

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services

Andy BeshearGovernor

275 East Main Street, 6WA Frankfort, KY 40621 www.chfs.ky.gov Lisa D. Lee Commissioner

Eric C. Friedlander Secretary

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) <u>must</u> provide the Department for Medicaid Services (DMS) notice that it and any listed Contract Pharmacy <u>will</u> 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.

The Department for Medicaid Services (DMS) is using a retrospective process where the Covered Entity's Third Party Administrator (TPA) 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 work with its TPA to 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.**

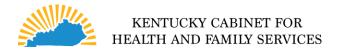
- Completed and signed Participation Notice forms received by the 15th calendar day of the last month of the quarter are considered for inclusion in 340B participation for that quarter.
- In-house pharmacies **MUST** choose a method of participation at the end of the below form.
- Forms received after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



Kentucky Medicaid Managed Care 340B Program Participation Notice

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. 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			
Contact Person Information			
Name			
Email Address			
Phone			
Covered Entity Information			
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				
Name				
NPI				
Address				
City				



Kentucky Medicaid Managed Ca Participation Notice	re 340B Program	
State		
Zip Code		
Pharmacy Phone No.		
identify 340B claims for rebate e ☐ The Covered Entity will s house pharmacy.	xclusion. (Select only on the control of the contro	of the statements below in order for DMS to properly one) rterly, in the DMS approved format, on behalf of the index de all pharmacy claims for the above referenced in-
Third Party Administrator (TPA)	Name:	
COVERED ENTITY		DEPARTMENT FOR MEDICAID SERVICES
Printed Name:		Printed Name:
Signature:		Signature:
Title:		Title:



Date: _____