



2027 TN Low Volume Pharmacy Certification

Please Complete the following. All fields required

PARTICIPATING PHARMACY: _____ **NCPDP:** _____

On behalf of Participating Pharmacy, I expect that Participating Pharmacy will dispense fewer than 65,000 prescriptions in 2025. As such, I certify that I expect Participating Pharmacy to be eligible to be paid the enhanced dispensing fee pursuant to T.C.A § 56-7-3206(f).

The total number of prescriptions dispensed between **July 1, 2025 and June 30, 2026**, from NCPDP # _____ was _____ (Annual Rx Volume). I have attached a screenshot from my pharmacy management system as verification of the total volume.

I confirm my understanding that Prescriptive reserves the right to audit claim volumes and request documentation in support of this certification at any time.

I confirm my understanding that if, at any point, I become aware that I do not meet the requirements for this enhanced dispensing fee, I will immediately notify Prescriptive via email at Pharmacyrelations@prescriptive.com. Prescriptive shall then have the right to recoup the modified dispensing fees paid to me, and Prescriptive may reverse impacted claims.

On behalf of the above-named Participating Pharmacy, the undersigned attests that the information contained in this Certification is true and accurate to the best of their knowledge.

Participating Pharmacy Authorized Signature: _____

Name (Print): _____

Title: _____

Date Signed: _____