



Pharmacy Billing Manual

Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
7/1/02	2.2	Removed the word “not” from the first sentence of the third bullet.
8/1/02	2.4	Clarification was added to the required field titled Prescriber ID.
8/1/02	Added Section 2.6	Added the DMAC Pricing Inquiry Worksheet form.
2/27/04	1.0 and 2.2	Changing POS DUR timely filing limit from 14 days to 100 days.
9/8/04	2.2, 2.4 and Appendix A	Pharmacies must give the DMAP credit for reusable medications returned to the dispensing pharmacy by a long term care facility. Information added on billing a client’s primary insurance prior to billing the DMAP. Appendix A added to give the NCPDP Other Coverage Codes.
5/5/05	2.3.1 and 2.3.2	Added two new sections entitled ‘NCPDP 5.1 Layouts – Request Reversals’ and ‘NCPDP 5.1 Layouts – Request Segments’.
12/13/05	1.3 and 2.2-2.7	Electronic and paper claim submission has changed for Medicare Part D. A new section has been created for Medicare Part D billing in section 2.6. The DMAC pricing inquiry worksheet has been moved to section 2.7
5/25/06	1.3	Modified the process for calculating co-payments.
9/18/06	1.3	Update to Delaware Prescription Assistance Program benefit amount based on Senate Bill # 297, 143 rd General Assembly (signed into State law on July 6, 2006). Also clarifying existing policy.
9/18/06	2.2, 2.3.2, 2.4, 2.6, and 3.0	Adding clarification to existing policy.
10/25/06	2.2 and Appendix A	Added the option of providing a license number instead of a DEA number when applicable. Added language directing providers to bill Medicare Part B for covered medications or devices and clarified correct use of NCPDP coverage codes.
3/10/07	2.2, and 2.4	Added instructions for the prescriber id field of the paper pharmacy claim form to include the National Provider Identifier (NPI).
3/25/07	2.3.1 and 2.3.2	Updated the NCPDP 5.1 layouts for NPI billing.

6/22/07	2.2.7, 2.3.2, 2.4 and 2.6	Clarification for billing after primary insurance. Update to data field 110-AK and clarification for billing compounds.
8/30/07	2.4, 2.6.1	Clarification has been made to the billing instructions.
10/3/07	Appendix B	Added newly mandated tamper resistant prescription pad legitimacy requirements.
11/26/07	2.4	Clarification has been made to the billing instructions for paper claims.
1/23/09	2.3.2	Updates have been made to the NCPDP Layouts. The updates are effective 3/2/09.
6/5/09	2.2.1	Clarification and instruction provided to verify eligibility in emergency situations.
8/5/11	2.7.1	Updated the DMAC Pricing Inquiry Worksheet for Generic Drug
11/1/11	2.2.1	Removed obsolete wording
12/6/11	2.2	Guidance regarding National Council for Prescription Drug Programs (NCPDP) claims.
12/6/11	2.3.2	The payer sheet has been updated
1/20/12	2.3.2	The D.Ø payer sheet has been updated.



Pharmacy Billing Instructions

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1.0 Introduction

The Delaware Division of Medicaid and Medical Assistance (DMMA) establishes all policies and procedures governing the Delaware Medical Assistance Program (DMAP) that includes Medicaid, The Delaware Healthy Children Program, The Chronic Renal Disease Program (CRDP) and the Delaware Prescription Assistance Program (DPAP). The General Policy and Provider Specific Policy manuals are to be referenced for all program guidelines.

HPES is the Delaware Medical Assistance Program Fiscal Agent. Providers are to bill HPES for the care and services rendered to DMAP clients.

The Pharmacy Billing Instructions section is designed as a reference tool to be utilized by DMAP providers when submitting claims for payment. This manual should be used in conjunction with the General Policy and Provider Specific Policy sections.

Participation in the POS program is mandatory for any pharmacy provider serving ambulatory clients. The POS-DUR program will have a 100-day timely filing limit, with the exception of claims submitted to a primary insurance. These claims can be submitted up to 120 days after the date of service. Claims adjudicated via the POS system will be reimbursed with a check or by Electronic Funds Transfer (EFT) on the next financial cycle. The submission of proper and complete billing documents by providers is essential for timely and accurate claims processing and payment. Providers are responsible for the accuracy of all data elements submitted on their claims including, but not limited to the metric quantity, days supply, diagnosis and correct identification of the prescriber.

Delaware is part of the CMS national drug rebate program. It is vital that claims are submitted with the NDC of the product actually dispensed. Only medications that were actually dispensed should be billed. (If a medication is not in stock, the claim should not be submitted.)

Initially, providers should carefully read this manual to become familiar with the contents. The manual should then be referenced when completing billing documents or forms. HPES will periodically update the Billing Manual on the DMAP Web site. Providers can opt to have paper updates sent through the mail. Revised pages should be promptly inserted into the manual for quick and accurate future reference.

1.1 Delaware Medical Assistance Program (DMAP) and the Delaware Healthy Children Program (DHCP)

The DMAP and the DHCP coverage is based on criteria as stated in the General Policy and the provider-specific sections of the manual. Medicaid's clinical staff will review any prescriptions over \$500.00.

1.2 Chronic Renal Disease Program (CRDP)

The CRDP has some coverages that are unique to the program. Eligible clients will have their own benefits package that may include a co-payment and a maximum benefit limit.

1.3 Delaware Prescription Assistance Program (DPAP)

The DPAP has some requirements that are unique. Clients are required to pay a co-pay for each prescription. DMMA will cover a portion of drugs covered by Part D if it is part

of the deductible or coverage gap. The PDP co-payment is the client's responsibility and based on the PDP transaction information.

For claims that are 100% covered by DMMA the co-pay will be equal to 25% of the allowed amount for the prescription or \$5.00, whichever is greater. There is no maximum on the amount of a co-pay.

The co-pay calculation on claims with a primary insurance payment takes the DMMA allowed amount and compares it to the sum of all other insurance payments. If the balance between DMMA's allowed amount and the total other insurance payment is less than DMMA's 25% of maximum allowed or \$5.00, the co-pay will be reduced. The co-pay will be calculated to be the difference between DMMA's allowed amount and the sum of the other insurance payments or \$0.00, whichever is greater.

The NCPDP response transaction will state the amount of co-pay required to be paid to the pharmacy prior to the medication being dispensed.

Eligible clients are limited to a \$3,000 benefit each calendar year effective July 6, 2006. If a client exceeds the maximum benefit the co-pay will be increased by the total amount that could not be covered by the program.

The DPAP cannot cover medications for Medicare covered clients except as noted above unless the medication is in an excluded Medicare category such as OTC products, benzodiazepines, barbiturates, cough and cold products or vitamins and minerals. There are detailed billing instructions for submitting a claim that needs a coordination of benefits in the Medicare Part D Billing Instructions section of this manual.

Medication coverage will also be based on the manufacturer's willingness to pay a rebate to the Department of Health and Social Services. Products labeled by non-participating manufacturers will not be covered.

Clients who obtain other prescription benefit coverage or no longer reside in Delaware or whose income exceeds 200% of poverty will no longer be eligible for the program. Providers are cautioned to verify eligibility before dispensing any medications.

2.0 Billing Instructions

2.1 Introduction

POS-DUR on-line adjudication has eliminated most paper claims. Pharmacy claims must be submitted using the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required transactions for pharmacy services. This is the NCPDP Version 5.1 transaction and code set. The Delaware Medical Assistance Programs uses NCPDP Version 5.1 in conjunction with the approved data dictionary from September 1999 to determine the specifications and definitions for transaction creation and submission. Additionally, should it be necessary to submit a paper claim, DMAP pharmacy services must be submitted on the NCPDP national standard claim form.

The provider should keep documentation of all authorization numbers to serve as a reference for on-line adjudication. The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important.

2.2 General Procedures

2.2.1 Providers are required to verify client eligibility and other important client information prior to rendering services. Eligibility and other important client information should be verified via the voice response system at 800-999-3371 or through the Interactive Services tab on the DMAP Website <http://www.dmap.state.de.us/home/index.html> regardless of the type of claim. The above two sources will provide either an eligibility or ineligibility response along with a verification number. Eligibility should always be verified in emergency situations. Providers submitting National Council for Prescription Drug Programs (NCPDP) claims that are interactive may treat the claim response as verification of eligibility, coverage and patient responsibility.

2.2.2 National Provider Identifier

2.2.2.1 The prescriber ID field must include the prescribing practitioner's NPI number.

2.2.2.2 If an NPI number is being submitted and the claim still rejects, the prescriber's information will need to be provided to HPES. The practitioner's full name and either address or phone must be included with the NPI number. This information can be faxed to 302-454-0224 or can be provided to HPES pharmacy provider call center at 800-999-3371. The information on the prescription must match the information submitted on the claim. If audited and discrepancies are found, monies may be recouped.

2.2.2.3 If a prescription is written by a prescriber with an NPI that has been removed from DMMA network, the claim will be denied and should not be submitted with an alternate identifier. If audited and such claims are found, monies may be recouped.

2.2.2.4 If the pharmacy is unable to obtain the physician's NPI number a temporary identifier may be provided by HPES.

2.2.2.5 If the physician is from an emergency department in order for the prescription to be considered valid, the prescribing provider's NPI must be submitted in the prescriber ID field.

2.2.2.6 If the prescriber's NPI is not available and it is after business hours and the pharmacist considers the medication to be critical, then DMMA will honor one emergency 72 hour supply. In order to process the claim the pharmacy can submit an emergency identifier of "NPI0000001" in the prescriber ID field. If you experience difficulties processing this type of claim, call HPES pharmacy provider call center at 800-999-3371.

- 2.2.3** The NCPDP submission clarification code is to be used only for a change in therapy. Inappropriate use of this code may result in monies being recouped.
- 2.2.4** Submit POS claims within 100 days of the dates of service. Paper claims should be submitted within time limits specified in the General Policy Manual.
- 2.2.5** Claims for prescriptions that are not dispensed and are returned to the pharmacy stock should be credited by reversing the claims. Medications that are returned by LTC facilities that can be issued to another resident must be credited. Reversal transactions can be submitted up to 120 days after initial submission.
- 2.2.6** Claims billed for clients with a primary insurance that covers drugs, or a Medicare segment (for a Medicare covered drug), should be billed to the primary insurance prior to billing the DMAP. When billing DMAP the pharmacy will receive a reject error that states, "Bill other insurance or primary payer". The pharmacy will enter one of the NCPDP Other Coverage Codes on the claim to let Medicaid know when (and if) the claim was submitted to the other insurance carrier. Appendix A lists the NCPDP Other Coverage Codes that are currently accepted by DMAP to allow for full payment. Claims for clients with Medicare Part D coverage must include a Coordination of Benefit segment that includes information received from the PDP.
- 2.2.7** Providers must bill Medicare Part B first for any medications or devices that are covered by the federal program. The coinsurance and co-payment must be submitted to HPES on a CMS1500 claim form. Please refer to the CMS1500 Billing Manual for instructions.
- 2.2.8** POS Claims: Formats for claims submitted via POS will differ based on the software system in use. Certified vendors comply with NCPDP 5.1 specifications.
- 2.2.9** Any provider who has dramatic and long-term system problems must contact HPES Provider Relations within 13 days of discovery of the problem. Indicating "System Problem" in the remarks section of a Pharmacy claim form is not a valid exception from POS-DUR claim submission. The information must be submitted in writing identifying the problem; action plan and estimate of the duration the system will be down.
- 2.2.10** Mail the completed invoices to the following address:

HPES**P.O. Box 909, Manor Branch****New Castle, Delaware 19720-0909****2.3 POS Transactions (Submitting a Claim)**

A standard claim is transaction code B1, compliance with the Delaware specifications.

A claim payable response will include total amount paid as well as the claim number. Claims submitted for the DPAP program will be reduced by the amount of the co-pay. Clients are expected to remit that amount prior to receiving their prescription.

A claim that is not adjudicated will contain a response status of **D** (duplicate billing), **R** (rejected) or **C** (captured). You will also receive all of the DUR conflict information and a message further defining the problem.

Claim reversal, transaction code B2, is used to cancel a prescription that has been paid within 120 days after initial submission. A reversal claim requires a version, bin number, processor control number, pharmacy provider number, date of service, transaction code B2, and prescription number. The DUR codes are optional. The HPES Help Desk cannot reverse a claim. The correct procedure for reversing a claim from both the pharmacy computer and DMAP should be well documented from the pharmacy's software vendor for the pharmacy staff to apply. The HPES Help Desk is unable to clarify problems associated with the software vendor.

2.3.1 NCPDP D.Ø Layouts – Request Reversal

If you do not receive confirmation that the reversal has been accepted, contact your software vendor or helpdesk. The HPES Pharmacy Team cannot reverse a claim.			
Data elements not listed in the table below are not required by the DMAP.			
Transaction Header Segment- Reversal			
Field	Field Name	Definition of Field	Delaware Requirements
1Ø1-A1	Bin Number	Card Issuer ID or Bank ID Number used for network routing.	Required field: 610452
1Ø2-A2	Version/Release Number	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	Required field: D.Ø
1Ø3-A3	Transaction Code	Code identifying the type of transaction.	Required field: B2 = Reversal
1Ø4-A4	Processor Control Number	Number assigned by the processor.	Part D = 'PDMAPPARTD' if routed through TrOOP Facilitator Non Part D = 'PDE610452'
1Ø9-A9	Transaction Count	Count of transactions in the transmission.	1= One Occurrence
2Ø2-B2	Service Provider ID Qualifier	Code qualifying the 'Service Provider ID' (2Ø1-B1).	Required field: Ø1=National Provider Identifier (NPI)

2Ø1-B1	Service Provider ID	ID assigned to a pharmacy or provider.	Required field: 10 digit assigned NPI
4Ø1-D1	Date of Service	Identifies date the prescription was filled or professional service rendered.	Required field: Format = CCYYMMDD
11Ø-AK	Software Vendor/Certification ID	ID assigned by the switch or processor to identify the software source.	Test = check with your vendor/clearing house Production – check with your vendor/clearing house
Patient Segment - Reversal			
Field	Field Name	Definition of Field	Delaware Requirements
This segment is not required for a claim reversal.			
Insurance Segment - Reversal			
Field	Field Name	Definition of Field	Delaware Requirements
This segment is not required for a claim reversal.			

Claim Segment - Reversal			
Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field: Ø7=Claim
147-U7	Pharmacy Service Type	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.	Required: Default to Ø if nothing entered. This is a 2 digit numeric field.
455-EM	Prescription/Service Reference Number Qualifier	Indicates the type of billing submitted.	Required field: 1=Rx Billing 2=Service Billing
4Ø2-D2	Prescription/Service Reference Number	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	Required field: Enter the twelvedigit numeric prescription number. The number must be identical to the initial claim.
436-E1	Product/Service ID Qualifier	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	Required field: Ø3 = National Drug Code (NDC) Ø6 = Drug Use Review/Professional Pharmacy Service (DUR/PPS)
4Ø7-D7	Product/Service ID	ID of the product dispensed or service provided.	Required field when 436-E1 is a Ø3: When the Prescription/Service Reference Number Qualifier is a '1', enter the 11-digit national drug code for the drug dispensed. If the Product/Service Id Qualifier is an 'Ø6' or the compound code is a 2, this field should contain a '0'.
4Ø6-D6	Compound Code	Code indicating whether or not the prescription is a compound.	Optional field: Ø=Not Specified 1=Not a Compound 2=Compound
DUR/PPS Segment - Reversal			
Field	Field Name	Definition of Field	Delaware Requirements
This segment is not required for a claim reversal.			
Pricing Segment - Reversal			
Field	Field Name	Definition of Field	Delaware Requirements
This segment is not required for a claim reversal.			

2.3.2 NCPDP D.Ø Layouts – Request Segments

Data elements not listed in the table below are not required by the DMAP.			
Transaction Header Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
1Ø1-A1	Bin Number	Card Issuer ID or Bank ID Number used for network routing.	Required field: 610452
1Ø2-A2	Version/Release Number	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	Required field: D.Ø
1Ø3-A3	Transaction Code	Code identifying the type of transaction.	Required field: B1 = Billing B3 = Rebill N1 = Information Reporting
1Ø4-A4	Processor Control Number	Number assigned by the processor.	Part D = 'PDMAPPARTD' if routed through TrOOP Facilitator Non Part D = 'PDE610452'
1Ø9-A9	Transaction Count	Count of transactions in the transmission.	1= One Occurrence
2Ø2-B2	Service Provider ID Qualifier	Code qualifying the 'Service Provider ID' (2Ø1-B1).	Required field: Ø1=National Provider Identifier (NPI)
2Ø1-B1	Service Provider ID	ID assigned to a pharmacy or provider.	Required field: 10 digit assigned NPI
4Ø1-D1	Date of Service	Identifies date the prescription was filled or professional service rendered.	Required field: Format = CCYYMMDD
11Ø-AK	Software Vendor/Certification ID	ID assigned by the switch or processor to identify the software source.	Test = check with your vendor/clearing house Production = check with your vendor/clearing house
Patient Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field: Ø1 = Patient
3Ø4-C4	Date of Birth	Date of Birth of Patient	Required CCYY/MM/DD
3Ø5-C5	Patient Gender	Code indicating the gender of the individual.	Required Ø - Not specified 1-Male, 2-Female
3Ø7-C7	Place of Service	Code identifying the location of the patient when receiving pharmacy services.	Required field: Required.
31Ø-CA	Patient First Name	Individual First Name	Required Enter the patient's first name – Alpha Only
311-CB	Patient Last Name	Individual Last Name	Required Enter the patient's last name – Alpha Only
335-2C	Pregnancy Indicator	Code indicating the patient as pregnant or non-pregnant.	Optional field: Blank=Not Specified 1=Not pregnant 2=Pregnant
Insurance Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements

111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field: Ø4=Insurance
3Ø2-C2	Cardholder ID	Insurance ID assigned to the cardholder.	Required field: Enter the 10 digit DMAP client ID number.
312-CC	Cardholder First Name	Individual first name.	Required field: Enter the clients first name. Alpha only.
313-CD	Cardholder Last Name	Individual last name.	Required field: Enter the clients last name. Alpha only.

Claim Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field: Ø7=Claim
455-EM	Prescription/Service Reference Number Qualifier	Indicates the type of billing submitted.	Required field: 1=Rx Billing 2=Service Billing
4Ø2-D2	Prescription/Service Reference Number	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	Required field: Enter the twelve digit numeric prescription number.
436-E1	Product/Service ID Qualifier	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	Required field: Ø3 = National Drug Code (NDC) Ø6 = Drug Use Review/Professional Pharmacy Service (DUR/PPS)
4Ø7-D7	Product/Service ID	ID of the product dispensed or service provided.	Required field when 436-E1 is a Ø3: When the Prescription/Service Reference Number Qualifier is a '1', enter the 11-digit national drug code for the drug dispensed. If the Product/Service Id Qualifier is an 'Ø6' or the compound code is a 2, this field should contain a '0'.
442-E7	Quantity Dispensed	Quantity dispensed expressed in metric decimal units.	Required field: Enter the ten digit metric decimal quantity of the drug dispensed in this field
4Ø3-D3	Fill Number	The code indicating whether the prescription is an original or a refill.	Required field: Ø=Original dispensing 1 to 99 = Refill number
4Ø5-D5	Days Supply	Estimated number of days the prescription will last.	Required field: Enter the estimated days supply of the drug dispensed.
4Ø6-D6	Compound Code	Code indicating whether or not the prescription is a compound.	Required field: Ø=not specified 1 = not a compound 2 = compound
4Ø8-D8	Dispense As Written (DAW)/Product Selection Code	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	Required field: Default to ØØ if nothing entered. Ø=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 9=Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product to be Dispensed
414-DE	Date Prescription Written	Date the prescription was written	Required Enter the date the rx was written. Format: CCYYMMDD

415-DF	Number of Refills Authorized	Number of refills authorized by the prescriber	Required Enter the number of authorized refills 0-99. 99 being as needed refills unlimited.
419-DJ	Prescription Origin Code	Code indicating the origin of the prescription	Required field: 1 = written 2 = telephone 3 = electronic 4 = facsimile 5 = pharmacy
354-NX	Submission Clarification Code Count	Count of the Submission Clarification Code occurrences.	Required if Submission Clarification Code 42Ø-DK is used. Maximum count of 3.
42Ø-DK	Submission Clarification Code	Code indicating that the pharmacist is clarifying the submission.	Optional field: 5=Therapy Change A code of 5 should be entered for a change in therapy with regard to the medication claims denying for therapeutic duplication. Inappropriate use of this code may result in monies being recouped
3Ø8-C8	Other Coverage Code	Code indicating whether or not the patient has other insurance coverage.	Required field: Ø1=No other coverage Ø2=Other coverage exists- payment collected Ø3=Other coverage exists- claim not covered Ø4=Other coverage exists- payment not collected-not participating provider This field must be sent on all COB claims.
429-DT	Special Packaging Indicator	Code indicating the type of dispensing dose.	Required Default to Ø if nothing entered. This is a 1 digit numeric field.
995-E2	Route of Administration	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.	Required: Default to Ø if nothing entered. This is an 11 digit alpha numeric field.
147-U7	Pharmacy Service Type	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.	Required: Default to Ø if nothing entered. This is a 2 digit numeric field.
462-EV	Prior Authorization Number Submitted	Number submitted by the provider to identify the prior authorization.	Optional Field: Enter the ten digit prior authorization number assigned.
Pharmacy Provider Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
Data elements not listed in this segment are not required by the DMAP.			

Prescriber Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field: Ø3=Prescriber
427-DR	Prescriber Last Name	Prescriber Last Name	Required field: Last name of prescriber
364-2J	Prescriber First Name	Prescriber First Name	Required: First name of the prescriber.
466-EZ	Prescriber ID Qualifier	Code qualifying the 'Prescriber ID' (411-DB).	Required field: Ø1=National Provider Identifier (NPI) 12= DEA
411-DB	Prescriber ID	ID assigned to the prescriber.	Required field: 10 digit assigned NPI

COB/Other Payments Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field if there is a COB payment: Ø5=Coordination of Benefits/Other Payments
337-4C	Coordination of Benefits/Other Payments Count	Count of other payment occurrences.	1 = 1 occurrence 2 = 2 occurrences 3 = 3 occurrences
338-5C	Other Payer Coverage Type	Code identifying the type of 'Other Payer ID' (34Ø-7C).	Required: Ø1=Primary Ø2=Secondary Ø3=Tertiary
339-6C	Other Payer ID Qualifier	Code qualifying the 'Other Payer ID' (34Ø-7C).	Required for all COB claims: must be '99' when Payer is Part D PDP Any valid NCPDP value if non-Part D PDP
34Ø-7C	Other Payer ID	ID assigned to the payer.	Required for all COB claims: must be 'PDP9999999' when Payer is Part D PDP value of payer ID when non-Part D PDP
443-E8	Other Payer Date	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	Required field: Format=CCYYMMDD
341-HB	Other Payer Amount Paid Count	Count of the payer amount paid occurrences.	Required for all COB claims: 1 = one occurrence allowed 2 = two occurrences allowed 3 = three occurrences allowed.
342-HC	Other Payer Amount Paid Qualifier	Code qualifying the 'Other Payer Amount Paid' (431-DV).	Required field if there is a COB payment: Ø7 = Drug Benefit
431-DV	Other Payer Amount Paid	Amount of any payment known by the pharmacy from other sources (including coupons).	Enter the total payment amount related to the occurrence for this payer Length of eight.
471-5E	Other Payer Reject Count	Count of 'Other Payer Reject Code' (472-6E) occurrences	1 = one occurrence allowed 2 = two occurrences allowed 3 = three occurrences allowed

COB/Other Payments Segment - Request			
472-6E	Other Payer Reject Code	The error encountered by the previous "Other Payer" in 'Reject Code' (511-FB)	Required for all COB claims when a denial was received from the other insurance. Must be present when Part D PDP rejected claim
353-NR	Other Payer patient Responsibility Amount Count	Count of "Other Payer-Patient Responsibility Amount" (352-NQ) and "Other Payer-Patient Responsibility Amount Qualifier" (351-NP) occurrences.	Required if other payer patient responsibility amount qualifier is used. Maximum count of 3
351-NP	Other Payer Patient Responsibility Amount Qualifier	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Required when the amount field is used. Valid Values: 01 – 13 and Blank
352-NQ	Other Payer Responsibility Amount	The patient's cost share from a previous year	Required when applicable:
392-MU	Benefit Stage Count	Count of 'Benefit Stage Amount' (394-MW) occurrences.	Required if Benefit State Amount is used Valid Values: 1, 2, or 3
393-MV	Benefit Stage Qualifier	Code qualifying the 'Benefit Stage Amount' (394-MW).	Required if Benefit Stage Amount is used. Valid Values: 01, 02, 03, 04, 50, 60, 70, and 80.
394-MW	Benefit Stage Amount	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV)	Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages.
Workers Compensation Segment - Request			
Data elements not listed in this segment are not required by the DMAP.			
DUR/PPS Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field if there is a DUR alert: 08=DUR/PPS
473-7E	DUR/PPS Code Counter	Counter number for each DUR/PPS set/logical grouping.	1 = 1 occurrence allowed

COB/Other Payments Segment - Request			
439-E4	Reason for Service Code	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	Required field if there is a DUR alert: DC = Drug Disease (inferred) DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse MC = Drug-Disease (Reported) MN = Insufficient Duration MX = Excessive Duration PA = Drug-Age PG = Drug-Pregnancy TD = Therapeutic
440-E5	Personal Service Code	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	Required field if there is a DUR alert: MØ = Prescriber consulted PØ = Patient consulted RØ = Pharmacist consulted other source
441-E6	Result of Service Code	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	Required field if there is a DUR alert: 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 2A = Prescription Not Filled 2B = Not Filled, Directions Clarified

Pricing Segment - Request			
Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field: 11=Pricing
426-DQ	Usual and Customary Charge	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	Required field when the Prescription/Service Reference Number Qualifier is a '1' in the claim segment: Format = \$\$\$\$\$cc.
43Ø-DU	Gross Amount Due	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).	Required field: Format = \$\$\$\$\$cc.
4Ø9-D9	Ingredient Cost Submitted	Submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due' (43Ø-DU).	Required
423-DN	Basis of Cost Determination	Code indicating the method by which 'Ingredient Cost Submitted' (Field 4Ø9-D9) was calculated	Required Valid Values: ØØ, Ø1, Ø2, Ø3, Ør, Ø5, Ø6, Ø7, Ø8, Ø9, 1Ø, 11, 12

433-DX	Patient Paid Amount Submitted	Amount pharmacy received from the patient for the prescription dispensed.	Required when pharmacy received payment from client for this prescription. Default to Ø if nothing entered.

Coupon Segment - Request

Data elements not listed in this segment are not required by the DMAP.

Compound Segment - Request

Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field when the claim is a compound: 1Ø=Compound
45Ø-EF	Compound Dosage Form Description Code	Dosage form of the complete compound mixture.	Optional field:
451-EG	Compound Dispensing Unit Form Indicator	NCPDP standard product billing codes.	Required field when the claim is a compound: Enter the appropriate indicator which represents the total compound metric decimal quantity.
447-EC	Compound Ingredient Compound Count	Count of compound product IDs (both active and inactive) in the compound mixture submitted.	Required field when the claim is a compound: A count of 1 to 10 allowed for interactive submission. A count of 1 to 25 allowed for batch submission.
488-RE	Compound Product ID Qualifier	Code qualifying the type of product dispensed.	Required field when the claim is a compound: Ø3 = National Drug Code One to ten occurrences allowed.
489-TE	Compound Product ID	Product identification of an ingredient used in a compound.	Required field when the claim is a compound: Enter the 11 digit NDC number. One to ten occurrences allowed.
448-ED	Compound Ingredient Quantity	Amount expressed in metric decimal units of the product included in the compound mixture.	Required field when the claim is a compound: Enter the metric decimal quantity of the drug dispensed. Field length of 10 One to ten occurrences allowed.
449-EE	Compound Ingredient Drug Cost	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	Required field when the claim is a compound: Enter the ingredient cost. One to ten occurrences allowed.

Prior Authorization Segment - Request

Field	Field Name	Definition of Field	Delaware Requirements
Data elements not listed in this segment are not required by the DMAP.			

Clinical Segment - Request

Field	Field Name	Definition of Field	Delaware Requirements
111-AM	Segment Identification	Identifies the segment in the request and/or response.	Required field when the segment is used: 13=Clinical
491-VE	Diagnosis Code Count	Count of diagnosis occurrences.	1 occurrence allowed
492-WE	Diagnosis Code Qualifier	Code qualifying the 'Diagnosis Code' (Field 424-DO)	Required Field when the 'Diagnosis Code' field is used: Valid Value: Ø1
424-DO	Diagnosis Code	Code identifying the diagnosis of the patient.	Required field when the segment is used: If a prescriber has provided an ICD-9 code on a prescription, that code must be entered while entering the prescription information. The ICD-9 code is essential to the prior authorization process. Without an appropriate ICD-9 diagnosis code, claims for medications requiring prior authorization will not pay. Co-payment exemption V22 —client is pregnant, can be by declaration. V771 —for use on claim for glucose monitor only. V24 —post partum for 90 days after delivery. V60 --when DMMA coverage policy requires two strengths of one medication be used instead of multiple smaller doses.

2.4 Completion of the Pharmacy Claim Form - Non-POS

This section provides specific instructions for completing the NCPDP Pharmacy claim form for the DMAP. Paper claims must be the NCPDP copyright form that was created in 2000. All paper forms must use the black ink and gray highlighted version. Claim data must be completed with either blue or black ink. A sample of the Pharmacy claim form is included for your reference.

Include only what is required in the following instructions (e.g., no stickers, no stamps, no unnecessary handwritten comments).

Field Name	Instructions for Completion
Header Information	
ID	Required Field. Enter the client's 10-digit Medicaid client id number.
Group ID	Not required
Name	Not required
Plan Name	Not required

Field Name	Instructions for Completion
Patient Name	Required field. Enter the client's last name, first name, and middle initial
Other Coverage Code	Required field. Enter the value from the back of the claim form or Appendix A. Code 0 – Not specified should be used when no specific primary insurance information is available.
Person Code	Not required
Patient Date of Birth	Not required
Patient Gender Code	Not required
Patient Relationship Code	Not required
Pharmacy Name	Required field. Enter the name of the pharmacy providing the service
Address	Required field. Enter the pharmacy address including the city, state, and ZIP code
Service Provider ID	Required field. Enter the 10-digit NPI
Qual	Required field. Valid code is 01 – Medicaid
Phone No.	Enter the provider's phone number
FAX number	Enter the provider's FAX number
Workers Comp Information	Not required
Certification Statement	Not required
Claim #1	
Prescription/serv. Ref#	Required field. Enter the 7-digit prescription number assigned to this prescription
Qual	Required field. Valid code is 1 – RX billing
Date Written	Not required
Date of Service	Required field. Enter the month, day, and year of the date of service in MMDDCCYY format.
Fill#	Required field
QTY Dispensed	Required field. Enter the metric quantity dispensed including the decimal. Do not indicate ounces, pounds, or number of packages. Indicate the metric quantity in numbers only. Do not use letters such as cc, ml, caps, tab, etc. Do not round, e.g., if dispensing 25 (2.5 mil) vials = 60. Lypholized powder is per vial. Questions related to quantity definitions can be verified via the Web/VRS or by contacting HPES Provider Relations.
Days Supply	Required field. Enter the number of days the dispensed quantity will last the client when consumed at the prescribed rate. The Days Supply must be entered as a

Field Name	Instructions for Completion
	numeric value greater than 0 .
Product/Service ID	Required field. Enter the 11-digit NDC for the product that was dispensed. Use modified NDC numbers for over-the-counter items
Qual	Required field. Use code 03 – National Drug Code (NDC)
DAW Code	Required field. Enter code 1 – Substitution not allowed by subscriber
Prior Auth# Submitted	Optional field. Enter the prior authorization number
PA Type	Optional field. If a prior authorization number is enter, use code 1 – Prior authorization
Prescriber ID	Required field. Enter the prescribing practitioner's NPI number. Please refer to section 2.2.2 for additional information.
Qual	Required field – Valid Prescriber ID qualifiers are 01 NPI and 12 DEA
DUR/PPS Codes	Optional field – refer to Section 5.0 of the Pharmacy Provider Specific Manual
Basis Cost	Not applicable
Provider ID	Not applicable
Qual	Not applicable
Diagnosis Code	Optional field – If a prescriber has provided an ICD-9 code on a prescription, that code must be entered while entering the prescription information. The ICD-9 code is essential to the prior authorization process. Without an appropriate ICD-9 diagnosis code, claims for medications requiring prior authorization will not pay. Co-payment exemption V22 —client is pregnant, can be by declaration. V771 — for use on claim for glucose monitor only. V24 —post partum for 90 days after delivery. V60 --when DMMA coverage policy requires two strengths of one medication be used instead of multiple smaller doses.
Qual	Optional field unless a diagnosis code is entered. Valid code is 01 – International

Field Name	Instructions for Completion
	Classification of Diseases (ICD9)
Other Payer Date	Optional field. Enter the date the other insurance processed the claim using a MMDDCCYY format.
Other Payer ID	Must be 'PDP9999999' when Payer is Part D PDP Any valid NCPDP value if non-Part D PDP
Qual	Must be '99' when Payer is Part D PDP Any valid NCPDP value if non-Part D Payer
Other Payer Reject Codes	Value must be present if Part D PDP denied claim
Usual & Customary Charge	Required field. Refer to Section 4.0 of the Pharmacy Provider Specific Manual
Fee	Enter the amount in the following fields: Gross Amount Due, Other Payer Amount Paid, and Net Amount Due
Compound Prescription	If you are billing a compound, print the words COMPOUND RX in the product service id field. The compound information is located on the back of the claim form. The claim definitions are the same as Claim #1 section.
Name	Required field. Enter the name of the drug for each ingredient
NDC	Required field. Enter the 11-digit NDC for each ingredient
Quantity	Required field. Enter the metric quantity for each ingredient including the decimal
Cost	Required field. List the cost of the product. Refer to Section 4.0 of the Pharmacy Provider Specific section of the manual
Claim #2	Same as Claim #1

2.5 Pharmacy Claim Form

I.D. _____		GROUP I.D. _____	
NAME _____		PLAN NAME _____	
PATIENT NAME _____		OTHER COVERAGE CODE (1) _____	PERSON CODE (2) _____
PATIENT DATE OF BIRTH MM DD CCYY _____		PATIENT (3) GENDER CODE _____	PATIENT (4) RELATIONSHIP CODE _____
PHARMACY NAME _____			
ADDRESS _____		SERVICE PROVIDER I.D. _____	QUAL (5) _____
CITY _____		PHONE NO. () _____	
STATE & ZIP CODE _____		FAX NO. () _____	
WORKERS COMP. INFORMATION EMPLOYER NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____		I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below. PATIENT / AUTHORIZED REPRESENTATIVE _____	
CARRIER I.D. (6) _____		EMPLOYER PHONE NO. _____	
DATE OF INJURY MM DD CCYY _____		CLAIM (7) REFERENCE I.D. _____	

ATTENTION RECIPIENT
 PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>PRESCRIPTION / SERV. REF. #</th> <th>QUAL (8)</th> <th>DATE WRITTEN MM DD CCYY</th> <th>DATE OF SERVICE MM DD CCYY</th> <th>FILL#</th> <th>QTY DISPENSED (9)</th> <th>DAYS SUPPLY</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th>PRODUCT / SERVICE I.D.</th> <th>QUAL (10)</th> <th>DAW CODE</th> <th>PRIOR AUTH # SUBMITTED</th> <th>PA TYPE (11)</th> <th>PRESCRIBER I.D.</th> <th>QUAL (12)</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th>DUR/PPS CODES (13)</th> <th>BASIS COST (14)</th> <th>PROVIDER I.D.</th> <th>QUAL (15)</th> <th>DIAGNOSIS CODE</th> <th>QUAL (16)</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th>OTHER PAYER DATE MM DD CCYY</th> <th>OTHER PAYER I.D. QUAL (17)</th> <th>OTHER PAYER REJECT CODES</th> <th>USUAL & CUST. CHARGE</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY								PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)								DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)							OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D. QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE					1
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	INGREDIENT COST SUBMITTED DISPENSING FEE SUBMITTED INCENTIVE AMOUNT SUBMITTED OTHER AMOUNT SUBMITTED SALES TAX SUBMITTED GROSS AMOUNT DUE SUBMITTED PATIENT PAID AMOUNT OTHER PAYER AMOUNT PAID NET AMOUNT DUE
--	--

2.6 Medicare Part D Billing Instructions

2.6.1 This section provides instructions for submitting claims related to Medicare Part D.

- **If a client has Part D, the Part D PDP must always be billed first.**
- If the Part D PDP approves the claim, a COB segment must be completed with a '99' Payer ID qualifier, a 'PDP9999999' Other Payer ID, and an other payer amount paid must be present, even if the paid amount is \$0.00.
- If the Part D PDP denies the claim, a COB segment must be completed with a '99' Payer ID qualifier, a 'PDP9999999' Payer ID, and an other payer reject code must be present. Pharmacies should not use the NCPDP other coverage codes listed in Appendix A to mask that the claim was rejected by the PDP.
- If the claim is routed through the TrOOP Facilitator, the PCN value must be '**PDMAPPARTD**'.
- For paper claims, if a client has Part D, the Part D qualifier must be completed in field 'QUAL (17)' and the Part D payer ID must be completed in field 'other payer ID'. Either the Part D reject code must be completed in field 'other payer reject codes' or the 'other payer amount paid' field must contain the Part D approved amount, which can be \$0.00 if the PDP approved the claim at \$0.00.
- For paper claims, if a reject code is present, it will be associated with the payer ID and qualifier from the claim.
- For paper claims, if both a reject code and an 'other payer amount paid' is present on the claim, only the reject code will be associated with the payer ID and qualifier from the claim. The paid amount will not be associated to the payer ID and qualifier.
- For paper claims, if the client has both Part D and TPL:
 - If the Part D PDP paid/approved the claim and the TPL carrier denied the claim, complete the form with the PDP information and include the TPL denial.
 - If the Part D PDP denied the claim and the TPL carrier denied the claim, complete the form with the PDP information and include the TPL denial.

- If the Part D PDP denied the claim and the TPL carrier paid the claim, complete the form with the PDP information and place only the TPL payment in the 'other payer amount paid' field on the claim. Include the TPL payment voucher.
- If the Part D PDP paid the claim and the TPL carrier paid the claim, complete the form with the PDP information. Only indicate the PDP payment in the 'other payer amount paid' field on the claim. Include the TPL payment voucher indicating the TPL payment.

2.6.2

The pharmacy is required to bill all active insurances before submitting a claim to CRDP.

- Primary coverage + Medicare Part D both pay on claim
 - If both the primary coverage and Medicare Part D coverage pay on the claim:

The pharmacy will need to bill the claim showing two Coordination of Benefit (COB) segments with paid amounts. The NCPDP other coverage code will need to be "02", other coverage exists payment collected.
- Primary coverage pays and Medicare Part D rejects claim
 - The pharmacy will need to submit claim with two COB segments. The first COB segment will need to show primary payer with paid amount on claim. The second COB segment will need to show Medicare Part D information with reject code. The NCPDP code will need to be "02", other coverage exists payment collected.
- Primary coverage rejects claim and Medicare Part D pays on claim.
 - The pharmacy will need to submit the COB segment for Medicare Part D with a paid amount and the NCPDP other coverage code "03", other coverage exists payment not collected, showing the primary coverage rejected the claim.

2.6.3

If a client is eligible for a Medicare Part D PDP and has not yet enrolled and has just become eligible for DMMA services, **WELLPOINT (transitional enrollment)** must be billed. 1-800-622-0210

2.7 DMAC Pricing Inquiry Worksheet

Instructions

The DMAC Pricing Inquiry Worksheet provides the opportunity for a pharmacy to indicate any difficulty that has been experienced in obtaining a specific drug at the price listed on the Delaware Maximum Allowable Cost list (DMAC) provided by the Delaware Medical Assistance Program. To ensure a timely response to comments for each drug that the pharmacy is not able to purchase at the State's MAC, the pharmacy must complete the attached form and include the following:

- NDC Code for the lowest priced product available
- Drug label name
- Generic name and strength
- Lowest price for which the pharmacy can obtain the drug
- Source of the product
- NDC(s) for other products that were researched
- Purchase invoice to document pricing

The form must be **faxed to HPES Pharmacy Services at (302) 454-0224**. Failure to include all of the required information will result in the inability to respond to pricing issues. Each inquiry will be researched and reviewed, and upon completion, a written response will be provided within 10 business days.

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2.7.1

DMAC Pricing Inquiry Worksheet for Generic Drugs

PLEASE READ BELOW BEFORE SUBMITTING

- DMAC pricing is a composite pricing on generic medications. It factors in the number of generics available and also compares the price to other states.
- In order to question the DMAC price, fill out the below form and attach an invoice showing the pricing of all the currently available generics.
- Please note: AWP drug prices are managed by an external drug vendor. Updates are applied once weekly to the system when they become available. These updates occur every Friday morning. Please check the NDC lookup under interactive services to obtain the most current reimbursement rate. Since pharmacy services are point-of-sale processing, price inquiries that do warrant updates will not be priced earlier than the day they are received.

NDC	Label Name	Strength	Drug Vendor Source	Lowest Price	Date of Search

Submitted By: _____

Pharmacy: _____

Phone Number: _____

Fax Number: _____

By submission and signature of this form the provider is attesting that the Lowest Price submitted includes any discounts or reduction in cost associated with prompt payment, rebates or 'free good' programs.

(Invoice Must Be on Attached Page)

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3.0 Appendix A – NCPDP Other Coverage Codes

Code	Description
01	No other coverage
02	Other coverage exists – payment collected
03	Other coverage exists – claim not covered
04	Other coverage exists – payment not collected
05	Managed care plan denial
06	Other coverage denied – not participating provider
07	Other coverage exists – not in effect on DOS
08	Claim is billing for a copay

The exception codes should only be used for commercial plans that do not have an open network or where Medicare B has rejected the claim. Providers must bill Medicare B first for any medications or devices that are covered by the federal program. Providers may not use the NCPDP coverage codes if they do not have the ability or choose not to bill the primary carrier to use DMMA as a primary coverage.

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4.0 Appendix B – DMMA Tamper-Resistant Prescription Pad Legitimacy

If a prescription is not on tamper-resistant paper, the pharmacy personnel should:

1. Call the practice and verify the client, both name and age.
2. Verify the drug (including strength).
3. Verify the quantity.
4. Verify the refills.
5. If more than one medication is specified, verify that all the medications were ordered.
6. Document the date, time, and person who verified the prescription. Notations can be made on the hard copy of the prescription or electronically.
7. If the prescription cannot be confirmed at the time the medication is needed, dispense a 72-hour supply. If the medication is in a non-divisible package (e.g., antibiotic suspension, ophthalmic or optic drops) or any specialized packaging, dispense the entire quantity. If the prescription is a schedule II, document the reason the prescription was believed to be unaltered on the prescription and dispense the full quantity.
8. **If a practice continues to use non-tamper-resistant prescription forms, please contact the HPES Pharmacy Call Center at 1-800-999-3371, option 0, and then option 1.**
9. DMMA is prepared to assist providers with an immediate, temporary supply of compliant prescription pads.

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