Notice of 340B Program Participation Form

for IHCP Managed Care Outpatient Drug Claims

Note: This notice does not apply to Indiana Health Coverage Programs (IHCP) fee-for-service (FFS) 340B program participation. Covered entities (CEs) wishing to submit 340B outpatient drug claims for IHCP FFS members must ensure they register with the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA) for inclusion on the Medicaid Exclusion File (MEF).

CEs choosing to participate in the 340B program for members enrolled in the IHCP managed care plans must notify the Office of Medicaid Policy and Planning (OMPP) using the *Notice of 340B Program Participation Form*. The OMPP must receive notice of participation from all CEs including stand alone, as well as in-house and contracted pharmacies that will submit 340B point-of-sale and physician-administered outpatient drug claims.

Duplicate discounts are prohibited per *United States Code 42 USC 256b(a)(5)(A)(i)*. IHCP policy requires that all 340B managed care outpatient drug claims include appropriate modifiers to prevent duplicate discounts. It is the CE's responsibility to ensure compliance with IHCP policy, as all claims without modifiers will be submitted for manufacturer rebate.

All CEs participating in the 340B program and submitting claims for IHCP managed care members, must complete and sign the *Notice of 340B Program Participation Form*. The CE's in-house and/or contract pharmacy information must also be included in the attached form.

The CE must ensure the following:

- All contact information is correct including contact, email and fax number for the CE and associated pharmacies.
- All 340B claims submitted to the IHCP for members enrolled in managed care include appropriate modifiers.
- All 340B claims include National Drug Codes (NDCs) and Healthcare Common Procedure Coding System (HCPCS) codes with correct units when applicable.

This *Notice of 340B Program Participation Form* must be completed, signed and submitted to the OMPP at OMPP340B@fssa.in.gov. The OMPP will acknowledge receipt of the completed form via email within 14 business days.

Questions regarding the managed care-specific 340B policies should be referred directly to the managed care entities (MCEs). MCE contact information can be found in the *IHCP Quick Reference Guide* or by visiting the MCE pharmacy webpages accessible via the *Pharmacy Services* webpage at in.gov/medicaid/providers.

Reason for Submission: (complete all applicable)

Update Reason	Check	Date of Change (MM/DD/YYYY)
New Covered Entity Enrollment **(Complete *Covered Entity Information* section)**	☐	
Update Covered Entity Contact Information **(Complete *Covered Entity Information* section)**	☐	
Add/Update Contract Pharmacy **(Complete *Covered Entity Information* AND *Pharmacy Information* sections)**	☐	
Add/Update In-House Pharmacy **(Complete *Covered Entity Information* AND *Pharmacy Information* sections)**	☐	

IHCP Managed Care 340B Program Participation Information

Note: If more space is needed, please create a Microsoft Excel sheet with the information needed from the table and attach with submission.

Covered Entity Information			
Contact Information			
Name			
Email Address			
Phone Number			
Covered Entity			
Name			
Address			
City			
State			
Zip Code			
NPI			
340B ID			
Medicaid Provider Number (IHCP Provider ID)			
Participation with Managed Care Plan (Yes or No)			
Anthem	☐ Yes	☐ No	
CareSource	☐ Yes	☐ No	
Humana	☐ Yes	☐ No	
Managed Health Services (MHS)	☐ Yes	☐ No	
MDwise	☐ Yes	☐ No	
UnitedHealthcare	☐ Yes	☐ No	

Pharmacy Information ☐ **In-House Pharmacy** **OR** ☐ **Contract Pharmacy**	
Contact Person Information ☐ **Same as Covered Entity**	
Name	
Email Address	
Phone Number	
Pharmacy Information	
Name	
Address	
City	
State	
Zip Code	
NPI	

Pharmacy Information ☐ **In-House Pharmacy** **OR** ☐ **Contract Pharmacy**	
Contact Person Information ☐ **Same as Covered Entity**	
Name	
Email Address	
Phone Number	
Pharmacy Information	
Name	
Address	
City	
State	
Zip Code	
NPI	

Covered Entity:

Printed Name: _____

Signature: _____

Title: _____

Date: _____

Office of Medicaid Policy and Planning:

Printed Name: _____

Signature: _____

Title: _____

Date: _____