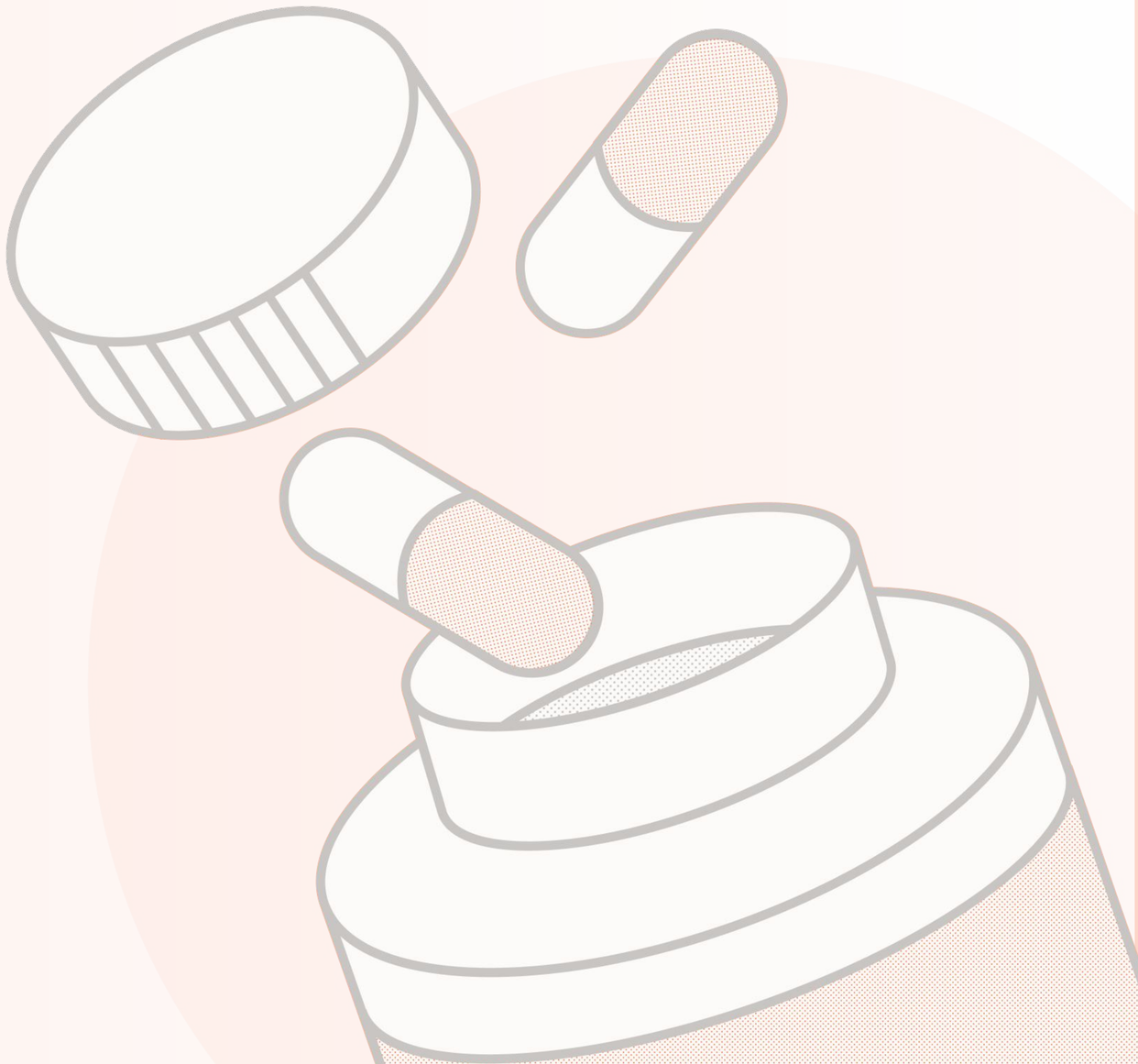
SmithRx

Welcome

Pharmacy Benefits, Evolved.

Visit smithrx.com to learn more



Patient (Member) Support

Toll-free Phone Number
(844) 454 - 5201

Email
help@smithrx.com

Connect Patient Support

Toll-free Phone Number
(844) 385 - 7612

Toll-free Fax Number
(866) 642 - 5620

Connect Access Plus
(844) 385 - 4565

Connect Access Specialty & Traditional
(844) 385 - 7612

Email
connect@smithrx.com

Pharmacy/ Provider Line

Toll-free Phone Number
(844) 512 - 3030

Toll-free Fax Number
(866) 642 - 5620

Email
provider@smithrx.com

Corporate

Toll-free Phone Number
(844) 454 - 0123

Toll-free Fax Number
(866) 642 - 5620

Email
info@smithrx.com

Address
Patient Support
P.O. Box 77864
San Francisco, CA 94107

Find self-serve tools and resources in the SmithRx Member Portal

SmithRx

SCAN ME

*SMS text and emails apply if SmithRx has the updated member contact information. You can update your contact information in the member portal - simply click your profile to add your email and phone number.

Pharmacy Benefits FAQ for Members

Commonly asked questions about pharmacy benefits

What if a member has a general Rx question?

Members should reach out to the SmithRx member support team. Online chat at www.smithrx.com, email help@smithrx.com, or call 844-454-5201.

What if a member has Connect 360 related questions?

Members should reach out to the SmithRx Connect team. Online chat at www.smithrx.com, email connect@smithrx.com, or call 844-385-7612.

What if a member gets a rejection at the pharmacy?

Members should follow these steps:

1. Make sure they have brought their new or most updated ID card to the pharmacy.
2. Make sure the pharmacy is using the correct/updated insurance information.
3. Ask the pharmacy to explain the rejection.
4. If the member or pharmacy still has questions, call SmithRx at 844-454-5201 immediately, ideally while the member is still at the pharmacy.

What if a drug has a prior authorization (PA) requirement?

Members can identify PA drugs using the formulary lookup tool on the member portal.

Members should advise their doctor to fax completed PA forms to SmithRx. 866-642-5620

Prescribers should call SmithRx with any questions. 844-512-3030

If members have questions about the PA, they should reach out to the SmithRx member support team. Online chat at www.smithrx.com, email help@smithrx.com, or call 844-454-5201.

What if a drug has a step therapy (ST) requirement and the member wants to understand the process?

Members can identify ST drugs using the formulary lookup tool on the member portal.

Members should reach out to the SmithRx member support team. Online chat at www.smithrx.com, email help@smithrx.com, or call 844-454-5201.

Pharmacy Benefits FAQ for Members

What if a member wants to check the price of their medication at various pharmacies?

Members can access the ***Find My Meds*** pricing tool by registering for the SmithRx member portal at member.mysmithrx.com. Within the tool, they can enter various drug details (ex: name, strength, quantity, and day supply) and find the price of the drug at pharmacies within a selected zip code or city.

What if a member's drug is considered specialty?

Members can identify specialty drugs using the ***Formulary Lookup*** tool on the member portal. Members should advise their doctor to send the script to Kroger Specialty or Senderra Rx.

> **Kroger Specialty Pharmacy**: Patients can reach Kroger Specialty Pharmacy for enrollment assistance by calling 888-355-4191. Prescribers can visit www.krogerspecialtypharmacy.com and fill out the appropriate forms for the appropriate department.
>
> **Senderra Rx**: Patients can reach Senderra for enrollment assistance by calling 888-777-5547. Prescribers can visit https://senderrarx.com/prescribers and fill out the appropriate forms for the appropriate department.

Once the member's prescriber has sent the script to the specialty pharmacy, the member should call the pharmacy to provide their insurance information and to schedule delivery.

What if a member wants to use mail order?

Members can utilize our mail order partner pharmacies for convenience and savings. Our standard mail order partner is Amazon, but some members might end up using Walmart Home Delivery if they are on particular drugs, and that would be communicated to them by our Connect team.

> **Amazon Pharmacy:** Patients can register at www.amazon.com/smithrx and reach the pharmacy at 855-745-5725.
>
> Prescribers can send prescriptions via electronic prescribing, fax or phone:
> - Name/E-scribe: Amazon Pharmacy Home Delivery
> - Amazon Pharmacy fax: 512-884-5981
> - Amazon prescriber and pharmacy line: 855-206-3605

Pharmacy Benefits FAQ for Members

Walmart Home Delivery: Patients can reach out for enrollment assistance by calling 800-273-3455, by email at wmsrx@wal-mart.com, or register at https://www.walmart.com/cp/pharmacy-mail-order/1042239.

Prescribers can send prescriptions via electronic prescribing, fax or phone:

- Walmart Pharmacy fax: 800 406-8976
- Walmart prescriber and pharmacy line: 800 273-3455
- Website: https://www.walmart.com/cp/1042239

Mark Cuban's Cost Plus (MCCP) pharmacy is another in-network mail order option. Members can check the Cost Plus website to see if generic medications are available there for a lower cost than what they are paying at retail. Additionally, the SmithRx Connect team may reach out to members about transitioning certain medications to MCCP.

Mark Cuban Cost Plus Drugs: Patients can see whether their medications are available at https://costplusdrugs.com/medications, contact the pharmacy by completing the form at costplusdrugs.com/contact/support, or contact Truepill (NPI: 1851947139) at (650) 353-5495.

Once your script has been sent by your prescriber to Mark Cuban Cost Plus Drug Company, you can register at costplusdrugs.com.

Prescribers can send prescriptions via electronic prescribing to:

- Name/E-scribe: Mark Cuban Cost Plus Drug Company (MCCPD)

What if a member is looking for more information on the cost, shipment, or delivery of their mail order or specialty medication?

Members should reach out directly to the pharmacy that processed their medication.

What if a member receives an email, call, or text from SmithRx?

Members should respond as soon as possible to the email or the phone number from the voicemail or text they received. Members can also reach out via online chat at www.smithrx.com, email help@smithrx.com, or call 844-454-5201.

Member Reimbursement Form

SmithRx

This form is intended for use in reimbursement of pharmacy claims only. The filing of this form does not guarantee reimbursement. Please consult your plan documents for additional coverage information. If you have any questions regarding this form, or require additional forms please contact the SmithRx Support Team at (844) 454-5201. Use a separate claim form for each covered member of the family.

IDENTIFICATION NUMBER		GROUP NUMBER	
LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MM/DD/YYYY)
PHONE NUMBER (XXX) XXX-XXXX	MAILING ADDRESS		
SEX ☐ M ☐ F ☐ OTHER	RELATION TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	EMAIL ADDRESS (REQUIRED FOR REIMBURSEMENT)	

Prescriber Information

PRESCRIBER FIRST AND LAST NAME	PRESCRIBER NPI (NATIONAL PROVIDER IDENTIFIER)
PRESCRIBER ADDRESS	PRESCRIBER PHONE NUMBER (XXX) XXX-XXXX

Pharmacy Information

PHARMACY NAME	PHARMACY PHONE NUMBER
PHARMACY ADDRESS	

Prescription Information

(Compound Section below must ALSO be filled out for Compounded Medications)

RX #	DRUG NDC (NATIONAL DRUG CODE NUMBER)	DATE DISPENSED (MM/DD/YYYY))		
MEDICATION NAME		QUANTITY DISPENSED	DAY SUPPLY	RX COST
RX #	DRUG NDC (NATIONAL DRUG CODE NUMBER)	DATE DISPENSED (MM/DD/YYYY))		
MEDICATION NAME		QUANTITY DISPENSED	DAY SUPPLY	RX COST
RX #	DRUG NDC (NATIONAL DRUG CODE NUMBER)	DATE DISPENSED (MM/DD/YYYY))		
MEDICATION NAME		QUANTITY DISPENSED	DAY SUPPLY	RX COST

Compounded Medication Information (If Applicable)

COMPOUND DRUG NAME		MEDICATION DOSAGE FORM ☐ CAPSULES ☐ TROCHE/LOZENGES ☐ ORAL LIQUID ☐ TOPICAL ☐ OTHER	
INGREDIENT #1 QUANTITY	INGREDIENT #1 COST	INGREDIENT #1 NDC NUMBER	INGREDIENT #1 DRUG NAME
INGREDIENT #2 QUANTITY	INGREDIENT #2 COST	INGREDIENT #2 NDC NUMBER	INGREDIENT #2 DRUG NAME
INGREDIENT #3 QUANTITY	INGREDIENT #3 COST	INGREDIENT #3 NDC NUMBER	INGREDIENT #3 DRUG NAME
INGREDIENT #4 QUANTITY	INGREDIENT #4 COST	INGREDIENT #4 NDC NUMBER	INGREDIENT #4 DRUG NAME
INGREDIENT #5 QUANTITY	INGREDIENT #5 COST	INGREDIENT #5 NDC NUMBER	INGREDIENT #5 DRUG NAME

FOR ADDITIONAL MEDICATION REIMBURSEMENTS, PLEASE ATTACH ANOTHER FORM AND SUBMIT WITH THE REQUIRED INFORMATION

Coordination of Benefits (If Applicable)

Are any of these medicines being used to treat on-the-job injuries?	☐ NO ☐ YES	Are any of these medicines covered under another group Insurance?	☐ NO ☐ YES
If you answered YES to either question ABOVE, please provide the information to the right:	Is the other coverage primary? ☐ NO ☐ YES	If yes, what is the INSURANCE NAME and ID NUMBER?	

You're almost done! Be sure to check your answers above as well as the details sections below before signing. Also check that your receipts cover each point in Submission Requirements at the bottom of this page. Missing or illegible information may result in a delay or denial of your claim. When you're ready to send, ensure your receipts are attached, read the following notice, sign below, and mail the forms. Your claim will be processed within 45-days of receipt.

Fraud Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

When complete, mail this form to:
SmithRx Reimbursement Service
P.O. Box 994
Lehi, UT 84043
-OR-
Fax to:
(866) 642-5620

I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

Need help filling out this form?
Contact:
SmithRx Support Team
Call (844) 454-5201
-OR-
Email
help@smithrx.com

SIGNATURE	NAME	DATE MM/DD/YYYY)

Release of Information: The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

Translated: By sending in this form, you give SmithRx permission to contact whomever we may need to so we can get you your money back.

Pharmacy Receipt Submission Requirements

- ○ Participant Name
- ○ Prescription Number
- ○ Drug Name and NDC Number
- ○ Metric Quantity/Day Supply
- ○ Pharmacy Name, Address or NABP Number
- ○ Purchase Date
- ○ Total Charge

Once you've confirmed your **original pharmacy receipts** (Med Guide PLUS cash register receipts showing proof of purchase) cover these points, please attach them to this form

Attach Receipts Here

Prior Authorization Form

SmithRx

Please check that all fields are completed and that chart notes and all other necessary clinical information is attached. To submit, please fax to (866) 642-5620. **PLEASE NOTE:** Chart notes are required for review. Lack of chart notes and complete information will result in denial.

☐ NON-URGENT ☐ URGENT	CLINICAL REASON FOR URGENCY:

Prescriber Information

PRESCRIBER NAME	PHONE NUMBER (XXX) XXX-XXXX
PRESCRIBER SPECIALTY	FAX NUMBER (HIPAA COMPLIANT)
NPI NUMBER	OFFICE CONTACT

Patient Information

PATIENT NAME	DATE OF BIRTH (MM/DD/YYYY)		
ID NUMBER	SEX	HEIGHT	WEIGHT
ALLERGIES			

Prescription/Medication Request

DRUG REQUESTED (INCLUDE STRENGTH & FORMULATION)
FULL DIRECTIONS FOR USE (INCLUDE DOSING INSTRUCTIONS & LIMITS, FREQUENCY/SCHEDULE OF ADMINISTRATION):

QUANTITY PER FILL	EXPECTED LENGTH OF THERAPY
DIAGNOSIS	ICD 10

Type of Therapy

☐ NEW THERAPY ☐ CONTINUATION OF THERAPY	DATE STARTED:
HAS THE MEMBER BEEN MAINTAINED ON THIS MEDICATION SINCE THE DATE ABOVE?	☐ YES ☐ NO

Medication History (For this Condition)

For any medications tried and failed, provide ALL of the following details for EACH medication. *Incomplete documentation may result in denial due to lack of required information.*

- Medication product and dose(s) used
- Start date - End date of prescriber-verified use (or start date - current if still using)
- Reason for failure (including details explaining why the medication is considered failed therapy)
    - If failed due to intolerance, provide details & description of intolerance.

Medication Tried Medication product & Dose(s) used	**Date & Duration of Trial** Start Date - End Date	**Reason for Failure or Intolerance** Details & Description

Documentation: Use of Preferred Medications

For any preferred medication therapies that are not possible to use, provide documentation to explain why each medication would be contraindicated or not clinically possible to use for the member

PRESCRIBER SIGNATURE	DATE

Additional Documentation Required

Provide and include the following with this form for submission:

- Any information/documentation that does not fit in the fields provided on the form
- Chart/office visit notes for this diagnosis, including the most recent assessment and treatment plan
- Relevant lab values
- Information & results from previous tests and procedures attempted
- Any other relevant test results and clinical assessment & evaluation

***Incomplete information or documentation may result in delay or denial due to lack of required information.**

Medical Necessity Form

SmithRx

Please submit one drug per form.

Questions? Contact us: **Phone: (844) 512-3030** | **Fax: (866) 642-5620**

Prescribing Physician

PRESCRIBER NAME	PHYSICIAN SPECIALTY
NPI NUMBER	DEA NUMBER
PHONE NUMBER	FAX NUMBER
REQUESTOR NAME	OFFICE CONTACT NAME

Patient Information

LAST NAME	FIRST NAME	M.I.
ID NUMBER	DATE OF BIRTH MM/DD/YYYY	SEX M/F
ALLERGIES	HEIGHT (IN/CM)	WEIGHT (LBS/KG)

Requested Drug Details

DRUG NAME	STRENGTH	DOSAGE FORM	LENGTH OF THERAPY/#OF REFILLS	QUANTITY

DIRECTIONS FOR USE

PATIENT'S DIAGNOSIS FOR USE OF THIS MEDICATION	ICD 9/10
SELECT ONE OF THE FOLLOWING:	☐ NEW PRESCRIPTION ☐ CONTINUATION OF THERAPY, START DATE:

Medical Necessity

1. This form must be returned along with recent chart/consultation notes and all relevant labs
2. Please Document all medications and non-drug therapies tried and failed for this condition. This must include:
    a. Medication name and dose (or non-drug therapy)
    b. Dates and duration of use
    c. Reason for failure
3. Please provide an explanation on why other covered medications are not possible to use.

PRESCRIBER SIGNATURE (REQUIRED)	DATE MM/DD/YYYY