PHARMACY BENEFITS MANAGEMENT SERVICES REVISION-B

Chapter Thirty-Seven of the Medicaid Services Manual

Issued May 27, 2020

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

PHARMACY BENEFITS MANAGEMENT SERVICES

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OVERVIEW

The Pharmacy Program within the Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) is responsible for the development, implementation and administration of the Medicaid Pharmacy Program, and is charged with the responsibility of assuring quality pharmacy services while developing efficiencies in operation, service and cost.

Other responsibilities include the daily operations for outpatient pharmacy prescription services. Although total parenteral nutrition (TPN) is reimbursed through the Pharmacy Program, it is managed in collaboration with the Durable Medical Equipment (DME) Program through the prior authorization (PA) process.

This provider manual chapter specifies the Medicaid benefits in the Pharmacy Program and the policies related to those benefits. This chapter is intended to explain covered pharmacy services and limits, how to file claims, Medicaid reimbursement, and other relative Medicaid pharmacy program policies and procedures. For various reference contacts and tools, refer to Appendices 37.5.1 through 37.5.14.

All Food and Drug Administration (FDA) approved legend drugs that meet the Omnibus Budget Reconciliation Act (OBRA) '90 and OBRA '93 criteria are covered with a few exceptions. The Pharmacy Program determines the reimbursement methodology for both the drug ingredient cost and the professional dispensing fee for covered drugs.

The Pharmacy Program is responsible for the following components:

1.   Policy;

2.   Program development and implementation;

3.   Network development;

4.   Program coverage;

5.   Preferred drug list (PDL) development and implementation and PA for certain therapeutic classes;

6.   Federal upper limit (FUL) for multiple source drugs;

7.   Claims management;

8.   Annual provider recertification;

9.   Clinical interventions;

10.   Prospective and retrospective drug utilization review (DUR);

11.   Federal and state supplemental pharmaceutical manufacturer rebates;

12.   Pharmacy provider desk audits;

13.   Beneficiary Lock-In program;

14.   Provider help desk;

15.   Beneficiary help desk;

16.   Provider relations; and

17.   Provider education for prescribers and pharmacists.

The Pharmacy Program also:

1.   Initiates policy development;

2.   Implements new policies and clarifies existing pharmacy policies, which include the services associated with outpatient drugs and Medicare/Medicaid pharmacy claims crossovers;

3.   Approves all new drugs added to program coverage; and

4.   Establishes any limitations on reimbursement or coverage in accordance with the federally approved reimbursement methodology.

The Pharmacy Program directs an extensive network of pharmacy providers and is also responsible for the integrity of several subsystems, including the drug file component of reference subsystem, the DUR subsystem and the drug portion of the Surveillance Utilization Review Subsystem (SURS).

Medicaid Enterprise System

The Medicaid Enterprise System (MES) is a computerized claims processing and information system designed to manage the Medicaid program's expenditures through effective claims processing and utilization control.

LDH contracts with a fiscal intermediary (FI) who operates the federally approved MES, which is consistent with the Centers for Medicare and Medicaid Services (CMS) and LDH requirements.

The FI is contracted to provide the following pharmacy-related services:

1. Pharmacy claim processing through an on-line, real-time point of sale (POS) system;

2. Coordination of the federally mandated Omnibus Budget Reconciliation Act of 1990 DUR Board activities;

3. Retrospective Drug Utilization Review (LaDUR);

4. Prospective Drug Utilization Review (UniDUR);

5. Educational articles - *Provider Update* newsletter article;

6. Lock-In Program;

7. DUR Board coordination;

8. PDL and PA system;

9. Monthly prescription limit system; and

10. Electronic Data Inquiry/Clinical Drug Inquiry System (e-CDI).

COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

This section provides the terms and conditions under which prescription services will be paid by the Medicaid program and a description of the authorized benefits for eligible beneficiaries.

Terms and Conditions

Licensed Prescribers

Payment will be made for prescription services only when issued by a licensed prescribing practitioner who has an active Medicaid prescriber number. (Refer to Section 37.5.6 - Prescribers for detailed information about prescribers).

Eligible Beneficiaries

The Medicaid program will only reimburse pharmacy claims when the beneficiary is eligible on the date of service. Pharmacy claims submitted with a date of service after a beneficiary's date of death are not allowed. (Refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on Medicaid eligibility).

Rebate Agreements

In accordance with Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the Medicaid program will pay only for those drug products for which the pharmaceutical company has entered into a federal rebate agreement with the U.S. Department of Health and Human Services (DHHS).

NOTE: The listing of Medicaid drug federal rebate participating pharmaceutical companies can be accessed at: www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf. This listing is updated periodically and is posted on the Louisiana Medicaid website. **Providers should take note of the effective dates of the labeler codes.**

Coverage will be provided for those drug products labeled by the pharmaceutical companies that have entered into a rebate agreement. As new pharmaceutical companies enter into rebate agreements, labeler codes will be added.

The therapeutic categories, e.g., cough and cold preparations, anorexics and cosmetic drugs, will remain non-payable. The *Medicaid Drug Federal Rebate Participation Pharmaceutical*

Companies listing and additional information can be accessed at: www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf or by visiting Section 37.5.1 of this manual chapter.

Medically Accepted Indications

A drug must be medically necessary and prescribed for medically accepted indications to be eligible for reimbursement.

As defined by Section 1927(k)(6) of the Social Security , the term "medically accepted indication" means any use for a covered outpatient drug which is approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Act or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: *American Hospital Formulary Service Drug Information, United States Pharmacopeia – Drug Information* (or its successor publications), and *DRUGDEX Information System.*

Drug Utilization Review

OBRA '90 also requires that states have a Drug Utilization Review (DUR) program in place and that this program assures that prescriptions are appropriate, are medically necessary and not likely to result in adverse medical results. The DUR program must include prospective drug review, retrospective drug review, and an educational program. (Refer to Section 37.5.12 - Patient Counseling, DUR for detailed information regarding DUR).

Patient Counseling Requirement

The Louisiana Board of Pharmacy's regulations require patient counseling, patient profiles, and prospective drug review, in accordance with OBRA '90.

Patient Counseling Documentation

Section 1927(g)(2)(ii)(I) of OBRA '90 requires that the pharmacist offer to discuss with each Medicaid beneficiary or a caregiver, in person whenever practicable, or by toll-free telephone for long distance calls, matters which, in their professional judgment, the pharmacist deems significant. Such counseling is subject to standards for counseling in accordance with the Louisiana Board of Pharmacy Regulations at LAC, 46:LIII, §517. Such counseling is to be provided unless refused by the beneficiary or caregiver. The Pharmacy Program will require counseling documentation for all prescriptions reimbursed by Louisiana Medicaid. According to

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the patient counseling standards in the OBRA'90, patient counseling begins with, and focuses on providing information related to the immediately prescribed drug. The only documentation required is a "yes" or "no" checked on the form next to the patient's signature to indicate whether they accepted the offer to provide this information. Counseling records must be retained in the pharmacy for five years from the date of payment and must be readily retrievable upon audit.

NOTE: Refer to Section 37.5.12 of this manual chapter for detailed information.

Pharmacy Signature and Delivery Logs

Pharmacy providers must obtain a signature from the patient or caregiver confirming the receipt of the prescription(s). This applies to all prescription pick-ups, home and facility deliveries. Claim submission is not proof that the prescription(s) or prescription order was actually furnished.

Pharmacy Pick-up

1.   Signature log documentation should include the prescription number(s) and the date the prescription was picked up. If multiple prescriptions are being picked up at one time, a single signature will be sufficient for all of the patient's prescriptions;

2.   Electronic signatures for receipt are permitted only if retrievable upon audit and kept on file by the pharmacy;

3.   Obtaining a signature to confirm receipt of prescription(s) can be part of a counseling log; and

4.   Signature confirmation must be maintained by the dispensing pharmacy for five years from the date of payment and must be retrievable upon audit.

Facility Delivery/Mail Order/Specialty

1.   A signature is required at the time of delivery;

2.   Signature documentation must also include the list of prescription number(s) and date the medication(s) was/were delivered. A single signature will be sufficient for all the medication in the delivery;

3.   Electronic signatures for receipt or electronic tracking slips for delivery are permitted only if retrievable on audit;

4.   A waiver signature form is not an acceptable practice and such forms will not serve as confirmation of delivery; and

5.   Confirmation of the delivery must be maintained by the pharmacy for five years from the date of payment and must be retrievable on audit. Delivery industry tracking receipts that contain a signature (e.g., FedEx, UPS, and USPS) qualify as a signature for receipt of delivery.

Home Delivery

1.   If a pharmacy provider chooses to have a pharmacy representative deliver prescription(s) to a beneficiary' s home, the pharmacy should inform the beneficiary or designee of the pharmacy's delivery schedule, verify the date and location for the delivery, and notify the beneficiary or designee that a signature will be required at the time of delivery; and

2.   The pharmacy representative will obtain a signature from the beneficiary or their designee confirming the delivery. A waiver signature form is not an acceptable practice, and such forms will not serve as confirmation of delivery. Delivery confirmation must be maintained by the pharmacy for five years from the date of payment and must be retrievable upon audit. Electronic signatures for receipt are permitted only if retrievable and kept on file by the pharmacy.

Prescription Duration

Scheduled narcotic prescriptions must be filled within six (6) months of the date issued, excluding Schedule II narcotic prescriptions. Schedule II narcotic prescriptions will expire 90 days after the date of issue in accordance with the Louisiana Board of Pharmacy regulations. Prescriptions for non-controlled substances expire after 11 authorized refills or one year after the date prescribed, whichever occurs first.

Prescription Transfers

The transfer of prescriptions, including those for Schedule III-V narcotics, must be in accordance with the Louisiana Board of Pharmacy regulations.

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Date of Service

The date of service is based on the adjudication process. The pharmacy staff should evaluate any prospective warnings or alerts based on internal software, or the Louisiana Program response generated during the claim submission. Based on this clinical review, the date the prescription was adjudicated is the service date except when long-term care eligibility determination is delayed.

Prescription Refills

Prescription refills can be provided if they are authorized specifically by the prescribing practitioner. Prescriptions for non-controlled substances have a one-year expiration and an 11-refill maximum from the date prescribed, whichever occurs first.

Refills for Scheduled III-V narcotics have a six (6) month expiration and a five refill maximum from the date prescribed, whichever occurs first.

No refills are allowed on Schedule II prescriptions.

National Drug Code

In order to be reimbursed for a pharmacy claim, prescribed items must have an assigned National Drug Code (NDC).

Prescriptions Received via Telecommunication

Most prescriptions are acceptable when received by telephone or other telecommunication device in accordance with state and federal regulations. Providers must file and log prescriptions received via telecommunication as they would any other written or electronic prescriptions.

Tamper Resistant Prescription Policy

Written, non-electronic prescriptions for Medicaid beneficiaries are required to be written on tamper-resistant pads.

The "Transitional Medical Assistance (TMA), Abstinence Education and QI Program Extension Act of 2007" (H.R. 3668) and the "U.S. Troop Readiness, Veterans' Health Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007" (H.R. 2206) states that all

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handwritten prescriptions or those printed from an electronic medical record (EMR), or an ePrescribing application must contain all three characteristics listed below. Exceeding these guidelines is permissible if:

1.   One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

2.   One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and

3.   One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

This provision applies to all written (non-electronic) prescriptions for outpatient drugs including over-the-counter drugs reimbursed by Pharmacy Program, regardless of whether Medicaid is the primary or secondary payer.

It is the responsibility of the prescriber to obtain and purchase tamper-resistant prescription pads.

NOTE: The *Table of Tamper Resistant Prescription Criteria and Examples* can be accessed in Section 37.5.12 at:
www.lamedicaid.com/Provweb1/manuals/App_L_Tamper_Res_Prescription.pdf

Excluded Prescriptions

The tamper-resistant requirement does not apply to prescriptions which are communicated by the prescriber to the pharmacy electronically, verbally or by facsimile.

Confirming Non-Compliant Prescriptions

If a prescription does not meet the requirements for tamper-resistance, pharmacies may obtain verbal confirmation and document appropriately. The pharmacy does not need to speak with the prescriber directly. They may receive confirmation from a nurse or administrative staff person who has authority to act on behalf of the prescriber.

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Emergency Fills

Emergency fills with non-compliant written prescriptions are permissible as long as the prescriber provides a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled. If an emergency fill is confirmed with a verbal order, the pharmacist must document the call on the face of the written prescription.

Authorized Benefits

Provided below are the authorized medications and/or supplies which are payable under Louisiana Medicaid.

NOTE: Refer to "Quantity Limitations" in this section and Section 37.3 - Reimbursement Services for detailed information regarding authorized benefits.

Legend Drugs

Legend drugs are drugs that require a prescription or that have the following statement on the label, "Caution: Federal law prohibits dispensing without a prescription." Medicaid reimbursement is available for most legend drugs that are dispensed in outpatient settings.

NOTE: Refer to "Non-Covered Services" in this section for detailed information regarding legend drugs.

Legend Vitamin and Mineral Products

Only the following legend vitamin and mineral products will be reimbursed by the Pharmacy Program:

Vitamin B 12 preparations	Vitamin E preparations	Pediatric vitamin preparations
Vitamin A preparations	Vitamin K preparations	Legend prenatal vitamins for pregnant and lactating beneficiaries
Vitamin B preparations	Calcium replacement	Magnesium salt replacement
Vitamin B1 preparations	Folic Acid preparation	Prescription strength fluoride as a single entity
Vitamin B6 preparations	Geriatric vitamin preparations	Urinary pH modifiers (Phosphorus)
Vitamin C preparations	Multivitamin preparations	

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Vitamin D preparations	Niacin preparations	

Injectable Drugs

Reimbursement is provided for most injectable drugs for outpatient beneficiaries when supplied by community pharmacies, long-term care (LTC) pharmacies, and home infusion pharmacies that are enrolled as Medicaid providers.

Some antibiotic and oncologic injections administered in practitioners offices and clinics are reimbursed through the Professional Services Program.

Non-Legend Drugs

Only a limited number of non-legend or over-the-counter (OTC) drugs can be reimbursed by the Louisiana Medicaid program. For Medicaid reimbursement, these drugs must be prescribed by licensed practitioners. **Providers must bill the NDC from the actual package dispensed. Also, the drug manufacturer must participate in the federal rebate program.**

The following non-legend drugs are covered when an authorized prescriber has written a prescription:

1.   Insulin;

2.   Sodium chloride solution for inhalation therapy;

3.   Contraceptives, topical;

4.   Urinary pH modifiers; and

5.   Other non-legend drugs that have Pharmacy Program approval.

Non-Legend Items and Supplies

Only a limited number of non-legend items and supplies can be reimbursed by the Medicaid Program. In order to receive Medicaid reimbursement, these items and supplies must be prescribed by licensed practitioners. **(Providers must bill the NDC from the actual package dispensed):**

1.   OTC Vitamin D preparations;

2.   OTC Vitamin E preparations;

3.   OTC Niacin preparations;

4.   OTC Calcium replacement agents;

5.   OTC Magnesium replacement agents;

6.   OTC Phosphate replacement agents;

7.   OTC Iron replacement agents;

8.   Normal saline and heparin flushes;

9.   Disposable needles and syringes used to administer insulin;

10.   Test strips for determining blood glucose levels;

11.   Lancets;

12.   Urine test strips (e.g., Clinitest® and Clinistix®);

13.   Family planning items; and

14.   Other non-legend items and supplies that have Pharmacy Program approval.

Total Parenteral Nutrition

Total Parenteral Nutrition (TPN) and associated supplies and equipment are covered services in the Pharmacy Program. (Refer to Section 37.5.10 - Total Parenteral Nutrition for additional information).

Medication Administration

Enrolled pharmacies may be reimbursed for the administration of select adult vaccines and the COVID vaccine. Pharmacists who have the "Authority to Administer" authorized by the Louisiana Board of Pharmacy may administer vaccines. (Refer to Section 37.5.11 - Medication Administration for detailed information).

Non-Covered Services

Drugs Excluded From Coverage

The following drugs and/or therapeutic categories are excluded from Medicaid coverage:

1. Select agents when used for anorexia, weight loss, or weight gain with the exception of orlistat (Xenical);

2. Select agents when used to promote fertility except vaginal progesterone when used for high-risk pregnancy to prevent premature births;

3. Select agents when used for symptomatic relief of cough and colds except prescription antihistamine and antihistamine/decongestant combination products;

4. Select prescription vitamins and mineral products except:

Vitamin B 12 preparations	Vitamin E preparations	Pediatric vitamin preparations
Vitamin A preparations	Vitamin K preparations	Legend prenatal vitamins for pregnant and lactating beneficiaries
Vitamin B preparations	Calcium replacement	Magnesium salt replacement
Vitamin B1 preparations	Folic Acid preparation	Prescription strength fluoride as a single entity
Vitamin B6 preparations	Geriatric vitamin preparations	Urinary pH modifiers (Phosphorus)
Vitamin C preparations	Multivitamin preparations	
Vitamin D preparations	Niacin preparations	

5. Select nonprescription drugs except OTC antihistamines and antihistamine/decongestant combinations, OTC naloxone, polyethylene glycol 3350, and OTC medications listed in the U.S. Preventive Service Task Force A and B Recommendations.

Otherwise Restricted Drugs include the following:

1.   The state will cover agents when used for cosmetic purposes or hair growth only when the state has determined that use to be medically necessary;

2.   Select drugs for erectile dysfunction except when used for the treatment of conditions, or indications approved by the FDA, other than erectile dysfunction;

3.   Compound prescriptions (mixtures of two or moe ingredients; the individual drugs will continue to be reimbursed);

4.   Drug Efficacy Study Implementation (DESI) Drugs (refer to those drugs that the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness);

5.   Experimental drugs;

6.   Medications which are included in the reimbursement to a facility, i.e. hospitals, skilled nursing facility for beneficiaries receiving benefits under Part A of Title XVIII, mental hospitals, or some other nursing facilities; and

7.   Vaccines covered in other programs. The state will cover select adult vaccines in the pharmacy program.

Durable Medical Equipment

The Medicaid Pharmacy Program will reimburse continuous glucose monitors and other diabetic supplies as a pharmacy benefit.   Preferred products and prior authorization (PA) criteria for continuous glucose monitors will be posted on the Single Preferred Drug List (PDL).

The following diabetic supplies with be reimbursed as a pharmacy benefit only:

1.   Diabetes glucose meters;

2.   Diabetic test strips;

3.   Continuous glucose meters;

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4.   Transmitters and sensors;

5.   External insulin pumps (i.e. Omnipod and V-Go);

6.   Control solution;

7.   Ketone test strips

8.   Lancets and devices;

9.   Pen needles;

10.   Re-usable insulin pens; and

11.   Syringes.

Prior Authorization and Single Preferred Drug List

The Medicaid Program administers a PA process for pharmacy services. This process utilizes a single PDL for selected therapeutic classes. Drugs included on the PDL are preferred. Drugs in these classes that are not included on the PDL require prescribers to obtain PA.

PDL Provider Notification

Lists of covered drug products, including those that require PA, will be posted on the Louisiana Medicaid website.

Prior Authorization Process General Information

The PA process provides for a turn-around response by either telephone or other telecommunications device within 24 hours of a PA request. In emergency situations, providers may dispense a minimum of a 72 hour or a three day supply of medication**.**

Prior Authorization and Single PDL Information Site

The *Louisiana Medicaid Single PDL/Non-Preferred Drug List (NPDL)* and the *Louisiana Uniform Prescription Drug Prior Authorization Form* and its instructions can be accessed at:

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf or by visiting Section 37.5.5 of this manual
chapter.

Who Can Obtain Prior Authorization

The prescribing practitioner is responsible for obtaining PA for non-preferred agents, agents which
require clinical PA or where PAs are otherwise required. Pharmacist or beneficiary calls/requests
will not be accepted. The prescribing practitioner must have and provide their valid individual
Louisiana Medicaid prescribing provider number to obtain PA. Only individual provider numbers
will be accepted.

The prescribing practitioner may obtain the PA by one of the following:

    1.   Electronic prior authorization (E-PA);

    2.   Telephone;

    3.   Facsimile; or

    4.   Mail.

NOTE: Refer to the Section 37.5.4 – Contact Information for access to additional information on
PA. In addition, refer to Section 37.5.5 of this manual chapter to access drug specific forms,
criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

The Prior Authorization Unit's (PAU's) hours of operation are 8:00 am to 6:00 pm Central Time,
Monday through Saturday.

**NOTE: National Provider Identifier (NPI) numbers that are assigned to a group are not
allowed to prescribe or obtain a PA.** If a prescribing practitioner does not have an individual
prescriber number, refer to Section 37.5.6 - Prescribers for detailed information.

Prior Authorization Request Form

The Louisiana Uniform Prescription Drug PA Form must be used by the prescriber to request a
PA.   The   form   and   its   instructions   can   be   accessed   at:
http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf or by visiting Section 37.5.5 of this manual
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Emergency Procedures

Prescriptions indicating emergency situations shall be dispensed in a minimum quantity of a three day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.** The beneficiary's practitioner must contact the PAU (RxPA) to request authorization to continue the medication past the emergency supply, and a new prescription must be issued.

This process may be used when the RxPA Unit is closed (Sundays; Monday – Saturday before 8:00 am and after 6:00 pm) or when the PA system is unavailable. The pharmacist may also use professional judgment in situations that would necessitate an emergency supply.

The prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription if hard copy, or if the prescription is called in to the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency Rx" on the hard copy prescription. When the pharmacist determines the prescription is an emergency, the pharmacist must indicate "Emergency by Pharmacist" on the hard copy prescription.

NOTE: The Point of Sale (*POS) User Guide* can be accessed at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed claim submission and processing information.

Beneficiaries are exempt from paying co-payments for emergency situations.

Monitoring of emergency prescriptions/beneficiaries is conducted on an ongoing basis through management reports, pharmacy provider audits, and other monitoring programs to review the number of and the reasons for these prescriptions.

Hospital Discharge Prescriptions for Atypical Antipsychotic Agents

When a beneficiary is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if it is a hard copy, that the prescription is a "Hospital Discharge". If the prescription is called in to the pharmacy, the "Hospital Discharge" status of the prescription must be communicated to the pharmacist who must indicate "Hospital Discharge" on the hard copy prescription.

In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is a "Hospital Discharge" prescription, the pharmacist must indicate "Hospital Discharge on the hard copy prescription.

Claims for "Hospital Discharge" prescriptions needing PA will be submitted using the same process used for an emergency override.

Prescriptions for "Hospital Discharge" products shall be dispensed in a minimum quantity of a three-day supply, and refills for the dispensing of the non-preferred products are not permitted. The beneficiary's practitioner must contact the RxPA Unit to request authorization to continue the medication past the "Hospital Discharge" supply, and a new prescription must be issued.

Prescriptions Issued Prior to the Effective Dates of Prior Authorization

The PA process does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to a drug's effective date of PA.

Beneficiaries with Retroactive Eligibility

Drugs that are not on the PDL are sometimes dispensed to patients who are awaiting Medicaid eligibility determinations.   Pharmacy providers will be reimbursed for these claims when the date of service falls within the beneficiaries' retroactive time period. The retroactive time period is defined as the time period between the first date of eligibility and the date that the beneficiary's eligibility is placed on the beneficiary file. Pharmacy providers shall submit these claims electronically.

Important Facts

When a beneficiary elects to self-pay for an original prescription which requires PA, attempts to have Medicaid pay for the refill of this prescription will result in the pharmacy claim being denied.

If an approved PA exists in the system, the pharmacy claim will bypass the PA edit and continue with existing POS edits. If an approved PA does not exist, the pharmacy claim will be denied through the POS system.

An approved PA does not guarantee payment of the claim by Medicaid. It only indicates that the drug has been approved as a course of treatment within the Medicaid Program. All existing POS claim edits will continue to be applied.

The PA process does not verify a beneficiary's Medicaid eligibility. It only verifies that the beneficiary is "on file" (i.e., has a valid Medicaid ID number on file – not that the beneficiary is eligible on the date of service). Beneficiary eligibility will continue to be verified by the Pharmacy POS subsystem or through the Medicaid Eligibility Verification System (MEVS) or Recipient Eligibility Verification System (REVS) automated beneficiary eligibility systems.

Only practitioners' individual prescriber numbers are accepted to request PA of a non-preferred drug. Any provider number other than an individual prescribing provider number **WILL NOT** be accepted to prior authorize non-preferred drugs.

Clinical Authorization

There are certain medications that require clinical authorization. Clinical authorization is a prescriber initiated request for authorization on a selected number of drugs.

Prescribers must complete the *Louisiana Uniform Prescription Drug Prior Authorization Form* in full. The clinical authorization criteria can be used as a reference when completing the form. Clinical authorization requests should be faxed or mailed to the RxPA Unit. (Refer to Section 37.5.4 – Contact Information in this manual chapter for contact information).

NOTE: Refer to the Single PDL to access the clinical authorization drug list, forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Monthly Service Limit

Limit

Medicaid reimburses up to four prescriptions per calendar month per beneficiary. Claims including those for emergency prescriptions and PA prescriptions that are in excess of four per calendar month per beneficiary will be denied.

Exceptions to Limit

The following federally mandated beneficiary groups are exempt from the 4 prescriptions per calendar month limitations:

1.   Persons under 21 years of age;

2.   Persons who are residents of long-term care institutions, such as nursing homes and Individuals with Intellectual Disabilities (ICF/IID) facilities; and

3.   Beneficiaries who are pregnant.

Limit Override Procedures

The four prescriptions per month limit can be exceeded when the prescriber determines an additional prescription is medically necessary and communicates the following information to the pharmacist on the hard prescription, by telephone or other telecommunications device:

1.   "Medically necessary override; and

2.   Valid diagnosis code that directly relates to each drug prescribed that is over the four prescription limit (an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM, or its successor) literal description is not acceptable).

The prescriber should use the Electronic Clinical Drug Inquiry (e-CDI) in their clinical assessment of the beneficiary's disease state or medical condition and the current drug regimen before making a determination that more than four prescriptions per calendar month is required by the beneficiary. (Refer to Section 37.5.4 for details on how to access the e-CDI).

Printed statements without the prescribing practitioner's signature, check-off boxes or stamped signatures are not acceptable documentation.

An acceptable statement and diagnosis code are required for each prescription in excess of four for each calendar month.

Pharmacists and prescribers are required to maintain documentation to support the override of a prescription limitation.

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NOTE: Refer to Section 37.5.1 to access the *POS User Guide* to obtain detailed billing instructions and override procedures at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Drugs with Special Payment Criteria/Limitations

Coverage of some drugs is limited to special criteria being met. These are explained below.

NOTE: Refer to Section 37.5.8 - Claim Submission for detailed override information as well as Section 37.5.1 to access the *POS User Guide* for detailed billing instructions, where applicable, at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Age and Gender Restricted Drugs

Certain drugs have age and gender restrictions placed on them. For further assistance, providers should contact the Gainwell Provider Helpdesk (Refer to Section 37.5.4 for contact information).

Acne Agents

Pharmacy claims for select acne agents have a quantity limit, age requirements, and/or clinical authorization requirement.

Clinical information (acne severity) is required for all topical acne agents.

All agents are limited to use in beneficiaries who are younger than 21 years of age when used for acne. Trifarotene (Aklief®) is limited to beneficiaries who are at least 9 years of age.

Pharmacy claims submitted with a diagnosis code for psoriasis (L40*) will bypass the age restriction for tazarotene cream or tazarotene gel.

** Any number or letter or combination of **UP TO 4** numbers and letters of an assigned ICD-10-CM diagnosis code*

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at:
http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Allergen Extracts

Pharmacy claims for allergen extracts may be subject to clinical authorization/PA, physician prescriber requirements, age requirements, diagnosis code requirements, and an auto-injectable epinephrine prescription requirement for reimbursement.

Select allergen extracts are listed in the following chart:

Generic Name (Brand Name Example)
Grass Pollen Allergen Extract (Timothy Grass) Sublingual Tablet (Grastek®)
House Dust Mite Allergen Extract Sublingual Tablet (Odactra™)
Mixed Grass Allergen Extracts Sublingual Tablet (Oralair®)
Peanut (*Arachis hypogaea*) Allergen Powder Capsule; Packet (Palforzia®)
Ragweed Pollen Allergen Extract Sublingual Tablet (Ragwitek®)

Physician Prescriber Requirements for Allergen Extracts

Prescribers of allergen extracts must have a specialty of 1) Allergy, 2) Otology, Laryngology, Rhinology, or 3) Ophthalmology, Otology, Laryngology, Rhinology for reimbursement.
NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Auto-Injectable Epinephrine Requirement for Allergen Extracts

Pharmacy claims for allergen extracts require a pharmacy claim for an auto-injectable epinephrine product within the last year for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Alzheimer's Agents

Select agents for the treatment of Alzheimers disease require clinical authorization or PA. The following chart lists select agents for the treatment of Alzheimer's disease.

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Generic Name (Brand Name Example)
Aducanumab-avwa (Aduhelm™)*
Donepezil ODT, Tablet (Aricept®)
Donepezil Transdermal Patch (Adlarity®)
Galantamine ER Capsule, Solution, Tablet
Lecanemab-irmb (Leqembi™)*
Memantine Solution, Tablet, Dose Pack (Namenda®, Namenda®Titration Pack)
Memantine ER Capsule, Dose Pack (Namenda XR®, Namenda XR® Titration Pack)
Memantine/Donepezil ER Capsule (Namzaric®)
Rivastigmine Capsule
Rivastigmine Transdermal Patch (Exelon®)

* Aducanumab-avwa (Aduhelm™) and lecanemab-irmb (Leqembi™) require a drug specific clinical authorization form.

Antiemetic/Antivertigo Agents

Pharmacy claims for select antiemtic/antivertigo agents may be subject to the following:

1.   Clinical authorization/PA;

2.   Behavioral health clinical authorization for ages less than 7 years (for prochlorperazine);

3.   Diagnosis code requirement; and

4.   Quantity limit.

The following bypass conditions apply for antiemtic/antivertigo agents:

1.   Prochlorperazine pharmacy claims that are submitted with a diagnosis code for severe nausea or vomiting will bypass the Behavioral Health Clinical Authorization requirement for children younger than 7 years of age; and

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2.   Ondansetron ODT and ondansetron tablet pharmacy claims that are submitted with a diagnosis code for cancer or palliative end-of-life care will bypass the quantity limit.

Select antiemetic/antivertigo agents are listed in the following chart.

Generic Name (Brand Name Example)	Generic Name (Brand Name Example)
Amisulpride Vial (Barhemsys®)	Metoclopramide Solution, Tablet, Vial (Reglan®)
Aprepitant Capsule, Pack, Powder for Oral Suspension (Emend®)	Metoclopramide Nasal (Gimoti®)
Aprepitant Vial (Aponvie®, Cinvanti®)	Netupitant/Palonosetron HCl Capsule (Akynzeo®)
Dimenhydrinate Vial	Ondansetron ODT, Solution, Tablet, Vial
Dolasetron Mesylate (Anzemet®)	Ondansetron Oral Film (Zuplenz®)
Doxylamine/Pyridoxine Tablet (Bonjesta®, Diclegis®)	Ondansetron Ampule, Syringe
Dronabinol Oral (Marinol®)	Palonosetron Vial (Aloxi®)
Fosaprepitant Dimeglumine Vial (Emend®	Prochlorperazine Rectal, Tablet, Vial (Compro®)
Fosnetupitant/Palonosetron Vial (Akynzeo®)	Promethazine Ampule, Rectal, Suppository, Syrup, Tablet, Vial (Phenergan®)
Granisetron ER Syringe, Tablet, Vial (Sustol®)	Rolapitant Tablet (Varubi®)
Granisetron Transdermal Patch (Sancuso®)	Scopolamine Transdermal (Transderm-Scop®)
Meclizine Tablet (Antivert®)	Trimethobenzamide Capsule, Vial (Tigan®)

The following **antiemetic/antivertigo** agent will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Ondansetron (Zofran®) ODT, Tablet (solid oral dosage forms)	30 tablets/30 days

Amifampridine (Firdapse®)

Pharmacy claims for amifampridine (Firdapse®) are subject to the following:

1.   Clinical authorization;

2.   Diagnosis code requirement; and

3.   Maximum daily dose.

The maximum daily dose for amifampridine (Firdapse®) is listed in the chart below.

Generic Name (Brand Name)	Maximum Daily Dose
Amifampridine (Firdapse®)	80 mg/day

Amyotrophic Lateral Sclerosis

Pharmacy claims for amyotrophic lateral sclerosis (ALS) agents require an appropriate diagnosis code entered at POS.

Select amyotrophic lateral sclerosis (ALS) agents are listed in the following chart.

Generic Name (Brand Name Example)
Edaravone (Radicava®; Radicava ORS®)
Riluzole (Rilutek®; Tiglutik™; Exservan™)
Sodium Phenylbutyrate and Taurursodiol (Relyvrio™)
Toferson (Qalsody™)

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Androgenic Agents

Select androgenics may be subject to the following:

1.   PA; and

2.   Diagnosis code requirement.

Select androgenic agents are listed in the following chart:

Generic Name (Brand Name Example)
Methyltestosterone Capsule (Methitest®)
Testosterone Gel, Gel Pump, Nasal, Oral, Transdermal (Androgel®, Natesto®, Androderm®)
Testosterone Cypionate IM Injection (Depo-Testosterone®)
Testosterone Enanthate SQ Injection (Xyosted®)
Testosterone Implant Pellet (Testopel®)
Testosterone Undecanoate Capsule, Injection (Jatenzo®, Aveed®)

Pharmacy claims for androgenic agents require an appropriate diagnosis code entered at POS for beneficiaries who are younger than 18 years of age. Pharmacy claims which are submitted with a diagnosis code associated with gender dysphoria or gender reassignment (F64*, Z87.890) will deny.

* – any number or letter or combination of **UP TO 4** numbers and letters of an assigned ICD–10–CM diagnosis code.

Anthelmintics

Select anthelmintics require PA.

Pharmacy claims for ivermectin (Stromectol®) have a diagnosis code requirement at POS.

Anti-Anxiety Drugs

Select anti-anxiety drugs may be subject to the following POS edits:

1.   PA;

2.   Age limit;

3.   Behavioral health clinical authorization for age less than 7 years;

4.   Quantity limit;

5.   Concurrent use;

6.   Prior use;

7.   Therapeutic duplication; and

8.   Diagnosis code requirements.

Select anti-anxiety drugs are listed in the following chart:

Generic Name (Brand Name Example)
Alprazolam ER tablet. ODT, tablet (Xanax®, Xanax XR®)
Alprazolam Intensol Concentrate ®
Buspirone
Chlordiazepoxide
Chlordiazepoxide/Clidinium (Librax®)
Clorazepate (Tranxene T-Tab®)
Diazepam Intensol Concentrate, Solution, Syringe, Tablet, Vial (Valium®)
Lorazepam ER capsule, tablet (Loreev XR ™; Ativan®)
Lorazepam Intensol Concentrate ®
Meprobamate
Oxazepam

Age Requirement

The following anti-anxiety agents are limited for use in beneficiaries who meet specific age requirements as listed in the chart.

Generic Name (Brand Name Example)	Age Limit
Alprazolam XR tablet (Xanax XR®)	> or = 18 years
Alprazolam ODT (Niravam®)	> or = 18 years
Lorazepam ER capsule (Loreev XR®)	> or = 18 years

Behavioral Health Clinical Authorization For Ages Less Than 7 Years

Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents, EXCEPT meprobamate, when requested for beneficiaries who are younger than 7 years of age.

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Quantity Limit

The following anti-anxiety agents will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit Per Rolling 30 Days
Alprazolam (Xanax®)	90 units
Alprazolam ER (Xanax XR®)	30 units
Alprazolam ODT (Niravam ™)	90 units
Chlordiazepoxide	90 units
Clorazepate (Tranxene T-Tab®)	90 units
Diazepam (Valium®)	90 units
Lorazepam (Ativan®)	90 units
Lorazepam ER (Loreev XR™)	90 units
Oxazepam (Serax®)	90 units

Quantity limits will be bypassed for clonazepam (Klonopin®), clorazepate (Tranxene®), and diazepam (Valium®) when an acceptable diagnosis code is submitted.

Acceptable diagnosis codes that will bypass the edit are:

ICD-10-CM Diagnosis Code	Description
P90	Convulsions in Newborn
G40.*	Epilepsy, Seizures
R56.*	Other Convulsions

Concurrent Use

Incoming benzodiazepine pharmacy claims will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for a buprenorphine-containing product used to treat opioid dependence.

Incoming benzodiazepine pharmacy claims will deny when the beneficiary has an active prescription for an opioid analgesic

Pharmacy claims for selected anxiolytics, when submitted with a seizure-related diagnosis code will bypass the behavioral-health clinical authorization requirement, the restriction on concurrent use with opioids, and quantity limits.

Pharmacy claims submitted with a diagnosis code for cancer or palliative end-of-life care will bypass the restriction on concurrent use of benzodiazepines with opioids.

Prior Use

An incoming pharmacy claim for lorazepam (Loreev XR™) will deny if there is no evidence of a pharmacy claim for **ONE** of the following in the most recent 30-day period:

1. A quantity of at least 90 lorazepam immediate-release tablets; **OR**

2. Any quantity of lorazepam (Loreev XR™).

Therapeutic Duplication

Pharmacy claims for anti-anxiety agents will deny at POS with a therapeutic duplication if there is an active claim for another anti-anxiety agent, with oxybate ((Xyrem®) and with oxybate salts (Xywav™).

Diagnosis Code Requirements

Pharmacy claims for alprazolam ER and alprazolam ODT require an appropriate diagnosis code.

NOTE: Refer to the Diagnosis Code Policy chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Analeptics: Armodafinil (Nuvigil®), Modafinil (Provigil®), Pitolisant (Wakix®), and Solriamfetol (Sunosi®)

Age Restriction

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when the beneficiary is 16 years of age or younger**.**

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Pharmacy claims for solriamfetol (Sunosi®) and pitolisant (Wakix®) will deny at POS when the beneficiary is less than 18 years old.

Diagnosis Code Requirements

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) require an appropriate diagnosis code documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.by the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis is required for claim submission. The appropriate diagnosis codes are listed in the chart:

Medication	Description of Diagnosis	ICD-10-CM Diagnosis Code
Armodafinil (Nuvigil®); Modafinil (Provigil®)	Obstructive Sleep Apnea	G47.33
	Circadian rhythm sleep disorder, shift work type	G47.26
	Narcolepsy	G47.4*
Solriamfetol (Sunosi™)	Obstructive Sleep Apnea	G47.33
	Narcolepsy	G47.4*
Pitolisant (Wakix®)	Narcolepsy	G47.4*

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Therapeutic Duplication

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the beneficiary's file for either armodafinil (Nuvigil®) or modafinil (Provigil®).

Therapeutic Duplication with Stimulants

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the beneficiary's file for other stimulants or atomoxetine (Strattera®).

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Pharmacy claims for solriamfetol (Sunosi®) or pitolisant (Wakix®) will deny at POS when there is an active claim on the beneficiary's file for either solriamfetol (Sunosi®), pitolisant (Wakix®), modafinil (Provigil®) or armodafinil (Nuvigil®). Also, modafinil (Provigil®) and armodafinil (Nuvigil®) should deny at POS when there is an active claim on the beneficiary's file for either solriamfetol (Sunosi®) or pitolisant (Wakix®).

Pharmacy claims for solriamfetol (Sunosi®) or pitolisant (Wakix®) will deny if there is an active claim on the beneficiary's file for another stimulant or atomoxetine (Strattera®).

Pharmacy claims for dextroamphetamine (Xelstrym™) will deny if there is an active claim on the beneficiary's file for solriamfetol (Sunosi™) or pitolisant (Wakix®) and vice versa.

Pharmacy claims for dextroamphetamine (Xelstrym™) will deny if there is an active claim on the beneficiary's file for modafinil (Provigil) or armodafinil (Nuvigil) and vice versa.

Concurrent Use with Sedative Hypnotics

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the beneficiary's file for a sedative hypnotic.

If in the professional judgment of the prescriber a determination is made which necessitates therapy with modafinil (Provigil®) or armodafinil (Nuvigil®) and a sedative hypnotic, the pharmacist may override this edit.   After consultation with the prescriber to verify the necessity of both agents, the pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason for concurrent therapy. The reason for service code, professional service code and result of service code used in submitting the claim must also be documented on the hardcopy prescription or in the pharmacy' electronic recordkeeping system.

Pharmacy claims for solriamfetol (Sunosi®) or pitolisant (Wakix®) will deny if there is an active claim on the beneficiary's file for a sedative hypnotic. Pharmacy claims for a sedative hypnotic will deny if there is an active claim on the beneficiary's file for solriamfetol (Sunosi®) or pitolisant (Wakix®).

Antibiotic-Otic Agents

Select antibiotic- otic agents are listed in the following chart.

Generic Name (Brand Name Example)
Ciprofloxacin Solution
Ciprofloxacin/Dexamethasone Susp (Ciprodex®)
Ciprofloxacin/Fluocinolone Acetonide Solution (Otovel®)
Ciprofloxacin/Hydrocortisone Suspension (Cipro HC Otic®)
Colistin/Neomycin/Thonzonium/Hydrocortisone Suspension (Cortisporin® TC)
Neomycin/Polymyxin B/Hydrocortisone Solution, Suspension
Ofloxacin Solution

Pharmacy claims for select antibiotic otic agents may be subject to the following:

1.   PA; and

2.   Quantity limit.

Select antibiotic-otic agents are listed in the following chart.

Generic Name (Brand Name Example)
Ciprofloxacin Solution
Ciprofloxacin/Dexamethasone Susp (Ciprodex®)
Ciprofloxacin/Fluocinolone Acetonide Solution (Otovel®)
Ciprofloxacin/Hydrocortisone Suspension (Cipro HC Otic®)
Colistin/Neomycin/Thonzonium/Hydrocortisone Suspension (Cortisporin® TC)
Neomycin/Polymyxin B/Hydrocortisone Solution, Suspension
Ofloxacin Solution

Pharmacy claims for the following **antibiotic-otic** agent will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Ciprofloxacin HCl 0.2% Otic Solution	2 packs of 14 single-use containers per 30 days

Anticoagulants

Prescriptions for select anticoagulants are subject to the following clinical edits for reimbursement:

1.   Quantity limits; and

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2.   Duration of therapy.

Quantity Limits

The quantity limits for anticoagulant agents are listed in the chart below:

Generic	Representative Brand	Dosage Form	Quantity Limit
Apixaban	Eliquis®	Tablet	60 units/30 days
Apixaban Starter Pack	Eliquis® Starter Pack	Tablet Dose Pack	1 unit/365 days
Dabigatran Etexilate Mesylate	Pradaxa®	Capsule	60 units/30 days
Dalteparin Sodium	Fragmin®	Vial/Syringe	60 units/30 days
Edoxaban Tosylate	Savaysa®	Tablet	30 units/30 days
Enoxaparin Sodium	Lovenox®	Vial/Syringe	60 units/30 days
Fondaparinux Sodium	Arixtra®	Syringe	30 units/30 days
Rivaroxaban 2.5mg	Xarelto®	Tablet	60 units/30 days
Rivaroxaban 10mg, 15mg & 20mg	Xarelto®	Tablet	30 units/30 days
Rivaroxaban Starter Pack	Xarelto® Starter Pack	Tablet Dose Pack	1 unit/365 days
Rivaroxaban	Xarelto® Oral Suspension	Suspension	4 bottles (155ml each)/ 31 days

Duration of Therapy

The duration of therapy for select anticoagulant agents are listed in the chart below:

Generic	Representative Brand	Maximum Duration of Therapy*
Dalteparin	Fragmin®	35 days
Enoxaparin	Lovenox®	35 days
Fondaparinux Sodium	Arixtra®	35 days

*Maximum 35-day course of therapy within a 90-day period

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Antidepressant Medications

Prescriptions for antidepressant medications will require an approved clinical authorization for beneficiaries under 6 years of age. Pharmacy claims for antidepressant medications will be checked for therapeutic duplication.

Therapeutic Duplication

Pharmacy claims for a tricyclic antidepressant will deny if there is an active claim on the beneficiary's file for a tricyclic antidepressant.

Pharmacy claims for selective serotonin reuptake inhibitors (SSRIs) will deny if there is an active claim on the beneficiary's file for a SSRI.

Antihistamine/ Decongestant Products

Antihistamine/decongestant products may require a PA for reimbursement.

Antihistamine/decongestant products are subject to a therapeutic duplication with each other and with other sedating antihistamines at POS.

The program, in accordance with the Social Security Act Section 1927 (d)(2), excludes drugs or classes of drugs containing cough and cold agents when those products are prescribed for the treatment of cough and cold.

Select covered antihistamine and antihistamine/decongestant products are listed in the following chart.

Generic Name (Brand Name Example)
Cetirizine Capsule OTC, Chewable Tablet OTC, Solution OTC, Solution Rx, Tablet OTC (Zyrtec)
Cetirizine/Pseudoephedrine Tablet OTC (Zyrtec-D)
Chlorpheniramine Maleate Tablet
Chlorpheniramine/Pseudoephedrine Liquid (Lohist-D)
Clemastine Fumarate Syrup, Tablet
Cyproheptadine Syrup, Tablet
Desloratadine ODT, Tablet (Clarinex®)
Desloratadine/Pseudoephedrine ER Tablet (Clarinex-D®)

Fexofenadine Suspension OTC, Tablet OTC (Allegra)
Fexofenadine/Pseudoephedrine Tablet OTC (Allegra-D)
Levocetirizine Solution, Tablet, Tablet OTC (Xyzal)
Loratadine Chewable Tablet OTC, ODT OTC, Solution OTC, Tablet OTC (Claritin)
Loratadine/Pseudoephedrine Tablet OTC (Claritin-D)

Therapeutic Duplication

Pharmacy claims for first and/or second generation antihistamines and antihistamine-decongestant products will deny if there is an active claim on the beneficiary's file for another first and/or second generation antihistamine or antihistamine-decongestant product. A change in therapy from an antihistamine to an antihistamine-decongestant or the reverse will have override provisions.

Exclusions

Claims for diphenhydramine, hydroxyzine HCL, and hydroxyzine pamoate are excluded from the therapeutic duplication.

After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic recordkeeping system the following:

1.   The reason the prescribing provider chose to override the therapeutic duplication; and

2.   The National Council for Prescription Drug Program (NCPDP) DUR override codes used in submitting the claim.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits" in this section for policy regarding first and second generation antihistamines and combination agents included in the therapeutic duplication edit.

Anti-Fungal

Pharmacy claims for select oral antifungal agents will be subject to the following:

1.   Prior or clinical authorization; and

2.   Quantity limit.

Select anti-fungals are listed in the following chart:

Generic Name (Brand Name Example)
Clotrimazole Troche
Fluconazole Suspension, Tablet (Diflucan®)
Flucytosine Capsule
Griseofulvin Suspension, Tablet, Ultramicrosize Tablet
Ibrexafungerp Citrate Tablet (Brexafemme™)
Isavuconazonium Capsule (Cresemba®)
Itraconazole Capsule, Solution (Sporanox®)
Itraconazole Capsule (Tolsura®)
Ketoconazole Tablet
Miconazole Buccal Tablet (Oravig®)
Nystatin Tablet
Oteseconazole Capsule (Vivjoa™)
Posaconazole Suspension, Suspension Packet, Tablet (Noxafil®)
Terbinafine Tablet
Voriconazole Suspension, Tablet (Generic; Vfend®)

Anti-Infective, Anti-Fungal, and Corticosteroids

Pharmacy claims for select anti-infective, anti-fungal, and corticosteroids have quantity limits.

Medication	Dosage Form	Quantity Limit
Ciclopirox Olamine 0.77%	Suspension	60ml/30 days
Ciprofloxacin HCl 0.2%	Otic Solution	2 packs of 14 singles/30 days
Clobetasol Propionate 0.05%	Cream	100gm/30 days

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Clobetasol Propionate 0.05%	Ointment	120gm/30 days
Clobetasol Propionate 0.05%	Solution	100ml/30 days
Doxycycline Hyclate / Monohydrate	Capsule	60 caps of any strength/30 days
Econazole Nitrate 1%	Cream	85gm/30 days
Gentamicin Sulfate 0.3%	Ophthalmic Ointment	3.5gm/30 days
Gentamicin Sulfate 0.3%	Ophthalmic Solution	5ml/30 days
Gentamicin Sulfate 0.1%	Cream	30gm/30 days
Gentamicin Sulfate 0.1%	Ointment	30gm/30 days
Itraconazole 100mg	Capsule	120 caps/30 days
Itraconazole 100mg	Capsule Pulsepak	1 pack (28 caps) / 28 days
Itraconazole 65mg	Capsule	120 caps/30 days
Ketoconazole 2%	Shampoo	120ml/30 days
Ketoconazole 2%	Cream	60gm/30 days
Mupirocin 2%	Cream	30gm/30 days
Mupirocin 2%	Ointment	22gm/30 days
Nystatin 100,000 units/gm	Cream	60gm/30 days
Nystatin 100,000 units/gm	External Powder	120mg (Two 60mg bottles)/30 days
Nystatin 100,000 units/gm	Ointment	60gm/30 days

Antimigraine Agents- CGRP Antagonists

Pharmacy claims for select antimigraine agents-CGRP antagonists may be subject to clinical or PA and quantity limits.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

The quantity limits for select CGRP antagonists are listed in the following chart:

Medication-Generic (Brand)	**Quantity Limit**
Atogepant (Qulipta)	30 tablets/30 days
Eptinezumab-jjmr (Vyepti™)	3 single dose vials (300mg)/90 days
Erenumab-aooe (Aimovig®) - 70mg, 140mg single dose syringe	3 single dose syringes/90 days

Fremanezumab-vfrm (Ajovy®) - 225mg single dose syringe	3 single dose syringes/90 days
Galcanezumab-gnlm (Emgality®) - 100mg single dose syringe	3 single dose syringes/30 days
Galcanezumab-gnlm (Emgality®) - 120mg single dose pen/syringe	7 single dose syringes/180 days
Rimegepant (Nurtec® ODT)	16 tablets/30 days
Ubrogepant (Ubrelvy™)	16 tablets/30 days

Antiretroviral Agents – HIV/AIDS

Pharmacy claims for select antiretroviral agents – HIV/AIDS require a diagnosis code and are monitored for therapeutic duplication.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Antipsychotic Agents

Pharmacy claims for select antipsychotic medications are subject to the following:

1.   Diagnosis Code Requirement;

2.   Age Requirements;

3.   Quantity limits;

4.   Maximum daily dose;

5.   Prior use; and

6.   Therapeutic Duplication.

Diagnosis Code Requirement on All Antipsychotic Medications

Prescriptions for antipsychotic agents require appropriate diagnosis codes.

The numeric diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Pharmacy claims for antipsychotic medications that have a missing or invalid diagnosis code will deny at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

If the prescriber does not indicate a diagnosis code, and the pharmacist determines the beneficiary cannot wait to receive the medication, the pharmacy provider may override the denial. The pharmacist must document "Emergency" on the hard copy prescription or in the pharmacy's electronic recordkeeping system and the reason for the emergency.

Antipsychotic agents are also subject to prospective DURs when a third antipsychotic agent is submitted for payment.

Age Requirements for Antipsychotic Medications

Select antipsychotic agents have age requirements. Pharmacy claims for pimavanserin (Nuplazid®) is limited to use in beneficiaries who are at least 18 years old.

Maximum Daily Dose for Antipsychotic Medications

The following antipsychotic agents are subject to a maximum daily dose limit as listed in the chart below.

Generic – Brand Example	Age (Years)						
<5		5	6-9	10-12	13-15	16-17	18 and older
Aripiprazole – Abilify®	5mg	20mg	20mg	20mg	30mg	30mg	30mg
Aripiprazole – Abilify® MyCite®	0mg	0mg	0mg	0mg	0mg	0mg	30mg

Asenapine – Saphris®	0mg	0mg	0mg	20mg	20mg	20mg	20mg
Asenapine Transdermal - Secuado®	0mg	0mg	0mg	0mg	0mg	0mg	7.6mg
Brexpiprazole – Rexulti®	0mg	0mg	0mg	0mg	0mg	4mg	4mg
Cariprazine – Vraylar®	0mg	0mg	0mg	0mg	0mg	4.5mg	6mg
Vraylar® Therapy Pack	0mg	0mg	0mg	0mg	0mg	4.5mg	6mg
Clozapine – Clozaril®, FazaClo®, Versacloz®	0mg	0mg	0mg	0mg	0mg	0mg	900mg
Iloperidone – Fanapt®	0mg	0mg	0mg	0mg	0mg	16mg	24mg
Lurasidone – Latuda®	0mg	0mg	0mg	80mg	80mg	80mg	160mg
Olanzapine – Zyprexa®	10mg	20mg	20mg	20mg	30mg	30mg	40mg
Olanzapine/Fluoxetine – Symbyax®	0mg	0mg	0mg	12mg/50mg	12mg/50mg	12mg/50mg	18mg/75mg
Paliperidone – Invega®	3mg	6mg	6mg	6mg	9mg	9mg	12mg
Quetiapine – Seroquel®	100mg	600mg	600mg	600mg	1000mg	1000mg	1200mg
Risperidone – Risperdal®	3mg	6mg	6mg	6mg	8mg	8mg	16mg
Ziprasidone – Geodon®	30mg	60mg	60mg	60mg	120mg	120mg	200mg

Quantity Limits

Pharmacy claims for selected antipsychotic medications have quantity limits.

Antipsychotic Oral/Transdermal Agents Quantity Limit Chart

The following antipsychotic oral/transdermal agents are subject to a quantity limit as listed in the chart below.

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Medication –Generic (Brand)	Quantity Limit
Asenapine (Secuado®)	30 patches per 30 days
Lurasidone (Latuda®) Tablet 20mg, 40mg, 60mg & 120mg	30 tablets per 30 days
Lurasidone (Latuda®) Tablet 80mg	60 tablets per 30 days
Olanzapine/Samidorphan (Lybalvi)	30 tablets per 30 days
Pimavanserin (Nuplazid™) 10 mg	30 tablets per 30 days
Pimavanserin (Nuplazid™) 34 mg	30 capsules per 30 days

Antipsychotic Injectable Agents Quantity Limit Chart

The following antipsychotic injectable agents are subject to quantity limit as listed in the chart below.

Medication-Generic (Brand)	Quantity Limit
Aripiprazole (Abilify Asimtufii®)	1 unit every 56 days
Aripiprazole (Abilify Maintena®)	1 unit every 28 days
Aripiprazole Lauroxil (Aristada®) 441 mg; 662 mg; 882 mg syringe	1 unit every 28 days
Aripiprazole Lauroxil (Aristada®) 1064mg syringe	1 unit every 56 days
Aripiprazole Lauroxil (Aristada® Initio™) 675mg syringe	Limited to 1 unit per 18-month period
Olanzapine (Zyprexa Relprevv®) 210mg & 300mg60 tablets per 30 days	2 units every 28 days
Olanzapine (Zyprexa Relprevv®) 405mg	1 unit every 28 days
Paliperidone Palmitate (Invega Hafyera®)	1 unit every 180 days
Paliperidone Palmitate (Invega Sustenna®)	Initiation: 2 units in 14 days; Maintenance: 1 unit every 28 days
Paliperidone Palmitate (Invega Trinza®)	1 unit every 84 days
Risperidone (Perseris™)	1 unit every 28 days
Risperidone (Risperdal Consta®)	2 units every 28 days
Risperidone Microspheres (Rykindo®)	2 units every 28 days
Risperidone (Uzedy™) 50mg; 75mg; 100mg; 125mg syringe	1 unit every 28 days

Risperidone (Uzedy™) 150mg; 200mg; 250mg syringe	1 unit every 56 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Therapeutic Duplication

Pharmacy claims for a beneficiary with an active oral antipsychotic prescription on file will deny when an additional pharmacy claim for a second oral antipsychotic prescription is submitted.

Pharmacy claims for a beneficiary with an active injectable antipsychotic prescription on file will deny when an additional pharmacy claim for a second injectable antipsychotic prescription is submitted.

Therapeutic Duplication of Olanzapine/Samidorphan (Lybalvi™) with Another Oral Antipsychotic Medication

An incoming pharmacy claim for olanzapine/samidorphan (Lybalvi™) will deny with a therapeutic duplication if there is an active claim for another oral antipsychotic medication on file. Conversely, a claim for another oral antipsychotic medication will deny with a therapeutic duplication if there is an active claim for olanzapine/samidorphan (Lybalvi™) on file.

Therapeutic Duplication of Paliperidone Palmitate (Invega Hafyera™) with Another Injectable Antipsychotic Medication

An incoming pharmacy claim for paliperidone palmitate (Invega Hafyera™) will deny with a therapeutic duplication, if there is an active claim for another injectable antipsychotic medication on file. Conversely, a claim for another injectable antipsychotic medication will deny with a therapeutic duplication, if there is an active claim for paliperidone palmitate (Invega Hafyera™) on file.

Prior Use Requirement Antipsychotic Agents

Select antipsychotic agents have a prior use requirement at POS.

Pharmacy claims for cariprazine (Vraylar®) have a prior use requirement of a previous claim for cariprazine **OR** a preferred generic oral antipsychotic within the previous 365 days.

Pharmacy claims for lurasidone (Latuda®) have a prior use requirement of a previous claim for lurasidone **OR** a preferred generic oral antipsychotic within the previous 365 days.

An incoming pharmacy claim for paliperidone palmitate (Invega Hafyera™) will require a previous claim for any **ONE** of the medications listed below including the requested medication:

1.   Four (4) claims for Invega Sustenna® in the previous 120-day period; **OR**

2.   One (1) claim for Invega Trinza® in the previous 90-day period; **OR**

3.   One (1) claim for Invega Hafyera™ in the previous 365 days.

Prior Use Requirement Antipsychotic Injectables Chart

These agents require evidence in pharmacy claims indicating established tolerance with previous use of an oral or injectable form.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Asthma/COPD- Immunomodulators

Pharmacy claims for select immunomodulators require PA.

Atidarsagene Autotemcel (Lenmeldy™)

Pharmacy claims for atidarsagene autotemcel (Lenmeldy™) require a clinical authorization.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) Agents

Prescriptions for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD agents will require an appropriate diagnosis code for reimbursement. Pharmacy claims for select ADD/ADHD medications will be subject to quantity limits. ADD/ADHD will be checked for therapeutic duplication.

The numeric diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Pharmacy claims for ADD and ADHD medications that have a missing or invalid diagnosis code will deny at POS.

When beneficiaries are established on ADD/ADHD medications, but the diagnosis codes submitted are not included in the table of covered diagnoses, prescribing providers may call the RxPA Unit (Refer to Section 37.5.4 for contact information.)

NOTE: Refer to the link to access the *POS User Guide* for detailed billing instructions at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Therapeutic Duplication

Pharmacy claims for ADD/ADHD medications will be subject to a therapeutic duplication.

An incoming pharmacy claim for a short-acting ADD/ADHD medication will deny when there is an active claim on file for another short-acting ADD/ADHD medication. An incoming claim for a long-acting ADD/ADHD medication will deny when there is an active claim on file for another long-acting ADD/ADHD medication.

An incoming pharmacy claim for an ADD/ADHD medication will deny when there is an active claim on file for another ADD/ADHD medication written by a different prescriber.

Therapeutic Duplication of Serdexmethylphenidate/ Dexmethylphenidate (Azstarys™) with Another Long-Acting ADD/ADHD Medication

An incoming pharmacy claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) will deny with a therapeutic duplication if there is an active claim for another long-acting ADD/ADHD medication on file. Conversely, a claim for long-acting ADD/ADHD medication will deny with a therapeutic duplication if there is an active claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) on file.

Therapeutic Duplication of Serdexmethylphenidate/ Dexmethylphenidate (Azstarys™) with Another Short-Acting ADD/ADHD Medication

An incoming pharmacy claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) will deny with a therapeutic duplication if there is an active claim for another short-acting ADD/ADHD medication on file. Conversely, a claim for short-acting ADD/ADHD medication will deny with a therapeutic duplication if there is an active claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) on file.

Therapeutic Duplication of Xelstrym™ with another Long-Acting Stimulant or Related Medication for ADHD

Pharmacy claims for dextroamphetamine (Xelstrym™) will deny if there is an active claim on the beneficiary's file for any other long-acting stimulant and related medication for ADHD and vice versa.

Behavioral Health Medications for Beneficiaries 7 Years of Age and Younger

Pharmacy claims for behavioral health medications for beneficiaries 7 years of age and younger require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Clinical Authorization for ADD/ADHD Medications for Beneficiaries Less Than 7 years of Age

Pharmacy claims for ADD/ADHD medications for beneficiaries less than 7 years of age require an approved clinical authorization for reimbursement.

Benign Prostatic Hyperplasia (BPH) Treatment Agents

Pharmacy claims for benign prostatic treatment agents may be subject to the following:

1. PA;

2. Diagnosis code requirement; and

3.   Duration of therapy.

Select benign prostatic treatment agents are listed in the following chart:

Generic Name (Brand Name Example)
Alfuzosin ER Tablet
Doxazosin ER Tablet, Tablet (Cardura XL®; Cardura®)
Dutasteride Capsule (Avodart®)
Dutasteride/Tamsulosin Capsule (Jalyn®)
Finasteride (Proscar®)
Finasteride/Tadalafil (Entadfi®)
Silodosin Capsule (Rapaflo®)
Tadalafil (Cialis®)
Tamsulosin Capsule (Flomax®)
Terazosin Capsule

Pharmacy claims for the BPH treatment agents listed in the following chart require an appropriate diagnosis code entered at POS for beneficiaries who are younger than 18 years of age.

Generic Name (Brand Name Example)
Dutasteride (Avodart®)
Finasteride (Proscar®)

Pharmacy claims for BPH treatment agents listed in the following chart require an appropriate diagnosis code for beneficiaries at any age.

Generic Name (Brand Name Example)
Finasteride/tadalafil (Entadfi®)
Tadalafil (Cialis®)

Pharmacy claims for the following **BPH** treatment agents are limited to a duration of therapy.

Generic Name (Brand Name Example)	Maximum Duration of Therapy
Finasteride/tadalafil (Entadfi®)	26 weeks
Tadalafil 2.5mg or 5mg (Cialis®) when used with finasteride (Proscar®)	26 weeks

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Beremagene geperpavec-sydt (Vyjuvek^{TM})

Pharmacy claims for beremagene geperpavec-sydt (Vyjuvek^{TM}) require an approved clinical authorization for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Birch triterpenes (Filsuvez®)

Pharmacy claims for birch triterpenes (Filsuvez®) require a clinical authorization for reimbursement.

Budesonide (Eohilia^{TM})

Pharmacy claims for budesonide (Eohilia^{TM}) will be subject to the following:

1.   Age Requirement;

2.   Diagnosis Code; and

3.   Duration of Therapy Edit.

Pharmacy claims for budesonide (Eohilia^{TM}) have diagnosis code and age requirement of 11 years of age or older on the date of service.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Prescriptions for budesonide (Eohilia^{TM}) will deny when the duration of therapy exceeds 12 weeks.

Cannabidiol (Epidiolex®)

Pharmacy claims for cannabidiol (Epidiolex®) have a prior use requirement (in a previous 365-day period) of the following:

1.   **ONE** paid claim for cannabidiol (Epidiolex®); **OR**

2. A paid claim in the previous 365 days for at least **TWO** of the following agents (brand/generic or preferred/non-preferred formulations) below:

   a. Clobazam;

   b. Felbamate;

   c. Lamotrigine;

   d. Levetiracetam;

   e. Rufinamide;

   f. Topiramate; and

   g. Valproate derivatives.

Carisoprodol

Pharmacy claims for carisoprodol will deny when the quantity exceeds 90 tablets per rolling 90 days. The quantity limit is cumulative and applies to all strengths and combinations of carisoprodol. The pharmacy claim will deny as exceeding the program's maximum allowed. **There are no provisions for overrides**.

Cefiderocol (Fetroja)

Pharmacy claims for cefiderocol (Fetroja®) have a clinical authorization requirement.

Chorionic Gonadotropin (Novarel®, Pregnyl®)

Pharmacy claims for chorionic gonadotropin (Novarel®, Pregnyl®) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

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Clotting Factor Products

Clotting factor products administered in an outpatient setting will **only** be reimbursed as a pharmacy benefit, not as a medical/professional benefit.

Select clotting factors products are reimbursed in the pharmacy program, exluding Hemlibra.

Brand name examples of clotting factor products are listed in the following chart.

Advate®	Feiba®	Nuwiq®
Adynovate®	Fibryga®	Obizur®
Afstyla®	Hemofil®	Profilnine®
Alphanate®	Humate®	Rebinyn®
Alphanine®	Idelvion ®	Recombinate^tm
Alprolix®	Ixinity®	Riastap Vial®
Altuviiio®	Jivi®	Rixubis®
Balfaxar®	Kcentra®	Sevenfact®
Benefix®	Koate®	Tretten®
Coagadex®	Kogenate®	Vonvendi®
Corifact®	Kovaltry®	Wilate®
Eloctate®	Novoeight®	Xyntha®
Esperoct®	Novoseven®	

Codeine

Pharmacy claims for products containing codeine have an age limit for reimbursement. The acceptable age limits are listed in the chart:

Description	Age (Y=Year)
Codeine (Single Ingredient)	$\geq$18 Y
Codeine Combination Product	$\geq$12 Y

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Collangenase Topical (Santyl®)

Prescriptions for collagenase topical (Santyl®) will have a quantity limit of 7 90 gram tubes per prescription, for a total of 630 grams.

Contraceptive Agents

Medicaid health plans are required to allow a six month supply (180 days supply) of contraceptive drugs to be obtained at one time by the beneficiary when the beneficiary has used the same contraceptive drugs for at least 6 consecutive months prior to receiving a 6-month supply, unless the following applies:

1.   The beneficiary requests a smaller supply; OR

2.   The prescribing provider instructs for the beneficiary to receive a smaller supply.

Drospirenone/Ethinylestradiol/Levomefolate Calcium (Beyaz®)

Pharmacy claims for Drospirenone/Ethinyl Estradiol/Levomefolate Calcium (Beyaz®) require an appropriate diagnosis code for reimbursement.   Claims submitted with diagnosis codes for cosmetic indications will deny.

Etonogestrel (Nexplanon®)

Pharmacy claims for Etonogestrel (Nexplanon®) will be limited to one implant every 2 years.

If the prescriber chooses to exceed the quantity limit for Etonogestrel (Nexplanon®), the pharmacist may override the limit after consultation with the prescribing practitioner. The pharmacist must document the NCPDP override codes and reason for the override on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Etonogesetrel/Ethinyl Estradiol Vaginal Ring (Nuvaring®)

Prescription claims for Etonogestrel/Ethinyl Estradiol vaginal ring (Nuvaring®) for quantities of four and greater will deny. There is no provision for override as these claims exceed the program maximum of a 100 unit doses.

In addition, there will be a valid days' supply range dependent on the quantity billed:

1.   If quantity = 1, then Days' Supply must be 21 to 28;

2.   If quantity = 2, then Days' Supply must be 42 to 56; and

3.   If quantity – 3, then Days' Supply must be 63 to 84.

Pharmacists are allowed to override the denial on days' supply after consultation with the prescriber.

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Oral Contraceptive Agents

Oral contraceptive agents will have an age limit of 12-55 years of age per program policy for legacy Medicaid.

Pharmacy claims for oral contraceptive agents are subject to an **educational alert** encouraging the submission of a diagnosis code at POS. The acceptable diagnosis codes for oral contraceptives as a family planning benefit or for menstrual disorders are listed in the chart.

ICD-10-CM Diagnosis Code	Diagnosis Description
Z30*	Encounter for oral contraceptive management
F32.81	Premenstrual dysphoric disorder
N92*	Excessive, frequent and irregular menstruation

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code.

Medroxyprogesterone Acetate Injectable

Prescription claims for Medroxyprogesterone Acetate injectable for female beneficiaries billed with a quantity of one and a days' supply less than 84 will deny. Quantities of two and greater

will not be payable with no provision for override as they exceed the program maximum of a 100 unit doses.

Claims for Medroxyprogesterone Acetate sub-q 104 injectable for female beneficiaries, billed with a quantity of 0.65 and a days' supply less than 84, will deny. Quantities of 1.3 and greater will not be payable, with no provision for override, as they exceed the program maximum of a 100 unit doses.

Pharmacists are allowed to override the denial on days' supply after consultation with the prescriber.

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Norelgestromin /Ethinyl Estradiol Transdermal Patches (Ortho-Evra) ®)

Reimbursement of these contraceptive transdermal patches when dispensed using the package size of three must be billed in multiples of three. If the quantity billed is not a multiple of three, the claim will deny. There are no provisions for override.

Corticotropin (Acthar® Gel, Cortropin^{TM} Gel)

Pharmacy claims for corticotropin (Acthar® Gel, Cortropin^{TM} Gel) require an approved clinical authorization for reimbursement.

Cytokine and Cell-Adhesion Molecule (CAM) Antagonists

Prescriptions for cytokine and cell-adhesion molecule (CAM) antagonists may require the following for reimbursement:

1. Clinical authorization or PA; and/or

2. Quantity limit.

The quantity limits for select cytokine and CAM antagonists are listed in the chart.

Generic (Brand Example)	Quantity Limit
Adalimumab (Humira®) 10mg, 20mg, 40mg	4 injections per 28 days

Adalimumab (Humira®) 80mg	2 injections per 28 days
Etanercept (Enbrel®)	Starting Dose – 8 injections per 28 days for 3 months (if applicable)
	Maintenance Dose – 4 injections per 28 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Cystic Fibrosis Agents

Pharmacy claims for select agents for the treatment of cystic fibrosis may require PA.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Danicopan (Voydeya®)

Pharmacy claims for danicopan (Voydeya®) require a diagnosis code for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Deferiprone (Ferriprox)

Pharmacy claims for deferiprone (Ferriprox) will require an approved diagnosis code for chronic iron overload due to blood transfusions (E83.111) entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at: https://ldh.la.gov/assets/HealthyLa/PDL/7.30.2020/Louisiana.Medicaid.ICD-10.Chart.docx

Deferasirox (Exjade ®, Jadenu®)

Pharmacy claims for deferasirox (Exjade®, Jadenu®) are subject to diagnosis code requirements and age limitations.

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Beneficiaries 2 years of age and less

Pharmacy claims for deferasirox (Exjade®, Jadenu®) will deny for beneficiaries 2 years of age or less.

Beneficiaries 2-9 years of age

Pharmacy claims for deferasirox (Exjade®, Jadenu®) require a valid diagnosis code for reimbursement.   The diagnosis code must be documented on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Beneficiaries 10 years of age and older

Pharmacy claims for deferasirox (Exjade®, Jadenu®) require a valid diagnosis code for reimbursement. The diagnosis code must be documented on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

The appropriate diagnosis codes for deferasirox (Exjade®) are listed in the chart:

Covered Indications at POS	ICD-10-CM Diagnosis Code
2-9 years of age	
Chronic iron overload due to blood transfusion	E83.111
10 years of age and older	
Chronic iron overload due to blood transfusion	E83.111
Chronic iron overload in non-transfusion-dependent thalassemia (NTDT) syndromes	D56.0, D56.1, D56.5, D56.8, D57.4*

* - any number or letter or combination of UP TO 4 numbers and letters of an assigned ICD-10-CM diagnosis code

Dermatology-Atopic Dermatitis Immunodulators

Pharmacy claims for atopic dermatitis immunodulators may require a clinical authorization or PA.

Pharmacy claims for crisaborole (Eucrisa®) have a quantity limit and prior use requirement.

Crisaborole Ointment (Eucrisa®) is subject to a quantity limit of 300 gm per rolling 365 days.

Pharmacy claims for crisaborole ointment (Eucrisa®) or ruxolitinib (Opzelura™), requires prior use of at least **ONE** paid claim in the previous 180 days for:

1.   Drug [crisaborole ointment (Eucrisa®) or ruxolitinib cream (Opzelura™)];

2.   Topical corticosteroid; **OR**

3.   Topical calcineurin inhibitor.

Point of Sale Bypass Diagnosis for Opzelura® (Ruxolitinib) Prior Drug Use Requirement

Pharmacy claims submitted for ruxolitinib (Opzelura®), when submitted with a diagnosis code for nonsegmental vitiligo (L80), will bypass the POS prior drug use requirement for ruxolitinib (Opzelura®), which requires prior use of ruxolitinib (Opzelura®), a topical corticosteroid, or topical calcineurin inhibitor.

Desmopressin (Nocdurna®)

Pharmacy claims for desmopressin (Nocdurna®) have a quantity limit.

Generic Name	Brand Name	Quantity Limit
Desmopressin	Nocdurna®	30 tablets/day

Diabetic Testing Supplies

The Pharmacy Program reimburses claims for prescribed diabetic testing supplies. Diabetic testing supplies will have a diagnosis code requirement and quantity limit.

Diagnosis Description	ICD-10-CM Diagnosis Code	Quantity Limit
Diabetes Due to Other Conditions or Causes	E08*, E09*, E013*	100/102 Test Strips/90 days and 100/102 Lancets/90 days

Type 2 Diabetes Mellitus	E11*	
Type 1 Diabetes Mellitus	E10*	200/204 Test Strips/30 days and 200/204 Lancets/30 days
Gestational Diabetes; Diabetes Mellitus in Pregnancy	O24.4*; O24*	
Long-Term (Current) Use of Insulin (Insulin Treated Non-Type 1 Diabetes Mellitus)	Z79.4*	

*any number or letter or combination of UP TO FOUR numbers or letters of an assigned ICD-10-CM diagnosis code.

All diabetic supply claims submitted to Medicaid will deny when beneficiaries are Medicare Part B eligible. Medicare Part B covers diabetic supplies for all diabetic beneficiaries regardless of insulin requirements. Pharmacy providers shall submit these claims to the Medicare durable medical equipment regional carrier (DMERC). These claims will then automatically cross over to the Medicaid fiscal intermediary (FI) for payment of the coinsurance and deductible amounts, where applicable.

Diabetic supplies and glucometers for long-term care beneficiaries are not covered in the Medicaid Pharmacy Program or through PA because they are covered in the nursing facility per diem rate.

It is allowable for Medicare Part B to be billed if the long-term care beneficiary is eligible for the benefit. Medicaid is not obligated to pay the coinsurance and deductible if the items are included in the Medicaid per diem. The Medicaid FI will automatically deny any crossover claims for diabetic supplies for long-term care beneficiaries.

NOTE: Refer to Section 37.5.7 - Medicare Prescription Drug Coverage for detailed information.

Dextromethorphan/Quinidine (Nuedexta®)

Pharmacy claims for dextromethorphan/quinidine (Nuedexta®) are subject to the quantity limit listed in the chart.

Generic Name	Brand Name	Quantity Limit
Dextromethorphan/Quinidine	Nuedexta®	60 tablets/30 days

Diroximel Fumarate (Vumerity®)

Pharmacy claims for diroximel fumarate (Vumerity®) are subject to the quantity limit listed in the chart.

Generic Name	Brand Name	Quantity Limit
Diroximel Fumarate	Vumerity®	1 starter bottle (106 capsules)/365 days
		1 maintenance bottle (120 capsules)/30 days

Dichlorphenamide (Keveyis®)

Pharmacy claims for dichlorphenamide are subject to a quantity limit of 120 tablets/30 days.

Dofetilide (Tikosyn®)

Pharmacy claims for dofetilide (Tikosyn®) have a clinical authorization requirement.

Doxepin Cream (Prudoxin®, Zonalon®)

Pharmacy claims for doxepin cream will be subject to the following edits:

1.   Diagnosis code requirement;

2.   Age limit;

3.   Quantity limit; and

4.   Therapeutic duplication.

Diagnosis Code Requirement

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon®) require a diagnosis code. The acceptable diagnosis codes are listed in the chart.

Generic Name	Brand Name	Description of Diagnosis	ICD-10-CM Diagnosis Code
Doxepin Cream	Prudoxin®, Zonalon®	Atopic Dermatitis	L20*
		Lichen Simplex Chronicus	L28.0

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Age Limit

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon®) will deny when the beneficiary is less than 18 years old.

Quantity Limit

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon® will have a quantity limit of 45 grams per rolling 30 days.

Therapeutic Duplication

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon®) will deny with a therapeutic duplication if there is an active claim on the beneficiary's file for doxepin cream (Prudoxin®, Zonalon®).

Duchenne Muscular Dystrophy

Pharmacy claims for select Duchenne Muscular Dystrophy agents require an approved clinical authorization.

Generic Name (Brand Name Example)
Casimersen (Amondys 45®)
Delandistrogene Moxeparvovec-rokl (Elevidys™)
Eteplirsen (Exondys 51®)
Golodirsen (Vyondys 53®)
Viltolarsen (Viltepso®)

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL, which gives drug specific clinical authorization criteria and instructions.

Eculizumab (Soliris®)

Pharmacy claims for eculizumab (Soliris®) require a diagnosis code for reimbursement.

ICD-10-CM Diagnosis Code*	Diagnosis Description
D59.3	Hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis Optica Spectrum Disorder (NMOSD)
G70.0	Myasthenia Gravis

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Epinephrine Injection (Generic, EpiPen®, and EpiPen Jr®)

Prescriptions for epinephrine injection have the following quantity limits for reimbursement.

Medication	Quantity Limit
Epipen® (Brand and Generic) Epipen Jr® (Brand and Generic)	4 boxes of 2 syringes (8 syringes total) per rolling 365 days

Esketamine Intranasal (Spravato®)

Pharmacy claims for esketamine intranasal (Spravato®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Elagolix (Orilissa ®)

Pharmacy claims for elagolix (Orilissa®) require an approved clinical authorization for reimbursement.

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Empagliflozin/Linagliptin/Metformin HCl (Trijardy®)

Pharmacy claims for empagliflozin/linagliptin/metformin HCl (Trijardy®) are subject to the following:

1.   Prior use requirement;

2.   Quantity limits; and

3.   Therapeutic Duplication.

Prior Use Requirement

An incoming claim for empagliflozin/linagliptin/metformin (Trijardy® XR), will deny if there is no evidence of one of the following in paid claims:

1.   At least a 90-day supply of ONE of the following in the previous 180-day period:

     a.   Metformin AND either a DPP-4 or an SGLT2;

     b.   A combination product of DPP-4/metformin or SGLT2/metformin; or

     c.   At least a 60-day supply of empagliflozin/linagliptin/metformin (Trijardy® XR) in the previous 90-day period.

Quantity Limit

Pharmacy claims for empagliflozin/linagliptin/metformin HCl (Trijardy XR®) have the following quantity limits listed in the chart:

Generic Name	Brand Name	Quantity Limit
Empagliflozin/linagliptin/ metformin HCl	Trijardy® XR 10/5/1000	30 tablets / 30 days
	Trijardy® XR 25/5/1000	30 tablets / 30 days
	Trijardy® XR 5/2.5/1000	60 tablets / 30 days
	Trijardy® XR 12.5/2.5/1000	60 tablets / 30 days

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Therapeutic Duplication

A pharmacy claim for empagliflozin/linagliptin/metformin HCl (Trijardy XR®) will deny at POS when there is an active claim on the beneficiary's file for another DPP-4 inhibitor or a SGLT2 Inhibitor. Conversely, a claim for a DPP-4 inhibitor or a SGLT2 Inhibitor will deny at POS when there is an active claim on the beneficiary's file for empagliflozin/linagliptin/metformin HCl (Trijardy XR®).

Fabry (-Anderson) Disease Agents

Pharmacy claims for Fabry (-Anderson) Disease agents will be subject to the following:

1.   Diagnosis code requirement and

2.   Therapeutic duplication.

Select Fabry (-Anderson) Disease agents are listed in the following chart.

Generic Name (Brand Name Example)
Agalsidase beta (Fabrazyme®)
Migalastat (Galafold™)
Pegunigalsidase alfa-iwxj (Elfabrio®)

Fecal Microbiota Spores, Live-brpk (Vowst^{TM})

Pharmacy claims for fecal microbiota spores, live-brpk (Vowst^{TM}) require a PA.

Fertility Agents

Fertility preparations, when they are used solely for the treatment of infertility, are not reimbursable. The drugs include Clomiphene citrate tablets 50mg, Urofollitropin ampules 75IU, and Menotropins ampules 150IU and 75IU.

Fidanacogene Elaparvovec-dzkt (Beqvez™)

Pharmacy claims for fidanacogene elaparvovec-dzkt (Beqvez^{TM}) require a PA.

Givosiran (Givlaari®)

Pharmacy claims for Givosiran (Givlaari®) have a clinical authorization requirement.

Ganaxolone (Ztalmy®)

Pharmacy claims for ganaxolone (Ztalmy®) may be subject to the following:

1.   Diagnosis code requirement;

2.   Clinical authorization; and

3.   Prior use.

If there is no evidence of prior use of ganaxolone (Ztalmy®) or two different anticonvulsant medications (brand or generic/preferred or non-preferred) within the previous 365 days, pharmacy claims submitted for ganaxolone (Ztalmy®) will deny.

Granulocyte Colony Stimulating Factor Agents (GCSF)

Pharmacy claims for Granulocyte Colony Stimulating Factor (GCSF) agents will be subject to the following:

1.   Prior or clinical authorization.

Select Granulocyte Colony Stimulating Factor (GCSF) agents are listed in the following chart.

Generic Name (Brand Name Example)
Eflapegrastim-xnst (Rolvedon™)
Filgrastim (Neupogen®)
Filgrastim-aafi (Nivestym®)
Filgrastim-ayow (Releuko®)
Filgrastim-sndz (Zarxio®)
Pegfilgrastim (Neulasta®)
Pegfilgrastim-apgf (Nyvepria®)

Generic Name (Brand Name Example)
Eflapegrastim-xnst (Rolvedon™)
Pegfilgrastim-bmez (Ziextenzo®)
Pegfilgrastim-cbqv (Udenyca®)
Pegfilgrastim-fpgk (Stimufend®)
Pegfilgrastim-jmdb (Fulphila®)
Pegfilgrastim-pbbk (Fylnetra®)
Sargramostim (Leukine®)
Tbo-filgrastim (Granix®)

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Growth Factor Agents

Pharmacy claims for Growth Factor agents require PA. Growth Factor agents are listed in the following chart.

Generic Name (Brand Name Example)
Mecasermin Subcutaneous (Increlex®)
Tesamorelin Acetate Subcutaneous (Egrifta SV®)
Vosoritide Vial (Voxzogo™)

Growth Hormone

Prescriptions for Growth Hormone will be reimbursed when:

1.   The prescriber has obtained an approved clinical authorization; and

2.   An acceptable diagnosis code has been submitted with the pharmacy claim.

Diagnosis Code Requirement

Pharmacy claims for Growth Hormone will require an acceptable diagnosis code for reimbursement.

Select Growth Hormone agents are listed in the following chart:

Generic Name (Brand Name Examples)
Lonapegsomatropin-tcgd (Skytrofa®)
Somatropin Cartridge, Syringe (Genotropin®)
Somatropin Pen (Norditropin® FlexPro®)
Somatropin Cartridge, Vial (Omnitrope®, Saizen®)
Somatropin Vial (Serostim®, Zomacton®, Zorbtive®)
Somapacitan-beco (Sogroya®)
Somatrogon-ghla (Ngenla®)

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Hepatitis C Virus Direct-Acting (DAA) Antiviral Agents

Hepatitis C Direct Acting Antiviral Agent(s) may be subject to PA and quantity limits.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Hemophilia Agents

Pharmacy claims for select hemophilia agents may be subject to the following:

1.   Prior/clinical authorization; and

2.   Diagnosis code requirement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/non-preferred agents, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Hereditary Angioedema (HAE) Agents

Pharmacy claims for Hereditary Angioedema agents require an approved clinical pre-authorization for reimbursement. The select HAE agents are as follows:

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1.   Berotralstat Hydrochlorode (Orladeyo);

2.   C1 Inhibitor, Human Injection (Berinert®);

3.   C1 Inhibitor, Human Injection (Cinryze®);

4.   C1 Inhibitor, Human Injection (Haegarda®);

5.   C1 Inhibitor (Recombinant) Injection (Ruconest®);

6.   Ecallantide Injection (Kalbitor®);

7.   Icatibant Acetate Subcutaneous (Generic);

8.   Icatibant Acetate Injection (Firazyr®); and

9.   Lanadelumab Injection (Takhzyro®).

Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Inhaled Antibiotics

Pharmacy claims for inhaled antibiotic agents may require the following:

1.   PA; and

2.   Diagnosis code requirement.

Select inhaled antibiotic agents are listed in the following chart:

Generic Name (Brand Name Example)
Amikacin inhalation suspension (Arikayce®)
Aztreonam solution (Cayston®)
Tobramycin nebulizer solution, inhaler (Bethkis®, Kitabis Pak®, Tobi®)

Imiquimod

Pharmacy claims for imiquimod require a diagnosis code. (See chart below).

Generic-Brand Example	Diagnosis	ICD-10-CM Diagnosis Code
Imiquimod – Zyclara® 2.5%	Actinic Keratosis	L57.0
Imiquimod – Zyclara® 3.75%	Actinic Keratosis	L57.0
	External Genital Warts (Condylomata Acuminata)	A63.0
Imiquimod – Aldara® 5%	Actinic Keratosis	L57.0
	External Genital Warts (Condylomata Acuminata)	A63.0
	Superficial Basal Cell Carcinoma	C44.•1*

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Immune Globulin (Human)

Pharmacy claims for select Immune Globulin (Human) agents have a clinical authorization requirement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Immunomodulators, Lupus

Pharmacy claims for immunomodulators for the treatment of lupus may require PA.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Immunosupressive Agents

Pharmacy claims for immunosuppressive agents may be subject to a prior or clinical authorization.

Select immunosuppressive agents are listed in the following chart.

Generic Name (Brand Name Example)
Avacopan Capsule (Tavneos™)
Azathioprine Tablet (Azasan®; Imuran®)
Belumosudil Tablet (Rezurock™)
Cyclosporine Capsule, Solution (Sandimmune®)
Cyclosporine Capsule, Softgel, Solution – MODIFIED (Neoral®)
Everolimus Tablet (Generic; Zortress®)
Mycophenolate Mofetil Capsule, Suspension, Tablet (CellCept®)
Mycophenolic Acid as Mycophenolate Sodium (Myfortic®)
Sirolimus Solution, Tablet (Rapamune®)
Tacrolimus Capsule, Granule Packet (Prograf®)
Tacrolimus ER Capsule (Astagraf ® XL)
Tacrolimus ER Tablet (Envarus® XR)

Incretin Mimetic/Enhancers

Prescriptions for incretin mimetic/enhancers may be subject to the following:

1.　　　Age requirement;

2.　　　Diagnosis code requirement;

3.　　　Prior or clinical authorization;

4.　　　Prior use [empagliflozin/linagliptin/metformin (Trijardy® XR)];

5. Quantity limits;

6. Maximum daily dose limits; and

7. Terapeutic duplication.

Age Requirement

The following chart list the age requirements for select incretin mimetic/enhancers.

Generic (Brand Example)	Minimum Age
Dulaglutide (Trulicity®)	10 years
Exenatide (Bydureon® BCise™)	10 years
Exenatide (Byetta®)	18 years
Liraglutide (Victoza®)	10 years
Semaglutide (Ozempic®, Rybelsus®)	18 years
Tirzepatide (Mounjaro®)	18 years

Diagnosis Code Requirement

Pharmacy claimes for select incretin mimetic/enhancers require a diagnosis code.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Prior or Clinical Authorization

Pharmacy claims for select incretin mimetic/enhancers may require a prior or clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at:
http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

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Prior Use for Empagliflozin/Linagliptin/Metformin (Trijardy® XR)

Pharmacy claims for empagliflozin/linagliptin/metformin (Trijardy® XR) will be subject to prior use verification that there has been one of the following:

1. At least a 90-day supply of **ONE** of the following in the previous 180-day period:

    a. Metformin **AND either** a DPP-4 **or** an SGLT2; **OR**

    b. A combination DPP-4/metformin **or** SGLT2/metformin.

2. At least a 60-day supply of empagliflozin/linagliptin/metformin (Trijardy® XR) in the previous 90-day period.

Quantity Limit

The quantity limits for select incretin mimetics/enhancers are listed in the chart below:

Generic Name (Brand Name Example)	Quantity Limit
Dulaglutide (Trulicity®)	1 syringe per week
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 5 mg / 2.5 mg / 1000 mg	60 tablets per 30 days
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 10 mg / 5 mg / 1000 mg	30 tablets per 30 days
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 12.5 mg / 2.5 mg / 1000 mg	60 tablets per 30 days
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 25 mg / 5 mg / 1000 mg	30 tablets per 30 days
Semaglutide (Rybelsus®)	30 tablets per 30 days
Tirzepatide (Mounjaro™)	1 syringe per week

Maximum Daily Dose Limit

The maximum dose for select incretin mimetic/enhancers are listed in the chart.

Medication (Brand Name Example)	Maximum Dose
Alogliptin (Nesina®)	25mg/day
Alogliptin/Metformin (Kazano®)	25mg/2000mg per day
Alogliptin/Pioglitazone (Oseni®)	25mg/45mg per day
Exenatide (Bydureon®, Bydureon® BCise™)	2mg/week
Exenatide (Byetta®)	20mcg/day
Linagliptin (Tradjenta®)	5mg/day
Linagliptin/Metformin (Jentadueto®, Jentadueto XR®)	5mg/2000mg per day
Liraglutide (Victoza®)	1.8mg/day
Pramlintide (Symlin®)	Type 1 diabetes: 60mcg SQ immediately prior to each major meal
	Type 2 diabetes: 120mcg SQ immediately prior to each major meal
Saxagliptin (Onglyza®)	5mg/day
Saxagliptin/Metformin ER (Kombiglyze XR®)	5mg/2000mg per day
Semaglutide (Ozempic®)	2mg/week
Sitagliptin (Januvia®)	100mg/day
Sitagliptin/Metformin (Janumet®, Janumet XR®)	100mg/2000mg per day
Sitagliptin (Zituvio™)	100mg/day

*Authorization at POS is required to exceed maximum doses.

Therapeutic Duplication

1. GLP-1 receptor agonists are monitored at the pharmacy POS for duplication of therapy with other GLP-1 receptor agonists or DPP-4 inhibitors;

2. DPP-4 inhibitors are monitored at the pharmacy POS for duplication of therapy with other DPP-4 inhibitors or GLP-1 receptor agonists;

3. Empagliflozin/Linagliptin/Metformin (Trijardy® XR) is monitored at the pharmacy POS for duplication of therapy with DPP-4 inhibitors. Conversely, DPP-4 inhibitors are monitored at the pharmacy POS for duplication of therapy with empagliflozin/linagliptin/metformin (Trijardy® XR); and

4. Empagliflozin/Linagliptin/Metformin (Trijardy® XR) is monitored at the pharmacy POS for duplication of therapy with SGLT2s. Conversely, SGLT2s are

monitored at the pharmacy POS for duplication of therapy with empagliflozin/linagliptin/metformin (Trijardy® XR).

Inotersen (Tegsedi®)

Pharmacy claims for inotersen (Tegsedi®) require a diagnosis code. The diagnosis code must be documented on the prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Generic Name	Brand Name	Diagnosis	ICD-10-CM Diagnosis Code
Inotersen	Tegsedi®)	Polyneuropathy of hereditary transthyretin-mediated amyloidosis	E85.1

Interferons

Select interferons have a diagnosis code requirement. (See chart below).

Generic-Brand Example	Diagnosis	ICD-10-CM Diagnosis Code
Interferon Alfa–2B Recombinant – Intron A®	AIDS–Related Kaposi's Sarcoma	C46.*
	Chronic Hepatitis B	B18.0, B18.1
	Chronic Hepatitis C	B18.2
	External Genital Warts (Condylomata Acuminata)	A63.0
	Follicular Lymphoma	C82.*
	Hairy Cell Leukemia	C91.4*
	Melanoma	C43.*

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Interferon Gamma–1B – Actimmune®	Chronic Granulomatous Disease	D71
	Malignant Osteopetrosis	Q78.2
Peginterferon Alfa–2A – Pegasys®	Chronic Hepatitis B	B18.0, B18.1
	Chronic Hepatitis C	B18.2
Peginterferon Alfa–2B – Sylatron®	Melanoma	C43.*

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Ivermectin (Stromectol®)

Pharmacy claims for ivermectin (Stromectol®) require an approved diagnosis code for reimbursement at POS.

Ketorolac

Pharmacy claims for oral forms of ketorolac will deny for a quantity greater than 20 or the day supply is greater than five days as exceeding the program's maximum allowed. The pharmacist may override the denial after consultation with the prescriber. The prescriber must supply the diagnosis code and the rationale for using greater than a five day supply of ketorolac. The diagnosis code is required for the claim submission.

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Lasmiditan (Reyvow®)

Pharmacy claims for lasmiditan (Reyvow®) have a quantity limit of 8 tablets per 30 days.

Lefamulin (Xenleta™)

Pharmacy claims for lefamulin (Xenleta™) have a clinical authorization requirement.

Leniolislab (Joenja®)

Pharmacy claims for leniolislab (Joenja®) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

L-glutamine oral powder (Endari®)

Pharmacy claims for l-glutamine oral powder (Endari®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Linezolid (Zyvox®)

Prescriptions for linezolid (Zyvox®) injections, tablets, and oral suspension will only be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Lipotropics

Pharmacy claims for select lipotropics may require the following:

  1.   Clinical authorization or PA; and

  2.   Quantity limit.

Select lipotropics are listed in the following chart:

Generic Name (Brand Name Example)
Alirocumab (Praluent®)
Bempedoic Acid Tablet (Nexletol™)
Bempedoic Acid and Ezetimibe Tablet (Nexlizet™)
Cholestyramine/Aspartame Packet, Powder
Cholestyramine/Sucrose Packet, Powder (Questran®)
Colesevelam Powder Pack, Tablet (Welchol®)
Colestipol Granules, Tablet (Colestid®)

Evinacumab-dgnb Vial (Evkeeza®)
Evolocumab Auto-Injector, Catridge, Prefiled Syringe (Repatha®)
Ezetimibe (Zetia®)
Fenofibrate Capsule Micronized, Capsule, Tablet, Tablet Nanocrystallized (Tricor®)
Fenofibric Acid Tablet (Fibricor®)
Fenofibric Acid Choline Capsule (Trilipix®)
Gemfibrozil Tablet (Lopid®)
Icosapent Ethyl Capsule (Vascepa®)
Inclisiran Syringe (Leqvio®)
Lomitapide Capsule (Juxtapid®)
Omega-3-acid Ethyl Esters Capsule (Lovaza®)

Select lipotropics have quantity limits as listed in the following chart:

Medication (Generic – Brand Example)	Quantity Limit
Alirocumab (Praluent®)	2 injections (2ml) per 28 days
Evolocumab (Repatha®) 140mg/ml	2 injections (2ml) per 28 days
Evolocumab (Repatha®) 420mg/3.5ml	2 injections (7ml) per 28 days
Inclisiran (Leqvio®)	3 injections (4.5mls) per 365 days
Lomitapide (Juxtapid®)	60 capsules per 30 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Lumateperone (Caplyta™)

Prescriptions for lumateperone (Caplyta™) are subject to the following edits:

1.   Clinical authorization;

2.   Diagnosis Code Requirement;

3.   Maximum Daily Dose; and

4.   Therapeutic Duplication.

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Clinical Authorization Requirement

Pharmacy claims submitted for lumateperone (Caplyta™) will require a clinical authorization for beneficiaries 0-5 years old.

Diagnosis Code Requirement

Pharmacy claims for lumateperone (Caplyta™) require a valid diagnosis code at POS.

Diagnosis	ICD-10-CM Diagnosis Code
Schizophrenia	F20.*

* any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Maximum Daily Dose Limit

Pharmacy claims submitted for lumateperone (Caplyta™) for beneficiaries 6-17 years old will deny.

Pharmacy claims submitted for lumateperone (Caplyta™) for beneficiaries 18 years old or older will deny when the dose exceeds 42mg/day.

Therapeutic Duplication

Pharmacy claims for lumateperone (Caplyta™) will deny if the beneficiary has an active prescription on file for a traditional or atypical oral antipsychotics. Pharmacy claims submitted for a traditional or atypical oral antipsychotic will deny if the beneficiary has an active prescription on file for lumateperone (Caplyta™).

Myasthenia Gravis Agents

Pharmacy claims for Myasthenia Gravis agents require a diagnosis code.

Select Myasthenia Gravis agents are listed in the following chart.

Generic Name (Brand Name Example)
Efgartigimod alfa-fcab (Vyvgart®)
Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart® Hytrulo)
Rozanolixizumab-noli (Rystiggo®)

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Mavacamten (Camzyos™)

Pharmacy claims for mavacamten (Camzyos™) will be subject to the following:

1. Clinical authorization; and

2. Quantity limit.

Quantity Limit

Pharmacy claims for mavacamten (Camzyos™) are subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Mavacamten (Camzyos™)	30 capsules per 30 days

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL, which gives drug specific Clinical Authorization criteria and instructions.

Mitapivat (Pyrukynd®)

Pharmacy claims for mitapivat (Pyrukynd®) require an approved clinical authorization for reimbursement.

Mosquito Repellents

Prescriptions for mosquito repellents are covered to decrease the risk of exposure to the Zika virus. Mosquito repellent coverage will be limited to Medicaid beneficiaries:

1. Who are pregnant; or

2. Of childbearing years (women and men 14-44 years of age) who are trying to conceive.

A prescription will be required to cover one of the following products:

Product Name	Ounces	Bill As
Cutter Backwoods 25 percent Spray	6 oz.	170 g
Cutter Skinsations 7 percent Spray	6 oz.	177 mL
OFF! Family Care 15 percent Spray	2.5 ounces	71 g
OFF! Deep Woods Dry 25 percent Spray	4 ounces	113 g
OFF! Deep Woods 25percent Spray	6 ounces	170 g
OFF! Active 15 percent Spray	6 ounces	170 g
Repel Sportsmen 25 percent Spray	6.5 ounces	184 g
Repel Sportsmen Max 40 percent Spray	6.5 ounces	184 g
Natrapel 20 percent Picaridin	5 ounces	177 mL
Sawyer Insect Repellent 20 percent Picaridin	4 ounces	118 mL

Quantity Limit

One bottle of mosquito repellent will be covered every rolling 30 days.

Age Restriction

Pharmacy claims for mosquito repellents have an age limit of 14 to 44 (of childbearing) years of age.

Multiple Sclerosis (MS) Treatment Agents

Prescriptions for Multiple Sclerosis treatment agents may require the following:

1.   Clinical authorization or PA; and

2.   Quantity limit.

Select MS treatment agents will be subject to the quantity limit as listed in the chart below:

Generic Name (Brand Name Example)	Quantity Limit
Diroximel fumerate (Vumerity)	120 capsules per 30 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Nedosiran (Rivfloza™)

Pharmacy claims for nedosiran (Rivfloza™) require an approved clinical authorization.

Naloxone

Pharmacy claims for naloxone have a quantity limit requirement for reimbursement. Refer to the chart below.

Generic (Brand Example)	**Quantity Limit**
Naloxone Nasal Spray (Narcan®)	4 units/30 days
Naloxone Nasal Spray (Kloxxado™)	4 units/30 days
Naloxone Injectable Solution/Cartridge 0.4mg/ml	4 units/30 days
Naloxone Injectable Solution Syringe 1mg/ml	4 units/30 days
Naloxone Injectable Solution (5ml, 10ml, 20ml) 1mg/ml	1 unit/30 days
Naloxone Injectable Solution (10ml) 0.4mg/ml	1 unit/30 days
Naloxone Injectable Solution (Zimhi™)	4 syringes (2ml)/30 days

Nicotine Transdermal Patches, Gum and Spray

Select nicotine transdermal patches, nicotine polacrilix gum, and nicotine spray are covered.

Nintedaib (Ofev®)

Pharmacy claims for nintedaib (Ofev®) have a clinical authorization requirement and quantity limit of 60 capsules/30 days.

Omaveloxolone (Skyclarys™)

Pharmacy claims for omaveloxolone (Skyclarys™) will be subject to the following:

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1.   Clinical Authorization; and

2.   Quantity Limit.

The quantity limit for omaveloxolone (Skyclarys™) is listed in the following chart:

Generic Name (Brand Example)	Quantity Limit
Omaveloxolone (Skyclarys™) capsule	90 capsules/30 days

Orlistat

Medicaid will provide reimbursement to outpatient pharmacies for orlistat prescriptions based on the following criteria:

1.   Patient is 12 years of age or older;

2.   The prescription is for a maximum of 90 capsules **and** 30 days' supply;

3.   The beneficiary has a documented current body mass index (BMI) of 27 or greater and the prescriber had identified the BMI, in their handwriting, on the dated prescription or a dated and signed attachment to the prescription or the BMI is entered by the pharmacist in the pharmacy's electronic record keeping system after it is communicated by the prescriber;

4.   The beneficiary has other risk factors warranting the use of Orlistat and the prescriber has identified an approved diagnosis code in their handwriting, on the dated prescription or a dated and signed attachment to the prescription; and

5.   There are no provisions for override of the prospective drug utilization edits, i.e., early refill (ER) and duplicate drug (ID) editing.

The beneficiary has a diagnosis for other risk factors warranting the use of orlistat (Xenical®) and the prescriber has identified an approved diagnosis code.

NOTE: Refer   to   the   Diagnosis   Code   Policy   Chart   at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Onasemnogene Abeparvovec Injection (Zolgensma®)

Pharmacy claims for onasemnogene abeparvovec injection (Zolgensma®) require a clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Oxybate Salts (Calcium, Magnesium, Potassium, and Sodium) Oral, (Xywav®)

Pharmacy claims for oxybate salts (calcium, magnesium, potassium and sodium) oral, (Xywav^{TM}) require clinical authorization and may be subject to a therapeutic duplication.

Incoming prescriptions for oxybate salts (calcium, magnesium, potassium and sodium) oral, (Xywav^{TM}) will deny with a therapeutic duplication when there is an active prescription on the beneficiary's file for a CNS depressant medication, whether as a single entity or as a component of a combination product. An active prescription is a prescription in which the days' supply has not expired. Alternately, incoming prescriptions for a CNS depressant medication will deny with a therapeutic duplication when there is an active prescription on the beneficiary's file for oxybate salts (calcium, magnesium, potassium and sodium) oral, (Xywav^{TM}).

Palivizumab (Synagis®)

Prescriptions for palivizumab (Synagis®) will only be reimbursed when prescriptions meet the following criteria:

1.   The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Respiratory Syncytial Virus Season

Louisiana's respiratory syncytial virus (RSV) activity may be followed during the RSV season by frequently accessing the Center for Disease Control's website. (Refer to Section 37.5.4 for web address). The RSV season in Louisiana begins November 1st and ends March 31st.

Age Restriction

Palivizumab claims for beneficiaries who are 24 months of age or younger on November 1st of the current RSV season meet the POS age requirement.

Early Refill

Palivizumab claims will only process for payment every 28 days. When a pharmacy submits a claim for Synagis® and there is an active paid Synagis® claim on file, the incoming claim will deny. An active prescription is a prescription in which the days' supply has not expired.

Maximum Number of Doses Allowed

Claims billed for Synagis® outside the allowable number of doses will deny, except in an extended RSV Season*. Based upon the diagnosis code submitted, a maximum of five doses of Synagis® will be reimbursed each RSV season. If the initial dose is given in October, the fifth and final dose should be given in February. If initial dose is given in November, the fifth and final dose should be given in March.

NOTE: *In an extended RSV season, the number of allowed doses reimbursable, is increased to accommodate dosing outside the usual RSV season.

Medical Reconsideration for Palivizumab (Synagis®)

Medical reconsideration of a denied clinical authorization decision may be requested by the prescribing practitioner. Medical reconsideration requires completion of the Palivizumab Request for Reconsideration Form.

Palivizumab Criteria ICD-10-CM Code and Medication List

NOTE: Any accepted diagnosis code listed on the Palivizumab Clinical Authorization Form must have supporting documentation attached. Supporting documentation is supplemental information submitted to support the patient meeting the criteria and may include copies of progress notes, hospital discharge notes, pediatric cardiologist consult notes, chart notes, pharmacy profiles, etc.

NOTE: Refer to the Diagnosis Code Policy Chart at:
https://ldh.la.gov/assets/HealthyLa/PDL/7.30.2020/Louisiana.Medicaid.ICD-10.Chart.docx

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Penicillamine (Cuprimine®, Depen®)

Pharmacy claims for penicillamine (Cuprimine®, Depen®) have quantity limits. The quantity limits are listed in the chart.

Generic Name	Brand Name	Quantity Limit
Penicillamine	Cuprimine®	240 capsules/30 days
	Depen®	240 tablets/30 days

Pituitary Suppressive Agents

Pharmacy claims for pituitary suppressive agents may require a PA and/or a diagnosis code at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Pompe Disease Agents

Pharmacy claims for Pompe Disease Agents require a diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Potassium Binders

Pharmacy claims for select potassium binder agents may require the following:

1.　　PA; and

2.　　Quantity limit.

Select Potassium binder agents are listed in the following chart:

Generic Name (Brand Name Example)
Patiromer (Veltassa®)*
Sodium Polystyrene Sulfonate Powder

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Sodium Zirconium Cyclosilicate (Lokelma®)

Pharmacy claims for the following **potassium binder** agent will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Patiromer (Veltassa®)	30 packets/30 days

Progestational Agents

Pharmacy claims for progestational agents may be subject to the following:

1.   PA;

2.   Day Supply; and

3.   Diagnosis code requirement.

Select progestational agents are listed in the following chart:

Generic Name (Brand Name Example)
Hydroxyprogesterone Caproate IM Injection*
Medroxyprogesterone Acetate IM, SQ Injection (Depo-Provera®)*
Medroxyprogesterone Acetate Tablet (Provera®)*
Norethindrone Acetate Tablet (Aygestin®)*
Progesterone Capsule, IM Injection (Prometrium®)*
Progesterone, Micronized Capsule,Vaginal Gel (Crinone®)

Select progestational agents dispensed with the following quantities are limited to specific days supply as listed in the chart:

Generic Name (Brand Name Example)	Quantity Dispensed	Days Supply
Medroxyprogesterone Acetate Injection (Depo-Provera®)	1 ml	84 days*

Medroxyprogesterone Acetate SQ Injection (Depo-Provera®)	0.65 ml	84 days**

Progesterone injectable agents require a diagnosis code.

Medication (Brand Example)	Diagnosis Description	Diagnosis Code
Progesterone Injectable	A diagnosis code is required on pharmacy claims for all ages. Pharmacy claims submitted with certain age-specific diagnosis codes **will deny**.	Diagnosis **must** be submitted but **cannot** be: F64* or Z87.890 if beneficiary is younger than 18 years old N97* if beneficiary is any age

Pyrimethamine (Daraprim®)

Prescriptions for pyrimethamine (Daraprim®) will be reimbursed when:

1.   The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Schedule II Narcotic Agents

All prescriptions for Schedule II narcotic agents require a diagnosis code indicating the reason for use documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code must be written on the hardcopy prescription by the prescribing practitioner or by the pharmacist in the pharmacy's electronic record keeping system after consultation with the prescriber.

Except for methadone, when the prescribing practitioner does not indicate a diagnosis code on the prescription and when the prescriber cannot be reached, a denial for a missing diagnosis code may

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be overridden if the pharmacist determines that the beneficiary cannot wait to receive the medication.

Schedule II narcotic agents are also subject to prospective DURs which address quantity limits.

NOTE:　Refer to "Prospective Drug Utilization Policies/Limits/Edits" in this section for further information.

Fentanyl Buccal and Sublingual Agents

Claims for fentanyl buccal and sublingual agents (Abstral®, Actiq®, Fentora® and Onsolis®) **must** contain a cancer-related diagnosis code in order for the claim to process for payment through the POS System.

Acceptable diagnosis codes are as follows:

ICD-10-CM Code Range	Description
C00.*-C96*	Cancer

Buccal and sublingual agents are subject to prospective DURs which address quantity limits.

Diagnosis Code Requirement

Pharmacy claims for fentanyl nasal solution (Lazanda®) and fentanyl sublingual liquid (Subsys®) require an appropriate diagnosis code documented on the hardcopy prescription by either the prescriber or pharmacist.　The pharmacist may document the diagnosis code after electronic or verbal consultation with the prescribing practitioner on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Age Restriction

Claims for fentanyl nasal solution (Lazanda®) and fentanyl sublingual liquid (Subsys®) will deny when the beneficiary is 17 years of age or younger.

Methadone

All prescriptions for methadone must have a diagnosis code for payment. There are no provisions for an override of methadone when a diagnosis code is omitted. Methadone products when used for the treatment of opioid addiction in detoxification or maintenance programs shall only be dispensed by opioid treatment programs certified by the Substance Abuse and Mental Health Services Administration.

Prescriptions for methadone will be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Morphine ER (Avinza®)

When the cumulative daily dosage for Morphine ER (Avinza®) exceeds the maximum daily dosage, the claim will deny. The maximum daily dosage for this agent is 1600mg per day. There is no provision for override through the POS system for Morphine ER (Avinza®) when the maximum daily dosage is exceeded.

Oxycodone/Acetaminophen 7.5/325mg (Xartemis XR®)

Prescriptions for oxycodone/acetaminophen (Xartemis XR®) require an appropriate diagnosis code documented on the hard copy prescription by the prescriber or pharmacist. The pharmacist may document the diagnosis code after electronic or verbal consultation with the prescribing practitioner on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Pharmacy claims for oxycodone/acetaminophen (Xartemis XR®) have a quantity limit of 30 units every 15 days within a 30-day period.

Paroxetine Mesylate (Brisdelle®)

Pharmacy claims for paroxetine mesylate (Brisdelle®) require submission of a valid diagnosis code at POS for reimbursement. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The following table lists the acceptable diagnosis codes for paroxetine mesylate (Brisdelle®).

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Medication	ICD-10-CM Diagnosis Code*	Diagnosis Description
Paroxetine Mesylate (Brisdelle®)	E28.310 E89.41 N95.1	Moderate to severe vasomotor symptoms associated with menopause

Patisiran (Onpattro®)

Pharmacy claims for patisiran (Onpattro®) require a diagnosis code. The diagnosis code must be documented on the prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Generic Name	Brand Name	Diagnosis	ICD-10-CM Diagnosis Code
Patisiran	Onpattro®	Polyneuropathy of hereditary transthyretin-mediated amyloidosis	E85.1

Perampanel (Fycompa®)

Age Limit

Pharmacy claims for perampanel (Fycompa®) will deny for beneficiaries under four years of age.

After consultation with the prescriber to verify the necessity of prescribing perampanel (Fycompa®) for a beneficiary under four years of age, the pharmacist may override the age restriction. The reason for service code, professional service code and result of service code used in submitting the claim must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Pirfenidone (Esbriet®)

Pharmacy claims for pirfenidone (Esbriet®) have a clinical authorization requirement and quantity limit of 90 capsules or tablets/30 days.

Pulmonary Arterial Hypertension (PAH)

Pharmacy claims for agents for the treatment of pulmonary arterial hypertension have the following edits:

    1.   Diagnosis code requirement;

    2.   Quantity limit; and

    3.   Monitoring for drug-drug interaction.

Pulmonary arterial hypertension treatment agents require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

The quantity limit for agents for the treatment of pulmonary arterial hypertension are listed in the chart below.

Medication	Quantity Limit
Ambrisentan Tablet (Letairis®)	30 tablets per 30 days
Bosentan Tablet for Suspension (Tracleer®)	120 tablets per 30 days
Bosentan Tablet (Tracleer®)	60 tablets per 30 days
Iloprost Inhalation Solution (Ventavis®)	9 cartons per 30 days

Macitentan Tablet (Opsumit®)	30 tablets per 30 days
Macitentan and Tadalafil (Opsynvi®)	30 tablets per 30 days
Riociguat Tablet (Adempas®)	90 tablets per 30 days
Selexipag Dose Pack (Uptravi®)	1 dose pack per 365 days
Selexipag Tablet (Uptravi®)	60 tablets per 30 days
Sildenafil Oral Suspension (Liqrev®)	1 bottle (122ml) per 20 days
Sildenafil Powder for Oral Suspension (Revatio®)	1 bottle (112ml) per 19 days
Sildenafil Tablet (Revatio®)	90 tablets per 30 days
Sotatercept-csrk (Winrevair™)	2 bottles (300ml) per 30 days
Tadalafil Tablet (Alyq™; Adcirca®)	60 tablets per 30 days
Tadalafil Suspension (Tadliq®)	2 bottles (300ml) per 30 days
Treprostinil ER Tablet Titration Kit (Month 1, 2, 3) (Orenitram®)	1 of each kit per 365 days
Treprostinil Inhalation Solution Starter Kit with Device (Tyvaso®)	1 starter kit per 2 years
Treprostinil Inhalation Solution Refill Kit (Tyvaso®)	1 refill kit per 28 days
Treprostinil Inhalation Powder Titration Kit (Tyvaso DPI™)	1 titration kit per 365 days
Treprostinil Inhalation Maintenance Kit (Tyvaso DPI™)	1 kit per 28 days

Drug-Drug Interaction

Pharmacy claims for macitentan/tadalafil, sildenafil and tadalafil are monitored at the pharmacy POS for a drug-drug interaction with nitrates.

1.   Incoming prescriptions for macitentan/tadalafil, sildenafil or tadalafil will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for a nitrate; and

2.   Incoming prescriptions for a nitrate will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for macitentan/tadalafil, sildenafil or tadalafil.

Quinine Sulfate

Pharmacy claims for quinine sulfate (Qualaquin®) 324mg have a quantity limit of

 42 capsules/7 day supply per 365 days.

Ravulizumab-cwvz (Ultomiris®)

Pharmacy claims for ravulizumab-cwvz (Ultomiris®) require an appropriate ICD-10-CM diagnosis code for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Resmetirom (Rezdiffra ™)

Pharmacy claims for resmetirom (Rezdiffra™) require a clinical authorization.

Risdiplam (Evrysdi™)

Pharmacy claims for risdiplam (Evrysdi™) have a quantity limit and clinical authorization requirement.

Generic Name	Brand Name	Quantity Limit
Risdiplam	Evrysdi™	160 ml (2-80 ml bottles)

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Ritlecitinib (Litfulo^TM)

Pharmacy claims for ritlecitinib (Litfulo^TM) require an approved clinical authorization for reimbursement.

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL, which gives drug specific clinical authorization criteria and instructions.

Ropeginterferon alfa-2b-njf (Besremi®)

Pharmacy claims for ropeginterferon alfa-2b-njf (Besremi®) require an appropriate diagnosis code for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Roflumilast (Daliresp®)

Pharmacy claims for roflumilast (Daliresp®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Selumetinib (Koselugo™)

Pharmacy claims for selumetinib (Koselugo®) have a clinical authorization requirement and quantity limit of 120 capsules/30 days.

Semaglutide (Rybelsus®)

Pharmacy claims for semaglutide (Rybelsus®) are subject to a prior use and quantity limit edit.

Pharmacy claims for semaglutide (Rybelsus®) will have a quantity limit of 30 tablets/30 days. Pharmacy claims for semaglutide (Rybelsus®) will require previous use of metformin or a paid claim for semaglutide (Rybelsus®) or another Incretin Mimetic Enhancers. An incoming claim for semaglutide (Rybelsus®) will deny if there is no evidence of a paid claim(s) for at least 90 days of metformin therapy in the previous 180-day period or if there is no evidence of paid

claims of at least 60 days of semaglutide (Rybelsus®) or other Incretin Mimetic/Enhancers within the previous 90 days.

Short-Acting Beta$_2$ Agonist Inhalers

Prescriptions for short- acting beta$_2$ agonist inhalers (SABAs) (i.e albuterol, levalbuterol, and pirbuterol):

1.   Require an appropriate diagnosis code; and

2.   Are subject to a maximum quantity of six short-acting beta$_2$ agonist inhalers per calendar year.

Diagnosis Code Requirement

The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone or facsimile.

Diagnosis codes which bypass the 6 inhaler limit are noted below:

Generic – Brand Example	Diagnosis Description	ICD-10-CM Diagnosis Code(s)
Albuterol – ProAir HFA®, ProAir RespiClick®, ProAir Digihaler®, Proventil HFA®, Ventolin HFA® **YQ** Levalbuterol – Xopenex HFA® **YQ** *Yearly Quantity Limit (YQ)*	Bronchitis, not specified	J40
	Chronic Airway Obstruction	J44.9
	Cystic Fibrosis	E84.*
	Emphysema	J43.*
	Obstructive Chronic Bronchitis, Chronic Obstructive Asthma	J44.*

* – any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code.

Pharmacy claims that do not indicate a diagnosis code on the prescription and the prescriber cannot be reached; a denial for a missing diagnosis code may be overridden by the pharmacist entering the emergency override.

Quantity Limit

If the prescriber chooses to exceed the quantity limit, the prescriber must provide the reason why the limit needs to be exceeded. The pharmacist may override the limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record-keeping system the following:

1.   The prescriber's reason why the limit needs to be exceeded; and

2.   The NCPDP DUR override codes used in submitting the claim.

If the prescriber cannot be reached, the pharmacist may override the quantity limit by entering the emergency override. The pharmacist must document "Emergency" on the hardcopy prescription and the reason for entering the emergency override.

Therapeutic Duplication

Pharmacy claims billed for concurrent use of different SABAs will deny with a therapeutic duplication. After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication. This consultation is necessary to confirm that:

1.   The prescriber is aware of the current active SABA claim; and

2.   The addition of a different SABA is necessary (i.e., a change in therapy).

To bill concurrent therapy with different SABAs, the pharmacist must document on the hardcopy prescription or the pharmacy's electronic recordkeeping system the following:

1.   The reason why an additional SABA was requested by the prescriber; and

2.   The NCPDP DUR override codes used in submitting the claim.

NOTE: Refer to 'Drugs with Special Payment Criteria/Limitations' in this section for further policy regarding short-acting beta$_2$ agonist inhalers.

Sickle Cell Anemia Treatment Agents

The following sickle cell anemia treatment agents may require PA:

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Generic Name (Brand Name)
Crizanlizumab-tmca Infusion (Adakveo®)
Exagamglogene autotemcel (Casgevy™)
Hydroxyurea Capsule (Generic; Droxia®)
Hydroxyurea Tablet (Siklos®)
L-glutamine Powder Pack (Generic; Endari™)
Lovotibeglogene autotemcel (Lyfgenia®)

Skeletal Muscle Relaxants

Pharmacy claims for skeletal muscle relaxants that contain codeine (carisoprodol-aspirin-codeine) will deny at the POS if the beneficiary is less than 12 years of age.

Pharmacy claims for skeletal muscle relaxants are subject to a quantity limit. (See chart below.)

Medication	Quantity Limit per 30 days
Baclofen 10mg	120 Units
Baclofen 20mg	120 Units
Cyclobenzaprine 5mg	90 Units
Cyclobenzaprine 7.5mg	90 Units
Cyclobenzaprine 10mg	90 Units
Cyclobenzaprine 15mg	30 Units
Cyclobenzaprine 30mg	30 Units
Tizanidine 2mg	90 Units
Tizanidine 4mg	90 Units
Tizanidine 6mg	180 Units

Smallpox and Monkeypox Live Vaccine (Jynneos)

The administration of the Smallpox and Monkeypox, Live Vaccine (Jynneos) is covered in the pharmacy program. The federal government covers the ingredient cost.

Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combination Products

Prescriptions for Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and combination products will be reimbursed when:

> 1.   The prescriber has obtained an approved clinical authorization.

Prior Use of Metformin Required (SGLT2 Inhibitors Only)

An incoming pharmacy claim for a SGLT2 inhibitor will require evidence of previous use of metformin or a paid claim for the requested medication or another medication within the same therapeutic class.

An incoming claim for a SGLT2 inhibitor will deny if there is not a paid claim(s) for at least 90 days of metformin therapy OR there is no evidence of at least 60 days of paid claims for the requested medication (or another SGLT2 inhibitor).

Exception: Pharmacy claims submitted for dapagliflozin (Farxiga®) and empagliflozin (Jardiance®) will bypass the POS prior drug use requirement for metformin and SGLT2 when submitted with an appropriate bypass diagnosis code of heart failure (I50*) or chronic kidney disease (N18*).

NOTE: *can be any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code.*

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Sodium Oxybate (Xyrem®)

Clinical Pre-Authorization

Pharmacy claims for sodium oxybate (Xyrem®) will be reimbursed when the prescriber has obtained an approved clinical authorization. A diagnosis of narcolepsy or cataplexy must be submitted in the clinical authorization process.

Therapeutic Duplication

Pharmacy claims for sodium oxybate (Xyrem®) will deny when the beneficiary has an active claim on file for a CNS depressant. Claims for CNS depressants will deny when the beneficiary has an active claim on file for sodium oxybate (Xyrem®).

CNS depressant medications include the following agents, whether given as a single entity or as a component of a combination product:

Alprazolam	Dantrolene	Metaxalone	Quazepam
Baclofen	Diazepam	Methadone	Ramelteon
Buprenorphine	Dihydrocodeine	Methocarbamol	Remifentanil
Buspirone	Doxepin	Midazolam	Secobarbital
Butabarbital	Estazolam	Morphine	Sufentanil
Butalbital	Eszopiclone	Nalbuphine	Suvorexant
Butorphanol	Fentanyl	Opium	Tapentadol
Carisoprodol	Flurazepam	Orphenadrine	Tasimelteon
Chlordiazepoxide	Hydrocodone	Oxazepam	Temazepam
Chlorzoxazone	Hydromorphone	Oxycodone	Tizanidine
Clonazepam	Levorphanol	Oxymorphone	Tramadol
Clorazepate	Lorazepam	Paregoric	Triazolam
Codeine	Meperidine	Pentazocine	Zaleplon
Cyclobenzaprine	Meprobamate	Phenobarbital	Zolpidem

The therapeutic duplication edit for sodium oxybate (Xyrem®) and CNS depressants can be overridden in emergency circumstances. These claims will require consultation and approval from the prescribing provider to override the therapeutic duplication. After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication with the emergency override. The pharmacist must document "**Emergency**" on the hardcopy prescription and the reason why the prescribing provider choose to override the therapeutic duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Somatropin

Pharmacy claims for Somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin®, Nutropin AQ®, Omnitrope®, Saizen®, Serostim®, Tev-Tropin®, and Zorbtive®) require an

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appropriate diagnosis code for reimbursement. The numeric code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile.

There are no overrides for this edit. However, the pharmacist may contact the prescriber for a valid diagnosis code and resubmit the claim.

The following chart addresses acceptable diagnosis code(s) which are in accordance with the reimbursement criteria for somatropin.

ICD-10-CM Diagnosis Code(s)	Diagnoses
N25.0	Growth failure in children associated with: Renal insufficiency or chronic kidney disease
Q87.1	Noonan Syndrome
Q87.1	Prader-Willi Syndrome
Q96	Turner Syndrome
P05.1	Small for gestational age at birth (fetal growth retardation) who fail to manifest catch-up growth or with no catch-up growth
R62.52	Short Stature in children (idiopathic or SHOX deficiency) 1. Short stature 2. Lack of expected normal physiological development in childhood
E23.0	Pituitary dwarfism
E23.0	Panhypopituitarism
E23.1, E89.3	Iatrogenic pituitary disorders
K90.2, K91.2	(Zorbitive® only) Short Bowel Syndrome in patients receiving specialized nutritional support: 1. Blind Loop Syndrome 2. Other unspecified post-surgical nonabsorption
R64	(Serostim® only) HIV-associated cachexia or wasting

Spinal Muscular Atrophy Agents

The following spinal muscular atrophy agents may require prior or clinical authorization.

Generic Name (Brand Name)
Nusinersen (Spinraza®)*
Onasemnogene abeparvovec-xioi (Zolgensma®)
Risdiplam (Evrysdi®)

*** *Nusinersen (Spinraza®) has a drug specific clinical authorization form.*

Quantity Limit

Risdiplam (Evrysdi™) is limited to a maximum quantity of 160ml (2-80ml bottles) every 24 days.

Statin Agents

Pharmacy claims for select statin agents may be subject to the following:

     1.   PA; and

     2.   Therapeutic duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Sulfonylurea Agents

Pharmacy claims for sulfonylurea agents may be subject to the following:

     1.   PA; and

     2.   Therapeutic duplication.

Sulfonylurea agents may be subject to a therapeutic duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Suvorexant (Belsomra®)

Pharmacy claims for suvorexant (Belsomra®) are subject to a maximum daily dosage limit of 20 mg/day.

Tafamidis (Vyndaqel®, Vyndamax®)

Pharmacy claims for tafamidis (Vyndaqel®, Vyndamax®) have a quantity limit.

Generic Name	Brand Name	Quantity Limit
Tafamidis	Vyndaqel®	120 capsules/30 days
Tafamidis	Vyndamax®	30 capsules/30days

Tasimelteon (Hetlioz®)

Prescription claims for tasimelteon (Hetlioz®) may be subject to the following clinical edits:

1.   Clinical Authorization;

2.   Quantity Limit;

3.   Maximum Daily Dose; and

4.   Therapeutic Duplication.

Clinical Authorization for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) will be reimbursed at POS when the prescriber has obtained an approved clinical authorization.

Override provisions should be addressed through the Clinical Authorization process.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Maximum Dose for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) have a maximum daily dose of 20mg/day. There are no override provisions through the POS system using NCPDP service codes.

Therapeutic Duplication for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) will deny at POS if there is an active claim for another sedative-hypnotic agent.

After consultation with the prescriber to verify the necessity of the therapeutic duplication, the pharmacist may override the therapeutic duplication.

The pharmacist must document the override codes on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Quantity Limit for tasimelteon (Hetlioz LQ™)

Pharmacy claims for tasimelteon (Hetlioz LQ™) have a maximum quantity of 158 mls per 31 days.

Tazarotene (Tazorac®)

Pharmacy claims for Tazarotene (Tazorac®) require an appropriate diagnosis code for reimbursement. The prescribing provider must document the diagnosis code on the hard copy prescription or may communicate the diagnosis code to the pharmacist electronically, via telephone, or facsimile.

The acceptable diagnosis codes are:

ICD-10-CM Code	Description
L40*	Psoriatic Arthritis

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Pharmacy providers may direct questions to the Provider Help Desk concerning overrides for this edit. (Refer to Section 37.5.4 for contact information).

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Tedizolid Phosphate (Sivextro®)

Prescriptions for tedizolid phosphate (Sivextro®) will be reimbursed when:

1.   The prescriber has obtained an approved clinical pre-authorization.

Teplizumab-mzwv(Tzield™)

Pharmacy claims for teplizumab-mzwv (Tzield™) require an approved clinical authorization for reimbursement.

Tesamorelin (Egrifta®)

Pharmacy claims for tesamorelin (Egrifta®) require a diagnosis code. The diagnosis code must be documented on the prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Tiotropium Bromide (Spiriva Respimat®)

Pharmacy claims for tiotropium bromide (Spiriva Respimat®) will require a diagnosis code.

Medication	Description of Diagnosis	ICD-10 Code
Spiriva Respimat® 1.25 mcg (tiotropium bromide)	Asthma	J45*
Spiriva Respimat® 2.5 mcg (tiotropium bromide)	COPD	J44*

*any number or letter or combination of UP TO 4 numbers and letters of an assigned ICD-10_CM diagnosis code.

Tolvaptan (Samsca®)

Pharmacy claims for tolvaptan (Samsca®) have quantity limits. The quantity limits for tolvaptan (Samsca®) are listed in the chart.

Generic Name	Brand Name	Quantity Limit
Tolvaptan	Samsca® 15mg	30 tablets/30 days
	Samsca® 30 mg	60 tablets/30 days

Tramadol

Pharmacy claims for tramadol–containing products have the following edits:

1. Age Limit;

2. Clinical Authorization; and

3. Maximum Daily Dose.

Description	Age (Y=Year)
Tramadol	≥12 Y
Tramadol Combination Product	≥12 Y

Pharmacy claims for tramadol and tramadol combination products will deny at POS if the beneficiary is less than 12 years of age.

Pharmacy claims for tramadol-containing products submitted for beneficiaries 12-17 years of age without an approved clinical authorization will deny.

Generic Name	Maximum Dose per Day	Age
Tramadol Immediate Release	400 mg/day	<76 years
Tramadol Immediate Release	300 mg/day	>75 years

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Tramadol Extended Release	300 mg/day	
Tramadol/Acetaminophen	8 tablets/day	

Trientine Tetrahydrochloride (Cuvrior™)

Pharmacy claims for trientine tetrahydrochloride (Cuvrior^TM) will be subject to the following:

1.   Clinical authorization; and

2.   Quantity limit.

The quantity limit for trientine tetrahydrochloride (Cuvrior^TM) is listed in the following chart.

Generic Name (Brand Example)	Quantity Limit
Trientine Tetrahydrochloride (Cuvrior™)	300 tablets/30 days

Trifarotene (Aklief®)

Pharmacy claims for trifarotene (Aklief®) will deny at POS when the beneficiary is younger than 9 years of age or older than 20 years of age.

Triptans

Pharmacy claims for triptans for beneficiaries under 18 years of age will require a valid diagnosis code for reimbursement. Triptans are identified in the following chart:

Generic Name	Representative Brand(s)
Almotriptan	Axert®6
Eletriptan	Relpax®
Frovatriptan	Frova®
Naratriptan	Amerge®
Rizatriptan	Maxalt®, Maxalt MLT®

Generic Name	Representative Brand(s)
Sumatriptan	Alsuma®, Imitrex®, Sumavel®, Zecuity®
Zolmitriptan	Zomig®, Zomig ZMT®

The acceptable ICD-10-CM diagnosis codes for triptans in beneficiaries less than 18 years of age are as follows:

Drug-Brand Example	Diagnosis	ICD-10-CM Diagnosis Code
Almotriptan – Axert® Eletriptan – Relpax® Frovatriptan – Frova® Naratriptan – Amerge® Rizatriptan – Maxalt®, Maxalt MLT® Sumatriptan [Oral, Nasal] – Imitrex®, Onzetra Xsail®, Tosymra® Sumatriptan [Injection] – Zembrace SymTouch® Zolmitriptan – Zomig®, Zomig ZMT®	Migraine	G43.0*, G43.1*, G43.7*
Sumatriptan [Injection] – Imitrex®, Sumavel®	Migraine	G43.0*, G43.1*, G43.7*
	Cluster Headache, Acute	G44.009

Trofinetide (Daybue™)

Pharmacy claims for trofinetide (Daybue™) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Urea Cycle Disorder Agents

Pharmacy claims for Urea Cycle Disorder agents may require a prior or clinical authorization.

Select Urea Cycle Disorder agents are listed in the following chart.

Generic Name (Brand Example)
Carglumic Acid (Carbaglu®)
Glycerol Phenylbutyrate (Ravicti®)
Sodium Phenylbutyrate Pellet (Pheburane®, Olpruva™)
Sodium Phenylbutyrate Powder, Tablet (Buphenyl®)

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL for preferred/non-preferred agents, drug specific clinical authorization criteria and instructions.

Vaccines (Adult)

Louisiana Medicaid will reimburse enrolled **pharmacies** for select adult vaccines and the COVID vaccine administered by a pharmacist with the "Authority to Administer" authorized by the Louisiana Board of Pharmacy. Adult vaccine reimbursement includes reimbursement for the ingredient cost and administration fee.

Counseling for Vaccines

Counseling for vaccines will be reimbursed for beneficiaries less than 21 years old when the vaccine is administered and criteria has been met.

The following criteria must be followed to receive reimbursement for vaccine counseling:

1. Confirm that the patient is not currently "up-to-date" with vaccine dosing, as recommended by the Advisory Committee on Immunization Practices (ACIP) or Centers for Disease Control and Prevention (CDC);

2. Confirm vaccination status in the Louisiana Immunization Network for Kids Statewide (LINKS), whenever possible;

3. Confirm patient consent of the parent, guardian or caregiver (if appropriate) to receive the counseling and vaccine;

4. Document the type and Brand of the vaccine or booster;

5. Confirm the Medicaid beneficiary is (for counseling reimbursement):

   a. From 3-20 years old for COVID vaccine;

   b. From 3-20 years old for influenza vaccine; or

   c. From 3-20 years old for all other vaccines:

NOTE: PREP Act allowance for ages 3-6 years until January 1, 2030 for COVID and influenza vaccines.

6. Counsel the patient, along with their parent, guardian, or caregiver (if appropriate) on the safety and effectiveness of vaccines;

7. Answer any questions that the patient or parent, guardian, or caregiver has regarding vaccination;

8. Counsel the patient, along with their parent, guardian, or caregiver (if appropriate) for a minimum of five minutes; and

9. Administer the vaccine.

Pharmacist Requirements

For adult vaccine reimbursement, the pharmacist shall:

1. Be registered with the Louisiana Board of Pharmacy with the "Authority to Administer" vaccines;

2. Be registered as a Louisiana Medicaid provider;

3.   Inform the individual that the administration of an immunization or vaccine is not to be construed as being in lieu of an annual preventive visit with the individual's primary care or family physician;

4.   Access the Louisiana Immunization Network for Kids (LINKS) prior to immunization administration, if possible, to verify appropriate utilization according to the Advisory Committee on Immunization Practices (ACIP) to prevent duplication, unnecessary doses, inappropriate age, etc.;

5.   Report each immunization to the Louisiana Department of Health (LDH), Office of Public Health's LINKS at the time of the immunization or as soon as reasonably possible, thereafter;

6.   Report all adverse events observed or which are reported to the pharmacist to the Vaccine Adverse Events Reporting System, or its successor program; and further, the pharmacist shall refer the patient with an adverse event to appropriate medical care;

7.   Report certain data elements to the CDC for each COVID vaccine administered within 24 hours of administration, as a vaccination Provider;

8.   Ensure that pharmacy technicians and/or state-authorized pharmacy interns administering COVID vaccines meet PREP Act qualifications. The qualified pharmacy technicians and/or state-authorized pharmacy interns act under the supervision of a qualified pharmacist. The supervising qualified pharmacist of qualified pharmacy technicians and/or state-authorized interns must comply with CDC, state, and federal requirements for COVID vaccine administration; and

9.   Request the name of a patient's primary care provider prior to the administering of any immunization. The pharmacist shall notify the primary care provider, by written or electronic communication, as soon as reasonably possible that the immunization was administered.

All 340B pharmacies carved-in to Medicaid may bill vaccines and the administration fee for adults (19 years and older) at POS as a pharmacy benefit.

There will be no copay assessed on adult vaccine claims. Third party billing policy will apply and Medicaid will be the payer of last resort.

Pharmacy claims for vaccines will bypass POS edits for the four prescription monthly limit and pharmacy Lock-In.

The following chart lists select adult vaccines with age limits covered when administered by a pharmacist as a pharmacy claim:

Vaccines	Brand Name Examples	Age Limit
BCG LIVE	BCG (TICE Strain)	≥ 19 years
COVID	Various Brands	*
H. influenzae Type B Conjugate	Hiberix	≥ 19 years
Hepatitis A Adult	Vaqta®, Havrix®	≥ 19 years
Hepatitis A – Hepatitis B Adult	Twinrix®	≥ 19 years
Hepatitis B Adult (recombinant adjuvanted)	Heplisav-B®	≥ 19 years
Hepatitis B Adult (recombinant)	Engerix-B®, *Recombivax HB®*	≥ 19 years
Hepatitis B vaccine [trivalent (recombinant)]	PreHevbrio®	≥ 19 years
HPV – Human Papillomavirus 9-valent	Gardasil®9	19-45 years
Influenza Vaccine	Various Brands	*
Japanese Encephalitis	Ixiaro	≥ 19 years
Measles, Mumps & Rubella	M-M-R®II, Priorix®	≥ 19 years
Meningococcal (Groups A, B, C, W, and Y)	Penbraya	10-25 years
Meningococcal Conjugate (Groups A, C, Y and W-135)	Menveo®, Menactra®, MenQuadfi®	≥ 19 years
MENB – Meningococcal Group B	Trumenba®, Bexsero®	≥ 19 years
Pneumococcal – 13-valent	Prevnar 13™	≥ 19 years
Pneumococcal – 15-valent	Vaxneuvance™	≥ 19 years
Pneumococcal – 20-valent	Prevnar 20™	≥ 19 years
Pneumococcal Polysaccharide (23-valent)	Pneumovax®23	≥ 19 years

Poliomyelitis	Ipol	≥ 19 years
Rabies Vaccine	Imovax®, RabAvert®	≥ 19 years
RSV Vaccine, Pref A and Pref B	Abrysvo	≥ 60 years
RSVPREF3 Antigen	Arexvy Kit, Arexvy Vial	≥ 60 years
Smallpox and Monkeypox	Jynneos	*
Tetanus and Diphtheria Toxoids	TDVAX®, *Tenivac*®	≥ 19 years
Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis	Adacel®, Boostrix®	≥ 19 years
Varicella	Varivax®	≥ 19 years
Yellow Fever	Stamaril, YF-Vax	≥ 19 years
Zoster Vaccine Recombinant, adjuvanted	Shingrix®	≥ 18 years

*There are select age ranges for specific vaccines based on the package insert.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

COVID Vaccine

The COVID vaccines are covered by the Louisiana Medicaid pharmacy program. The at home administration of the COVID vaccine is not a covered service effective May 12, 2023. The COVID vaccine administration by pharmacist will be covered for beneficiaries 3 years of age and older in accordance with current prescribing information and PREP ACT guidelines until January 1, 2030.

COVID Oral Agents

Pharmacy claims for nirmatrelvir/ritonavir (Paxlovid®) used in the treatment of COVID are covered.

Nirmatrelvir/ritonavir (Paxlovid®) is subject to the following quantity limit and age requirements.

Drug	Quantity Limit	Age Requirement
nirmatrelvir/ritonavir (Paxlovid®)	30 tablets/5 days	≥12 years

COVID Over-the-Counter (OTC) At Home Tests

COVID OTC at home diagnostic tests are not covered. Reimbursement for COVID OTC tests ended September 30, 2024.

Vamorolone (Agamree®)

Pharmacy claims for vamorolone (Agamree®) require an approved clinical authorization.

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

Prescriptions for Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors: deutetrabenazine (Austedo®), tetrabenazine (Xenazine®), and valbenazine (Ingrezza®) will be reimbursed when:

    1.   The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Velmanase alfa-tycv (Lamzede®)

Pharmacy claims for velmanase alfa-tycv (Lamzede®) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Zoledronic Acid (Reclast®)

Pharmacy claims for zoledronic acid (Reclast®) are subject to the quantity limit listed in the chart.

Generic Name	Brand Name	Quantity Limit
Zoledronic Acid	Reclast®	1 vial/365 days

Zuranolone (Zurzuvae™)

Pharmacy claims for zuranolone (Zurzuvae™) require a PA and are subject to the quantity limits listed in the chart below.

Medication (Brand Example)	Quantity Limit
Zuranolone (Zurzuvae™) 20 mg	28 capsules per 14 days
Zuranolone (Zurzuvae™) 25 mg	28 capsules per 14 days
Zuranolone (Zurzuvae™) 30 mg	14 capsules per 14 days

Diagnosis Code Requirement for Selected Medications

Prescriptions for selected medications require a diagnosis code for reimbursement for both FFS Medicaid and the MCOs. The diagnosis code should be documented on the hardcopy prescription by the prescriber or pharmacist. The pharmacist may document the diagnosis code on the hardcopy prescription or in the pharmacy's electronic recordkeeping system after electronic or verbal consultation with the prescribing practitioner.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Prospective Drug Utilization Policies/Limits/Edits

Pharmacy claims are processed utilizing prospective DUR system which consists of criteria set forth by the state-established DUR board which monitors for inappropriate use of medications and identifies potential drug conflicts. It is designed to work alongside the POS claims processing and eligibility systems, displaying alert messages, based on severity level, to alert of any possible harmful effects that a medication may have on a patient. The alerts generated are caused by various

combinations of interactions between a beneficiary's condition, beneficiary's historical drug prescription records on file and the current medications prescribed for them.

Professional judgment regarding appropriate drug use is the responsibility of the pharmacist. Improper use of DUR override codes by pharmacy staff may result in the disallowance of these override codes and administrative sanctions by Medicaid and the Board of Pharmacy.

Prospective DUR monitors:

1.   Duration of therapy;

2.   Early refill;

3.   Duplicate drug therapy;

4.   Pregnancy and FDA Category X drugs;

5.   Therapeutic duplication;

6.   Drug to drug interaction;

7.   Unnecessary drug therapy;

8.   Age and gender restrictions;

9.   Maximum dosage;

10.   Quantity Limits; and

11.   Drugs to diagnosis.

NOTE: Refer to Section 37.5.12 for an overview of Patient Counseling, DUR.

Histamine (H$_2$) Antagonists

Pharmacy claims for H$_2$ antagonists may be subject to a PA.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Proton Pump Inhibitors (PPIs)

Pharmacy claims for proton pump inhibitors (PPIs) may be subject to following:

> 1.   Prior or clinical authorization;
>
> 2.   Duration of therapy;
>
> 3.   Quantity limit; and
>
> 4.   Therapeutic duplication.

Select proton pump inhibitors (PPIs) are listed in the following chart.

Generic Name (Brand Name Example)
Dexlansoprazole Capsule (Dexilant®)
Esomeprazole Capsule, Suspension (Nexium®)
Lansoprazole Capsule, ODT (Prevacid®, Prevacid SoluTab®)
Omeprazole Capsule Rx, Granules for Suspension (Prilosec®)
Omeprazole/Sodium Bicarbonate Oral Suspension (Konvomep®)
Omeprazole/Sodium Bicarbonate Rx Capsule, Packet (Zegerid®)
Pantoprazole Suspension, Tablet (Protonix®)
Rabeprazole Tablet (AcipHex®)

Duration of Therapy

Pharmacy claims for all PPIs are subject to a duration of therapy limit of **180 days** in a rolling **365-day period**.

Duration of Therapy Exemptions

The following conditions are exempt from the duration of therapy limit:

> 1.   Beneficiaries under 6 years of age; OR

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2.   Beneficiaries receiving pancreatic enzymes; OR

3.   Pharmacy claims submitted with an appropriate bypass diagnosis code.

Diagnosis Codes Exempt from the Duration of Therapy Limit for PPIs

Select diagnosis codes are exempt and bypass the duration of therapy edit for PPIs. (See the following chart for the listing).

Diagnosis	ICD-10-CM Diagnosis Code(s)
Abscess of Esophagus	K20.8
Angiodysplasia of Stomach and Duodenum (with OR without Mention of Hemorrhage)	K31.81*
Atrophic Gastritis with Hemorrhage	K29.41
Barrett's Esophagus	K22.7*
Cerebral Palsy (*new Aug 2019*)	G80*
Chronic Pancreatitis	K86.0, K86.1
Congenital Tracheoesophageal Fistula	Q39.1, Q39.2
Cystic Fibrosis	E84.*
Eosinophilic Esophagitis	K20.0
Eosinophilic Gastritis	K52.81
Gastrointestinal Hemorrhage	K92.2
Gastrointestinal Mucositis (Ulcerative)	K92.81
Malignant Mast Cell Tumors	C96.2*
Multiple Endocrine Adenomas	D44.0, D44.2, D44.9
Tracheoesophageal Fistula	J86.0, J95.04
Ulcer of Esophagus with OR without Bleeding	K22.1*
Zollinger-Ellison Syndrome	E16.4

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Quantity Limit

Pharmacy claims for PPIs will be subject to a quantity limit as listed in the chart:

Generic Name (Brand Name Example)	Quantity Limit per 30 Days
Dexlansoprazole Capsule (Dexilant®)	30 capsules
Esomeprazole Capsule (Nexium®)	30 capsules
Esomeprazole Granules for Oral Suspension (Nexium®)	1 carton of 30 packets
Lansoprazole Capsule (Prevacid®)	30 capsules
Lansoprazole ODT (Prevacid® SoluTab®)	30 tablets
Omeprazole Capsule/Tablet (Prilosec®)	30 capsules/tablets
Omeprazole Granules for Oral Suspension (Prilosec®)	1 carton of 30 packets
Omeprazole/Sodium Bicarbonate Capsule (Zegerid®)	30 capsules
Omeprazole/Sodium Bicarbonate Packet (Zegerid®)	30 packets
Omeprazole/Sodium Bicarbonate Suspension (Konvomep™)	600 ml
Pantoprazole Granules for Oral Suspension (Protonix®)	1 carton of 30 packets
Pantoprazole Tablet (Protonix®)	30 tablets
Rabeprazole Sprinkle Capsule (AcipHex® Sprinkle™)	30 capsules
Rabeprazole Tablet (AcipHex®)	30 tablets

Therapeutic Duplication

Pharmacy claims for PPIs will deny at POS with a therapeutic duplication if there is an active claim for another PPI on the beneficiary's file.

Early Refill

The Medicaid Program denies pharmacy claims for early refills if the patient has requested the same medication at the same pharmacy prior to 85 percent of medication being utilized. This translates into a five day window based on a 30-day supply.

Prescriptions for narcotic analgesics will deny for an early refill edit when less than 90 percent of the medication had been utilized. This translates into a two day window based on a 30-day supply.

Pharmacists must enter the actual days' supply for each pharmacy claim. If the number of days is not apparent, an estimate must be given based on professional judgment.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a beneficiary's request for medication earlier than previously reported in the estimated days' supply.

The pharmacist must document the circumstances on the prescription hard copy.

NOTE: The *POS User Guide* can be accessed at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Duplicate Drug Therapy

A claim denial will occur if the beneficiary attempts to obtain the same drug (form and strength) from a different pharmacy sooner than is anticipated based on the estimated days' supply.

After consultation with the physician, beneficiary and/or the POS help desk, the provider must determine whether there are extenuating circumstances which substantiate the dispensing of a duplicate claim.

The pharmacy provider shall record documentation of circumstances and specific contacts for the override.

For those isolated instances when one pharmacy has billed a claim, and special circumstances prevented the beneficiary from receiving the prescription from the pharmacy originally billing the claim an override is allowed. An override should only be used if the second pharmacy attempting to bill a claim for the same ingredient for the same beneficiary and cannot have the first claim reversed by the original billing pharmacy. A notation to that effect must be written on the hardcopy prescription or in the pharmacy's electronic record keeping system. Pharmacy claims submitted with an override code are subject to the pharmacy audit process.

When both duplicate drug therapy and early refill clinical events occur, reimbursement will not be made. These situations indicate multiple pharmacy shopping patterns.

NOTE: The *POS User Guide* can be accessed at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Pregnancy and FDA Category X Drugs

The Medicaid Program denies pharmacy claims with FDA Pregnancy Category for pregnant women. Pharmacy claims submitted for a drug in this category for beneficiaries with a co-payment designation of pregnancy will be denied.

The specific drugs that are currently included in FDA Pregnancy Category X are listed below. The Medicaid Program may add drugs to these lists as new drugs appear on the market or as FDA indications change.

There is no override option for these claims.

Pregnancy and FDA Category D Drugs

Pharmacy claims submitted with FDA Pregnancy Category D drugs will receive an educational edit in the response from the Medicaid Program. These claims will not deny.

Prior Drug Use

Pharmacy claims for select drugs will require prior use of other drug(s) before reimbursement.

Olmesartan/amlodipine/hydrochlorothiazide (Tribenzor®) and amlodipine/valsartan/hydrochlorothiazide (Exforge HCT®) will require prior drug use of two drug therapies from these select drug classes: calcium channel blockers, angiotensin receptor blockers, and/or diuretics. If previous claims for drugs in two of these three drug classes (calcium channel blockers, angiotensin receptor blockers, and/or diuretics) are not identified, the pharmacy claim will deny.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Therapeutic Duplication

The Medicaid Program denies pharmacy claims for oral formulations of drugs in the following classes and specific drugs if the beneficiary has an active paid claim on file for another drug in the

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same therapeutic class. An active prescription is a prescription in which the days' supply has not expired.

If an override is determined appropriate after contacting the prescriber, additional documentation of the reason for service code, professional service code and result of service code is required on the hard copy prescription or in the pharmacy's electronic record keeping system. Additional requirements may be associated with certain drug classes or specific drugs.

First Generation Antihistamine

Brompheniramine Maleate	Carbinoxamine Maleate
Clemastine Fumarate	Cyproheptadine HCL

If a first generation antihistamine is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

Second Generation Antihistamine

Cetirizine HCL	Desloratadine
Fexofenadine HCL	Levocetirizine Dihydrochloride
Loratadine	

If a second generation antihistamine is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

First Generation Antihistamine-Decongestant

Pseudoephedrine HCL/Brompheniramine	Psuedoephedrine HCL/Triprolidine HCL
Phenylephrine/Diphenhydramine	Pseudoephedrine HCL/Chlorpheniramine

If a first generation antihistamine-decongestant product, is given with another first and/or second generation antihistamine or antihistamine-decongestant product, he claim will deny due to a therapeutic duplication.

Second Generation Antihistamine-Decongestant

Cetirizine HCL/Pseudoephedrine	Fexofenadine/Pseudoephedrine

Loratadine/Pseudoephedrine	Desloratadine/Pseudoephedrine

If a second generation antihistamine-decongestant product, is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

Claims for diphenhydramine, hydroxyzine HCl, and hydroxyzine pamoate are not included in the antihistamine edits for therapeutic duplication.

Angiotensin Converting Enzyme (ACE) Inhibitors and ACE Inhibitor/Diuretic Combinations

Benazepril HCl	Lisinopril/Hydrochlorothiazide
Benazepril HCl/Hydrochlorothiazide	Moexipril HCl
Captopril	Moexipril/Hydrochlorothiazide
Captopril/Hydrochlorothiazide	Perindopril Erbumine
Enalapril Maleate	Quinapril HCl
Enalapril/Hydrochlorothiazide	Quinapril/Hydrochlorothiazide
Fosinopril Sodium	Fosinopril Sodium
Fosinopril/Hydrochlorothiazide	Ramipril
Lisinopril	Trandolapril

ACE Inhibitors/Calcium Channel Blocker Combinations

Benazepril/Amloipine	Trandolapril/Verapamil HCl

Angiotensin Receptor Antagonists (ARB) and ARB/Diuretic Combinations

Candesartan Cilexetil	Losartan/Hydrochlorothiazide
Candesartan/Hydrochlorothiazide	Olmesartan Medoxomil
Eprosartan Mesylate	Olmesartan/Hydrochlorothiazide
Eprosartan/Hydrochlorothiazide	Telmisartan
Irbesartan	Telmisartan/Hydrochlorothiazide
Irbesartan/Hydrochlorothiazide	Valsartan
Losartan Potassium	Valsartan/Hydrochlorothiazide

ARB/Calcium Channel Blocker Combinations

Olmesartan Medoxomil/Amlodipine	Valsartan/Amlodipine

Beta-Adrenergic Blocking Agents and Beta-Adrenergic Blocking Agent/Diuretic Combinations

Acebutolol HCl	Nadolol
Atenolol	Nadolol/Bendroflumethiazide
Atenolol/Chlorthalidone	Nebivolol HCl
Betaxolol HCl	Penbutolol Sulfate
Bisoprolol Fumarate	Pindolol
Bisoprolol/Hydrochlorothiazide	Propranolol HCl
Carvedilol	Propranolol/Hydrochlorothiazide
Carvedilol CR	Sotalol AF
Labetalol HCl	Sotalol HCl
Metoprolol ER	Timolol Maleate
Metoprolol Tartrate	Timolol/Hydrochlorothiazide
Metoprolol/Hydrochlorothiazide	

Calcium Channel Blockers

Amlodipine	Nifedipine
Diltiazem	Nimodipine
Felodipine	Nisoldipine
Isradipine	Verapamil
Nicardipine	

Calcium Channel Blocker/Antihyperlipemia Agent Combination

Amlodipine/Atorvastatin Calcium

Potassium Replacement

Potassium Acetate	Potassium Bicarbonate/Citric Acid
Potassium Chloride	Potassium Citrate

Tricyclic Antidepressants

Amitriptyline HCl	Imipramine Pamoate
Amoxapine	Maprotiline HCl
Clomipramine HCl	Nortriptyline HCl
Desipramine HCl	Protriptyline HCl
Doxepin HCl	Trimipramine Maleate
Imipramine HCl	

Selective Serotonin Reuptake Inhibitors

Citalopram HBr	Paroxetine HCl
Escitalopram Oxalate	Paroxetine Mesylate
Fluoxetine HCl	Sertraline HCl
Fluvoxamine Maleate	

Antipsychotic Agents (Typical and Atypical)

Prescriptions for antipsychotic agents will deny for therapeutic duplication when the beneficiary has two active antipsychotic prescriptions on their file. The pharmacist must document on the hard copy prescription the reason the prescriber required the beneficiary to receive a third antipsychotic agent.

Note: Refer to "Drugs with Special Payment Criteria/Limitations" in this section for further policy regarding antipsychotic agents.

Typical Antipsychotic Agents

Chlorpromazine	Pimozide
Fluphenazine	Thioridazine
Haloperidol	Thiothixene
Loxapine	Trifluoperazine
Molindone	
Perphenazine	

Atypical Antipsychotic Agents

Aripiprazole	Lurasidone
Asenapine	Olanzapine
Brexpiprazole	Paliperidone
Cariprazine	Quetiapine
Clozapine	Risperidone
Iloperidone	Ziprasidone

Antipsychotic /Selective Serotonin Reuptake Inhibitor Combinations

Pharmacy claims for olanzapine/fluoxetine will deny when there are two active prescriptions for antipsychotic agents on the beneficiary's file or when there is one active prescription for a selective serotonin reuptake inhibitor (SSRI) on the beneficiary's history file.

> Olanzapine/Fluoxetine

Anti-Anxiety Agents

Alprazolam	Hydroxyzine
Buspirone	Lorazepam, Lorazepam XR
Chlordiazepoxide	Meprobamate
Chlorazepate	Oxazepam
Diazepam	

The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic recod keeping system the reason an additional anti-anxiety agent was requested by the prescriber.

An additional anti-anxiety agent may be submitted without a therapeutic duplication when the beneficiary has a diagnosis of seizures. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system, after written or verbal consultation with the prescriber and submitted electronically for the override.

Acceptable diagnosis codes are:

ICD-10-CM Diagnosis Code(s)	Description
P90	Convulsions in Newborn
G40.*	Epilepsy, Seizures
R56.*	Other Convulsions

Sedative Hypnotic Agents

Estazolam	Temazepam
Eszopiclone	Triazolam
Flurazepam HCl	Zaleplon
Quazepam	Zolpidem Tartrate

Attention Deficit Disorder (ADD) Agents

Armodafinil	Guanfacine
Atomoxetine	Lisdexamfetamine
Dexmethylphenidate	Methylphenidate
Dextroamphetamine	Modafinil
Dextroamphentamine/amphetamine	

An incoming pharmacy claim for any of the above ADD agents will deny when there is an active paid claim for any of these agents on the beneficiary's file written by a different prescriber.

Non-Steroidal Anti-Inflammatory Agents

Celecoxib	Ibuprofen	Meloxicam
Diclofenac Potassium	Ibuprofen/Hydrocodone Bitartrate	Nabumetone
Diclofenac Sodium	Ibuprofen/Oxycodone	Naproxen
Diclofenac Sodium/Misoprostol	Indomethacin	Naproxen Sodium
Diflunisal	Ketoprofen	Naproxen/Lansoprazole
Etodolac	Ketorolac Tromethamine	Oxaprozin
Fenoprofen Calcium	Meclofenamate Sodium	Piroxicam
Flurbiprofen	Mefenamic Acid	Tolmetin Sodium

Short-Acting Beta₂ Agonist Inhalers

Albuterol	Pirbuterol
Levalbuterol	

Pharmacy claims billed for concurrent use of different short-acting beta₂ agonist inhalers
(SABAs) will deny with a therapeutic duplication.

Note: Refer to 'Drugs with Special Payment Criteria/Limitations' in this section for further policy
regarding short-acting beta₂ agonist inhalers.

Short-Acting Opiate Agents

Buprenorphine*	Hydrocodone/APAP
Buprenorphine/Naloxone*	Hydrocodone/Ibuprofen
Butorphanol Tartrate	Hydromorphone HCl IR
Codeine Phosphate	Levorphanol Tartrate
Codeine Phosphate/APAP	Meperidine HCl
Codeine/ASA	Methadone HCl
Codeine Sulfate	Morphine Sulfate IR
Codeine/APAP/Caffeine/Butalbital	Oxycodone HCl IR
Codeine/ASA/Caffeine/Butalbital	Oxycodone/APAP
Codeine/Carisoprodol/ASA	Oxycodone ASA
Dihydrocodeine/APAP/Caffeine	Oxycodone/Ibuprofen
Fentanyl Ciltrate Buccal	Oxymorphone
Pentazocine/APAP	Tramadol HCl
Pentazocine/Naloxone	Tramadol HCl/APAP

NOTE: Concurrent prescriptions for opioid analgesics with buprenorphine agents may only be
overridden when issued by the same physician.

Long-Acting Opiate Agents

Fentanyl Transdermal	Oxycodone HCl CR
Morphine Sulfate CR	Oxymorphone ER

Proton Pump Inhibitors

Esomerprazole	Omeprazole/Soduim Bicarbonate
Lansoprazole	Pantoprazole
Omeprazole	Rabeprazole

Sulfonylureas

A pharmacy claim for a sulfonylurea will deny if there is an active claim on the beneficiary's file for another sulfonylurea.

The Department may add drugs to these lists as new drugs appear on the market.

NOTE: Refer to Section 37.5.8 - Claim Submission and Processing Payments for override information as well as the *POS User Guide* accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing information.

Drug/Drug Interaction

There may be some situations where adverse interactions could potentially occur between two drugs. In these instances the UniDUR system denies one or both of these claims.

Prescriptions for nitrates will deny when there is an active prescription for Sildenafil (Revatio®) or Tadalafil (Adcirca®) on the beneficiary's drug history file. Conversely, prescriptions for Sildenafil (Revatio®) and Tadalafil (Adcirca®) will deny when there is an active prescription for nitrates on the drug history file.

Upon consultation with the prescriber, the pharmacist may override this interaction. The pharmacist must document the reason the prescriber required the beneficiary to receive a nitrate and Sildenafil (Revatio®) or Tadalafil (Adcirca®). In addition, documentation of the reason for service code, professional service code and result of service code is required on the hardcopy prescription or in the pharmacy's electronic record keeping system. These DUR codes are required for the claim submission.

Unnecessary Drug Therapy

Selective Cox-2 Inhibitor

Pharmacy claims for the selective COX-2 inhibitor, celecoxib (Celebrex®) will deny for "drug use not warranted" if they are not submitted with an appropriate diagnosis code and reason for treatment documented on the hard prescription.

The FDA issued a public health advisory which stated that use of a COX-2 selective agent may be associated with an increased risk of serious cardiovascular events, especially when it is used for long periods of time or in very high-risk settings (e.g. immediately after heart surgery).

The FDA made the following interim recommendations:

1.   Practitioners prescribing Celecoxib (Celebrex®) should consider this emerging information when weighing the benefits against risks for individual patients. Patients who are at a high risk of gastrointestinal (GI) bleeding, have a history of intolerance to non-selective NSAIDs or are not doing well on non-selective NSAIDs may be appropriate candidates for COX-2 selective agents; and

2.   Individual patient risk for cardiovascular events and other risks commonly associated with NSAIDs should be taken into account for each prescribing situation.

As a result of this public health advisory and to help ensure the safety and well-being of Medicaid beneficiaries, the prescribing practitioner must include:

1.   The condition being treated with the COX-2 selective agent by indicating the diagnosis code of the treated condition on all new prescriptions written for a COX-2 selective agent; and

2.   The reason a COX-2 selective agent is used rather than a non-selective NSAID (e.g. treatment failure or history of a GI bleed).

The diagnosis code and the rationale for the choice of a COX-2 selective agent must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system after consultation with the prescriber. The diagnosis code and the rationale may be submitted as an attachment to the original prescription via facsimile.

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A prescription written for a COX-2 selective agent for a Medicaid beneficiary will only process without an override when the following conditions are met:

    1.   A diagnosis code indicating the reason for treatment is documented and submitted; and

    2.   When one of the following conditions exists:

        a.   Beneficiary has current prescription for H2 receptor antagonist;

        b.   Beneficiary has current prescription for proton pump inhibitor;

        c.   Beneficiary has current prescription for warfarin;

        d.   Beneficiary has current prescriptions indicating chronic use of oral steroids; or

        e.   Beneficiary is 60 years of age or older.

If, in the professional judgment of the prescriber, a determination is made which necessitates therapy with a COX-2 selective agent, the pharmacist may override this edit. The pharmacy provider must supply the reason for service code, professional service code and result of service code with the POS submission of the claim and have the information recorded on the hardcopy prescription or in the pharmacy's electronic record keeping system.

NOTE: Refer to Section 37.5.8 - Claim Submission and Processing Payments for override information as well as the *POS User Guide* accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing information.

Maximum Dosage

Atypical Antipsychotic Agents

Pharmacy claims for doses of antipsychotic agents which exceed the maximum recommended doses will deny.

NOTE: Refer to Antipsychotic Agents of this section for the age limits and dosage schedules for antipsychotic agents.

The prescriber may choose to override an age or dosage limit for an antipsychotic medication. Overrides for antipsychotic medications can be addressed by the provider contacting the RxPA Unit. When the pharmacist cannot reach the prescriber or the RxPA Unit is closed, the pharmacist, using their professional judgment, may deem the filling of the antipsychotic prescription to be an "emergency." In these emergency cases, the pharmacist must indicate "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system and override the age or dosage limit.

Agents Containing Acetaminophen or Aspirin

Due to the potential of hepatotoxicity, claims billed with a dosage of acetaminophen that exceeds four grams per day will deny. Claims for products containing aspirin will deny payment when the maximum daily dosage billed exceeds four grams per day. Please note that patients may also be consuming over the counter products that contain either acetaminophen or aspirin.

The maximum regimens apply to both brand name and generic products. As new products are added to the drug file, maximum daily dosages will apply.

Overrides for the (high dose) denial are only acceptable when the prescriber is consulted and approval is given. A notation stating the reason and the codes used to override the claim should be noted on the hardcopy prescription or in the pharmacy's electronic record keeping system.

It is imperative that pharmacists use their professional judgment to determine an appropriate days' supply based upon the directions noted by the prescriber.

Suspending Agents

Pharmacy claims for the following select suspending agents are reimbursable:

Generic Name	Trade Name1
Compounding Vehicle Suspension No. 19	Mx-Sol Blend; Ora Blend

Compound Vehicle Suspension SF No. 20	Ora Plus
Compounding Vehicle No. 8	Ora Sweet
Compound Vehicle Sugar Free No. 9	Ora Sweet SF

Sedative Hypnotic Agents

Pharmacy claims which exceed the maximum daily dosage limit for selected sedative hypnotic agents will deny at POS.

The maximum daily doses for the selected sedative hypnotic agents are as follows:

Generic Name	Brand Name	Maximum Dose Per Day
Daridorexant	QuvivqTM	50mg/day
Doxepin (sedative-hypnotic only)	Silenor®	6 mg/day
Estazolam	Prosom®	2 mg/day
Eszopiclone	Lunesta®	3 mg/day
Flurazepam	Dalmane®	30 mg/day
Lemborexant	Dayvigo®	10mg/day
Quazepam	Doral®	15 mg/day
Ramelteon	Rozerem®	8 mg/day
Suvorexant	Belsomra®	20mg/day
Tasimelteon	Heltioz®	20mg/day
Temazepam	Restoril®	30 mg/day
Triazolam	Halcion®	0.5 mg/day

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Generic Name	Brand Name	Maximum Dose Per Day
Zaleplon	Sonata®	20 mg/day
Zolpidem IR tablet	Ambien®	10 mg/day
Zolpidem SL tablet	Edluar®	10 mg/day
Zolpidem oral spray	Zolpimist®	10 mg (2sprays)/day
Zolpidem ER tablet	Ambien CR®	12.5 mg/day
Zolpidem SL tablet	Intermezzo®	1.75mg/day (female)
Zolpidem SL tablet	Intermezzo®	3.5 mg/day (male)

NOTE: The *POS User Guide* can be accessed at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdfor by visiting
Section 37.5.1 for detailed billing instructions and override procedures.

Pharmacy claims for the following sedative hypnotics will be subject to thequantity limits listed
in the chart below:

Generic Name (Brand Name Example)	Naïve 7-day supply per rolling 30 days[1]	Chronic Use 15-day supply per 30 rolling days[2]
Daridorexant (Quviviq™)	7 tablets	15 tablets
Doxepin Tablet (Silenor®)	7 tablets	15 tablets
Estazolam Tablet (ProSom®)	7 tablets	15 tablets
Eszopiclone Tablet (Lunesta®)	7 tablets	15 tablets
Flurazepam Capsule (Dalmane®)	7 capsules	15 capsules
Lemborexant (Dayvigo®)	7 tablets	15 tablets
Ramelteon Tablet (Rozerem®)	7 tablets	15 tablets
Suvorexant Tablet (Belsomra®)	7 tablets	15 tablets
Temazepam Capsule (Restoril®)	7 capsules	15 capsules
Triazolam Tablet (Halcion®)	7 tablets	15 tablets
Zaleplon Capsule (Sonata®)	7 capsules	15 capsules
Zolpidem IR (Ambien®)	7 tablets	15 tablets
Zolpidem ER (Ambien CR®)	7 tablets	15 tablets

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Generic Name (Brand Name Example)	Naïve 7-day supply per rolling 30 days[1]	Chronic Use 15-day supply per 30 rolling days[2]
Zolpidem Sublingual (Edluar®; Intermezzo®)	7 tablets	15 tablets

[1] Oral sedative hypnotics for a naïve beneficiary have a 7 day supply per rolling 30 days. Naïve is defined as having no paid claims for a sedative hypnotic in the previous 60 days.

[2] Oral sedative hypnotics for chronic use have a 15 day supply per rolling 30 days. Chronic use is defined as having a paid claim for a sedative hypnotic in the previous 60 days.

Additional information for oral sedative hypnotics:

1. Pharmacy claims for all sedative/hypnotic agents (except dexmedetomidine, tasimelteon capsule and zolpidem tartrate oral spray) are limited to:

    a. A quantity of 7 per rolling 30 days for beneficiaries who have no sedative/hypnotic pharmacy claims in the previous 60-day period;

    b. A quantity of 15 per rolling 30 days for beneficiaries who have any sedative/hypnotic pharmacy claim in the previous 60-day period; and

    c. Tasimelteon (Hetlioz LQ™) is limited to a maximum quantity of 158 ml per 31 days.

Exclusions for quantity limit edits for oral sedative hypnotics:

1. Pharmacy claims submitted with an ICD-10-CM diagnosis code of palliative care (Z51.5) in **NCPDP field 424-DO** will bypass the quantity limit; and

2. Pharmacy claims submitted for tasimelteon capsule (Hetlioz®) and zolpidem tartrate oral spray (ZolpiMist®) are excluded.

Sedative hypnotics are monitored at POS for duplication of therapy with other sedative/hypnotic agents.

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Tapentadol (Nucynta®)

When the cumulative daily dosage for Tapentadol (Nucynta®) exceeds the maximum daily dosage of 700mg per day, the claim will deny.

If the prescribing practitioner chooses to exceed the maximum daily dosage, the prescribing practitioner must provide the reason why the daily dosage limit needs to be exceeded. The pharmacist may override the dosage limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic recordkeeping system the reason for service code, professional service code and result of service code with the POS submission.

Agents containing Tramadol

Pharmacy claims for doses of agents containing Tramadol which exceed the maximum recommended doses will deny.

The maximum daily doses for agents containing Tramadol are as follows:

Generic Name	Maximum Dose per Day	Age
Tramadol Immediate Release	400mg/day	<76 years
Tramadol Immediate Release	300mg/day	>75 years
Tramadol Sustained Release	300mg/day	
Tramadol/Acetaminophen	8 tablets/day	

If the prescribing practitioner chooses to exceed the maximum daily dosage, the prescribing practitioner must provide the reason why the daily dosage limit needs to be exceeded. The ***pharmacist may override the dosage limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record

keeping system the reason for service code, professional service code and result of service code with the POS submission.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Tramadol/Celecoxib (Seglentis®)

Pharmacy claims for tramadol/celecoxib (Seglentis®) will have the following POS edits:

1. Age limit;

2. Concurrent Use;

3. Drug-Drug Interaction;

4. Maximum Daily Dose;

5. Morphine Milligram Equivalent (MME) Limit;

6. Quantity limit; and

7. Therapeutic Duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Botulinum Toxins OnabotulinumtoxinA (Botox®), IncobotulinumtoxinA (Xeomin®), RimabotulinumtoxinB (Myobloc®)

Quantity Limit

Pharmacy claims for onabotulinumtoxinA (Botox®) will have quantity limits of 6 units every rolling 84 days for the 100 unit vial and 3 units every rolling 84 days for the 200 unit vial. Pharmacy claims for incobotulinumtoxinA (Xeomin®) will have quantity limits of 400 units every rolling 84 days.

Diagnosis Code Requirement

Prescriptions for onabotulinumtoxinA (Botox®) and incobotulinumtoxinA (Xeomin®) require an appropriate diagnosis code documented on the hard copy prescription by either the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Acceptable Diagnosis Codes for OnabotulinumtoxinA (Botox®)

ICD-10-CM Diagnosis Code(s)	Description
L74.510	Axillary Hyperhidrosis
G24.5	Blepharospasm
G24.3	Cervical Dystonia
G43.7*	Chronic Migraine (Prophylaxis)
N32.81	Overactive Bladder
H49*, H50*, H51*	Strabismus
G35	Upper or Lower Limb Spasticity Associated with Multiple Sclerosis (Relapsing)
G80.0, G80.1, G80.2, G80.4, G80.8, G80.9	Upper or Lower Limb Spasticity Associated with Cerebral Palsy
G81.1*	Upper or Lower Limb Spasticity Associated with Spastic Hemiplegia
G82.53	Upper or Lower Limb Spasticity Associated with Complete Quadriplegia
G82.54	Upper or Lower Limb Spasticity Associated with Incomplete Quadriplegia
G83.0	Upper Limb Spasticity Associated with Diplegia of Upper Limb
G83.1*, G83.2*, G83.3*	Spasticity Associated with Monoplegia of Upper or Lower Limb

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ICD-10-CM Diagnosis Code(s)	Description
L74.510	Axillary Hyperhidrosis
G24.5	Blepharospasm
G24.3	Cervical Dystonia
G43.7*	Chronic Migraine (Prophylaxis)
N32.81	Overactive Bladder
H49*, H50*, H51*	Strabismus
I69.•31, I69.•32, I69.•33, I69.•34, I69.•39, I69.•41, I69.•42, I69.•43, I69.•44, I69.•49	Spasticity Associated with Monoplegia of Upper or Lower Limb due to Late Effects Cerebrovascular Disease
S06.1*, S06.2*, S06.3*, S06.4*, S06.5*, S06.6*, S06.8*, S06.9*	Upper or Lower Limb Spasticity Associated with Intracranial Injury of Other and Unspecified Nature (Traumatic Brain Injury)
S14.0*, S14.1•5*, S14.1•6*, S14.1•7*	Upper or Lower Limb Spasticity Associated with Spinal Cord Injury without Evidence of Spinal Bone Injury
N36.44, N31.9	Urinary Incontinence (Detrusor Overactivity Associated with Neurological Disease)

* - any number or letter or combination of UP TO FOUR numbers and letters of a valid ICD-10-CM diagnosis code

• - any ONE number or letter of a valid ICD-10-CM diagnosis code

Acceptable Diagnosis Codes for IncobotulinumtoxinA (Xeomin®)

ICD-10-CM Diagnosis Code(s)	Description
G24.5	Blepharospasm
G24.3	Cervical Dystonia
K11.7	Chronic Sialorrhea
G35	Upper Limb Spasticity (ULS) Associated with Multiple Sclerosis (Relapsing)
G80.0, G80.1, G80.2, G80.4, G80.8, G80.9	Upper Limb Spasticity (ULS) Associated with Cerebral Palsy
G81.1*	Upper Limb Spasticity (ULS) Associated with Spastic Hemiplegia
G82.53	Upper Limb Spasticity (ULS) Associated with C5-C7 Complete Quadriplegia
G82.54	Upper Limb Spasticity (ULS) Associated with C5-C7 Incomplete Quadriplegia
G83.0	Upper Limb Spasticity (ULS) Associated with Diplegia of Upper Limb
I69.□31, I69.□32, I69.□33, I69.□34, I69.□39	Upper Limb Spasticity (ULS) Associated with Monoplegia of Upper Limb due to Late Effects of Cerebrovascular Disease
I69.□51, I69.□52, I69.□53, I69.□54, I69.□59	Upper Limb Spasticity (ULS) Associated with Hemiplegia due to Late Effects of Cerebrovascular Disease
S06.1*, S06.2*, S06.3*, S06.4*, S06.5*, S06.6*, S06.8*, S06.9*	Upper Limb Spasticity (ULS) Associated with Intracranial Injury of Other and Unspecified Nature (Traumatic Brain Injury)
G83.2*	Upper Limb Spasticity (ULS) Associated with Monoplegia of Upper Limb
S14.0*, S14.1□5, S14.1□6, S14.1□7	Upper Limb Spasticity (ULS) Associated with Spinal Cord Injury without Evidence of Spinal Bone Injury (C5-C7)

* - any number or letter or combination of UP TO FOUR numbers and letters of a valid ICD-10-CM diagnosis code

• - any ONE number or letter of a valid ICD-10-CM diagnosis code

Acceptable Diagnosis Codes for RimabotulinumtoxinB (Myobloc®)

ICD-10-CM Diagnosis Code(s)	Description
K11.7	Chronic sialorrhea

Lidocaine Patches (Lidoderm®)

Pharmacy claims for lidocaine patches (Lidoderm®) have a quantity limit of 30 patches every rolling 30 days.

Select lidocaine patches (Lidoderm®) and lidocaine patch kits may require PA or clinical authorization.

Lofexidine (Lucemyra®)

Pharmacy claims for lofexidine (Lucemyra®) are subject to the following:

1. Age limit;

2. Maximum Daily Dose;

3. Quantity Limit; and

4. Diagnosis Code Requirement.

Pharmacy claims for lofexidine (Lucemyra®) will deny for beneficiaries 17 years or younger.

Lofexidine (Lucemyra®) pharmacy claims are subject to a maximum daily dose of 2.88 mg (16 tablets) per day.

Pharmacy claims for lofexidine (Lucemyra®) tablets are limited to a 14-day supply (224 tablets) per 6-month period (180 days).

Lofexidine (Lucemyra®) pharmacy claims have the following diagnosis code requirement.

Midazolam (Nayzilam®)

Pharmacy claims for midazolam (Nayzilam ®) have a quantity limit.

Generic (Brand Example)	Quantity Limit
Midazolam (Nayzilam®)	5 boxes (10 doses) per 30 days

Naltrexone Tablets

Naltrexone tablets are subject to the following:

1. Age limit;

2. Diagnosis code requirement;

3. Drug-Drug Interaction; and

4. Therapeutic Duplication.

Pharmacy claims for naltrexone tablets will deny for beneficiaries 17 years or younger.

Generic – Brand Example	Diagnosis Description	ICD-10-CM Diagnosis Code(s)
Lofexidine – Lucemyra®	Opioid abuse with withdrawal	F11.13
	Opioid dependence with withdrawal	F11.23
	Opioid use, unspecified with withdrawal	F11.93

Pharmacy claims for naltrexone tablets have the following diagnosis code requirement.

Generic Name	Diagnosis Description	ICD-10-CM Diagnosis Code(s)
Naltrexone Tablets	Opioid dependence	F11.2*
	Alcohol dependence	F10.2*

	* – any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD–10–CM diagnosis code

Pharmacy claims for naltrexone tablets will deny at POS with a drug-drug interaction when there is an active claim on the beneficiary's file for an opioid or buprenorphine-containing product. Pharmacy claims for opioids or buprenorphine-containing products will deny with a drug-drug interaction when there is an active claim on the beneficiary's file for naltrexone tablet.

Incoming pharmacy claims for any naltrexone agent will deny for therapeutic duplication when the beneficiary has an active prescription on file for any other naltrexone agent.

Naltrexone Injection (Vivitrol®)

Pharmacy claims for naltrexone injection (Vivitrol® are subject to the following for reimbursement:

1.   Diagnosis code requirement;

2.   Age Limit;

3.   Quantity Limit; and

4.   Drug-Drug Interaction.

Diagnosis Code Requirement

The acceptable diagnosis code(s) for naltrexone injection (Vivitrol®) are listed below:

Medication	Diagnosis Description	ICD-10-CM Diagnosis Code
Naltrexone Injection (Vivitrol®)	Alcohol Dependence	F10.2*
	Opioid Dependence	F11.2*

* any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

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Age Limit

Pharmacy claims for naltrexone injection (Vivitrol®) have a minimum age requirement of 18 years old and older.

Quantity Limit

Pharmacy claims for naltrexone injection (Vivitrol®) have a quantity limit of 1 unit (380mg/vial dose kit) per 28 rolling days.

Drug-Drug Interaction

Pharmacy claims for naltrexone injection (Vivitrol®) prescriptions will deny if there is an active claim on the beneficiary's file for an opioid.   Pharmacy claims for opioid prescriptions will deny if there is an active claim on the beneficiary's file for naltrexone injection (Vivitrol®).

Opioids

Opioid prescription drugs have the following clinical edits:

1. Diagnosis code requirement for all Schedule II narcotics;

2. 30-day quantity limit for long-acting opioids;

3. 7-day quantity limit for select opioids for opioid naïve beneficiaries;

4. Maximum of 90 Morphine Milligram Equivalent (MME) per day; and

5. Prior drug use required for long-acting opioids.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Morphine Milligram Equivalent (MME) Limit

The Morphine Milligram Equivalent (MME) per day for all active opioid prescriptions for a beneficiary will be calculated. For each beneficiary, the cumulative daily MME for all active opioid prescriptions will be limited to a maximum of 90 MME per day.

Opioid pharmacy claims with a total daily Morphine Milligram Equivalent (MME) ≥ 50 MME per day will flag at POS as an educational alert for review by the pharmacist.

Buprenorphine products for the treatment of Substance Use Disorder (SUD) will not be included in the MME limit.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Long-Acting Opioid Prior Use Requirement

Pharmacy claims for an incoming prescription for a long-acting opioid will deny if there is not a paid claim for either a short-acting or long-acting opioid medication within the previous 90 days.

Opioid Quantity and MME Limit Exemptions

All Schedule II opioid prescriptions require a valid diagnosis code to process. There are exemptions to the edits for quantity limits and maximum daily MME limits for opioids. Pharmacy claims for opioid products will not be subject to the opioid quantity limits or 90 MME per day limit when the beneficiary has a diagnosis of burn, sickle cell crisis, cancer and/or palliative care. The exemptions to the opioid quantity and MME limit are listed in the chart.

ICD-10-CM Diagnosis Code	Description
T20.2*	Burn of second degree of head, face, and neck
T20.3*	Burn of third degree of head, face, and neck
T20.6*	Corrosion of second degree of head, face, and neck
T20.7*	Corrosion of third degree of head, face, and neck
T21.2*	Burn of second degree trunk
T21.3*	Burn of third degree trunk
T21.6*	Corrosion of second degree of trunk
T21.7*	Corrosion of third degree trunk
T22.2*	Burn of second degree of shoulder and upper limb, except wrist and hand
T22.3*	Burn of third degree of shoulder and upper limb, except wrist and hand

ICD-10-CM Diagnosis Code	Description
T22.6*	Corrosion of second degree of shoulder and upper limb, except wrist and hand
T22.7*	Corrosion of third degree of shoulder and upper limb, except wrist and hand
T23.2*	Burn of second degree of wrist and hand
T23.3*	Burn of third degree of wrist and hand
T23.6*	Corrosion of second degree of wrist and hand
T23.7*	Corrosion of third degree of wrist and hand
T24.2*	Burn of second degree of lower limb, except ankle and foot
T24.3*	Burn of third degree of lower limb, except ankle and foot
T24.6*	Corrosion of second degree of lower limb, except ankle and foot
T24.7*	Corrosion of third degree of lower limb, except ankle and foot
T25.2*	Burn of second degree of ankle and foot
T25.3*	Burn of third degree of ankle and foot
T25.6*	Corrosion of second degree of ankle and foot
T25.7*	Corrosion of third degree of ankle and foot
D57.0	Hb-SS disease with crisis
D57.00	Hb-SS disease with crisis, unspecified
D57.01	Hb-SS disease with acute chest syndrome
D57.02	Hb-SS disease with splenic sequestration
D57.21	Sickle-cell/Hb-C disease with crisis
D57.211	Sickle-cell/Hb-C disease with acute chest syndrome
D57.212	Sickle-cell/Hb-C disease with splenic sequestration
D57.219	Sickle-cell/Hb-C disease with splenic sequestration
D57.41	Sickle-cell thalassemia with crisis
D57.411	Sickle-cell thalassemia with acute chest syndrome
D57.412	Sickle-cell thalassemia with splenic sequestration
D57.419	Sickle-cell thalassemia with crisis, unspecified
D57.81	Other sickle-cell disorders with crisis

ICD-10-CM Diagnosis Code	Description
D57.811	Other sickle-cell disorders with acute chest syndrome
D57.812	Other sickle-cell disorders with splenic sequestration
D57.819	Other sickle-cell disorders with crisis, unspecified
C00.*-C96.*	Cancer
Z51.5	Palliative Care

* - any number or letter or combination of UP TO 4 numbers and letters of an assigned ICD-10-CM diagnosis code.

Opioid (Oral) Liquids

Prescriptions for opioid oral liquids will have a quantity limit of 180 mls or a 7-day supply, whichever is less.

Opioid Dependence Agents

Prescriptions for opioid dependence agents are subject to the following:

1. Age requirement;

2. Concurrent use;

3. Drug-drug interaction;

4. Diagnosis code;

5. Maximum Daily Dose; and

6. Therapeutic Duplication.

Select opioid dependence agents will have the age requirement listed in the chart.

Generic (Brand Example)	Minimum Age
Buprenorphine (Brixadi™, Sublocade®)	18 years
Buprenorphine SL	16 years

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Buprenorphine/Naloxone (Suboxone®, Zubsolv®)	16 years
Lofexidine (Lucemyra®)	18 years
Nalmefene (Opvee®)	12 years
Naltrexone Extended-Release Injectable Suspension (Vivitrol®)	18 years
Naltrexone Tablet	18 years

Opioid dependence agents are monitored for concurrent use with other agents.

1. Incoming pharmacy claims for an opioid analgesic will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for an opiate dependence agent; and

2. Incoming pharmacy claims for a benzodiazepine will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for an opiate dependence agent.

Pharmacy claims for naltrexone tablets or naltrexone extended-release injectable suspension (Vivitrol®) will deny for drug-drug interaction when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for any opioid (including buprenorphine-containing products) and vice versa

Pharmacy claims for select opioid dependence agents must be submitted with an appropriate diagnosis code.

1. Pharmacy claims for all buprenorphine opiate dependence agents (single-ingredient and combination) must be submitted with a diagnosis code for opioid dependence (F11.2*);

2. Pharmacy claims for lofexidine (Lucemyra®) must be submitted with a diagnosis code for ONE of the following:

     a. Opioid abuse with withdrawal – F11.13;

     b. Opioid dependence with withdrawal – F11.23; and

     c. Opioid use, unspecified with withdrawal – F11.93.

3. Pharmacy claims for naltrexone tablets or naltrexone extended-release injectable suspension (Vivitrol®) must be submitted with either a diagnosis code for opioid dependence (F11.2*) or alcohol dependence (F10.2*).

Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Oral buprenorphine agents (single-ingredient and combination) are limited to a maximum daily dose of 24mg per day of buprenorphine or buprenorphine equivalent.

The quantity limits for select opioid dependence agents are listed in the following chart.

Generic Name (Brand Example)	Quantity Limit
Buprenorphine Extended-Release Injection Weekly (Brixadi™) 8mg, 16mg, 24mg or 32mg	4 units/21 days
Buprenorphine Extended-Release Injection Monthly (Brixadi™) 64mg, 96mg or 128mg	1 unit/21 days
Buprenorphine Extended-Release Injection (Sublocade®)	1 unit/26 days
Buprenorphine SL Tablet 2mg	2 units/day
Buprenorphine SL Tablet 8mg	3 units/day
Buprenorphine/Naloxone 2mg/0.5mg SL Tab (Suboxone®)	2 units/day
Buprenorphine/Naloxone 2mg/0.5mg SL Film (Suboxone®)	1 unit/day
Buprenorphine/Naloxone 4mg/1mg SL Film (Suboxone®)	1 unit/day
Buprenorphine/Naloxone 8mg/2mg SL Film/Tab (Suboxone®)	3 units/day
Buprenorphine/Naloxone 12mg/3mg SL Film (Suboxone®)	2 units/day
Buprenorphine/Naloxone SL Tablet 0.7mg/0.18mg (Zubsolv®)	1 unit/day
Buprenorphine/Naloxone SL Tablet 1.4mg/0.36mg (Zubsolv®)	1 unit/day
Buprenorphine/Naloxone SL Tablet 2.9mg/0.71mg (Zubsolv®)	1 unit/day
Buprenorphine/Naloxone SL Tablet 5.7mg/1.4mg (Zubsolv®)	3 units/day
Buprenorphine/Naloxone SL Tablet 8.6mg/2.1mg (Zubsolv®)	2 units/day
Buprenorphine/Naloxone SL Tablet 11.4mg/2.9mg (Zubsolv®)	1 unit/day
Nalmefene (Opvee®)	4 units/30 days
Naloxone Nasal Spray (Narcan®)*	4 units/30 days
Naloxone Nasal Spray (Kloxxado™)*	4 units/30 days
Naloxone Injectable Solution Cartridge/Vial (1ml) 0.4mg/ml*	4 units/30 days
Naloxone Injectable Solution Syringe 1mg/ml*	4 units/30 days
Naloxone Injectable Solution (5ml, 10ml, 20ml) 1mg/ml*	1 unit/30 days

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Naloxone Injectable Solution (10ml) 0.4mg/ml*	1 unit/30 days
Naloxone Injectable Solution (Zimhi™)*	4 syringes (2ml)/30 days
Naltrexone Extended-Release Injectable Suspension (Vivitrol®)	1 unit/28 days

Note: Oral buprenorphine agents (single-ingredient and combination) are limited to a maximum daily dose of 24mg per day of buprenorphine or buprenorphine equivalent.

Opiate dependent agents are monitored at the pharmacy POS for duplication of therapy with each other.

1.   Incoming prescriptions for buprenorphine or buprenorphine/naloxone agents will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for any buprenorphine or buprenorphine/naloxone agent; and

2.   Incoming prescriptions for any naltrexone agent will deny when the beneficiary has an active prescription for any other naltrexone agent.

Serotonin Agents (Triptans)

Pharmacy claims for quantities of Serotonin agents (Triptans) which are in excess of the quantity limit will deny. Quantity limits are cumulative and are based on a rolling 30 day period. Unless otherwise specified, quantity limits apply to all strengths of an agent.

Quantity limits for Serotonin agents (Triptans) are as follows:

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
Almotriptan Maleate	Tablet	12 units
Eletriptan HBr	Tablet	6 units
Frovatriptan Succinate	Tablet	9 units
Naratriptan HCl	Tablet	9 units
Rizatriptan Benzoate	Tablet, Tablet rapid dissolve	12 units

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
Sumatriptan Succinate (Nasal)	Exhaler Powder	1 kit* (package size = 16)
Sumatriptan Succinate/ Naproxen Na	Tablet	9 units
Sumatriptan Succinate	Tablet	9 units
Zolmitriptan	Tablet, Tablet rapid dissolve	6 units

If the prescribing practitioner chooses to exceed the quantity limit, the prescribing practitioner must provide the reason why the quantity limit needs to be exceeded. The pharmacist may override the quantity limit after consulting with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason why the quantity limit needs to be exceeded. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the reason for service code, professional service code and result of service code with the POS submission.

Spironolactone

Pharmacy claims for spironolactone require a valid diagnosis code submitted for beneficiaries who are younger than 18 years of age. Pharmacy claims which are submitted with a diagnosis code associated with gender dysphoria or gender reassignment (F64*, Z87.890) will deny.

* – any number or letter or combination of **UP TO 4** numbers and letters of an assigned ICD–10–CM diagnosis code

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Quantity Limitations

Prescriptions payable under the Medicaid Program are limited as follows.

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Maximum Allowable Quantities

The maximum quantity payable is either a one month's supply or 100 unit doses, whichever is greater.

Maintenance Medication

Pharmacy claims for select maintenance medications will have a 90-day allowance at POS. A 90-day supply is allowed on maintenance drugs after a beneficiary has been on the same drug and strength for 60 days.

Dispensing Fee for Select Maintenance Medications

An educational edit will alert pharmacies when they are submitting pharmacy claims for maintenance medications that are not dispensed in at least a 30 day supply If a Generic/Brand product and strength has been dispensed for at least 60 days, and the current pharmacy claim is for the same Generic/Brand product and strength and is **NOT** dispensed in a 30 day supply, then an educational alert will be sent. The dispensing fee will not be reimbursed. The pharmacy will still be reimbursed for the ingredient cost on each dispensing.

Override procedures are available. Upon consultation with the prescriber to verify the necessity of the short fill (quantity less than 30 days' supply), the pharmacist may override the claim and be reimbursed the dispensing fee.

The quarterly FFS Maintenance Medication List can be found at the following link: https://ldh.la.gov/assets/docs/BayouHealth/Pharmacy/MaintenanceMedications.pdf

Coverage and Limitations for Long-Term Care Beneficiaries

Quantities for Long-Term Care Beneficiaries

Providers shall dispense a one month's supply, unless the prescribing provider specifies a smaller quantity for medical reasons, to beneficiaries in long-term care facilities. Dispensing a smaller quantity should only be done in exceptional cases.

Specific quantity limitations for maintenance medications and prn prescriptions are as follows:

1. "Maintenance" medications are those used to treat chronic conditions or illnesses (see Maintenance Medication section above for quantity limits); and

2. "PRN" prescriptions are those prescriptions that patients utilize on an "as needed" basis. For "prn" prescriptions, thirty units or a 10-day supply shall be supplied, unless otherwise specified by the prescriber.

The beneficiary profile should be periodically reviewed to determine if the "prn" order has become a "maintenance" one. In that event, refer to the "maintenance" drug policy. Otherwise, if every six months, a quantity of the "prn" medication remains unused by the resident, the profile should be reevaluated to determine the necessity of the order as well as the quantity of the prescribed medication. Should the prescriber authorize an additional "prn" medication, then the subsequent dispensed quantity shall be reduced to an amount equal to the utilization of the prior six-month period.

Pharmacies are providing twenty-four hours coverage to the long-term care facilities. Prescription reorders should not be made until a three-day supply remains.

Co-Payment Exemption

Long-term care beneficiaries (residing in a nursing facility or ICF/IID) are exempt from co-payments and monthly prescriptions limits.

NOTE: Refer to Chapters 26: Intermediate Care Facilities for Individuals with Intellectual Disabilities and 34 – Nursing Facilities of the *Medicaid Services Manual* for detailed information regarding beneficiaries in LTC facilities.

Over-the-Counter Drugs

LTC facilities are responsible for providing all OTC drugs to Medicaid beneficiaries. OTC drugs are part of the per diem for LTC beneficiaries.

Over the Counter Drugs for Preventive Care

Select OTC agents for preventive care will be reimbursed when:

1.   The prescribing practitioner issues the beneficiary a prescription for the preventive care OTC agent; and

2.   The beneficiary meets the criteria to obtain the preventive care OTC agent.

OTC Drug	Medicaid Beneficiary	Preventive Care
Aspirin 81 mg	Women greater than 12 years of age Men greater than 44 years of age	Cardiovascular disease, colorectal cancer, and preeclampsia prevention
Folic Acid 0.4mg and 0.8mg	Women ages 12-54	Pregnancy planning
Vitamin D 400 IU	Women and men greater than 64 years of age	Fall prevention

Age Restriction

Pharmacy claims submitted for beneficiaries outside of the age limits listed above will deny at POS.

Days' Supply

Quantities of 100 units with 100 days' supply will be allowed to process for payment.

Copayment

Pharmacy claims for the select preventive care OTC agents listed above will be exempt from copayment.

Coverage for aspirin 81 mg will be continued for beneficiaries greater than 79 years old; however, these pharmacy claims will be subject to copayment.

Diabetic Supplies

Medicaid will not reimburse pharmacies for claims for diabetic supplies when an individual resides in a long-term care facility.

NOTE: Refer to "Drugs with Special Payment Criteria/Limitations; Diabetic Testing Supplies" in this section for detailed information.

Nebulizer Medications

Medicaid will reimburse pharmacies for the nebulizer medications for those individuals who reside in a long-term care facility who do not have Medicare.

Medicare Skilled Nursing Facilities

When a resident of a skilled nursing facility is in Medicare payment status, payment for prescription medications is the responsibility of the facility, as prescription services are included in the per diem paid by Medicare.

Emergency Kits

All drugs dispensed from an emergency kit shall be billed to the Medicaid Program indicating the date of service that coincides with the date of administration.

Outpatient Drugs Covered by Medicare Part B

Medicare Part B covers oral anticancer drugs, antiemetics, diabetic supplies, glucometers, antihemophilia factor products, oral immunosuppressive drugs, nebulizer medication and some other medications. Providers must be enrolled as Medicare suppliers and must bill Medicare first if the beneficiary receives Medicare benefits. Medicaid will pay any applicable deductibles and coinsurances.

NOTE: Refer to Section 37.5.7 Medicare Prescription Drug Coverage for detailed information on drugs covered by Medicare Part B.

Drug Services for Hospice Beneficiaries

"Hospice" is a concept that extends a process of care to terminally ill patients.

Hospice is a program of palliative (control of pain and symptoms) and supportive services that provides physical, psychological, social and spiritual care for dying persons and their families. Hospice care concentrates on assuring the quality of the terminal patient's remaining life rather than on trying to prolong the length of that life.

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For Medicare/Medicaid patients who have elected hospice, services covered in the beneficiary's plan of care should not be billed to Medicaid.   These services are covered in the hospice reimbursement.

To ensure the correct billing of drug services, it is imperative that the hospice provider communicate with the pharmacist to verify which drugs are related to the terminal illness (billed to the hospice) and which drugs are not related to the terminal illness (billed to Medicaid).   The hospice shall assume that the distinction in billing drugs is understood by enrolled pharmacists who render services to the Medicaid beneficiaries who have elected hospice.

The pharmacy provider shall bill Louisiana Medicaid for out-patient pharmacy claims only for those drugs unrelated to the terminal illness.

Recoupment of drug claims erroneously paid to a pharmacy provider through Medicaid for those Medicaid beneficiaries who have elected hospice will be performed as they are identified.   Any provider of services to a hospice beneficiary needs to clear with the hospice provider that the billed service is not included in the beneficiary's plan of care.   Erroneous payment will be recouped as identified.

NOTE: Refer to Chapter 24 - Hospice of the *Medicaid Services Manual* for detailed information.

GENERAL PROGRAM INFORMATION

The Pharmacy Program within the LDH, Bureau of Health Services Financing (BHSF) covers all FDA approved legend drugs that meet the Omnibus Budget Reconciliation Act (OBRA) '90 and OBRA '93 criteria with a few exceptions.   The Pharmacy Program determines the reimbursement methodology for both the drug ingredient cost and the maximum allowable overhead cost (dispensing fee) for covered drugs.

The Pharmacy Program is responsible for the following components:

1.   Policy;

2.   Program development and implementation;

3.   Network development;

4.   Program coverage;

5.   PDL development and implementation and PA for certain therapeutic classes;

6.   Federal upper limit (FUL) for multiple source drugs;

7.   Claims management;

8.   Annual provider recertification;

9.   Clinical interventions;

10.   Prospective and retrospective DUR;

11.   Federal and state supplemental pharmaceutical manufacturer rebates;

12.   Pharmacy provider desk audits;

13.   Beneficiary Lock-In program;

14.   Provider help desk;

15.   Beneficiary help desk;

16.   Provider relations; and

17.   Provider education for prescribers and pharmacists.

The Pharmacy Program:

1.   Initiates policy development;

2.   Implements new policies and clarifies existing pharmacy policies, which include the services associated with outpatient drugs and Medicare/Medicaid pharmacy claims crossovers;

3.   Approves all new drugs added to program coverage; and

4.   Establishes any limitations on reimbursement or coverage in accordance with the federally approved reimbursement methodology.

The Pharmacy Program directs an extensive network of pharmacy providers and is also responsible for the integrity of several subsystems, including the drug file component of reference subsystem, the DUR subsystem and the drug portion of the Surveillance Utilization Review Subsystem (SURS).

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is a computerized claims processing and information system designed to manage the Medicaid Program's expenditures through effective claims processing and utilization control.

LDH contracts with a FI who operates the federally approved MMIS which is consistent with the Centers for Medicare and Medicaid Services (CMS) and LDH requirements.

The FI is contracted to provide the following pharmacy-related services:

1.   Pharmacy claim processing through an on-line, real-time POS system;

2.   Coordination of the federally mandated Omnibus Budget Reconciliation Act of 1990 DUR Board activities;

3.   Retrospective DUR (LaDUR);

4.   Prospective DUR (UniDUR);

5.   Educational articles - *Provider Update* newsletter article;

6.   Lock-In Program;

7.   DUR Board coordination;

8.   PDL and PA system;

9.   Monthly prescription limit system; and

10.   Electronic Data Inquiry/Clinical Drug Inquiry System (e-CDI).

CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES

SECTION 37.2: PROVIDER REQUIREMENTS AND PARTICIPATION GUIDELINES　　　　　　　　　　　　　　　　**PAGE(S) 19**

PROVIDER REQUIREMENTS AND PARTICIPATION GUIDELINES

This section describes pharmacy provider qualifications, enrollment and provider records, how the provider can make changes to the provider record, Internal Revenue Services (IRS) reporting, provider rights and responsibilities, record keeping requirements, billing agents, and point of sale (POS) enrollment.

Providers should refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on provider enrollment and requirements, including general standards for participation. (See Section 37.5.4 for information on accessing Chapter 1).

Provider Qualifications

The Medicaid Program reimburses pharmacies, not individual pharmacists, for the provision of prescribed drugs.

A pharmacy is a facility licensed in accordance with R.S. 37:1164 (36): "Pharmacy means any place located within this state where drugs are dispensed and pharmacy primary care is provided, and any place outside of this state where drugs are dispensed and pharmacy primary care is provided to residents of this state."

To enroll in the Medicaid Program, the pharmacy must have a community pharmacy or institutional pharmacy permit issued by the Louisiana Board of Pharmacy as defined by the Board's regulations at LAC 46:LIII.1301 and §1701.

Administering Pharmacists

Pharmacists who have the "Authority to Administer" authorized by the Louisiana Board of Pharmacy may administer the influenza vaccines. For COVID-19 vaccines only, the administration of the vaccine may be given by a pharmacist, and/or a qualified pharmacy technician, and/or a state-authorized pharmacy intern acting under the supervision of a qualified pharmacist during a Public Health Emergency (PHE). Pharmacists who have this authority are required to obtain a Medicaid provider number in order for the enrolled pharmacies to be reimbursed for the administration of this vaccine. (Refer to Section 37.5.11 Medication Administration of this manual chapter for detailed information on medication administration, including vaccinations).

Dispensing Physicians

Payment will be made for medications dispensed by a physician on a continuous basis only if the physician meets all of the following conditions:

1.   Is permitted as a dispensing physician with the Louisiana Board of Medical Examiners;

2.   When their main office is more than 5 miles from a facility which dispenses drugs; and

3.   Enrolls in the Medicaid Program as a pharmacy provider and complies with all other requirements of the prescribed drug services program.

Under the above circumstances, vendor payment (when the treating physician dispenses their own medications and bills under their own name or the name of their own clinic or hospital) will be made on the same basis as to pharmacy providers. (Refer to Section 37.3 - Reimbursement for Services of this manual chapter for detailed information on reimbursement).

Provider Rights and Responsibilities

Right to Refuse Services

A provider is not required to provide services to every beneficiary who requests services. A provider can limit the number of Medicaid beneficiaries that the provider serves, and accept or reject beneficiaries according to the pharmacy's policies, except for the reasons described below:

1.   A provider cannot deny services to a beneficiary solely due to race, creed, color, national origin, disabling condition, or disability in accordance with the federal anti-discrimination laws; and

2.   A provider cannot deny services to a beneficiary solely due to the presence of third party insurance coverage or the beneficiary's inability to pay a Medicaid co-payment.

Medical Assistance Program Integrity

The Louisiana Medical Assistance Program Integrity Law (MAPIL), R.S. 46:437.1-46 and 440.3, imposes terms and conditions on Medicaid providers. See Chapter 1 of the *Medicaid Services Manual*, Section 1 for information concerning the terms and conditions.

Prescription Provider Fee

A prescription provider fee shall be paid by each pharmacy and dispensing physician for each outpatient prescription (Medicaid and non-Medicaid) dispensed. The fee shall be $.10 per prescription dispensed by a pharmacist or dispensing physician. When a prescription is filled outside of Louisiana, but not shipped or delivered in any form or manner to a patient in the state, no provider fee shall be imposed. However, out-of-state pharmacies or dispensing physicians dispensing prescriptions which are shipped, mailed or delivered in any manner inside the state of Louisiana, shall be subject to the $0.10 fee per prescription. Medicaid enrolled pharmacy providers must comply with this requirement as a condition of participation in the Medicaid Program.

Activity reports, either manually or electronically produced, must be available upon request and on-site at the pharmacy. These reports must detail the number of prescriptions dispensed and which provider fees were paid by month for any given month. Providers are assessed on a quarterly basis by the Louisiana Department of Health (LDH). This information must be readily available during an audit when requested by a representative of the Medicaid Program.

Cost of Professional Dispensing Fee Survey

All pharmacy providers must complete the cost of professional dispensing fee surveys. These surveys are conducted periodically to determine the accuracy of the maximum allowable overhead cost (professional dispensing fee).

Federal Anti-Discrimination Laws

Providers must adhere to the following federal laws in order to maintain eligibility:

1. Civil Rights Act of 1964, which prohibits discrimination on the basis of race, creed, color or national origin;

2. Section 504 of the Rehabilitation Act of 1975, which prohibits discrimination on the basis of a disabling condition; and

3.   Americans with Disabilities Act of 1990, which assures equal access to services for persons with disabilities.

Solicitation

In accordance with R.S. 46:438.2, 46:438.4 and 42 U.S.C.1320a-7b, it is unlawful to knowingly solicit, offer, pay or receive any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made, in whole or in part, under the Medicaid Program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item or service for which payment may be made, in whole or in part, under the Medicaid Program.

Confidentiality

All information about Medicaid beneficiaries is confidential under federal law. Information cannot be released without the patient's written consent unless the provider is billing a third party or releasing the information to a billing agent. Billing agents must adhere to all federal and state confidentiality requirements.

All medical and billing records must be made available to official representatives of the Medicaid Program upon request. The representative making the request must possess proper identification.

Health Insurance Portability and Accountability Act

State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations 42 CFR 447.202.

LDH is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and is exempt from the HIPAA privacy regulations regarding records for any claims for which Medicaid reimbursement is sought. This exemption extends to LDH contractors when acting on behalf of LDH. The HIPAA privacy regulations, 45 CFR 164.506 (a), provide that covered entities are permitted to use or disclose protected health information (PHI) for treatment, payment, or health care operations. In addition, a "HIPAA Authorization" or "Opportunity to Agree or Object" by the individual is not required for uses and disclosures required by law.

Record Keeping Requirements

The provider must retain all medical, fiscal, professional, and business records on all services provided to all Medicaid beneficiaries for a period of 6 years from the date of service. The records must be accessible, legible and comprehensible. If the provider is being audited, records must be retained until the audit is complete, even if 6 years is exceeded.

These records may be paper, film, or electronic, except as otherwise required by law or Medicaid policy.

Types of Records That Must Be Retained

The following types of records, as appropriate for the type of service provided, must be retained (the list is not all inclusive):

1.　　　Medicaid claim forms and any documents that are attached;

2.　　　Professional records, such as patient treatment plans and patient records;

3.　　　Prior authorization (PA) and service authorization information;

4.　　　Prescription records for Medicaid and other third party payors (including Medicare, private pay and cash);

5.　　　Business records, such as accounting ledgers, financial statements, purchase/acquisition records, invoices, inventory records, check registers, canceled checks, sales records, etc.;

6.　　　Tax records, including purchase documentation; and

7.　　　Provider enrollment documentation.

Requirements for Prescription Record

A patient record must be maintained for each beneficiary for whom new or refill prescriptions are dispensed. The record may be electronic or hard copy. The pharmacy's patient record system must provide for the immediate retrieval of the information necessary for the pharmacist to identify previously dispensed drugs when dispensing a new or refill prescription.

All records must be maintained in accordance with the Louisiana Board of Pharmacy regulations.

Right to Review Records

Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records without prior notice. This includes, but is not limited to, the following governmental authorities: LDH, the State Attorney General's Medicaid Fraud Control Unit and the Department of Health and Human Services (DHHS). Providers must allow access to all Medicaid beneficiary records and other information that cannot be separated from the records.

If requested, providers must furnish, at the provider's expense, legible copies of all Medicaid related information to LDH, federal agencies or their representatives.

Incomplete Records

Providers who are not in compliance with the Medicaid documentation and record retention policies described in this section may be subject to administrative sanctions and recoupment of Medicaid payments. Medicaid payments for services lacking required documentation or appropriate signatures will be recouped.

Prohibition of Reassignment of Provider Claims

Medicaid payments cannot be reassigned to a factor. A factor is defined as an individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a billing agent.

Out-Of-State Providers

Enrollment Criteria

In accordance with LAC 50:I.701 (B), out-of-state pharmacies may enroll as providers in the Louisiana Medicaid Program to secure reimbursement for a specific claim or claims **only** under the following circumstances:

    1.   When an emergency arises from an accident or illness;

2.   When the health of the individual would be endangered if they undertook travel or
        if care and services are postponed until their return to Louisiana;

3.   When it is general practice for residents of a particular locality to use medical
        resources in the medical trade areas outside of the state; or

4.   When the medical care and services, or needed supplementary resources, are not
        available within the state. Prior approval for these services is required.

If services are provided to a Medicaid beneficiary in accordance with the criteria detailed above,
enrollment will be allowed to obtain a Medicaid provider number to secure payment of the claim.
However, this Medicaid provider number will only be active to finalize the claim at issue, not to
allow the out-of-state pharmacy to maintain continuous and active enrolled provider status.

In no event can an out-of-state Medicaid provider number be active for 12 months from the date
of service to secure payment of a single claim.

Medicare Crossover Claims

Out-of-state pharmacy providers will be allowed continuous Medicaid enrollment for crossover
claims only. The out-of-state pharmacy must be enrolled in Medicare prior to enrolling in
Louisiana's Medicaid Program. When enrolling in the Medicaid Program, the out-of-state
pharmacy must indicate that crossover billing is requested and submit a copy of their Medicare
certification letter.

Enrollment Forms

Enrollment for the payment of a claim or claims meeting the above-referenced criteria, or for the
payment of Medicare crossover claims, providers need to complete the "Basic Provider Enrollment
Packet for Entities/Businesses" and the provider type-specific packet "26 Pharmacy". (See Section
37.5.4 for information regarding provider enrollment).

Beneficiaries Out of the Country

Medicaid does not reimburse for services provided to beneficiaries when they are out of the United
States.

Provider Enrollment

Every pharmacy must submit a provider enrollment application and sign an agreement in order to provide Medicaid services.

Medicaid Durable Medical Equipment/Supplies

A pharmacy provider is enrolled to bill for pharmacy services and durable medical equipment (DME) with one provider number.

NOTE: Refer to the *Medicaid Services Manual*, Chapter 18 - Durable Medical Equipment for detailed information.

Medicare Enrollment

Pharmacies must contact the Medicare regional carrier to enroll as a Medicare provider. (See Section 37.5.4 for contact information).

Refer to Section 37.5.7 Medicare Prescription Drug Coverage of this manual chapter for detailed information on Medicare prescription drug coverage.

Enrollment Process

The provider must submit a completed Medicaid enrollment package to the Medicaid fiscal intermediary (FI). The provider will be notified in writing by the FI when enrollment is complete. Refer to Section 37.5.4 for information on how to obtain provider enrollment forms.

The enrollment packet must include the following documents:

1.   Completed Form PE-50;

2.   Copy of pre-printed IRS document showing employer identification number (EIN) – CPO-545 or pre-printed payment coupon is acceptable – (W-9 forms are not acceptable);

3.   Completed Disclosure of Ownership and Control Interest Statement (CMS-1513) Form;

4.   Completed Dispensing Cost Survey forms;

5.   Completed POS forms (located in provider type-specific packet 26-Pharmacy);

6.   Copy of a voided check from the account where funds are to be electronically deposited (deposit slips are not accepted); and

7.   Copy of pharmacy license from the Louisiana Board of Pharmacy.

NOTE: If the request is for retroactive coverage, the license must be submitted that covers the retroactive period of coverage.

Out-of-State Pharmacy

When a pharmacy is located out-of-state and mails or delivers drugs to the state of Louisiana, the Louisiana Board of Pharmacy permit must be submitted along with the provider's Board of Pharmacy permit from their home state.

Accuracy of Information

All statements or documents submitted by the provider must be true and accurate. Filing of false information is sufficient cause for termination from participation or denial of an application for enrollment.

Effective Date of Enrollment

Providers can request the desired date their new Medicaid provider number will become effective. The effective date entered will be considered in the enrollment process. All eligibility requirements must be met on the date requested for the date to be considered.

Reimbursement due shall not precede the Louisiana Board of Pharmacy permit due.

Providers shall not bill Medicaid prior to receipt of confirmation that they are successfully enrolled. Reimbursement will not be provided prior to the provider's effective date of enrollment.

Licensure and Permits

Prescribed drug services providers must submit complete and legible copies of the required licenses and permits with the enrollment applications.

National Provider Identifier

As a provision of the HIPAA, providers must obtain and use their national provider identifier (NPI) number on all claims submissions. Providers who do not provide medical services are exempt from this requirement (i.e., non-emergency transportation, case management, and some home and community-based waiver services). Although HIPAA regulations address only electronic transactions, the Medicaid Program requires both the NPI number and the legacy 7-digit Medicaid provider number on hard copy claims.

Termination

A provider agreement can be terminated for any reason, at any time, by the provider or the state with 30-day written notice. All the conditions of the agreement remain in effect during the 30-day notice period and until termination is completed.

Exceptions to the 30-day notice, including but not limited to, are:

1. If the provider is required to be licensed or certified, the effective date of termination will be the date that the license or certification became invalid;

2. If the provider is suspended, excluded or terminated from Medicare or any state's Medicaid program; or

3. If the provider's business is closed, abandoned, or non-operational, the effective date of termination will be the date that the business was closed, abandoned, or became non-operational.

Reinstatement

A provider must submit a new application, provider agreement, and other required forms to the fiscal agent to request reinstatement after a termination or suspension period. If the provider is

enrolling under a different name or different tax ID number, the provider must furnish the prior name and tax ID number with the application.

POS Enrollment

POS claims processing provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed through the claims processing cycle in real-time with a response to the pharmacy within seconds of submission that indicates the beneficiary's eligibility, and whether the claim is payable or rejected.

Application Forms

Providers must obtain authorization to submit claims via POS by completing the required forms included in the provider enrollment packet:

1.   Medicaid Pharmacy POS Provider Certification;

2.   Medicaid POS Agreement; and

3.   Pharmacy Provider Enrollment Amendment POS Enrollment.

Annual Re-certification

POS Certifications must be renewed annually. All applicable sections of this form must be completed in order for the recertification to be accepted by LDH. Recertification forms are mailed in October by LDH and are effective the following January.

Provider Record

A provider record is created by the Medicaid FI for each provider based on the information from the initial enrollment application.

Provider Identification Number

A 7-digit provider ID number is assigned by the FI when the provider has been approved for enrollment in the Medicaid Program. The provider ID number is used to identify the provider for

billing and correspondence purposes. The provider ID number must be included on all correspondence to the FI or the Medicaid office.

Reporting Changes

All changes must be reported promptly to the FI. Information in a provider's record can only be changed by submitting a written, signed and dated request on the provider's letterhead stationery to the FI. (See Section 37.5.4 for contact information for Provider Enrollment).

NOTE: All correspondence must include the Medicaid provider number.

Change of Address

The provider must notify the FI of any change of address. The notification must include:

      1.   The new business and mailing address(es);

      2.   The physical location, if different;

      3.   The provider's previous address(es); and

      4.   The effective date of the change.

Medicaid correspondence is sent to the billing address listed on the provider record.

Change in Telephone Number

The provider must notify the FI of any changes in telephone numbers. Notice of a change in telephone number(s) must include:

      1.   The new telephone number(s);

      2.   The provider's previous telephone number(s); and

      3.   The effective date of the change.

Change in Electronic Funds Transfer

The provider must notify the FI in writing **at least 60 days in advance of any change in financial institutions or accounts**. Failure to do so may result in lack of payment.

Change in Federal Tax ID/ Social Security Number

A new provider enrollment application must be completed if a provider's federal tax identification/social security number changes.

Provider No Longer Accepts Medicaid

The provider must notify the FI should the pharmacy no longer accept Medicaid for any reason, including closing the business.

Change of Ownership

The provider must notify the FI immediately of a change in ownership. Failure to do so may result in departmental review. (See the *Medicaid Services Manual*, Chapter 1, Section 1.1, for a full description of Change in Ownership).

The Pharmacy Program defines change of ownership based on the Louisiana Board of Pharmacy's definition. Therefore, if a new Board of Pharmacy permit is issued due to a 50 percent or more shift in ownership, the provider is required to obtain a new Medicaid provider number.

Reporting to the IRS

Federal law requires Medicaid to report to IRS all payments made during the calendar year to any provider under a tax ID number.

Louisiana Medicaid Website

The "Pharmacy and Prescribing Providers" link on the Louisiana Medicaid website contains information to assist pharmacy providers in obtaining the following commonly requested information (See Section 37.5.4 for web address):

1. **Single Preferred List** - The Single Preferred Drug List (PDL) is a reference for the most current listing of preferred drugs as well as those drugs requiring PA. This list is updated every 6 months. For additional information, refer to the PA and Single PDL in Section 37.1 Covered Services, Limitations, and Exclusions of this manual chapter;

2. **Clinical Drug Inquiries -** The Clinical Drug Inquiry is a component of the Clinical Data Inquiry (e-CDI) that is available to pharmacists. It promotes the deliberate evaluation by providers to help prevent duplicate or inappropriate drug therapy. The e-CDI is available 24 hours a day and is updated on a daily basis. Encounters from managed care organizations (MCOs) pharmacy claims have a lag time before available on e-CDI. The e-CDI will provide clinical historical data on each Medicaid beneficiary for the current month, prior month, or prior 12 months. A copy of the displayed information can be printed in a print friendly version for the beneficiary's clinical chart;

3. **Prescriber Numbers -** A list of prescribing practitioner numbers and NPI numbers are available on the website. This listing is updated on a daily basis. Encounters from MCO pharmacy claims have a lag time before available. For additional information refer to the "Accessing Prescriber Numbers" in Section 37.5.6 Prescribers of this manual chapter for more detailed information;

4. **Prior Approval Program -** Details about the Prior Approval Program and process are available on the website along with contact numbers;

5. **Beneficiary Eligibility:**

    a. **Medicaid Eligibility Verification System (MEVS) -** MEVS is an electronic system used to verify Medicaid beneficiary eligibility and third party liability information. This electronic verification process expedites reimbursement, reduces claim denials, and helps to eliminate fraud. Eligibility information for a beneficiary, including third party liability, health plan linkages, service limits and any restrictions, including Lock-In, may be obtained by accessing information through MEVS. Only one eligibility inquiry at a time may be made when using the web application. This system is available seven days a week, 24 hours per day except for occasional short maintenance periods. For additional information, refer to

"Medicaid Verification" in Chapter 1 of the *Medicaid Services Manual*, Section 1.2 Beneficiary Eligibility; and

b.   **Recipient Eligibility Verification System (REVS) -** A telephonic system is also available to providers to verify eligibility information. REVS may be accessed through touch-tone telephone equipment using the FI's toll-free telephone number. (See Section 37.5.4 for contact information). For additional information, refer to "Medicaid Verification" in Chapter 1 of the *Medicaid Services Manual*, Section 1.2 Beneficiary Eligibility.

6.   **POS User Guide -** The POS User Guide details the required information for claim submittal. This helpful manual lists National Council for Prescription Drug Program (NCPDP) fields and instructions for proper usage;

7.   **Vendor Specifications Document for the POS System -** Pharmacy providers using the Medicaid POS system are required to transmit their POS claims through an authorized telecommunications switch vendor. This document outlines the requirements necessary for switch vendors to transmit pharmacy claims; and

8.   **Third Party Liability Carrier Code List -** Private insurance companies are assigned a unique Louisiana carrier code. Pharmacy providers are asked to submit the third party liability (TPL) carrier code when coordinating claims for payment with a primary payor. For additional information, refer to "Third Party Liability" in Chapter 1 of the *Medicaid Services Manual*, and Section 37.3 of this manual chapter.

Medicaid Fraud and Abuse

To maintain the programmatic and fiscal integrity of the Medicaid Program, the federal and state governments have enacted laws, promulgated regulations and policies concerning fraud and abuse. It is the responsibility of the provider to become familiar with these laws and regulations.

In order for the LDH to receive federal funding for Medicaid services, federal regulations mandate that LDH perform certain program integrity functions. The primary functions of the Program Integrity Section are:

1.   Provider Enrollment;

2.   Fraud and Abuse Detection;

3.   Investigations;

4.   Enforcement;

5.   Administrative Sanctions; and

6.   Payment Error Rate Measurement (PERM).

Refer to Chapter 1 of the *Medicaid Services Manual*, Section 1.3 Program Integrity, to become familiar with the laws and regulations concerning fraud, abuse and other incorrect practices. This section is not all-inclusive nor does it constitute legal authority.

To report Medicaid fraud and/or abuse, contact Program Integrity. (Refer to the Section 37.5.4 for contact information).

Beneficiary Prescription Verification Letters

Prescription verification letters are sent to beneficiaries in an effort to ensure that pharmacy services billed to Medicaid were received by the correct beneficiary and correctly billed. Each dispense date includes a picture of the actual drug(s) billed to Medicaid on the patient's behalf. The beneficiary is asked to verify:

1.   They received a drug on that date of service;

2.   That the drug they received looks like the drug in the picture; and

3.   Confirm the amount of co-payment that they were asked to pay, if any.

All exceptions are investigated.

Surveillance Utilization Review Subsystem

The FI, through its Surveillance Utilization Review Subsystem (SURS), can identify potential fraud and abuse situations by means of profile (SURS) reports. For detailed information concerning SURs and SURs profile reports, refer to Title 50, Part I, Subpart 5, Chapter 41 – the Surveillance Utilization Review System (SURs) Rule.

Appeals

LDH provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Division of Administrative Law (DAL), Health and Hospitals Section is responsible for conducting hearings for providers who have complaints. Requests for hearings should explain the reason for the request and should be made in writing. The request should be sent directly to the DAL.

Detailed information regarding the appeals procedure may be obtained from the DAL. (See Section 37.5.4 for contact information).

Provider Audits

Federal and state laws and regulations require the State Medicaid agency to ensure the integrity of the program through various monitoring, review and audit mechanisms. The Pharmacy Program is responsible for auditing Medicaid pharmacy providers. This section explains the audit program and provider responsibilities relative to audits.

Audit Purpose

The purpose of the pharmacy review/audit function is to assure that Medicaid pharmacy providers are billing and being reimbursed in compliance with federal and state laws and regulations and Pharmacy Program policy.

Audit Authority

State Medicaid programs are required to conduct reviews and audits of claims in order to comply with federal regulations at 42 CFR 447.202.

LDH is a covered entity under HIPAA of 1996. Therefore, LDH is exempt from the HIPAA privacy regulations regarding records for any claims which Medicaid reimbursement is sought. This exemption extends to LDH contractors when acting on behalf of LDH. The federal HIPAA privacy regulations, 45 CFR 164.506 (a), provide that covered entities are permitted to use or disclose PHI for treatment, payment or health care operations. In addition, a "HIPAA Authorization" or "Opportunity to Agree or Object" by the individual is not required for uses and disclosures required by law.

Audit Overview and Process

Since the inception of Medicaid, the Pharmacy Program has complied with the federal audit mandate.

Medicaid monitors the use of overrides for bypassing denial edits. Improper use of overrides and codes associated with these overrides by pharmacy providers may result in the disallowance of these overrides and administrative sanctions by Medicaid and the Board of Pharmacy.

Program reviews are also conducted of billings to assure required documentation is noted on hardcopy prescriptions or electronic records for pharmacy claims when an override indicator was used.

Pharmacists may receive written or telephonic requests from the auditors requesting additional information or copies of the hardcopy prescriptions, electronic records, or invoices in an effort to complete audit functions. When applicable, they may only ask for affirmation of correct billing.

Provider Responsibilities

Each provider upon enrolling in the Medicaid Program agrees to dispense prescriptions and operate within the Program's laws and regulations as set forth in the approved Medicaid State Plans, administrative rules, *Medicaid Program Provider Manual* and other directives.

In an effort to facilitate the pharmacy audit process, information must be available upon request. This information is necessary in order to comply with the requirements for a pharmacy services provider enrolled in the Medicaid Program as stated in the provider enrollment form (PE 50) and to meet the requirements of the Louisiana State Board of Pharmacy.

At the time of audit, all Medicaid pharmacy providers must be able to produce a daily log or prescription register. This daily log whether routinely produced in hard copy or producible in hard copy at the time of audit, must contain at a minimum, for audit purposes, the following prescription data:

    1.   Prescription number;

    2.   Indicator as to new or refill prescription (0-11);

3.   Date of dispensing;

4.   Beneficiary's name;

5.   Prescriber's name;

6.   Drug name;

7.   National Drug Code (NDC) number;

8.   Quantity dispensed;

9.   Plan identifier indicating case or plan making payment; and

10.   Amount paid (including both copayment and plan payment, which may or may not be separated, i.e., *AMOUNT PAID = AMOUNT PLAN PAID + AMOUNT PATIENT PAID)*.

Providers are required to refund overpayments identified by the audits and take appropriate corrective action.

REIMBURSEMENT FOR PHARMACY SERVICES

This section describes the reimbursement methodologies used by Louisiana Medicaid for prescribed drugs.

Reimbursement Methodology

The amount of reimbursement to pharmacies is determined by federal regulations and state policy. A provider fee of $0.10 is added to reimbursement of all pharmacy claims. The fiscal intermediary (FI) has weekly check writes to reimburse the provider for those valid claims which are processed.

Medicaid reimburses the lower of the following:

1.   National Drug Acquisition Cost (NADAC) plus the professional dispensing fee;

     a.   If NADAC is not available, use the Wholesale Acquisition Cost (WAC) plus the professional dispensing fee.

2.   Federal Upper Limit (FUL) plus the professional dispensing fee; or

3.   Providers' usual and customary charge to the general public.

340B Purchased Drugs

Payment for self-administered drugs purchased by a covered entity through the 340B program shall be made at the 340B actual acquisition cost, which can be no more than the 340B ceiling price, plus the professional dispensing fee.

Clotting Factor

Pharmacy claims for clotting factor, with the exception of Hemlibra, shall be reimbursed using the Louisiana clotting factor average acquisition cost (AAC) and a unit based professional dispensing fee reimbursement methodology. The clotting factor professional dispensing fee is $0.03500 per unit dispensed, up to a maximum amount of $1,676.22. Hemlibra shall be reimbursed using the "lower of" reimbursement methodology.

Investigational or Experimental Drugs

Louisiana Medicaid will not provide reimbursement for investigational or experimental drugs.

Mail Order, Long-Term Care and Specialty

Drugs not distributed by a retail community pharmacy e.g., drugs dispensed by mail order, long-term care (LTC) and/or specialty pharmacies, will be reimbursed using the "lower of" reimbursement methodology.

National Drug Code System

Drugs are identified by the National Drug Code (NDC). The NDC is an 11-digit number. The first 5 digits identify the manufacturer or supplier, the next 4 digits identify the product, and the last 2 digits identify the package size.

The provider must enter the entire 11-digit NDC for the actual product and package size dispensed on the claim as the NDC is critical for accurate reimbursement. Billing an NDC number other than the one for the product dispensed is a false claim, a violation of Medicaid policy and may be recouped.

Medicaid can only reimburse drugs whose NDC codes are on the Medicaid drug file.

Medicaid uses ingredient costs that are supplied and updated each week by a nationally recognized compendia.

Professional Dispensing Fee

The pharmacy provider will be reimbursed at the appropriate ingredient cost plus the professional dispensing fee or the usual and customary charge, whichever is less.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid beneficiaries will not exceed $11.81 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid beneficiaries and obtained through the Health Resources & Services Administration (HRSA) 340B Program will be $11.81 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

LOUISIANA MEDICAID PROGRAM

ISSUED: 04/22/25

REPLACED: 03/07/25

CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES

SECTION 37.3: REIMBURSEMENT

PAGE(S) 6

Provider Fee

All pharmacy providers and dispensing physicians are responsible for paying a 10 cent provider fee to the Louisiana Department of Health (LDH) on **all** prescriptions they fill. The health insurance issuers shall reimburse pharmacists/pharmacies for payment of the provider fee in accordance with state legislation.

Usual and Customary Charges

Federal regulations governing the Medicaid Program require that participating providers agree to charge no more for services to eligible beneficiaries than they charge for similar services to the general public.

In implementing this regulation, the Medicaid Program states that providers in the Pharmacy Program may not charge a higher professional dispensing fee, on the average, for Medicaid beneficiary's prescriptions than is charged for non-beneficiary's prescriptions. Consequently, pharmacists are required to indicate their usual and customary charge on their claims for prescription services even if this charge exceeds the Medicaid maximum payment.

Federal Upper Limits Regulations

FUL prices are established by the Centers for Medicare and Medicaid Services (CMS). Federal regulations prohibit Medicaid from reimbursing providers more than the FUL, except as instructed.

When a prescriber indicates the brand name product is medically necessary for a particular beneficiary, and certifies that in his professional judgment the generic equivalent is not indicated, the FUL or Louisiana State Maximum Allowable Cost (LMAC) limitations will not apply. The following procedure will apply in these cases:

1. Certification must be in the prescriber's handwriting and signed unless the prescription is submitted electronically;

2. Certification may be written either directly on the prescription or on a separate sheet which is attached to the prescription or submitted electronically with prescriber approval;

3. Standard phrases written by the prescriber on the prescription shall testify to the medical necessity of the brand name drug. The only acceptable phrases are "brand necessary" or "brand medically necessary";

4.   If multiple prescriptions are written on the same prescription blank, the prescriber must certify which drugs require the brand name product, indicating "Brand Medically Necessary" for each prescription which requires the branded product;

5.   Phrases such as *do not substitute, no generics* or *dispense as written* are not acceptable for overriding the maximum allowable cost (MAC) limitations;

6.   Providers should verify that the appropriate wording is properly documented at the time of dispensing; and

7.   Checking a printed box on the prescription to indicate that the brand is necessary is unacceptable.

Co-Payments for Prescription Services

The co-payment will be paid by the beneficiary and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the co-payment amount for which the beneficiary is liable. Providers shall continue billing their usual and customary charges for prescription services. The FI will calculate and deduct the co-payment amount from the amount allowed.

Co-payment Schedule

The following is the prescription co-payment schedule:

Monthly Income	Copayment
when 5 percent of family's monthly income is spent on copays	$0.00
Medication Cost	**Copayment**
$5.00 or less	$0.00
$5.01 to $10.00	$0.50
$10.01 to 25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

Co-payment Exemptions

The following pharmacy services are exempt from the co-payment requirement:

1.   Family planning services and supplies;

2.   Emergency services;

3.   Individuals younger than 21 years old;

4.   Pregnant women;

5.   LTC beneficiaries (residing in a nursing facility or an Intermediate Care Facility

      for Individuals with Intellectual Disabilities (ICF/IID));

6.   Native Americans;

7.   Alaskan Eskimos;

8.   Women who are receiving services on the basis of breast and cervical cancer;

9.   Beneficiaries receiving preventive services included in U.S. Preventive Services
      Task Force (USPSTF) A and B Recommendations, some examples are:

      a.   Aspirin 81 mg for women ages 12-19 years of age and men ages 45-79
            years of age;

      b.   Folic acid 0.4mg and 0.8mg for women ages 12-54 years of age; and

      c.   Vitamin D 400 IU for women and men ages 65 and older.

10.   Beneficiaries receiving hospice services; and

11.   Beneficiaries with waiver type cases.

NOTE: Refer to Section 37.5.4, Point of Sale (POS) User Guide for billing instructions.

Other Co-payment and Policies

In accordance with 42 CFR §447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the co-payment amount. The beneficiary's assertion of their inability to pay the co-payment establishes the inability. Under 42 CFR §447.15, this service statement does not apply to any individual who is able to pay, nor does an individual's inability to pay eliminate their liability for the co-payment.

Providers shall not waive the beneficiary's co-payment liability.

The pharmacy provider shall collect a co-payment for each drug dispensed and covered by Medicaid excluding some pharmacy services/populations. **This co-payment is NOT taxable**. Providers should not collect tax on the co-payment.

Quantities dispensed by pharmacists shall not be adjusted to reflect the co-payment amounts paid by the beneficiary. By participation in the Pharmacy Program, providers have agreed to accept, as payment in full, the amounts paid by the agency plus any deductible, co-insurance or co-payment.

In accordance with 42 CFR §447.56, co-payments of Medicaid household members are not to exceed 5 percent of the family income.

Department monitoring and auditing will be conducted to determine provider policies and compliance. Violators of this policy will be subject to penalty such as suspension from the program for one year.

Medicare Crossover Claims

Refer to Section 37.5.7 - Medicare Prescription Drug Coverage regarding payment of services for which Medicaid reimburses providers for participants' responsibilities of coinsurance and deductible payments.

Third Party Liability Claims

Refer to Section 37.5.15 –Third Party Liability (TPL)/Coordination of Benefits, regarding services which must be billed to Medicaid as the payor of last resort.

MANAGED CARE APPLICABILITY

Chapter 37: Pharmacy Benefits Management Services of the *Medicaid Services Manual* contains information about the fee-for-service (FFS) benefits for Medicaid beneficiaries. This manual chapter provides the minimum service requirements for the Pharmacy Services Program. Providers must comply with the service coverage requirements outlined in this policy.

For information concerning managed care benefits, providers should refer to the Managed Care Organization (MCO) manual.

APPENDIXES

The following list includes the Appendixes contained in this section:

1. 37.5.1 – Forms and Links;

2. 37.5.2 – Claims Related Information;

3. 37.5.3 – Glossary;

4. 37.5.4 – Contact Information;

5. 37.5.5 – Preferred Drug List (PDL);

6. 37.5.6 – Prescribers;

7. 37.5.7 – Medicare Prescription Drug Coverage;

8. 37.5.8 – Claims Submission and Processing Payments;

9. 37.5.9 – Public Health Service 340B Drug Pricing Program;

10. 37.5.10 – Total Parenteral Nutrition (TPN);

11. 37.5.11 – Medication Administration;

12. 37.5.12 – Patient Counseling and Drug Utilization Review (DUR);

13. 37.5.13 – Lock-In Program;

14. 37.5.14 – Medicaid Drug Rebate; and

15. 37.5.15 – Third Party Liability (TPL)/Coordination of Benefits

FORMS AND LINKS

FORM	USE
[PA01](#)	Total Parenteral Nutrition (TPN) providers are required to utilize this form to request prior authorization (PA) for TPN services.
CMS-1500	This form is submitted to receive reimbursement for TPN services.
List of Drugs Payable on Drug File	www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDA.pdf
List of Drugs with Average Acquisition Rates	http://www.mslc.com/Louisiana/
List of DESI Drugs by National Drug Code (NDC)	www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDB.pdf
Medicaid Drug Federal Rebate Participation Pharmaceutical Companies	www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf
Point of Sale (POS) User Guide	www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf
Single Preferred Drug List (PDL)	This link contains all forms in the clinical authorization and PA process listed by drug. http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf
The National Council for Prescription Drug Program (NCPDP) Universal Claim Form and Instructions	http://www.lamedicaid.com/provweb1/billing_information/NCPDP_Billing_Instructions.pdf
Form 211 – Drug Adjustment/Void	Form_211.pdf (lamedicaid.com)
PA01 Form – TPN PA Form	www.lamedicaid.com/Provweb1/Forms/RevisedPA-010205052004WithInsts.pdf
Tamper Resistant Prescription Criteria and Examples	www.lamedicaid.com/Provweb1/manuals/App_L_Tamper_Res_Prescription.pdf
Diagnosis Code Chart	http://www.lamedicaid.com/provweb1/Pharmacy/mFFS_ICD-10_Conversion_Table_Condensed.xlsx

CLAIMS RELATED INFORMATION

Hard copy billing of total parenteral nutrition (TPN) services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this section are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as required, situational or optional.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required (but only in certain circumstances as detailed in the instructions that follow).

Paper claims should be submitted to:

<div align="center">

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

</div>

NOTE: Electronic claims submission is the preferred method for billing. Claims are submitted on the 837P with the Durable Medical Equipment (DME) file extension. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This section includes the following:

1. Instructions for completing the CMS-1500 claim form and a sample of a completed CMS-1500 claim form; and

2. Instructions for adjusting/voiding a claim and a sample of an adjusted CMS-1500 claim form.

CMS 1500 (02/12) INSTRUCTIONS FOR PHARMACY TPN SERVICES

You must write "DME" at the top center of the claim form!

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	**You must write "DME" at the top center of the Louisiana Medicaid claim form in LARGE letters.**
1a	Insured's Identification (ID) Number	**Required** – Enter the beneficiary's 13 digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through Medicaid Eligibility Verification System (MEVS), eMEVS, or Recipient Eligibility Verification System (REVS). **NOTE:** The beneficiary's 13-digit Medicaid ID number <u>must</u> be used to bill claims. The card control number (CCN) from the plastic ID card is **NOT** acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	**Required** – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Date of Birth (DOB) Sex	**Situational** – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only 1 digit in this field, precede that digit with a 0 (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	**Situational** – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	

7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Reserved for National Uniform Claim Committee (NUCC) Use	**Leave Blank.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If beneficiary has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit third-party liability (TPL) carrier code is **required** in this block. The carrier code is indicated on the MEVS response as the Network Provider Identification Number. Make sure the explanation of benefits (EOBs) or EOBs from other insurance(s) are attached to the claim.	**ONLY the 6-digit code should be entered for commercial and Medicare Health Maintenance Organizations (HMO's) in this field.** **DO NOT enter dashes, hyphens, or the word TPL in the field.** **NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE**
9b	Reserved For NUCC Use	**Leave Blank.**	
9c	Reserved For NUCC Use	**Leave Blank.**	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or Federal Employees Compensation Act (FECA) Number	**Situational** – Complete if appropriate or leave blank.	

11a	Insured's DOB Sex	**Situational** – Complete if appropriate or leave blank.	
11b	Other Claim ID (Designated by NUCC)	**Leave Blank.**	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	Other Date	**Leave Blank.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	**Required-** Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported. DN Referring Provider DK Ordering Provider Enter the name (First Name, MI, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.	**If multiple providers are involved, enter one provider using the following priority order:** **1. Referring Provider** **2. Ordering Provider**

17a	Other ID number	**Required –** Enter the 7 digit Medicaid ID number of the referring or ordering provider**.**	
17b	National Provider Identifier (NPI) number	**Required -** Enter the NPI number of the referring or ordering provider	**The 10-digit NPI Number is required.**
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Additional Claim Information (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab?	**Optional.**	
21	International Classification of Diseases (ICD) Ind. Diagnosis or Nature of Illness or Injury	**Required** – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM **Required** – Enter the most current ICD diagnosis code. NOTE: **ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.**	The most specific diagnosis codes must be used. General codes are not acceptable. **ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.** **Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).**
22	Resubmission and/or Original Reference Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason	**To adjust or void more than one claim line on a claim, a**

		codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice (RA) in the "Original Ref. No." portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization (PA) Number	**Required** – Enter the correct 9-Digit PA number in this field.	
24	Supplemental Information	**Situational – DME Providers are required to enter 11-digit National Drug Code (NDC) on claim detail lines for enteral feeding products only.** In addition to the procedure code, **the NDC is required** by the Deficit Reduction Act of 2005 and <u>**shall be entered**</u> in the **shaded** section of 24A through 24G. <u>**Claims for enteral feeding products must include the NDC from the label of the product administered.**</u> <u>**A list of the procedure codes and NDCs for products that currently require NDC**</u>	**DME providers must enter NDC information in the SHADED section of 24A – 24G of appropriate detail lines only.** **This information must be entered in addition to the procedure code(s).** **The NDC indicated on the claim must match the NDC on the PA.**

		information can be found on www.lamedicaid.com **under the Fee Schedules directory link.**	
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (EMG)	**Situational** – Complete is appropriate or leave blank.	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). When a modifier(s) is required, enter the applicable modifier in the appropriate field.	**Where modifiers are required, the modifier(s) on the claim must match the modifier(s) on the PA.**
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) / Family Plan	**Situational** – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	ID Qualifier	**Optional.** If possible, leave blank for Louisiana Medicaid billing**.**	
24J	Rendering Provider ID number	**Leave Blank.**	

25	Federal Tax ID Number	**Optional.**	
26	Patient's Account Number	**Situational** – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the RA. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. **Do not report Medicare payments in this field.**	
30	Reserved For NUCC Use	**Leave Blank.**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional.** The practitioner or the practitioner's authorized representative's original signature is no longer required. Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI number	**Optional.**	
32b	Other ID number	**Situational –** Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone number	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI number	**Required –** Enter the billing provider's 10-digit NPI number.	**The 10-digit NPI Number must appear on paper claims.**

33b	Other ID number	**Required** – Enter the billing provider's 7-digit Medicaid ID number. **ID Qualifier – Optional –** If possible, leave blank for Louisiana Medicaid claims.	**The 7-digit Medicaid Provider Number must appear on paper claims.**

A sample form is on the following page

SAMPLE CLAIM FORM

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the RA, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved international control number (ICN) can be adjusted or voided; thus:

1.   If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; and

2.   If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Beneficiary/Patient Identification

Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the RA

When an Adjustment/Void Form has been processed, it will appear on the RA under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the RA.

NOTE: DME must be written in large letters in the blank area at the top of the claim form.

A sample form is on the following page.

Health Insurance Claim Form (SAMPLE) — Approved OMB-0938-1197 FORM 1500 (02-12), approved by National Uniform Claim Committee (NUCC) 02/12.

GLOSSARY AND ACRONYMS

This is a list of abbreviations, acronyms, and definitions used in the Pharmacy Program manual chapter.

Average Wholesale Price (AWP) – The published suggested wholesale price of a drug. It is often used by pharmacies as a cost basis for pricing prescriptions.

Beneficiary – An individual who has been certified for medical benefits by the Medicaid Program. A beneficiary certified for Medicaid home and community-based waiver services (HCBS) may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health (LDH) responsible for the administration of the Medicaid Program.

Centers for Medicare and Medicaid Services (CMS) – The government agency within the U.S. Department of Health and Human Services (DHHS) responsible for federal administration of the Medicare and Medicaid programs (Titles XVIII, XIX and XXI of the Social Security Act).

Date of Service – The date the prescription was dispensed to the beneficiary or the date the prescription was filled (date the prescription was prepared), depending on the pharmacy's Point of Sale (POS) system.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicare and Medicaid Programs and other public health programs.

Drug Efficacy Study Implementation (DESI) Drugs – Drugs the Food and Drug Administration (FDA) has proposed to withdraw from the market because they lack substantial evidence of effectiveness.

Dispense as Written (DAW) – A prescribing directive issued by physicians to indicate that the pharmacy should not in any way alter a prescription. Such alterations are usually done in order to substitute a generic drug for the brand-name drug ordered.

Drug Utilization Review (DUR) – The quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.

Dual Eligible – Beneficiaries who have Medicare and Medicaid coverage.

Eligible (For purposes of the Pharmacy Program) – An individual who has been determined to meet the Medicaid program's eligibility criteria and is enrolled in the program.

Estimated Acquisition Cost (EAC) – An estimate of the price generally, and currently, paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

Federal Upper Limits (FUL) – The upper limit amount that Medicaid can reimburse for a drug product if there are 3 or more generic versions of the product rated therapeutically equivalent, and there are at least 3 suppliers listed in the current editions of published national compendia. These limits are intended to assure that the federal government acts as a prudent buyer of drugs. The upper limits program seeks to achieve savings by taking advantage of current market prices.

Fiscal Intermediary (FI) – The private fiscal agent with which LDH contracts to operate the Medicaid Management Information System (MMIS). The FI processes claims for Medicaid services provided under the Medical Assistance Program, issues appropriate payment and provides assistance to providers on claims.

Full Benefit Dual Eligibles – A population of low-income elderly individuals and individuals with disabilities who qualify for both Medicare and Medicaid coverage. While Medicare covers basic health services, including physician and hospital care, full benefit dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care and some prescription drugs.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A public or private facility that provides health and rehabilitation services to people with intellectual disabilities. An ICF/IID has 4 or more beds and provides "active treatment" to the residents.

International Classification of Diseases, 10th Edition Clinical Modification (ICD-10-CM) (or its successor) – A standard listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communications on claim forms.

Lock-In – An educational program administered by the Medicaid pharmacy program staff which restricts certain Medicaid enrollees to a specific physician and/or pharmacy.

Intradialytic Parenteral Nutrition Therapy – A parenteral therapy provided to an end stage renal disease (ESRD) beneficiary while the beneficiary is being dialyzed.

Intravenous Nutrition – Also referred to as Total Parenteral Nutrition (TPN) or hyperalimentation therapy.

Long-Term Care (LTC) – A set of health care, personal care and social services required by

persons who have lost, or never acquired, some degree of functional capacity (e.g., individuals who are chronically ill, aged, have a physical, mental or intellectual disability) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing facilities, homes for individuals with intellectual disabilities and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

Louisiana Department of Health (LDH) – The state agency responsible for administering the state's Medicaid Program and other health and related services, including aging and adult services, public health, behavioral health, intellectual disabilities and addictive disorder services.

Medicaid – A joint federal and state program that helps with medical costs for some individuals with limited income and resources according to approved Medicaid State Plans pursuant to Title XIX and XXI of the Social Security Act.

Medicaid Eligibility Verification System (MEVS) – Louisiana Medicaid's electronic eligibility verification system accessed through a switch vendor.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the Department. (R.S. 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Medicare – The federal health insurance program which provides coverage to the aged and persons with disabilities under Title XVIII of the Social Security Act.

Medicare (Part A/Part B) – A U. S. health insurance program which provides hospital insurance (Part A) and supplemental medical insurance (Part B) for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need a kidney transplant or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured.

Medicare Part D – Prescription drug coverage established by the Medicare Prescription Drug, Improvement and Modernization Act of, which is available to all Medicare beneficiaries. Prescription drug coverage is available through private prescription drug plans, which offer only prescription drug coverage, and Medicare Advantage Plans, which offer drug coverage integrated

with the health coverage provided by the managed care plan. **Full benefit dual eligible Medicaid beneficiaries no longer receive their pharmacy benefits through the Louisiana Medicaid Pharmacy Program, with the exception of some drugs excluded from the Part D benefit.**

National Drug Code (NDC) – A national classification system for identification of drugs that is similar to the Universal Product Code (UPC).

National Provider Identifier (NPI) – A 10-digit number mandated by the Health Insurance Portability and Accountability Act (HIPAA) for health care providers, which is a single provider identifier that replaces the multiple provider identifiers currently used to bill health plans.

Parenteral Nutrition Therapy – The introduction of nutrients by some means other than through the gastrointestinal tract, in particular intravenous, subcutaneous, intramuscular or intramedullary injection.

Over the Counter (OTC) – A drug product that does not require a prescription under federal or state law.

Point of Sale System (POS) – An electronic claims processing system which provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed entirely through the claims processing cycle in real-time, and within seconds of submission, a response is returned to the pharmacy that the beneficiary is eligible or ineligible and the claim is payable, duplicated or rejected.

Prior Authorization (PA) – The process of obtaining prior approval for a service or medication before payment can be made by the program. PA does not guarantee coverage as all program criteria must be met, such as beneficiary eligibility.

Provider/Provider Agency – An individual or agency enrolled with Medicaid under a provider agreement to furnish services to Medicaid beneficiaries. Pharmacies or physicians may enroll with the state to prescribe/dispense prescriptions to Medicaid beneficiaries.

Rebate – A monetary amount that is returned to a payor from a prescription drug manufacturer based upon utilization by a covered person or purchases by a provider.

Retrospective Review – Determination of medical necessity and/or appropriate billing practice for services already rendered.

Single Preferred Drug List (PDL) – Drugs that do NOT require PA. These drugs may require clinical authorization.

Telecommunication Switch Vendor – A telecommunications services vendor who transfers via telephone lines, the prescription transaction from the pharmacy to the Medicaid FI.

Third Party Liability (TPL) – Under Medicaid, TPL exists if there is any entity (i.e., other government programs or insurance) which is, or may be, liable to pay all or part of the medical cost or injury, disease, or disability of an applicant or beneficiary of Medicaid.

UniDUR – As part of the POS system, claims are subjected to editing for prospective DUR.

ACRONYMS

AAP	American Academy of Pediatrics
ASP	Average Sales Price
AWP	Any Willing Provider OR Average Wholesale Price
BMI	Body Mass Index
CDI	Clinical Drug Inquiry
CFR	Code of Federal Regulations
CMSO	Center for Medicaid and State Operations
COB	Coordination of Benefits
DME	Durable Medical Equipment
DSM	Disease State Management
EFT	Electronic Funds Transfer
EOMB	Explanation of Medicare Benefits
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration

HCPCS	HCFA Common Procedural Coding System
HRSA	Health Resources and Services Administration
ICN	Internal Control Number
IDPN	Intradialytic Parenteral Nutrition Therapy
LAC	Louisiana Administrative Code
LADUR	Louisiana Retrospective Drug Utilization Review
LAPRIMS	Louisiana Pharmacy Rebate Information Management System
R.S.	Louisiana Revised Statute
LMAC	Louisiana Maximum Allowable Cost
MAC	Maximum Allowable Cost
MAPIL	Medical Assistance Program Integrity Law
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
NCPDP	National Council for Prescription Drug Program
OBRA	Omnibus Budget Reconciliation Act
OTC	Over-the-Counter (drugs)
PA	Physician's Assistant OR Prior Authorization
PAU	Prior Authorization Unit
PBM	Pharmacy Benefits Management
PCP	Primary Care Provider
PDL	Preferred Drug List

PHI	Protected Health Information
PHS	Public Health Service
PPBP	Provider Peer Based Profiling
PRN	As needed
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
REOMB	Recipient's Explanation of Medical Benefits
REVS	Recipient Eligibility Verification System
SURS	Surveillance and Utilization Review Subsystem
TPN	Total Parenteral Nutrition
UCF	Universal Claim Form
ULM	University of Louisiana at Monroe

CONTACT INFORMATION

Gainwell Technologies

Contact the Medicaid Program's fiscal intermediary (FI), Gainwell Technologies for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	Gainwell Technologies (877) 598-8753
Electronic Media Claims (EMC) Electronic Claims sign up and testing	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) *After hours, please call REVS*
Prior Authorization Unit (PAU)	Gainwell Technologies – Prior Authorization Phone: (800) 807-1320 E-PA Fax: 225-216-6481
Provider Enrollment Unit (PEU)	Gainwell Technologies - Provider Enrollment P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
Provider Relations Unit (PR)	Gainwell Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)
Weekly Remittance Advice (RA)	https://www.lamedicaid.com/sitesearch/searchpura.aspx

Louisiana Department of Health (LDH)

TYPE OF ASSISTANCE	CONTACT INFORMATION
Bureau of Health Services Financing (BHSF) – Medicaid State Office	P.O. Box 91030 Baton Rouge, LA 70821 Hot Line: (888) 342-6207 (Toll Free) http://www.dhh.la.gov/index.cfm/subhome/1/n/331
Health Standards Section (HHS)	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0128 Fax: (225) 5292 http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1623
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://ldh.la.gov/index.cfm/page/224
Office of Aging and Adult Services (OAAS)	P.O. Box 2031 Baton Rouge, LA 70821 Phone: (866) 758-5038 Fax: (225) 219-0202 E-mail: MedWeb@dhh.la.gov http://www.ldh.la.gov/index.cfm/subhome/12/n/7
Office of Behavioral Health (OBH)	P.O. Box 629 Baton Rouge, LA 70821-0629 Phone: 225-342-9500 Fax: 225-342-5568 Medicaid Customer Service (888) 342-6207 http://ldh.la.gov/index.cfm/subhome/10
Office for Citizens with Developmental Disabilities (OCDD)	628 N. Fourth Street Baton Rouge, LA 70802 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: ocddinfo@la.gov http://www.ldh.la.gov/index.cfm/subhome/11/n/8
Pharmacy Program	(800) 437-9101
Take Charge Plus	Phone: (888) 342-6207

TYPE OF ASSISTANCE	CONTACT INFORMATION
Third Party Liability (TPL) Recovery and Premium Assistance Section	P. O. Box 3558 Baton Rouge, LA 70821 Phone: (225) 342-8662 Fax: (225) 342-1376

Fraud Hotline

TYPE OF ASSISTANCE	CONTACT INFORMATION
To report fraud	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://new.dhh.louisiana.gov/index.cfm/page/219

Appeals

TYPE OF ASSISTANCE	CONTACT INFORMATION
To file an appeal	Division of Administrative Law (DAL) - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 225-342-0443 225-219-9823 (Fax)

Other Helpful Contact Information:

TYPE OF ASSISTANCE	CONTACT INFORMATION
Centers for Medicare and Medicaid Services (CMS)	https://www.cms.gov/
Communi Form, LLS National Council for Prescription Drug Program (NCPDP) Universal Claims Forms	Communi Form, LLC Phone: (877) 817-3676 https://www.ncpdp.org/Products/Universal-Claim-Forms

TYPE OF ASSISTANCE	CONTACT INFORMATION
Office of Pharmacy Affairs HSB/HRSA	5600 Fishers Lane Rockville, MD 20857 301-594-4353 800-628-6297 OpaStaff@hrsa.hhs.gov https://www.hrsa.gov/opa
340B Exclusion File	https://340bopais.hrsa.gov/medicaidexclusionfiles
Health Management Systems, Inc. (HMS) Urgent Private TPL and Urgent Medicare Advantage Plan Update Request	**Aetna Better Health** Mailbox-MBU-LA_Enrollment@AETNA.com **LHCC Healthcare Connections** OICRequest@centene.com **UHC Community Care Plan** PI_COB_research@uhc.com **Amerigroup** ccuohi@amerigroup.com **AmeriHealthCarnitas** 888-922-0007 **Fee-for-Service** Phone: (877) 204-1324 Fax: (877) 204-1325 E-mail: latpr@hms.com
Novitas Solutions, Inc. Medicaid Part B Carrier	P.O. Box 3097 Mechanicsburg, LA 17055-1815 (855) 252-8782
Office of Population Affairs (OPA) Clearinghouse	P.O. Box 30686 Bethesda, MD 20824-0686 Phone: (866) 640-7827 Fax: (866) 592-3299 E-mail: Info@OPAclearinghouse.org

TYPE OF ASSISTANCE	CONTACT INFORMATION
Louisiana Medicaid RxPA Operation ULM, School of Pharmacy To obtain clinical pre-authorization	1800 Bienville Drive Monroe, LA 71201-3765 Phone: (866) 730-4357 Fax: (866) 797-2329 http://www.lamedicaid.com/provweb1/Pharmacy/rxpa/rxpaindex.htm
U.S. Department of Health and Human Services (DHHS) Sterilization and Consent Forms	https://www.hhs.gov/opa/title-x-family-planning/training-and-resources/documents-and-tools/index.html

TYPE OF ASSISTANCE	CONTACT INFORMATION
Pharmacy Help Desk Questions concerning pharmacy claims billing	
Aetna	CVS Health (855) 364-2977
AmeriHealth Caritas	PerformRx (800) 684-5502
Fee-for-Service	Gainwell Technologies (800) 648-0790
Healthy Blue	Express Scripts (844) 367-6111
Louisiana Healthcare Connections	CVS Caremark (800) 311-0543
United Healthcare	Optum Rx (866) 328-3108

LOUISIANA MEDICAID PROGRAM   **ISSUED:**   **01/28/22**
                                          REPLACED: **05/27/20**

CHAPTER 37: PHARMACY BENEFITS MANAGEMENT SERVICES

SECTION 37.5.5– LOUISIANA MEDICAID   **PAGE(S) 1**
 PREFERRED DRUG LIST (PDL)
AND NON-PREFERRED DRUG LIST (NPDL)

**LOUISIANA MEDICAID SINGLE PREFERRED DRUG LIST (PDL)
AND NON-PREFERRED DRUG LIST (NPDL)**

To access the most current and complete listing of criteria, forms, and drugs in the Medicaid PDL, prior authorization (PA), and clinical pre-authorization process, click here:
http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf.

PRESCRIBERS

This section defines medical practitioners who are authorized to prescribe drugs covered by the Louisiana Medicaid Pharmacy Program. In addition, this section explains the requirement that all prescribers must have an individual Medicaid prescriber number and a National Provider Identifier (NPI) as a condition for prescription reimbursement by the program.

Qualified Prescribers

The Medicaid Program provides reimbursement for prescriptions provided to eligible beneficiaries under regulations governing the Pharmacy Program. The prescriptions may be written by appropriate professionals who are authorized to prescribe under state law and have prescriptive authority from their licensing board. A qualified prescriber must be an enrolled Medicaid provider.

Prescriber Numbers

The integrity of the Pharmacy Program is dependent upon utilizing accurate data.

Each Medicaid prescriber is required to have an individual NPI and a Medicaid provider/prescriber number when submitting pharmacy claims for payment. In rare cases where a prescriber does not have a NPI, or the pharmacy cannot obtain the NPI, the pharmacy may substitute the prescriber's Medicaid identification (ID) number in the claim submission. The system will only allow claims to be submitted with a 7-digit individual prescribing practitioner Medicaid ID number.

Prescribing practitioners who deliver health care services in state-operated mental health clinics, developmental centers and public health clinics must also have an assigned individual prescriber identification number and a NPI in order for the prescription to be reimbursed by the Medicaid Program.

Individual prescriber ID numbers are issued to all interns, residents and fellows currently in training.

Prescribers Who Are Not Medicaid Program Providers

Pharmacy providers may be reimbursed for prescriptions, which are issued by prescribers who do not participate in the Medicaid Program but who have a valid Medicaid provider *prescriber only* number and a NPI.

If a prescribing practitioner does not have an individual Medicaid provider number, they should contact the fiscal intermediary (FI) Provider Enrollment Unit. (See Section 37.5.4 for contact information).

Sanctioned Prescribers

The Medicaid Program will not reimburse pharmacy claims when the prescribing practitioner is sanctioned and/or is excluded from Medicaid program participation.

Edits have been placed on the prescriber ID numbers when prescriber licenses have been restricted, suspended or revoked. Pharmacy claims will be denied when the prescribing provider does not have prescriptive authority.

Accessing Prescriber Numbers

Pharmacy providers must make every effort to assure that the prescribing practitioner number billed is accurate. A listing of prescribing practitioner numbers is available on the Louisiana Medicaid website. This listing is updated monthly. (See Section 37.5.4 for information on accessing the website).

Pharmacy providers may verify prescriber numbers by calling the Point of Sale (POS) Pharmacy Help Desk. (See Section 37.5.4 for contact information).

MEDICARE PRESCRIPTION DRUG COVERAGE

This section describes the coordination of benefits between the Medicare program and the Louisiana Medicaid program for dual-eligibles.

Medicare

Medicare was enacted by Congress as part of the Social Security Amendments of 1965. It is a federal program managed by the Centers for Medicare and Medicaid Services (CMS). The state of Louisiana has no authority over the rules and laws that govern the Medicare Program.

For additional information concerning the Medicare program, visit CMS' website. (See Section 37.5.4 for contact information).

Medicare Part B Crossover Claims

Medicare Part B covers a limited number of outpatient prescription drugs.

Medicare crossover claims are claims that have been approved for payment by Medicare and sent to Medicaid for payment towards the Medicare deductible and coinsurance.

Medicaid will only pay a crossover claim for beneficiaries who are Qualified Medicare Beneficiaries (QMBs) when the service is covered by Medicaid. Other claims will deny as "non-covered".

Coinsurance and deductibles are reimbursed through the Point of Sale (POS) system for covered Medicare Part B drugs and supplies when a dual-eligible individual is enrolled in the Medicare Advantage (Part C) Plan. The claims must be submitted to the Medicare Advantage Plan for payment prior to submitting to Medicaid as a coordinated claim.

Medicare Crossover Claims Submission

The provider must send claims for service provided to dual-eligible beneficiaries to the Medicare carrier or intermediary for processing. Medicare will send the provider an explanation of Medicare benefits after the claim is processed. If Medicare has approved the claim, Medicaid will pay the deductible and/or coinsurance.

Medicare crossover claims are submitted to the Medicaid fiscal agent by one of the following methods:

1.   An electronic submission generated automatically by the Medicare intermediary or carrier; or

2.   A paper submission by the provider that includes the claim and the Explanation of Medicare Benefits (EOMB).

Automated Crossover Carrier/Intermediary

The automated Medicare intermediary/carrier for Part B prescription drugs is Cigna, also known as DMERC (Durable Medical Equipment Regional Carrier).

The provider may contact the National Supplier Clearinghouse. (See Section 37.5.4 for contact information).

General Medicare Part B Crossover Reimbursement Policies

Provider Participation

A provider must be enrolled as a Medicaid provider in order to submit Medicare crossover claims.

Time Limits

The time limit for filing crossover claims with the Medicaid Program is 6 months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (12 months from the date of service).

Reimbursement

Payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the Average Sales Price (ASP).

Mandatory Assignment on all Drugs

Under Section 114 of the Federal Benefits Improvement and Protection Act of 2000, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts.

Assignment is an agreement between the provider and the beneficiary. The provider agrees to accept the Medicare-approved amount as full payment for covered items or services.

If the provider accepts assignment, the beneficiary pays only 20 percent of the Medicare-approved charge, plus any portion of the unmet deductible. The beneficiary is not responsible for charges over the Medicare-approved amount.

Pharmacy providers who have agreed to accept assignment on all of their services are called "participating" providers. These providers always accept the Medicare-approved amount as payment in full for covered services.

Providers who choose to participate must do so for the calendar year. Providers who do not participate may still accept assignment on a claim-by-claim basis.

Coordination of Benefits with Part B

Pharmacy claim reimbursement must be coordinated with Medicare Part B and any private insurance plan in which a beneficiary is enrolled. Medicare may be primary or secondary to a private insurance plan. To determine whether Medicare is primary, contact Medicare. (See Section 37.5.4 for contact information).

Answers to Questions

If providers have questions or concerns about Medicare claim processing or Medicare policy, they must follow Medicare's procedures for resolving those issues.

If there are problems or concerns regarding Medicaid's payment of crossover claims, the provider should contact the fiscal intermediary (FI).

Medicare Part B Outpatient Drug Coverage

Medicare Part B covers a limited number of outpatient prescription drugs. Medicare Part B covers oral anticancer drugs, antiemetics, diabetic supplies, glucometers, antihemophilia factor products, oral immunosuppressive drugs, nebulizer medication and other medications. Providers must be enrolled as Medicare suppliers and must bill Medicare first if the beneficiary receives Medicare benefits. Medicaid will pay any applicable deductibles and coinsurances. Pharmacy providers must accept assignment on Medicare-covered prescription drugs.

Listed below are some of the outpatient drugs covered by Medicare and their payment criteria, if applicable.

Note: Refer to DMERC and the local Part B carrier for complete coverage information and updated the Healthcare Common Procedure Coding System (HCPCS) codes utilized in claim submissions.

Immunosuppressive Drugs

Immunosuppressive drugs are covered only for Medicare covered transplants. When a prescription is filled for these drugs and the individual is not an organ transplant beneficiary or Medicare Part B did not cover the transplant, refer to the Medicare Part D prescription drug plan.

Oral Cancer Chemotherapy Drugs

Medicare Part B provides coverage of oral, self-administered, anticancer chemotherapeutic agents.

These drugs must be billed with National Drug Code (NDC) System.

Antiemetic Drugs

When oral antiemetic drugs are used in conjunction with intravenous cancer chemotherapeutic regimens, pharmacies shall bill Medicare first. The oral medication must be used as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, and must not exceed a 48-hour dosage regimen.

Nebulizer Drugs

Medicare will pay for medications used in a nebulizer for those beneficiaries eligible for Medicare Part B. Refer to the Medicare Part D prescription drug plan when the beneficiary is in a long-term care (LTC) facility.

Diabetic Supplies

Medicare Part B covers diabetic supplies (lancets, lancet devices, glucose control solutions and blood glucose strips). Glucometers are covered in some instances.

Diabetic supplies and glucometers for LTC beneficiaries are covered in the nursing home per diem rate. It is allowable for Medicare Part B to be billed if the LTC beneficiary is eligible for the benefit. Medicaid is not obligated to pay the coinsurance and deductible if the items are included in the Medicaid per diem. The Medicaid FI will automatically deny any crossover claims for diabetic supplies for LTC beneficiaries.

Dispensing/Supply Fees

Medicare reimburses for dispensing/supply fees when submitted with certain Part B payable drug claims. Dispensing fees are associated with nebulizer drugs. Supply fees are associated with oral anticancer drugs, oral antiemetic drugs or immunosuppressive drugs.

Antihemophilia Drugs

Claims submitted by pharmacy providers for blood clotting factors shall be processed by the local Part B carrier. The local Medicare Part B carrier for the state of Louisiana is Novitas Solutions, Inc. (See Section 37.5.4 for contact information).

Medicare Part D Outpatient Drug Coverage

Medicare Part D covered drugs include most prescription drugs, biological products, certain vaccines, insulin and medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs and gauze). Some drugs will be excluded from Medicare Part D coverage as they are part of the Medicaid non-mandatory coverage provisions under sections 1927 (d)(2) and (d)(3) of the Social Security Act, or they are covered by Medicare Part A or B. The one exception is smoking cessation products, such as nicotine patches and gum, which will be covered by Medicare Part D. Reimbursement of prescription claims are determined by each individual prescription drug plan.

Medicare Part D will not cover those medications reimbursed by Medicare Part B. However, should Medicare Part B deny coverage because the drug does not meet the criteria for a Part B covered indication, the pharmacy provider should contact the Part D prescription plan.

Medicaid Coverage for Other Excluded Part D Drugs

To the extent that the Louisiana Medicaid Program covers the following Medicare excluded drugs for Medicaid beneficiaries who are not full benefit dual Part D eligibles, Medicaid will be required to cover the excluded drugs for full benefit dual-eligibles.

All existing Pharmacy Program limits, co-payments and reimbursement policies apply to the Part D excluded prescriptions paid by the Medicaid program.

Prescription Drug Program (PDP) or Medicare Advantage Plan non-preferred drugs are not covered, as there is a Medicare appeal process to obtain these medications.

The following excluded drugs are covered by the Medicaid program unless they are covered by Medicare Part B or Part D:

1. Agents when used for anorexia, weight loss or weight gain (Orlistat only);

2. Agents when used to promote fertility when used for non-fertility treatment as described under specific state criteria;

3. Agents when used for cosmetic purposes or hair growth (Isotretinoin only);

4. Agents when used to promote smoking cessation as described under specific state criteria;

5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride:

    a. Vitamin A preparations;

    b. Vitamin B preparations;

    c. Vitamin C preparations;

    d. Vitamin D preparations;

    e. Vitamin E preparations;

    f. Geriatric vitamin preparations;

  g. Pediatric vitamin preparations;

  h. Vitamin K preparations;

  i. Vitamin B 12 preparations;

  j. Folic Acid preparations;

  k. Niacin preparations;

  l. Vitamin B6 preparations;

  m. Vitamin B1 preparations;

  n. Multivitamin preparations;

  o. Magnesium salt replacement;

  p. Calcium replacement; and

  q. Urinary pH modifiers (Phosphorus).

6. Nonprescription drugs:

  a. Sodium Chloride inhalation agents;

  b. Contraceptives, topical;

  c. Urinary pH modifiers;

  d. Antihistamines (Diphenhydramine only);

  e. 2nd Generation Antihistamines; and

  f. 2nd Generation Antihistamine – Decongestant Combinations.

The Medicaid program provides coverage for the following items, which are not covered under 1927(d) (2) of the Social Security Act to all Medicaid beneficiaries, including full benefit dual-eligibles unless Medicare Part B or Part D plans reimburse for the following items:

1.   OTC Vitamin D preparations;

2.   OTC Vitamin E preparations;

3.   OTC Niacin preparations;

4.   OTC Calcium replacement agents;

5.   OTC Magnesium replacement agents;

6.   OTC Phosphate replacement agents;

7.   OTC Iron replacement agents;

8.   Normal saline and Heparin flushes;

9.   Diabetic supplies; and

10. Family planning items.

Co-payments

The Medicaid co-payment schedule will apply for prescriptions for Part D excluded drugs that are covered by Medicaid.

CLAIMS SUBMISSION AND PROCESSING PAYMENTS

CLAIM SUBMISSION

This section describes the following:

1.   Claim submission requirements, including expression of drug quantities;

2.   Overrides;

3.   Time limits for claim submission; and

4.   Methods of claim submission.

National Drug Code

Drugs are identified on Medicaid claims and the Medicaid computer system drug file by the National Drug Code (NDC). The NDC is an 11-digit number. The first 5 digits identify the manufacturer or supplier, the next 4 digits identify the product and the last 2 digits identify the package size.

Use of NDCs

The provider must enter the entire 11-digit NDC for the actual product dispensed on the claim. Billing an NDC number, other than the one for the product dispensed, is a false claim and a violation of Medicaid policy.

NDC Not on the Drug File

Medicaid can only reimburse drugs whose NDCs are on the Medicaid computer system drug file. If the NDC is not on the Medicaid drug file, the provider may contact the Pharmacy Benefits Management (PBM) Help Desk and request that the drug be added. Drugs may be added in accordance with program policy and/or manufacturer participation in the federal drug rebate program. (See Section 37.5.4 for contact information).

Drug Quantities and Unit of Measurement

Billing Unit Standard

Medicaid has adopted the National Council for Prescription Drug Programs (NCPDP) unit of measurement for the billing unit standard.

The NCPDP standard uses only 3 billing units to describe all drug products:

1.   Each;

2.   Milliliter (ml); or

3.   Gram (gm).

The use of "tablet," "patch," "kit," etc. is not appropriate since these are dosage forms or package descriptions.

Dosage Forms Expressed as "Each"

The dosage forms that are expressed as "each" are, as follows:

1.   Solid oral medications such as tablets, capsules, etc., even when presented in dose packs or cycles;

2.   Suppositories;

3.   Transdermal patches;

4.   Powder packets;

5.   Disposable syringes; and

6.   Powder-filled vials, ampules and syringes for injection; irrigation; or inhalation (the quantity is the total number of vials dispensed, not the mls or gms of the final product).

Dosage Forms Expressed as "ml"

Dosage Forms that are expressed as "ml" are, as follows:

1.　　　Liquid oral medications;

2.　　　Ophthalmic and optic drops and suspensions;

3.　　　Reconstitutable oral products (the quantity is the number of milliliters in the bottle after reconstitution);

4.　　　Topical lotions or solutions;

5.　　　Liquid-filled vials, ampules or syringes for injection, irrigation or inhalation (the quantity is the total number of milliliters dispensed); and

6.　　　Inhalers and aerosols that are specified in milliliters by the manufacturer on the labeling.

Dosage Forms Expressed as "gm"

Dosage forms that are expressed as "gm" are, as follows:

1.　　　Topical or ophthalmic ointments and creams; and

2.　　　Inhalers and aerosols that are specified in grams by the manufacturer on the labeling.

Exceptions to the NCPDP Standard

The following are examples of exceptions to the NCPDP billing unit standard:

1.　　　Antihemophilic products must be expressed as the number of antihemophilic units dispensed, which will vary from vial to vial;

2.　　　Cordran® Tape and EpiPen® must be expressed as "each";

3.　　　One Imitrex® or Diastat® kit with two syringes must be expressed as one "each";

4.   One tube of Emla® cream with Tegaderm® patches must be expressed as one "each";

5.   One heparin flush kit containing one syringe of heparin and two syringes of saline packaged in the same bag must be expressed as one "each"; and

6.   Helidac® combination therapy must be expressed as 56 dosing units.

Metric Decimal Quantities

Metric decimal quantity is used to express quantity dispensed. Providers must bill for drug quantities using decimal numbers. Whole drug numbers are no longer required. The provider must ensure that their software enters the correct quantity in the metric decimal field (i.e., 0.030 does not equal 30.000). Rounding is not allowed (i.e., 3.500 cannot be billed as 4.000).

Billing Questions

Billing questions regarding the correct unit type should be directed to the fiscal intermediary (FI) from 8:00am to 5:00pm, Monday through Friday. (See Section 37.5.4 for contact information).

Prescriber Numbers

Prescription claims must indicate a valid individual Louisiana Medicaid prescriber number or National Provider Identifier (NPI) until only the NPI is required. Group practice numbers, hospital numbers and clinic numbers are not acceptable.

NOTE: See Section 37.5.6 Prescribers of this manual chapter for detailed prescriber policy.

Diagnosis Codes

Some pharmacy claims require diagnosis codes as a condition for program coverage and override of monthly prescription limits.

NOTE: See Section 37.1 Covered Services, Limitations and Exclusions of this manual chapter for specific program policy involving diagnosis codes.

Overrides

Listed below are the detailed policies regarding overrides. Refer to Section 37.5.1 for the link to access point of sale (POS) User Guide for details regarding claims submission requiring overrides.

Federal Upper Limits /Louisiana Maximum Allowable Cost Limitations

A prescriber may certify that a specified brand is medically necessary for a particular beneficiary. The Federal upper limit (FUL) or Louisiana Maximum Allowable Cost (LMAC) limitations for that medication will not apply.

The certification must be written either directly on, or must be a signed attachment (which may be faxed) to, the prescription. The certification must be continued in the prescriber's handwriting. The only acceptable phrases are "brand necessary" or "brand medically necessary".

NOTE: See "Multiple Source Drugs" in Section 37.3 Reimbursement for Services of this manual chapter for detailed information.

Prescriptions Limit

The Medicaid Program has a 4 prescription monthly limit. The prescription monthly limit can be overridden when the prescribing practitioner authorizes the medical necessity of the drug and communicates to the pharmacist the following information in his own handwriting or by telephone or other telecommunications device noted on, or attached to, the hard copy prescription:

1. "Medically Necessary Override"; and

2. A valid numeric diagnosis code that directly relates to each drug prescribed that is over the 4 prescription limit. (A literal description is not acceptable in lieu of a diagnosis code).

Early Refills

If the beneficiary has requested the same medication at the same pharmacy 5 or more days early for a 30-day supply, or prior to 85 percent of medication being utilized, a claim is denied for early refill. Narcotic analgesics will deny for an early refill edit when less than 90 percent of the medication has been utilized. This translates into a 2-day window based on a 30-day supply.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a beneficiary's request for medication earlier than previously reported in the estimated days' supply. With those requests, pharmacists may override this edit by documenting the circumstances on the prescription hard copy and reference the POS User Guide for detailed claims filing instructions.

Ingredient Duplication

A claim denial will occur as the beneficiary attempts to obtain the same drug from a different pharmacy sooner than is anticipated based on the estimated days' supply.

After consultation with a physician, beneficiary, and/or the POS Help Desk, the provider must determine whether there are extenuating circumstances which substantiate the dispensing of a duplicate claim. If extenuating circumstances exist, the provider must use procedures to initiate an override of the denial for the duplicate ingredient.

The provider must document on the prescription hard copy the circumstances for the override and reference the POS User Guide for detailed filing instructions.

Duration of Therapy

The Pharmacy Program has duration of therapy modules for the H2 antagonists, proton pump inhibitors (PPIs), sucralfate, and Hepatitis C medications.

NOTE: See Section 37.1 Covered Services, Limitations and Exclusions and Section 37.5.1 for the link to access the POS User Guide of this manual chapter for detailed information.

Therapeutic Duplication

The Medicaid Program denies pharmacy claims for drugs in the following classes if the beneficiary has an active paid claim on file for another drug in the same therapeutic class. Antipsychotic agents require 2 active prescriptions on file to deny for therapeutic duplication:

1. First and second generation antihistamines and first and second generation antihistamine combination agents;

2. Angiotensin Converting Enzyme (ACE) Inhibitors and ACE Inhibitor/Diuretic Combinations, ACE Inhibitors/Calcium Channel Blocker Combinations;

3.   Angiotensin Receptor Antagonists (ARB) and ARB/Diuretic Combinations;

4.   ARB/Calcium Channel Blocker Combinations;

5.   Beta Adrenergic Blocking Agents and Beta-adrenergic Blocking Agent/Diuretic Combinations;

6.   Calcium Channel Blockers;

7.   Calcium Channel Blocker/Antihyperlipidemia Agent Combination;

8.   Potassium Replacement Agents;

9.   Tricyclic Antidepressants;

10.   Selective Serotonin Reuptake Inhibitors;

11.   Antipsychotic Agents (typical and atypical);

12.   Antipsychotic/Selective Serotonin Reuptake Inhibitor Combinations;

13.   Anti-anxiety Agents;

14.   Sedative Hypnotic Agents;

15.   Attention Deficit Disorder (ADD) Agents;

16.   Non-steroidal Anti-inflammatory Agents (inclusive of COX-2 selective agent);

17.   Short Acting Opiate Agents;

18.   Long Acting Opiate Agents; and

19.   Proton Pump Inhibitors.

Override provisions will be allowed after contacting the prescriber. If an override is determined to be appropriate, additional hard-copy documentation on the new prescription is necessary. The

reason for service code, professional service code and result of service code are required for audit purposes. Diagnosis codes may be required in some instances.

NOTE: See Section 37.1 Covered Services, Limitations and Exclusions and Section 37.5.1 for the link to access the POS User Guide of this manual chapter for detailed claims filing instructions.

Unnecessary Drug Therapy

The Pharmacy Program has an unnecessary drug therapy module for the use of celecoxib (Celebrex®), armodafinil (Nuvigil®), and modafinil (Provigil®).

A valid diagnosis code is required, as well as a valid condition, warranting the COX-2 selective agent, celecoxib (Celebrex®), and armodafinil (Nuvigil®, and modafinil (Provigil®). Should the beneficiary not have a valid condition, and the prescriber determines that the drug therapy is necessary, the pharmacy provider must supply the reason for service code, professional service code and result of service code with the POS submission. This information must be documented on the hard copy prescription.

NOTE: See "Prospective Drug Utilization Policies/Limits/Edits" in Section 37.1 Covered Services, Limitations and Exclusions of this manual chapter for detailed information.

Drug/Drug Interaction

A valid diagnosis code is required for all Sildenafil (Revatio®) and Tadalafil (Adcirca®) prescriptions.

Override provisions for the drug to drug interaction between Sildenafil or Tadalafil and nitrates will be allowed after contacting the prescriber. The pharmacist must document the reason the prescriber required both drugs. Additionally, documentation of the reason for service code, professional service code and result of service code is required on the hard copy prescription and for submission of the POS claim.

Coordination of Benefits

Certain circumstances allow for the override of edits, which allows Medicaid to be the primary payor.

NOTE: See "Override Capabilities and Codes" in Section 37.3 Reimbursement/Third Party Liability (TPL)/Coordination of Benefits of this manual chapter for detailed information on these overrides.

Pregnancy Co-Payment

Services furnished to pregnant women, if such services are related to the pregnancy or any other medical conditions that complicate the pregnancy, are exempt from co-payments.

When a prescribing provider issues a prescription to a pregnant woman, they shall indicate on the prescription that the beneficiary is pregnant. In the case of a telephoned prescription, the information that the beneficiary is pregnant shall be communicated to the pharmacist and the pharmacist must document on the prescription that the beneficiary is pregnant.

When the prescribing provider authorizes a prescription for a pregnant beneficiary, the pharmacist shall maintain the proper documentation on the prescription, for audit purposes, indicating that the individual is pregnant.

NOTE: See Section 37.5.1 for the link to access POS User Guide of this manual chapter for detailed claims filing instructions.

Age and Gender Overrides

Some drugs have age and/or sex restrictions.

Pharmacy providers should contact the Pharmacy Program to address questions regarding age or sex restrictions. (See Section 37.5.4 for contact information).

NOTE: See "Drugs with Special Payment Criteria/Limitations" in Section 37.1 Covered Services, Limitations and Exclusions for other criteria and Section 37.5.1 to access the link to the POS User Guide for detailed billing information.

Maximum Dosage

Selected medications have maximum dosage limits. Prescriptions for atypical antipsychotic agents, agents containing tramadol and tapentadol (Nucynta®) will deny when the maximum recommended doses are exceeded.

Due to the potential of hepatotoxicity, claims billed with a dosage of acetaminophen that exceeds four grams per day will deny. Claims for products containing aspirin will deny payment when the maximum daily dosage billed exceeds 6 grams a day.

The prescriber must be consulted and the reason and override codes must be documented on the hard copy prescription. The pharmacy must supply the reason for service code, professional service code and result of service code with the POS submission.

Quantity Exceeds Program Maximum

Pharmacy claims for selected medications used in the management of pain are subject to maximum quantities. Quantity limits are cumulative, based on a rolling days' supply and apply to all strengths of an agent. Selected medications may be eligible for an override with prescriber authorization and documentation. If the prescriber chooses to exceed the limit, they must provide the reason why the quantity limit needs to be exceeded. After consulting with the prescriber, the pharmacist must document the prescriber's reason and drug utilization review (DUR) override codes on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist should reference the POS User Guide for detailed claims filing instructions.

Most prescriptions for beneficiaries who have confirmed diagnosis of cancer are exempt from quantity limits for pain medications. All prescriptions for Schedule II narcotic agents require a diagnosis code documented on the hardcopy prescription. When a diagnosis code is not on the prescription and the prescriber cannot be reached, the pharmacist can then determine if the beneficiary cannot wait to receive the medication and override the edit.

Prior Authorization Emergency

This emergency procedure may be used when the Prior Authorization Unit (PAU) is closed (Sundays and Monday-Saturday before 8am and after 6pm) or when the prior authorization (PA) system is unavailable. The pharmacist should also use professional judgment in situations that would necessitate an emergency supply.

Prescriptions indicating emergency situations shall be dispensed in a minimum quantity of a 72-hour or a 3-day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.**

The prescribing practitioner must indicate that the prescription is an emergency prescription on the face of the prescription if hard copy or if the prescription is called in to the pharmacy, the

emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency by Pharmacist" on the hard copy prescription.

Hospital Discharge Prescriptions for Atypical Antipsychotic Agents

When a beneficiary is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if the prescription is hard copy, that the prescription is a "Hospital Discharge." If the prescription is called in to the pharmacy, the "Hospital Discharge" status of the prescription must be communicated to the pharmacist who must indicate "Hospital Discharge" on the hard copy of the prescription.

In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is a "Hospital Discharge" prescription, the pharmacist must indicate "Hospital Discharge" on the hard copy prescription.

Claims for "Hospital Discharge" prescriptions needing PA will be submitted using the same process used for an emergency override.

Prescriptions for "Hospital Discharge" products shall be dispensed in a minimum quantity of a 3-day supply and refills for the dispensing of the non-preferred products are not permitted. The beneficiary's practitioner must contact the PAU to request authorization to continue the medication past the "Hospital Discharge" supply, and a new prescription must be issued.

Lock-In Emergency

This override is provided because the Louisiana Department of Health (LDH) recognizes that there may be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In beneficiary when the provider is not the Lock-In provider. Payment will be made to any pharmacist enrolled in the Medicaid Program who grants services to a Lock-In beneficiary in emergency situations or when life sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed.

The notation **"**Emergency Prescription" or "Discharge Prescription" should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist. Please ensure that the notation is included on the hard copy claim for audit purposes.

NOTE: See Section 37.5.13 Lock-In Program of this manual chapter for detailed information.

Types of Pharmacy Claims

Types of Claim Submissions

Providers can submit prescribed drug claims through the POS system, an electronic batch system upon testing and approval, or on paper claim forms. The paper claim form for Medicaid prescribed drug services is the NCPDP Universal Claim Form.

POS Claim Submission

Medicaid pharmacy providers can submit Medicaid claims through a LDH authorized electronic switch vendor using on-line, real time, POS processing. The transaction is processed through the claims processing cycle, and the disposition of the claim is returned to the pharmacy within seconds of submission.

POS processing is available through authorized telecommunication vendors that are connected to virtually every pharmacy in the United States.

Features of POS

The POS system is designed to work under the general framework of standards and protocols established by the NCPDP. It uses methods of communication that are in place for other pharmacy POS processing. POS uses the Health Insurance Portability and Accountability Act (HIPAA) approved telecommunication standard, NCPDP D.0.

The POS system is available 24 hours per day, 7 days per week, except for scheduled downtime for system maintenance.

Authorization to Use POS

To obtain authorization to submit Medicaid claims through POS, the provider must submit the POS authorization agreements to the Medicaid fiscal agent.

NOTE: See "POS Enrollment" in Section 37.2 Provider Requirements and Participation Guidelines in this manual chapter for information on provider enrollment.

Electronic Claim Submission (BATCH)

Providers interested in using the NCPDP 1.2 Batch version must contact the POS Help Desk. Testing and approval are required. (See Section 37.5.4 for contact information).

Hard Copy Submission

When it is necessary to paper bill the Medicaid Program for services, pharmacy providers must use the NCPDP Universal Claim Form (UCF) regardless of date of service. No photocopied versions are acceptable.

Ordering the Claim Forms

NCPDP Universal Claim Forms may be purchased from Communi Form, LLC. (See Section 37.5.4 for contact information).

Claim Submission

All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form. Claims submitted on the UCF claim form to the FI.

Retroactive Eligibility Claim Submission

When filing prescription claims for beneficiaries with retroactive Medicaid, with a date of service greater than one year, providers must file these claims hard copy for special handling.

Claims less than one year may be submitted on-line, with some exceptions. Claims over one year for beneficiaries with retroactive coverage, e.g., spend-down medically needy beneficiaries, should be sent to Medicaid Management Information Systems (MMIS) within LDH with a note of explanation or a copy of the beneficiary's Medicaid identification card as soon as possible. These claims must be sent to the Bureau of Health Services Financing (BHSF). (See Section 37.5.4 for contact information).

Billing Instructions

All fields of the Universal Claim Form are not numbered; however, all fields are denoted as "Required", "Not Required", or "Leave Blank" as appropriate.

"Required" information must be entered to ensure processing of the claim. "Not required" information is optional, based on entry of a previous field. "Leave Blank" is a field unrelated to pharmacy claims.

NOTE: See Section 37.5.1 of this manual chapter for an example of the Universal Claim Form and billing instructions.

Claim Adjustments

From time to time some claims submitted and paid require adjustments. This can be done through the POS claim reversal process, which involves reversing the incorrect claim and resubmitting a new, corrected claim via POS. Claims requiring adjustments may be reversed within the timely filing period by using the pharmacy provider NPI, date of service and prescription number. Upon reversal, the claim may be resubmitted with the corrected information.

In some instances, it is necessary to submit a hard copy adjustment claim form.

NOTE: See Section 37.5.1 to access the link to the POS User Guide of this manual chapter for instructions for both types of claim adjustments.

NOTE: See Section 37.5.1 of this manual chapter for Form 211 Drug Adjustment Form and instructions for completion.

Time Limit for Submission of Medicaid Claims

Timely Claim Submission

Medicaid providers should submit claims immediately after providing services so that any problems with a claim can be corrected and the claim resubmitted before the filing deadline.

Twelve Month Filing Limit

A claim for services rendered must be received by the Department or its FI no later than 12 months from the date of service.

Dates of Service Greater Than 2 Years Old

Claims with dates of service over 2 years old are not to be submitted to the FI or to Medicaid for overriding of the timely filing edit unless one or more of the guidelines listed below is met:

1. The beneficiary was certified for retroactive Medicaid benefits;

2. The beneficiary won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits; and/or

3. The failure of the claim to pay was not the fault of the provider each time the claim was adjudicated.

Medicare/Third Party Payor Insurance Claims

Claims for beneficiaries who have Medicare or other insurance must be submitted to a third party payor prior to sending the claim to Medicaid.

A claim coordinated with a third party payor shall be submitted to the FI within 12 months of the date of service.

The time limit for filing Medicare crossover claims to the Medicaid Program is 6 months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (12 months from the date of service).

Proof of Timely Filing

Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following:

1. A Remittance Advice (RA) indicating that the claim was processed earlier (within the specified timeframe); or

2. Proof of retroactive eligibility.

When resubmitting the claim and documentation, providers must be certain that the claim is legible to ensure accurate processing. Documentation must reference the individual beneficiary and date of service.

Billing for Spend-Down Medically Needy Beneficiaries

Any provider who has medical bills from the exact date of the beneficiary's spend-down will receive a Spend-down Medically Needy Notice (Form 110-MNP) from the local Medicaid office. This form will notify the provider of the co-payment amount due by the beneficiary and the amount to be billed to Medicaid. *The provider must attach this form to the claim and submit the claim manually to the FI for processing.* The provider cannot bill the beneficiary for any amount over the amount specified on the Form 110-MNP under beneficiary liability. If service(s) were provided on the date of spend-down but does not appear on the 110-MNP form, the provider should contact the local Medicaid office that issued the form to get a corrected form.

CLAIMS PROCESSING and PAYMENTS

Claims for Medicaid reimbursement are processed by the Medicaid FI. This section describes claims processing and gives the provider information about the remittance advice as well as how to obtain help with claims processing problems.

Claims Processing

Claim Entry

POS claims enter the claims processing system directly through a telecommunications network and adjudicate in real time. Paper claims are keyed directly into the system for adjudication. Paper claims should be submitted to the FI. (See Section 37.5.4 for contact information).

Claim Adjudication

The system edits the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

Disposition of Claim

A claim disposition can be:

1.   Paid - payment is approved in accordance with program criteria; or

2.   Denied - payment cannot be made because the information supplied indicates the claim does not meet program criteria, or information necessary for payment was either erroneous or missing.

Processing Time Frames

POS claims submitted by the end of the day on Thursday typically appear as adjudicated/pended on the provider's RA the following Tuesday. Payments are made to the provider based upon LDH payment guidelines. Paper claims are processed for adjudication within 10 to 30 days.

POS Claims

Pharmacy claims are processed through a LDH approved switch vendor through the POS system. The POS system is designed to work under the general framework of standards and protocols established by NCPDP. It uses methods of communication which are in place for other pharmacy POS processing.

NOTE: Refer to Section 37.5.1 for the link to access of the POS User Guide of this manual chapter for comprehensive information.

Paper Claims

Paper claims are screened for completion. If information is missing, the claim will not be entered into the system and will be returned to the provider. The provider needs to correct the error, attach any missing documentation and return the claim for processing.

Pharmacy providers should verify payment or denial of paper claims on their weekly RA. Paper claims should be resubmitted if the services meet the criteria for payment.

Remittance Advice

The RA plays an important communication role between the provider, the Medicaid Program, and the FI. Aside from providing a record of transactions, the RA assists providers in resolving and correcting possible errors and reconciling paid claims. The RA also serves as a bulletin board for messages from the Medicaid Program.

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out each week when the provider has an adjudicated claim.

On the line immediately below each claim, a code will be printed representing denial reasons and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (which may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the beneficiary's number.

Internal Control Number

At the end of each claim line is the 13-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the 13-digits of the ICN and what they represent:

Position 1:   Last Digit of Current Year

Positions 2-4:   Julian Date - ordinal day of 365-day year

Position 5:   Media Code - 0 = paper claim with no attachments

                     1 = Electronic batched claim
                     3 = System adjustment
                     4 = System void
                     5 = Paper claim with attachments
                     6 = Resubmission
                     7 = Pharmacy POS electronic claim

Positions 6-8:   Batch Number - for FI internal purposes

Positions 9-11:   Sequence Number - for FI internal purposes

Positions 12-13:　　Number of Lines within Claim

　　　　　　　　00 = First line
　　　　　　　　01 = Second line
　　　　　　　　02 = Third line, etc.

Copies of the 5 most current weeks' RAs are available on the Louisiana Medicaid website's password-protected section, "Weekly Remittance Advices".

Electronic Remittance Advice

The Electronic Media Claims (EMC) Department offers Electronic Remittance Advices (ERA) in the ANSI X12 835 format. The 835 would be in addition to the NCPDP response. This allows providers to have their RAs transmitted from the FI and posted to accounts electronically. Further information may be obtained by calling the FI. (See Section 37.5.4 for contact information).

Remittance Advice Breakdown

Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, providers should look carefully at the heading under which the claims appear to assist with the reconciliation process.

Claims appearing under the heading, "Claims in Process", indicate claims that have been received by the FI, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims."

Remittance Summary

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an ICN which is assigned to the check. If claims associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset the amount recouped from

the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RA's until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

It is the provider's responsibility to track these refund checks and corresponding claims until they are all processed.

When providers choose to submit adjustment/void forms for refunds, the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to the provider's check and the payment should be posted to the appropriate beneficiary's account. If money is being recouped, it will be deducted from the provider's check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate beneficiary accounts through the bookkeeping process, and the recoupments must be deducted from the accounts of the beneficiaries for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, Surveillance and Utilization Review Subsystem (SURS) recoupments and cost settlements.

Below are the summary headings which may appear on the financial summary page and an explanation of each:

1. **Suspense Balance Brought Forward** - A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed;

2.　　**Approved Original Claim -** Total of all approved (paid) claims appearing on this RA;

3.　　**Adjustment Claims -** Total of all claims being adjusted on this RA;

4.　　**Previously Paid Claim -** Total of all previously paid claims which correspond to an adjustment or void appearing on this RA;

5.　　**Void Claims -** Total of all claims being voided on this RA;

6.　　**Net Current Claims Transactions -** Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process);

7.　　**Suspense Balance Brought Forward** - A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed;

8.　　**Approved Original Claim -** Total of all approved (paid) claims appearing on this RA;

9.　　**Adjustment Claims -** Total of all claims being adjusted on this RA;

10.　　**Previously Paid Claim -** Total of all previously paid claims which correspond to an adjustment or void appearing on this RA;

11.　　**Void Claims -** Total of all claims being voided on this RA;

12.　　**Net Current Claims Transactions -** Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process);

13.   **Net Current Financial Transactions -** Total number of all financial transactions appearing on the RA;

14.   **Prior Negative Balance -** If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements);

15.   **Recoupment Bypassed by LDH**;

16.   **Withheld for Future Recoveries -** Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA);

17.   **Total Payments This RA -** Total of current check;

18.   **Total Copayment Deducted This RA -** Total pharmacy co-payments deducted for this RA;

19.   **Suspense Balance Carried Forward -** Total of Suspense Balance Brought Forward and withheld for future recoveries;

20.   **Y-T-D Amount Paid -** Total amount paid for the calendar year;

21.   **Denied Claims -** Total of all denied claims appearing on this RA; and

22.   **Claims in Process -** Total of all pending claims appearing on this RA.

Messages

Important messages appear on the RA pertinent to the pharmacy program. Messages include, but are not limited to the following:

1.   Updates to program policy;

2.   Changes in participating manufacturers in the federal rebate program; and

3.   Changes in the FULs and LMACs.

Help Desk

POS information is available to Pharmacy providers between 8:00 a.m. and 5:00 p.m. Monday through Friday by contacting the FI's POS Helpdesk. (See Section 37.5.4 for contact information).

PUBLIC HEALTH SERVICES 340B DRUG PRICING PROGRAM

The Drug Rebate program was established in 1990. The Veterans Health Care Act of 1992 established the 340B Drug Pricing Program through the enactment of Public Law 102-585. The Veterans Health Care Act of 1992 is codified as Section 340B of the Public Health Services (PHS) Act.

Section 340B of the PHS Act requires drug manufacturers that receive reimbursement from state Medicaid programs to supply drugs to the 340B Drug Pricing Program at a discounted rate. The Office of Pharmacy Affairs (OPA) of the Bureau of Primary Health Care at the Health Resources and Services Administration (HRSA) administers the program. This Federal program is run by Apexus' Prime Vendor Program, which negotiates discounted drug products for use by covered entities that are certified as 340B providers.

To participate in the 340B program eligible entities must register with HRSA. Recertification must be completed annually, and 340B drugs may only be dispensed by eligible organizations to eligible patients. Drug manufacturers and HRSA have the authority to audit covered entities for program compliance. Additional information may be found on the HRSA website. (See Section 37.5.4 for contact information).

Reimbursement Methodology

Covered Entity

Self-administered drugs (ambulatory and retail medications) that are purchased by a covered entity through the 340B program, and dispensed to patients, who are covered by Medicaid, shall be billed to Medicaid at actual acquisition cost plus a professional dispensing fee. 340B drug stock cannot be used in an inpatient setting.

Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing.

Contract Pharmacies

Covered entities that are not equipped to provide pharmacy services may contract with pharmacy providers. A "ship to, bill to" procedure is used in which the covered entity purchases 340B stock that is shipped directly to the contract pharmacy.

Claims billed to Medicaid by contract pharmacies are only excluded from Medicaid's drug rebate program if the contract pharmacy is listed in the HRSA Exclusion File. To be listed in the exclusion file, the pharmacy:

1.   Has attested to HRSA that all of its Medicaid claims are "carved-in" to the 340B program; and

2.   All of their Medicaid claims are dispensed from 340B stock, whether the claims were billed for the covered entity or as part of the pharmacy's regular retail business.

It is the responsibility of the covered entity to ensure their 340B program and any contract pharmacies are in compliance with HRSA requirements. Information on HRSA's guidelines for contract pharmacy agreements, responsibilities and requirements can be located on HRSA website. (See Section 37.5.4 for contact information).

NOTE: Refer to Section 37.2 Pharmacy Provider Enrollment and Participation Guidelines of this manual chapter for additional enrollment and participation information.

HRSA maintains a national 340B exclusion file for use by all state Medicaid programs during drug rebate invoicing. The file is available to the public for download. (See Section 37.5.4 for information on accessing the file).

All 340B covered entities are required to determine whether their Medicaid claims are "carved-in" or "carved-out" of their 340B program. "Carved-in" means that all drug claims billed to Medicaid are dispensed from regular stock purchased through the 340B program. Each covered entity attests to its status to HRSA and only those that carve all Medicaid patients into their 340B programs are excluded from each state's drug rebate program.

Claims billed to Medicaid by contract pharmacies are only excluded from drug rebate invoicing if the contract pharmacy has attested to HRSA that all Medicaid claims are "carved-in" to the 340B program and all of their Medicaid claims are dispensed from 340B stock. The covered entity's carved-in status does not apply to its network pharmacies. If the contract pharmacy bills Medicaid

claims in its regular business, none of that pharmacy's claims will be excluded from drug rebate invoicing.

The Medicaid Program reviews the HRSA exclusion file quarterly with each invoicing cycle and removes providers from drug rebate invoicing according to the term dates provided by HRSA.

The Medicaid Program invoices drug manufacturers for fee-for-service (FFS) Medicaid and managed care Medicaid claims. Claims billed by covered entities that are listed on the HRSA exclusion file are removed from invoicing for both FFS and managed care Medicaid patients.

Questions regarding the 340B program should be directed to HRSA, Office of Pharmacy Affairs. (See Section 37.5.4 for contact information).

Providers may also contact the Pharmacy Program.

TOTAL PARENTERAL NUTRITION

This section explains the Total Parenteral Nutrition (TPN) therapy coverage, limitations, prior authorization (PA), reimbursement methodology, and claim submission.

Provider Enrollment

Refer to Section 37.2 Provider Requirements and Participation Guidelines for enrollment instructions.

Program Coverage

The program covers the following services, equipment and supplies when medical necessity and other program criteria are met:

1. Parenteral Nutrition Therapy/TPN is covered for a patient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the beneficiary's general condition;

2. Intradialytic Parenteral Nutrition Therapy (IDPN) provided to an end stage renal disease (ESRD) patient while the patient is being dialyzed; and/or

3. Equipment and supplies, infusion pumps and accessories.

TPN Medical Necessity Criteria

1. Parenteral nutrition is covered for a beneficiary with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the beneficiary's general condition;

2. Parenteral nutrition is considered to be medically necessary when any of the following conditions exist. The conditions must be deemed to be severe enough that the beneficiary would not be able to maintain their weight and strength on only

oral intake or tube enteral nutrition. The beneficiary:

a.   Has undergone recent (within the past 3 months) massive small bowel resection leaving less than or equal to 5 feet of small bowel beyond the ligament of Treitz;

b.   Has a short bowel syndrome that is severe enough that the beneficiary has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5-3 liters/day the enteral losses exceed 50 percent of the oral/enteral intake and the urine output is less than 1 liter/day;

c.   Requires bowel rest for at least 3 months and is receiving intravenously 20-35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula is not possible;

d.   Has complete mechanical small bowel obstruction where surgery is not an option;

e.   Is significantly malnourished (10 percent weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has very severe fat malabsorption (fecal fat exceeds 50 percent of oral/enteral intake on a diet of at least 50 gm of fat/day as measured by a standard 72 hour fecal fat test); or

f.   Is significantly malnourished (10 percent weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has a severe motility disturbance of the small intestine and/or stomach which is unresponsive to prokinetic medication. Prokinetic medication is defined as the presence of daily symptoms of nausea and vomiting while taking maximal doses and is demonstrated either:

    i.   Scintigraphically (solid meal gastric emptying study demonstrates that the isotope fails to reach the right colon by 6 hours following ingestion); or

ii.   Radiographically (barium or radiopaque pellets fail to reach the right colon by 6 hours following administration).

NOTE: These studies must be performed when the beneficiary is not acutely ill and is not on any medication which would decrease bowel motility.

3.   Maintenance of weight and strength commensurate with the beneficiary's overall health status must require intravenous nutrition and must not be possible utilizing all of the following approaches:

   a.   Modifying the nutrient composition of the enteral diet (e.g., lactose free, gluten free, low in long chain triglycerides, substitution with medium chain triglycerides, provision of protein as peptides or amino acids, etc.); and

   b.   Utilizing pharmacologic means to treat the etiology of the malabsorption (e.g., pancreatic enzymes or bile salts, broad spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, etc.).

4.   Beneficiaries who do not meet the criteria in B.1-6.b must meet criteria in C.1-2 (modification of diet and pharmacologic intervention) in addition to the following criteria:

   a.   The beneficiary is malnourished (10 percent weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl); and

   b.   A disease and clinical condition has been documented as being present and it has not responded to altering the manner of delivery of appropriate nutrients (e.g., slow infusion of nutrients through a tube with the tip located in the stomach or jejunum).

5.   The following are some examples of moderate abnormalities which would require a failed trial of tube enteral nutrition before parenteral nutrition would be covered:

   a.   Moderate fat malabsorption - fecal fat exceeds 25 percent of oral/enteral intake on a diet of at least 50 gm fat/day as measured by a standard 72 hour fecal fat test;

     b.   Diagnosis of malabsorption with objective confirmation by methods other than 72 hour fecal fat test (e.g., Sudan stain of stool, dxylose test, etc.);

     c.   Gastroparesis which has been demonstrated:

        i.   Radiographically or scintigraphically as described in Subsection B above with the isotope or pellets failing to reach the jejunum in three to 6 hours; or

        ii.   By manometric motility studies with results consistent with an abnormal gastric emptying, and which is unresponsive to prokinetic medication.

     d.   A small bowel motility disturbance which is unresponsive to prokinetic medication, demonstrated with a gastric to right colon transit time between 3 to 6 hours;

     e.   Small bowel resection leaving greater than 5 feet of small bowel beyond the ligament of Treitz;

     f.   Short bowel syndrome which is not severe (as defined in B.2);

     g.   Mild to moderate exacerbation of regional enteritis, or an enterocutaneous fistula; or

     h.   Partial mechanical small bowel obstruction where surgery is not an option.

6.   Documentation must support that a concerted effort has been made to place a tube. For gastroparesis, tube placement must be post-pylorus, preferably in the jejunum. Use of a double lumen tube should be considered. Placement of the tube in the jejunum must be objectively verified by radiographic studies or luoroscopy. Placement via endoscopy or open surgical procedure would also verify location of the tube;

7.   A trial with enteral nutrition must be documented, with appropriate attention to dilution, rate, and alternative formulas to address side effects of diarrhea;

8.   Parenteral nutrition can be covered in a beneficiary with the ability to obtain partial nutrition from oral intake or a combination of oral/enteral or oral/enteral/parenteral intake as long as the following criteria are met:

a.   A permanent condition of the alimentary tract is present which has been deemed to require parenteral therapy because of its severity;

b.   A permanent condition of the alimentary tract is present which is unresponsive to standard medical management; and

c.   The person is unable to maintain weight and strength.

9.   If the medical necessity criteria for parenteral nutrition are met, medically necessary nutrients, administration supplies and equipment are covered. Parenteral nutrition solutions containing little or no amino acids and/or carbohydrates would be covered only in situations stated in B.1, 2, or 4 above.

Documentation Requirements

Beneficiaries covered under Paragraph B.4 must have documentation of the persistence of their condition. Beneficiaries covered under B.5–D.2 must have documentation that sufficient improvement of their underlying condition has not occurred which would permit discontinuation of parenteral nutrition. Coverage for these beneficiaries would be continued if the treatment has been effective as evidenced by an improvement of weight and/or serum albumin. If there has been no improvement, subsequent claims will be denied unless the physician clearly documents the medical necessity for continued parenteral nutrition and any changes to the therapeutic regimen that are planned, e.g., an increase in the quantity of parenteral nutrients provided.

A total caloric daily intake (parenteral, enteral and oral) of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate body weight. The ordering physician must document in the medical record the medical necessity for a caloric intake outside this range in an individual beneficiary.

Parenteral nutrition would usually be non-covered for beneficiaries who do not meet criteria in H.1-3, but will be considered on an individual case basis if detailed documentation is submitted.

Beneficiaries covered under criteria in B.1 or 2 must have documentation that adequate small

bowel adaptation had not occurred which would permit tube enteral or oral feedings.

Beneficiaries covered under B.3 must have documentation of worsening of their underlying condition during attempts to resume oral feedings.

The ordering physician must document the medical necessity for protein orders outside of the range of 0.8-1.5 gm/kg/day, dextrose concentration less than 10 percent, or lipid use greater than 15 units of a 20 percent solution or 30 units of a 10 percent solution per month.

If the medical necessity for special parenteral formulas is not substantiated, authorization of payment will be denied.

For the initial request and for revised requests or reconsiderations involving a change in the order, there must be additional documentation to support the medical necessity of the following orders, if applicable:

1.　　　The need for special nutrients;

2.　　　The need for dextrose concentration less than 10 percent; and

3.　　　The need for lipids more than 15 units of a 20 percent solution or 30 units of a 10 percent solution per month.

After the first 6 months, the PA request must include a physician's statement describing the continued need for parenteral nutrition. For situations described in B.5-D.2 under Medical Necessity Criteria, the PA request must include the results of the most recent serum albumin (within two weeks of the request date) and the beneficiary's most recent weight with the date of each. If the results indicate malnutrition, there should be a physician's statement describing the continued need for parenteral nutrition and any changes to the therapeutic regimen that are planned.

Exclusionary Criteria

Parenteral nutrition will be denied as non-covered in situations involving temporary impairments. The beneficiary must have one of the following:

1.　　　A condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients; or

2.   A disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the gastrointestinal (GI) system. There must be objective evidence supporting the clinical diagnosis.

Parenteral nutrition is not covered for the beneficiary with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to:

1.   A swallowing disorder;

2.   A temporary defect in gastric emptying such as a metabolic or electrolyte disorder;

3.   A psychological disorder impairing food intake such as depression;

4.   A metabolic disorder inducing anorexia such as cancer;

5.   A physical disorder impairing food intake such as the dyspnea of severe pulmonary or cardiac disease;

6.   A side effect of a medication; or

7.   Renal failure and/or dialysis.

Intradialytic Parenteral Nutrition Therapy

IDPN is parenteral nutrition therapy provided to a beneficiary with ESRD while the beneficiary is being dialyzed.

In order to cover IDPN, documentation must be clear and precise to verify that the beneficiary suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. The supporting documentation must substantiate that the beneficiary cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, the beneficiary must be intravenously infused with nutrients.

Infusions must be vital to the nutritional stability of the beneficiary and not supplemental to a deficient diet or deficiencies caused by dialysis. Physical signs, symptoms and test results

indicating severe pathology of the alimentary tract must be clearly evident in any documentation submitted. Beneficiaries receiving IDPN must also meet the criteria for parenteral nutrition.

If the medical necessity criteria for parenteral nutrition are met, one supply kit and one administration kit will be covered for each day that parenteral nutrition is necessary and used.

Equipment and Supplies

An infusion pump is used to deliver nutritional requirements intravenously. Infusion pumps are covered for the delivery of parenteral nutrition for those beneficiaries who cannot absorb nutrients by the gastrointestinal tract. Only one pump (ambulatory or stationary) will be covered at any one time. Additional pumps will be denied as not medically necessary.

1.   An external ambulatory infusion pump is a small portable electrical device that is used to deliver parenteral nutrition. It is designed to be carried or worn by the beneficiary; or

2.   A stationary infusion pump is an electrical device, which serves the same purpose as an ambulatory pump, but is larger and typically mounted on a pole.

An intravenous (IV) pole is a device to suspend fluid to be administered by gravity or pump. An IV pole will be covered when a beneficiary is receiving parenteral fluids and the beneficiary is not using an ambulatory infusion pump.

Infusion pumps, ambulatory and stationary, are indicated for the administration of parenteral medication in the home when parenteral administration of the medication in the home is reasonable and medically necessary, and an infusion pump is necessary to safely administer the medication.

An external ambulatory infusion pump is a small portable electrical device that is used to deliver parenteral medication. It is designed to be carried or worn by the beneficiary.

Prior Authorization

Prior Authorization Requirements

Parenteral nutrition therapy may be approved by the Prior Authorization Unit (PAU) at periodic intervals not to exceed 6 months. However, Medicaid will pay for no more than one month's supply of nutrients at any one time. All requests to the PAU shall include the following:

1. The prognosis as well as the diagnosis;

2. The date the beneficiary was first infused;

3. Whether the beneficiary has been trained to use parenteral equipment;

4. A statement that the beneficiary is capable of operating the parenteral equipment;

5. Either the Medicaid certificate of medical necessity form for TPN, or the Medicare certificate of medical necessity form, Form DMERC 10.02A, completed and signed by the treating physician; and

6. Documentation showing that the beneficiary has a permanent impairment. Permanence does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. Medical documentation must substantiate that the condition is expected to last a long and indefinite duration (at least 3 months).

Additional documentation must be included with the initial request for parenteral nutrition.

In the situations addressed in B.1-4 under Medical Necessity Criteria, the documentation must include copies of the operative report and/or hospital discharge summary and/or x-ray reports and/or a physician letter which document the condition and the necessity for parenteral nutrition therapy.

For the situations addressed in B.5 and D.2 under Medical Necessity Criteria (when appropriate), include the results of the fecal fat test and dates of the test.

For the situations addressed in B.6 and D.2 under Medical Necessity Criteria, include a copy of the report of the small bowel motility study and a list of medications that the beneficiary was on at the time of the test.

For the situations addressed in B.5 – D.2 under Medical Necessity Criteria, include the results of serum albumin and the date of the test (within one week prior to initiation of parenteral nutrition) and a copy of a nutritional assessment by a physician, dietitian or other qualified professional

within one week prior to initiation of PN, to include the following information:

1.   Current weight with date and weight one – 3 months prior to initiation of parenteral nutrition;

2.   Estimated daily calorie intake during the prior month and by what route (e.g., oral, tube);

3.   Statement of whether there were caloric losses from vomiting or diarrhea and whether these estimated losses are reflected in the calorie count; and

4.   Description of any dietary modifications made or supplements tried during the prior month (e.g., low fat, extra medium chain triglycerides, etc.).

For situations described in D.2 under Medical Necessity Criteria, include:

1.   A statement from the physician;

2.   Copies of objective studies; and

3.   Excerpts of the medical record giving the following information:

   a.   Specific etiology for the gastroparesis, small bowel dysmotility, malabsorption;

   b.   A detailed description of the trial of tube enteral nutrition including the beginning and ending dates of the trial, duration of time that the tube was in place, the type and size of tube, the location of tip of the tube, the name of the enteral nutrient, the quantity, concentration and rate of administration, and the results;

   c.   A copy of the x-ray report or procedure report documenting placement of the tube in the jejunum;

   d.   Prokinetic medications used, dosage, and dates of use;

   e.   Nondietary treatment given during prior month directed at etiology of

malabsorption (e.g., antibiotic for bacterial overgrowth); and

f.   Any medications used that might impair GI tolerance to enteral feedings (e.g., anticholinergics, opiates, tricyclics, phenothiazines, etc.) or that might interfere with test results (e.g., mineral oil, etc.) and a statement explaining the need for these medications.

Any other information which supports the medical necessity for parenteral nutrition may also be included.

Prior Authorization Requests

The PA request shall be submitted to the fiscal intermediary (FI) PAU where it will be considered for payment. Provider may contact the PAU. (See Appendix 37.5.4 for contact information).

Providers may complete and submit electronic PA forms. These forms may be accessed at www.lamedicaid.com. For more information contact the PAU.

NOTE: Refer to Appendix 37.5.1 for Form PA01 and instructions or providers may access this form at www.lamedicaid.com.

Once a PA request is approved, the provider and beneficiary are notified of the approval, as well as what services have been approved. A PA number is attached to the approved request. This number is to be used in the billing process.

Emergency Requests

A request is considered an emergency if a delay in obtaining the parenteral nutrition therapy would be life-threatening to the beneficiary. Providers should call the PAU's toll-free number. Providers should then fax a completed PA 01 form, documentation of the parenteral therapy and life-threatening situation (i.e. pending discharge). Once an approval or denial is determined within 48 hours, the procedure codes, authorized reimbursement rate and PA number is phoned to the provider. A determination letter is later mailed to the provider and beneficiary.

Medicare Crossover Claims

Claims for TPN and equipment reimbursed by Medicare do not require PA from Medicaid when these claims cross over from Medicare to Medicaid for payment.

Claims denied by Medicare due to lack of medical necessity will not be considered for coverage by Medicaid.

Medicare non-covered services may be considered for coverage by Medicaid Claims, when that service is a Medicaid covered service; however PA is necessary.

Third Party Liability

When a Medicaid beneficiary has private insurance and Medicaid, PA is required from all payors, including Medicaid.

Reimbursement Methodology

The following is the Medicaid reimbursement schedule:

1. Reimbursement for TPN formula is 80 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount;

2. Reimbursement for TPN supplies is 70 percent of the Medicare Fee Schedule or billed charges, whichever is the lesser amount; and

3. Reimbursement for TPN infusion pumps is 70 percent of the Medicare Fee Schedule or billed charges, whichever is the lesser amount.

Claim Submission

Medicaid Claims

Claims for TPN should be submitted on the CMS-1500. (See Appendix 37.5.1 for information on how to access this form).

Medicare Crossover Claims

Medicare claims will automatically cross over to Medicaid when the provider is enrolled as a Medicare provider.

NOTE: See Medicare Part B Crossover Claims in Appendix G: Medicare Prescription Drug Coverage for additional detailed information.

Third Party Liability

When a beneficiary has both Medicaid and private insurance, the provider is required to submit the claim to the private insurance first. The provider's remittance advice (RA) from the private insurance company should be submitted with the claim to Medicaid.

Adjustments/Voids

Providers should complete Form 213 Adjustment/Void form for TPN services submitted that require adjustments or voids.

NOTE: Refer to Appendix 37.5.1 of this manual chapter for a copy of this form.

MEDICATION ADMINISTRATION

The Louisiana Board of Pharmacy has set minimum requirements regarding the administration of medications by licensed Louisiana pharmacists. Currently the Medicaid program will reimburse enrolled pharmacies when these credentialed pharmacists administer select adult vaccines.

Louisiana Board of Pharmacy

Pharmacists in Louisiana must be registered by the Louisiana Board of Pharmacy to administer medications. Louisiana Board of Pharmacy Regulations regarding Prescription Orders to Administer Medications may be found at LAC 46:LIII.521.

Pharmacist Provider Number

Authorized Pharmacists

Pharmacists who are registered with the Louisiana Board of Pharmacy and have the "*Authority to Administer*" must obtain a Medicaid pharmacist provider number in order to bill the Medicaid program. To confirm or request enrollment, authorized pharmacists should contact the Provider Enrollment Unit. (See Section 37.5.4 for contact information).

National Provider Identifier (NPI)

Pharmacists who have a National Provider Identifier (NPI) must report it to the fiscal intermediary (FI) and may include it in the claim submission.

Adult Vaccine Administration by Pharmacist

Claim Requirements

The Medicaid program will reimburse enrolled pharmacies when an immunization is given by a pharmacist who has a Louisiana Board of Pharmacy "*Authority to Administer*". For COVID-19 vaccines only, the administration of the vaccine may be given by a pharmacist, and or qualified pharmacy technician and/or a state-authorized pharmacy intern acting under the supervision of a qualified pharmacist during a Public Health Emergency (PHE). The administering pharmacist's Medicaid provider number or their NPI must be included on the claim.

When a prescription for a select adult vaccine is written by a prescribing practitioner, that practitioner's NPI or Medicaid number should be included in the claim. When a prescription order does not exist, the vaccinating pharmacist shall enter their Medicaid provider number or NPI as the prescriber and submit the claim.

Vaccination Reimbursement

The Medicaid program reimburses enrolled pharmacies for the administration and the cost of select adult vaccines with the exception of vaccines supplied by the federal government. For the vaccines supplied by the federal government, the **administration fee only** is reimbursable. Currently, the ingredient cost of the COVID-19 vaccines are covered by the federal government.

No reimbursement of the vaccine or supplies will be made for children under the age of 19. Only the administration fee will be reimbursed for these beneficiaries.

Bypassed Editing

Claims for select adult vaccines will process without edits for the 4 prescription limit, requirements to bill other insurance and Lock-In.

Copayments

Beneficiaries may not be charged co-payments for select adult vaccines.

NOTE: See Section 37.5.1 for the link to access the Point of Sale (POS) User Guide for detailed information regarding the submission of these claims.

Electronic Drug Clinical Inquiry (e-CDI)

Paid claims for administration fees will be posted on the Electronic Clinical Drug Inquiry (e-CDI). When Medicaid reimburses a pharmacy for an administration fee claim, the name of the vaccine and date of payment will be listed. This application is available on the Louisiana Medicaid website.

Vaccination Documentation

 For vaccine administration reimbursement, the pharmacist shall:

1.   Be registered with the Louisiana Board of Pharmacy with the "Authority to Administer" vaccines;

2.   Be registered as a Louisiana Medicaid provider;

3.   Inform the individual that the administration of an immunization or vaccine is not to be construed as being in lieu of an annual preventive visit with the individual's primary care or family physician;

4.   Access Louisiana Immunization Network Kids Statewide (LINKS) prior to immunization administration to verify appropriate utilization according to Advisory Committee on Immunization Practices (ACIP) to prevent duplication, unnecessary doses, inappropriate age, etc., if possible;

5.   Report each immunization to the Louisiana Department of Health (LDH), Office of Public Health's LINKS at the time of the immunization or as soon as reasonably practicable, thereafter;

6.   Report all adverse events observed or which are reported to the pharmacist to the Vaccine Adverse Events Reporting System, or its successor program; and further, the pharmacist shall refer the patient with an adverse event to appropriate medical care; and

7.   Request the name of a patient's primary care provider prior to the administering of any immunization. The pharmacist shall notify the primary care provider (PCP), by written or electronic communication, as soon as reasonably possible that the immunization was administered.

For COVID-19 Vaccines Only:

1.   Report certain data elements to the Centers for Disease Control and Prevention (CDC) for each COVID-19 dose administered within 24 hours of administration, as a vaccination provider;

2.   Pharmacy technicians and/or interns administering COVID-19 vaccines meet Public Readiness and Emergency Preparedness (PREP) Act qualifications;

3.   The qualified pharmacy technicians and/or state-authorized pharmacy interns act under the supervision of a qualified pharmacist; and

4.   The supervising qualified pharmacist of qualified pharmacy technicians and/or state-authorized interns must comply with CDC, state, and federal requirements for COVID-19 vaccine administration.

PATIENT COUNSELING AND DRUG UTILIZATION REVIEW

Federal and state laws and regulations require that pharmacists provide the pharmaceutical care services described below. The intent of the laws and regulations is to improve the quality of pharmaceutical care by ensuring that medications are appropriate, medically necessary and not likely to have adverse medical results.

The Pharmacy Program utilizes several different Drug Utilization Review (DUR) applications in its program that are either federally and/or state mandated.

In 1990 the federal Omnibus Budget Reconciliation Act (OBRA) amended the Social Security Act to include the specific requirement that states must administer a DUR Program with a DUR Board. OBRA 90 states that a drug use review program assures that prescriptions are appropriate, are medically necessary and are not likely to result in adverse medical results. In accordance with the Act and federal regulations, states are mandated to have a Medicaid DUR program with the goal, "…to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individual drug therapy." The federal DUR program's required components are:

1.   Beneficiary counseling;

2.   Prospective drug review;

3.   Retrospective drug use review;

4.   Educational program; and

5.   State DUR Board.

Patient Counseling

Patient counseling must be offered and provided in accordance with the Louisiana Board of Pharmacy Regulations at the Louisiana Administrative Code (LAC), 46:LIII, §517.

Components of Patient Counseling

In accordance with those regulations, the pharmacist, at a minimum, should be convinced that the beneficiary or caregiver is informed of the following:

1.   Name and description of the medications;

2.   Dosage form, dosage, route of administration and duration of therapy;

3.   Special directions and precautions for preparation, administration and use by the beneficiary;

4.   Common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required in the event of their occurrence;

5.   Techniques for self-monitoring drug therapy;

6.   Proper storage of the medication;

7.   Prescription refill information, if any; and

8.   The action to be taken in the event of a missed dose.

Exceptions to Counseling Requirement

Counseling is not required for inpatients of a hospital or institution where a nurse or other licensed health care professional is authorized to administer medications.

Waiver

According to the regulations, no pharmacist or pharmacy may solicit or encourage blanket waivers for patient counseling. However, the regulations do not prohibit the beneficiary or caregiver from declining patient counseling.

Prospective Utilization Review (UniDUR)

Prior to filling or refilling a prescription, the pharmacist must review the prescription and the patient record for therapeutic appropriateness.

If there is an indication of possible drug contraindications or abuse, the pharmacist must take appropriate action to resolve the issue(s).

UniDUR Features

UniDUR has the following features:

1.   UniDUR provides real-time screening of all Point of Sale (POS) prescription drug claims against the Louisiana Medicaid clinical database;

2.   UniDUR reports "clinical events" as defined by the Pharmacy Program. The events are based on extensive development research done by the program staff, contractors, fiscal intermediary (FI), University of Louisiana at Monroe (ULM) School of Pharmacy, and the DUR Board; and

3.   UniDUR provides an on-line response to a pharmacy within seconds of significant UniDUR events with the disposition of the claim.

How UniDUR Works

The UniDUR system accepts POS transactions from the Medicaid claims adjudication system and screens each prescription against a patient's prescription profile. The profile includes the beneficiary's active drug products, medical diagnosis profile, gender and age.

Screening occurs using one or more of the clinical screening modules that are based upon the clinical criteria defined by Pharmacy Program staff. The results of the screening are returned to the claims adjudication system in the form of clinical events. The system then completes the adjudication of the claim according to the program's established parameters and sends a response to the pharmacy.

Clinical Events

If a potential drug issue is identified, a clinical event is triggered, and the pharmacy will receive a UniDUR message. Prescriptions are screened for the following potential drug issues:

1.   Compliance Monitoring – refills too early or too late;

2.   Prescribing Limits – excessive or inadequate dosages, or duration of therapy;

3.   Therapeutic Duplication – 2 or more prescriptions with duplicative actions, whether prescribed by the same or different prescribers;

4.   Drug-Drug Interaction – drugs that should not be taken concurrently;

5.   Drug-Disease Precaution – specific drugs that may cause harm in beneficiaries with certain known medical conditions;

6.   Disease-Drug Precaution – diseases where specified drugs are suggested for use to deter disease progression or complications; and

7.   Pregnancy Precaution – drugs with high risk of fetal harm dispensed to childbearing women.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits" in Section 37.1 Covered Services, Limitations, and Exclusions of this manual chapter for detailed policy information.

Medicaid Responses to a Clinical Event

Depending on the severity of the clinical event, Medicaid may:

1.   Suppress the response to the pharmacy, but report it in aggregate to Medicaid staff;

2.   Return the response to the pharmacy for informational purposes, not require any action and pay the claim as submitted; or

3.   Return the response to the pharmacy, require the pharmacist to take appropriate action and report that action in the form of a claim override. Medicaid will deny payment if the pharmacist does not correctly override the claim.

Required Action

When a UniDUR response is received, the pharmacist must verify the information against the beneficiary's drug profile and current prescription, evaluate the conflict and decide whether or not to dispense the drug. Actions can range from conferring with the beneficiary and checking the beneficiary's profile to consulting with the prescriber.

If the message is "early refill" or "therapeutic duplication", the pharmacist must determine whether the prescription should be filled, refused or changed.

If the pharmacist or beneficiary is unaware of any conflicting prescriptions, the pharmacist may call the POS Help Desk for additional information on the UniDUR message. (See Section 37.5.4 for POS Help Desk contact number).

NOTE: Refer to Section 37.5.1 to access the POS User Guide and Section 37.1 Covered Services, Limitations, and Exclusions of this manual chapter for detailed information and instructions on the UniDUR feature of the LMPBM System.

Retrospective Drug Utilization Review

The federal retrospective DUR requirements recognize the functions of Medicaid Management Information Systems (MMIS) and Surveillance and Utilization Review (SUR) subsystems which were in effect prior to OBRA 1990. The regulations, therefore, permit states to *limit retrospective DUR review activities to those that focus on appropriate and medically necessary care to avoid duplication of activities relating to fraud and abuse under the SUR program.*

LaDUR

The retrospective drug utilization review program in Louisiana is called LaDUR. The Pharmacy Program, through a contract with the FI, Gainwell Technologies, administers LaDUR as a component of its DUR system.

The LaDUR program includes four regional committees, each comprised of 3 pharmacist providers and one physician provider located throughout the state, who conduct monthly reviews of Medicaid beneficiary's prescription profiles. (These reviews assess the possibility of underutilization, over-utilization or contra-indications of prescription therapy by querying a beneficiary's disease history and drug utilization). The committees correspond with beneficiary's prescribers and pharmacists regarding their observations in an effort to identify prescription therapies and utilization patterns that correspond to specified therapeutic criteria.

LaDUR's Enhanced Focus

LaDUR has been enhanced in recent years by shifting its focus from a fundamental review of therapeutic drug criteria based on a beneficiary's prescription utilization to the examination of a beneficiary's disease states.

Extensive technical programming enhancements have allowed identification of prescription use or absence within a disease state. This shifts the program's focus from issues of over-utilization and drug duplication to a disease management focus. For example, clinical practice guidelines from

the American Diabetes Association were reviewed by the DUR Board to develop standards for LaDUR.

Drug Utilization Review Board

The federal OBRA '90 statute requires each state to establish a DUR Board. The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) has established a DUR Board to assist the agency in assessing its DUR Program.

DUR Board Functions

The Board should:

1. Make recommendations and approve predetermined criteria established in retrospective DUR and prospective DUR;

2. Evaluate the use of predetermined criteria and standards in use and make recommendations to the BHSF concerning modification or elimination of existing predetermined criteria and standards or the adoption of new ones;

3. Recommend guidelines governing written predetermined criteria and standards that pharmacies not using approved software must use in performing prospective DUR;

4. Identify educational topics to improve prescribing and dispensing practices;

5. Make recommendations regarding interventions to improve quality of drug therapy;

6. Periodically re-evaluate educational interventions;

7. Be a knowledgeable group, dedicated to assisting the agency in the administration of its DUR Program in an advisory capacity; and

8. Prepare an annual report.

LaDUR Board Membership

Federal statute specifies the general board membership.

The membership of the DUR Board shall consist of at least one-third, but not more than 51 percent, licensed and actively practicing physicians, and at least one third licensed and actively practicing pharmacists.

The committee shall be composed of at least 8 members (or approved designees) appointed by the secretary of LDH.

The committee shall consist of healthcare professionals who have recognized knowledge in:

1.   Clinically appropriate prescribing of covered outpatient drugs;

2.   Clinically appropriate dispensing and monitoring of covered outpatient drugs;

3.   Drug use review, evaluation, and intervention; and

4.   Medical quality assurance.

LOCK-IN PROGRAM

The Lock-In Program is designed to educate beneficiaries who may be misusing program benefits and to ensure that program funds are used to provide optimum healthcare services for beneficiaries. Beneficiaries who misuse or over-utilize pharmacy and physician benefits may be restricted to the use of:

1.   One pharmacy and/or specialty pharmacy;

2.   One physician; and

3.   Up to 3 specialists, if needed, for Physician-Pharmacy Lock-In.

In addition, beneficiaries may be restricted to one pharmacy and/or specialty pharmacy provider (for Pharmacy Only Lock-In). Claims written by dental prescribers are exempt from Lock-In edits.

Choosing a Lock-In Provider

A Medicaid beneficiary loses their freedom of choice of providers when selected for enrollment in the Lock-In program. A Lock-In beneficiary must choose the following as their Lock-in providers:

1.   One primary care physician (PCP) provider;

2.   Up to 3 specialist(s) when warranted; and

3.   One pharmacy provider and/or specialty pharmacy if needed.

Only physicians can prescribe medications for Lock-In beneficiaries. Approval of selections is required from the Louisiana Medicaid Pharmacy Program.

Under most circumstances, beneficiaries with providers listed under the Lock-In segment of Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) are restricted to receiving physician and pharmacy services from these providers.

The Lock-In system affects the beneficiaries only in the areas of physician and pharmacy services. Services other than physician or prescription drug services may be rendered to eligible beneficiaries without Lock-In restrictions.

If a beneficiary chooses to change Lock-In provider(s) or add a specialist, the beneficiary must contact the Lock-In Unit. If a provider chooses to no longer be a beneficiary's Lock-In provider, the provider should contact the Lock-In Unit. (See Section 37.5.4 for contact information).

Specialist

The beneficiary may add up to 3 specialist providers when their medical condition warrants treatment by a specialist.

Infusion Pharmacy

In special circumstances, a beneficiary may need the services of an infusion pharmacy and is allowed to add a second pharmacy to bill intravenous medication only.

Lock-In Emergencies

Providers not named on the Lock-In segment accessed through MEVS or REVS can provide services; however, no payment will be made to these providers. The Bureau of Health Services Financing (BHSF) recognizes that there will be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In beneficiary when the provider is not named on the eligibility file on REVS or MEVS. Payment will be made to any physician or pharmacist enrolled in Louisiana Medicaid who grants services to a Lock-In beneficiary in emergency situations, or when life-sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed. These claims should be submitted electronically with an emergency override.

The notation "Emergency Prescription" or "Discharge Prescription" must be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist.

NOTE: Refer to Section 37.5.1 for a link to access the point of sale (POS) User Guide for detailed information regarding submission of these claims.

Referrals

There may be circumstances under which it is necessary for a Lock-In physician to refer the Lock-In beneficiary for consultation with another physician on a short term basis. (The consulting physician may be reimbursed for the consultation if that consulting physician enters the name and provider number of the referring Lock-In physician in the Referring Physician block on the claim).

Prescriptions written by the consulting physician will deny when submitted by the Lock-In pharmacy. These prescriptions may be rewritten or authorized by one of the beneficiary's Lock-In physicians. The pharmacist should submit these prescription claims with the authorizing Lock-In physician's Medicaid provider number.

MEDICAID DRUG REBATE PROGRAM

Rebate Programs

The Pharmacy Program administers the federally mandated drug rebate program and the State Supplemental Drug Rebate Program for Louisiana's Medicaid Program. The Pharmacy Program contracts with the University of New Orleans (UNO) to operate both drug rebate programs.

Pharmacists must bill the actual national drug code (NDC) of the drug dispensed to ensure that the rebate paid by the drug manufacturer is correct.

Manufacturers are allowed to audit utilization data of both rebate programs. The Pharmacy Program also audits this data to ensure accurate provider billing as this data is used to calculate the rebate amounts. Providers may be contacted by rebate staff in an effort to resolve rebate disputes with the manufacturers. Providers must respond to the auditor's request for information.

The state supplemental and federal unit rebate amounts are confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

Federally Mandated Drug Rebate Program

The federally mandated drug rebate program is one of the provisions included by Congress in its budget bill, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). It is the result of Congress' attempt to reduce and control federal and state expenditures for prescription drug products provided to Medicaid patients and to eliminate discriminatory pricing.

The law requires a drug manufacturer to enter into, and have in effect, a national rebate agreement with the Secretary of the Department of Health and Human Services (DHHS) for states to receive federal funding for outpatient drugs dispensed to Medicaid patients.

The drug rebate program is administered at the national level by the DHHS Centers for Medicare and Medicaid Services (CMS)' Center for Medicaid and State Operations (CMSO).

State Supplemental Drug Rebate Program

Louisiana Medicaid's State Supplemental Drug Rebate Program provides state and manufacturer contracted rebates in addition to those received through the federally mandated rebate program.

Effective October 1, 2004, CMS authorized the state to expand its supplemental rebate program and enter into a Multi-State Pooling Supplemental Rebate Agreement (SRA) with the intent of increasing efficiency and economy in the Medicaid program.

The state separately reports the supplemental rebate agreements to the Secretary of DHHS.

THIRD PARTY LIABILITY/COORDINATION OF BENEFITS

This section describes the Pharmacy program's policy regarding beneficiaries who have other third party resources that can be applied to their pharmacy expenses.

Third Party Liability

Federal regulations and applicable state laws require that third party resources be used before Medicaid is billed, as Medicaid by law, is intended to be the payor of last resort. Third party liability (TPL) refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the Medicaid beneficiary's medical and health expenses.

Coordination of Benefits

Providers are able to coordinate benefits or "split-bill" pharmacy claims through the Medicaid Point of Sale (POS) system. Providers must bill beneficiaries' primary insurance companies before billing Medicaid. Medicaid will reimburse providers for the beneficiary's responsibility of coinsurance, co-payments and/or deductibles with other insurance companies up to the maximum Medicaid allowed amount. This will be accomplished by Medicaid payment of the outstanding balance remaining after the payment by the primary payor has been deducted from the maximum Medicaid allowed amount. Medicaid co-payments should still be collected, if applicable.

Pharmacy Providers' Roles

The provider should inquire if the beneficiary has private insurance coverage with prescription benefits. This information is entered in the beneficiary's profile of the pharmacy's software. When a pharmacy claim is filled, it is submitted to the primary insurance company(ies). The other payor's paid amount should be submitted on the pharmacy claim to Medicaid.

Pharmacy claims billed to Medicaid first, when drug coverage with another insurance company is noted on the beneficiary's resource file and with no indication that the applicable private insurance has been previously billed, will deny.

Providers must log into the Louisiana Medicaid website to view the Medicaid Eligibility Verification System (MEVS). Providers may view the beneficiary's other insurance company and Medicaid carrier code number.

Valid insurance coverage may differ from what is on the beneficiary's resource file. Pharmacy providers must enter the correct coverage and coordinate benefits. Providers may contact the Louisiana Department of Health's (LDH) TPL Unit with updated traditional Medicare insurance coverage. (See Section 37.5.4 for Contact Information).

Urgent TPL requests are defined as the inability of a beneficiary to have a prescription filled or the inability of a beneficiary to access immediate care because of the incorrect third party insurance coverage.

Urgent private insurance and Medicare Advantage Plan update requests for beneficiaries enrolled in a Healthy Louisiana plan for pharmacy and medical benefits must be submitted to the beneficiary's Healthy Louisiana plan.

Urgent private and urgent Medicare Advantage Plan update requests for beneficiaries whose Pharmacy benefit is paid by fee-for-service Medicaid must be submitted to LDH's TPL contractor, Health Management Systems, Inc. (HMS).

NOTE: See Section 37.5.1 – Forms and Links of this manual chapter for the POS User Guide for claim submission details.

Coordination of Benefits Exemptions

Certain conditions exist that are exempt from coordination of benefits and Medicaid is mandated to pay and chase claims. A pharmacy provider may override the coordination of benefits edit when:

1. Medicaid beneficiary has court ordered medical child support;

2. Pharmacy claims are deemed preventative care for individuals under age 21; and

3. Pharmacy claims are deemed preventive care for pregnant women.

NOTE: Documentation of court ordered medical child support or preventative care on the hard copy prescription or in the pharmacy's electronic recordkeeping system by the pharmacist is required for the above circumstances.

Exemptions to Medicaid Program Restrictions

Certain restrictions will be by-passed. Claims that are coordinated with primary insurance companies will process without edits for:

1.   Prior authorization (PA);

2.   Prescription monthly limit of 4; and

3.   Orlistat (the age edit will still apply).

Claims for Beneficiaries with Multiple Insurance Coverage

Some beneficiaries have one or more insurance companies for prescription coverage. The pharmacy should coordinate payment with other insurance companies prior to billing Medicaid, as Medicaid is the payor of last resort.

Override Capabilities and Codes

Override capabilities exist to allow providers to process claims and receive payment when a beneficiary would be delayed in receiving their prescriptions.

NOTE: See Section 37.5.1 – Forms and Links of this manual chapter for the POS User Guide for detailed billing information.

The Pharmacy program monitors pharmacy providers' usage of override codes. Corrective actions will be offered to better utilize the coordination of benefits process.

Override codes should be used under the following conditions:

1.   No other coverage:

   a.   Pharmacy submits claim to other insurance company. Claim denies due to coverage expired. Pharmacist inquires of beneficiary regarding other insurance coverage. Beneficiary does not have, or cannot supply the pharmacy with other insurance information; or

   b.   Pharmacy submits claim to other insurance company. The other insurance company does not include a pharmacy benefit. Pharmacist asks beneficiary for other insurance coverage, but beneficiary has none.

2.   Other coverage billed - claim not covered: Pharmacy submits claim to other payor. The other payor denies the claim due to non-coverage of drug.

3.   Other coverage exists - payment not collected:

   a.   Beneficiary has insurance coverage (ex. 80/20 insurance) which requires the beneficiary to pay for the prescriptions, then the insurance company would reimburse the beneficiary a certain percentage of the claim;

   b.   Pharmacy submits claim to other payor. The beneficiary must meet a deductible before benefits pay for pharmacy claims. The other payor applies the claim to the beneficiary's deductible for the other insurance. The provider then submits the usual and customary charge to Medicaid;

   c.   Beneficiary has court ordered medical child support:

   d.   Preventative care for a beneficiary under the age of 21 or a woman who is pregnant;

   e.   Pharmacy submits claim to other insurance company. The other insurance company is a mail-order only company;

f.   Beneficiary has other insurance coverage. The pharmacy claim requires PA from the other insurance. The PA process shall be commenced by the provider. Should the access of the beneficiary's prescription be delayed due to the PA process, the pharmacy may submit the claim to Medicaid with the above other coverage code. However, once the PA is acquired, the claim must be reversed and coordinated with all insurance carriers with Medicaid as last payor; or

g.   Beneficiary has insurance coverage, but the pharmacy and/or physician is out of the insurance company's network.

TPL Carrier Code List

Private insurance companies are assigned a unique Louisiana carrier code. Pharmacy providers are asked to submit the TPL carrier code when coordinating claims for payment with a primary payor. For additional information, refer to "Third Party Liability" in Chapter 1 of the *Medicaid Services Manual*, and Section 37.5.15 of this manual chapter.

NOTE: The TPL Carrier Code List can be accessed at:
https://www.lamedicaid.com/apps/TPLCarrier/CodeSearch.aspx