CABINET FOR HEAI AMILY SERVICES
Department f d Services

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340B Non-Participation Notice Form for
Kentucky Medicaid Managed Care Pharmacy Claims

At any time, a Covered Entity **may choose to end participation** in the 340B Program for Kentucky Medicaid Managed Care Organization (MCO) pharmacy claims, they **must** provide the Department for Medicaid Services (DMS) notice that it and any listed Contract Pharmacy will **not** use 340B drugs to fill prescriptions for qualified pharmacy claims. Subsequently, these pharmacy claims will be eligible for Federal and supplemental drug rebate invoicing.

Qualified pharmacy claims are only claims for Kentucky Medicaid MCO members who receive prescription drug benefits coverage where claims are determined to be 340B eligible per the Health Resources and Services Administration (HRSA) 340B patient definition guidelines.

This notice and associated processes conform with HRSA's 34B duplicate discount guidance recommending that Medicaid agencies and 340B Covered Entities have a process in place to avoid duplicate discounts for drug claims identified as 340B. This also allows DMS to monitor Covered Entities and their Contract Pharmacies for compliance with applicable State and Federal regulations.
IMPORTANT: By completing and signing the attached 340B **Non-Participation Notice** form, the Covered Entity is notifying DMS they are subsequently **ending** their previous participation in the 340B Program along with any listed Contract Pharmacy under the Kentucky Medicaid MCO plan. The Non-Participation Notice must be completed and submitted to DMS340B@ky.gov to **be excluded from** participation or ending previous participation in the program. **DMS will not accept any paper or fax notices.**

- Completed and signed 340B Non-Participation Notice forms received by the fifteen (15) of the last month prior to the end of a quarter will be effective in that quarter.

- Forms received after the required timeframe for a given quarter will be effective in the following quarter.

DMS will acknowledge receipt of the completed form, via email, within seven (7) business days of receiving the form. We strongly encourage Covered Entities to submit forms early in the event information

is identified as missing or incorrect to allow time for correction. DMS is not responsible for assuring corrections within the required timeframes.

Please send any questions/concerns to DMS340B@ky.gov

Kentucky Medicaid Managed Care 340B Program
Non-Participation Notice

Covered Entity and/or Contract Pharmacy Information to NOT Participate in 340B for Medicaid Managed Care

- If more space is needed, please duplicate the below tables on additional pages.
- Indicate whether the Covered Entity is ending participation in the first table below.
- Please include only the pharmacy information in the second table that you wish to end participation.

Covered Entity Information	
Contact Person Information	
Indicate if the Covered Entity will end participation: ☐ Yes ☐ No	
Name	
Email Address	
Phone	
Covered Entity Information	
Name	
NPI	
Address	
City	
State	
Zip Code	

Pharmacy Information In-House ☐ Contract Pharmacy *please indicate the type of pharmacy	
Contact Person Information ☐ same as covered entity	
Name	
Email Address	
Phone	
Pharmacy Information	
Name	
NPI	
Address	
City	
State	
Zip Code	

KENTUCKY CABINET FOR
HEALTH AND FAMILY SERVICES

Kentucky Medicaid Managed Care 340B Program
Non-Participation Notice

Third Party Administrator (TPA) Name: _____

COVERED ENTITY

Printed Name: _____

Signature: _____

Title: _____

Date: _____

DEPARTMENT FOR MEDICAID SERVICES

Printed Name: _____

Signature: _____

Title: _____

Date: _____