37.5 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

Provided in this Section are the terms and conditions under which prescription services will be paid by Medicaid of Louisiana and a description of the authorized benefits for eligible recipients.

In This Section

This Section contains:

37.5.1 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.

Note: Refer to Section 37.4 for Prescribers for detailed information.

Eligible Recipients

Louisiana Medicaid will only reimburse pharmacy claims when the recipient is eligible on the date of service. Pharmacy claims submitted with a date of service after a recipient's date of death are not allowed.

Note: Refer to Section 37.3 Medicaid Recipient Eligibility for detailed information.

Rebate Agreements

In accordance with Section 4401 of the **Omnibus Budget Reconciliation Act of 1990 (OBRA 90)**, Louisiana Medicaid will pay only for those drug products for which the pharmaceutical company has entered into a rebate agreement with the U. S. Department of Health and Human Services. Provided in **Appendix C** at the end of this manual is a listing of pharmaceutical companies which have entered into an agreement with the federal government. This appendix is updated periodically and is posted at www.lamedicaid.com. Providers should take note of the effective dates of the labeler codes.

Louisiana Medicaid will provide coverage for only those drug products labeled by the pharmaceutical companies that are identified in **Appendix C.** The therapeutic categories, e.g., cough and cold preparations, anorexics and cosmetic drugs, will remain non-payable. The limited over-the-counter items covered by Medicaid are payable only if the manufacturer for the drug is listed in **Appendix C.**

Note: As new pharmaceutical companies enter into rebate agreements, labeler codes will be added, and the updated information will be mailed to providers via remittance advice messages and added to the website.

Medically Accepted Indications

To be reimbursed by Medicaid, a drug must be medically necessary and prescribed for medically accepted indications.

As defined by OBRA 93, the term "medically accepted indication" means any use for a covered outpatient drug which is approved 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* 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 are not likely to result in adverse medical results. The DUR program must include prospective drug review, retrospective drug review, and an educational program. **Note:** Refer to Section 37.16 as well as this Section for detailed information regarding DUR.
Patient Counseling	The Louisiana Board of Pharmacy's regulations require patient counseling, patient profiles, and prospective drug review, in accordance with OBRA 90. **Note:** Refer to Section 37.16 for detailed information.
Prescription Duration	Program policy requires that prescriptions shall be filled within six months of the date issued including Schedule II narcotic analgesics.
Prescription Transfers	Transfer of a prescription from one pharmacy to another is allowed if less than 6 months has passed since the issued date of the prescription if the transfer is done in accordance with the Louisiana Board of Pharmacy regulations.
Date of Service	Claims shall be submitted for the date of service the prescription was dispensed.
Prescription Refills	Refills can be provided if they are authorized specifically by the prescribing practitioner. However, no prescription may be refilled more than five times or more than six months after the date issued.
National Drug Code	The 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. However, providers must file and log these prescriptions as they would any other written prescriptions.

37.5.2 TAMPER RESISTANT PRESCRIPTION POLICY

Written, non-electronic prescriptions for Medicaid recipients are required to be tamper-resistant.

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

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form,
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber and
- 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 the Louisiana Medicaid 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: Refer to Appendix L Table of Tamper Resistant Prescription Criteria and Examples and to www.lamedicaid.com for detailed information.

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.

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.

Recipients with Retroactive Eligibility

When a recipient has retroactive eligibility, pharmacies are not required to obtain compliant prescriptions for the period of retroactive eligibility. However, the pharmacy must obtain a tamper-resistant prescription for any refills after the date of eligibility.

37.5.3 AUTHORIZED BENEFITS

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

Note: Refer to Section 37.5.8 Quantity Limitations and Section 37.6 Reimbursement for Services for detailed information.

Legend Drugs

The Medicaid Pharmacy program reimburses for most legend drugs that are dispensed by community pharmacies and used in outpatient settings. Legend drugs are drugs that require a p rescription or that have the following statement on the label, "Caution: Federal law prohibits dispensing without a prescription."

Note: Refer to Section 37.5.3 Non-Covered Services for the legend drugs that Medicaid does not reimburse.

Legend Vitamin and Mineral Products

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

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

Injectable Drugs

Medicaid Pharmacy Program reimburses for most injectable drugs for outpatient recipients when supplied by community pharmacies, long term care pharmacies, and home infusion pharmacies that are enrolled as Medicaid providers.

Some injections administered in practitioners offices and clinics are reimbursed through the physicians' 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:

- Insulin;
- Sodium chloride solution for inhalation therapy;
- Contraceptives, topical;
- Urinary pH modifiers; and
- Other non-legend drugs that have Medicaid Pharmacy Program approval.

Non-Legend Items and Supplies

Only a limited number of non-legend items and supplies can be reimbursed by the Louisiana Medicaid program. For reimbursement, these items and supplies must be prescribed by licensed practitioners. **Providers must bill the NDC from the actual package dispensed.**

- OTC Vitamin D preparations;
- OTC Vitamin E preparations;
- OTC Niacin preparations;
- OTC Calcium replacement agents;
- OTC Magnesium replacement agents;
- OTC Phosphate replacement agents;
- OTC Iron replacement agents;
- Normal saline and heparin flushes;
- Disposable needles and syringes used to administer insulin;
- Test strips for determining blood glucose levels;
- Lancets;
- Urine test strips (e.g., Clinitest® and Clinistix®);
- Family planning items; and
- Other non-legend items and supplies that have Medicaid Pharmacy program approval.

Total Parenteral Nutrition	Total Parenteral Nutrition and associated supplies and equipment are covered services in the pharmacy program. **Note:** Refer to Section 37.12 Total Parenteral Nutrition for detailed information.
Medication Administration	Enrolled pharmacies may be reimbursed for the administration of the influenza vaccine. Pharmacists who have the Authority to Administer authorized by the Louisiana Board of Pharmacy may administer the vaccine. **Note:** Refer to Section 37.14 Medication Administration for detailed information.

37.5.4 NON-COVERED SERVICES

Drugs Excluded From Coverage

The Medicaid program excludes the following drugs and/or therapeutic categories from coverage:

- Anorexics – Medicaid does not reimburse for anorexics with the exception of orlistat;
  Note: Refer to Section 37.5.6 for program restrictions.
- Compounded prescriptions (mixtures of two or more ingredients; the individual drugs will continue to be reimbursed);
- Cosmetic drugs;
- Cough and cold preparations;
- 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;
- Erectile dysfunction drugs
- Experimental drugs;
- Fertility drugs when used for fertility treatment;
- Medications which are included in the reimbursement to a facility, i.e. hospitals, skilled nursing facility for recipients receiving benefits under Part A of Title XVIII, mental hospitals, or some other nursing facilities;
- Narcotics prescribed only for narcotic addiction;
- Non-legend or OTC drugs or items with some exceptions; and
  Note: Refer to Section 37.5.2 Authorized Benefits for exceptions.
- Vaccines covered in other programs.

Durable Medical Equipment/Supplies Excluded	Durable medical equipment and supplies, other than those included in this Section under Authorized Benefits 37.5.2, are not covered in the pharmacy program. These items are covered in the Durable Medical Equipment Program and must be billed to that program. **Note:** Refer to Chapter 18 Durable Medical Equipment of the Louisiana Medicaid Program Provider Manual for specific information on this program.

37.5.5 PRIOR AUTHORIZATION AND PREFERRED DRUG LIST

The Medicaid program administers a p rior authorization process for services in its Pharmacy Benefits Management System.

This process utilizes a preferred drug list (PDL) for selected therapeutic classes. Drugs included on the PDL are automatically prior authorized. Drugs in these classes that are not included on the PDL require prescribers to obtain prior authorization.

PDL Provider Notification	Providers are notified of the drugs selected for placement on the PDL by therapeutic classes prior to implementation of the prior authorization process and as additional drugs are subsequently added to the list. Lists of covered drug products, including those that require prior authorization, will be provided by either the Louisiana Medicaid website or provider notices.
Prior Authorization Process General Information	The Prior Authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four (24) hours of receipt of a prior authorization request. In emergency situations, providers may dispense **at least** a seventy-two (72) hour or a three (3) day supply of medication
Prior Authorization and PDL Information Site	Information is available on the Louisiana Medicaid Website at www.lamedicaid.com.

Who Can Obtain Prior Authorization

The prescribing practitioner is responsible for obtaining prior authorization. Pharmacist or recipient calls/requests will not be accepted. The prescribing practitioner must have and provide his/her valid individual Louisiana Medicaid prescribing provider number to obtain prior authorization. Only individual provider numbers will be accepted. The prescribing practitioner may obtain the PA by telephone, facsimile or mail.

Phone: 1-866-730-4357
Fax: 1-866-797-2329 – Do not send a cover sheet with the facsimile

Mail: ULM
College of Pharmacy
1800 Bienville Dr.
Monroe, LA 71201-3765

The hours of operation for the ULM Prior Authorization Unit are 8am to 6pm Central Time, Monday through Saturday.

Note: If a prescribing practitioner does not have an individual prescriber number, refer to Section 37.4 Prescribers for detailed information.

Prior Authorization Request Form

A facsimile of Form RXPA is found as Appendix F. It can also be found at www.lamedicaid.com.

Emergency Procedures

Prescriptions indicating emergency situations shall be dispensed in a MINIMUM quantity of a three (3) day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.** The recipient's practitioner must contact the Prior Authorization Unit 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 Prior Authorization Unit is closed (Sundays; Monday – Saturday before 8am and after 6 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: Refer to Appendix D Point of Sale User Guide for detailed claim submission information.

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

DHH will monitor emergency prescriptions/recipients on an ongoing basis through management reports, pharmacy provider audits, and other monitoring programs to review the number of these prescriptions and the reasons for them.

Hospital Discharge Prescriptions for Atypical Antipsychotic Agents

When a recipient 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 hard copy, that the prescription is a "Hospital Discharge" or 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 prior authorization (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 recipient's practitioner must contact the Prior Authorization 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 prior authorization process does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to a drug's effective date of prior authorization. Refills of prescriptions issued prior to an effective PA date will not be impacted as long as they are within the five refills and six-month program limits.

Recipients with Retroactive Eligibility

Drugs that are not on the preferred drug list are sometimes dispensed to patients who are awaiting Medicaid eligibility determinations. The Medicaid Pharmacy Program will reimburse pharmacy providers for these claims when the date of service falls within the recipients' retroactive time period. A Medicaid recipient's retroactive time period is defined as the time period between the first date of eligibility and the date that the recipient's eligibility is placed on the Medicaid recipient file. Pharmacy providers shall submit these claims electronically.

Important Facts

Should a recipient elect to self-pay for an original prescription which requires a PA, then attempts to have Medicaid pay for a refill of this prescription, this pharmacy claim will deny.

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

An approved prior authorization 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 prior authorization process does not verify recipient Medicaid eligibility. It only verifies that the recipient is "on file" (i.e., has a valid Medicaid ID number on file – not that the recipient is eligible on the date of service). Recipient eligibility will continue to be verified by the Pharmacy POS subsystem or through the MEVS or REVS automated recipient eligibility systems.

Only practitioners' individual prescriber numbers are accepted to request prior authorization 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.

37.5.6 MONTHLY SERVICE LIMIT

Limit

Medicaid reimburses up to four (4) prescriptions per calendar month per recipient. Claims including those for emergency prescriptions and prior-authorization prescriptions that are in excess of four per calendar month per recipient will deny.

Exceptions to Limit

The following federally mandated recipient groups are exempt from the four prescriptions per calendar month limitations:

- Persons under twenty-one years of age;
- Persons who are residents of long-term care institutions, such as nursing homes and ICF/DD facilities; and
- Pregnant women.

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 in his own handwriting or by telephone or other telecommunications device:

- "Medically necessary override;" and
- A valid ICD-9-CM Diagnosis Code that directly relates to each drug prescribed that is over the four prescription limit (an ICD-9-CM literal description is not acceptable).

The prescriber should use the Electronic Clinical Drug Inquiry found at www.lamedicaid.com in his/her clinical assessment of the patient's disease state or medical condition and the current drug regime before making a determination that more than four prescriptions per calendar month is required by the recipient.

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

An acceptable statement and ICD-9-CM are required for each prescription in excess of four for that month.

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

Note: Refer to Appendix D the Point of Sale User Guide for detailed billing instructions.

37.5.7 DRUGS WITH SPECIAL PAYMENT CRITERIA/LIMITATIONS

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

Note: Refer to Appendix D the Point of Sale User Guide for detailed billing instructions and Section 37.9.5 for detailed override information where applicable.

Age and Gender Restricted Drugs

Certain drugs have age and gender restrictions placed on them. Manufacturer guidelines are followed. (i.e. – Oral contraceptives are indicated for females aged 12 – 55.) For further assistance, providers should contact the Medicaid Pharmacy Benefits Management Section at 225-342-9768.

Amphetamines

Pharmacy claims for amphetamine drug products, when prescribed for Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and narcolepsy will be reimbursed when the policy for coverage is followed.

Age limitations for most amphetamines are from three years old to twenty-one years old. When a FDA approved indication exists for an amphetamine product for ages greater than twenty-one, that product is covered when a diagnosis of ADD, ADHD or narcolepsy is submitted with the pharmacy claim. For those products which do not have a FDA approved indication for ages greater than twenty-one, only a diagnosis of narcolepsy is acceptable.

The prescription must be **hand-written** with the prescribing practitioner's written statement of the medically accepted indication for the drug. The ICD-9-CM diagnosis code is required in the claim submission.

The ICD-9-CM diagnosis codes are as follows:

ICD-9-CM Code	Description
314.00	ADD
314.01	ADHD
347	Narcolepsy

This documentation shall be retained by the pharmacy provider as evidence of compliance with program policy and readily retrievable when requested by the pharmacy audit staff.

Antihistamine/ Decongestant Products

Prescribed single-entity antihistamines are covered for all recipients. Antihistamine-decongestant combinations are covered for all recipients when prescribed for the medically approved indication of allergic rhinitis (seasonal or perennial).

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.

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for policy regarding second generation antihistamines and combination agents included in the therapeutic duplication edit.

Antipsychotic Agents (Typical and Atypical)

Prescriptions for typical and atypical antipsychotic agents require appropriate ICD-9-CM diagnosis codes documented on all new prescriptions.

The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The ICD-9-CM code may be communicated to the pharmacist electronically or via telephone or facsimile. The ICD-9-CM diagnosis code is required for the claim submission.

Acceptable ICD-9-CM diagnosis codes are as follows:

ICD-9-CM Code	Description
290.0 – 319.9	Mental Disorders
781.0	Abnormal Involuntary Movements

If the prescriber does not indicate a diagnosis code, and the pharmacist determines the patient cannot wait to receive the medication, the pharmacy provider may override the denial. The pharmacist must document "Emergency" on the hard copy prescription. Additionally, the pharmacist must document the reason for the emergency.

Antipsychotic agents are also subject to Prospective Drug Utilization Reviews when a third antipsychotic agent is submitted for payment. Atypical antipsychotic agents exceeding maximum recommended doses will also deny.

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits; Therapeutic Duplication for further policy.

Buprenorphine Agents (Suboxone® and Subutex®)

Prescriptions for Buprenorphine Agents (Suboxone® and Subutex®) are reimbursed only when the following criteria are met:

- The prescriber is a physician;
- The physician has an X DEA number;
- The prescriber is licensed to prescribe Suboxone® and Subutex® and has provided a copy of his/her current Controlled Substance Registration Certificate indicating the X DEA number and a copy of a Provider Enrollment File Update Form to Provider Enrollment at 1-225-216-6370;
- Refills for Suboxone® and Subutex® are not allowed;
- Concurrent prescriptions for opioid analgesics and/or benzodiazepines are only reimbursed when written by the same physician who prescribed Suboxone® and Subutex®;
- Patients must be sixteen years of age or older;
- Prescriptions for Suboxone® are allowed a maximum daily dose of 24mg/day; and
- Prescriptions for Subutex® are allowed a maximum daily dose of 16mg/day.

Prescriptions for buprenorphine agents require an appropriate ICD-9-C diagnosis code documented on the hard copy prescription after written or verbal consultation with the physician. The diagnosis code is required for the claim submission.

Acceptable ICD-9-CM diagnosis codes are as follows:

ICD-9-CM Code	Description
304.0 through 304.03	Opioid Type Dependence
304.7 through 304.73	Combinations of Opioid Type Drug with Any Other

Buprenorphine Agents are also subject to Prospective Drug Utilization Reviews when concurrent opioid analgesics (including Suboxone® and Subutex®) are written by the same physician

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits; Therapeutic Duplication for further policy as well as Appendix D Point of Sale user Guide for detailed billing information.

Buprenorphine Transdermal Patches (Butrans®)

Pharmacy claims for Buprenorphine Transdermal Patches (Butrans®) require an appropriate ICD-9-CM diagnosis code for reimbursement. The diagnosis code must be written on the hardcopy prescription by the prescribing practitioner or by the pharmacist after consultation with the prescriber. Claims submitted without a diagnosis code or with a diagnosis code related to the management of addictive disorders or substance abuse will deny.

There is no provision to override the denial when the diagnosis code is related to the management of addictive disorders or substance abuse. When the prescribing provider does not indicate a diagnosis code on the prescription and when the prescriber cannot be reached, a denial for a missing diagnosis code may be overridden if the pharmacist determines that the recipient cannot wait to receive the medication.

When the cumulative daily dosage for Buprenorphine Transdermal Patches (Butrans®) exceeds the maximum daily dosage, the claim will deny. The maximum daily dosage for this agent is 480 mcg/24hr (20mcg/hr). Do not exceed a dose of one 20mcg/hr buprenorphine patch. See prescribing information. Each patch is intended to be worn for seven days.

There is no provision for override through the Point of Sale system for Buprenorphine Transdermal Patches (Butrans®) when the maximum daily dosage is exceeded.

Carisoprodol

Pharmacy claims for carisoprodol will deny when the quantity exceeds ninety (90) tablets per rolling ninety (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**.

ContraceptiveAgents

DROSPIRENONE/ETHINYLESTRADIOL/LEVOMEFOLATE CALCIUM (BEYAZ®)

Pharmacy claims for Drospirenone/Ethinyl Estradiol/Levomefolate Calcium (Beyaz®) require an appropriate ICD-9-CM diagnosis code for reimbursement. Claims submitted with diagnosis codes for cosmetic indications will deny.

ETONOGESTREL/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 days supply.

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

- If quantity = 1, then Days Supply must be 21 to 28,
- If quantity = 2, then Days Supply must be 42 to 56,
- 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: Refer to Appendix D Point of Sale User Guide for detailed billing information.

MEDROXYPROGESTERONE ACETATE INJECTABLE

Prescription claims for Medroxyprogesterone Acetate injectable for a days supply less than 84 with a bill quantity of one for female recipients 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 days supply.

Claims for Medroxyprogesterone Acetate sub-q 104 injectable for a days supply less than 84 with a bill quantity of 0.65 for female recipients will also 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 days supply.
Pharmacists are allowed to override the denial on days supply after consultation with the prescriber.

Note: Refer to Appendix D Point of Sale User Guide for detailed billing information.

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NORELGESTROMIN/ETHINYL ESTRADIOL TRANSDERMAL PATCHES (ORTHO-EVRA®)

Reimbursement of these contraceptive transdermal patches when dispensed using the package size of three (3) 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.

Diabetic Testing Supplies

The Medicaid Pharmacy Program reimburses claims for prescribed diabetic testing supplies.

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

Diabetic supplies and glucometers for long term care recipients are not covered in the Medicaid Pharmacy Program or through prior authorization because they are covered in the nursing home per diem rate.

It is allowable for Medicare Part B to be billed if the long term care recipient 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 fiscal intermediary will automatically deny any crossover claims for diabetic supplies for long term care recipients.

Note: Refer to Section 37.7 Medicare Prescription Drug Coverage for detailed information.

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. If prescriptions for these products are prescribed for any indications other than infertility, the physician shall certify the indication, in his own handwriting, on the prescription. In order for the pharmacist to be reimbursed for the product, a hard copy claim along with a copy of the original prescription will have to be submitted to the fiscal intermediary for processing indicating a diagnosis other than infertility.
Isotretinoin	Isotretinoin capsules will be covered only if a handwritten prescription signed by the prescribing practitioner, with no provisions for refills, is submitted.
Ketorolac	Pharmacy claims for oral forms of ketorolac will deny for a quantity greater than twenty (20) or the days supply is greater than five (5) days as exceeding the program's maximum allowed. The pharmacist may override the denial after consultation with the prescriber. The prescriber must supply the ICD-9-CM diagnosis code and the rationale for using greater than a five days supply of ketorolac. The ICD-9-CM diagnosis code is required for the claim submission. **Note:** Refer to Appendix D Point of Sale User Guide for detailed billing information.
Nicotine Transdermal Patches,Gum and Spray	Nicotine transdermal patches, nicotine polacrilix gum, and nicotine spray are covered only with a handwritten prescription signed by the prescribing practitioner. There are no provisions for refills. The physician will need to rewrite a prescription each time. Also, physicians must certify, in their own handwriting, either directly on the prescription or on an attachment to the prescription that the recipient is enrolled in a **physician-supervised** behavioral program in order for Medicaid to provide coverage for nicotine adhesive patches, gum and spray. Pharmacy providers should verify that the above noted documentation is written on or attached to the prescription when the prescription is dispensed. This information must be retained by the pharmacy as evidence of compliance with program policy, and it must be readily retrievable when requested by audit staff.
Orlistat	Medicaid will provide reimbursement to outpatient pharmacies for orlistat prescriptions based on the following criteria: • An authorized prescriber has hand written the prescription - no facsimiles allowed; • Patient is twelve years of age or older; • Only original prescriptions—no refills are allowed; • Maximums of ninety (90) capsules **and** thirty (30) days supply;

- Patient has a documented current body mass index (BMI) of twenty-seven (27) or greater and the prescriber had identified the BMI, in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription;
- Patient has other risk factors warranting the use of Orlistat and the prescriber has identified an approved **ICD-9-CM diagnosis code** in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription; and
- No provisions for override of the prospective drug utilization edits, i.e., early refill (ER) and duplicate drug (ID) editing.

The following risk factors, as identified by ICD-9-CM **numeric codes only**, are acceptable:

ICD-9-CM Code	Description
250.00 through 250.93	Type II Diabetes
271.3	Impaired Glucose Tolerance
251.0 through 251.2	Hyperinsulinemia
272.0 through 272.4	Dyslipidemia
401.00 through 405.99	Hypertension
410.00 through 414.99	Ischemic Heart Disease
429.2	Cardiovascular Disease, unspecified
440.00 through 440.90	Atherosclerosis
443.00 through 443.90	Other peripheral vascular diseases
530.11 and 530.81	Gastric Reflux Disease
715.05 through 715.97	Osteoarthritis of Hips/Knees
780.51, 780.53 and 780.57	Sleep Apnea
430.00 through 438.99	Cerebrovascular Disease
348.2	Pseudotumor cerebri
454.2	Varicose Veins of the lower extremities with ulcer and inflammation
451.0	Phlebitis & Thrombophlebitis of the superficial vessels of the lower extremities
451.11	Phlebitis & Thrombophlebitis of the femoral vein
451.19	Phlebitis & Thrombophlebitis of other deep vessels
451.2	Phlebitis & Thrombophlebitis of lower extremities, unspecified
454.0	Varicose veins of lower extremities, with ulcer
454.1	Varicose veins of lower extremities, with inflammation
454.9	Varicose veins of lower extremities, without mention of ulcer & inflammation

The prescriber identified ICD-9-CM diagnosis code must be included in the claim submission. The required supporting documentation for coverage must be retained by the pharmacy as evidence of compliance with program policy, and it must be readily retrievable when requested by audit staff.

Palivizumab (Synagis®)

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

- Dates of service are within the Respiratory Syncytial Virus (RSV) season;
- Synagis® therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on Novernber 1st of the RSV season;
- Claims for Synagis® will only process for payment every twenty-eight (28) days;
- A maximum of five (5) doses of Synagis® will be reimbursed each RSV season;
- An appropriate ICD-9-CM diagnosis code must be documented on the hardcopy prescription after written, electronic or verbal consultation with the prescribing practitioner.

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits, and Appendix D the Point of Sale User Guide for detailed claims filing instructions.

RSV Season

Synagis® claims with dates of service outside of RSV season will deny. The RSV season in Louisiana may vary depending on the geographic location. Louisiana's RSV activity may be followed during the RSV season by frequently accessing the website http://www.cdc.gov/surveillance/nrevss/rsv/state.html. The RSV season begins November 1st and ends March 31st.

Claims billed for dates of service outside the RSV season will require **a hardcopy prescription with justification for Synagis® use handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested continued by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® outside the five (5) month RSV season.

Age Restriction

Claims for Synagis® therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1st of the RSV season. Once a recipient meets the age requirement for Synagis®, subsequent claims during that RSV season will continue to be reimbursed without further age evaluation. Claims for recipients who are twenty-five (25) months of age or older on November 1st will deny.

When justified by the prescriber, pharmacy claims for Synagis® may be reimbursed for recipients twenty-five (25) months of age or older; however, these **pharmacy claims will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

Early Refill

Claims for Synagis® will only process for payment every twenty-eight (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. After consultation with and approval from the prescribing practitioner, the pharmacist may override the early refill edit.

Maximum Number of Doses Allowed

Claims billed for Synagis® outside the allowable number of doses will deny. Based upon the diagnosis code submitted, a maximum of five (5) 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.

If a diagnosis code of 765.27 (33-34 completed weeks of gestation) is billed, then a maximum of three (3) doses will be reimbursed each RSV season.

Claims billed for greater than the number of allowable doses of Synagis® will require **a hardcopy prescription which includes justification handwritten by the prescriber.** The prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of continued pharmacy claims billed for Synagis® greater than the allowable number of maximum doses.

ICD-9-CM Diagnosis Code Requirement

An appropriate ICD-9-CM diagnosis code must be documented on the hardcopy prescription after written, electronic, or verbal consultation with the prescribing practitioner. Claims for Synagis® submitted without an appropriate diagnosis code or without any diagnosis code will deny. The following diagnosis codes are acceptable:

ICD-9-CM Diagnosis Code	Description
415.0	Acute cor pulmonale
416.0	Primary pulmonary hypertension
416.8	Pulmonary hypertension, secondary
745.0	Truncus arteriosus
745.10-745.11	Transposition of the great vessels
745.19	Other transposition of the great vessels
745.2	Tetralogy of Fallot
746.1	Tricuspid atresia and stenosis, congenital
746.2	Ebstein's anomaly
747.41	Total anomalous pulmonary venous return

747.83	Persistent pulmonary hypertension, primary pulmonary hypertension of the newborn (Persistent fetal circulation)
765.21	Less than 24 completed weeks of gestation
765.22	24 completed weeks of gestation
765.23	25-26 completed weeks of gestation
765.24	27-28 completed weeks of gestation
765.25	29-30 completed weeks of gestation
765.26	31-32 completed weeks of gestation
765.27	33-34 completed weeks of gestation
770.7	Chronic respiratory disease arising in perinatal period (CLD/BPD/interstitial pulmonary fibrosis of infancy/Wilson-Mikity syndrome)

Other diagnosis may be used to justify Synagis® depending on recipient-specific factors. The following diagnosis codes **could** be used to justify immunoprophylaxis with Synagis®, and are subject to prescriber assessment and judgment.

ICD-9-CM Diagnosis Code	**Description**
042	Human immunodeficiency virus (HIV) disease
045.00-045.13	Infantile paralysis
277.00-277.09	Cystic fibrosis
279.00-279.90	Disorders involving the immune system
335.0	Werdnig-Hoffman disease
335.10-335.11	Spinal muscular atrophy
335.20-335.24	Motor neuron disease
343.0-343.9	Infantile cerebral palsy
358.0-358.9	Myoneural disorders
359.0-359.9	Muscular dystrophies and other myopathies
396.0-396.9	Diseases of mitral and aortic valves
424.1	Aortic stenosis
425.00-425.90	Cardiomyopathy
428.0-428.9	Heart failure
519.1	Other diseases of the trachea and bronchus, not elsewhere classified (Must specify tracheomalacia or tracheal stenosis)
745.4	Ventricular septal defect
745.5	Atrial septal defect
745.60-745.69	Atrioventricular canal (endocardial cushion defect)
746.7	Hypoplastic left heart
746.89	Hypoplastic right heart
748.3	Other anomalies of the larynx, trachea and bronchus (Must specify congenital tracheal stenosis, atresia of trachea, absence or agenesis of bronshus, trachea)

748.4	Congenital cystic lung
748.5	Agenesis, hypoplasia, and dysplasia of the lung
748.61	Congenital bronchiectasis
750.15	Macroglossia
750.9	Uvula anomaly
759.89	Congenital malmation syndromes affecting multiple systems, not elsewhere classified (Beckwith Wiedmann syndrome)

In the event, that the prescribing provider cannot be contacted, the pharmacist may override the missing or invalid diagnosis code edit. The pharmacist must document "Emergency Prescription" on the hard copy prescription and submit the appropriate override.

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits, and Appendix D the Point of Sale User Guide for detailed claims filing instructions.

Schedule II Narcotic Agents

All prescriptions for Schedule II narcotic agents require an ICD-9-CM diagnosis code indicating the reason for use documented on the hardcopy prescription. The diagnosis code must be written on the hardcopy prescription by the prescribing practitioner or by the pharmacist 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 be overridden if the pharmacist determines that the recipient cannot wait to receive the medication.

Schedule II narcotic agents are also subject to Prospective Drug Utilization Reviews which address quantity limits.

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for further policy.

FENTANYL BUCCAL AND SUBLINGUAL AGENTS

Claims for fentanyl buccal and sublingual agents (Abstral®, Actiq®, Fentora® and Onsolis®) **must** contain a cancer-related ICD-9-CM diagnosis code in order for the claim to process for payment through the Point of Sale System.

Acceptable ICD-9-CM diagnosis codes are as follows:

ICD-9-CM Code Range	Description
140-149.99	Malignant Neoplasm of lip, oral cavity and pharynx
150-159.99	Malignant neoplasm of digestive organs and peritoneum
160-165.99	Malignant neoplasm of respiratory and intrathoracic organs
170-176.99	Malignant neoplasm of bone, connective tissue, skin and Breast
179-189.99	Malignant neoplasm or genitourinary system
190-199.99	Malignant neoplasm of other and unspecified sites
200-208.99	Malignant neoplasm of lymphatic and hematopoietic tissue
209.0-209.39	Malignant carcinoid tumors

Buccal and sublingual agents are subject to Prospective Drug Utilization Reviews which address quantity limits.

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for further policy.

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.

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 Point of Sale system for Morphine ER (Avinza®) when the maximum daily dosage is exceeded.

Sildenafil (Revatio®) And Tadalafil (Adcirca®)

Prescriptions for Sildenafil (Revatio®) and Tadalafil (Adcirca®) are payable when prescribed for primary pulmonary hypertension. An appropriate ICD-9-CM diagnosis code must be documented on all prescriptions by either the prescriber or the pharmacist. The ICD-9-CM code may be communicated to the pharmacist electronically, via telephone or facsimile. The ICD-9-CM diagnosis code is required for the claim submission.

The following ICD-9-CM diagnosis codes are acceptable:

ICD-9-CM Code	Description
416.0	Primary pulmonary hypertension
416.8	Other chronic pulmonary heart disease

Tazarotene (Tazorac®)

Pharmacy claims for Tazarotene (Tazorac®) require an appropriate ICD-9-CM diagnosis code for reimbursement. The prescribing provider must document the diagnosis code on the hard copy prescription or may communicate the diagnosis code over the phone.

The acceptable ICD-9-CM diagnosis codes are:

ICD-9-CM Code	Description
696.0	Psoriatic Arthropathy
696.1	Other Psoriasis

37.5.8 PROSPECTIVE DRUG UTILIZATION POLICIES/LIMITS/EDITS

Prospective drug utilization review (UniDUR) consists of criteria set forth by the state-established Drug Utilization Review (DUR) board which monitors for inappropriate use of medications and identifies potential drug conflicts. UniDUR is designed to work alongside the POS claims processing and
eligibility systems. Prospective Drug Utilization Review displays 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 patient's condition, patient'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.

UniDUR has predetermined standards to monitor:

- Duration of therapy;
- Early refill;
- Duplicate drug therapy;
- Pregnancy and FDA Category X drugs;
- Therapeutic duplication;
- Drug to drug interaction;
- Unnecessary drug therapy;
- Age and gender restrictions;
- Maximum dosage;
- Quantity Limits; and
- Drugs to diagnosis.

Note: Refer to Section 37.16 for an overview of Patient Counseling, Drug Utilization Review (DUR) and Provider Peer Based Profiling.

Duration of Therapy Limits

Proton Pump Inhibitors, H2 Antagonists & Sucralfate

The program utilizes a duration of therapy module for H2 antagonists, proton pump inhibitors (PPIs) and sucralfate for recipients who are 16 and older.. Acute dosage guidelines for these drugs are monitored. T he chronic use of these agents at full therapeutic dosage is generally not indicated. T he duration of therapy period begins every calendar year.

The acute dosage schedules of these drugs are as follows:

Proton Pump Inhibitors

Generic Description	Acute mg/day dose	Duration of Therapy
Omeprazole	20 mg	16 weeks (120 days)
Lansoprazole	30 mg	16 weeks (120 days)
Pantoprazole	40 mg	16 weeks (120 days)
Rabeprazole	20 mg	16 weeks (120 days)
Esomeprazole	40 mg	16 weeks (120 days)

H2 Antagonists & Sucralfate

Generic Description	Acute mg/day dose	Duration of Therapy
Ranitidine HCl	300 mg	12 weeks (90 days)
Cimetidine	1200 mg	12 weeks (90 days)
Nizatidine	300 mg	12 weeks (90 days)
Famotidine	40 mg	12 weeks (90 days)
Sucralfate	4000 mg	12 weeks (90 days)

Maintenance dose drug therapy will continue to be payable after the 90 days or 120 days of the appropriate drug therapy.

If, in the professional judgement of the prescriber, a determination is made to continue acute therapy beyond the appropriate duration of therapy, the prescriber must indicate in writing on the prescription or a signed and dated attachment, a diagnosis code necessitating the continuation of acute therapy. Recipient specific diagnosis information from the prescriber via facsimile is acceptable.

Only the prescriber who issues a prescription is authorized to sign off on a diagnosis override.

For acute therapy to continue as a reimbursable service beyond the above listed Therapy Limits, duration of therapy, the pharmacy provider must supply the reason for service code, professional service code and result of service code.

Note: Refer to Appendix D Point of Sale User Guide for detailed billing information.

An acceptable ICD-9-CM diagnosis code indicating the condition identified by the prescriber which warrants continuation of the acute dosage must be written on the prescription. The pharmacy provider must supply that information accurately as provided by the prescriber. Only claims with one of the diagnoses listed below will be reimbursable for an excessive duration of therapy.

ICD-9-CM Code	Description
041.86	H. Pylori
202.60 through 202.68	Systemic Mastocytosis
237.4	Multiple Endocrine Adenomas
251.5	Zollinger-Ellison Syndrome
530.10	Esophagitis
530.11	Gastroesophageal Reflux Disease (GERD)
530.19	Esophagitis
530.81	Gastroesophageal Reflux Disease (GERD)
530.20	Barrett's Esophagitis
531.00 through 531.91	Gastric Ulcer
532.00 through 532.91	Duodenal Ulcer
533.00 through 533.91	Peptic Ulcer (H. Pylori)
535.00 through 535.51	Gastritis
535.50	Gastroduodenitis
535.51	Gastroduodenitis
535.60	Duodenitis
535.61	Duodenitis
536.80	Dyspepsia
536.80	Gastric Hypersecretion
537.90	Unspecified disorder of stomach and duodenum
555.90	Crohn's Disease
569.90	Unspecified disorder of the intestines
577.10	Chronic Pancreatitis
578.90	Gastrointestinal Bleeding

Palivizumab (Synagis®)

Respiratory Syncytial Virus (RSV) Season

Synagis® claims with dates of service outside of RSV season will deny. The RSV season may begin in either October or November and ends March 31st. Claims billed for dates of service outside the RSV season will require **a hardcopy prescription with justification for Synagis® use handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® outside the five (5) month RSV season.

The pharmacist may override the maximum duration of therapy edit. The pharmacy provider must document and supply the reason for service code, professional service code and result of service code.

Maximum Number of Doses Allowed

Claims billed for Synagis® outside the allowable number of doses will deny. Based upon the diagnosis code submitted, the maximum number of doses any recipient should receive is five (5). 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. If a diagnosis code of 765.27 (33-34 completed weeks of gestation) is billed, then a maximum of three (3) doses will be reimbursed each RSV season.

Claims billed for greater than the number of allowable doses of Synagis® will require **a hardcopy prescription which includes justification handwritten by the prescriber.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review. Medical records may be requested by the pharmacy compliance audit program for verification purposes of pharmacy claims billed for Synagis® greater than the allowable number of maximum doses.

The pharmacist may override the maximum duration of therapy edit. The pharmacy provider must document and supply the reason for service code, professional service code and result of service code.

Note: Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for other criteria and Appendix D Point of Sale User Guide for detailed billing information.

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 seventy-five percent of medication being utilized. This translates into a seven (7) day window based on a thirty (30) day supply.

Prescriptions for narcotic analgesics will deny for an early refill edit when less than eighty-five percent of the medication had been utilized. This translates into a three (3) day window based on a thirty (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 patient'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: Refer to Appendix D Point of Sale User Guide for detailed billing information.

Duplicate Drug Therapy

A claim denial will occur if the patient 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, patient 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 recipient 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 recipient and cannot have the first claim reversed by the original billing pharmacy. A notation to that effect **must be written on the hardcopy prescription**. Please note, we will include a review of pharmacy claims billed with an override code in our 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: Refer to Appendix D Point of Sale User Guide for detailed billing information.

Pregnancy and FDA Category X Drugs

The Medicaid Program denies pharmacy claims with FDA Pregnancy Category X drugs for pregnant women. Pharmacy claims submitted for a drug in this category for recipients 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.

FDA PREGNANCY CATEGORY X

Acetohydroxamic Acid
Acitretin
Ambrisentan
Anastrozole
Androgens
Bexarotene
Bicalutamide
Bosentan
Chorionic Gonadotropin (Human)
Clomiphene Citrate
Danazol
Degarelix
Dihydroergotamine Mesylate (Inj;Nasal)
Drospirenone
Dutasteride
Ergotamine Tartrate
Estazolam
Estradiol
Estrogenic Agents
Ethinyl Estradiol
Ethynodiol Acetate
Etonogestrel
Finasteride
Fluorouracil (Topical)
Fluoxymesterone
Flurazepam Hydrochloride
Goserelin
HMG COA Reductase Inhibitors
Isotretinoin
Leflunomide
Leuprolide Acetate
Levonorgestrel
Lutropin Alpha
Medroxyprogesterone Acetate (Intramuscular)
Medroxyprogesterone Acetate (Non-Intramuscular)
Megestrol Acetate
Menotropins
Meprobamate
Mestranol
Methotrexate
Methyl Testosterone
Miglustat
Misoprostol
Nafarelin Acetate
Nandrolone (Decanoate, Phenpropionate)
Norelgestromin
Norethindrone (As Progestogen)
Norgestrel (As Progestogen)

Oral Contraceptives
Oxandrolone
Oxymetholone
Quazepam
Raloxifene
Ribavirin
Rosuvastatin
Stanozolol
Tazarotene
Temazepam
Testosterone
Thalidomide
Triazolam
Vitamin A
Warfarin Sodium

Pregnancy and FDA Category D Drugs

Pharmacy claims submitted with FDA Pregnancy Category D drugs will receive an educational edit in the response from Louisiana Medicaid. These claims will not deny.

Therapeutic Duplication

The Medicaid Program denies pharmacy claims for oral formulations of drugs in the following classes and specific drugs if the recipient has an **active** paid claim on file for another drug in the 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 hard-copy documentation of the reason for service code, professional service code and result of service code is required on the new prescription for audit purposes. Additional requirements may be associated with certain drug classes or specific drugs.

SECOND GENERATION ANTIHISTAMINES AND SECOND GENERATION ANTIHISTAMINE COMBINATION AGENTS

Cetirizine
Cetirizine/Pseudoephedrine
Desloratadine
Desloratadine/Pseudoephedrine
Fexofenadine
Fexofenadine/Pseudoephedrine
Levocetirizine Dihydrochloride
Loratadine
Loratadine/Pseudoephedrine

ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS AND ACE INHIBITOR/DIURETIC COMBINATIONS

Benazepril HCl
Benazepril HCl/Hydrochlorothiazide
Captopril
Captopril/Hydrochlorothiazide
Enalapril Maleate
Lisinopril/Hydrochlorothiazide
Moexipril HCl
Moexipril/Hydrochlorothiazide
Perindopril Erbumine
Quinapril HCl

Enalapril/Hydrochlorothiazide
Fosinopril Sodium
Fosinopril/Hydrochlorothiazide
Lisinopril
Quinapril/Hydrochlorothiazide
Ramipril
Trandolapril

ACE INHIBITORS/CALCIUM CHANNEL BLOCKER COMBINATIONS

Benazepril/Amlodipine
Trandolapril/Verapamil HCl

ANGIOTENSIN RECEPTOR ANTAGONISTS (ARB) AND ARB /DIURETIC COMBINATIONS

Candesartan Cilexetil
Candesartan/Hydrochlorothiazide
Eprosartan Mesylate
Eprosartan/Hydrochlorothiazide
Irbesartan
Irbesartan/Hydrochlorothiazide
Losartan Potassium
Losartan/Hydrochlorothiazide
Olmesartan Medoxomil
Olmesartan/Hydrochlorothiazide
Telmisartan
Telmisartan/Hydrochlorothiazide
Valsartan
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
Atenolol
Atenolol/Chlorthalidone
Betaxolol HCl
Bisoprolol Fumarate
Bisoprolol/Hydrochlorothiazide
Carvedilol
Carvedilol CR
Labetalol HCl
Metoprolol ER
Metoprolol Tartrate
Metoprolol/Hydrochlorothiazide
Nadolol
Nadolol/Bendroflumethiazide
Nebivolol HCl
Penbutolol Sulfate
Pindolol
Propranolol HCl
Propranolol/Hydrochlorothiazide
Sotalol AF
Sotalol HCl
Timolol Maleate
Timolol/Hydrochlorothiazide

CALCIUM CHANNEL BLOCKERS

Amlodipine
Diltiazem
Felodipine
Isradipine
Nicardipine
Nifedipine
Nimodipine
Nisoldipine
Verapamil

CALCIUM CHANNEL BLOCKER/ANTIHYPERLIPIDEMIA AGENT COMBINATION

Amlodipine/Atorvastatin Calcium

POTASSIUM REPLACEMENT

Potassium Acetate
Potassium Bicarbonate / Citric Acid
Potassium Chloride
Potassium Citrate

TRICYCLIC ANTIDEPRESSANTS

Amitriptyline HCl
Amoxapine
Clomipramine HCl
Desipramine HCl
Doxepin HCl
Imipramine HCl
Imipramine Pamoate
Maprotiline HCl
Nortriptyline HCl
Protriptyline HCl
Trimipramine Maleate

SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Citalopram HBr
Escitalopram Oxalate
Fluoxetine HCl
Fluvoxamine Maleate
Paroxetine HCl
Paroxetine Mesylate
Sertraline HCl

ANTIPSYCHOTIC AGENTS (TYPICAL AND ATYPICAL)

Prescriptions for antipsychotic agents will deny for therapeutic duplication when the recipient has two active antipsychotic prescriptions on their file. The pharmacist must document on the hard copy prescription the reason the prescriber required the patient to receive a third antipsychotic agent.

Note: Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for further policy regarding Antipsychotic Agents.

Typical Antipsychotic Agents

Chlorpromazine
Fluphenazine
Haloperidol
Loxapine
Molindone
Perphenazine
Pimozide
Prochlorperazine
Thioridazine
Thiothixene
Trifluoperazine

Atypical Antipsychotic Agents

Aripiprazole
Asenapine
Paliperidone
Quetiapine

Clozapine
Iloperidone
Olanzapine
Risperidone
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 recipient's file **or** when there is **one** active prescription for a selective serotonin reuptake inhibitor (SSRI) on the recipient's history file.

Olanzapine/Fluoxetine

ANTI-ANXIETY AGENTS

Alprazolam
Buspirone
Chlordiazepoxide
Chlorazepate
Diazepam
Hydroxyzine
Lorazepam
Meprobamate
Oxazepam

The pharmacist must document on the hardcopy prescription 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 recipient has a diagnosis of **seizures**. The diagnosis code must be documented on the hardcopy prescription after written or verbal consultation with the prescriber and submitted electronically for the override.

Acceptable ICD-9-CM diagnosis codes are:

ICD-9-CM Code	**Description**
345.0 through 345.99	Epilepsy
780.30 through 780.39	Convulsions

SEDATIVE HYPNOTIC AGENTS

Estazolam
Eszopiclone
Flurazepam HCl
Quazepam
Temazepam
Triazolam
Zaleplon
Zolpidem Tartrate

ATTENTION DEFICIT DISORDER AGENTS

Armodafinil
Atomoxetine
Dexmethylphenidate
Dextroamphetamine
Dextroamphentamine/amphetamine
Guanfacine
Lisdexamfetamine
Methylphenidate
Modafinil

An incoming pharmacy claim for any of the above Attention Deficit Disorder agents will deny when there is an active paid claim for any of these agents on the recipient's file written by a different prescriber.

NON-STEROIDAL ANTI-INFLAMMATORY AGENTS

Celecoxib
Diclofenac Potassium
Diclofenac Sodium
Diclofenac Sodium / Misoprostol
Diflunisal
Etodolac
Fenoprofen Calcium
Flurbiprofen
Ibuprofen
Ibuprofen / Hydrocodone Bitartrate
Ibuprofen/Oxycodone
Indomethacin
Ketoprofen
Ketorolac Tromethamine
Meclofenamate Sodium
Mefenamic Acid
Meloxicam
Nabumetone
Naproxen
Naproxen Sodium
Naproxen/Lansoprazole
Oxaprozin
Piroxicam
Sulindac
Tolmetin Sodium

SHORT ACTING OPIATE AGENTS

Buprenorphine*
Buprenorphine/Naloxone*
Butorphanol Tartrate
Codeine Phosphate
Codeine Phosphate/APAP
Codeine/ASA
Codeine Sulfate
Codeine/APAP/Caffeine/Butalbital
Codeine/ASA/Caffeine/Butalbital
Codeine/Carisoprodol/ASA
Dihydrocodeine/APAP/Caffeine
Fentanyl Ciltrate Buccal
Pentazocine/APAP
Pentazocine/Naloxone
Propoxyphene HC1
Propoxyphene/Napsylate
Hydrocodone/APAP
Hydrocodone/Ibuprofen
Hydromorphone HCl IR
Levorphanol Tartrate
Meperidine HCl
Methadone HCl
Morphine Sulfate IR
Oxycodone HCl IR
Oxycodone/APAP
Oxycodone ASA
Oxycodone/Ibuprofen
Oxymorphone
Propoxyphene/APAP
Tramadol HCl
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
Morphine Sulfate CR
Oxycodone HCl CR
Oxymorphone ER

PROTON PUMP INHIBITORS

Esomeprazole	Omeprazole/Sodium Bicarbonate
Lansoprazole	Pantoprazole
Omeprazole	Rabeprazole

The Department may add drugs to these lists as new drugs appear on the market.

Note: Refer to Section 37.9.5 for override information as well as Appendix D Point of Sale User Guide 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 recipient'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 patient 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. These DUR codes are required for the claim submission.

Unnecessary Drug Therapy

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:

- 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.

- 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 patients, the prescribing practitioner **must include**:

- **The condition being treated with the COX-2 selective agent by indicating the ICD-9-CM diagnosis code of the treated condition (e.g. Osteoarthritis – 715.0) on all new prescriptions written for a COX-2 selective agent; and**
- **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 ICD-9-CM diagnosis code and the rationale for the choice of a COX-2 selective agent must be noted in the prescriber's handwriting. A rubber stamp notation is not acceptable. The ICD-9-CM diagnosis code and the rationale may be submitted as an attachment to the original prescription via facsimile. The attachment must be dated and written in the prescriber's handwriting.

A prescription written for a COX-2 selective agent for a Medicaid patient will only process without an override when the following conditions **are met**:

- **An ICD-9-CM diagnosis code indicating the reason for treatment is documented and submitted;**
- **and when one of the following conditions exists:**
  - **Patient has current prescription for H2 receptor antagonist;**
  - **Patient has current prescription for proton pump inhibitor;**
  - **Patient has current prescription for warfarin;**
  - **Patient has current prescriptions indicating chronic use of oral steroids; or**
  - **Patient is sixty years old or greater.**

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 Point of Sale submission of the claim and have the information recorded on the hardcopy.

Note: Refer to Section 37.9.5 for override information as well as Appendix D Point of Sale User Guide for detailed billing information.

Maximum Dosage

ATYPICAL ANTIPSYCHOTIC AGENTS

Pharmacy claims for doses of atypical antipsychotic agents which exceed the maximum recommended doses will deny.

The maximum dosage schedules for recipients eighteen (18) years of age or older for these drugs are as follows:

Generic Name	Brand Name	Maximum Dose Per Day
Aripiprazole	Abilify	30mg/day
Asenapine	Saphris	20mg/day
Clozapine	Clozaril	900mg/day
Iloperidone	Fanapt	24mg/day
Olanzapine	Zyprexa	40mg/day
Olanzapine/Fluoxetine	Symbyax	18mg/day/75mg/day

Paliperidone	Invega	12mg/day
Paliperidone	Invega Sustenna	234mg/day
Quetiapine	Seroquel	1200mg/day
Risperidone	Risperdal	16mg/day
Ziprasidone	Geodon	200mg/day

Daily doses for atypical antipsychotic agents used in recipients less than eighteen (18) years of age must not exceed an established maximum daily dose. Maximum daily doses for these agents are listed below:

Brand Name	< 5 years old	5-12 years old	13-17 years old
Abilify®	5 mg daily	20 mg daily	30 mg daily
Risperdal®	3 mg daily	6 mg daily	8 mg daily
Invega®	3 mg daily	6 mg daily	9 mg daily
Seroquel®	100 mg daily	600 mg daily	1000 mg daily
Geodon®	30 mg daily	60 mg daily	120 mg daily
Zyprexa®	10 mg daily	20 mg daily	30 mg daily

To override a denial, the pharmacy provider must consult with the prescriber and document on the hardcopy prescription, the reason the prescriber requires a dose above the maximum recommended dose. The pharmacist must supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

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 **six 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.

It is imperative that pharmacists use their professional judgment to determine an appropriate days supply based upon the directions noted by the prescriber.

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 the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale 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 the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

Note: Refer to Appendix D Point of Sale User Guide for detailed billing information.

Quantity Limits

SCHEDULE II NARCOTIC AGENTS

Pharmacy claims for quantities of Schedule II narcotic agents which are in excess of the quantity limit will deny. Quantity limits are cumulative and are based on a rolling thirty (30) days. Unless otherwise specified, quantity limits apply to all strengths of an agent.

Quantity limits for Schedule II narcotic agents are as follows:

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
Fentanyl	Patch 12, 25, 50mcg/hr	10 units each strength
Fentanyl	Patch 75, 100mcg/hr	20 units each strength
Fentanyl Citrate Immediate Release	Tablet sublingual, Effervescence Lozenge HD, Film	120 units
Hydromorphone HCl ER	Tablet ER 24hr	30 units
Morphine Sulfate SR	CPMP 24hr	30 units
Morphine Sulfate SR	Capsule SR Pellet	60 units
Morphine Sulfate SA	Tablet SA	60 units
Morphine Sulfate/ Naltrexone SR	Capsule SR Pellet	60 units
Oxycodone HCl SR	Tablet SR 12hr	60 units
Oxycodone	Tablet or Capsule	120 units
Oxycodone/ Acetaminophen	Tablet or Capsule	120 units
Oxycodone/Aspirin	Tablet or Capsule	120 units
Oxycodone/Ibuprofen	Tablet	28 units
Oxymorphone HCl SR	Tablet SR 12hr	60 units

With the exception of the fentanyl buccal and sublingual products, recipients receiving agents listed above for the management of cancer pain are not subject to quantity limits.

Note: Refer to 37.5.7 Drugs with Special Payment Criteria/Limitations for acceptable ICD-9-CM diagnosis codes associated with cancer.

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 must document on the hardcopy prescription the prescriber's reason why the quantity limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

Note: Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for ICD-9-CM diagnosis code policy for Schedule II narcotic agents.

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 thirty (30) days. 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
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 the prescriber's reason why the quantity limit needs to be exceeded. The pharmacist must document on the hardcopy prescription and supply the reason for service code, professional service code and result of service code with the Point of Sale submission.

Age Restriction

Claims for palivizumab (Synagis®) therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1st of the Respiratory Syncytial Virus (RSV) season. Once a recipient meets the age requirement for Synagis®, subsequent claims during that RSV season will continue to be reimbursed without further age evaluation. Claims for recipients who are twenty-five (25) months of age or older on November 1st will deny.

When justified by the prescriber, pharmacy claims for Synagis® may be reimbursed for recipients twenty-five (25) months of age or older; however, these pharmacy claims will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber**.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

The pharmacist may override the age restriction edit. The pharmacist must document and supply the reason for service code, professional service code and result of service code.

Note: Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for other criteria and Appendix D Point of Sale User Guide for detailed billing information.

37.5.9 QUANTITY LIMITATIONS

Prescriptions payable under Louisiana Medicaid are limited as follows:

Maximum Allowable Quantities

The maximum quantity payable is either a one month's supply or 100 unit doses, whichever is greater.

Maintenance Medication Quantities

Prescribed maintenance drugs for chronic illnesses should be prescribed and dispensed in economic quantities sufficient to meet the medical needs of the recipient. Listed below are drugs to be considered as maintenance drugs; these drugs should be dispensed in a one month's supply:

- Anti-coagulants;
- Anti-convulsants;
- Oral anti-diabetics;
- Calcium gluconate and calcium lactate;
- Cardiovascular drugs, including diuretics, anti-hypertensives, and anti-hyperlipidemics;
- Estrogens;
- Iron supplements;
- Potassium supplements;
- Thyroids and anti-thyroid drugs; and
- Vitamins – D, K, B12 injections, folic acid, and nicotinic acid.

37.5.10 COVERAGE AND LIMITATIONS FOR LONG TERM CARE RECIPIENTS

Quantities for Long Term Care Recipients

Providers shall dispense a one month's supply, unless the prescribing provider specifies a smaller quantity for medical reasons, to recipients 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:

"Maintenance" medications are those used to treat chronic conditions or illnesses. Initial therapy of a "maintenance" medication may be dispensed in a small quantity (e.g. a ten-day supply) to ensure patient tolerance before dispensing a one month's supply of medication. The prospective DUR compliance module will only allow a refill on the eighth day of a ten-day therapy period. If on the eighth day of therapy the patient has progressed with no adverse effects, a one-month's supply shall be dispensed unless otherwise specified by the prescriber.

"PRN" prescriptions are those prescriptions that patients utilize on an "as needed" basis. For "prn" prescriptions, thirty units or a ten-day supply shall be supplied, unless otherwise specified by the prescriber.

The nursing home pharmacy consultant should periodically review 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 health care team (nursing home administration, medical, nursing or pharmacy consultant) should reevaluate 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 (LTC) recipients are exempt from co-payments and monthly prescriptions limits.

Note: Refer to Chapters 26 & 34 of the Louisiana Medicaid Program Provider Manual for detailed information regarding recipients in LTC facilities (ICF/MR and Nursing Homes).

Over the Counter (OTC) Drugs

LTC facilities are responsible for providing all OTC drugs to Medicaid recipients.

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 Section 37.5.7 Drugs with Special Payment Criteria/Limitations; Diabetic Testing Supplies 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 Louisiana Medicaid indicating the date of service that coincides with the date of administration.

37.5.11 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 recipient receives Medicare benefits. Medicaid will pay any applicable deductibles and coinsurances.

Note: Refer to Section 37.7 Medicare Prescription Drug Coverage for detailed information on drugs covered by Medicare Part B.

37.5.12 DRUG SERVICES FOR HOSPICE RECIPIENTS

"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.

For Medicare/Medicaid patients who have elected Hospice, services covered in the patient'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 recipients 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 recipients who have elected hospice will be performed as they are identified. Any provider of services to a hospice recipient

needs to clear with the hospice that the billed service is not included in the recipient's plan of care. Erroneous payment will be recouped as identified.

Note: Refer to Chapter 24 Hospice of the Louisiana Medicaid Program Provider Manual for detailed information.