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 recipients.

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 37.4 - Prescribers for detailed information about prescribers).

Eligible Recipients

The Medicaid Program 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. (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: Refer to Appendix C of this manual chapter for a listing of Medicaid drug federal rebate participating pharmaceutical companies. 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. (Refer to Appendix C of this manual chapter for additional information).

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 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 37.16 - Patient Counseling, Drug Utilization Review (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 recipient or a caregiver, in person whenever practicable, or by toll-free telephone for long distance calls, matters which, in his/her 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 recipient or caregiver. Effective May 1, 20l6, the Pharmacy Program will require counseling documentation for all prescriptions reimbursed by Louisiana Medicaid. According to 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 he or she 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 37.16 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

- The 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.
- Electronic signatures for receipt are permitted only if retrievable upon audit and kept on file by the pharmacy.
- Obtaining a signature to confirm receipt of prescription(s) can be part of a counseling log.
- The 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

- A signature is required at the time of delivery.
- The 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.
- Electronic signatures for receipt or electronic tracking slips for delivery are permitted only if retrievable on audit.
- A waiver signature form is not an acceptable practice and such forms will not serve as confirmation of delivery.

- 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

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

- The pharmacy representative will obtain a signature from the recipient 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 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 comes 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.

Date of Service

Claims shall be submitted for the date of service the prescription was dispensed.

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

- 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 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 Table of Tamper Resistant Prescription Criteria and Examples in Appendix L 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.

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

Injectable Drugs

Reimbursement is provided for most injectable drugs for outpatient recipients 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:

- Insulin;
- Sodium chloride solution for inhalation therapy;
- Contraceptives, topical;
- Urinary pH modifiers; and
- 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.**

- 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 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 37.12 - Total Parenteral Nutrition for additional 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. (Refer to Section 37.14 - Medication Administration for detailed information).

Non-Covered Services

Drugs Excluded From Coverage

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

- Anorexics – Medicaid does not reimburse for anorexics with the exception of orlistat;
- 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
- Vaccines covered in other programs.

Durable Medical Equipment/Supplies Excluded

Durable medical equipment (DME) and supplies, other than those included in this section , are not covered in the Pharmacy Program. These items are covered in the Home Health Program and must be billed to that program. (Refer to Chapter 18 Durable Medical Equipment of the *Medicaid Services Manual* for specific information covered through the DME program).

Prior Authorization and Preferred Drug List

The Medicaid Program administers a prior authorization process for pharmacy services. This process utilizes a preferred drug list (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 prior authorization.

PDL Provider Notification

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

Prior Authorization Process General Information

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

Prior Authorization and PDL Information Site

Refer to Appendix N for information on prior authorization and the PDL.

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 prior authorization by telephone, facsimile or mail. (Refer to Appendix N for information on prior authorization).

The Prior Authorization Unit's hours of operation are 8:00 am to 6:00 pm 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

The "Request for Prescription Prior Authorization" form (RX PA01) must be used by the prescriber to request a prior authorization. Refer to Appendix F for information on how to obtain the "Request for Prescription Prior Authorization" form (RX PA01).

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 recipient's practitioner must contact the Prior Authorization Unit (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: Refer to Point of Sale User Guide in Appendix D for detailed claim submission information.

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

Monitoring of emergency prescriptions/recipients 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 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". 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 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 recipient'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 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.

Recipients 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 recipients' retroactive time period. The 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 recipient file. Pharmacy providers shall submit these claims electronically.

Important Facts

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

If an approved prior authorization exists in the system, the pharmacy claim will bypass the prior authorization edit and continue with existing Point of Sale (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 a recipient's 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 Medicaid Eligibility Verification System (MEVS) or Recipient Eligibility Verification System (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.

Clinical Pre-Authorization

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

Prescribers must complete the Clinical Pre-Authorization form in full. Clinical pre-authorization requests should be faxed or mailed to the RxPA Unit. (Refer to Appendix N for contact information).

NOTE: Refer to Appendix D, Point of Sale User Guide for detailed claims filing instructions and Appendix F for the Clinical Pre-Authorization form and instructions.

Monthly Service Limit

Limit

Medicaid reimburses up to four 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 21 years of age;
- Persons who are residents of long-term care institutions, such as nursing homes and Individuals with Intellectual Disabilities (ICF/IID) facilities; and
- Recipients 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:

- "Medically necessary override; and

- A 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 his/her clinical assessment of the recipient'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 recipient. (Refer to Appendix N for information on accessing 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.

NOTE: Refer to Appendix D, Point of Sale User Guide for detailed billing instructions.

Drugs with Special Payment Criteria/Limitations

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

NOTE: Refer to Point of Sale User Guide in Appendix D for detailed billing instructions and Section 37.9 - Claim Submission for detailed override information where applicable.

Age and Gender Restricted Drugs

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

Allergen Extracts

Pharmacy claims for the following allergen extracts are subject to physician prescriber requirements and an auto-injectable epinephrine prescription requirement for reimbursement:

- Timothy Grass Pollen Allergen Extract (Grastek®);

- Short Ragweed Pollen Allergen Extract (Ragwitek®); and
- Grass Mixed Pollens Allergen Extract (Oralair®).

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.

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.

Anti-Anxiety Drugs

Pharmacy claims for solid oral dosage forms of alprazolam IR (Xanax®), chlordiazepoxide (Librium®), lorazepam (Ativan®), oxazepam (Serax®), clonazepam (Klonopin®), clorazepate (Tranxene®), and diazepam (Valium®) have quantity limits of 90 units per rolling 30 days.

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

Alprazolam ER (Xanax XR®) and Alprazolam ODT (Niravam®)

Pharmacy claims for alprazolam ER (Xanax XR®) and alprazolam ODT (Niravam®) are subject to the following for reimbursement:

- Age Restriction; and

- Diagnosis Code Requirements.

Pharmacy claims for alprazolam ER (Xanax XR®) also have quantity limits.

Age Restriction

Pharmacy claims for alprazolam ER (Xanax XR®) and alprazolam ODT (Niravam®) will deny at POS for recipients 17 years old or younger on the date of service.

Diagnosis Code Requirements

Pharmacy claims for alprazolam ER (Xanax XR®) and alprazolam ODT (Niravam®) require a diagnosis code. The diagnosis code must be documented 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 code is required for the claim submission.

Acceptable diagnosis codes for alprazolam ER (Xanax XR®) are:

ICD-10-CM Diagnosis Code	Description
F40.01	Panic Disorder with Agoraphobia
F41.0	Panic Disorder without Agoraphobia

Acceptable diagnosis codes for alprazolam ODT (Niravam®) are:

ICD-10-CM Diagnosis Code	Description
F41.1	Generalized Anxiety Disorder
F40.01	Panic Disorder with Agoraphobia
F41.0	Panic Disorder without Agoraphobia

Quantity Limits

There is a quantity limit of 30 units per rolling 30 days for alprazolam ER (Xanax XR®).

Analeptics: Armodafinil (Nuvigil®) and Modafinil (Provigil®)

Age Restriction

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

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:

ICD-10-CM Diagnosis Code(s)	Diagnosis
G47.33	Obstructive sleep apnea (OSA)
G47.26	Circadian rhythm sleep disorder, shift work type
G47.4*	Narcolepsy

* - 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 recipient'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 recipient's file for other stimulants or atomoxetine (Strattera®).

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 recipient'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 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.

Androgenic Agents (Testosterone and Methyltestosterone containing products)

Pharmacy claims for androgenic agents (testosterone and methyltestosterone containing products, excluding oxandrolone) require an approved clinical pre-authorization for reimbursement. Prescribers should complete in full and submit a clinical pre-authorization form to the RxPA Unit.

NOTE: Refer to Appendix D, POS User Manual and Appendix F, Forms for complete billing instructions, criteria, and Clinical Pre-Authorization Form.

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.

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 recipient'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:

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

Antisense Oligonucleotides: Nusinersen sodium (Spinraza®) and Eteplirsen (Exondys 51®)

Pharmacy claims for nusinersen sodium (Spinraza®) and eteplirsen (Exondys 51®) will be subject to the following for reimbursement:

- Clinical pre-authorization; and
- Diagnosis code requirements.

Clinical Pre-Authorization Requirement

Pharmacy claims for nusinersen sodium (Spinraza®) and eteplirsen (Exondys 51®) require an approved clinical pre-authorization. Prescribers should complete in full and submit a clinical pre-authorization form to the RxPA Unit.

Diagnosis Code Requirement

The acceptable diagnosis codes for nusinersen sodium (Spinraza®) and eteplirsen (Exondys 51®) are listed in the chart.

Medication	Diagnosis	ICD-10-CM Diagnosis Code
Nusinersen Sodium (Spinraza®)	Spinal Muscular Atrophy	G12.0; G12.1
Eteplirsen (Exondys 51®)	Duchenne Muscular Dystrophy	G71.0

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

NOTE: Refer to Appendix D, POS User Manual and Appendix F, Forms for complete billing instructions, criteria, and Clinical Pre-Authorization Form.

Antipsychotic Agents

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

- Diagnosis Code Requirement; and
- Age and Dosage Limits.

Diagnosis Code Requirement on All Antipsychotic Medications

Prescriptions for antipsychotic agents require appropriate diagnosis codes documented on all prescriptions.

The numeric diagnosis code must be documented on the hardcopy prescription by either the prescriber or the 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.

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

NOTE: Refer to Appendix P for the Fee for Service (FFS) and MCOs (Managed Care Organizations) ICD-10-CM Diagnosis Code Policy Chart.

If the prescriber does not indicate a diagnosis code, and the pharmacist determines the recipient 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 drug utilization reviews when a third antipsychotic agent is submitted for payment.

Age and Dosage Limits

Pharmacy claims for selected antipsychotic medications will be subject to age and dosage limits.

The chart below lists age and dosage limits for selected antipsychotic medications.

Description	Maximum Dosage	Limit	Sample Brand Name	Age (Y = Year)
Aripiprazole	30 mg	Daily	Abilify®	18 Y And >
Aripiprazole	5 mg	Daily	Abilify®	< 5 Y
Aripiprazole	20 mg	Daily	Abilify®	5 - 12 Y
Aripiprazole	30 mg	Daily	Abilify®	13 - 17 Y
Asenapine	N/A	N/A	Saphris®	<10Y
Asenapine	20 mg	Daily	Saphris®	10Y And >
Clozapine	900mg	Daily	Clozaril®	18Y And>
Iloperidone	N/A	N/A	Fanapt®	<15 Y
Iloperidone	16 mg	Daily	Fanapt®	16-17 Y
Iloperidone	24 mg	Daily	Fanapt®	18 Y And >
Lurasidone	N/A	N/A	Latuda®	≤9Y
Lurasidone	80 mg	Daily	Latuda®	10-17 Y
Lurasidone	160 mg	Daily	Latuda®	18 Y And >
Olanzapine	40 mg	Daily	Zyprexa®	18 Y And >
Olanzapine	10 mg	Daily	Zyprexa®	< 5 Y
Olanzapine	20 mg	Daily	Zyprexa®	5 - 12 Y
Olanzapine	30 mg	Daily	Zyprexa®	13 - 17 Y

Description	Maximum Dosage	Limit	Sample Brand Name	Age (Y = Year)
Olanzapine/Fluoxetine	18 mg / 75 mg	Daily	Symbyax®	18 Y And >
Paliperidone	12 mg	Daily	Invega®	18 Y And >
Paliperidone	3 mg	Daily	Invega®	< 5 Y
Paliperidone	6 mg	Daily	Invega®	5 - 12 Y
Paliperidone	9 mg	Daily	Invega®	13 - 17 Y
Quetiapine	1200 mg	Daily	Seroquel®	18 Y And >
Quetiapine	100 mg	Daily	Seroquel®	< 5 Y
Quetiapine	600 mg	Daily	Seroquel®	5 - 12 Y
Quetiapine	1000 mg	Daily	Seroquel®	13 - 17 Y
Risperidone	16 mg	Daily	Risperdal®	18 Y And >
Risperidone	3 mg	Daily	Risperdal®	< 5 Y
Risperidone	6 mg	Daily	Risperdal®	5 - 12 Y
Risperidone	8 mg	Daily	Risperdal®	13 - 17 Y
Ziprasidone	200 mg	Daily	Geodon®	18 Y And >
Ziprasidone	30 mg	Daily	Geodon®	< 5 Y
Ziprasidone	60 mg	Daily	Geodon®	5 - 12 Y
Ziprasidone	120 mg	Daily	Geodon®	13 - 17 Y

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. ADD/ADHD will be checked for therapeutic duplication.

The numeric diagnosis code must be documented on the hardcopy prescription by either the prescriber or the 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.

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

When recipients 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 Appendix N for contact information.)

NOTE: Refer to Appendix P for the FFS and MCOs ICD-10-CM Diagnosis Code Policy Chart and the Point of Sale User Guide in Appendix D for detailed billing instructions.

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.

Behavioral Health Medications for Recipients Less Than 6 Years of Age

Pharmacy claims for behavioral health medications for recipients less than 6 years of age require an approved clinical pre-authorization for reimbursement.

If a prescriber chooses to prescribe a behavioral health medication for a recipient less than 6 years old, the prescriber must complete in full the Behavioral Medication Therapy Clinical Pre-Authorization Form (RX PA 17). The completed form can be faxed to the RxPA Unit.

NOTE: Refer to Point of Sale User Guide or www.lamedicaid.com for additional information on Clinical Pre-Authorization and Forms.

Clinical Pre-Authorization for ADHD Medications for Recipients Less Than 48 Months of Age

Pharmacy claims for ADHD medications for recipients less than 48 months of age require an approved clinical pre-authorization for reimbursement.

If a prescriber chooses to prescribe an ADHD medication for a recipient less than 48 months of age, the prescriber must complete in full and submit the following:

- The Behavioral Medication Therapy Clinical Pre-Authorization Form; and
- The Behavioral Medication Therapy Worksheet.

The Behavioral Medication Therapy Clinical Pre-Authorization Form and Worksheet can be submitted to the Rx PA Unit.

Buprenorphine and Buprenorphine/Naloxone Agents (Bunavail, Suboxone®, and Zubsolv®)

Prescriptions for buprenorphine and buprenorphine/naloxone agents (i.e. Bunavail®, Suboxone®, and Zubsolv®) are only reimbursed when the following criteria are met:

- The prescriber is a physician;
- The physician has an X Drug Enforcement Administration (DEA) number;
- The prescriber is licensed to prescribe buprenorphine and buprenorphine/naloxone agents (i.e. Bunavail®,Suboxone®, and Zubsolv®) 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;
- Refills for buprenorphine and buprenorphine/naloxone agents are not allowed;
- Concurrent prescriptions for opioid analgesics and/or benzodiazepines are only reimbursed when written by the same physician who prescribed the buprenorphine or buprenorphine/naloxone;
- Recipients must be sixteen years of age or older;
- Prescriptions for Suboxone® (buprenorphine/naloxone) are allowed a maximum daily dose of 24mg/day (based on buprenorphine) per recipient for an initial 90 consecutive day period. After the initial 90-day period, a maximum daily dosage of up to 16 mg/day (based on buprenorphine) is allowed per recipient;
- Prescriptions for buprenorphine agents are allowed a maximum daily dose of 16mg/day; and

- Prescriptions for Zubsolv® are allowed a maximum of up to 17.1 mg/day (based on buprenorphine) per recipient for an initial 90 consecutive day period. After the initial 90 day period, a maximum daily dose of up to 11.4 mg/day (based on buprenorphine) is allowed per recipient.

Diagnosis Code Requirement

Prescriptions for buprenorphine agents require an appropriate 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 diagnosis codes are as follows:

ICD-10-CM Diagnosis Code(s)	Description
F11.2*	Opioid Type Dependence

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

Buprenorphine Agents are also subject to prospective drug utilization reviews when concurrent opioid analgesics (i.e. Suboxone, and Zubsolv®) are written by the same physician.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits; Therapeutic Duplication" in this section for further policy as well as Appendix D for detailed billing information.

Quantity Limits on Buprenorphine-Naloxone Products

The quantity limits for buprenorphine/naloxone products are listed in the following chart:

Product	Dose Form Route	Buprenorphine/Naloxone Strength		Quantity Limit (units/day)
Bunavail®	Film Buccal	2.1mg	0.3mg	1
		4.2mg	0.7mg	2
		6.3mg	1mg	2
Buprenorphine/Naloxone	Tablet Sublingual	2mg	0.5mg	1
		8mg	2mg	2
Suboxone®	Film Sublingual	2mg	0.5mg	1
		4mg	1mg	1
		8mg	2mg	2
		12mg	3mg	2

Product	Dose Form Route	Buprenorphine/Naloxone Strength		Quantity Limit (units/day)
Zubsolv®	Tablet Sublingual	1.4mg	0.36mg	1
		2.9mg	0.71mg	1
		5.7mg	1.4mg	1
		8.6mg	2.1mg	2
		11.4mg	2.9mg	1

Concurrent Opioid Analgesic and/or Benzodiazepine Therapies

- Concurrent opioid analgesic, benzodiazepine, and/or any buprenorphine containing agent prescriptions written by a different prescriber for recipients on a buprenorphine agent will deny. There are no override provisions through the POS system using NCPDP service codes;

- Incoming prescriptions for buprenorphine agents will deny when there is an active prescription for any buprenorphine containing agent on the recipient's file. There are no override provisions through the POS system using NCPDP service codes; and

- When a recipient has an active prescription for any opioid analgesic and/or any buprenorphine containing agent by the same prescriber, the incoming prescription will deny as a therapeutic duplication. The pharmacist must contact the physician for his/her authorization to assure the physician wants concurrent therapy before overriding the denial edit and filling the incoming prescription.

Buprenorphine Buccal Film (Belbuca®)

Prescriptions for buprenorphine buccal film (Belbuca®) will be reimbursed when:

- A valid diagnosis code is entered at claims submission; and
- The maximum daily dose limit of 1800 mcg/day is not exceeded.

All diagnosis codes are acceptable **EXCEPT** for the following:

ICD-10-CM Diagnosis Code(s)	Description
F11.2*	Opioid Type Dependence

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

Buprenorphine Extended-Release Injection (Sublocade®)

Buprenorphine extended-release injection (Sublocade®) will be reimbursed when the following criteria is met:

- Prescriber requirements;
- Age requirements;
- Diagnosis code requirements;
- Quantity limits; and
- Therapeutic duplication.

Prescriber Requirements

The prescriber is:

- A physician;
- Has an XDEA number; and
- Is licensed to prescribe buprenorphine extended-release injection (Sublocade®) and has provided a copy of his/her current Controlled Substance Registration Certificate indicating XDEA number and a copy of a Provider Enrollment File Update form to Provider Enrollment.

Age Requirements

- The patient must be 18 years of age or older.

Diagnosis Code Requirements

Prescriptions for buprenorphine agents require an appropriate diagnosis code entered at claim submission. The diagnosis code may be documented on the hard copy prescription or by the pharmacist after written or verbal consultation with the physician.

ICD-10-CM Diagnosis Code (s)	Description
F11.2*	Opioid Type Dependence

Quantity Limits

Buprenorphine extended-release injection (Sublocade®) have a quantity limit of one pre-filled syringe per rolling 30 days.

Therapeutic Duplication

When a patient has an active prescription for any opioid analgesic (including buprenorphine) written by the same prescriber, the incoming buprenorphine prescription will deny as a therapeutic duplication. **Override provisions are available.** The pharmacist will have to contact the physician for his/her authorization to verify the physician wants concurrent therapy.

Concurrent opioid analgesic and/or benzodiazepines prescriptions written by a different prescriber for patients on buprenorphine will deny. **There are no provisions for overrides.**

Incoming prescriptions for buprenorphine agents will deny when there is an active prescription for buprenorphine agents on the recipient's file. **There are no provisions for overrides.**

NOTE: Refer to the POS User Guide for detailed billing instructions and override procedures.

Buprenorphine Implant Kit (Probuphine®)

Buprenorphine implant kit (Probuphine®) will be reimbursed when the following criteria is met:

- Prescriber requirements;
- Age requirements;
- Diagnosis code requirements;
- Quantity limits; and
- Therapeutic duplication.

Prescriber Requirements

The prescriber is:

- A physician;
- Has an XDEA number;
- Is licensed to prescribe buprenorphine implant (Probuphine®) and has provided a copy of his/her current Controlled Substance Registration Certificate indicating

XDEA number and a copy of a Provider Enrollment File Update form to Provider Enrollment; and

- Only original prescriptions are covered with no allowances for refills.

Age Requirements

- The patient must be 16 years of age or older.

Diagnosis Code Requirements

Prescriptions for buprenorphine agents require an appropriate diagnosis code entered at claim submission. The diagnosis code may be documented on the hard copy prescription or by the pharmacist after written or verbal consultation with the physician.

ICD-10-CM Diagnosis Code (s)	Description
F11.2*	Opioid Type Dependence

Quantity Limits

Buprenorphine implant kits (Probuphine®) have a quantity limit of two implant kits per 720 rolling days.

Therapeutic Duplication

When a patient has an active prescription for any opioid analgesic (including buprenorphine) written by the same prescriber, the incoming buprenorphine prescription will deny as a therapeutic duplication. **Override provisions are available.** The pharmacist will have to contact the physician for his/her authorization to verify the physician wants concurrent therapy.

Concurrent opioid analgesic and/or benzodiazepines prescriptions written by a different prescriber for patients on buprenorphine will deny. **There are no provisions for overrides.**

Incoming prescriptions for buprenorphine agents will deny when there is an active prescription for buprenorphine agents on the recipient's file. **There are no provisions for overrides.**

NOTE: Refer to the POS User Guide for detailed billing instructions and override procedures.

Buprenorphine Transdermal Patches (Butrans®)

Pharmacy claims for Buprenorphine Transdermal Patches (Butrans®) require an appropriate 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. Refer to prescribing information. Each patch is intended to be worn for seven days.

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

Cariprazine (Vraylar®) and Cariprazine (Vraylar®) Therapy Pack

Dose Limit for cariprazine (Vraylar®)

Recipients 15 Years of Age or Younger

All pharmacy claims for any strength of cariprazine (Vraylar®) for recipients 15 years of age or younger will deny. Overrides will be addressed by faxing a Request for Prescription Override Form (Rx PA16) to the RXPA Unit.

Recipients 16 – 17 Years of Age

Pharmacy claims for cariprazine (Vraylar®) for recipients 16 – 17 years of age, with a dose greater than 4.5mg/day, will deny. Overrides will be addressed by faxing a Rx PA16 to the RXPA Unit.

Recipients 18 Years of Age or Older

Pharmacy claims for cariprazine (Vraylar®) for recipients 18 years of age or older, with a dose greater than 6 mg/day, will deny.

After consultation with the prescriber to verify the necessity of exceeding 6mg/day for recipients 18 years of age and older, the pharmacist may override the denial. 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: Refer to POS User Guide for detailed billing instructions.

Age Limit for Cariprazine (Vraylar®) Therapy Pack

Recipients 15 Years of Age or Younger

All pharmacy claims for any strength of cariprazine (Vraylar®) therapy pack will deny for recipients 15 years of age or younger. There are no override provisions through the POS system using NCPDP service codes.

Quantity Limit for Cariprazine (Vraylar®) Therapy Pack

Pharmacy claims for cariprazine (Vraylar®) therapy pack will have a quantity limit of one package per recipient (not to exceed one package per 18 months). There are no override provisions through the POS system using NCPDP service codes.

Diagnosis Requirement for Cariprazine (Vraylar®) and Cariprazine (Vraylar®) Therapy Pack

Pharmacy claims for cariprazine (Vraylar®) and cariprazine (Vraylar®) therapy pack require a valid diagnosis code submitted at POS. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The chart below contains the valid diagnosis codes for cariprazine (Vraylar®).

Diagnosis	ICD-10-CM Diagnosis Code(s)
Schizophrenia or Schizoaffective Disorder	F20.*, F25.*
Major Depressive Disorder, Psychoses in Major Depressive Disorder	F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9

Diagnosis	ICD-10-CM Diagnosis Code(s)
Delusions, Dementia, Psychoses	F01.*, F02.*, F03.*, F04, F05, F06.0, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.8, F10.150, F10.151, F10.250, F10.251, F10.26, F10.94, F10.950, F10.951, F10.96, F10.97, F11.121, F11.150, F11.151, F11.221, F11.250, F11.251, F11.921, F11.950, F11.951, F12.121, F12.150, F12.151, F12.221, F12.250, F12.251, F12.921, F12.950, F12.951, F13.121, F13.150, F13.151, F13.221, F13.250, F13.251, F13.27, F13.921, F13.950, F13.951, F13.97, F14.121, F14.150, F14.151, F14.221, F14.250, F14.251, F14.921, F14.950, F14.951, F15.121, F15.150, F15.151, F15.221, F15.250, F15.251, F15.921, F15.950, F15.951, F16.121, F16.150, F16.151, F16.221, F16.250, F16.251, F16.921, F16.950, F16.951, F18.121, F18.150, F18.151, F18.17, F18.221, F18.250, F18.251, F18.27, F18.921, F18.950, F18.951, F18.97, F19.121, F19.150, F19.151, F19.17, F19.221, F19.250, F19.251, F19.27, F19.921, F19.950, F19.951, F19.97, F22, F23, F24, F28, F29, F32.3, F33.3, F44.89
Psychoses in Bipolar Disorder, Psychoses in Other Episodic Mood Disorders	F30.*, F31.*, F32.8, F34.8, F34.9, F39
Aggression or Irritability in Pervasive Developmental Disorder (PDD)	F84.*

Cariprazine (Vraylar®) and cariprazine (Vraylar®) therapy pack claims submitted at POS without a valid diagnosis will deny.

Prescribing providers may call Louisiana Medicaid RxPA Unit for guidance when recipients are established on antipsychotic medications but the diagnosis codes submitted are not included in the table of covered diagnoses.

When the diagnosis code written on the prescription is not included in the list of covered diagnoses, and when the pharmacist cannot reach the prescriber or when the RxPA Unit is closed, the pharmacist, using his/her 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 may override the diagnosis code requirement.

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**.

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)	≥18 Y
Codeine Combination Product	≥12 Y

Contraceptive Agents

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 two 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 day 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; and
- 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 for detailed billing information.

Oral Contraceptive Agents

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

Medroxyprogesterone Acetate Injectable

Prescription claims for Medroxyprogesterone Acetate injectable for female recipients 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 days' supply.

Claims for Medroxyprogesterone Acetate sub-q 104 injectable for female recipients, 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 days' supply.

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

NOTE: Refer to Appendix D for detailed billing information.

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.

Deferasirox (Exjade ®)

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

Recipients 2 years of age and less

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

Recipients 2-9 years of age

Pharmacy claims for deferasirox (Exjade®) require a diagnosis code of chronic iron overload due to blood transfusions for payment for recipients 2-9 years of age. 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.

Recipients 10 years of age and older

Pharmacy claims for deferasirox (Exjade®) require a valid numeric diagnosis code for reimbursement.

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

Covered Indications at POS	ICD-10-CM Diagnosis Code
2 years and up	
Chronic iron overload due to blood transfusion	E83.111
10 years and up Chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndromes	
β-thalassemia intermedia	D56.1
Hemoglobin E/β-thalassemia	D56.5
Hemoglobin S/β-thalassemia	D57.4*
10 years and up Chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndromes	
Hemoglobin C/ β-thalassemia	D56.8
α-thalassemia intermedia [hemoglobin H disease]	D56.0

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

Diabetic Testing Supplies

The 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 durable medical equipment regional carrier (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 facility 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.

Eculizumab (Soliris®)

Pharmacy claims for eculizumab (Soliris®) 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 eculizumab (Soliris®).

Medication	ICD-10-CM Diagnosis Code*	Diagnosis Description
Eculizumab (Soliris®)	D59.3	Hemolytic-uremic syndrome
	D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
	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

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.

Granulocyte Colony Stimulating Factor Agents (Granix®/ Leukine®/ Neulasta®/ Neupogen®)

Prescriptions for Granulocyte Colony Stimulating Factor Agents (Granix®/ Leukine®/ Neulasta®/ Neupogen®) will be reimbursed when:

- The prescriber has completed in full and submitted a Clinical Pre-Authorization Form; and
- The prescriber has obtained an approved clinical pre-authorization.

NOTE: Refer to Appendix D for detailed claims filing instructions and Appendix F for the Clinical Pre-Authorization form and instructions.

Hepatitis C Virus Direct-Acting (DAA) Antiviral Agents

There are clinical edits for the following Hepatitis C Virus (HCV) Direct-Acting Antiviral (DAA) Agents:

- Daclatasvir (Daklinza®);
- Elbasvir/Grazoprevir (Zepatier);
- Glecaprevir/Pibrentasvir (Mavyret®);
- Ledipasvir/Sofosbuvir (Harvoni®);
- Ombitasvir/Paritaprevir/Ritonavir (Technivie®);
- Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir (Viekira®);

- Simeprevir (Olysio®);
- Sofosbuvir (Sovaldi®); and
- Sofosbuvir/Velpatasvir (Epclusa®).

Prescriptions for Hepatitis C Virus Direct-Acting Antiviral Agents will be subject to one or more of the following for reimbursement:

- Clinical Pre-Authorization;
- Age Limits;
- Duration of Therapy;
- Quantity Limits;
- Diagnosis Code Requirement;
- Early Refill; and
- Therapeutic Duplication.

Clinical Pre-Authorization

Pharmacy claims for Hepatitis C Virus Direct-Acting Antiviral Agents will be reimbursed when the prescriber has obtained an approved clinical pre-authorization.

Prescribers must complete in full the Clinical Pre-Authorization Form and Hepatitis C Virus (HCV) Medication Therapy Worksheet. Prescribers and patients must complete in full their designated sections of the Hepatitis C Virus (HCV) Treatment Agreement Form (for initial requests).

Age Restriction

Pharmacy claims for Hepatitis C Virus Direct-Acting Agents will deny when the recipient is 17 years of age or younger.

Duration of Therapy

The duration of therapy for Hepatitis C Virus Direct-Acting Antiviral (DAA) Agents are listed in the chart.

Medication	Duration[a]
Daclatasvir + Sofosbuvir	12 weeks
Ledipasvir/Sofosbuvir	12-24[b] weeks
Elbasvir/Grazoprevir	12-16[c] weeks
Ombitasvir/Paritaprevir/Ritonavir	12 weeks
Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir	12-24[d] weeks
Simeprevir	12 weeks
Simeprevir + Sofosbuvir	12-24[e] weeks
Sofosbuvir	12-4[f] weeks
Sofosbuvir/Velpatasvir	12 weeks

a. maximum duration of DAA agent therapy over patient lifetime
b. maximum duration of treatment with ledipasvir/sofosbuvir for genotype 1 treatment-experienced patients with cirrhosis is 24 weeks
c. maximum duration of treatment with elbasvir/grazoprevir for genotype 1a treatment-naïve or treatment- experienced patients with baseline NS5A polymorphisms or genotype 4 treatment-experienced patients is 16 weeks
d. maximum duration of treatment with ombitasvir/paritaprevir/ritonavir with dasabuvir for patients with genotype 1a, genotype 1 unknown subtype or mixed genotype 1 with cirrhosis is 24 weeks
e. maximum duration of treatment with simeprevir + sofosbuvir for patients with genotype 1 with cirrhosis is 24 weeks
f. maximum duration of treatment with sofosbuvir for genotypes 1, 2, or 4 is 12 weeks, maximum duration for genotype 3 is 24 weeks, and maximum duration for HCV in patients with hepatocellular carcinoma awaiting liver transplantation is up to 48 weeks or until liver transplantation, whichever occurs first.

If the prescriber chooses to exceed the duration of therapy allowed, then the prescriber should complete and fax a Request for Prescription Override Form (RxPA-16) to the RxPA Unit.

Quantity Limits

Prescriptions for Hepatitis C Virus Direct-Acting Antiviral Agents will be subject to quantity limits.

Medication	Maximum Units Per Rolling 28 Days
Daclatasvir[a]	28 units (30mg or 60mg dose); 56 units (30mg+ 60mg = 90mg dose)
Elbasvir/Grazoprevir[b]	28 units

Medication	Maximum Units Per Rolling 28 Days
Ombitasvir/Paritaprevir/Ritonavir[c]	56 units
Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir[d]	112 units
Ledipasvir/Sofosbuvir[e]	28 units
Simeprevir[f]	28 units
Sofosbuvir[g]	28 units
Sofosbuvir/Velpatasvir[g]	28 units

a. Daclatasvir quantity limits: maximum 1 tablet per day (30 or 60mg dose), 28 tablets per rolling 28 days; maximum 2 tablets per day (30mg+60mg= 90mg dose), 56 tablets per rolling 28 days
b. Elbasvir/Grazoprevir quantity limits: maximum 1 tablet per day, 28 tablets per rolling 28 days
c. Ombitasvir/Paritaprevir/Ritonavir quantity limits: maximum of 2 tablets per day, 56 tablets per rolling 28 days
d. Ombitasvir/Paritaprevir/Ritonavir with Dasabuvir quantity limits: maximum of 4 tablets per day, 112 tablets per rolling 28 days
e. Ledipasvir/sofosbuvir quantity limits: maximum 1 tablet per day, 28 tablets per rolling 28 days
f. Simeprevir quantity limits: maximum 1 capsule per day, 28 capsules per rolling 28 days
g. Sofosbuvir quantity limits: maximum 1 tablet per day, 28 tablets per rolling 28 days
h. Sofosbuvir/Velpatasvir quantity limits: maximum 1 tablet per day, 28 tablets per rolling 28 days

Diagnosis Code Requirement

Pharmacy claims for Hepatitis C Virus Direct-Acting Antiviral Agents will require a diagnosis code of B18.2 for payment. The diagnosis code should be documented on the hardcopy prescription 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 code is required for the claim submission.

Early Refill

Pharmacy claims Hepatitis C Virus Direct-Acting Antiviral Agents will not be allowed to process for payment before 89 percent of the days' supply has been exhausted.

After consultation with the prescriber to verify the necessity of the early refill, the pharmacist may override the early refill denial. The pharmacist must document the NCPDP DUR override codes and reason for the override on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Therapeutic Duplication

Pharmacy claims for Hepatitis C Virus Direct- Acting Antiviral Agents will deny when there is an active claim on file for another one of these same Hepatitis C Virus Direct-Acting Antiviral Agents, if the incoming agent is identified as having a therapeutic duplication with the current agent within the last 12 months. Therapeutic duplication does not apply to Hepatitis C Virus Direct-Acting Antiviral Agents that are approved for administration with another Hepatitis C Virus Direct- Acting Antiviral Agent.

There are no override provisions through the POS system using the NCPDP service codes.

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 for entering the emergency override.

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

Hydroxyprogesterone Caproate (Makena®)

Hydroxyprogesterone Caproate (Makena®) is a covered pharmacy and medical benefit.

Prescripitions for hydroxyprogesterone caproate (Makena®) require the following for reimbursement:

- The prescriber has submitted an acceptable diagnosis code of O09.21* Pregnancy with a history of pre-term labor.
- The acceptable diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code may be communicated to the pharmacist from the prescriber (or prescriber's agent) electronically, via telephone, or facsimile.
- The acceptable diagnosis code must be submitted at POS.

When the prescriber does 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. The pharmacist must also document "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

NOTE: Refer to Point of Sale User Guide and www.lamedicaid.com for additional information.

Isotretinoin

Isotretinoin capsules will be covered only if a handwritten prescription signed by the prescribing practitioner, with no provisions for refills, is submitted.

Ivacaftor (Kalydeco®)

Pharmacy claims for Ivacaftor (Kalydeco®) require an approved clinical pre-authorization for reimbursement. Prescribers should complete in full and submit a clinical pre-authorization form to the RxPA Unit.

NOTE: Refer to POS User Guide in Appendix D and Forms in Appendix F for complete billing instructions, criteria, and Clinical Pre-Authorization Form.

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: Refer to Appendix D for detailed billing information.

Linezolid (Zyvox®)

Pharmacy claims for linezolid (Zyvox®) require clinical pre-authorization.

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

NOTE: Refer to the Appendix D for detailed claims filing instructions and Appendix F, Forms for the clinical pre-authorization form and instructions.

Lumacaftor/Ivacaftor (Orkambi®)

Clinical Pre-Authorization

Pharmacy claims for lumacaftor/ivacaftor (Orkambi®) will be reimbursed at POS when the prescriber has obtained an approved clinical pre-authorization.

Pharmacy claims for lumacaftor/ivacaftor (Orkambi®) without an approved clinical pre-authorization will deny.

Override provisions should be addressed through the Clinical Pre-Authorization process.

Diagnosis Code Requirements

Pharmacy claims for lumacaftor/ivacaftor (Orkambi®) require a valid ICD-10-CM diagnosis code. 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 code for lumacaftor/ivacaftor (Orkambi®).

Diagnosis	ICD-10-CM Diagnosis Code(s)
Cystic fibrosis	E84.*

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

Lumacaftor/ivacaftor (Orkambi®) claims submitted at POS without a valid diagnosis code will deny.

Prescribing providers may call the RxPA Unit for guidance when recipients are established on medications but the ICD-10-CM diagnosis code(s) submitted are not included in the covered diagnoses.

When the diagnosis code written on the prescription is not included in the list of covered diagnoses AND when the pharmacist cannot reach the prescriber OR when the RxPA Unit is closed, the pharmacist, using his/her professional judgment, may deem the filling of the 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 may override the diagnosis code requirement.

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 recipients:

- Who are pregnant; or
- 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.

Naloxone

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

Description	Dosage Form	Strength	Units per 90 Rolling Days	Representative Brand
Naloxone	Injectable Solution	0.4mg/ml	2	Naloxone

Description	Dosage Form	Strength	Units per 90 Rolling Days	Representative Brand
Naloxone	Injectable Solution Cartridge	0.4mg/ml	2	Naloxone
Naloxone	Injectable Solution Prefilled Syringe	1mg/ml	2	Naloxone
Naloxone	Injectable Solution (5ml, 10ml, 20ml)	1mg/ml	1	Naloxone
Naloxone	Injectable Solution (10ml)	0.4mg/ml	1	Naloxone
Naloxone	Injectable Solution Auto-Injector	0.4mg/0.4ml	2	Evzio®
Naloxone	Nasal Liquid	4mg/0.1ml	2	Narcan®

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.

Omalizumab (Xolair®)

Prescriptions for omalizumab (Xolair®) will be reimbursed when the following criteria are met:

- The prescriber has obtained prior authorization for the recipient to receive the omalizumab or the recipient has an existing prior authorization for omalizumab; and

- The recipient is 12 years of age or older on the date of service.

The following are acceptable diagnoses for omalizumab claims submitted for prior authorization:

Diagnosis Description
Allergic (extrinsic) asthma
Allergic (extrinsic) asthma unspecified
Allergic (extrinsic) asthma with status asthmaticus
Allergic (extrinsic) asthma with acute exacerbation
Chronic Idiopathic Urticaria

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 12 years of age or older;
- The prescription is an original—no refills are allowed;
- The prescription is for a maximum of 90 capsules **and** 30 days' supply;
- The recipient has a documented current body mass index (BMI) of 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;
- The recipient has other risk factors warranting the use of Orlistat and the prescriber has identified an approved diagnosis code in his/her handwriting, on the dated prescription or a dated and signed attachment to the prescription; and
- There are 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-10-CM **numeric codes only**, are acceptable:

ICD-10-CM Code	Description
E11.*	Type II Diabetes
R73.02	Impaired Glucose Tolerance
E15, E16.1	Hyperinsulinemia
E78.0-E78.5	Dyslipidemia
I10, I11.*, I12.*, I13.*, I15.*	Hypertension
I21.*, I22.*, I24.*, I25.*	Ischemic Heart Disease
I70	Atherosclerosis
I73	Other peripheral vascular diseases
K21.0, K21.9	Gastric Reflux Disease
M16.*, M17.*	Osteoarthritis of Hips/Knees
G47.30	Sleep Apnea
I60.*, I61.*, I62.*, I63.*, I65.*, I66.*, I67.*, I68.*, I69.*	Cerebrovascular Disease
G93.2	Pseudotumor cerebri
I83.2	Varicose Veins of the lower extremities with ulcer and inflammation
I80.0	Phlebitis & Thrombophlebitis of the superficial vessels of the lower extremities
I80.1	Phlebitis & Thrombophlebitis of the femoral vein
I80.2	Phlebitis & Thrombophlebitis of other deep vessels
I80.3	Phlebitis & Thrombophlebitis of lower extremities, unspecified
I83.0	Varicose veins of lower extremities, with ulcer
I83.1	Varicose veins of lower extremities, with inflammation
I83.9	Varicose veins of lower extremities, without mention of ulcer & inflammation

The prescriber identified 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 palivizumab (Synagis®) will only be reimbursed when prescriptions meet the following criteria:

- The prescriber has completed in full and submitted a Clinical Pre-Authorization Form; and
- The prescriber has obtained an approved clinical pre-authorization.

NOTE: Refer to the Louisiana Medicaid website for the Clinical Pre-Authorization Form and the Palivizumab (Synagis®) Criteria.

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 Appendix N for web address.) The RSV season in Louisiana begins November 1st and ends March 31st.

Age Restriction

Palivizumab claims for recipients 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. 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.

Medical Reconsideration for Palivizumab (Synagis®)

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

NOTE: Refer to Appendix F for the Palivizumab Request for Reconsideration Form.

Palivizumab Criteria ICD-10-CM Code and Medication List

Note: Any accepted diagnosis code listed on the clinical pre-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.

Neuromuscular Disorders

Acceptable ICD-10 codes include:

ICD-10-CM Code	Description
A80.0-A80.39	Infantile paralysis
G31.9	Cerebral degenerations
G25.3	Myoclonus
G11.1, G11.4	Spinocerebellar disease
G12.0	Werdnig-Hoffman disease (Infantile spinal muscular atrophy)
G12.1, G12.8, G12.9	Spinal muscular atrophy
G12.2*	Motor neuron disease

Exclude (but not limited to) the following (i.e. the following are NOT accepted):

ICD-10-CM Code	Description
G80*	Cerebral palsy
G40.3*	Generalized convulsive epilepsy
G40.4*	Grand mal seizures

ICD-10-CM Code	Description
G40*	Epilepsy
Q05*	Spina bifida
P90	Newborn seizures
R56*	Infantile seizures

Congenital Abnormalities of the Airways

Acceptable ICD-10 codes include:

ICD-10-CM Code	Description
G47.35	Congenital central alveolar hypoventilation syndrome
Q32.0, Q32.1	Other diseases of the trachea and bronchus, not elsewhere classified (Must specify Tracheomalacia or tracheal stenosis)
Q31.1, Q31.5, Q32.1, Q32.4	Other anomalies of larynx, trachea, and bronchus (Must specify congenital tracheal stenosis, subglottic stenosis, atresia of trachea, laryngomalacia, or absence or agenesis of bronchus, trachea)
Q33.0	Congenital cystic lung
Q33.3, Q33.6	Agenesis, hypoplasia, and dysplasia of the lung
Q33.4	Congenital bronchiectasis
Q38.2	Macroglossia
Q38.5	Uvula anomaly
J98.6	Diaphragmatic paralysis
Q87.3	Beckwith-Wiedemann syndrome

Exclude (but not limited to) the following (i.e. the following are NOT accepted):

ICD-10-CM Code	Description
Q33.9	Anomaly of lung, unspecified
Q33.1, Q33.8	Other anomaly of the lung

Chronic Lung Disease

Acceptable ICD-10 code:

ICD-10-CM Code	Description
P27*	Chronic respiratory disease arising in the perinatal period (CLD/BPD/Interstitial pulmonary fibrosis of prematurity/Wilson-Mikity syndrome)

Exclude (but not limited to) the following (i.e. the following are NOT accepted):

ICD-10-CM Code	Description
J05.0	Croup
J06*	URI
J20*	Bronchitis
J21*	Bronchiolitis
J45*	Asthma
R06.2	Wheezing

Congenital Heart Diseases

Per AAP guidelines, prophylaxis with palivizumab in children with chronic heart disease (CHD) should be made on the degree of cardiovascular compromise. CHD that is deemed hemodynamically insignificant will not meet criteria. Documentation must specifically support CHD being hemodynamically significant (e.g. medications, etc.).

Acceptable ICD-10 codes include:

Acyanotic CHD

ICD-10-CM Code	Description
Q23.0	Aortic stenosis
I37.0, I37.1, I37.2, Q22.1, Q22.2	Pulmonary valve disorders (incompetence, insufficiency, regurgitation, and stenosis)
I42*, I43	Cardiomyopathy (must be moderate to severe)
Q21.0	Ventricular septal defect
Q21.1	Atrial septal defect
Q21.2	Atrioventricular canal (endocardial cushion defect)
Q22.3	Anomalies of pulmonary valve congenital
Q22.1	Pulmonic stenosis
Q23.0	Congenital stenosis of aortic valve (congenital aortic stenosis) [Excludes: congenital subaortic stenosis; supravalvular aortic stenosis]
Q23.3	Congenital mitral insufficiency
Q25.0	Patent ductus arteriosus
Q25.1	Coarctation of the aorta
Q25.2, Q25.3	Atresia and stenosis of aorta (absence, aplasia, hypoplasia, stricture of the aorta) Supra (valvular)-aortic stenosis [Excludes: congenital aortic (valvular) stenosis or stricture; hypoplasia of aorta in hypoplastic left heart syndrome]

NOTE: Must currently be receiving medication to control congestive hart failure.

Cyanotic CHD

ICD-10-CM Code	Description
Q20.0	Truncus arteriosus
Q20.3	Transposition of the great vessels
Q21.3	Tetralogy of Fallot
Q22.0	Atresia, congenital
Q22.4	Tricuspid atresia and stenosis, congenital
Q22.5	Ebstein's anomaly
Q23.4	Hypoplastic left heart
Q22.6	Hypoplastic right heart
Q25.5	Pulmonary atresia
Q26.2	Total anomalous pulmonary venous return

NOTE: Does not require use of medication/must not have had or completed surgical correction.

Pulmonary Hypertension

ICD-10-CM Code	Description
I26.0*	Acute cor pulmonale
I27.0	Primary pulmonary hypertension
I27.2	Other chronic pulmonary heart disease (pulmonary hypertension, secondary)
P29.3	Persistent fetal circulation (persistent pulmonary hypertension/primary pulmonary hypertension of newborn)

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

Acceptable Medications Used in CHD

Digoxin	ACE Inhibitors	Supplemental oxygen
Beta Blockers	Nitroglycerin	Diuretics
Calcium Channel Blockers	Anti-Coagulants	

NOTE: Refer to "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 a 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 "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 drug utilization reviews 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 recipient 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.

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.

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®).

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

Perampanel (Fycompa®)

Age Limit

Pharmacy claims for perampanel (Fycompa®) will deny for recipients under 12 years of age.

After consultation with the prescriber to verify the necessity of prescribing perampanel (Fycompa®) for a recipient under 12 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: Refer to POS User Guide for detailed billing instructions.

Roflumilast (Daliresp®)

Pharmacy claims for roflumilast (Daliresp®) require an approved clinical pre-authorization for reimbursement. Prescribers should complete in full and submit a clinical pre-authorization form to the RxPA Unit.

NOTE: Refer to POS User Guide in Appendix D and Forms in Appendix F for detailed billing instructions, criteria, and Clinical Pre-Authorization Form.

Short-Acting Beta$_2$ Agonist Inhalers

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

- Require an appropriate diagnosis code; and

- 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 by either the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone or facsimile. Claims submitted with a diagnosis associated with chronic obstructive pulmonary disease, emphysema, or cystic fibrosis will bypass the edit.

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

ICD-10-CM Diagnosis Code(s)	Diagnosis Description
E84*	Cystic fibrosis
J40	Bronchitis, not specified
J44*	Obstructive chronic bronchitis
J43*	Emphysema
J44*	Chronic obstructive asthma
J44.9	Chronic airway obstruction

* - 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:

- The prescriber's reason why the limit needs to be exceeded; and
- 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:

- The prescriber is aware of the current active SABA claim; and
- 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:

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

Sildenafil (Revatio®) And Tadalafil (Adcirca®)

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

The following diagnosis codes are acceptable:

ICD-10-CM Code	Description
I27.0, I27.2, I27.89, P29.3	Pulmonary Arterial Hypertension

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:

- The prescriber has completed in full and submitted a Clinical Pre-Authorization Form; and
- The prescriber has obtained an approved clinical pre-authorization.

Sodium Oxybate (Xyrem®)

Clinical Pre-Authorization

Pharmacy claims for sodium oxybate (Xyrem®) will be reimbursed when the prescriber has obtained an approved clinical pre-authorization. Prescribers must complete the Clinical Pre-Authorization Form in full and fax it to the RxPA Unit. A diagnosis of narcolepsy or cataplexy must be submitted in the clinical pre-authorization process.

Therapeutic Duplication

Pharmacy claims for sodium oxybate (Xyrem®) will deny when the recipient has an active claim on file for a CNS depressant. Claims for CNS depressants will deny when the recipient 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 www.lamedicaid.com for the Clinical Pre-Authorization Form/Criteria and the Point of Sale User Guide for detailed billing information.

Somatropin

Pharmacy claims for Somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin®, Nutropin AQ®, Omnitrope®, Saizen®, Serostim®, Tev-Tropin®, and Zorbtive®) require an appropriate diagnosis code for reimbursement. The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. 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) • Short stature • 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: • Blind Loop Syndrome • Other unspecified post-surgical nonabsorption
R64	(Serostim® only) HIV-associated cachexia or wasting

Suvorexant (Belsomra®)

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

Tasimelteon (Hetlioz®)

Prescription claims for tasimelteon (Hetlioz®) will have the following clinical edits:

- Clinical Pre-Authorization;
- Maximum Daily Dose; and
- Therapeutic Duplication.

Clinical Pre-Authorization for tasimelteon (Hetlioz®)

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

Pharmacy claims for tasimelteon (Hetlioz®) without an approved clinical pre-authorization will deny at POS.

Override provisions should be addressed through the Clinical Pre-Authorization process.

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.

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 Appendix N for contact information).

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

Tedizolid Phosphate (Sivextro®)

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

- The prescriber has completed in full and submitted a Clinical Pre-Authorization Form; and
- The prescriber has obtained an approved clinical pre-authorization.

Tramadol

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

Description	Age (Y=Year)
Tramadol	≥17 Y
Tramadol Combination Product	≥17 Y

Triptans

Pharmacy claims for triptans for recipients 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®
Sumatriptan	Alsuma®, Imitrex®, Sumavel®, Zecuity®

Generic Name	Representative Brand(s)
Zolmitriptan	Zomig®, Zomig ZMT®

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

Descripton	ICD-10-CM Diagnosis Codes
Migraine diagnosis	G43.0*, G43.1*, G43.7*

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:

- The prescriber has completed in full, and submitted, a Clinical Pre-Authorization Form; and
- The prescriber has obtained an approved clinical pre-authorization.

NOTE: Refer to Appendix D, Point of Sale User Guide for detailed claims filing instructions and Appendix F for the Clinical Pre-Authorization form and instructions.

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 Appendix P for the FFS and MCOs ICD-10-CM Diagnosis Code Policy Chart.

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 recipient's condition, recipient'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).

Duration of Therapy Limits

H_2 Antagonists & Sucralfate

The program utilizes a duration of therapy module for H_2 antagonists, and sucralfate for recipients who are 16 and older. Acute dosage guidelines for these drugs are monitored. Acute dosing of H_2 antagonists and sucralfate beyond 90 days, requires documentation of an appropriate diagnosis code. When authorized by the prescriber, claims for acute doses beyond 90 days can be processed through the POS system at the pharmacy. The chronic use of these agents at full therapeutic dosage is generally not indicated. The duration of therapy period begins every calendar year.

The acute dosage schedules of these drugs are as follows:

H_2 Antagonists & Sucralfate		
Generic Description	**Acute mg/day dose**	**Duration of Therapy**
Ranitidine HCl	300	12 weeks (90 days)
Cimetidine	1200	12 weeks (90 days)
Nizatidine	300	12 weeks (90 days)
Famotidine	40	12 weeks (90 days)
Sucralfate	4000	12 weeks (90 days)

Maintenance dose drug therapy will continue to be payable after the 90 days of the appropriate drug therapy with prescriber authorization.

If, in the professional judgment 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 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 H_2 antagonists and sucralfate.

Select diagnosis codes which may justify the long-term usage of H2 antagonists and sucralfate are listed below.

ICD-10-CM Diagnosis Code(s)	Diagnosis
B96.81	*H. pylori*
C96.2	Malignant Mast Cell Tumors
D44.0, D44.2, D44.9	Multiple Endocrine Adenomas
E16.4	Zollinger-Ellison Syndrome
K20.9	Esophagitis, Unspecified
K21.0	Reflux Esophagitis
K20.8	Abscess of Esophagus
K22.1*	Ulcer of Esophagus with or without bleeding
K22.7*	Barrett's Esophagus
K25.*	Gastric Ulcer
K26.*	Duodenal Ulcer
K27.*	Peptic Ulcer
K29.*	Gastritis/Duodenitis
K30	Gastric Hyperacidity
K21.9	Gastroesophageal Reflux Disease (GERD)
K50.*	Crohn's Disease

ICD-10-CM Diagnosis Code(s)	Diagnosis
K86.0, K86.1	Chronic Pancreatitis
K92.2	Gastrointestinal Hemorrhage

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

Proton Pump Inhibitors (PPIs)

Prescriptions for Proton Pump Inhibitors which exceed 120 days duration of therapy limit will be reimbursed when:

- The prescriber has completed in full and submitted a PA Request for Prescription Override; and
- The prescriber has obtained an approved PA Request for Prescription Override.

The select diagnosis codes below will bypass (be exempt from) the duration of therapy limit for PPIs.

ICD-10-CM Diagnosis Code(s)	Diagnosis Description
C96.2	Malignant Mast Cell Tumors
D44.0, D44.2, D44.9	Multiple Endocrine Adenomas
E16.4	Zollinger-Ellison Syndrome
E84.*	Cystic Fibrosis
K20.0	Eosinophilia Esophagitis
K20.8	Abscess of Esophagus
K22.1*	Ulcer of Esophagus with or without Bleeding
J86.0	Tracheoesophageal Fistula
K22.7	Barrett's Esophagus
K29.41	Atrophic Gastritis with Hemorrhage

ICD-10-CM Diagnosis Code(s)	Diagnosis Description
K52.81	Eosinophilic Gastritis
K31.81*	Angiodysplasia of Stomach and Duodenum with or without Mention of Hemorrhage
K92.81	Gastrointestinal Mucositis (Ulcerative)
K86.0, K86.1	Chronic Pancreatitis
K92.2	Gastrointestinal Hemorrhage
Q39.1, Q39.2	Congenital Tracheoesophageal Fistula

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

Claims for recipients under six years of age are excluded from the PPI duration of therapy module. In addition, claims for recipients receiving pancreatic enzymes are excluded from the PPI duration of therapy module as well.

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 recipient'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 for detailed billing information.

Duplicate Drug Therapy

A claim denial will occur if the recipient 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, recipient 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. 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: Refer to Appendix D for detailed billing information.

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 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.

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: Refer to the POS User Guide 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 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.

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
Pseudoephedrine 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
Benazepril HCl/Hydrochlorothiazide
Captopril
Captopril/Hydrochlorothiazide
Enalapril Maleate
Enalapril/Hydrochlorothiazide
Fosinopril Sodium
Fosinopril/Hydrochlorothiazide
Lisinopril
Lisinopril/Hydrochlorothiazide
Moexipril HCl
Moexipril/Hydrochlorothiazide
Perindopril Erbumine
Quinapril HCl
Quinapril/Hydrochlorothiazide
Fosinopril Sodium
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/Antihyperlipemia Agent Combination

Amlodipine/Atorvastatin Calcium

Potassium Replacement

Potassium Acetate
Potassium Chloride
Potassium Bicarbonate / Citric Acid
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 recipient 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
Fluphenazine
Haloperidol
Loxapine
Molindone
Perphenazine
Pimozide
Thioridazine
Thiothixene
Trifluoperazine

Atypical Antipsychotic Agents

Aripiprazole
Asenapine
Brexpiprazole
Cariprazine
Clozapine
Iloperidone
Lurasidone
Olanzapine
Paliperidone
Quetiapine
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 diagnosis codes are:

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

Sedative Hypnotic Agents

Estazolam
Eszopiclone
Flurazepam HCl
Quazepam
Temazepam
Triazolam
Zaleplon
Zolpidem Tartrate

Attention Deficit Disorder (ADD) Agents

Armodafinil
Atomoxetine
Dexmethylphenidate
Dextroamphetamine
Dextroamphentamine/amphetamine
Guanfacine
Lisdexamfetamine
Methylphenidate
Modafinil

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 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 Beta$_2$ Agonist Inhalers

Albuterol
Pirbuterol
Levalbuterol

Pharmacy claims billed for concurrent use of different short-acting beta$_2$ 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 beta$_2$ agonist inhalers.

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 - Claim Submissions for override information as well as Point of Sale User Guide in Appendix D 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 recipient 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

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:

- 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 recipients, the prescribing practitioner must include:

- 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

- 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 noted in the prescriber's handwriting. A rubber stamp notation is not acceptable. The 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 recipient will only process without an override when the following conditions are met:

- A diagnosis code indicating the reason for treatment is documented and submitted; and

- When one of the following conditions exists:

    - Recipient has current prescription for H2 receptor antagonist;

    - Recipient has current prescription for proton pump inhibitor;

    - Recipient has current prescription for warfarin;

- Recipient has current prescriptions indicating chronic use of oral steroids; or

- Recipient 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.

NOTE: Refer to Section 37.9 - Claim Submissions for override information as well as Point of Sale User Guide in Appendix D 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 his/her 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 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.

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
Doxepin (sedative-hypnotic only)	Silenor®	6 mg/day
Estazolam	Prosom®	2 mg/day
Eszopiclone	Lunesta®	3 mg/day
Flurazepam	Dalmane®	30 mg/day
Quazepam	Doral®	15 mg/day
Ramelteon	Rozerem®	8 mg/day
Temazepam	Restoril®	30 mg/day
Triazolam	Halcion®	0.5 mg/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)

Generic Name	Brand Name	Maximum Dose Per Day
Zolpidem SL tablet	Intermezzo®	3.5 mg/day (male)

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

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 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 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 POS submission.

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

Botulinum Toxins OnabotulinumtoxinA (Botox®) and IncobotulinumtoxinA (Xeomin®)

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

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
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
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
G35	Upper Limb Spasticity Associated with Multiple Sclerosis (Relapsing)
G80.0, G80.1, G80.2, G80.4, G80.8, G80.9	Upper Limb Spasticity Associated with Cerebral Palsy
G81.1*	Upper Limb Spasticity Associated with Spastic Hemiplegia
G82.53	Upper Limb Spasticity Associated with C5-C7 Complete Quadriplegia
G82.54	Upper Limb Spasticity Associated with C5-C7 Incomplete Quadriplegia
G83.0	Upper Limb Spasticity Associated with Diplegia of Upper Limb
G83.2*	Spasticity Associated with Monoplegia of Upper Limb
ICD-10-CM Diagnosis Code(s)	**Description**
I69.•31, I69.•32, I69.•33, I69.•34, I69.•39	Spasticity Associated with Monoplegia of Upper Limb due to Late Effects Cerebrovascular Disease
I69.•51, I69.•52, I69.•53, I69.•54, I69.•59	Upper Limb Spasticity 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 Associated with Intracranial Injury of Other and Unspecified Nature (Traumatic Brain Injury)
S14.0*, S14.1•5*, S14.1•6*, S14.1•7*	Upper Limb Spasticity Associated with Spinal Cord Injury without Evidence of Spinal Bone Injury

* - 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

Hydrocodone Containing Agents

Prescriptions for hydrocodone containing drugs will be limited to:

- 45 units per 15 days for hydrocodone/acetaminophen;
- 30 units per 15 days for hydrocodone bitartrate capsule ER 12 hour;
- 15 units per 15 days for hydrocodone bitartrate tablet ER 24 hour; and
- 30 units per 15 days for hydrocodone/ibuprofen within a 30-day period.

If a prescriber chooses to exceed the 15-day quantity limit for hydrocodone, he/she must submit a Rx PA16 to the RxPA Unit.

NOTE: All Schedule II prescriptions require a valid diagnosis code to process. Hydrocodone claims will not be subject to the 15-day quantity limit when one of the diagnosis codes below is submitted.

ICD-10 Diagnosis Code(s)	Diagnosis
C00.*-C96.*	Cancer
Z51.5	Palliative Care

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

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

Lidocaine Patches (Lidoderm®)

Pharmacy claims for lidocaine patches (Lidoderm®) have a quantity limit of 30 patches every rolling thirty days.

If a prescriber chooses to exceed 30 patches every rolling 30 days, the claim will be reimbursed when:

- The prescriber has completed in full and submitted a PA Request for Prescription Override Form (RxPA16); and
- The prescriber has obtained an approved PA Request for Prescription Override.

Naltrexone Injection (Vivitrol®)

Pharmacy claims for naltrexone injection (Vivitrol® are subject to the following for reimbursement:

- Diagnosis code requirement;
- Age Limit;
- Quantity Limit; and
- 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

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 recipient's file for an opioid. Pharmacy claims for opioid prescriptions will deny if there is an active claim on the recipient's file for naltrexone injection (Vivitrol®).

Opioids

Opioid prescription drugs have the following clinical edits:

- Diagnosis code requirement for all Schedule II narcotics;
- 15-day quantity limit for select opioids;
- 7-day quantity limit for select opioids for opioid naïve recipients;
- Maximum of 90 Morphine Milligram Equivalent (MME) per day; and
- Prior drug use required for long-acting opioids.

Opioid 15-day Quantity Limit

Pharmacy claims for opioids will be subject to a 15-day quantity limit. The opioid quantity limits per 15-days are listed in the chart below.

Opioid Quantity Limits, Units per 15 Days Supply within a 30 day period			
Description	**Dosage Form**	**Units / 15 days**	**Representative Brand**
Hydrocodone Bitartrate, Hydrocodone/Ibuprofen	Capsule ER 12 hr, Tablet	30 units	Zohydro ER®, Vicoprofen®
Hydrocodone Bitartrate	Tablet ER 24 hr	15 units	Hysingla ER®
Hydrocodone/Acetaminophen	Short Acting Tablet/Capsule	45 units	Lortab®, Vicodin®
Hydromorphone HCl	Short Acting Tablet	45 units	Dilaudid®
Hydromorphone HCl	Tablet ER 24 hr	15 units	Exalgo®
Meperidine	Tablet	45 units	Demerol®
Methadone	Tablet	45 units	
Morphine Sulfate	Tablet	45 units	
Morphine Sulfate	Capsule ER 24 hr	15 units	Avinza®
Morphine Sulfate	Capsule SR Pellet, Tablet SA	30 units	Kadian®, MS Contin®
Morphine Sulfate	Tablet ER	60 units	Arymo ER ®
Morphine Sulfate/Naltrexone	Capsule SR Pellet	30 units	Embeda®

Opioid Quantity Limits, Units per 15 Days Supply within a 30 day period			
Description	**Dosage Form**	**Units / 15 days**	**Representative Brand**
Oxycodone HCl, Oxycodone, Oxycodone/Acetaminophen	Tablet SR 12 hr, Capsule ER 12 hr Tablet ER 12 hr	30 units	Oxycontin® Xtampza ER® Xartemis XR®
Oxycodone HCl, Oxycodone/Acetaminophen, Oxycodone/Aspirin	Tablet/Capsule	45 units	Roxicodone®, Endocet®, Percocet®, Roxicet®
Oxycodone/Ibuprofen	Tablet	14 units	
Oxymorphone HCl	Tablet	45 units	Opana®
Oxymorphone HCl	Tablet SR 12 hr	30 units	Opana ER®
Tapentadol	Tablet	45 units	Nucynta®
Tapentadol	Tablet ER 12 hr	30 units	Nucynta ER®
Tramadol HCl	Tablet	45 units	Ultram®
Tramadol HCl	Tablet ER 24 hr Capsule ER 24 hr	15 units	Ultram ER® ConZip®
Tramadol/Acetaminophen	Tablet	40 units	Ultracet®

Fentanyl Transdermal Patch Quantity Limits- Units per 30 Rolling Day Period					
Description	**Dosage Form**	**Route**	**Strength**	**Units/30 Rolling Days**	**Representative Brand**
Fentanyl	Patch	Transdermal	12, 25, 37.5, and 50 mcg/hr	10 units	Duragesic®
Fentanyl	Patch	Transdermal	62.5, 75, 87.5, and 100 mcg/hr	20 units	Duragesic®

Overrides for quantities greater than the opioid 15-day quantity limits listed in the tables above for opioids will be addressed using the *Opioid Analgesic Treatment Worksheet*. The prescriber must fax the completed forms and applicable supporting documentation to the RxPA Unit.

NOTE: Refer to the POS User Guide for detailed billing instructions and override procedures.

Short-Acting Opioid 7-Day Quantity Limit (Opioid Naïve Recipients)

Short-acting opioids will be limited to a 7-day supply for opioid-naïve recipients. For this edit, opioid-naïve recipients are defined as those who have not had an opioid claim paid within the last

90 days. The following chart lists short-acting opioids and corresponding quantity limits for opioid-naïve recipients.

Description	Dosage Form	Units/7 days	Representative Brand
Codeine/Acetaminophen	Tablet	**28**	Tylenol® with Codeine
Hydrocodone/Acetaminophen	Tablet	**28**	Lortab®, Vicodin®
Hydrocodone/Ibuprofen	Tablet	**28**	Vicoprofen®
Hydromorphone HCl	Tablet	**28**	Dilaudid®
Meperidine	Tablet	**28**	Demerol®
Morphine Sulfate	Tablet/Capsule	**28**	
Oxycodone		**28**	Roxicodone®
Oxycodone/Acetaminophen		**28**	Endocet®, Percocet®, Roxicet®
Oxycodone/Aspirin		**28**	
Oxycodone/Ibuprofen	Tablet	**28**	
Oxymorphone HCl	Tablet	**28**	Opana®
Tapentadol	Tablet	**28**	Nucynta®
Tramadol	Tablet	**28**	Ultram®
Tramadol/Acetaminophen	Tablet	**28**	Ultracet®

Overrides for quantities greater than the opioid 7-day quantity limits listed in the tables above for opioids will be addressed using the *Opioid Analgesic Treatment Worksheet*. The prescriber must fax the completed forms and applicable supporting documentation to the RxPA Unit.

NOTE: Refer to the POS User Guide for detailed billing instructions and override procedures.

Morphine Milligram Equivalent (MME) Limit

The Morphine Milligram Equivalent (MME) per day for all active opioid prescriptions for a recipient will be calculated. For each recipient, the cumulative daily MME for all active opioid prescriptions will be limited to a maximum of 90 MME per day.

Buprenorphine products for the treatment of Substance Use Disorder (SUD) will not be included in the MME limit.

Overrides for doses greater than 90 MME per day will be addressed using the *Opioid Analgesic Treatment Worksheet*. The prescriber must fax the completed forms and applicable documentation to the RXPA Unit. A prescriber may also submit an Opioid Analgesic Treatment Worksheet to increase a previously approved MME limit. (Refer to Appendix F for the Opioid Analgesic Treatment Form and instructions).

Note: Refer to POS User Guide 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 recipient has a diagnosis of burn, 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
C00.*-C96.*	Cancer
Z51.5	Palliative Care

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

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 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

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
Frovatriptan Succinate	Tablet	9 units
Naratriptan HCl	Tablet	9 units
Rizatriptan Benzoate	Tablet, Tablet rapid dissolve	12 units
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 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 Point of Sale submission.

Quantity Limitations

Prescriptions payable under the Medicaid Program 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.

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 10-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 10-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 recipients are exempt from co-payments and monthly prescriptions limits.

NOTE: Refer to Chapters 26 and 34 of the *Medicaid Services Manual* for detailed information regarding recipients in LTC facilities (ICF/DD and Nursing Homes).

Over the Counter Drugs

LTC facilities are responsible for providing all over the counter (OTC) drugs to Medicaid recipients. OTC drugs are part of the per diem for LTC recipients.

Over the Counter Drugs for Preventive Care

Select over the counter (OTC) agents for preventive care will be reimbursed when:

- The prescribing practitioner issues the recipient a prescription for the preventive care OTC agent; and
- The recipient meets the criteria to obtain the preventive care OTC agent.

OTC Drug	Medicaid Recipient	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

OTC Drug	Medicaid Recipient	Preventive Care
Vitamin D 400 IU	Women and men greater than 64 years of age	Fall prevention

Age Restriction

Pharmacy claims submitted for recipients outside of the age limits listed above will deny at Point of Sale.

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 recipients 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 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.

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 recipient'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 provider 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 *Medicaid Services Manual* for detailed information.