CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services

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340B Participation Notice Form for Kentucky Medicaid Managed Care Pharmacy Claims

Covered Entities wishing to participate in the 340B Program as it relates to the Kentucky Medicaid Managed Care Organization (MCO) **must** provide the Department for Medicaid Services (DMS) notice that it and any listed Contract Pharmacy **will** use 340B drugs to fill prescriptions for qualified pharmacy claims. Qualified pharmacy claims are only claims for Kentucky Medicaid MCO members who receive prescription drug benefits coverage and who are determined as eligible per the Health Resources and Services Administration (HRSA) 340B patient definition guidelines.

DMS is using a retrospective process where the Covered Entity's Third Party Administrator (TPA) or covered entity itself will provide a DMS-specified paid prescription claims file identifying claims for which the Covered Entity and/or its Contract Pharmacy provided drugs purchased under 340B.

This notice and associated processes conform with HRSA's 340B duplicate discount guidance recommending that Medicaid agencies and 340B Covered Entities have a process in place to avoid duplicate discounts for drug claims identified as 340B. This also allows DMS to monitor Covered Entities and their Contract Pharmacies for compliance with applicable State and Federal regulations.

IMPORTANT: By completing and signing the attached 340B **Participation Notice** form, the Covered Entity is notifying DMS they are participating in the 340B program along with any listed associated Contract Pharmacies. The Covered Entity must ensure the appropriate claims file is submitted in the required timeframe. The 340B Participation Notice form must be completed and submitted to DMS340B@ky.gov to participate. **DMS will not accept any paper or fax notices.**

- Completed and signed Participation Notice forms received by the 15th calendar day of the last month of the quarter are considered for inclusion in 340B participation for that quarter.
- In-house pharmacies **MUST** choose a method of participation at the end of the below form.
- Forms received after the required timeframe for a given quarter will be effective in the following quarter.

DMS will acknowledge receipt of the completed forms, via email, within seven (7) business days of receiving the forms. We strongly encourage Covered Entities to submit forms early in the event information is identified as missing or incorrect to allow time for correction and inclusion in the 340B program. DMS is not responsible for assuring corrections within the required timeframes and corrected forms must be received by DMS prior to the 15th calendar day of the last month of the quarter. Covered entities should submit an updated form immediately upon a change to the Operational or Executive Contact.

Please send any questions/concerns to DMS340B@ky.gov.

NOTE: This 340B Participation Form does not apply to Fee for Service (FFS) pharmacy claims. Covered Entities who want to use 340B drugs for pharmacy claims reimbursed under FFS must be appropriately registered in HRSA's quarterly Medicaid Exclusion File.

Covered Entity and/or Contract Pharmacy Information to Participate in 340B for Medicaid Managed Care
(Note: If more space is needed, please duplicate the below tables on additional pages.)

Covered Entity Information	
Executive Contact Person Information	
Name	
Email Address	
Phone	
Operations Contact Person Information	
Name	
Email Address	
Phone	
Covered Entity Information	
Facility Name	
NPI	
Address	
City	
State	
Zip Code	
340B ID	
Medicaid Number	

Pharmacy Information ☐ In-House ☐ Contract Pharmacy *please indicate the type of pharmacy	
Contact Person Information ☐ same as covered entity	
Name	
Email Address	

Phone	
Pharmacy Information	
Pharmacy Name	
NPI	
Address	
City	
State	
Zip Code	
Pharmacy Phone No.	

For In-House Pharmacies ONLY Please select one of the statements below in order for DMS to properly identify 340B claims for rebate exclusion. (Select only one)

☐ The Covered Entity will submit a claims file quarterly, in the DMS approved format, on behalf of the in-house pharmacy.

☐ The Covered Entity agrees that DMS will exclude **all** pharmacy claims for the above referenced in-house pharmacies.

Third Party Administrator (TPA) Name: ____

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Third Party Administrator Contact Name and Email Address: ________________________________

COVERED ENTITY____________________

Printed Name: ________________________

Signature: ____________________________

Title: ________________________________

Date: ________________________________

DEPARTMENT FOR MEDICAID SERVICES

Printed Name: ________________________

Signature: ____________________________

Title: ________________________________

Date: ________________________________

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