	Blood pressure entered in XXX/YYY format in which XXX=systolic, /=divider, and YYY is diastolic. Temperature entered in XXX.X format always including decimal point.	

Claim Billing Paid Response (B1)
Billing Paid Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
102-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
103-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
109-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
501-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (201-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo from B1 request.
201-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
401-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Paid Response (B1)

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Claim Billing Paid Response (B1)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	P
503-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(20)	20		13 digit ICN (internal control number) assigned to paid claim.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., 0-9, A-Z).	X(2)	2	01 = Used for first line of free form text with no pre-defined structure. 02 = Second line. 03 = Third line. 04 = Fourth line. 05 = Fifth line. 06 = Sixth line. 07 = Seventh line. 08 = Eighth line. 09 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(40)	40	Comments: The maximum length of field is 40 characters.	Will be used to put EOB message concerning how the claim paid.

Claim Billing Paid Response (B1)

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Claim Billing Paid Response (B1)

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	23 = Response Pricing	23
505-F5	PATIENT PAY AMOUNT	R	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, et	s9(6)v99	8	Format 999999.99	Total amount of copay to be paid by the patient.
506-F6	INGREDIENT COST PAID	Q	Drug ingredient cost paid included in the 'Total Amount Paid' (509-F9).	s9(6)v99	8	Format 999999.99	Total amount that will be paid for the drug dispensed.
507-F7	DISPENSING FEE PAID	Q	Dispensing fee paid included in the 'Total Amount Paid' (509-F9).	s9(6)v99	8	Format 999999.99	The dispensing fee amount that will be paid for this claim (system generated).
509-F9	TOTAL AMOUNT PAID	R	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (506-F6), 'Dispensing Fee Paid' (507-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive	s9(6)v99	8	Format 999999.99	Total amount that will be paid to the provider for this claim.

Claim Billing Paid Response (B1)

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Q	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (506-F6).	9(2)	2	0 = Not Specified 1 = Ingredient Cost Paid as Submitted 2 = Ingredient Cost Reduced to AWP Pricing 3 = Ingredient Cost Reduced to AWP Less X% Pricing 4 = Usual & Customary Paid as Submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual and Customary 6 = MAC Pricing Ingredient Cost Paid 7 = MAC Pricing Ingredient Cost Reduced to MAC 8 = Contract Pricing 9 = Acquisition Pricing 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = 340B/Disproportionate Share/Public Health Service Pricing 13 = WAC (Wholesale Acquisition Cost) 14 = Other Payer-Patient Responsibility Amount 15 = Patient Pay Amount 16 = Coupon Payment	Value of 0 = DOJ Value of 1 = the billed amt was less than the allowed/calculated amt Value of 3 = paid the AWP price less X% Pricing Value of 4 = Usual & Customary Value of 6 = paid at MAC or FUL price Value of 9 = paid at DOJ or, AAC price Value of 13 = paid at WAC price Value of 14 = Other Payer-Patient Responsibility Amount
518-FI	AMOUNT OF COPAY	Q	Amount to be collected from the patient that is included in 'Patient Pay Amount' (505-F5) that is due to a per prescription copay.	s9(6)v99	8		The value returned is the same as 505-F5 for the paid B1 claim.
566-J5	Other Payer Amount Recognized	Q	Claim Billing/Encounter: Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero and Coordination of Benefits/Other Payments segment is supported.	S(9)6v99	8	Format 999999.99	This amount is to be included in instances where the TPL amount is greater than zero.

Claim Billing Paid Response (B1)

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2008 Appendix A.	
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
530-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	10		
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	0 = Not Specified 1 = Same Prescriber 2 = Other Prescriber	
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(30)	30		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Rejected Response (B1)
Billing Rejected Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
102-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
103-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
109-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
501-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (201-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B1 request.
201-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
401-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Claim Billing Rejected Response (B1)

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		This field will contain the number of errors generated, as well as the internal four digit numbers that correspond to the rejection or informational codes generated on the transaction. Format will be AAXXXYYYYZZZ where AA will indicate the number of codes, and XXXX, YYYY, and ZZZZ would represent the internal error codes or informational codes generated on the transaction.

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Rejected Response (B1)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	R
510-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		1 to 5
511-FB	REJECT CODE	R***R*** (up to 5)	Code indicating the error encountered.	x(3)	3	See NCPDP D.Ø Data Dictionary.	The two digit NCPDP reject code.
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R*** (up to 5)	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		On multiple detail transactions, this field will reflect the detail number to which the reject code applies.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	This field will contain the text descriptions that correspond to the codes returned in the Response Message segment, field 5Ø4-F4. Each description will be no more than 4Ø bytes in length, and will be separated by a semi-colon.

Claim Billing Rejected Response (B1)

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Claim Billing Rejected Response (B1)

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		1 - 3 allowed
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2008 Appendix A.	DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse PA = Drug-Age PS = Product Selection TD = Therapeutic Duplication
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
529-FT	OTHER PHARMACY INDICATOR	Q***R*** (up to 3)	Code indicating the pharmacy responsible for the previous event involved in the DUR conflict.	9(1)	1	Ø = Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	
530-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		Format = CCYYMMDD
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	1Ø		Format = 9999999V999.
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	Blank = Not Specified 1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	

Claim Billing Rejected Response (B1)

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(3Ø)	3Ø		1 - 3Ø characters.

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

**Claim Billing Duplicate Billing Response (B1)
Billing Duplicate Response (B1 Response)**

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
102-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	D0 = Version D.0	D0
103-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
109-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
501-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (201-B1).	x(2)	2	01 = National Provider Identifier (NPI)	Echo back from B1 request.
201-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
401-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Claim Billing Duplicate Billing Response (B1)

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		This field will contain the number of errors generated, as well as the internal four digit numbers that correspond to the rejection or informational codes generated on the transaction. Format will be AAXXXYYYYZZZ where AA will indicate the number of codes, and XXXX, YYYY, and ZZZZ would represent the internal error codes or informational codes generated on the transaction

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Duplicate Billing Response (B1)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	D
503-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(20)	20		13 digit ICN (internal control number) assigned to previously paid claim.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., 0-9, A-Z).	X(2)	2	01 = Used for first line of free form text with no pre-defined structure. 02 = Second line. 03 = Third line. 04 = Fourth line. 05 = Fifth line. 06 = Sixth line. 07 = Seventh line. 08 = Eighth line. 09 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(40)	40	Comments: The maximum length of field is 40 characters.	This will be a 40 byte message field indicating additional information. For a duplicate, a message indicating the transaction is a duplicate will appear in the 40 byte area, followed by the date the claim was submitted. If the pharmacy billing the transaction is different from the claim in history, a message indicating only the ICN will appear in the 40 byte area.

Claim Billing Duplicate Billing Response (B1)

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Claim Billing Duplicate Billing Response (B1)

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	23 = Response Pricing	23
505-F5	PATIENT PAY AMOUNT	R	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, et	s9(6)v99	8	Format 999999.99	Total amount of copay paid by the patient on the claim in history. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
506-F6	INGREDIENT COST PAID	Q	Drug ingredient cost paid included in the 'Total Amount Paid' (509-F9).	s9(6)v99	8	Format 999999.99	Total amount that was paid for the drug dispensed. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
507-F7	DISPENSING FEE PAID	Q	Dispensing fee paid included in the 'Total Amount Paid' (509-F9).	s9(6)v99	8	Format 999999.99	The dispensing fee amount that was paid for this claim. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.

Claim Billing Duplicate Billing Response (B1)

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
509-F9	TOTAL AMOUNT PAID	R	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (506-F6), 'Dispensing Fee Paid' (507-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive	s9(6)v99	8	Format 999999.99	Total amount that was paid to the provider for the claim in history. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Q	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (506-F6).	9(2)	2	Ø = Not Specified 1 = Ingredient Cost Paid as Submitted 2 = Ingredient Cost Reduced to AWP Pricing 3 = Ingredient Cost Reduced to AWP Less X% Pricing 4 = Usual & Customary Paid as Submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual and Customary 6 = MAC Pricing Ingredient paid 7 = MAC Pricing Ingredient Cost Reduced to MAC 8 = Contract Pricing 9 = Acquisition Pricing 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = 340B/Disproportionate Share/Public Health Service Pricing 13 = WAC (Wholesale Acquisition Cost) 14 = Other Payer-Patient Responsibility Amount 15 = Patient Pay Amount 16 = Coupon Payment	Value is based on claim processing rules. 7/14 – Asked Gwen if she has some test data to see if this element is returned on a duplicate claim.

Claim Billing Duplicate Billing Response (B1)
Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2008 Appendix A.	
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
529-FT	OTHER PHARMACY INDICATOR	Q***R*** (up to 3)	Code indicating the pharmacy responsible for the previous event involved in the DUR conflict.	9(1)	1	Ø=Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	
530-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	10		
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(30)	30		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

**Claim Reversal Transaction (B2)
Reversal Transaction (B2 Request)**

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card Issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	x(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1 = One Occurrence (only one reversal will be permitted on a transmission)
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		10 digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	x(1Ø)	1Ø		N/A

Insurance Segment: Not Used

This segment will not be used in Alabama.

Claim Reversal Transaction (B2)

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø7 = Claim	Ø7
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Twelve digit numeric prescription number.
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	x(2)	2	Ø3 = National Drug Code	Ø3
4Ø7-D7	PRODUCT/SERVICE ID	M	ID of the product dispensed or service provided.	x(19)	19		The 11-digit national drug code for the drug dispensed.

DUR/PPS Segment: Not Used

This segment will not be used in Alabama.

Pricing Segment: Not Used

This segment will not be used in Alabama.

Coordination of Benefits/Other Payments Segment: Not Used

This segment will not be used in Alabama.

Claim Reversal Approval Response (B2)
Reversal Approval Response (B2 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
102-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
103-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
109-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1
501-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (201-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B2 request.
201-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B2 request.
401-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B2 request.

Claim Reversal Approval Response (B2)
Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Claim Reversal Approval Response (B2)
Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	A = Approved
503-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(20)	20		For a Claim Reversal, the authorization number will be the 13 digit voided ICN #.
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., 0-9, A-Z).	X(2)	2	01 = Used for first line of free form text with no pre-defined structure. 02 = Second line. 03 = Third line. 04 = Fourth line. 05 = Fifth line. 06 = Sixth line. 07 = Seventh line. 08 = Eighth line. 09 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(40)	40	Comments: The maximum length of field is 40 characters.	

Claim Reversal Approval Response (B2)
Claim Response Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
402-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B2 request.

Claim Reversal Rejection Response (B2)
Reversal Rejection Response (B2 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo from B2 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B2 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B2 request.

Claim Reversal Rejection Response (B2)

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Claim Reversal Rejection Response (B2)
Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	R = Rejected	R
503-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(20)	20		
510-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		Number of rejection codes set on the reversal txn.
511-FB	REJECT CODE	R***R*** (up to 5)	Code indicating the error encountered.	x(3)	3		NCPDP two-digit rejection code that applies.
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R*** (up to 5)	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., 0-9, A-Z).	X(2)	2	01 = Used for first line of free form text with no pre-defined structure. 02 = Second line. 03 = Third line. 04 = Fourth line. 05 = Fifth line. 06 = Sixth line. 07 = Seventh line. 08 = Eighth line. 09 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(40)	40	Comments: The maximum length of field is 40 characters.	

Claim Reversal Rejection Response (B2)
Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B2 request.

Eligibility Verification Request (E1)
Eligibility Request Transaction (E1 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	X(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	X(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1 = One Occurrence	1
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		10 digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	X(1Ø)	1Ø		N/A

Eligibility Verification Request (E1)

Insurance Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	Ø4 = Insurance	Ø4
3Ø2-C2	CARDHOLDER ID	M	Insurance ID assigned to the cardholder.	X(2Ø)	2Ø		Enter first12 digits of Medicaid ID number.

Patient Segment: Not Used

This segment will not be used in Alabama.

Pharmacy Provider Segment: Not Used

This segment will not be used in Alabama.

Prescriber Segment: Not Used

This segment will not be used in Alabama.

Additional Documentation Segment: Not Used

This segment will not be used in Alabama.

Eligibility Verification Response (E1)

Eligibility Response Approved Transaction (E1 Response)

Response Header Segment– Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
102-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	X(2)	2	DØ = Version D.Ø	DØ
103-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
109-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1, 2, 3, 4	1=One Occurrence
501-F1	HEADER RESPONSE STATUS	M	Response Status	X(1)	1	A = Accepted R = Rejected	
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2		Echo back from E1 request.
201-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		Echo back from E1 request.
401-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Echo back from E1 request.

Response Message Segment: Not Used

This segment will not be used in Alabama.

Eligibility Verification Response (E1)

Response Insurance Segment– Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	25 = Response Insurance	25
302-C2	CARDHOLDER ID	Q	Insurance ID assigned to the cardholder.	x(20)	20		Echo back from E1 request.

Response Insurance Additional Information Segment: Not Used

This segment will not be used in Alabama.

Eligibility Verification Response (E1)

Response Patient Segment – Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	29 = Response Patient	29
310-CA	PATIENT FIRST NAME	Q	Individual first name.	x(12)	12		
311-CB	PATIENT LAST NAME	Q	Individual last name.	x(15)	15		
304-C4	DATE OF BIRTH	Q	Date of birth of patient.	9(8)	8		

Eligibility Verification Response (E1)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	X(1)	1	A = Approved	A
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., 0-9, A-Z).	X(2)	2	01 = Used for first line of free form text with no pre-defined structure. 02 = Second line. 03 = Third line. 04 = Fourth line. 05 = Fifth line. 06 = Sixth line. 07 = Seventh line. 08 = Eighth line. 09 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free form text message.	x(1)-x(40)	1-40		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Eligibility Verification Response (E1)

Eligibility Response Rejected Transaction (E1 Response)

Response Header Segment – Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
102-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	X(2)	2	DØ = Version D.Ø	DØ
103-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
109-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1, 2, 3, 4	1=One Occurrence
501-F1	HEADER RESPONSE STATUS	M	Response Status	X(1)	1	A = Accepted R = Rejected	
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2		Echo back from E1 request.
201-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		Echo back from E1 request.
401-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Echo back from E1 request.

Eligibility Verification Response (E1)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	R = Rejected	R
510-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		
511-FB	REJECT CODE	R***R***	Code indicating the error encountered.	X(3)	3	Refer to the NCPDP External Code List dated June 2008 Appendix A.	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R***	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., 0-9, A-Z).	X(2)	2	01 = Used for first line of free form text with no pre-defined structure. 02 = Second line. 03 = Third line. 04 = Fourth line. 05 = Fifth line. 06 = Sixth line. 07 = Seventh line. 08 = Eighth line. 09 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(40)	1-40		



ALABAMA MEDICAID AGENCY PDL REFERENCE TOOL

Table of Contents

Antihistamines	Page 2
Anti-infective Agents	Page 3
Behavioral Health	Page 8
Cardiovascular Health	Page 11
Diabetic Agents	Page 16
Disease-Modifying Antirheumatic Drugs	Page 18
Eye, Ear, Nose, and Throat (EENT) Preparations	Page 19
Gastrointestinal Agents	Page 21
Genitourinary Agents	Page 22
Hormones and Synthetic Substitutes	Page 23
Immunomodulatory Agents used to treat MS	Page 24
Pain Management & Autonomic Agents	Page 25
Allergy and Respiratory Agents	Page 27
Skin & Mucous Membrane Agents	Page 29
Women's Health	Page 33

**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Antihistamines**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
First Generation Antihistamine Agents	none		Karbinal ER
			Ryvent
		carbinoxamine	
		clemastine	
		diphenhydramine	
		phenylephrine and chlorpheniramine	

*Denotes a generic available in at least one dosage form or strength

**Will be reviewed at a future time when eligible

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Anti-infective Agents**

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Adamantanes	none	amantadine rimantadine	Flumadine*
Amebicides	none	paromomycin	none
Aminoglycosides	Bethkis		
	Kitabis		
			tobramycin inhalation solution (generic)
			TOBI*
			TOBI Podhaler
		amikacin	
		gentamicin	
		neomycin	
Anthelmintics	none		Albenza
			Biltricide
			Emverm
		ivermectin	Stromectol*
			Abelcet
			AmBisome
		flucytosine	Ancobon*
			Cancidas
Antifungals	none		Cresemba
		fluconazole	Diflucan*
			Eraxis
		griseofulvin ultramicrosize	Gris-Peg*
		terbinafine	Lamisil*
			Mycamine
			Noxafil
			Onmel
		itraconazole	Sporanox*
		voriconazole	Vfend*
		amphotericin B	
		griseofulvin microsize	
		ketoconazole	
		nystatin	
Antimalarials	none		Coartem
			Daraprim
		atovaquone and proguanil	Malarone*
		hydroxychloroquine	Plaquenil*
		quinine	Qulaquin*
		chloroquine	
mefloquine			
primaquine			

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Antituberculosis Agents	none		Capastat Sulfate
		ethambutol	Myambutol*
		rifabutin	Mycobutin*
			Paser
			Priftin
		rifampin	Rifadin*
			Rifamate
			Rifater
			Sirturo
			Trecator
Cephalosporins	none		Avycaz
		ceftibuten	Cedax*
		cefuroxime	Ceftin*
		cefotaxime	Claforan*
		ceftazidime	Fortaz*
		cephalexin	Keflex*
		cefepime	Maxipime*
		cefixime	Suprax*
		ceftazidime	Tazicef*
			Teflaro
			Zerbaxa
		cefuroxime	Zinacef *
		cefaclor	
		cefadroxil	
		cefazolin	
		cefdinir	
		cefpodoxime	
cefprozil			
ceftriaxone			
Chloramphenicol	none	chloramphenicol	
HCV Antivirals	Epclusa ^{CC}	none	
	Harvoni ^{CC}		
	Mavyret ^{CC}		
	Technivie ^{CC}		
	Viekira Pak ^{CC}		
	Zepatier ^{CC}		
		Daklinza	
		Olysio	
		Sovaldi	
		Viekira XR	
		Vosevi	
Interferons	none	none	Intron A
			Pegasys
			PegIntron

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Macrolides	none	clarithromycin	Biaxin*
			Dificid
		erythromycin ethylsuccinate	E.E.S.*
			EryPed
			Ketek
			PCE
		azithromycin	Zithromax*
	Zmax		
	clarithromycin ER		
	erythromycin base		
Miscellaneous Antibacterials	none	bacitracin	Baciim*
		clindamycin	Cleocin*
		colistimethate	Coly-Mycin M*
			Cubicin
			Dalvance
		lincomycin	Lincocin*
			Orbactiv
			Pylera
			Sivextro
			Synercid
	vancomycin	Vancocin*	
		Vibativ	
		Xifaxan	
	linezolid	Zyvox*	
	polymyxin B sulfate		
Miscellaneous Antimycobacterials	none	dapsone	none
Miscellaneous Antiprotozoals	none		Alinia
			Flagyl*
			Flagyl ER
			Impavido**
		atovaquone	Mepron*
			NebuPent
			Pentam 300
	Solosec**		
	tinidazole	Tindamax*	
Miscellaneous Antivirals	none		Prevymis**
		foscarnet	
Miscellaneous β-Lactams	none	aztreonam	Azactam*
			Cayston
			Doribax
			Invanz
			Mefoxin
		meropenem	Merrem*
		imipenem and cilastatin	Primaxin*
			Vabomere**
	cefotetan		
	cefoxitin		
Neuraminidase Inhibitors †The preferred status of this product is contingent upon statewide influenza epidemiology status as reported by the CDC	Relenza†		
	Tamiflu†*	oseltamivir†	
			Rapivab

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Nucleosides and Nucleotides	none	entecavir	Baraclude*
		ribavirin	Copegus*
		ganciclovir	Cytovene*
		famciclovir	Famvir*
		adefovir	Hepsera*
			Rebetol
			Sitavig
			Tyzeka
		valganciclovir	Valcyte*
		valacyclovir	Valtrex*
			Velmidy**
		ribavirin	Virazole*
		acyclovir	Zovirax*
	cidofovir		
Penicillins	none	amoxicillin and clavulanate	Augmentin*
		amoxicillin and clavulanate	Augmentin XR*
			Bicillin C-R
			Bicillin L-A
			Moxatag
		penicillin G	Pfizerpen*
		ampicillin and sulbactam	Unasyn*
		piperacillin and tazobactam	Zosyn*
		amoxicillin	
		ampicillin	
		dicloxacillin	
		nafcillin	
		oxacillin	
penicillin V			
Quinolones	none	moxifloxacin	Avelox *
		ciprofloxacin	Cipro*
		ciprofloxacin ER	Cipro XR*
		levofloxacin	Levaquin*
		ofloxacin	
Sulfonamides	none	sulfasalazine	Azulfidine*
		sulfamethoxazole and trimethoprim	Bactrim*
		sulfamethoxazole and trimethoprim	Bactrim DS*
		sulfamethoxazole and trimethoprim	Sulfatrim*
		sulfadiazine	
Tetracyclines	none	doxycycline	Adoxa*
		doxycycline	Doryx*
		doxycycline	Morgidox*
		tigecycline	Tygacil*
		doxycycline	Vibramycin*
		demeclocycline	
		minocycline	
tetracycline			

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Urinary Anti-infectives	none	nitrofurantoin	Furadantin*
		methenamine	Hiprex*
		nitrofurantoin and nitrofurantoin macrocrystals	Macrobid*
		nitrofurantoin macrocrystals	Macrochantin*
			Monurol
			Primsol
			Urimar-T
		methenamine, methylene blue, phenyl salicylate, sodium phosphate, and hyoscyamine	Urin D.S.*
		methenamine, methylene blue, phenyl salicylate, sodium phosphate, and hyoscyamine	Utira-C*
		methenamine, sodium phosphate, methylene blue and hyoscyamine	
	trimethoprim		

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Behavioral Health**

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Alzheimer's Agents	Aricept*	donepezil	
		rivastigmine	Exelon*
		memantine	Namenda*
		memantine	Namenda XR*
			Namzaric
		galantamine	Razadyne*
		galantamine	Razadyne ER*
Antidepressants	none	clomipramine	Anafranil*
			Aplenzin
			Brisdelle
		citalopram	Celexa*
		duloxetine	Cymbalta*
			Desvenlafaxine ER
		venlafaxine	Effexor XR*
			Emsam
			Fetzima
			Forfivo XL
		duloxetine	Irenka*
		desvenlafaxine	Khedezla*
		escitalopram	Lexapro*
			Marplan
		phenelzine	Nardil*
		desipramine	Norpramin*
			Olepto ER
		nortriptyline	Pamelor*
		tranylcypromine	Parnate*
		paroxetine	Paxil*
		paroxetine	Paxil CR*
			Pexeva
		desvenlafaxine	Pristiq*
		fluoxetine	Prozac*
		fluoxetine	Prozac Weekly*
		mirtazapine	Remeron*
		fluoxetine	Sarafem*
			Silenor
			Surmontil
		imipramine	Tofranil*
imipramine	Tofranil-PM*		
	Trintellix		
	Viibryd		
bupropion	Wellbutrin*		
bupropion	Wellbutrin SR*		
bupropion	Wellbutrin XL*		
sertraline	Zoloft*		
amitriptyline			
amitriptyline and chlordiazepoxide			
amoxapine			
doxepin			
protriptyline			

Antidepressants continued on next page

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Antidepressants (continued)	<i>Antidepressants continued from previous page</i>		
		fluvoxamine	
		maprotiline	
		nefazodone	
		trazodone	
Anxiolytics, Sedatives, and Hypnotics: Barbiturates	none		Amytal Sodium
		phenobarbital	Butisol Sodium Seconal Sodium
Anxiolytics, Sedatives, and Hypnotics: Benzodiazepines	Diastat*		diazepam rectal kit (generic)
	Diastat AcuDial*		diazepam rectal kit (generic)
			Alprazolam IntenSol
		lorazepam	Ativan*
		triazolam	Halcion*
		clonazepam	Klonopin*
		lorazepam	Lorazepam IntenSol*
		temazepam	Restoril*
		clorazepate	Tranxene*
		alprazolam	Xanax*
		alprazolam ER	Xanax XR*
		chlordiazepoxide	
		diazepam	
	estazolam		
	flurazepam		
	midazolam		
	oxazepam		
Anxiolytics, Sedatives, and Hypnotics: Miscellaneous Agents	none	zolpidem	Ambien*
		zolpidem	Ambien CR*
			Belsomra
			Eduar
			Hellioz
		zolpidem	Intermezzo*
		eszopiclone	Lunesta*
		dexmedetomidine	Precedex*
			Rozerem
		zaleplon	Sonata*
hydroxyzine	Vistaril*		
	buspirone		
	droperidol		
	meprobamate		

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Cerebral Stimulants/ Agents Used for ADHD (Short- and Intermediate-Acting)	Focalin*		dexmethylphenidate IR (generic)
	Ritalin*	methylphenidate	
		amphetamine-dextroamphetamine	Adderall*
		methamphetamine	Desoxyn*
		dextroamphetamine	Dexedrine*
			Evekeo
		methylphenidate	Metadate ER*
		methylphenidate	Methylin*
Cerebral Stimulants/ Agents Used for ADHD (Long-Acting)		dextroamphetamine	ProCentra*
		dextroamphetamine	Zenedi*
	Adderall XR*		amphetamine-dextroamphetamine (generic)
	Adzenys XR		
	Concerta*		methylphenidate ER (generic)
	Focalin XR*		dexmethylphenidate ER (generic)
	Kapvay*		clonidine ER (generic)
	Strattera*	atomoxetine	
	Vyvanse (capsules only)		
			Aptensio
			Cotempla XR-ODT
			Daytrana
			Dyanavel XR
		guanfacine ER	Intuniv*
		Mydayis	
		Quillichew ER	
		Quillivant	
	methylphenidate	Ritalin LA*	
		Vyvanse (chewable tablets)	
Wakefulness Promoting Agents	Provigil*		modafinil (generic)
		armodafonil	Nuvigil*
			Xyrem

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Cardiovascular Health**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
ACE Inhibitors	none	quinapril	Accupril*
		quinapril and HCTZ	Accuretic*
		perindopril	Aceon*
		ramipril	Altace*
			Epaned
		benazepril	Lotensin*
		benazepril and HCTZ	Lotensin HCT*
		lisinopril	Prinivil*
		lisinopril and HCTZ	Prinzide*
			Qbrelis
		trandolapril and verapamil ER	Tarka*
		enalapril and HCTZ	Vaseretic*
		enalapril	Vasotec*
		lisinopril and HCTZ	Zestoretic*
		lisinopril	Zestril*
		captopril	
		captopril and HCTZ	
		fosinopril	
fosinopril and HCTZ			
moexipril and HCTZ			
moexipril			
trandolapril			
Alpha-Adrenergic Blocking Agents	none	doxazosin	Cardura*
			Cardura XL
		prazosin	Minipress*
		terazosin	
Angiotensin II Receptor Antagonists	none	candesartan	Atacand*
		candesartan and HCTZ	Atacand HCT*
		irbesartan and HCTZ	Avalide*
		irbesartan	Avapro*
		olmesartan	Benicar*
		olmesartan and HCTZ	Benicar HCT*
			Byvalson
		losartan	Cozaar*
		valsartan	Diovan*
		valsartan and HCTZ	Diovan HCT*
			Edarbi
			Edarbyclor
		losartan and HCTZ	Hyzaar*
		telmisartan	Micardis*
telmisartan and HCTZ	Micardis HCT*		
olmesartan, amlodipine, and HCTZ	Tribenzor*		
telmisartan and amlodipine	Twynsta*		
eprosartan			

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Antiarrhythmic Agents	none	amiodarone	Cordarone*
			Multaq
			Nexterone
		disopyramide	Norpace*
			Norpace CR
		amiodarone	Pacerone*
		propafenone	Rythmol*
		propafenone	Rythmol SR*
		dofetilide	Tikosyn*
		flecainide	
mexiletine			
quinidine			
Oral Anticoagulants	Coumadin*	warfarin	
	Eliquis		
	Pradaxa		
	Xarelto		
			Savaysa
Beta-Adrenergic Blocking Agents	none	sotalol	Betapace*
		sotalol	Betapace AF*
			Bystolic
		carvedilol	Coreg*
			Coreg CR
		nadolol	Corgard*
		nadolol and bendroflumethiazide	Corzide*
			Dutoprol
			Hemangeol
		propranolol	Inderal LA*
			Inderal XL
			InnoPran XL
			Levatol
		metoprolol	Lopressor*
			Sotylize
		atenolol and chlorthalidone	Tenoretic*
		atenolol	Tenormin*
		metoprolol	Toprol XL*
		bisoprolol and HCTZ	Ziac*
		acebutolol	
		betaxolol	
bisoprolol			
labetalol			
metoprolol and HCTZ			
pindolol			
propranolol and HCTZ			
timolol			

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Calcium-Channel Blocking Agents	none	nifedipine	Adalat CC*
		amlodipine and olmesartan	Azor*
		verapamil	Calan*
		verapamil	Calan SR*
		diltiazem	Cardizem*
		diltiazem	Cardizem CD*
		diltiazem	Cardizem LA*
		amlodipine and valsartan	Exforge*
		amlodipine, valsartan and HCTZ	Exforge HCT*
		amlodipine and benazepril	Lotrel*
		diltiazem	Matzim LA*
		amlodipine	Norvasc*
			Nymalize
			Prestalia
		nifedipine	Procardia*
		nifedipine	Procardia XL*
		nisoldipine	Sular ER*
		diltiazem	Tiazac*
		verapamil	Verelan*
		verapamil	Verelan PM*
felodipine			
isradipine			
nicardipine			
nimodipine			
nisoldipine			
Cardiotonic Agents	none	digoxin	Digitek*
		digoxin	Lanoxin*
			Lanoxin Pediatric
Central Alpha-Agonists	Catapres-TTS*		clonidine patches (generic)
		clonidine	Catapres*
		guanfacine	
		methyldopa	
		methyldopa and HCTZ	
Direct Vasodilators	none		BiDil
		hydralazine	
		minoxidil	

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Diuretics	none	torseamide	Demadex*
		triamterene and HCTZ	Diuril
			Dyazide*
			Dyrenium
		ethacrynic acid	Edecrin*
		furosemide	Lasix*
		triamterene and HCTZ	Maxzide*
		hydrochlorothiazide (HCTZ)	Microzide*
		amiloride	
		amiloride and HCTZ	
		bumetanide	
		chlorthalidone	
		chlorothiazide	
indapamide			
methyclothiazide			
metolazone			
Vasopressin Antagonists	none	none	Samsca
Mineralocorticoid (Aldosterone) Receptor Antagonists	none	spironolactone and HCTZ	Aldactazide*
		spironolactone	Aldactone*
			Carospir**
	eplerenone	Inspra*	
Miscellaneous Cardiac Drugs	none	none	Corlanor
			Ranexa
Miscellaneous Hypotensive Agents	none	none	Vecamyl
Nitrates and Nitrites	Nitro-Bid Nitrostat*		
		nitroglycerin	
			Dilatrate-SR
			GoNitro
		isosorbide dinitrate	Isordil*
		nitroglycerin	Minitran*
		nitroglycerin	Nitro-Dur*
		nitroglycerin	Nitrolingual*
nitroglycerin	NitroMist*		
	isosorbide mononitrate		
Platelet-aggregation Inhibitors	Brilinta		
		aspirin and dipyridamole	Aggrenox*
			Durlaza ER
		prasugrel	Effient*
		clopidogrel	Plavix*
			Zontivity
	cilostazol		
	dipyridamole		
	ticlopidine		
Renin-Angiotensin-Aldosterone System Inhibitors, Misc	Entresto	none	none
Renin Inhibitors	none	none	Tekturna
			Tekturna HCT
Bile Acid Sequestrants	none	colestipol	Colestid*
		cholestyramine	Questran*
		cholestyramine	Questran Light*
			Welchol

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Cholesterol Absorption Inhibitors	none	ezetemibe	Zetia*
Fibric Acid Derivatives	none		Antara
		fenofibrate	Fenoglide*
		fenofibric acid	Fibricor*
		fenofibrate	Lipofen*
		gemfibrozil	Lopid*
		fenofibrate, nanocrystallized	TriCor*
		fenofibric acid	Trilipix*
HMG-CoA Reductase Inhibitors	none		Altoprev
		amlodipine/atorvastatin	Caduet*
		rosuvastatin	Crestor*
		fluvastatin	Lescol XL*
		atorvastatin	Lipitor*
			Livalo
		pravastatin	Pravachol*
		simvastatin/ezetimibe	Vytorin*
Miscellaneous Antilipemic Agents	Niacor		Juxtapid
			Kynamro
		omega-3 ethyl ester	Lovaza*
		niacin	Niaspan*
			Vascepa
Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors	none	none	Praluent Repatha

*Denotes a generic available in at least one dosage form or strength

**Will be reviewed at a future time when eligible

ccDenotes agent is preferred with clinical criteria in place.

**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Diabetic Agents**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Alpha-Glucosidase Inhibitors	none	miglitol acarbose	Glyset* Precose*
Amylinomimetics	none	none	SymlinPen
Antidiabetic Agents, Miscellaneous	none	none	Korlym
Biguanides	none		Fortamet*
		metformin	Glucophage*
		metformin	Glucophage XR*
			Glumetza*
			metformin ER (generic Fortamet ER and Glumetza ER) Riomet
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Janumet	none	
	Janumet XR		
	Januvia		
			alogliptin (generic)
			alogliptin-metformin (generic)
			alogliptin-pioglitazone (generic)
			Jentadueto
			Jentadueto XR
			Kazano*
	Kombiglyze XR		
	Nesina*		
	Onglyza		
	Oseni*		
	Tradjenta		
Incretin Mimetics	none	none	Adlyxin**
			Bydureon
			Byetta
			Ozempic**
			Tanzeum
			Trulicity
			Victoza
Insulins	Lantus		
	Levemir		
	Novolog		
	Novolog Mix 70/30		
			Admelog**
			Afrezza
			Apidra
			Basaglar**
			Fiasp**
			Humalog
			Humalog Mix 50/50
			Humalog Mix 75/25
			Humulin R (U-500)
			Soliqua**
			Toujeo
			Tresiba
			Xultophy**
		Humulin N	
	Humulin R		
	Humulin 70/30		
	Novolin N		
	Novolin R		
	Novolin 70/30		

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 A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Meglitinides	Prandin*	repaglinide	
		nateglinide	Starlix*
		repaglinide and metformin	
Sodium-glucose Co-transporter 2 Inhibitor	none	none	Farxiga
			Glyxambi
			Invokamet
			Invokamet XR
			Invokana
			Jardiance
			Segluromet**
			Steglatro**
			Steglujan**
			Synjardy
Synjardy XR			
Xigduo			
Sulfonylureas	none	glimepiride	Amaryl*
		glyburide	DiaBeta*
		glipizide	Glucotrol*
		glipizide	Glucotrol XL*
		glyburide and metformin	Glucovance*
		glyburide	Glynase*
		chlorpropamide	
		glipizide and metformin	
		tolazamide	
tolbutamide			
Thiazolidinediones	Actos*	pioglitazone	
		pioglitazone and metformin	Actoplus Met*
			Actoplus Met XR
			Avandia
		pioglitazone and glimepiride	Duetact*

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Disease-Modifying Antirheumatic Agents**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Disease-Modifying Antirheumatic Agents	Cimzia ^{CC}		
	Enbrel ^{CC}		
	Humira ^{CC}		
			Actemra
		leflunomide	Arava*
			Inflectra**
			Kevzara**
			Kineret
			Orencia
			Otezla
			Remicade
			Renflexis
			Siliq**
			Simponi
		Simponi Aria	
		Xeljanz	
		Xeljanz XR	

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**Will be reviewed at a future time when eligible

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Eye, Ear, Nose, and Throat (EENT) Preparations**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Antiallergic Agents	Bepreve		
	Patanase*		olopatadine nasal spray (generic)
	Pazeo		
		azelastine	Astepro*
			Alocril
			Alomide
		epinastine	Elestat*
			Emadine
			Lastacaft
		Pataday	
	olopatadine	Patanol*	
	cromolyn		
Antibacterials	Besivance		
	Blephamide		
	Cipro HC		
	Ciprodex		
	Vigamox*		moxifloxacin ophthalmic solution (generic)
	Zylet		
			AzaSite
		sulfacetamide	Bleph-10*
			Blephamide SOP
		ciprofloxacin	Ciloxan*
			Coly-Mycin S
		gentamicin	Garamycin*
		erythromycin base	Ilotycin*
		neomycin, polymyxin B and dexamethasone	Maxitrol*
			Moxeza
		neomycin, polymyxin B and gramicidin	Neosporin*
		ofloxacin	Ocuflox*
			Otiprio
			Otovel**
		polymyxin B and trimethoprim	Polytrim*
			Pred-G
		tobramycin and dexamethasone	TobraDex*
			TobraDex ST
		tobramycin	Tobrex*
	gatifloxacin	Zymaxid*	
	bacitracin		
	bacitracin and polymyxin B		
	levofloxacin		
	neomycin, bacitracin and polymyxin B		
	neomycin, bacitracin, polymyxin B and hydrocortisone		
	neomycin, polymyxin B and hydrocortisone		
	sulfacetamide		
	sulfacetamide and prednisolone		

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Intranasal Corticosteroids	Nasonex*		mometasone nasal spray (generic)
	Omnaris		
	Zetonna		
			Beconase AQ
			Dymista
			QNASL
			QNASL Children
Vasoconstrictors	none	flunisolide	
		fluticasone	
			Tyzine Pediatric
		naphazoline	
		phenylephrine	

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Gastrointestinal Agents**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
5-HT ₃ Receptor Antagonists	none		Aloxi
			Anzemet
		granisetron	Kytril*
			Sancuso
			Sustol
		ondansetron	Zofran*
		ondansetron	Zofran ODT*
		Zuplenz	
Antiemetic Antihistamines	none		Bonjesta**
			Diclegis
		trimethobenzamide dimenhydrinate	Tigan*
		meclizine	
		prochlorperazine	
Miscellaneous Antiemetics	none		Akynzeo
			Cesamet
			Cinvanti**
			Emend
		dronabinol	Marinol*
		scopolamine	Transderm-Scop*
		Varubi**	
Proton-Pump Inhibitors	Nexium*		esomeprazole magnesium (generic)
		rabeprazole	Aciphex*
			Aciphex Sprinkle
			Dexilant
			Esomeprazole strontium
			omeprazole/sodium bicarbonate (generic)
		lansoprazole	Prevacid*
		lansoprazole/amoxicillin/ clarithromycin	Prevpac*
		omeprazole	Prilosec*
	pantoprazole	Protonix*	

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Genitourinary Agents**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Genitourinary Smooth Muscle Relaxants	Oxytrol		
	Toviaz		
		tolterodine	Detrol*
		tolterodine	Detrol LA*
		oxybutynin	Ditropan XL*
		darifenacin	Enablex*
			Gelnique
			Myrbetriq
			Vesicare
		flavoxate	
	tropium		

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**Will be reviewed at a future time when eligible

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Hormones and Synthetic Substitutes**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Androgens	none		Anadrol
			Androderm
		testosterone	AndroGel*
		methyltestosterone	Android*
			Aveed
			Axiron
		testosterone cypionate	Depo-Testosterone*
		testosterone	Fortesta*
			Natesto
			Striant
		testosterone	Testim*
			Testopel
		methyltestosterone	Testred*
		testosterone	Vogelxo*
	danazol		
	oxandrolone		
	testosterone enanthate		

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Immunomodulatory Agents used to treat MS**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Immunomodulatory Agents used to treat MS	Aubagio		
	Betaseron		
	Copaxone*		Glatopa (generic Copaxone)
	Extavia		
	Gilenya		
	Rebif		
	Tysabri		
			Avonex
			Ocrevus**
			Plegridy
		Tecfidera	
		Zinbryta	

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Pain Management & Autonomic Agents**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A “substitution allowed” physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED	
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic	
Centrally Acting Skeletal Muscle Relaxants	none		Amrix	
			carisoprodol (generic)	
			carisoprodol/aspirin (generic)	
			codeine/carisoprodol/aspirin (generic)	
		cyclobenzaprine	Fexmid*	
			Lorzone	
		chlorzoxazone	Parafon Forte DSC*	
		methocarbamol	Robaxin*	
		metaxalone	Skelaxin*	
	Soma*			
	tizanidine	Zanaflex*		
	cyclobenzaprine			
Direct-Acting Skeletal Muscle Relaxants	none	dantrolene	Dantrium*	
			Revonto	
			Ryanodex	
GABA-derivative Skeletal Muscle Relaxants	none		Gablofen	
			Lioresal Intrathecal	
	baclofen			
Miscellaneous Skeletal Muscle Relaxants	none	orphenadrine	none	
Opiate Agonists	none		Abstral	
		fentanyl	Actiq*	
		alfentanil	Alfenta*	
		morphine	Astramorph-PF*	
			Capital w/codeine	
		tramadol	ConZip*	
		meperidine	Demerol*	
		hydromorphone	Dilaudid*	
		methadone	Dolophine*	
		fentanyl	Duragesic*	
			Duramorph	
			Fentora	
			codeine/butalbital/acetaminophen/caffeine	Fioricet w/codeine*
			codeine/butalbital/aspirin/caffeine	Fiorinal w/codeine*
			hydrocodone/acetaminophen	Hycet*
			hydrocodone/ibuprofen	Ibudone*
				Infumorph
				Lazanda
			hydrocodone/acetaminophen	Lorcet*
			hydrocodone/acetaminophen	Lortab*
				methadone (generic)
				Methadose*
			hydrocodone/acetaminophen	Norco*
		Nucynta		
		Nucynta ER		
	oxymorphone	Opana*		

Opiate Agonists continued on next page

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DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED	
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic	
Opiate Agonists (continued)	none	<i>Opiate Agonists continued from previous page</i>		
			Oxecta	
		oxycodone/acetaminophen	Percocet*	
		oxycodone/aspirin	Percodan*	
			Primlev	
		oxycodone	Roxicodone*	
		fentanyl	Sublimaze*	
			Subsys	
		sufentanil	Sufenta*	
		dihydrocodeine/apap/ caffeine	Synalgos-DC*	
		acetaminophen/codeine	Tylenol w/codeine*	
			Ultiva	
		tramadol/acetaminophen	Ultracet*	
		tramadol	Ultram*	
		tramadol	Ultram ER*	
		hydrocodone/acetaminophen	Verdrocet*	
		hydrocodone/acetaminophen	Vicodin*	
		hydrocodone/ibuprofen	Vicoprofen*	
			Xartemis XR	
		hydrocodone/acetaminophen	Xodol*	
hydrocodone/ibuprofen	Xylon*			
	Zamicet			
	codeine			
	ibuprofen/oxycodone			
	levorphanol			
	opium/belladonna			
Opiate Partial Agonists	none		Belbuca	
			Bunavail	
			Buprenex*	
			buprenorphine (generic)	
			buprenorphine/naloxone (generic)	
			Butrans*	
			Probuphine	
			Sublocade**	
			Suboxone*	
			Talwin	
			Zubsolv	
			butorphanol	
			nalbuphine	
	pentazocine/naloxone			
Selective Serotonin Agonists	Relpax			
		sumatriptan	Alsuma*	
		naratriptan	Amerge*	
		almotriptan	Axert*	
		frovatriptan	Frova*	
		sumatriptan	Imitrex*	
		rizatriptan	Maxalt*	
		rizatriptan	Maxalt MLT*	
			Onzetra Xsail	
			Sumavel DosePro	
		sumatriptan and naproxen	Treximet*	
			Zecuity**	
			Zembrace	
		zolmitriptan	Zomig*	
	zolmitriptan	Zomig ZMT*		

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**Will be reviewed at a future time when eligible

ccDenotes agent is preferred with clinical criteria in place.

**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Allergy and Respiratory Agents**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Inhaled Antimuscarinics	Atrovent HFA		
	Seebri Neohaler		
	Spiriva Handihaler		
	Spiriva Respimat		
	Tudorza Pressair		
			Incruse Ellipta
		ipratropium bromide	
Inhaled Mast-Cell Stabilizers	none	cromolyn sodium	none
Leukotriene Modifiers	Zyflo CR*		zileuton (generic)
		zafirlukast	Accolate*
		montelukast	Singulair*
			Zyflo
Respiratory Corticosteroids	Alvesco		
	Asmanex HFA		
	Asmanex Twisthaler		
	Dulera		
	Flovent Diskus		
	Flovent HFA		
	Pulmicort Flexhaler		
	Pulmicort Respules*		budesonide (generic)
	Symbicort		
			Advair Diskus
			Advair HFA
			Aerospan
		salmeterol/fluticasone	AirDuo Respiclick*
			Armonair Respiclick
			Arnuity Ellipta
		Breo Ellipta	
		QVAR	
		QVAR Redihaler**	
		Trelegy Ellipta**	

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This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
 A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Respiratory Beta-Adrenergic Agonists	ProAir HFA		
	Proventil HFA		
	Serevent Diskus		
	Xopenex HFA*		levalbuterol HFA (generic)
			Anoro Ellipta
			Arcapta Neohaler
			Bevespi Aerosphere
			Brovana
			Combivent Respimat
			Foradil
			Perforomist
			ProAir Respiclick
			Stiolto Respimat
			Striverdi Respimat
		Utibron Neohaler	
		Ventolin HFA	
	levalbuterol inhalation solution	Xopenex Inhalation Solution*	
	albuterol		
	albuterol/ipratropium		
	metaproterenol		
	terbutaline		
Respiratory Smooth Muscle Relaxants	none		Elixophyllin
			Theo-24
		aminophylline	
		theophylline	

*Denotes a generic available in at least one dosage form or strength

**Will be reviewed at a future time when eligible

ccDenotes agent is preferred with clinical criteria in place.

**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Skin & Mucous Membrane Agents**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Antibacterials	none		Altabax
		mupirocin	Bactroban*
		mupirocin	Centany*
			Centany AT
		clindamycin (vaginal only)	Cleocin*
			Clindesse
			Cortisporin
		metronidazole	MetroGel-Vaginal*
		neomycin and polymyxin B	Neosporin G.U. Irrigant*
		metronidazole	Nuversa
gentamicin	Vandazole*		
Antifungals	none	ciclopirox	Ciclodan*
			Ertaczo
			Exelderm
		ketoconazole	Extina*
			Gynazole-1
			Jublia
			Kerydin
			Lamisil
		ciclopirox	Loprox*
		clotrimazole and betamethasone	Lotrisone*
			Luzu
			Mentax
		naftifine	Naftin*
		ketoconazole	Nizoral*
		oxiconazole	Oxistat*
		ciclopirox	Penlac*
		terconazole	Terazol 3*
		terconazole	Terazol 7*
			Vusion
		clotrimazole	
econazole			
miconazole			
nystatin			
nystatin and triamcinolone			

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**Will be reviewed at a future time when eligible

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This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Anti-inflammatory Agents	Capex Shampoo		
		hydrocortisone	Anusol-HC*
			ApexiCon E
		clobetasol	Clobex*
		clobetasol	Clodan*
		clocortolone	Cloderm
			Cordran
		hydrocortisone	Cortenema*
			Cortifoam
		fluticasone	Cutivate*
		Fluocinolone	Derma-Smooth/FS*
		prednicarbate	Dermatop*
			Desonate
		betamethasone dipropionate and propylene glycol	Diprolene*
		betamethasone dipropionate and propylene glycol	Diprolene AF*
		mometasone	Elocon*
			Eucrisa**
			Halog
		triamcinalone	Kenalog*
		betamethasone valerate	Luxiq*
		clobetasol	Olux*
		clobetasol	Olux-E*
		triamcinolone	Oralene*
			Pandel
			PramCort
			ProctoFoam-HC
		diflorasone	Psorcon*
			Sernivo
		fluocinolone	Synalar*
		clobetasol	Temovate*
		clobetasol and emollient	Temovate Emollient*
			Texacort
		desoximetasone	Topicort*
		Trianex	
	halobetasol	Ultravate*	
	fluocinonode	Vanos*	
	alclometasone		
	amcinonide		
	betamethasone dipropionate		
	betamethasone valerate		
	desonide		
	fluranderenolide		
	hydrocortisone and aloe vera		
	hydrocortisone, mineral oil and white petrolatum		
	hydrocortisone acetate		
	hydrocortisone acetate and urea		
	hydrocortisone butyrate		
	hydrocortisone valerate		

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**Will be reviewed at a future time when eligible

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This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
 A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Antipruritics and Local Anesthetics	none	lidocaine topical patch	Lidoderm*
			Lidotral
		doxepin	Prudoxin*
			Synera
		doxepin	Zonalon*
		hydrocortisone and lidocaine	
		hydrocortisone, lidocaine and aloe vera	
		lidocaine	
	lidocaine and prilocaine		
Antivirals	Zovirax (cream)		Denavir
			Xerese
			Zovirax (ointment)*
		acyclovir	
Astringents	none		Xerac AC
Keratolytic Agents	none		Aluvea
			Bensal HP
		salicylic acid	Salex*
			Umecta
			Umecta PD
			Uramaxin
		urea	Uramaxin GT*
Miscellaneous Local Anti-infectives	none		AVC
		silver sulfadiazine	Silvadene*
		silver sulfadiazine	SSD*
			Sulfamylon

*Denotes a generic available in at least one dosage form or strength

**Will be reviewed at a future time when eligible

ccDenotes agent is preferred with clinical criteria in place.

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Miscellaneous Skin and Mucous Membrane Agents	Elidel		
		imiquimod	Aldara*
			Artiss
		fluorouracil	Carac*
		podofilox	Condylox*
		calcipotriene	Dovonex*
			Dupixent**
		fluorouracil	Efudex*
			Enstilar
			Levulan
			Panretin
			Picato
			Podocon-25
		tacrolimus	Protopic*
			Qutenza
			Rectiv
			Regranex
			Santyl
			Solaraze
		diclofenac	Soriatane*
			Sorilux
		calcipotriene	Taclonex*
			Targretin
		Tazorac	
		Tolak	
		Valchlor	
	calcitriol	Vectical*	
		Veregen	
		Zyclara	
Scabicides and Pediculicides	Sklice		
	Ulesfia		
		permethrin	Elimite*
			Eurax
			lindane (generic)
		spinosad	Natroba*
	malathion	Ovide*	

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**ALABAMA MEDICAID AGENCY
PDL REFERENCE TOOL – Women’s Health**

This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED
	Preferred Brand	Preferred Generic	Non-Preferred Brand or PA Generic
Estrogens	Menest		
	Premarin (tablets only)		
		estradiol and norethindrone	Activella*
		estradiol	Alora*
		estradiol and norethindrone	Amabelz*
			Angeliq
		estradiol	Climara*
			Climara Pro
			Combipatch
		estradiol valerate	Delestrogen*
			Depo-Estradiol
			Divigel
			Duavee
			Elestrin
			Enjuvia
		estradiol	Estrace*
			Estring
			Evamist
		ethinyl estradiol and norethindrone	FemHRT*
			Femring
		ethinyl estradiol and norethindrone	Jevantique*
		ethinyl estradiol and norethindrone	Jinteli*
			Menostar
		estradiol and norethindrone	Mimvey*
		estradiol and norethindrone	Mimvey Lo*
		estradiol	Minivelle*
		Prefest	
		Premarin (cream and injection)	
		Premphase	
		Prempro	
	estradiol	Vagifem*	
	estradiol	Vivelle-Dot*	
	estropipate		

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**Will be reviewed at a future time when eligible

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This PDL reference tool is to aid a prescribing physician with generic availability and preferred product status.
A "substitution allowed" physician signature on a prescription should not require a PA to be obtained if a generic agent is available.

DRUG CLASS	NO PA REQUIRED	NO PA REQUIRED	PA REQUIRED for NAME
	Preferred Brand	Preferred Generic	Non-Preferred Brand
Prenatal Vitamins	Citranatal 90 DHA*	prenatal vitamins, iron, folic acid, DHA, docusate	
	Citranatal Assure*	prenatal vitamins, iron, folic acid, DHA, docusate	
	Citranatal B-Calm		
	Citranatal Bloom		
	Citranatal DHA		
	Citranatal Harmony		
		Prenatal vitamins, iron, folic acid, DHA	Active OB*
			Bal-Care DHA Essential
			Citranatal Rx
		prenatal vitamins, iron, folic acid, omega-3 fatty acids	Concept DHA*
		prenatal vitamins, iron, folic acid	Concept OB*
			Natalvit
		prenatal vitamins, iron, folic acid	Nestabs*
			Nestabs ABC
		prenatal vitamins, iron, folic acid, DHA	Nestabs DHA*
			Nexa Plus
			OB Complete
			OB Complete One
			OB Complete Petite
			OB-Complete Premier
			OB Complete with DHA
			Paire OB Plus DHA
		prenatal vitamins, iron, folic acid, omega-3 fatty acids	PR Natal 400*
			PR Natal 430
			PR Natal 400 EC
			PR Natal 430 EC
		prenatal vitamins, iron, folic acid, omega-3 fatty acids, DHA	Prefera OB*
		prenatal vitamins, iron, folic acid, DHA	Prefera-OB One*
		prenatal vitamins, iron, folic acid, omega-3 fatty acids, DHA	Prefera-OB Plus DHA*
			Prenata
			Prenate AM
			Prenate Chewable
			Prenate DHA
			Prenate Elite
			Prenate Enhance
			Prenate Essential
			Prenate Mini
			Prenate Pixie
			Prenate Restore
			Prenate Star
		Preque 10	
		Primacare	
		Provida DHA	
		Provida OB	
	prenatal vitamins, iron, folic acid, omega 3 fatty acids	Relnate DHA*	
		Select-OB	
<i>Prenatal Vitamins continued on next page</i>			

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<i>Prenatal Vitamins continued from previous page</i>		
Prenatal Vitamins (continued)	prenatal vitamins, iron, folic acid, DHA	Select-OB+DHA*
		Tricare
		Tricare Prenatal DHA One
		Vinate II
		Vinate DHA RF
	prenatal vitamins, iron, folic acid, selenium	Vinate-M*
		Vitafol-OB
	prenatal vitamins, iron, folic acid, DHA	Vitafol-OB+DHA*
	prenatal vitamins, iron, folic acid, DHA	Vitafol-One *
		Vitafol Nano
		Vitafol Ultra
		VP CH Ultra

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**Will be reviewed at a future time when eligible

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RFP #: 2018-PAS-01**Alabama Medicaid Agency Pharmacy Administrative Services RFP****Contractor Questions and Agency Answers****May 7, 2018**

Question ID:	1
Date Question Asked:	4/19/2018
Question:	Can you confirm if Health Information Designs is the incumbent vendor for this contract? If so, what is the contract expiration?
Section Number:	N/A
RFP Page Number:	N/A
AGENCY Answer:	Health Information Designs, LLC is the incumbent vendor for this contract. The current contract expires October 31, 2018.
Question ID:	2
Date Question Asked:	4/19/2018
Question:	What is the estimated budget the agency has for this project?
Section Number:	Section III.
RFP Page Number:	Page 54
AGENCY Answer:	The estimated budget for this project will not be provided. The Agency requests all prospective bidders to submit their best and final price.
Question ID:	3
Date Question Asked:	4/19/2018
Question:	Would this be considered a module for the Alabama Medicaid Management Information System (MMIS)?
Section Number:	N/A
RFP Page Number:	N/A
AGENCY Answer:	No.
Question ID:	4

Date Question Asked:	4/20/2018
Question:	I am respectfully requesting your consideration of an extension of the proposal date by 30 days, or June 13, 2018.
Section Number:	N/A
RFP Page Number:	N/A
AGENCY Answer:	The proposal due date is May 16, 2018 by 5:00p.m. There will not be any changes or extensions to the due date.
Question ID:	5
Date Question Asked:	4/20/2018
Question:	Likewise, should you do so, we would respectfully request an extension of the question submission deadline, or alternatively, an opportunity at a later date to submit a second round of questions.
Section Number:	N/A
RFP Page Number:	Page 3
AGENCY Answer:	There will not be any changes/extension to the RFP due date or the question and answer section.
Question ID:	6
Date Question Asked:	4/23/2018
Question:	Regarding, "C. Term of Contract - The initial contract term shall be for 2 years effective November 1, 2018, through October 31, 2020." – How will the Agency's planned move to MITA affect the scope of work and any future interfaces needed for this procurement?
Section Number:	Section IX: General Terms and Conditions
RFP Page Number:	Page 62
AGENCY Answer:	The successful vendor will need to establish interfacing and maintain a setup by SFTP method with the fiscal agent vendor to provide the services requested in the RFP. Once a vendor is selected for the AMMIS RFP, the successful vendor of the Pharmacy Administrative Services contract would work with the AMMIS vendor to establish interfacing and connections. Complete interfacing information can be found in the AMMIS Interfacing Standards document located on the Procurement page of the Alabama Medicaid website.
Question ID:	7

Date Question Asked:	4/23/2018
Question:	AMMIS Interface Standards Document – Please confirm that the document dated 10/3/2012 is the most up-to-date interface standards. This document can also be found on the Alabama Medicaid website.
Section Number:	N/A
RFP Page Number:	N/A
AGENCY Answer:	Yes, the document dated 10.3.12 is the most up to date document of the interface standards.
Question ID:	8
Date Question Asked:	4/23/2018
Question:	Regarding I.A Project Manager (PM) – Does the Project Manager need to be full-time dedicated to the contract?
Section Number:	Section II: I: Scope of Work-Key Personnel
RFP Page Number:	Page 12-13
AGENCY Answer:	The Project Manager does not have to be full time dedicated to the contract but shall act as a liaison between Medicaid and the vendor. The Project Manager must be available and responsible for consultation and assistance regarding issues arising regarding the scope of the contract.
Question ID:	9
Date Question Asked:	4/23/2018
Question:	Call Center – Please provide expected volume and current wait times for the call center.
Section Number:	Section II: V. Help Desk
RFP Page Number:	Page 42-43
AGENCY Answer:	Contractor shall provide a minimum of twenty dedicated toll free phone lines for instate calls and bordering states, eight dedicated toll-free FAX lines to Medicaid providers, and computer stations sufficient for the requirements of the Help Desk. Average wait time for Help Desk calls is not to exceed twenty seconds. Currently, thirty-one representatives make up the total of help desk representatives.
Question ID:	10
Date Question Asked:	4/23/2018

Question:	R – Incentive Program – Please provide details of the current “Gold Standard Program”, so that we understand the impact to Providers for any newly developed program.
Section Number:	Section II: R: Incentive Program
RFP Page Number:	Page 35-36
AGENCY Answer:	The incentive program shall recognize prescribers who demonstrate high compliance with the Alabama Medicaid Preferred Drug List (PDL) based on AMMIS system data, and reward the provider with exemptions from prior authorization (PA) requirements when certain prescription-based criteria are met in a given timeframe on a regular basis.