

Insulin and EpiPen Terms and Conditions: Deep Dive Frequently Asked Questions

The Executive Order (EO) "[Lowering Drug Prices by Once Again Putting Americans First](#)" requires health centers to establish practices to make insulin and injectable epinephrine affordable to individuals with low incomes under the 340B program. On June 24, 2025, health centers received new notice of awards (NOAs) and were notified of the new terms and conditions to implement the EO. See NACHC's [340B webpage](#) for more information, including a [general FAQ](#) and [sample policies and procedures](#).

1. How should we select drugs for an insulin and injectable epinephrine formulary if the health center is not required to discount ALL available insulin and injectable epinephrine?

At a minimum, a health center pharmacy would want to have one rapid-acting insulin, one long-acting basal insulin, and one injectable epinephrine on the formulary to ensure availability in line with what is clinically appropriate for your patients.

2. At an entity-owned pharmacy, is the dispensing fee (the administration fee) subject to the sliding scale?

Per the EO, health centers are allowed to charge a "minimal administration fee." This is distinct from a service cost and is not subject to the sliding fee.

3. How should an administration fee be set?

The minimal administration fee can differ across the contract pharmacies where the EO policy and procedures are being implemented; therefore, it is fine for different dispensing fees to exist. Furthermore, it can be detailed as a specific dollar amount of an equation. Health centers should reference where the information is being pulled from. Additionally, the Medicaid Cost of Dispensing Survey can be used as a justification. For more information, review our previous [FAQ here](#).

4. What can a health center do when the patient is insured? Can they slide that portion of the copay?

Whether a health center can slide a portion of the copay depends on the insurance type. If the patient is a Medicare patient, a health center can slide the portion of the copay. Per the Health Center Manual, for other types of insurance, health centers are expected to maximize their billing opportunities including the collection of the full copayment for the patient in accordance with health center fee schedules and the corresponding schedule of discounts. The EO creates a new schedule of discounts for health centers to extend to

patients as long as this is not precluded or prohibited by the applicable insurance contracts. NACHC recommends reviewing your pharmacy contracts with your legal counsel.

5. Do health centers need to adjudicate with the insurance?

According to the health center manual, health centers should maximize their ability to receive payments from payers. So, when available, the health center should adjudicate any insurance as part of the process to determine if the low-income individual meets the “high cost-sharing” or “high unmet deductible” requirements and is eligible to receive discounts under their 340B Injectable Epinephrine and Insulin Pricing policy.

6. How should a health center showcase in their policies & procedures which contract pharmacies are selected to offer injectable epinephrine/insulin products, in line with the EO?

One way health centers could showcase how they have made injectable epinephrine and insulin products accessible at an affordable price is to create an appendix to the procedure that lists the pharmacies where discounted pricing is available. This way, health center providers and staff would know which pharmacies to send patients to and provide proper documentation in case of an OSV review.

7. Once the terms “high-deductible” and “high-cost sharing” are defined in a health center’s policies and procedures, how can the pharmacy find out what a patient’s deductible is?

Health centers can bill the claim to determine if the patient meets the definition of "high-cost sharing" or "high unmet deductible." From there, the pharmacy software should allow you to see the data received from the insurance claim (which also includes payment information) and may include the deductible information as well. For many payers, this is returned in the Electronic Data Exchange (EDI) received from the Pharmacy Benefit Manager (PBM) at adjudication.

8. What should health centers do with high deductible and high copay patients at contract pharmacies?

Many contract pharmacies have prohibitions on waiving or reducing copays/fees for the insured. On the other side, FQHCs have a directive from our 330 statute requiring that no patient be denied health care services due to an individual’s inability to pay for such services. Additionally, the EO directs health centers to offer these specific medications at a discounted rate to certain patients. To ensure compliance, health centers should have

written documentation, such as via email, that they made a good faith effort to work with their contract pharmacies to offer these medications in compliance with the EO.

9. How would a cash plan work at a contract pharmacy?

If someone comes in who is uninsured, they can access the 340B price plus a dispensing fee; this is in line with the EO. The 340B price and administration fee are passed along. A cash plan is basically a patient access program (cash card program). The administration fee (dispensing fee) is significantly lower than what health centers are paying for the other prescriptions.

10. How should an entity-owned pharmacy operationalize this discount for insured patients?

To operationalize the discount for insured patients, a health center could use its software to bill a second plan after insurance. This removes staff judgment calls on how much to charge the patient, but there may be limitations on calculations depending on the software used. Some health centers may choose to operationalize the discount for insured patients via Accounts Receivable (A/R), which may be easier to implement but requires more staff time through regular reconciliation and staff making judgment calls at the point of sale. It is important to note that if a Health Center chooses to use the A/R functionality of a pharmacy software to implement the EO, that they do not attempt to collect the difference between the usual and customary cost or copay and the 340B acquisition cost plus minimal dispensing fee.

11. How can my pharmacy utilize manufacturer coupons to help our patients?

A health center can bill primary to insurance, secondary to a manufacturer coupon, and then provide a tertiary discount to the patient. The resulting price paid by the patient should be no more than the 340B price plus minimal administration fee.

Manufacturer coupons cannot be the health centers' only strategy to implement these Terms and Conditions, so the policy and procedures must create access. Health centers should maximize all billing opportunities first, then apply the EO pricing as essentially the payer of last resort.