PARTICIPATING PHARMACY COMPLIANCE, FRAUD, WASTE, AND ABUSE (FWA) ATTESTATION

This Compliance and Fraud Waste and Abuse ("FWA") Attestation is required for contracted pharmacies for a Medicare-approved Part D Plan Sponsor and other Plan Sponsors that utilize the PDMI Network. In accordance with PDMI Pharmacy Services Agreement, you have agreed to cooperate with Part D Plan Sponsors' respective policies and procedures, including policies, procedures, reporting, corrective action plans, and training and education that support such Part D Plan Sponsors' respective compliance and fraud, waste and abuse programs. You will be removed from the PMDI networks if you cannot attest to the following:

PHARMACY COMPLIANCE/FWA CERTIFICATION	Agree	Disagree
Neither Pharmacy, nor any individual or entity employed by or under contract with Pharmacy, is excluded from providing services under any federal or state healthcare program or third party payer program, nor is Pharmacy or any such individual or entity otherwise prohibited from providing services to Medicare or Medicaid beneficiaries.		
My Pharmacy has policies and procedures in place to review the Office of Inspector General and General Services Administration exclusion lists to confirm upon initial hiring or contracting and, at a minimum, monthly thereafter, that Pharmacy personnel have not been excluded from providing services under any federal or state health care program or third party payer program, and are not otherwise prohibited from providing services to Medicare or Medicaid beneficiaries.		
My Pharmacy follows a ten-year record retention policy that complies with Medicare Part D, Centers for Medicaid and Medicare Services ("CMS") requirements and other applicable state and federal laws.		
My Pharmacy provides compliance and fraud, waste, and abuse ("FWA") training to all Pharmacy personnel and contractors who are involved in administering or delivering Medicare Part D benefits in accordance with the Prescription Drug Benefit Manual, Chapter 9, "Part D Program to Control Fraud, Waste and Abuse," and 42 C.F.R. §423.504(b)(4)(vi). At a minimum, such compliance and FWA training addresses: (i) laws and regulations related to Medicare Part D, including FWA; (ii) individuals and entities excluded from performing Medicare Part D activities; (iii) how to detect and prevent prescription drug FWA; and (iv) how to report suspected Medicare Part D		
My Pharmacy maintains a log of Pharmacy personnel who have received said compliance and FWA training and a copy of such training materials, all of which are available for review upon request.		

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My Pharmacy has a conflict of interest policy or procedures to ensure that its managers, officers and directors who are involved in administering or delivering Medicare Part D benefits are free from any conflict of interest in administering or delivering Medicare Part D benefits.		
My Pharmacy maintains, in good standing, all applicable federal, state, and local approvals, licenses, permits, authorizations, franchises, certifications and insurance (copies of which are available upon request).		
My Pharmacy ensures that Pharmacy personnel and contractors maintain in good standing, all applicable federal, state, and local licenses and certifications (copies of which are available upon request).		

1. I agree to immediately notify Company in writing if a change occurs that would make any of the above answers untrue, incomplete, or inaccurate.

2. Further, I agree to immediately notify Company if any Pharmacy is not in compliance with the requirements set forth above.

3. I acknowledge that any response of "Disagree" in the chart above, as applicable to any Pharmacy may result in:

3.1 the immediate execution of a corrective action plan, or

3.2 such Pharmacy being rendered ineligible to participate in the PDMI network.

4. I acknowledge that failure to completely answer this certification and return it to Company may result in exclusion or termination, as applicable, from the PDMI network.

5. I represent and warrant that the person signing this certification is duly authorized to bind all terms and conditions herein.

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FWA CERTIFICATION AND SIGNATURE

By my signature below I hereby certify on behalf of Pharmacy that the above responses are true, complete and accurate, and each Pharmacy will at all times abide by the requirements set forth in this Attestation.

NCPDP ID #: ____________________________________

NCPDP CHAIN CODE (if applicable): ____________________________________

PHARMACY NAME: ____

PRINTED NAME OF AUTHORIZED AGENT:____

SIGNATURE OF AUTHORIZED AGENT:____

DATE:_______________/______________/____________________________

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