PROVIDER MANUAL

Pharmacy Network Administration and Claims Processing

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Classification: Provider-Facing Operational Guidance

Document Control and Use

Version	Effective Date	Description	Approved By
1.0	October 2025	Original Provider Manual	Executive Team
2.0	January 2026	Expanded and updated Provider Manual	Executive Team

Important: This manual summarizes operational requirements for participating pharmacies. The Participating Pharmacy Agreement, applicable plan terms, state and federal law, and point-of-sale messaging control if there is a conflict. State-specific requirements may supplement or modify this manual.

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1. Introduction and Overview

Phoenix Benefits Management, LLC ("Phoenix") is a pharmacy benefit manager that provides pharmacy claims administration, network management, formulary support, utilization management, 340B-related services, hospice pharmacy support, and prescription discount-card programs for self-funded employer groups, third-party administrators, health care organizations, and other plan sponsors.

Phoenix seeks to simplify pharmacy benefit administration through clear information, flexible plan designs, transparent communication, and responsive provider support. Participating pharmacies are important partners in helping members obtain safe, clinically appropriate, and cost-effective prescription drug services.

This Provider Manual describes operational standards and procedures that apply to pharmacies participating in Phoenix-administered networks. It is intended to support accurate claims submission, regulatory compliance, timely reimbursement, member safety, and effective coordination between Phoenix and participating pharmacies.

2. Contact Information

Contact Type	Information
Mailing Address	Phoenix Benefits Management, LLC 410 Peachtree Parkway, Building 400, Suite 4225 Cumming, GA 30041
Provider Services	877-643-2067
Provider Service Hours	Monday-Friday: 8:00 a.m.-10:00 p.m. Eastern Time Saturday-Sunday: 10:00 a.m.-6:00 p.m. Eastern Time
Website	www.PhoenixPBM.com
Regulatory and Provider Resources	www.PhoenixPBM.com/Regulatory
MAC Appeals and MAC List Requests	quality@phoenixpbm.com
Fraud, Waste, and Abuse Reports	877-643-2067

System Availability: The Rx Logic claims adjudication platform is generally available 24 hours a day, seven days a week, except during scheduled or emergency maintenance. Provider service staff are available during the hours listed above.

3. Network Participation

A pharmacy seeking participation in a Phoenix-administered network must complete the applicable contracting and credentialing process before submitting claims as a participating pharmacy. Participation is not effective until Phoenix confirms approval, executes or accepts the applicable agreement, and activates the pharmacy in Rx Logic.

3.1 Participation Request

- Contact Provider Services to request participation materials or network information.
- Submit all requested applications, agreements, tax information, licenses, insurance documents, ownership disclosures, and operational information.
- Provide accurate NCPDP, NPI, DEA, state license, tax identification, address, and contact information.
- Identify whether the pharmacy contracts directly or through a pharmacy services administrative organization (PSAO), chain headquarters, or other authorized contracting entity.
- Complete any additional requirements applicable to specialty, mail-order, long-term care, home infusion, compounding, or other specialized services.

3.2 Participation Standards

- Maintain all licenses, permits, registrations, and certifications required to provide pharmacy services.
- Maintain an active NCPDP Provider ID and NPI consistent with the pharmacy location and legal entity.
- Maintain DEA registration when dispensing controlled substances.
- Maintain professional and general liability insurance in the amounts required by the Participating Pharmacy Agreement.
- Comply with applicable federal and state law, NCPDP standards, HIPAA, fraud-prevention requirements, and Phoenix policies.
- Possess the operational capability to submit and receive electronic pharmacy claims and point-of-sale messages.
- Remain in good standing and not be excluded, suspended, or debarred from applicable government health care programs.

3.3 Non-Discrimination and Fair Participation

Phoenix applies network participation and credentialing standards in a consistent manner. Participation decisions are based on licensure, credentialing, operational capability, contractual terms, network needs, quality, compliance, and applicable law. Phoenix does not discriminate based on pharmacy ownership or affiliation except where a lawful network design, specialty capability requirement, or other documented operational requirement applies.

4. Credentialing and Recredentialing

Phoenix credentials pharmacies before initial participation and periodically recredentials participating pharmacies to verify continued compliance with network standards. The process may be completed directly by Phoenix or supported by validated data sources and authorized vendors.

4.1 Initial Credentialing Documentation

- Completed credentialing application and certification;
- Current state pharmacy license and expiration date;
- DEA registration, when applicable;
- NCPDP Provider ID and NPI;
- Pharmacist-in-Charge information and license, when requested;
- Current certificate of insurance;
- Ownership, legal entity, tax identification, and contact information;
- W-9 and other tax documentation;
- Hours of operation and service capabilities;
- Any additional accreditation, licensure, or documentation required for specialized pharmacy services.

4.2 Primary-Source and Database Verification

Phoenix may verify pharmacy information using state boards of pharmacy, NPPES, DEA resources, NCPDP DataQ, exclusion databases, business-registration records, insurance certificates, and other reliable sources. A pharmacy must respond promptly to requests for clarification or missing documentation.

4.3 Recredentialing

Participating pharmacies are subject to recredentialing at least every three years, or more frequently when required by law, contract, accreditation standard, or a material change. Phoenix may request updated applications, licenses, insurance, ownership information, sanction disclosures, and other supporting documentation.

4.4 Material Changes

A pharmacy must notify Phoenix promptly, and no later than 30 calendar days unless a shorter period applies, of any material change, including:

- Ownership, controlling interest, legal entity, tax identification number, merger, acquisition, or sale;
- Change from PSAO participation to independent contracting, independent contracting to PSAO participation, or change in PSAO affiliation;
- Name, address, NPI, NCPDP number, DEA registration, state license, or Pharmacist-in-Charge;
- Closure, relocation, bankruptcy, insolvency, suspension, or interruption of operations;
- Disciplinary action, sanction, exclusion, investigation, or restriction affecting the pharmacy or its ability to provide services.

5. Claims Processing

5.1 Electronic Submission

Participating pharmacies must submit claims electronically through the current NCPDP-standard transaction format designated by Phoenix. This includes paid claims, reversals, adjustments, and zero-balance claims when required by the applicable plan or claim-processing rules.

5.2 Required Claim Information

Category	Common Required Fields
Member and Plan	Member ID, person code, date of birth, BIN, PCN, group ID, date of service
Pharmacy	Pharmacy NPI/NCPDP identifier and applicable service/provider information
Prescriber	Valid prescriber NPI and other required identifiers
Drug and Service	11-digit NDC, quantity, days supply, refill number, DAW code, compound information when applicable
Pricing	Usual and customary charge, ingredient cost submitted, dispensing fee, tax, and other required amounts
Clinical and Other	Prior authorization number, clarification codes, DUR/PPS codes, and plan-specific fields when applicable

The pharmacy must review all point-of-sale messages and submit complete and accurate data. Claims may reject or pay incorrectly when information is missing, inconsistent, or inaccurate.

5.3 Eligibility and Benefit Verification

Eligibility and benefit information should be verified through the point-of-sale transaction. Provider Services may assist with questions; however, the claim response and applicable plan terms control. A successful claim response does not waive pharmacy obligations to submit accurate information or comply with applicable dispensing requirements.

5.4 Reversals, Returns to Stock, and Adjustments

- Reverse claims promptly when a prescription is not picked up, delivered, or otherwise provided to the member.
- Reverse duplicate or erroneous claims as soon as identified.
- Use the appropriate NCPDP transaction and reason codes for reversals, resubmissions, and adjustments.
- Maintain documentation supporting returned, reversed, partial-fill, short-fill, and adjusted claims.
- Do not retain payment for a prescription that was not dispensed or received by the member.

5.5 Coordination of Benefits and Other Coverage

When other coverage applies, pharmacies must submit coordination-of-benefits information accurately and follow applicable NCPDP standards and point-of-sale instructions. Government program, workers compensation, 340B, hospice, discount-card, or other specialized claims may have separate processing requirements.

6. Utilization Management and Clinical Programs

Certain plan designs use prior authorization, quantity limits, step therapy, formulary controls, dose optimization, safety edits, and other utilization-management programs. These requirements are established by the applicable plan and administered in accordance with plan terms and applicable law.

6.1 Common Review and Override Types

Type	Description
Clinical Prior Authorization	Clinical review of coverage criteria, diagnosis, treatment history, or medical necessity.
Administrative or One-Time Override	Limited override for situations such as vacation supply, lost/spilled medication, emergency supply, or dose change, subject to plan rules.
Formulary Exception	Request for a clinically appropriate drug that is not otherwise covered or preferred.
Quantity Limit	Review of a quantity or days supply exceeding plan parameters.
Step Therapy	Review when the plan requires trial of one or more preferred therapies before another drug is covered.
Cost Exceeds Maximum	Review when a claim exceeds a plan or system dollar threshold.
Retail/Specialty Access Exception	Review to permit dispensing at a qualified in-network retail pharmacy when an exclusive specialty requirement would otherwise restrict access and no documented special-handling or distribution reason prevents retail dispensing.

6.2 Standard and Expedited Reviews

Where applicable, Phoenix maintains standard and expedited procedures for non-formulary exceptions and other urgent requests. An enrollee, authorized designee, or prescribing provider may request review. Expedited handling is available when delay could seriously jeopardize the member's health, ability to regain maximum function, or continuity of an active course of treatment.

6.3 Pharmacy Role

- Review point-of-sale rejection messages and communicate needed information to the member and prescriber.
- Provide supporting dispensing or claim information when requested.
- Do not represent that a denial is final when appeal or exception rights may be available.
- Use emergency or transition procedures only as permitted by the applicable plan and law.
- Contact Provider Services when claim messaging is unclear or member access may be disrupted.

7. Drug Utilization Review and Professional Judgment

Rx Logic may transmit concurrent drug-utilization-review (DUR) alerts, claim rejects, and informational messages designed to support safe dispensing. Common alerts include drug-drug interaction, therapeutic duplication, refill-

too-soon, dose screening, age or sex precaution, allergy information when available, and duplicate prescribing or pharmacy utilization.

The pharmacy must review and respond to DUR messages using the pharmacist's independent professional judgment. Phoenix's system messages are decision-support tools and are not a substitute for the pharmacist's or prescriber's professional responsibility. A pharmacist is not required to dispense a medication that the pharmacist reasonably believes should not be dispensed.

8. Formulary, Generic Substitution, and Retail Access

8.1 Formulary

A formulary is a general list of medications organized by coverage tier or status. Inclusion on a formulary does not guarantee coverage for every member or plan. Coverage may also depend on plan-specific exclusions, prior authorization, step therapy, quantity limits, age or diagnosis criteria, benefit limits, and other plan provisions.

8.2 Formulary Changes

Phoenix communicates material formulary changes to applicable plan sponsors or carriers using electronic notices, client communications, or other approved methods. Pharmacies should rely on current point-of-sale responses and provider resources for member-specific coverage information.

8.3 Generic Substitution

Phoenix encourages lawful use of therapeutically equivalent generic drugs when clinically appropriate and permitted by the prescription and applicable law. Pharmacies must use the correct NCPDP Dispense As Written (DAW) code and must not submit a code that misrepresents the dispensing circumstances.

DAW Code	Meaning
0	No product selection indicated
1	Substitution not allowed by prescriber
2	Substitution allowed - patient requested brand
3	Substitution allowed - pharmacist selected brand
4	Substitution allowed - generic not in stock
5	Substitution allowed - brand dispensed as generic
6	Override
7	Substitution not allowed - brand mandated by law
8	Substitution allowed - generic not available in marketplace
9	Other

8.4 Access to In-Network Retail Pharmacies

Covered prescriptions should generally be accessible through qualified in-network retail pharmacies. A drug may be restricted to a specialty or other designated channel when a documented reason applies, such as FDA-restricted distribution, manufacturer limited distribution, or special handling, provider coordination, monitoring, or patient education that the requested retail pharmacy cannot provide. Specialty classification or plan preference alone does not establish that retail dispensing is unavailable.

When an exclusive specialty requirement would prevent retail access and no documented permissible reason applies, an enrollee, authorized representative, prescriber, or in-network retail pharmacy may request a retail-access exception. Phoenix will evaluate the pharmacy's licensure, product access, handling capabilities, member circumstances, continuity-of-care needs, and applicable law.

9. Maximum Allowable Cost (MAC) Program

Phoenix maintains one or more MAC lists for designated generic or multi-source drugs. Current MAC information and appeal instructions are available through the Phoenix regulatory/provider resources page or as otherwise required by contract and state law.

9.1 MAC List Access

- Visit www.PhoenixPBM.com/Regulatory to access available MAC lists and provider resources.
- Email quality@phoenixpbm.com for assistance or a MAC list request.
- Review current state-specific instructions because access, update frequency, and notice requirements may vary.

9.2 MAC Appeal Submission

A contracted pharmacy, PSAO, or GPO may submit a MAC appeal in accordance with the applicable state process. The appeal should include sufficient information to identify the claim and support the requested review, including:

- Pharmacy name, NPI, and NCPDP number;
- Contact name, telephone number, and email address;
- Prescription number and date of service;
- NDC, drug name, strength, and dosage form;
- Quantity and days supply;
- Adjudicated ingredient cost or reimbursement amount;
- Pharmacy acquisition cost and supporting invoice or wholesaler information, when required;
- Any other information required by applicable state law.

Appeals may be submitted to quality@phoenixpbm.com or by other methods published on the Provider Portal. State-specific filing and response deadlines apply. Phoenix will provide a written determination and, when an appeal is granted, will implement required claim or MAC updates and publish revised pricing through the Provider Portal. Where law requires individualized notice in addition to portal publication, Phoenix will use the required communication method.

9.3 Approved and Denied Appeals

- Approved appeals may result in claim reprocessing, retroactive adjustment, and/or modification of the applicable MAC price, as required by law.
- Denied appeal notices will include the reason for the decision and any additional information required by applicable state law, which may include an available NDC and wholesaler source.
- Appeal records and pricing implementation evidence are retained in accordance with Phoenix policy and applicable law.

10. Participating Pharmacy Responsibilities

- Provide pharmacy services in accordance with the prescription, professional standards, applicable law, the Participating Pharmacy Agreement, plan requirements, and point-of-sale instructions.
- Collect only the member cost share or other amount permitted by the claim response and applicable law.
- Maintain accurate prescriptions, refill authorizations, patient profiles, dispensing records, pickup or delivery evidence, purchase invoices, and other supporting records.
- Keep NCPDP, NPI, licensure, DEA, ownership, address, hours, and contact information current.
- Promptly reverse prescriptions that are not picked up or delivered and accurately process partial fills, return-to-stock transactions, and adjustments.

- Protect member information and comply with HIPAA and other privacy and security requirements.
- Cooperate with credentialing, recredentialing, audits, investigations, quality reviews, and regulatory inquiries.
- Report suspected fraud, waste, abuse, privacy incidents, and material compliance concerns.
- Do not discriminate against members based on plan participation or any protected characteristic.
- Use independent professional judgment and communicate appropriately with members and prescribers.

10.1 NCPDP Data Updates

Pharmacies must submit demographic and operational changes directly to NCPDP through the applicable NCPDP process. Phoenix receives regular NCPDP updates for loading into Rx Logic. Direct notification to Phoenix may also be required for material changes, contract changes, ownership changes, closures, or matters affecting network participation.

11. Nondiscrimination, Language Access, and Accessibility

Participating pharmacies must provide services without unlawful discrimination and should support reasonable access for members with disabilities, limited English proficiency, limited health literacy, and diverse cultural or ethnic backgrounds. Pharmacies should provide or facilitate communication assistance, accessible services, and reasonable accommodations as required by law and within the pharmacy's capabilities.

Provider Services may assist with pharmacy-benefit questions. Clinical counseling, label translation, auxiliary aids, and pharmacy-facility accessibility remain subject to the pharmacy's professional and legal responsibilities.

12. Member and Pharmacy Complaints, Grievances, and Appeals

Phoenix maintains processes for receiving, investigating, and resolving complaints and grievances regarding claims, access, network participation, utilization management, reimbursement, audits, and other pharmacy benefit matters.

- Document the issue, relevant claim numbers, dates, member or pharmacy information, and requested resolution.
- Contact Provider Services for claim or network inquiries and use published appeal channels for MAC, audit, or other formal disputes.
- Identify urgent member-access issues so they can be escalated promptly.
- Cooperate with requests for supporting documentation.
- Use state-specific appeal or complaint processes when applicable.

13. Fraud, Waste, and Abuse

Phoenix and participating pharmacies share responsibility for protecting the integrity of pharmacy benefit programs. Suspicious activity should be reported promptly to Provider Services at 877-643-2067 or through another designated reporting channel.

13.1 Examples

- Identity theft or use of another individual's coverage;
- Drug diversion, resale, forged prescriptions, stolen prescription pads, or prescriber shopping;
- Billing for prescriptions not dispensed or not received;
- Billing brand products when generics were dispensed or misusing DAW codes;
- Duplicate billing, billing multiple payers improperly, or submitting false coordination-of-benefits information;
- Splitting prescriptions to generate additional dispensing fees;

- Billing an incorrect NDC, quantity, days supply, ingredient, compound, or service;
- Failing to reverse unclaimed or returned prescriptions;
- Shorting quantities or substituting products without proper authorization;
- Other intentional misrepresentation, concealment, or abuse of the benefit program.

14. Pharmacy Audits

Phoenix may conduct desk, remote, on-site, targeted, random, investigative, or other audits permitted by the Participating Pharmacy Agreement and applicable law. Audit procedures are intended to verify claim accuracy, contractual compliance, documentation, proper dispensing, and program integrity.

14.1 Audit Notice and Scope

Except when a different period is required by law or when fraud, waste, abuse, patient safety, or other urgent concerns are suspected, Phoenix will provide reasonable advance notice. The notice will identify the audit scope, review period, requested records, due date, and contact information.

14.2 Common Documentation

- Original or valid electronic prescriptions and refill authorizations;
- Patient profiles, dispensing logs, counseling or DUR documentation where applicable;
- Pickup signatures, delivery logs, shipping confirmations, or other proof of receipt;
- Wholesaler or manufacturer purchase invoices;
- Compound worksheets, ingredient records, and applicable calculations;
- Reversal, return-to-stock, partial-fill, and adjustment documentation;
- Prescriber communications and clinical clarification records;
- Licensure, credentialing, accreditation, or operational records relevant to the audit.

14.3 Findings and Appeals

Phoenix will provide a written audit report or notice of findings. Unless a different timeframe is required by law or contract, the pharmacy may submit a written appeal within 30 calendar days with supporting documentation. Phoenix will review the appeal and provide a written determination. Valid underpayments identified through an audit will be corrected, and recoveries or offsets will be administered in accordance with applicable law and contract terms.

Phoenix will not use extrapolation, projection, or contingency-fee audit practices where prohibited by applicable law. State-specific audit protections control when they are more restrictive than this manual.

15. Records, Confidentiality, and Security

Participating pharmacies must retain claim, prescription, financial, administrative, and patient records for the period required by the Participating Pharmacy Agreement and applicable law. Records must be complete, accurate, secure, and available for authorized audit, regulatory, or legal review.

- Maintain member-identifying information confidentially and prevent unauthorized disclosure.
- Disclose information only as permitted or required by law, authorized by the individual, or necessary for lawful treatment, payment, health care operations, benefit administration, or regulatory purposes.
- Use appropriate administrative, physical, and technical safeguards.
- Promptly report suspected privacy or security incidents through the appropriate Phoenix contact and comply with applicable breach-notification requirements.

16. Suspension, Termination, and Post-Termination Obligations

A pharmacy's participation may be suspended, restricted, or terminated in accordance with the Participating Pharmacy Agreement and applicable law. Grounds may include loss or restriction of licensure, exclusion, fraud, material breach, failure to maintain insurance or credentialing requirements, refusal to cooperate with audits, patient-safety concerns, insolvency, or other material compliance failures.

- Phoenix will provide notice and opportunity to cure or appeal when required by law or contract.
- Immediate action may be taken when necessary to protect members, comply with a regulatory order, address suspected fraud, or respond to loss of legal authority to operate.
- Termination does not relieve Phoenix of the obligation to pay amounts properly due for covered pharmacy services rendered before the effective date of termination, subject to valid claim submission, reconciliation, audit, and offset rights.
- The pharmacy remains responsible for records, confidentiality, audits, adjustments, overpayments, appeals, and other obligations that survive termination.

17. State-Specific Requirements

Pharmacy benefit laws vary by state and may impose additional or different requirements regarding MAC lists, appeals, audits, reimbursement, payment timing, network access, pharmacy choice, notices, termination, credentialing, and other matters. Phoenix maintains state-specific policies, addenda, Provider Portal notices, and operational procedures as necessary.

Where state law provides greater pharmacy or member protections than this manual, the state requirement controls. Pharmacies should review the Regulatory section of the Phoenix website and applicable contractual addenda for current requirements.

Appendix A - Common Claim Rejection and Support Checklist

Issue	Pharmacy Review	Next Step
Member not found/ineligible	Verify member ID, person code, DOB, BIN/PCN, group, and date of service.	Contact Provider Services if data matches the card and eligibility remains unresolved.
Prior authorization required	Review reject message and confirm drug, NDC, quantity, days supply, diagnosis or prescriber information.	Refer member/prescriber to the applicable PA or exception process.
Refill too soon	Review prior fill, quantity, days supply, reversal history, and plan allowance.	Use applicable override process for documented vacation, lost medication, dose change, or other allowed circumstance.
Quantity limit exceeded	Verify quantity, days supply, package size, and directions.	Correct claim or request a quantity-limit review.
Pharmacy not in network	Verify NPI/NCPDP and network status.	Contact Provider Services; do not represent the pharmacy as participating until confirmed.
Cost exceeds maximum	Verify NDC, quantity, U&C, ingredient cost, and compound details.	Contact Provider Services or request required plan review.
DUR reject	Review the clinical message and exercise professional judgment.	Submit appropriate DUR/PPS codes only when supported and permitted.

Appendix B - MAC Appeal Submission Checklist

[ ] Pharmacy name and contact information

[ ] NPI and NCPDP number

[ ] Prescription number and date of service

[ ] Drug name, strength, dosage form, and NDC

[ ] Quantity and days supply

[ ] Adjudicated reimbursement

[ ] Acquisition cost and supporting documentation

[ ] Wholesaler/source information if required

[ ] Specific basis for the appeal

[ ] State or network identification if applicable

Appendix C - Audit Response Checklist

[ ] Review audit notice and due date

[ ] Identify internal contact responsible for response

[ ] Preserve all relevant records

[ ] Provide legible and complete documentation

[ ] Explain any missing or unusual documentation

[ ] Maintain copies of all submitted materials

[ ] Review preliminary or final findings

[ ] Submit appeal within applicable deadline

[ ] Track final determination and payment adjustment

Appendix D - Provider Manual Acknowledgement

The undersigned acknowledges receipt of or access to the Phoenix Benefits Management Provider Manual and understands that the manual supplements, but does not replace, the Participating Pharmacy Agreement, applicable plan documents, point-of-sale instructions, and governing law.

Pharmacy Name: _____

NCPDP Number: _____

Authorized Representative: _____

Title: _____

Signature: _____

Date: _____