

STATE OF OHIO
DEPARTMENT OF ADMINISTRATIVE SERVICES
GENERAL SERVICES DIVISION
OFFICE OF PROCUREMENT SERVICES
4200 SURFACE ROAD, COLUMBUS, OH 43228-1395

REQUIREMENTS CONTRACT: STATE OF OHIO EMPLOYEE PHARMACY BENEFITS MANAGEMENT (PBM) SERVICES

CONTRACT No.: CSP900510

EFFECTIVE DATES: 07/01/09 to 06/30/12

The Department of Administrative Services has accepted Proposals submitted in response to Request for Proposal (RFP) No. CSP900510 that opened on February 27, 2009. The evaluation of the Proposal responses has been completed. The Offeror listed herein has been determined to be the highest ranking Offeror and has been awarded a Contract for the services listed. The respective Proposal response including, Contract Terms & Conditions, any Proposal amendment, special Contract Terms & Conditions, specifications, pricing schedules and any attachments incorporated by reference and accepted by DAS become a part of this Services Contract.

This Requirements Contract is effective beginning and ending on the dates noted above unless, prior to the expiration date, the Contract is renewed, terminated, or cancelled in accordance with the Contract Terms and Conditions.

This Requirements Contract is available to the Ohio Department of Administrative Services, Benefits Administration Services Office as applicable.

The BAS Office is eligible to utilize the contracted services in any amount and at any time as determined by the agency. The State makes no representation or guarantee that the agency will purchase the volume of services as advertised in the Request for Proposal.

Questions regarding this and/or the Requirements Contract may be directed to:

Dana L. King, CPPB
dana.king@das.state.oh.us

This Requirements Contract and any Amendments thereto are available from the DAS Web site at the following address:



www.ohio.gov/procure

Signed: _____
Hugh Quill, Director

A. CONTRACT REQUIREMENT SYNOPSIS: This section gives only a summary of the Project requirements and the Contractor's responsibilities. The Contractor shall provide and/or coordinate services related to the following:

1. All aspects of the PBM program and serve as the single point of accountability and management for the Contract.
2. Implementation and transition services.
3. Claims Processing.
4. Retail Network.
5. Mail Order.
6. Exclusive Specialty services.
7. Formulary and rebates management.
8. Clinical programs and edits.
9. Customer service.
10. Member Card production.

B. DEFINITIONS.

1. AGENCY. The Ohio Department of Administrative Services (DAS), Office of Benefits Administration Services (BAS).
2. AWP. The average wholesale price of the Covered Drug (whether dispensed through the Retail Pharmacy Program or the Mail Order Pharmacy Program), based on its 11 digit National Drug Code (NDC), as supplied on the date of service by First DataBank's National Drug Data File, or other nationally recognized source selected by Contractor, provided that in no event will Contractor utilize more than one pricing source concurrently. For a given Covered Drug, the Contractor must use the same AWP in calculating both the price to be paid by the State and the price to be paid to the Participating Pharmacy. If First DataBank or other applicable source changes the methodology for calculating AWP or pricing for Covered Drugs in a way that materially changes the economics of the Program, the parties shall negotiate in good faith to modify the Program Pricing Terms to preserve the parties' relative economics before such changed methodology. If, after 90 days, the parties have been unable to reach agreement on an equitable modification to the Program Pricing Terms, then either party may terminate this Contract with 60 days written notice to the other party.
3. BRAND NAME DRUGS. All brand drugs set forth in First Databank's National Drug Data File, or such other nationally recognized source, as reasonably determined by Contractor, provided that in no event will more than one source be used concurrently for this purpose. The Contractor shall not modify the brand/generic classification of a drug without the State's prior written consent. Once a drug has been classified as a Brand Name Drug, it shall be used as such for all contractual terms inclusive of pricing guarantees, rebates, and other financial considerations.
4. BUSINESS DAYS. All days except Saturdays, Sundays and holidays. All references to "day(s)" are to calendar days unless "business day" is specified.
5. CALENDAR YEAR. January 1 through December 31 of the respective year.
6. COMPOUND PRESCRIPTION. A prescription that meets the following criteria: two (2) or more solid, semi-solid, or liquid ingredients, at least one of which is a Covered Drug, that are weighed or measured then prepared according to the prescriber's order and the pharmacist's art.
7. CONTRACT. This Contract for pharmacy benefits management services between the State and Contractor and which is composed of all documents as listed in Part Five of this RFP.

8. CONTRACT ADMINISTRATOR. The BAS representative responsible for Contract administration.
9. CONTRACT QUARTER. The full three (3) month period commencing on the Effective Date, and each full consecutive three (3) month period thereafter that this Contract remains in effect.
10. CONTRACT YEAR. The full 12 month period commencing on the Effective Date, and each full consecutive 12 month period thereafter that this Contract remains in effect.
11. CONTRACTOR'S PROPOSAL. The final Proposal, including any addenda and negotiated changes as described in Part Four of the RFP, submitted by Contractor in response to the RFP and accepted by the State via the Contract award, and which is an integral part of this Contract.
12. COPAYMENT AND/OR COINSURANCE. The amount to be paid by an Eligible Person for each prescription or authorized refill as designated for each Group in the applicable Plan Design(s). Eligible Persons will pay the lowest of:
 - a. Copayment/Coinsurance amount;
 - b. U&C;
 - c. MAC, where applicable, plus the Dispensing Fee contracted with the pharmacy; or
 - d. AWP less the AWP discount plus the Dispensing Fee contracted with the pharmacy.

In no event will an Eligible Person pay the full Copayment/Coinsurance amount if the reimbursement amount contracted with the pharmacy is lower.

13. COVERED DRUGS. The prescription drugs or other items or supplies (which may include over the counter ("OTC") products) for which an Eligible Person has prescription benefit coverage. Prescription Drugs or other items or supplies that are not Covered Drugs, shall be "Exclusions." Covered Drugs and/or Exclusions applicable to any individual Group will be designated by the State in the applicable Plan Design.
14. CPT. Physician's Current Procedural Terminology - Unique sets of five-digit codes that identify the medical service or procedure performed by physicians and other providers; services established by the CPT Editorial Panel of the American Medical Association (AMA), has become the industry coding standard for reporting.
15. DAW - Dispense as Written. A notation used by physicians that will determine whether or not generic substitution is to occur when a prescription is filled. The dispensing pharmacist translates the notation of the physician when submitting a claim.
16. DAW 2 Penalty. Dispense as Written. The DAW 2 code is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the patient requests the brand product.

Penalty. In the current plan design, the member is responsible for the difference in the cost between the brand and the generic drug cost.
17. DISPENSING FEE. The amount payable by the State pursuant to this Contract for a Participating Pharmacy or Contractor to dispense a prescription or authorized refill to an Eligible Person. The State will receive the benefit of the Contractor's contracted pharmacy dispensing fee rates. Such rates shall be passed through to the State without any mark-up by the Contractor.
18. DM. Disease Management. Refers to a system of coordinated health care interventions and communications for individuals with Covered Diseases in which patient self-care efforts are significant.
19. DUR. Drug Utilization Review - A system of drug use review that can detect potential adverse drug interactions, drug-pregnancy conflicts, therapeutic duplication, drug-age conflicts, etc. There are three (3) forms of DUR:
 - a. Prospective (before dispensing).
 - b. Concurrent (at the time of prescription dispensing)
 - c. Retrospective (after the therapy has been completed).

DUR can reduce hospitalization and other costs related to inappropriate drug use.

20. **ELIGIBLE PERSON.** Each person who, through affiliation with a Group, is eligible for prescription drug benefits pursuant to this Contract, and such person's qualified dependents.
21. **GENERIC DRUG.** A generic drug set forth in First Databank's National Drug Data File, or such other nationally recognized source, as reasonably determined by Contractor, provided that in no event will more than one source be used concurrently for this purpose. Contractor shall not modify the generic/brand classification of a drug without the State's prior written consent. Once a drug has been classified as a Generic Drug, it will be used as such for all contractual terms inclusive of pricing guarantees, rebates and other financial considerations.
22. **GROUP.** A group of Eligible Persons that have the same Plan Design as designated by the State.
23. **ICD 9.** International Classification of Diseases, 9th Revision - A statistical classification system consisting of a listing of diagnoses and identifying codes for reporting diagnosis of health plan enrollees identified by physicians; coding and terminology to accurately describe primary and secondary diagnosis and provide for consistent documentation for claims; the codes are revised periodically by the World Health Organizations; since the Medicare Catastrophic Coverage Act of 1988, ICD-9 is mandatory for Medicare claims.
24. **INTEGRATED PROGRAM.** A program in which Eligible Persons enrolled in such program may have prescriptions dispensed either by:
 - a. A Participating Pharmacy under the Retail Pharmacy Program; or
 - b. The Contractor under the Mail Order Pharmacy Program.

Reference to the Retail Pharmacy Program and/or Mail Order Pharmacy Program herein will include services performed by Contractor for Eligible Persons enrolled in the Integrated Program.
25. **MAC AND/OR THE MAXIMUM ALLOWABLE COST.** Consists of a list of generic drugs subject to maximum allowable cost payment schedules developed or selected by Contractor. The payment schedules specify the maximum unit ingredient cost payable by the State, and to the Participating Pharmacy, for drugs on the MAC list. The MAC list and payment schedules are frequently updated. For a given generic Covered Drug, the Contractor must use the same MAC in calculating both the price to be paid by the State and the price to be paid to the Participating Pharmacy.
26. **MAIL ORDER PHARMACY PROGRAM.** The Contractor's program, as described in Contractor's Proposal and meeting the PBM Service Requirements set forth in Attachment One, Part One to the RFP, in which Eligible Persons may submit a prescription along with the applicable Copayment/Coinsurance to Contractor for dispensing via mail order.
27. **NON-PROTOCOL PRESCRIPTIONS.** Mail Order Pharmacy Program prescriptions for Covered Drugs received by Contractor that are in stock and which do not require physician or patient contact or other non-standard procedures prior to dispensing by Contractor.
28. **ON-LINE SYSTEM.** The Contractor's real time, on-line system for adjudicating prescription drug claims submitted by retail pharmacies.
29. **PA.** Prior Authorization.
30. **PARTICIPATING PHARMACY.** A retail pharmacy that has entered into an arrangement with Contractor that specifies the terms and conditions of the pharmacy's participation in Contractor's retail pharmacy network servicing the State's Program, including the rates that Contractor will pay the pharmacy.
31. **PHM.** Population Health Management. Refers to a comprehensive approach to health management that involves the integration, coordination, and management of all of a population's healthcare needs covering the full continuum of health, from health and wellness to serious illness.
32. **PLAN DESIGN.** Program drug coverage, days supply limitation, Copayment/Coinsurance, Formulary (including Formulary drug selection and relative cost indication), and other Program specifications applicable to the Program designated by the State as set forth in this Contract or otherwise documented between the parties.

33. PMPM. Per Member Per Month. In this context, refers to the cost of providing subject pharmacy service stated as the average cost to provide that service to one (1) eligible member for one (1) month.
34. PRIMARY ELIGIBLE PARTICIPANT. Each Eligible Person, excluding Eligible Persons who are qualified dependents.
35. PROGRAM. The State's pharmacy benefit program that is the subject of the RFP and Contractor's Proposal.
36. PROGRAM PRICING TERMS. The (i) financial or pricing terms, allowances, guarantees and incentives set forth in the Contractor's Proposal, (ii) performance standards and penalties set forth in Contractor's Proposal, and (iii) any funds due the State from the collection of rebates, administrative fees, and other program fees received by Contractor from pharmaceutical manufacturers relating to the State's Covered Drug utilization.
37. QUALITY ASSURANCE/QUALITY ASSESSMENT. The activity that monitors the level of care being provided by physicians, medical institutions, or any health care provider in order to ensure that health plan enrollees are receiving the best possible care. The level of care is measured against pre-established standards, some of which are mandated by law.
38. RETAIL PHARMACY PROGRAM. Contractor's program, as described in Contractor's Proposal and meeting the PBM Service Requirements set forth in Attachment One, Part One to the RFP, in which Eligible Persons may purchase Covered Drugs from a Participating Pharmacy upon verification of Program eligibility and payment of the applicable Copayment/Coinsurance, and the claim is submitted by the Participating Pharmacy to Contractor for payment in accordance with this Contract and the applicable Contractor Participating Pharmacy Contract.
39. RFP. That certain Request for Proposal for State of Ohio Employee Pharmacy Benefits Management (PBM) Services numbered as CSP900510, issued by the state of Ohio, through the Department of Administrative Services, Office of Procurement Services, for the Benefits Administration Services Office, including any addenda, which by its terms is an integral part of this Contract.
40. SPECIALTY DRUGS. Those pharmaceutical products that have been selected by the State to be part of its Specialty Drug Program. Such pharmaceutical products are generally biotechnological in nature, with many requiring injection or other non-oral methods of administration, and that have special shipping or handling requirements. Following the Effective Date, new products and pricing shall be added to the list of Specialty Drugs upon mutual agreement of the parties.
41. STATE. Refers to the state of Ohio, through any of its departments, agencies, or representatives.
42. STATE OF OHIO FISCAL YEAR. The period from July 1 of a given calendar year through June 30 of the following calendar year.
43. SUBCONTRACTOR. Any service provider hired under contract with the Contractor to meet the requirements of this agreement.
44. TERM BY ABSENCE. The process where a member's eligibility for drug coverage would be terminated if the State does not include that member's information on an eligibility file sent to the PBM. This allows the State to terminate a member's eligibility for drug coverage without having to create a specific record on the eligibility file sent to the PBM.
45. U & C. Usual and Customary.
46. VENDOR/CONTRACTOR. A successful Offeror who will perform the duties specified in the Contract.

C. MUTUALLY AGREED UPON CLARIFICATIONS AND MODIFICATIONS – STATE OF OHIO EMPLOYEE PBM PROGRAM

1. The general Terms and Conditions for the Contract are contained in Attachment Three of the RFP for Project. The Contract consists of:
 - a. The original RFP and any addendums.
 - b. The documents and materials incorporated by reference in the RFP.
 - c. The Contactor's Proposals, as amended, clarified, and accepted by the State.
 - d. The documents and materials incorporated by reference in the Offeror's Proposal and subsequent accepted clarifications.
 - e. Any related amendments issued subsequent to Contract award.
2. The BAS Office and the Contractor shall notify the DAS, Office of Procurement Services within ten (10) business days in the event of a change in personnel, financial, or contact information.
3. Contract Term. The term of this Contract shall be from 7/1/09 through 6/30/12. The State may renew this Contract for up to two (2) additional years, subject to and contingent upon the discretionary decision of the Ohio General Assembly; the appropriation of funds for this activity; and the satisfactory performance of the Contractor.
4. The State reserves the right to negotiate cooperative purchasing efforts with other government entities during the initial or renewal Contract term(s).

The Contractor shall provide the DAS Office of Procurement updated insurance, DMA, and EOD forms for the Contractor's organization on an annual basis, or as appropriate when changes go into effect. In addition, the Contractor shall submit, on an annual basis, its financial statements that have been prepared in accordance with Generally Accepted Accounting Principles (GAAP) in the United States of America and audited in accordance with GAAP in the United States of America. The financial statements shall be submitted to the OPS within 30 days of the closing of the Contractor's fiscal year.

5. The State shall ensure accurate historical claims data from the third party payors is sent in a timely manner to the Contractor in an agreed upon format which the Contractor can receive, analyze and test.
6. The Contractor shall sign and return to the state of Ohio the Business Associate Agreement in Supplement One of the RFP.

D. GENERAL PBM PROGRAM REQUIREMENTS.

1. MARKET EXPERIENCE AND CRITICAL COMPONENTS.

- a. Disaster Recovery. The Contractor shall maintain disaster recovery plans for all of the following services:
 - 1) Customer Service
 - 2) Mail Order
 - 3) Specialty Pharmacy
 - 4) Claims Processing
 - 5) Web site

The Contractor shall review all disaster recovery plans on an annual basis and update as necessary.

- b. \$4 - \$10 Generic Program. The Contractor shall work with the State to develop and implement a PBM program that optimizes these retail options, with the goal of increasing generic utilization.
- c. Pharmacy Program Fund (PPF).
 - 1) The process that will be used to access the fund. The State may draw upon the Pharmacy Program Fund (PPF) to pay for additional services and programs associated with the State's Pharmacy Benefit Program. For services and programs provided by the Contractor, the Contractor shall be responsible for any required documentation. Payment for such programs will be deducted directly from the Pharmacy Program Fund upon the State's approval.

- 2) If external services or programs are purchased, the State shall provide documentation to the Contractor regarding the services or programs purchased. The written documentation shall include:
 - a) A description of the services or products.
 - b) The fair market value of the services or products.
 - c) If not readily apparent, a clear description of how the products or services relate to a program, service, report, or communication that allows the State to manage their pharmacy trend or educate their members or prescribers.
 - d) Invoices outlining associated charges and fees.
- 3) The Pharmacy Program Fund can be utilized for member/prescriber mailings. The costs associated with these mailings shall be documented at fair market value and deducted from balance.
- 4) The allocation of funds shall be tracked by the Contractor and the balance reported on a yearly basis or at the request of the State. Agreement shall be sought by both parties prior to the funds being used for program implementation, service, reporting, communication, etc.
- 5) The Contractor shall reimburse the State for any such external services or programs from the Pharmacy Program Fund within 30 days of receipt of adequate written documentation of such expenses from the State.

2. CLAIMS ADJUDICATION AND INFORMATION TECHNOLOGY.

- a. AWP source used to adjudicate charges. The Contractor shall utilize a nationally recognized publication source for drug pricing information. Currently, the Contractor utilizes Medi-Span as the source for AWP pricing for all claims, including retail, mail order, and specialty. Files are updated on a weekly basis. The Contractor shall maintain a single source of AWP pricing for all distribution channels. The state of Ohio requires notification in writing at least 60 days prior to a change in the source of AWP pricing.
- b. First Data Bank Settlement. The state of Ohio and the Contractor recognize that AWP may be re-valued or replaced on an industry-wide basis with respect to a number of prescription drugs pursuant to a court sanctioned settlement or judicial order; in which event the state of Ohio agrees that the terms of this Contract shall be adjusted to provide each Party with the same economic result it had enjoyed immediately prior to such event. To implement such an adjustment, the Contractor shall provide written notice to the State (BAS and OPS offices) with language or formula changes constituting the adjustment, accompanied by documentation of an analysis reasonably demonstrating that the adjustment places each Party in substantially the same position as before the change regarding the valuation or use of AWP.
- c. In the event that the Contractor elects to adjust the pricing terms or financial guarantees based on the above event, the Contractor shall provide the State at least 60 days prior written notice of such changes or, if such notice is not feasible, as much notice as is reasonably possible. The State may object to the adjustment by providing written notice to the Contractor within 45 days of receipt of notice from the Contractor.

If the State objects to the revised pricing terms, the parties will negotiate, in good faith, to revise the Contractor's adjustment to certain pricing terms relating to the triggering event. If the parties cannot agree within 90 days of the Contractor the State's written notice, either party may terminate this Contract by providing the other party at least 90 days prior written notice.

In the event the State does not timely object, the State will have no right to terminate this Contract prior to the natural expiration date of the then-current Term based on the revised pricing.

Unless agreed otherwise by the parties in the aforementioned described negotiations, the revised pricing terms noticed by the Contractor shall be effective as of the calendar quarter following the date notice is given by the Contractor, or such earlier date following notice given by the Contractor as any law mandating such change may become effective.

- d. FSA. The Contractor agrees to deduct copayments, deductibles, and/or co-insurance from a member's FSA account.
- e. Integration of Claims Data. Network claims shall be processed in "real-time," by the Contractor whether fulfilled by a retail, mail service, or specialty provider. Non-network claims will be processed via the direct member reimbursement process.

- f. Reference Based Pricing Reimbursement. Upon request by the state of Ohio, the Contractor shall work with the State to determine the appropriate reference base price within targeted therapeutic classes as mutually defined and agreed upon. A reference base price shall be instituted within a therapeutic GPI; this baseline price shall be the basis for all other drugs within that class (i.e., coverage for drugs costing over the established baseline shall be covered as determined by the State, for example, not covered, covered, higher copay than the baseline price, etc.)
- g. Real-Time Overrides for Prior Authorization. The state of Ohio shall have access to the Contractor's systems too manage prior authorizations, implement overrides, and view historical claims data.

3. MAIL SERVICE.

- a. Location of Mail Service for the state of Ohio. Mail service for the state of Ohio shall be provided by the Contractor's mail service facility in Avon Lake, Ohio.
- b. Development of Mail Strategy. The Contractor shall work with the state of Ohio to develop a strategy to encourage and increase overall mail participation with the elimination of mandatory mail beginning July 1, 2009.
- c. System Access to track Status. The Contractor shall provide the state of Ohio access to systems which track the fulfillment status of individual participant prescriptions in order to facilitate and resolve customer questions.
- d. Communication with patients when there is a problem filling a prescription at mail. The Contractor shall reach out to the patient if there is a problem filling a prescription including but not limited to the following reasons:
 - 1) Medication is unavailable. At the request of the member the Contractor shall contact the prescribing physician to see if there is an alternative drug that may be dispensed. If the prescribing physician approves the dispensing of an alternative drug, the Contractor shall provide notification of the change of prescribed drugs along with the new medication. If the prescribing physician does not approve an alternative medication, the prescription shall be returned to the member with explanation and instructions to utilize a retail pharmacy to fill the prescription.
 - 2) Prior Authorization is expiring
 - 3) More than one prescription sent in with one that is problematic. All others without problems shall be processed. The member shall be notified regarding the incomplete order and the reason for the delay of problematic item.
 - 4) Prescription has expired.
 - 5) Incomplete prescription (if attempt to contact prescriber is unsuccessful). The Contractor shall attempt to contact the patient by phone or if an e-mail address is available, via e-mail. If a phone attempt is unsuccessful, a letter shall be sent.

The communication shall include the following information:

- 1) A description of the issue
 - 2) What options are available to patient to obtain the medication
 - 3) Contact information for questions
- e. Proactive Communication with patients. The Contractor shall reach out to the patient proactively to help ensure medication adherence. Some examples of times when proactive communication would apply include:
 - 1) Prior Authorization about to expire
 - 2) Prescription is about to expire – once a member has filled the last refill or within 30 days of the expiration date of a prescription

A letter providing the patient with timely notification will meet the State's needs.

f. Prescriber Communication.

- 1) Contact prescriber when prescription is going to expire. When a member places a refill order for a prescription that is either expired or has no refills remaining, The Contractor shall automatically contact the prescriber.
- 2) Contact prescriber when prior authorization request has not been returned within 24 to 48 hours

Three (3) attempts to contact the prescriber's office shall be made over three (3) consecutive business days. If a completed prior authorization form or letter with supporting documentation is not received on the fourth business day, a technical denial letter shall be faxed to the prescriber. This same process is followed if additional information is needed once a prior authorization request form is received from the provider. All requests that are technically denied shall be reconsidered once the appropriate information is received.

- 3) Contact prescriber when an incomplete prescription is sent to mail provider. Management of incomplete prescriptions includes a comprehensive attempt at resolution prior to member involvement. If an order is received by the mail service pharmacy that is incomplete, an attempt shall be made to resolve the error by direct contact with the prescriber's office. In the event an immediate resolution can not be obtained; three (3) attempts to make contact with the prescriber's office on three (3) consecutive business days shall be made. In the event the prescriber is not responding to the attempts at resolution, the order shall be forwarded to the call center to contact the member and inform them of the situation. At this point, the order shall be cancelled unless the member can intervene and provide assistance in clarifying the error.

g. Other Mail Order Requirements.

- 1) Compounding Services. The Contractor's mail service pharmacy shall provide compounding services for simple medications including topical creams and ointments or oral liquids. The mail service pharmacy does not provide compounding of sterile injectable or inhalation medications.
- 2) OTC Products. The mail service pharmacy currently provides all OTC medications that are included on the State's formulary and processed via prescription adjudication. The Contractor will collaborate with the State to evaluate the inclusion of other OTC products in the State's pharmacy program. The mail service pharmacy will make all reasonable efforts to provide any new OTC products covered by the State. Currently, the State's plan includes a provision whereby Prilosec OTC is covered with a copay incentive. The Contractor also recommends OTC nicotine replacement products be covered through the mail service utilizing a similar copay incentive, and shall work closely with the State and the mail service pharmacy to set up a program for members looking to quit smoking.
- 3) Generic substitution. The mail service pharmacy shall substitute a generic when available unless the member or prescriber specifically requests the brand medication.
- 4) Accepting New Prescriptions. The mail service pharmacy shall accept new prescriptions from prescribers either by mail, e-prescribing, fax, or via verbal authorization over the phone.
- 5) Payment Guidelines. Copayments shall be sent in by the member at the time of request for a prescription. If being filled via the Internet, phone or fax, electronic payment methods may be utilized. If the member has not included the copay with an order, the mail service pharmacy shall place the order, but contact the member for payment before dispensing and shipping.
- 6) Tracking Prescriptions. The Contractor shall provide members the ability to track their mail service prescriptions through the fulfillment process via the Web or via their dedicated toll-free number. The Contractor shall work with the State to develop other strategies to provide members information regarding the status of their prescription during the fulfillment process.
- 7) Shipping Prescriptions. The majority of prescriptions are to be shipped via US Postal Service First Class mail. However, the mail service pharmacy utilizes UPS for secure next day delivery when an order contains a Schedule II narcotic, a temperature-sensitive item, or an extremely high cost item.

All temperature sensitive products shall be shipped in refrigerated coolers with ice packs on an expedited basis through UPS. High value and extremely temperature sensitive medications shall be

shipped via Next Day Air. Other refrigerated products, such as insulin, shall be shipped via 2 Day Air.

If a member requests expedited shipping outside of normal mail service operating procedures, the mail service shall honor this request and charge a corresponding fee that is appropriate for the service requested.

In the unlikely event that a prescription needs to be sent through expedited shipping because of the actions of the mail service pharmacy, the Contractor shall not charge the member for shipping costs.

If a prescription is not received by the patient within ten (10) business days of shipping, an expedited reshipment of the order shall be sent to the member at The Contractor's expense. To ensure the maintenance of consistent drug therapy, reshipments, including those for damaged packages, are executed at the discretion of a registered pharmacist. Alternatively, a short-term prescription may be filled at a retail pharmacy when necessary.

The mail service does not require signature of high dollar orders. However, in the event a high dollar value item is processed and prepared to ship, the mail service pharmacy shall proactively contact the member to ensure the member shall be available for delivery prior to being shipped.

Shipping prescriptions directly to a prescriber's office is available upon the receipt of a request and explicit specifications.

4. FORMULARY AND REBATES.

- a. Formulary Updates. The timeline for updating the Contractor Preferred Drug List is once annually. The formulary shall be reviewed quarterly for new medication additions and annually for comprehensive drug revisions and deletions.
- b. Notification Regarding Changes to Formulary. The Contractor shall agree to notify the State of any modification to the formulary as well as develop strategies to more effectively communicate formulary changes. Methodologies include, but are not limited to:
 - 1) Prescribers
 - Formulary directory in hard copy
 - Formulary poster
 - Chart-sized formulary overview
 - Formulary accessible on our Web site
 - 2) Members
 - Pocket Preferred Drug List
 - Searchable formulary on our Web site
 - Targeted formulary change letters
 - 3) Pharmacies
 - Fax blasts regarding formulary changes
 - On-line messaging

The notification must include a statement as to the reason for the modification and must be provided at least 30 days prior to any negative formulary modification. In the event that the Contractor is removing a drug from the Formulary that is one of the top 15 drugs (by prescription volume) utilized by Eligible Persons, then the Contractor shall provide a more detailed analysis justifying the proposed removal of the drug from the Formulary.

- c. OTC Options and Member Education. The Contractor shall provide timely recommendations post-OTC launch regarding how the remaining prescription products within the OTC's class should be managed from a formulary perspective (if applicable). In addition, as deemed appropriate, the Contractor's Clinical Team shall develop targeted member mailings encouraging the use of OTC and Generic alternatives through education as well as money saving coupons. The Contractor shall work with the State to educate members regarding the practice of Generic substitution. The state of Ohio shall have the option to cover or exclude products that transition from Rx to OTC. Estimated impact savings analyses shall be provided for the State based on prescription products available.

- d. Rebates. The rebate agreement shall be a pass-through program in which 100% of all funds received from manufacturers related to the state of Ohio's utilization shall be passed to the State. This includes all administrative fees, formulary access fees, base rebates, performance rebates, data fees, and any other funds received from manufacturers related to the state of Ohio's utilization. Payment of rebates earned by the State shall be made quarterly with an annual true-up/reconciliation to be completed within 90 days following the end of the contract year.

The Contractor shall recommend, when appropriate, clinically-focused programs in partnership with pharmaceutical manufacturers on an opt-in basis and only when these programs support the specific goals of the state of Ohio. Initiatives include opt-in targeted letter programs with promotional coupons for over-the-counter products such as Prilosec OTC, paycheck stuffers which discuss the benefits of generic products, and prescriber over-the-counter sampling. These programs are not a profit center for the Contractor and any funds received are utilized to offset associated costs. The Contractor shall disclose any related agreement upon request from the State.

- f. Rebate Contract Changes. The Contractor shall provide notification of rebate contract changes that may impact the State during the term of the contract. The Client Services Team assigned to the State shall remain abreast of rebate contract changes and their impact on the State's program. The Contractor shall work with the State to implement a suitable notification process.
- g. Rebate Reconciliation and Reporting. The Contractor shall provide rebate reconciliation data at either the 11-digit NDC level or manufacturer level as requested by the State. In addition to providing the Rebate Reconciliation Report, the Contractor shall allow the State to have independent auditors review The Contractor's rebate contracts, billings, and cash collections to further assure that all funds are appropriately distributed.

5. DRUG UTILIZATION REVIEW AND CLINICAL PROGRAMS. The Contractor shall provide the following Drug Utilization Review strategies throughout the term of the Contract.

- a. Prospective DUR. Prospective DUR involves the assessment of prescribed drug therapy before the medication is dispensed to the patient. Prospective DUR consists of the following interventions and communication methods:
 - 1) Provider prescription profiling analysis and consultation
 - 2) Pharmacists academic detailing
 - 3) Provider and patient mailing to change prescription habits
 - 4) Step therapy prescribing guidelines
 - 5) Case management enhancement / intervention
 - 6) Quarterly newsletter with information on specific formularies, preferred products, and new medication guidelines
- b. Concurrent DUR. Concurrent DUR involves evaluation of drug therapy and intervention, if necessary, while the patient is undergoing therapy. Concurrent DUR may include elements of both prospective and retrospective DUR.
- c. Retrospective DUR. Retrospective DUR involves evaluation of medication already administered to a patient. On a monthly basis, drug therapy already administered to patients shall be reviewed by the Contractor clinical pharmacists to determine if the therapy met approved or standard of care criteria.
- d. Disease Management (DM) Program Interaction. The Contractor shall work with the State to customize disease management programs according to the needs of the State. Intervention activities include, but are not limited to, a series of targeted member and/or prescriber mailings, group member education/intervention, and targeted prescriber detailing.

The Contractor shall coordinate efforts with the State's utilization management, disease management, and case management vendors. The Contractor Clinical and Client Services Teams shall work closely with the vendors to jointly develop an action plan that incorporates the individual and joint goals of each organization. Specific tasks are outlined so that the Contractor and the vendors can work together to meet the needs of the State and their employees. Based on mutually agreed upon timeframes, The Contractor shall provide data and

reports to support the State's efforts to improve the health of its members. The current programs for this effort include Tobacco Cessation and Diabetes, but others may be added during the course of the contract.

- e. Diabetic Supplies. The Contractor agrees to collaborate with the State's Disease Management program on providing diabetic supplies for members who are enrolled in the state of Ohio Take Charge! Live Well! Diabetes Chronic Condition Management Program, when the items are ordered or prescribed by a physician. These items shall be discussed and agreed upon by the Contractor and the State to meet the needs of the State's plan participants.
- f. Prior Authorization. The Contractor categorizes prior authorizations as benefit design PAs or clinical PAs. Benefit design PAs are based on relevant client-specific plan design criteria and can be customized. Clinical PAs are clinical drug decisions based on FDA guidelines. The Contractor shall use this approach to the prior authorization service which is divided into two (2) levels based on the type of PA request.
 - 1) Level 1 Prior Authorization. Level 1 PAs are associated with routine benefit design exceptions such as vacation overrides, dosage change, and refill-too-soon exceptions. Level 1 PA requests are reviewed by nationally certified pharmacy technicians.
 - 2) Level 2 Prior Authorization. Level 2 PAs are associated with formulary and utilization management initiatives such as formulary alternatives and quantity limits, step therapy, and medical necessity reviews. Level 2 PA requests are conducted by the Prior Authorization Team composed of both pharmacists and nationally certified pharmacy technicians.

The Contractor's PA procedure may be modified based on the State's needs.

- g. Appeal Process. The Contractor shall follow the guidelines of the Appeal process outlined in the response to the RFP on pages 53 to 57.
- h. Academic Detailing. The Contractor shall provide two (2) full time dedicated pharmacists for the purpose of academic detailing as outline in the response to the RFP pages 59 to 60.
- i. Step Therapy Opportunities. The Contractor shall work with the State to investigate and implement Step Therapy programs that may include:

Potential Step Therapy Opportunities		
Category	Rationale	Prerequisite Requirements
Angiotensin II Receptor Antagonists (ARB)	Encourage use of first line angiotensin converting enzyme inhibitors (ACEI) prior ARB.	Checks claims history (180 days) for prior use of ACEIs. If systematic criteria are not met a prior authorization is required.
HMG CoA Reductase Inhibitors (Statins)	Requires use of generic statin prior to approval of a branded agent.	Checks claims history (180 days) for prior use of generic statin. Claims processes for Lipitor 80 mg or Crestor 40mg. If systematic criteria are not met prior authorization is required.
Proton Pump Inhibitors	Ensure the use of generic or OTC Proton Pump Inhibitors are utilized as first line agents.	Checks claims history (180 days) for use of generic or OTC Proton Pump Inhibitors. If systematic criteria are not met a prior authorization is required.

Potential Step Therapy Opportunities		
Category	Rationale	Prerequisite Requirements
Selective Serotonin Reuptake Inhibitors (SSRIs), Norepinephrine Selective Reuptake Inhibitors (SNRIs)	Ensure use of generic or preferred products as first line agents.	Checks claims history (180 days) for use of generic SSRI or SNRI prior to approval of non-preferred branded agent. If systemic criteria are not met, a prior authorization is required.

6. CUSTOMER SERVICE.

- a. Call Center. The Contractor shall provide a dedicated Customer Service phone number with custom messaging for the state of Ohio members, pharmacists and providers; 1-866-854-8850; and continue to maintain fully-integrated national Customer Service Centers throughout the United States which operate 24 hours a day, seven days a week, every day of the year.

The Contractor shall utilize the complaint process outlined in the response to the RFP on pages 74 and 75.

- b. Client Services Response Times. The Client Services Team shall respond to the State's phone calls and e-mails within two (2) hours of receipt. Even if an inquiry from the State cannot be fully satisfied within that time frame, a Client Services Team member shall still contact the State to report on the progress. If an issue requires additional research and input from other department staff members, resolution may take up to 48 hours.
- c. Web site. The Contractor shall work with the State to develop communications materials that promote the Contractor's Web site and services provided on the Web outlined on pages 79 – 87 of the response to the RFP

The Contractor shall work with the State to ensure that the employees working with the Pharmacy Benefit can access Web-based reports and other Web-based tools outlined on pages 87 and 88 of the response to the RFP.

The Contractor shall work with prescribers and pharmacists to ensure that they understand how to utilize the available technology in order to provide services to the State's plan participants as outlined on page 88 of the response to the RFP.

- d. Communication Opportunities. The Contractor shall customize communication materials to meet the specific needs of the state of Ohio. The Contractor shall customize communication materials upon request by the State as long as information provided adheres to nationally accepted guidelines and standards.

The Contractor shall provide written materials, such as pamphlets, articles and brochures for up to 30 annual, statewide open enrollment meetings, and/or regional wellness fairs at the state of Ohio's request. In addition, members of the State's Client and Clinical Service Teams shall be available at such meetings to answer questions.

7. NETWORK.

Network Audits. The Contractor shall provide Network audits and provide the State with reports identified in the response to the RFP pages 92 to 95.

8. ELIGIBILITY.

- a. Access for the state of Ohio. The Contractor shall provide access to the eligibility and adjudication system at no additional cost. The system shall enable real time, on-line updates of all related eligibility information. In addition, via this access, the State can manage prior authorizations, implement overrides, and view historical claims data.

- b. Reporting Eligibility Errors. The Contractor shall analyze eligibility transmission files for errors and rejects. Error and rejection reports shall be produced and, if necessary, the eligibility process shall be halted according to the State-established error threshold implemented for the eligibility process. Reports shall be reviewed immediately by the Contractor's Eligibility Team and discussed with the State for resolution of issues. In addition, The Contractor shall maintain an eligibility transmission schedule and shall notify the State when an expected file is not received.
- c. Retroactive Enrollments. The Contractor shall process retroactive adjustments based on changes in eligibility or benefit design. A member's enrollment shall be retroactively adjusted for a maximum period of 90 days. After the adjustment, the appropriate credit or deduction shall be applied to the State's account. The Contractor shall work with the State and member to rectify the processing of any claims that may have been impacted. In addition, The Contractor shall provide a retrospective termination report that identifies all claims paid for members that were subsequently terminated. This documentation is provided at no additional charge.

9. IMPLEMENTATION.

- a. The Contractor shall work with the State to transition mail service from Walgreens to the facility located in the state of Ohio effective July 1, 2009, following the detailed Work Plan outlined in the finalist interview questions.
- b. Communication. During the implementation of the new mail service provider, The Contractor shall also include communication regarding Web site enhancements and plan design changes scheduled to be implemented July 1, 2009 (examples include: Tobacco Cessation, Diabetes, Vitamin PA process, Epi Pens, etc.) along with typical implementation communication outlined on page 103 of the response to the RFP.

10. ACCOUNT MANAGEMENT. The Contractor agrees to provide the account management services outlined in the response to the RFP on pages 103 to 116.

11. MANAGEMENT REPORTS.

- a. The Contractor agrees to provide support and reporting as described in the Response to the RFP pages 116 to 123.
- b. The Contractor agrees to provide access to reports requested by the State's Chronic Condition and Disease Management programs and to develop mutually agreed upon timeframes for data exchanges.
- c. The Contractor agrees to provide access and training to the State to run standard reports.

12. SPECIALTY PHARMACY.

- a. The state of Ohio requires the option to renegotiate specialty pricing and services on an annual basis.
- b. The specialty pharmacy shall provide enrollment packages, brochures, employer announcement letters, and other implementation and disease state materials as requested by the Contractor for administration of the State's specialty program. They shall maintain systems for eligible members to submit refill requests via the Internet as well as by telephone and provide access to pharmacists 24 hours a day, seven days a week. Upon receipt of a prescription and required copayment, the specialty pharmacy shall provide covered drugs and clinical follow-up services to all participants upon request. In addition, the specialty pharmacy shall comply with performance guarantees as provided within the Pricing Proposal Form of the Cost Proposal.
- c. The Contractor shall provide the services outlined in the response to RFP pages 116 to 137 of the response to the RFP. The Contractor agrees to work with the State to develop cost managing/saving strategies related to the Specialty Pharmacy program.

E. GENERAL REQUIREMENTS – BUSINESS AND PRICING. The State and the Contractor are in agreement that:

1. Performance guarantee penalties shall be established to meet the state of Ohio's objectives. Program changes, including changes to the Formulary, shall not impact or change performance guarantees unless mutually agreed upon by the parties, and reduced to writing by the DAS, Office of Procurement Services.
2. Quarterly review meetings shall be held to review the operations and financial performance of the program. These meetings shall take place at the state of Ohio offices in Columbus, OH.
3. All meeting material shall be provided to all plan participants at least seven (7) business days before the quarterly meetings.
4. The state of Ohio requires a complete account team that can provide both daily operational support and strategic planning and analysis. All members must have experience with large employers and there must be two (2) dedicated, licensed pharmacists included as members of this team.
5. An annual member satisfaction survey shall be administered to state of Ohio plan participants after review and approval by the state of Ohio and the JHCC.
6. There are no additional fees (beyond those outlined in the pricing section) required to administer the services outlined in this Proposal.
7. The State's pharmacy utilization data shall be posted FTP or provided bi-weekly, monthly, or on a reasonable periodic schedule as required by the Contractor. The data shall include, at a minimum, the required data elements that have been outlined in Supplement One of the RFP, to up to ten (10) Contractors on behalf of the State at no additional cost.
8. The State shall ensure the Contractor receives one (1) year of historical pharmacy claims data at no additional cost.
9. The state of Ohio has the right to audit, with full cooperation of the Contractor, the services and pricing (including rebates) provided by the Contractor to validate compliance with all program requirements and contractual guarantees. All eligibility and claims data belong to the state of Ohio.
10. The state of Ohio shall not be held responsible for time or miscellaneous costs incurred by the PBM in association with an audit including, but not limited to, the costs associated with providing audit reports, system access or space.
11. The PBM must be, and continue to be, in total compliance with all HIPAA requirements including, but not limited to, safeguards of data integrity, confidentiality, and availability. Any data that contains patient-specific information that leaves the organization's firewall must be encrypted. (See specific information contained in Attachment One, Part One of the RFP.)
12. The Contractor shall provide system access for eight (8) state of Ohio associates (various security levels), and on-line reporting access for five (5) associates at no additional costs.
13. The Contractor shall provide on-line access to an ad hoc reporting tool and an eligibility updating tool and tool for tracking mail prescriptions.
14. The Contractor shall provide detailed customer service statistics for the state of Ohio membership experience on a quarterly basis.
15. Subcontractor oversight: <ol style="list-style-type: none"> a. The Contractor shall assume responsibility for its performance including the performance of any subcontractor. b. The state of Ohio shall consider the Contractor to be the sole point of contact with regard to contractual matters. c. The Contractor shall be fully responsible for any default by a subcontractor, just as if the Contractor itself had defaulted. d. The Contractor shall be solely responsible for satisfying any claims of its subcontractors for any suspension or termination and shall indemnify the state of Ohio for any liability to them. e. Each subcontractor shall hold the state of Ohio harmless for any damage caused to them from a suspension or termination and shall look solely to the Contractor for any compensation to which they may be entitled.
16. Eligibility information shall be received on a full replacement basis every two (2) weeks.
17. Eligibility information shall be processed and effective within two (2) business days of receipt of the eligibility information.
18. The Contractor shall be willing to allow formulary customizations with input from the state of Ohio if the State so chooses.
19. The Contractor shall be willing to dispense OTC products at retail and mail service with pricing as outlined in the pricing section.

20. The Contractor shall maintain a dedicated toll-free customer service phone line for state of Ohio members with hours of operation between 7 a.m. and 8 p.m. with some weekend hours.
21. The Contractor network shall maintain the following access standards: 99% of primary eligible participants shall have at least one (1) participating pharmacy within five (5) miles of his/her five (5) digit home zip code (where a retail pharmacy exists within five (5) miles).
22. The state of Ohio will review and approve any member communication materials before they are distributed to members.
23. The Contractor shall provide pharmacy related written materials (e.g., self-produced pamphlets, articles, brochures, etc.) to participants at up to 30 annual, statewide open enrollment meetings and/or regional wellness fairs and be available to answer questions.
24. The Contractor shall not implement or administer any program that results in the therapeutic switching of members from lower net cost products to higher net cost products without the prior written consent of the state of Ohio.
25. Member ID cards provided by the Contractor shall use non-social security number identification numbers for members.
26. The Contractor agrees to grandfather the formulary (preferred) copay for any state of Ohio members that are currently using non-formulary (non-preferred) products for a period of six (6) months post-implementation.
27. The Contractor shall load all current Prior Authorizations and open mail order refills that exist for current members from all existing PBMs.
28. The Contractor shall notify the state of Ohio if a formulary drug that is one(1) of the top 15 drugs (by prescription volume) utilized by the State members is targeted to be removed from the formulary utilized by the State and shall provide an analysis that justifies this decision.
29. The Contractor shall notify the state of Ohio and any individual impacted members of any deletions or tier changes to drugs on the Formulary 30 days prior to such changes.
30. The Contractor shall continue to be capable of customizing the paper claims review process to meet the State's needs.
31. The Contractor shall maintain a process and criteria for providing the initial review for copay exception requests.
32. The Contractor mail order service must notify state of Ohio members prior to substituting products that will result in a higher member copay.
33. The Contractor shall not transition state of Ohio from the claims adjudication platform that they are implemented onto during the term of this Contract.
34. Upon expiration or termination of the Contract, the Contractor shall, at the state of Ohio's request, provide mutually agreed upon post-termination services. These services shall include, but are not limited to the following: <ul style="list-style-type: none">a. Processing of mail service prescriptions not requiring clarification and electronically-submitted retail claims that are received prior to the termination date.b. Processing of paper claims for which it receives complete information and that were incurred prior to the termination date for a period of 90 days following the termination date.c. Provision of special reports requested by the state of Ohio.d. Transmission of eligibility and open refill files (including prior authorization) to the subsequent Contractor.e. Provision of claims history in a format as mutually agreed upon by both parties. Reports, eligibility files, open refill files and claims history files shall be provided within 30 days of receipt of written request by the state of Ohio unless otherwise agreed upon by both parties.
35. The state of Ohio, at its discretion, will provide coverage for selected pharmacy related medical supplies as well as durable medical equipment and will require the processing of these products through the Contractor's claims adjudication system provided that the product has been assigned a NDC number.

F. GENERAL REQUIREMENTS – PRICING. The State and the Contractor are in agreement that:

1. The state of Ohio will not provide a security deposit.
2. AWP is based on 11 digit NDC as supplied by a nationally recognized pricing source (i.e., First Databank or MediSpan) on the date of service (for both retail and mail).
3. The pricing shall be based on approved and paid claims not rejected or reversed claims.
4. Members will pay the lowest of: <ul style="list-style-type: none"> a. Copay; b. U&C; or c. Contracted rate <p>In no event will the member pay full copay if the contracted cost is lower.</p>
5. The Contractor shall pass-through 100% of negotiated discounts with network pharmacies at the point-of-service (i.e., the Contractor shall not retail spread as a revenue source).
6. The Contractor agrees to disclose all externally funded programs or services to the state of Ohio.
7. The state of Ohio shall require a quarterly report demonstrating that pass-through pricing has been achieved at retail.
8. The Contractor shall apply MAC at mail at NDC level discounts equal to or greater than the MAC discount rates applied at retail.
9. Minimum Generic Effective Rate Guarantees for both mail and retail shall be defined as follows: <p>[1-(Aggregate Discounted Ingredient Cost/ Aggregate Undiscounted AWP)]</p> <ul style="list-style-type: none"> a. Aggregate Discounted Ingredient Cost before the application of copayments shall be used in this calculation. b. Aggregate Undiscounted AWP shall be from a single, nationally recognized price source for all claims. c. Dispensing Fees shall not be included in the Aggregate Discounted Ingredient Cost. d. Both the Aggregate Discounted Ingredient Cost and Aggregate Undiscounted AWP from the date of adjudication shall be used. e. Aggregate Undiscounted AWP shall be the AWP of the 11-digit NDC of the product dispensed and in no event shall Average AWP be used. f. Both single-source and multi-source generic products shall be included in the guarantee. g. Claims paid 100% by the member copayment shall be included in the calculation with the applicable Discounted Ingredient Cost. h. Only compounds, defined Specialty claims through the Contractor's specialty pharmacy, OTC claims, and claims with ancillary charges shall be excluded from the calculation. i. Guarantees shall be reconciled in the aggregate on a semi-annual basis. Any shortfall between the actual result and the minimum guarantee shall be paid, dollar-for-dollar, to the client within 60 days of the end of the measurement period.
10. Minimum Brand Effective Rate Guarantees for both mail and retail shall be defined as follows: <p>[1-(Aggregate Discounted Ingredient Cost/ Aggregate Undiscounted AWP)]</p> <ul style="list-style-type: none"> a. Aggregate Discounted Ingredient Cost before the application of copayments shall be used in this calculation. b. Aggregate Undiscounted AWP shall be from a single, nationally recognized price source for all claims. c. Dispensing Fees shall not be included in the Aggregate Discounted Ingredient Cost. d. Both the Aggregate Discounted Ingredient Cost and Aggregate Undiscounted AWP from the date of adjudication shall be used. e. Aggregate Undiscounted AWP shall be the AWP of the 11-digit NDC of the product dispensed, and in no event shall Average AWP be used. f. Both Single-source and multi-source brand products shall be included in the guarantee. g. Claims paid 100% by the member copayment shall be included in the calculation with the applicable Discounted Ingredient Cost.

<p>h. Only compounds, defined Specialty claims through the Contractor's specialty pharmacy, and OTC claims shall be excluded from the calculation.</p> <p>i. Guarantees shall be reconciled in the aggregate on a semi-annual basis. Any shortfall between the actual result and the minimum guarantee shall be paid dollar-for-dollar to the client within 60 days of the end of the measurement period.</p>
<p>11. Maximum Brand and Generic Aggregate Dispensing Fee Guarantees for both mail and retail shall be defined as follows:</p> <p style="padding-left: 40px;">Aggregate Dispensing Fees of applicable claims / Total number of applicable claims</p> <p>a. Aggregate Dispensing Fees shall be the total of all dispensing fees charged on applicable claims before the application of copayments.</p> <p>b. Compounds, defined Specialty claims and OTC claims shall be excluded from the calculation.</p> <p>c. Guarantees shall be reconciled in the aggregate on a semi-annual basis. Any shortfall between the actual result and the minimum guarantee shall be paid dollar-for-dollar to the client within 60 days of the end of the measurement period.</p>
<p>12. 100% of manufacturer rebates and all administrative and other fees collected from pharmaceutical manufacturers based on the State's claims shall be paid to the state of Ohio.</p>
<p>13. All rebate revenue earned by state of Ohio shall be paid out to state of Ohio regardless of their termination status as a client.</p>
<p>14. The state of Ohio shall define the final list of products that are part of the specialty program. The state of Ohio and the Contractor shall mutually agree on the addition of new products and pricing to this list going forward.</p>
<p>15. The state of Ohio reserves the right to renegotiate improvements in the specialty pharmacy pricing on an annual basis.</p>
<p>16. The state of Ohio requires rebate and administrative fee reporting quarterly and payments on a quarterly basis (with an annual reconciliation to the guarantees).</p>
<p>17. Pricing elements (including fees) offered shall be effective and guaranteed for the term of the Contract (excluding the renegotiated specialty pricing) and shall not include adjustments for claims volume shifts amongst the various provider channels (i.e., mail utilization rates decline or 90 day retail utilization increases) or for changes in membership volumes.</p> <p style="padding-left: 40px;">Claims shall be priced at the time of adjudication for all dispensing methods (i.e., Retail, Mail Service, and Specialty).</p>
<p>18. Rebates offered are based on sponsor allowing up to a 30 days supply in the standard retail network, up to a 90 day supply in the retail 90 network, and up to 90 days at mail. The rebate offer by delivery channel shall apply regardless of actual achieved average day supply.</p>
<p>19. Retail 90 pricing shall apply on retail claims greater than 30 days supply dispensed at participating pharmacies. Mail order pricing shall apply to all claims that process via the mail benefit.</p>
<p>20. If the state of Ohio elects to make a formulary change from the Contractor's standard formulary that was proposed in response to this RFP (and used for generating the rebate guarantees outlined in the pricing section), the Contractor shall calculate the impact the formulary change will have on the rebates generated and provided to the state of Ohio within 30 days of a request. Rebate guarantee values shall be adjusted appropriately upon confirmation by the state of Ohio of such formulary change. In no event shall the other pricing parameters of the Contract be impacted. The Contractor also understands Nexium® shall be a non-formulary product.</p>
<p>21. The Contractor shall establish and fund a Pharmacy Program Fund (PPF) on a monthly basis with a value of \$0.15 PMPM for the state of Ohio to use for programs, reports, services, or communications that would help the state of Ohio manage its pharmacy trend or educate its members.</p> <p style="padding-left: 40px;">Examples of communications that the PPF would be used for include, but are not limited to: communication to members regarding potential negative drug interactions, targeted communication to members who are impacted by Formulary changes, and regulations that require changes in medications for members. The PPF would be used for the development, printing, and mailing of these communications.</p>
<p>22. The Contractor shall dispense medications if a member's current balance is less than or equal to \$125.00. The state of Ohio will not be responsible for any member outstanding balances.</p>

COST SUMMARY

TITLE: STATE OF OHIO EMPLOYEE PHARMACY BENEFITS MANAGEMENT (PBM) SERVICES

RFP NO.: CSP900510

INDEX NO.: DAS060T

UNSPSC NO.: 80101500

EFFECTIVE DATE OF SERVICES: July 1, 2009

ITEM NO.:

ADMIN FEES:	16207
PHARM. FEES:	16206

All pricing elements and/or performance guarantees (PGs) shall be based upon the Contractor's Best and Final Offer (BAFO) and negotiations which concluded on May 28, 2009.

CONTRACTOR INDEX

CONTRACTOR AND TERMS:

OAKS Vendor ID No.: HR00001254

Catalyst Health Solutions
800 King Farm Blvd.
Rockville, MD 20850

Remit to:

Remit checks via mail to:
Catalyst Rx
P.O. Box 60129
Charlotte, NC 28260-1616

Remit via Wire/ACH to:
Wachovia Bank, Rockville, MD
Account Name: Catalyst Rx
Account Number: 2000013846958
ABA Number: 055003201

Remit checks via overnight delivery:
Catalyst Rx
Lockbox #60129
1525 West WT Harris Blvd 2C2
Charlotte, NC 28260

CONTRACTOR'S CONTACTS:

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CONTRACT NO.: CSP900510-1 (06/30/12)

TERMS:

ADMIN FEES: Net 45 Days
PHARM. FEES: Net 10 Days

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