Summary of COVID-19 Pharmacy-based Oral Antiviral Program:
CVS Caremark will provide claims processing services for Pharmacy-based COVID-19 Oral Antivirals (hereinafter the "Program").

Program Coverage Options – CVS Caremark is offering two coverage options:

- **Dispensing Only Option** – Pharmacies will be paid a $10 dispensing fee for dispensing a COVID-19 Oral Antiviral, in lieu of the standard network dispensing fee); **or**
- **RPH Assessment and Dispensing Option*** – Coverage of an eligibility assessment performed by a pharmacist practicing at a "Pharmacist Assessment Contracted Pharmacy" contracted by CVS Caremark. The pharmacy will be paid a professional fee of $60 for performing the eligibility assessment, whether or not the COVID-19 Oral Antiviral is determined to be appropriate and dispensed, plus a $10 dispensing fee for dispensing the COVID-19 Oral Antiviral, in lieu of the standard network dispensing fee).

Please indicate your Coverage election:

Select One Option	Option 1: Dispensing Only Option ☐	Option 2: RPH Assessment and Dispensing Option *Commercial Lines of Business Only* ☐

Program Details

- To the extent different, the terms and conditions of this Program Enrollment Form supersede the terms and conditions of any previous enrollment form or communication.
- COVID-19 Oral Antivirals will only be prescribed and dispensed once FDA approval or Emergency Use Authorization ("EUA") has been received, and any other regulatory guidance has been provided and the product has been released to the marketplace. *(Example products include: Paxlovid and Lagevrio)*
- Participating retail pharmacies will utilize NCPDP standards for claims submission and FDA EUA guidelines when prescribing and/or dispensing COVID-19 Oral Antivirals.
- Current outlined dispensing and professional fees, as set forth above, are subject to change. Changes to fees will be communicated to client via an updated rate sheet and such updated rates shall apply 30 days after receipt by the plan, or as otherwise stated in the rate sheet.
- The Program applies to all of client's covered members unless otherwise instructed by client.
- Enrollment in the Program is only applicable during the time that the federal government is funding the cost of the Oral Antiviral ("Government Funding Phase"). You will be in the Program until the Government Funding Phase is terminated. Once the Government Funding Phase is no longer providing zero cost COVID-19 Oral Antivirals for all Americans, a new Program Enrollment Form may be sent to you that incorporates reimbursement methodology for product ingredient cost, dispensing fee as well as other professional service fees.

  *Pharmacist authority to assess and prescribe COVID-19 Oral Antivirals is currently limited to the duration of the Public Health Emergency.

COVID-19 Oral Antivirals shall be excluded from the calculation of financial and performance guarantees in the PBM services contract between client and CVS Caremark. The prescriber and/or pharmacy will be responsible for the determination of the appropriateness of repeat dispensing of COVID Oral Antivirals following the FDA EUA guidance.

By signing below, Client agrees to participate in the CVS Caremark COVID-19 Pharmacy-based Oral Antiviral Program, as indicated. Client understands and agrees to the terms and conditions stated above. This Enrollment Form and the PBM services contract between client and CVS Caremark constitute the entire agreement of the parties with respect to the subject matter of this Enrollment Form, and supersede any and all other agreements, writings, and understandings.

Client Info: *(Please Print)*

Client Name Client Address / City / State / Zip

Client Contact Name **Date Signed**

Authorized Client Signature Title

INTERNAL (ACCOUNT TEAM) USE ONLY

Instructions:

Fill out this section completely and obtain client's signature on the Enrollment Form. Work with your BRM to submit a BAR case with the completed and signed Enrollment Form attached.

Account Team Information	
SAE/AE Name:	
Email:	
AM Name:	
Email:	
Health Plan Client Information	
Client Name:	
Client Name aka/fka/abbreviation (if applicable):	
Carrier ID(s):	
Total Lives:	
Client Type	
Line of Business	
☐ **Entire Client** ☐ **Partial Client (provide hierarchy in an excel document)**	
Effective Date:	**FILL IN EFFECTIVE DATE**
RxID Card Information (required for pharmacy communications- review BPG info in RxClaim to obtain)	
RxBin#	
RxPCN	
RxGroup	