State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services
and
Department of Health & Senior Services
Division of Senior Benefits and
Utilization Management

Newsletter

Volume 14 No. 56 **December 2004**

TO: Fee-for-Service Providers of Pharmaceutical Services

SUBJECT: Form FD-70, Pharmacy Provider Certification Statement (Rev. 10/04)

BACKGROUND: Each participating Medicaid/NJ FamilyCare pharmacy provider and, on behalf of the Department of Health and Senior Services (DHSS), each Pharmaceutical Assistance to the Aged and Disabled (PAAD), Senior Gold, AIDS Drugs Distribution Program (ADDP) and Cystic Fibrosis (CF) pharmacy provider, must submit to the Division of Medical Assistance and Health Services (DMAHS) information concerning the level of pharmacy services they provide, annually. This information is used to determine appropriate dispensing fees for pharmacy claims submitted to the State for payment consideration, as described in N.J.A.C. 10:51-1.7 and 8:83C-1.

To qualify for optional increments to the basic dispensing fee, information relevant to 24-hour emergency service, patient consultation, and impact allowance is required. (See Form FD-70, Section I.)

ACTION: Each pharmacy provider must complete and return the Pharmacy Provider Certification Statement and attach a copy of its valid pharmacy permit **no later than February 15, 2005.** Please forward the documents to:

Unisys
P. O. Box 4804
Trenton, NJ 08650-4804
Attn: Form FD-70

ALL QUESTIONS ON THE FORM FD-70 MUST BE COMPLETED. INCOMPLETE FORMS WILL BE RETURNED TO YOUR PHARMACY FOR COMPLETION.

NOTE: If you fail to complete and return the Pharmacy Provider Certification Statement by January 15, 2005, the State will automatically assign the base dispensing fee, without increments, to your pharmacy. No changes will become effective until a properly completed Pharmacy Provider Certification Statement, including a copy of its valid pharmacy permit, is received by Unisys.

If you have any questions regarding this Newsletter, please contact the Chief, Pharmaceutical Services, DMAHS, at (609) 588-2724, or Unisys Provider Services at (800) 776-6334.

If you have any questions regarding PAAD, ADDP, CF or Senior Gold, please contact the DHSS Pharmacy Consultant, at (609) 588-7640.

RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB (BLUE TAB MARKED "5")

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
AND
DEPARTMENT OF HEALTH AND SENIOR SERVICES

PHARMACY PROVIDER CERTIFICATION STATEMENT FOR CALENDAR YEAR 2004

Pharmacy Name _____ **Provider ID #** _____

Address _____ **E-Mail Address** _____

_____ **Telephone ( )** _____

SECTION I. FEE INCREMENTS ADDED TO BASIC DISPENSING FEE

1. Impact Allowance..... $0.15

This provider has a combined Medicaid/NJ FamilyCare/PAAD/ADDP/CF/Senior Gold prescription volume (including LTCF Rxs) equal to or greater than 50% of the total Rx volume and qualifies for "Impact Allowance".

Actual Percentage: _____ _____ **Yes** _____ **No**

Note: If conditions for earning impact allowance change, the provider must notify Unisys, in writing, at P.O. Box 4804, Trenton, NJ 08650-4804, within 30 days of change, and must immediately cease adding the impact allowance increment to the basic dispensing fee. If the State determines that the provider has not met the impact allowance requirements, the State shall recover the total reimbursement for this increment, retroactive to the date of this Statement.

2. 24-Hour Emergency Service $0.11

Provider certifies availability of 24 hours/day, 365 days/year prescription service. _____ **Yes** _____ **No**

If yes, identify below the method used by your pharmacy to post notification of this service.

_____ **Window Sign** _____ **Prescription Counter Sign**

_____ **Other** **Note: If "Other" is checked, please attach a complete description of the notification method used by your pharmacy to notify beneficiaries of this service.**

24-Hour Emergency Service Telephone Number ( ) _____

The 24-Hour Emergency Service Telephone Number must be a local call for beneficiaries serviced by your pharmacy. Failure to provide this number will result in the return of this form.

Note: If a provider discontinues 24-hour emergency service, the provider must notify Unisys, in writing, at P.O. Box 4804, Trenton, NJ 08650-4804 within 72 hours of this decision, and must immediately cease adding the increment to the basic dispensing fee.

3. Patient Consultation $0.08

Provider agrees to monitor all Medicaid/NJ FamilyCare/PAAD/ADDP/CF/Senior Gold patient profiles in accordance with N.J.A.C. 13:39-7.14 (State Board of Pharmacy rules) and the Federal Omnibus Budget Reconciliation Act of 1993, including, but not limited to, offers to consult with beneficiaries concerning proper drug administration/storage, and potential drug interactions/conflicts identified by reviews of patient profiles, or as advised by the State's Point of Sale (POS)/Prospective Drug Utilization Review (PDUR) claims processing system.

_____ **Yes** _____ **No**

SECTION II. OWNERSHIP DISCLOSURE STATEMENT

1. _____**Pharmacy Name**

Chain Pharmacy ___ Yes ___ No

If yes, please indicate the number of pharmacies operating in the State of New Jersey: ____

2. Does any person in your organization currently own or have an interest in or any relationship with any other corporation, partnership, or other organization providing services under the New Jersey Medicaid, NJ FamilyCare, PAAD, ADDP, CF or Senior Gold? _____ Yes _____ No

If yes, please explain such affiliations on a separate page and attach to the Certification Statement.

3. Indicate the legal status of your organization below.

__Sole Proprietor __Partnership __Non-Profit Corporation

__For-Profit Corporation __Government __Other (Specify)_____

List names, professional degrees, <u>home</u> addresses, and percentage of ownership for all partners, directors, officers, and/or stockholders, as applicable:

	NAME	**DEGREE**	**HOME ADDRESS**	**% OWNERSHIP**
1.				
2.				
3.				
4.				
5.				

I HAVE READ THE PHARMACY PROVIDER CERTIFICATION STATEMENT AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN. I UNDERSTAND THAT THE MAXIMUM CHARGE TO THE STATE OF NEW JERSEY FOR ALL MEDICAID, NJ FAMILYCARE, PAAD, ADDP, CF AND SENIOR GOLD PRESCRIPTIONS FOR COVERED DRUGS AND RELATED PHARMACEUTICAL PRODUCTS/DEVICES SHALL NOT EXCEED THE PRICING POLICIES OF THE STATE AS DESCRIBED IN N.J.A.C. 10:51-1.7 AND N.J.A.C. 8:83C-1.

Legal Signature of Principal: _____Date: _____

Print Name: _____Title: _____

Pharmacy Name:_____

Pharmacist in Charge:_____License Eff. Date:_____License Exp. Date:_____

<u>NOTE:</u> ALL STATEMENTS IN THIS CERTIFICATION ARE SUBJECT TO AUDIT AND REVIEW BY THE NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS) AND/OR THE NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS), THEIR CONTRACTORS, OR OTHER STATE AND FEDERAL AGENCIES.

AFFIX
PHARMACY LABEL
HERE