State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

# NEWSLETTER

Volume 5 No. 65 December 1995

**TO:** Providers of Pharmaceutical Services

**SUBJECT:** Form FD-70, Pharmacy Provider Certification Statement, (Rev. 11/95)

**BACKGROUND:** Annually, each participating Medicaid and/or Pharmaceutical Assistance to the Aged and Disabled (PAAD) pharmacy provider must submit to the Division of Medical Assistance and Health Services (DMAHS) information concerning the provider's total prescription volume and pharmacy services provided. This information is used by the Division to determine the basis of payment for reimbursement of legend drug claims submitted as described in N.J.A.C. 10:51-1.6.

When completing the Form FD-70, the total shall include all prescriptions filled, both original and refills, for private patients, Medicaid, PAAD, and all other third party carriers, including nursing facility recipients. (See Form FD-70, Pharmacy Provider Certification Statement, Section I.) In addition, each pharmacy provider **must** attach to the Pharmacy Provider Certification Statement, a **copy** of its valid pharmacy permit.

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 II.)

**ACTION:** Each pharmacy provider must complete and return the Pharmacy Certification Statement and attach a copy of its valid pharmacy permit **no later than December 15, 1995.** 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 ANSWERED OR IT WILL BE RETURNED TO YOU FOR INCLUSION OF THE MISSING INFORMATION.**

**EXCEPTION:** Pharmacy providers with a total annual prescription volume of 50,000 prescriptions or greater may choose not to report their total annual prescription volume on Form FD-70. These providers will automatically be placed in the maximum regression (discount) category by the Division. Providers must, however, complete all remaining sections of Form FD-70 and return it with a copy of their valid pharmacy permit.

**NOTE:** **Failure to complete and return the Pharmacy Provider Certification Statement will automatically place the pharmacy provider in the maximum regression (discount) category and in the basic dispensing fee category without qualifying for increments. Changes cannot be effective until a properly completed Pharmacy Provider Certification Statement is received by Unisys.**

Any pharmacy provider who has been in business less than one year must have the prescription volume projected for the entire year to determine its appropriate regression category.

If you have any questions regarding this Newsletter, please telephone Unisys at 1-800-776-6334.

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

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

**PHARMACY PROVIDER CERTIFICATION STATEMENT**

Pharmacy Name_____ Provider ID # _____
Address_____
_____ Telephone(___)_____

**Section I. ANNUAL CERTIFICATION OF TOTAL PRESCRIPTION VOLUME FOR 1995**

Prescriptions Filled: Original_____+Refills_____=(TOTAL)*_____
*Total: Include all third party and non-third party Rxs.
Combine totals for both regular and LTCF numbers, if applicable.

**Section II. FEE INCREMENTS ADDED TO BASIC DISPENSING FEE**

1. Impact Allowance..... $0.15

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

**NOTE:** If conditions for earning impact allowance change, provider must notify Unisys, P. O. Box 4804, Trenton, N.J. 08650-4804, in writing within 30 days of change, and must immediately cease adding the increment to the basic dispensing fee. If the New Jersey Medicaid program determines that the provider has not met the impact allowance requirements, the New Jersey Medicaid program will recover the total reimbursement paid for this increment, retroactive to the date of this agreement.

2. 24-Hour Emergency Service Availability..... $0.11

Provider certifies availability of 24 hours/day, 365 days/year prescription service. ___Yes ___No

If yes, service availability made known by:

_____Sign in store window _____Sign at prescription counter

_____Other **NOTE:** If "Other" is checked a complete description must be attached explaining how service availability is made known.

Telephone number for this service is (___)_____
Telephone number for this service must be a local call. If a telephone number is not given, this form will be returned.

3. Patient Consultation..... $0.08

Provider agrees to monitor all Medicaid and PAAD patient profiles for drug interactions, contraindications, and adverse reactions. Provider will attempt to discuss therapy with the patient with emphasis on compliance and proper utilization of prescriptions. ___Yes ___No

**NOTE:** If provider discontinues **24-hour emergency service or patient consultation**, he/she must notify Unisys, P. O. Box 4804, Trenton, N.J. 08650-4804, in writing within 72 hours of such discontinuance, and must immediately cease adding the increments to the basic dispensing fee.

**FD-70 (REV. 11/95)**

**Section III. OWNERSHIP DISCLOSURE STATEMENT**

1. _____ Chain Store/Chain Name

   _____ Independent Pharmacy

2. Does any person in your organization own or have an interest in or any relationship with any other corporation, partnership, or other organization providing services under the New Jersey Medicaid program? ___Yes ___No

   If yes, explain on a separate page.

3. Indicate the legal status of your organization:

   ____Sole Proprietor ____Partnership ____Non-Profit Corporation

   ____For-Profit Corporation ____Government ____Other (Specify)_____

4. List names, professional degrees, home 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 NEW JERSEY MEDICAID PROGRAM FOR A MEDICAID OR PAAD RX FOR A COVERED LEGEND DRUG MAY NOT EXCEED THE PRICING POLICIES OF THE DIVISION AS CONTAINED IN CHAPTER 51 (10:51-1.5 AND 1.7).**

**THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A COVERED NON-LEGEND PRODUCT MAY NOT EXCEED THE PRICING POLICIES OF THE DIVISION AS CONTAINED IN CHAPTER 51 (10:51-1.5(d)).**

Legal Signature of Principal:_____Date:_____
Print Name:_____Title:_____
Pharmacy Name:_____

**NOTE:** All of the above statements are subject to audit and review by Division personnel, its contractors, or other State & Federal agencies.

AFFIX
PHARMACY LABEL
HERE