PHARMACY DATA REQUEST

ASCENDPBM
PHARMACY BENEFIT MANAGEMENT

Savings RePrice

At ASCEND, we work across the health care continuum connect diagnostics with prescribing to ensure proper alignment, superior value, and positive outcomes throughout the patient's health journey. **We bridge the gap between cost + value.**

At your convenience, **please provide 3-months (at minimum) or 6-months of claim utilization data from the below fields.** Some fields are required in order to perform a Savings Analysis RePrice and are indicated below. Additionally, when submitting data, please provide responses to the below questions to assist in preparing the most applicable repricing information specific to your group.

If you have any questions, specific requests, or needs, please contact us at 833.200.5040, or email info@ASCENDpbm.com. We look forward to working with you and providing impactful, innovative solutions to present to your clients.

Data Fields	Required (Y/N)
NDC	**Y**
*Label Name	N
Drug Strength/Dosage	**Y**
*Drug Type (brand, generic, specialty)	N
Quantity or Days' Supply	**Y**
Dispense Date	**Y**
*Plan Pay	N
*Member Pay	N
Member Identifier	**Y**
*Dependent Indicator (employee, spouse, child)	N
*Dispense Channel (mail, retail, specialty)	N
*Drug Indicator (brand, specialty, generic)	N

**Not required, but preferred if available*

1. What is the plan's individual annual deductible?
2. Is the Plan Administrator proving pharmacy benefits through an Employer Group Waiver Program (EGWP)?
3. How many covered lives are in this plan?

MEDICAL DATA REQUEST

ASCENDPBM
PHARMACY BENEFIT MANAGEMENT

Savings RePrice

At ASCEND, we work across the health care continuum connect diagnostics with prescribing to ensure proper alignment, superior value, and positive outcomes throughout the patient's health journey. **We bridge the gap between cost + value.**

At your convenience, **please provide 6-months (at minimum) or 12-months of claim utilization data from the below fields.** Some fields are required in order to perform a Savings Analysis RePrice and are indicated below. Additionally, when submitting data, please provide responses to the below questions to assist in preparing the most applicable repricing information specific to your group.

If you have any questions, specific requests, or needs, please contact us at 833.200.5040, or email info@ASCENDpbm.com. We look forward to working with you and providing impactful, innovative solutions to present to your clients.

Data Fields	Required (Y/N)
HCPC Code	**Y**
*Drug or Service Description	N
Drug Strength/Dosage	**Y**
*Place of Service Indicator (hospital, outpatient, office, etc.)	N
Number of Units	**Y**
Date of Service	**Y**
*Plan Pay	N
*Member Pay	N
Member Identifier	**Y**
*Dependent Indicator (employee, spouse, child)	N
*Dispense Channel (mail, retail, specialty)	N
*Drug Indicator (brand, specialty, generic)	N

**Not required, but preferred if available*

1. What is the plan's individual annual deductible?
2. Is the Plan Administrator proving pharmacy benefits through an Employer Group Waiver Program (EGWP)?
3. How many covered lives are in this plan?