

PART II

POLICIES AND PROCEDURES
for
PHARMACY SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: July 1, 2019

2019 Policy Manual Revisions

****Please Note:** Quantity Level Limits(QLLs) are updated quarterly and can be found in Appendix B**

January 2019 (1st Quarter)

- **Appendix B**
 - QLL: update

April 2019 (2nd Quarter)

- **602.6 Insulin Days Supply:** new policy addition
- **607.5 340B Outpatient Pharmacy (Point-of-Sale) Billing:** addition of Actual Acquisition Cost
- **1001 Determining Usual and Customary Charges:** redefining of Usual and Customary Charges
- **1001 Non-Profit Pharmacy:** policy removed
- **Appendix B**
 - QLL: update
 - **Abbott Diabetes Care Blood Glucose Monitors:** update

July 2019 (3rd Quarter)

- **Appendix B**
 - QLL: update

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I - CHAPTER 600

SPECIAL CONDITIONS FOR ENROLLMENT AND PARTICIPATION

In addition to those conditions for participation in the Medicaid program as outlined in **Part I**, the following also apply to Pharmacy Services.

601. License Requirements

All pharmacies enrolling in the Georgia Medicaid program to provide Pharmacy Services must be licensed by the Georgia State Board of Pharmacy and be in good standing with that office.

601.1 Pharmacies must ensure that all services billed are performed by or under the immediate supervision of a licensed pharmacist (as defined in OCGA Section 26-4-2 (9), Pharmacy Laws of GA).

601.2 Pharmacists servicing Nursing Homes and Long Term Care Facilities as a Vendor or Consultant must be licensed in the State of Georgia as required by the Georgia State Board of Pharmacy Rules, Chapter 480-24-.02. Authority Ga.L.1974, pp221-270; O.C.G.A. Secs. 26-4-37, 26-4-53.

601.3 The following information and/or documentation is required to complete the application for enrollment in the pharmacy programs

Provider Enrollment Application (DMA-001)

Must have the original signature of the authorized representative of the applicant

Statement of Participation (DMA-002)

Must have the original signature of the authorized representative of the applicant

IRS Form W-9

The payee name on the W-9 must match the business name as registered with the IRS.

Power of Attorney

If the designated payee is different from the applicant, a signed and notarized Power of Attorney for Payee must be completed for Payee.

Electronic Funds Transfer Agreement (DMA-006)

Copy of Pharmacy license issued by the state's Board of Pharmacy (027)

National Council for Prescription Drug Program (NCPDP) number

(Note: Dispenser Class and Type {7}) are not eligible for COS 300/321 enrollment)

Copy of Drug Enforcement Administration Certificate

Georgia Medicaid Disclosure of Ownership and Control Interest Statement form (or a copy of Form CMS 1513 filed with Medicare)

Rev. 04/15

Effective September 1, 2014, DCH will no longer accept paper provider enrollment applications for all facility types, including pharmacies, additional locations, out-of-state emergency, and the various waiver programs. In extreme hardship cases, DCH may waive this requirement; this request must be in writing and submitted to DCH Provider Enrollment for consideration. Facility applicants must enroll online by clicking on Provider Enrollment/Enrollment Wizard. Facilities eligible to enroll using an Additional Location application must first login to the web portal.

601.4 Change of Ownership or Legal Status (CHOW)

The successor provider must submit a new enrollment application and supporting documentation to become effective at the time of the change of ownership. A change of ownership includes, but is not limited to, a dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger, or joint venture whereby the provider either becomes a different legal entity or is replaced in the program by another provider.

Any person or entity that is a Medicaid/PeachCare for Kids provider, and any person or entity that replaces a provider, shall be deemed to have accepted joint and several liability, along with its predecessor, for any overpayment and/or provider fee sought to be recovered by the Division after the effective date of the successor provider's enrollment, regardless of the successor's enrollment status or lack of affiliation with its predecessor at the time the overpayment was made. An entity shall be deemed to have replaced a provider if it 1) effectively became a different legal entity through incorporation, re-incorporation, merger, joint venture, dissolution, creation of a partnership, or reorganization, 2) took over more than fifty percent (50%) of the predecessor's assets, Medicaid/PeachCare for Kids clients or Medicaid/PeachCare for Kids billings, or 3) has substituted for the predecessor in the program, as evidenced by all attendant circumstances. Reimbursement for services rendered prior to the effective date of enrollment of a successor provider (including any adjustments for underpayments made by the Division) shall be made to the provider of record at the time the payment is made or to that provider's payee as properly designated on the appropriate form(s) required by the Division. Any dispute or conflict, legal or otherwise, arising between the currently enrolled provider and the predecessor provider concerning either apportionment of liability for any overpayment previously made by the Division or the right to additional reimbursement for any underpayments previously made by the Division shall be the sole responsibility of such parties and shall not include the Division. **The new owner applying for enrollment may not request a change of the predecessor's provider number without the express consent of the Chief of the Division of Medical Assistance.**

Rev. 07/14

602. Prescription Requirements

Pharmacies must maintain a prescription on file for five (5) years to support any claim submitted for reimbursement by the Division. Prescriptions supporting claims submitted to the fiscal agent must be initiated and recorded in conformance with all State and

Federal laws. Such prescriptions, whether new or refill, must include all original documentation containing proper information as required by the Georgia State Board of Pharmacy Rules Chapter 480-10-15. Oral prescriptions must have the date, time, name of person calling in the prescription and initials of the pharmacist must be transcribed to hand written order and must include the date, time, name of person calling in the prescription accepting the order as required by 26-4-80 (i) O.C.G.A. In addition, pharmacies must maintain on file a prescription for any legend or non-legend drug, such as insulin, for which a claim is submitted. Please see Chapter 900.

Rev. 01/13

Prescription refills shall be performed and recorded in a manner consistent with existent State and Federal Laws, Rules and Regulations. **Automatic refills are not allowed.** All prescription refills shall be initiated by a request from the physician, member, or other person acting as an agent of the member (i.e.: family member).

Long Term Care (LTC) Facilities: In the event the member is residing in a LTC facility or other institution, a nurse, pharmacist or other authorized agent of the facility pursuant to a valid physician's order may initiate the request for refills.

Documentation of the prescription number, member name, delivery date, and receipt date is required by the Division for each prescription dispensed or administered to a LTC Medicaid member. Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.

Prescribers must use tamper-resistant prescription pads for any new prescription with fill dates on and after April 1, 2008. This requirement applies to hard copy prescription orders for any drug, device or product covered through the Medicaid FFS outpatient pharmacy program whether legend or over-the-counter. Please see Appendix G for a detailed description of this requirement.

Rev. 07/16

Antihemophilic Factor: Effective August 1, 2016, patients receiving factor VIII or factor IX products for prophylaxis and on-demand (breakthrough bleeding) episodes are required to have two separate prescriptions. Prescriptions should be written with $\pm 3\%$ aggregate of the prescribed target dose.

602.1 National Drug Code Numbers

Pharmacies must bill the specific national drug code (NDC) number for the drug dispensed in the amount dispensed and maintain invoices of drug purchases that document proof of purchase for quantities of specific drugs reimbursed by the Division. Pharmacies must reflect purchase dates consistent with dispensing dates. These records

should be maintained for a period of five (5) years. Claims identified as having been billed using the wrong NDC or quantity will be subject to recoupment.

602.2 Diabetic Supplies

All pharmacies enrolled as pharmacy providers are eligible to dispense insulin syringes, lancets, glucose monitoring strips and glucose monitors to non-nursing home Medicaid diabetic patients. Please see Appendix B for manufacturer details and therapy limitations. Legitimate prescriptions must accompany diabetic supplies dispensed for billing purposes.

Effective March 6, 2012, the Department of Community Health (DCH) implemented an enhancement to its prior authorization protocol for diabetic supply coverage (test strips and lancets). Prenatal vitamins (PNV) will be added to the list of medications that will allow a diabetic supply claim to process without PA if the PNV claim has been paid within 90 days (from the date filled) of the diabetic supply billing.

For a complete listing of covered diabetic supplies please refer online under www.mmis.georgia.gov → Pharmacy → Other Documents → Covered Diabetic Supplies. Prior Authorization (PA) requests should be directed to the OptumRx Clinical Call Center at 1-866-525-5827.

Rev. 10/15

DCH will only accept ICD-10 codes on pharmacy claims with dates of service on or after October 1, 2015. Listed in the table below are the ICD-10 codes that when submitted on a point-of-sale pharmacy claim will bypass PA required for covered diabetic supplies.

Effective October 1, 2014	
ICD-10 Code	ICD-10 Code Description
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
O99.810	Abnormal glucose complicating pregnancy
O99.814	Abnormal glucose complicating childbirth
O99.815	Abnormal glucose complicating the puerperium

602.3 Receipt of Prescription

Rev. 10/16

Documentation of receipt of prescriptions is required by the Division for each prescription dispensed to a Medicaid Member. Documentation must include at a minimum the date, prescription number, member name and member's signature or member's legal representative receiving the prescription, date filled and date picked up.

The signature logs are required on all (Desk and On-Site) audits. Signature logs are not accepted post-audit. For On-Site audits the following will apply:

- A list of prescriptions will be provided at the time of the on-site audit
 - If the pharmacy has electronic signature capture, signature logs may be reviewed on-site. Any missing signatures will have to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days
 - If the pharmacy has paper logs, paper delivery logs, or signature logs not reviewed on site, signature logs will need to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days
- After 15 days, documentation submitted will be reviewed and an initial findings letter will be sent out
- For those signature logs that were not received prior to the initial findings, only a patient attestation will be accepted

Rev. 07/14

If the auditor requests further review of a signature log on a audit, only an original signed attestation from the member, verifying receipt of the medication, can be provided to the designated Medicaid Pharmacy Audit vendor within the time period allotted. The attestation must include the date, prescription number, member name and member's signature, date filled, dated picked up, member contact information, and permission for the designated Medicaid Pharmacy Audit vendor to contact them via mail or phone if necessary.



Rev. 10/16

Documentation Policy

- ❖ Both the exact quantity and the days supply must be billed to the Georgia Medicaid based on the metric decimal quantity prescribed and the prescriber's exact written directions, but it cannot go over what the plan allows (30 days supply). The billing system does not read the directions submitted, only the day's supply/quantity dispensed. **Per Georgia Department of Community Health: Eye drops = 16gtts/1ml Inhalers = Use how many puffs per day the patient is taking vs. how many metered doses are in the canister.**
- ❖ Quantities Dispensed: Always submit the quantity prescribed, and submit the **exact** calculation of days supply per the Prescriber's dosing instructions. "As directed" or "PRN" Prescriber directions must be clarified with Prescriber or Member. Verifying pharmacist must document and initial the information on the prescription.
- ❖ Oral prescriptions must have the date, time, name of person calling and the hand written initials of the pharmacist/intern who took the call.
- ❖ **Automatic refills are not allowed.** All prescription refills shall be initiated by a request from the physician, member, or other person acting as an agent of the member, i.e., family member. In the event the member is residing in a Long Term Care Facility or other institution, a nurse or other authorized agent of the facility pursuant to a valid physician's order may initiate the request for refill. Any prescription, regardless of the authorization to refill given by the prescribing practitioner, may not be billed to the Department after one (1) year has elapsed from the date it was written.
- ❖ Documentation of receipt of prescriptions is required by the Division for each prescription dispensed to a Medicaid Member. Documentation must include at a minimum the date, prescription number, member name and member's signature or member's legal representative receiving the prescription, date filled and date picked up. Signature logs are not accepted after the initial audit results have been provided. Only an original signed attestation from the member, verifying receipt of the medication, can be provided NHC within the time period allotted. The attestation must include member contact information and permission for NHC to contact them via mail or phone if necessary.

For On-Site audits the following will apply:

 - ❖ A list of prescriptions will be provided at the time of the on-site audit
 - If the pharmacy has electronic signature capture, signature logs may be reviewed on-site. Any missing signatures will have to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days
 - If the pharmacy has paper logs, paper delivery logs, or signature logs not reviewed on site, signature logs will need to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days

- ❖ After 15 days, documentation submitted will be reviewed and an initial findings letter will be sent out
- ❖ For those signature logs that were not received prior to the initial findings, only a patient attestation will be accepted

- ❖ **Long Term Care (LTC) Facilities:** In the event the member is residing in a LTC facility or other institution, a nurse, pharmacist or other authorized agent of the facility pursuant to a valid physician's order may initiate the request for refills. Documentation of the prescription number, member name, delivery date, receipt date is required by the Division for each prescription dispensed or administered to a LTC Medicaid member. Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.
For On-Site audits the following will apply:
 - ❖ A list of prescriptions will be provided at the time of the on-site audit
 - If the pharmacy has electronic signature capture, signature logs may be reviewed on-site. Any missing signatures will have to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days.
 - If the pharmacy has paper logs, paper delivery logs, or signature logs not reviewed on site, signature logs will need to be submitted to the Medicaid Pharmacy Audit Vendor within 15 days
 - ❖ After 15 days, documentation submitted will be reviewed and an initial findings letter will be sent out
 - ❖ For those signature logs that were not received prior to the initial findings, only a patient attestation will be accepted

- ❖ All prescriptions will be reversed and returned to stock within 14 calendar days of dispensing if not picked-up by the recipient.

- ❖ **Only copies of original documentation from the prescribing physician are accepted post-audit for unauthorized refills, missing or as directed prescriptions during an on-site audit. Telephone prescriptions and computer-generated prescriptions are NOT allowed to be submitted for review.** To receive credit post-audit these copies must be sent to NHC in the time period allotted.

- ❖ Documentation must be sent in before the deadline of the appropriate discrepancy report. Information sent in post deadline will not be reviewed. If an extension is needed, please call the auditor provided one week prior to deadline. **Extensions will not be granted if requests are made one day prior, the day of, or after the deadline.**

- ❖ Documentation received by NHC may be rejected if the originator (example; physician, patient, etc.) is unwilling or unable to provide verification

- ❖ Prescribers must use **tamper-resistant prescription pads** for any new prescription with fill dates on and after April 1, 2008. This requirement applies to hard copy prescription orders for any drug, device or product covered through the Medicaid FFS outpatient pharmacy program whether legend or over-the-counter.

- ❖ When audits are being performed, whether on-site or desk, **DO NOT** reverse the claims in question, any discrepancies found will be corrected after the audit is completely closed.

Failure to comply with any of these guidelines can result in a charged back amount to the pharmacy. We hope to make your audit experience as convenient as possible. Also, we hope that you find these guidelines useful. Thank you for your time and cooperation.



Rev. 04/17

602.4 Return To Stock

All prescriptions will be reversed and returned to stock within (14) calendar days of dispensing if not picked-up by the patient.

602.5 Exact Directions for Use Required

If a Prescriber does not provide exact directions, or writes “as directed” or “prn”, the pharmacist must call the Prescriber and obtain directions. The Pharmacist must document such directions on the prescription, initial same, and bill the Division for the exact days supply based on those directions and the quantity prescribed.

Both the exact quantity and the days supply must be billed to the Division based on the metric decimal quantity prescribed and the Prescriber’s exact written directions.

Rev. 04/19

602.6 Insulin Days Supply

Effective April 1, 2019, the Department of Community Health is requiring that all pharmacy providers bill the smallest commercially available package size for Insulin Products **and** are required to bill the Division for the exact days’ supply*, based on the directions and quantity prescribed. In some situations, such as packaged insulin products, a day supply greater than 30 may be permitted. For the billing of a day supply value greater than 30 days to be reimbursed, one of the following circumstances must be met:

- The prescription is written such that the smallest commercially available package size of the product will exceed a 30 day supply
- or**
- The prescription is written so that the smallest commercially available package size is less than a 30 days’ supply and requires an additional package that will supply the member as close to a 30 days’ supply as possible. When billing Georgia Medicaid for multiple packages, the calculated days’ supply cannot exceed 59 days.

In the instance that the smallest available package size will exceed a 59 day supply, providers may contact the Technical Help Desk at 866-525-5826 for further assistance.

*For multi-dose vials (MDV) of insulin, in the instance that the smallest available package will exceed the manufacturer’s “*use within*” date range, do not bill for a days’ supply greater than what is instructed per the manufacturer’s requirement.

602.7 Prescription Refills

Rev. 01/17

Any prescription, regardless of the authorization to refill given by the prescribing practitioner, may not be billed to the Department after one (1) year has elapsed from the date it was written. When refilled, the prescription may be billed only in keeping with the number of doses ordered and the directions for use.

Members, pharmacies, physicians etc. may fax in documentation to 877-633-4765 to request an early refill related to lost, stolen, broken, or damaged products. The request must include the following information:

- Type of request
- Member's name and phone number
- Member's Medicaid ID
- Medication name, strength, quantity and day supply
- Filling pharmacy name and phone number
- Police report, physician letter, etc.

602.8 Transmitting or Receiving Prescription Drugs via Facsimile Machine or Other Electronic Means

All prescription drug orders sent via facsimile or other electronic means must meet the requirements of O.C.G.A. § 26-4-5 and O.C.G.A. § 26-4-80 and Chapter 480-22, 480-27-.02 and 480-27-.04 of the Board Rules and the requirements for the electronic transmission of prescription drug orders. Prescription drug orders electronically generated and directly transmitted from the practitioner to a pharmacy must bear unique serial numbers to authenticate the transmission.

Rev. 01/17

602.9 Pharmacist Administered Vaccines

Influenza Vaccine

GA Medicaid Fee-for-Service (FFS) members 19 years of age and older are able to obtain their seasonal flu vaccine from their pharmacy or physician. Claims can only be submitted for dates of service between August and February annually. Pharmacy claims submitted outside of the August – February timeframe will not be paid.

Pneumococcal, Meningitis And Zoster Vaccines

FFS members 21 years of age and older are able to obtain their Pneumococcal and Meningitis vaccines and members 50 years of age and older are able to obtain their Zoster vaccine from their pharmacy or physician.

Vaccine Billing

Claims submitted by the pharmacist at point-of-sale (POS) will follow the 837P Companion Guide – 5010 and will be processed through DXC Technology through the Georgia Medicaid Management Information System (GAMMIS).

Pharmacists can obtain member eligibility status from the GAMMIS web portal, eligibility transaction (270/271) or via phone.

Pharmacists must enter the patient's vaccination information in the Georgia Registry of Immunization Transactions and Services ("GRITS") within fifteen (15) days of administration of the vaccination (O.C.G.A. Section 43-34-26.1).

If you have questions, please reference the GAMMIS 5010 837P Companion Guide (www.mmis.georgia.gov → EDI → Companion Guides); contact EDI Services at (877) 261-8785 (toll- free) or (770) 325-9590 (locally); or the DXC Technology Provider

Services Contact Center at 1-800-766-4456. Vaccine billing inquiries should be emailed to Claimsreprocessing@hpe.com.

Further details pertaining to the vaccine program can be found in the weekly pharmacy banner message (www.mmis.georgia.gov → Pharmacy → Pharmacy Notices).

Rev. 10/15
Rev. 01/16

603. Notification of Change

Pharmacies must notify the Fiscal Agent, DXC Technology, in writing should any change in enrollment status occurs such as: change in ownership, new address, change in payee or pharmacy permit change. See Part I, Section 104. All forms should be submitted through the GAMMIS Web Portal (www.mmis.georgia.gov) using a secure log-in.

604. Out of State Enrollment and Border Provider Enrollment

The Division will not enroll pharmacies outside the State of Georgia except for the following:

- A) Border pharmacies defined as retail pharmacies within fifty (50) miles from the Georgia border who service walk-in Medicaid members. Walk-in customers must represent at least (75%) of the pharmacy's prescription volume.
- B) Retail pharmacies that are servicing foster children living out of state are allowed to temporarily enroll as a provider only for the length of time they are providing pharmacy services for a foster child enrolled in the Georgia Medicaid Program.
- C) Out-of-State pharmacies servicing members receiving pre-approved transplants who require medication during after care while residing out of state.
- D) Pharmacies providing products with limited or exclusive distribution channels for which there is no such potential provider within the State of Georgia.
- E) Other exceptions due to extenuating circumstances which may impair access to pharmaceuticals issued. Such exceptions are solely at the discretion of the Georgia Department of Community Health.

605. Internet Pharmacies

Effective February 1, 2000, the Division of Medical Assistance (DMA) of the Department of Community Health (DCH) does **not enroll internet** pharmacy providers in the Georgia Medicaid program. An Internet pharmacy is defined as a pharmacy that is primarily engaged in receiving prescriptions over the Internet for later dispensation.

606. Pharmacy Lock-In

Federal regulations provide that the Division may place restrictions on the provider or providers from which a member can receive items or services if the Division has determined that the member has utilized such items or services at a frequency or amount

not medically necessary in accordance with utilization guidelines established by the Division. Members determined to be abusing the Medicaid Pharmacy Benefit shall be placed in Pharmacy Services Lock-in status for an initial period not to exceed twenty four (24) months. Members will be restricted to one or more controlled substance prescriber to prescribe controlled substances and one pharmacy to obtain all of their Medicaid prescriptions; other pharmacies will not be paid if they fill Medicaid prescriptions for the member. Also the lock-in pharmacy will not be paid if they fill controlled substance prescriptions not prescribed by the member's designated controlled substance prescriber. The Point of Sale system will alert pharmacies of any lock-in restrictions placed on an individual member during on-line/real-time adjudication. The designated controlled substance prescriber must be an enrolled Medicaid provider or a DATA 2000 waived physician. The member's lock-in pharmacy or any other pharmacy that has knowledge of the member being enrolled in Medicaid is prohibited from accepting cash payments from the member for controlled substance prescriptions that do not adjudicate. At the conclusion of the lock-in period, the member's usage will be reevaluated to determine whether or not restrictions should continue.

Pharmacy Services Lock-in will be under the purview of the Division's Program Integrity Unit who shall determine the need for lock-in according to established utilization criteria. Please review Part II Policies and Procedures for Pharmacy Services manual Section 606.1, and Part I Policies and Procedures Section 109.1.

606.1 Pharmacy Lock-in Criteria

The following criteria are utilized in the recommendation for pharmacy lock in:

1. Drug therapy must correlate with either the primary or secondary diagnosis in The Department's claims data, if not it is the member's responsibility to have the prescribing physician submit the member's complete medical record.
2. Initial complaint indicates the member is suspected of drug abuse or fraudulent activities (forged prescriptions, borrowed ID cards, etc)
3. The member has filled prescriptions at more than 2 pharmacies/month or more than 5 pharmacies/year. If greater, the address of the member should have changed.
4. The member has received more than 3 Controlled Substances/month.
5. The number of prescriptions for controlled substances filled by the member (this includes all drugs with abuse potential) exceeds 10% of the total number of prescriptions filled by the member.

6. The member was seen in the Hospital Emergency Room more than twice per year. If greater, the recorded diagnosis should be consistent with an emergency medical condition.
7. The member received duplicate therapy from different physicians.
8. The member received prescriptions from pharmacies or visited physicians located outside the member's county of residence.
9. The member purchased drugs of abuse without utilizing their Medicaid prescription benefits.
10. The member has a diagnosis of narcotic poisoning or drug abuse.
11. The member has previously been in one of the CMO's lock-in programs.
12. The member is taking >120mg Morphine sulfate equivalents per day.
Studies show patients receiving 100 mg/d or more have an 8.9-fold increase in overdose risk and a 1.8% annual overdose rate.

Morphine Equivalent Dose for Selected Opioids	
Opioid	Approximate Equianalgesic Dose (oral & transdermal)*
Morphine (reference)	30mg
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone	Chronic: 4mg†
Oxycodone	20mg
Oxymorphone	10mg

Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010;152(2):85-92

Each member is given an opportunity to appeal the Lock-In determination by requesting a hearing in writing within 30 days of the determination to:

Department of Community Health
Legal Services Section
Division of Medical Assistance
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

Rev. 04/18

607. 340B Program

The 340B Drug Discount Program is a federal program created in 1992 that requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities (CE's) at significantly reduced prices. Maintaining services and lowering medication costs for patients is consistent with the purpose of the program. This requirement is described in Section 340B of the Public Health Service. The Office of Pharmacy Affairs (OPA) is the office responsible for administering the 340B Program and is part of Health Resources and Services Administration (HRSA). Federal Law prohibits duplicate discounts, which means that manufactures are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug; CE's must have procedures in place to prevent duplicate discounts from occurring. Other products available through the 340B pricing program includes: vaccines and diabetic supplies (lancets, meters, strips, and syringes).

607.1 340B Participation

1. In order to participate in the 340B program, the eligible entity must first register by submitting a request on the [OPA](#) website within [HRSA](#). A new site can only be added to the 340B database during the quarterly open registration windows. Once registered, covered entities must recertify their eligibility annually.

Registration	Start Date
January 1 st – 15 th	April 1 st
April 1 st – 15 th	July 1 st
July 1 st – 15 th	October 1 st
October 1 st – 15 th	January 1 st

2. To ensure all the information on the HRSA Medicaid Exclusion File is accurate, the CE should review their information on the [340B OPAIS](#) website and keep it up to date. **Note:** Please provide the correct Medicaid Provider Number (MPN) **and** National Provider Identifier (NPI) at the time of enrollment.
3. CE's must inform OPA at the time of enrollment on their intentions to carve-in or carve-out when purchasing drugs or other covered products for their Medicaid members.

607.2 Medicaid Carve-Out

- All prescriptions, physician-administered drugs, and all other products must be purchased **outside** of the 340B program.
- Bill in accordance with existing Medicaid (FFS or managed care) reimbursement methodologies, allowing rebates to be collected where appropriate.
- The CE's MPN and NPI should not be listed on the HRSA Medicaid Exclusion File.

607.3 Medicaid Carve-In

- All eligible prescriptions, physician-administered drugs, and all other products must be purchased through the 340B program.
- Purchase all drugs and other products billed to Medicaid (FFS and managed care) on the CE's MPN and NPI under the 340B program unless the product is not eligible for 340B pricing. **Do not** bill Medicaid (FFS and managed care) for 340B acquired drugs and products if your MPN and NPI is **not** listed on the HRSA Medicaid Exclusion File.

607.4 Vaccine and Diabetic Supplies

Submit claims for 340B acquired products to Medicaid (FFS or managed care) at your

340B actual acquisition cost (AAC) on the UB04 or CMS 1500 claim form.

607.5 340B Outpatient Pharmacy (Point-of-Sale) Billing

1. Effective April 1, 2017, all 340B covered entities are required to use a submission clarification code when billing the Georgia Medicaid Division on Fee-for-Service (FFS) and Care Management Organization (CMO) outpatient pharmacy claims.
2. Claims submitted via the NCPDP format to the Pharmacy Benefit Manager (PBM) must include:
 - a) A “20” in the submission clarification code field 420-DK
 - b) The National Drug Code (NDC)
 - c) Actual Acquisition Cost (AAC)
3. If the product is not purchased at 340B pricing, do not include the basis of cost determination or the submission clarification code values and bill at the regular Medicaid (FFS or managed care) rate.

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607.6 340B Outpatient Hospital/Clinic (Physician-Administered) Billing

DCH will use the MEF as the sole means to identify 340B drug claims. All CE's should indicate their decision to carve-in or carve-out Medicaid to the OPA prior to the HRSA quarterly deadline for all 340B purchased drugs. The MPN and NPI should be provided for each CE that has been chosen to carve-in Medicaid. It is the CE's responsibility to check the MEF at the start of each quarter for the accuracy of their specific Medicaid billing information to help ensure the overall validity of the data in the file and to avoid duplicate discounts.

607.7 340B Contract Pharmacies

Contract pharmacies may not submit claims and are not allowed to bill DCH for 340B purchased drugs. All 340B acquired drugs identified and discounted at the claim level must be **carved out** for Medicaid (FFS or managed care).

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607.8 Definitions

- 340B Covered Entity (CE) is a facility that is eligible to purchase drugs through the 340B Program and appears on the OPAIS.
- 340B Drug Discount Program (340B) is section 340B of the Public Health Service (PHS) Act (1992) that requires drug manufactures participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services.
- Actual Acquisition Cost is the net cost of a drug or product paid by a pharmacy.
- Contract Pharmacy is a pharmacy under contract with a CE that provides services to the CE's patients, which includes dispensing the entity-owned 340B drugs.
- Fee-for-Service (FFS) bills directly to Georgia Medicaid for prescriptions and physician administered drugs they provide to FFS members.

- Health Resources and Services Administration (HRSA) is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
- Medicaid Carve-In means a CE has elected to use drugs purchased at 340B prices for all Medicaid members (FFS and CMO).
- Medicaid Carve-Out means a CE has elected to use non-340B purchased drugs for all Medicaid members.
- Medicaid Exclusion File (MEF) was established by HRSA to help support 340B covered entities and states in the prevention of duplicate discounts for drugs subject to Medicaid rebates.
- Medicaid Provider Number (MPN) is an identifier issued to health care providers by CMS that allows the provider to bill Medicaid for services.
- National Drug Code (NDC) is a drug product that is identified and reported using a unique, three-segment number, which serves as a universal product identifier for the specific drug.
- National Provider Identifier (NPI) is a unique identification number for covered health care providers.
- Not Otherwise Classified (NOC) codes are used when there is not a HCPCS code available that accurately identifies the service or procedure performed.
- Office of Pharmacy Affairs (OPA) is a part of the HRSA and is responsible for administering the 340B program.
- Physician-Administered Drugs are administered directly by a physician or a physician designee to a patient. This may occur in an outpatient clinic setting of a hospital.

If you have any questions regarding Georgia Medicaid's policy on the 340B program, please contact the DCH by e-mail at 340B@dch.ga.gov.

PART II - CHAPTER 700
ELIGIBILITY REQUIREMENTS

No special eligibility conditions other than those listed in Part 1, Chapter 106, are required for member utilization of Pharmacy Services.

PART II - CHAPTER 800

PRIOR APPROVAL

801. General

The Division may, with sufficient justification, approve exceptions to the limitations of therapy, or number of prescriptions allowed monthly, or allows payment for drugs that require prior authorization. Medically necessary pharmacy services will be provided to all members under age 21 when documented by the prescriber and are provided in a manner consistent with the policies and procedures stipulated in this manual.

801.1 Drugs that Require Prior Approval

Drugs requiring prior approval will not be covered by Medicaid, unless prior approval is obtained prior to the drug being dispensed to Medicaid members. See Section 802 for a description of the prior approval process.

801.2 Drugs with Therapy Limitations

A complete listing of drugs with therapy limitations or Quantity Level Limits can be found . Appendix B of the Part II - Policies and Procedures for Pharmacy Services Manual.

801.3 Drugs for ESRD Patients

To receive reimbursement for medications dispensed to ESRD patients, pharmacy providers must use only products from manufacturers participating in the drug rebate program. The following products are available to ESRD patients and require Prior Approval before dispensing:

Calcium Carbonate, Aluminum Hydroxide, Calcium Acetate, Legend Vitamin D Products, Calcium Carbonate with Glycine, Calcium Lactate, Docusate Calcium, Docusate Sodium, Niacin, Pyridoxine Hydrochloride, Sodium Bicarbonate, Thiamine Hydrochloride and Vitamin B Complex.

Please review the Preferred Drug List (PDL) for other ESRD drugs requiring Prior Approval at www.mmis.georgia.gov → Pharmacy → Other Documents.

801.4 Compounded Prescriptions

Reimbursement for all drugs is contingent upon dispensing a drug that is manufactured by a company who has a signed rebate agreement for that drug with the Centers for Medicare and Medicaid Services (CMS) **and** the member's eligibility at the time of service.

Effective July 17, 2017, compound requests for select compounded ingredients (**in addition** to compounds for omeprazole, lansoprazole and common TPN ingredients) will no longer require a Prior Authorization (PA). Any ingredient utilized outside of the select ingredients will still require a PA. Please review your final claim submission to determine if any ingredients still require PA. Other non-rebateable and non-covered OTC ingredients continue to be not covered in all compounds. The Submission Clarification Code (Field: 42Ø-DK) of Ø8 – Process Compound for Approved Ingredients, should still be used to allow the claim to process for covered ingredients

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within the compound. PA requests for other ingredients, should continue to be faxed to OptumRx at 1-888-491-9742 using a Multi-Ingredient Compound Drug PA Request Form. This form may be found online under www.mmis.georgia.gov → Provider Information → Forms for Providers → Multi-Ingredient Compound Drug PA Request Form. As a reminder, the Department does not consider admixtures, e.g. vancomycin and NS, compounded prescriptions and therefore they should be billed as single line item ingredients.

Compounded products are covered for members less than 21 years of age when the physician documents that the drug is medically necessary. All compounded prescriptions are non-preferred products.

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801.5 Compound Claim Segment Identification

Effective November 1, 2017, NCPDP Field 996-G1 – Compound Type will be required when submitting compound claims. The valid codes for this field are listed in the table below. Please contact your software help desk for assistance on locating and/or transmitting this field on compound claims.

996-G1 – Compound Type – Clarifies the type of compound	
Code	Description
Ø1	Anti-infective—a medicinal product intended to treat pathogens such as bacteria, viruses, fungi or parasites
Ø2	Ionotropic—a medicinal product intended to correct irregular heart rhythms
Ø3	Chemotherapy—a medicinal product intended to treat cancer
Ø4	Pain management—a regimen of therapy intended to ameliorate mild to severe discomfort
Ø5	TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition—products intended to provide nourishment by central or peripheral veins for patients with compromised digestive tracts
Ø6	Hydration—a product intended to restore body fluids
Ø7	Ophthalmic—a product intended to be applied to or instill in the surface of the eye
99	Other—not defined by other available codes

802. Prior Approval Procedures

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Effective January 1, 2007, the Georgia Department of Community Health - Division of Medical Assistance contracted the drug prior approval function to OptumRx. All pharmacy prior approval requests should be made to this agent. As a policy, the Division does not grant retroactive prior approval.

Should any of the drugs approved, later become non-covered or have dispensing limitations placed on them, the authorization for the drugs will be null and void. In

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addition, reimbursement is contingent upon the member's eligibility at the time service is rendered.

Obtaining prior approval does not guarantee reimbursement.

802.1 Override Code – To Exclude Copayment (populate field 416-DG)

As a reminder, all new nursing home patients will be exempted from drug co-payment, by using “1111”. Nursing home member overrides are exempt from the co-payment requirement. Use of this code also requires an “04” in the Prior Authorization Type Code” field (461-EU).

802.2 Requests via Telephone or Facsimile

Requests for drugs to exceed therapy limitations or for drugs that require prior approval shall be directed to the agent, OptumRx by phone. Contact by fax or mail is not preferable, but allowed.

The agent's Prior Authorization Department is staffed by associates and clinical pharmacists. The Prior Authorization Department hours are as follows: 8am-8pm M-F (EST), 8am-4:30pm Sat., Closed Sunday & Holidays. Associates and clinical pharmacists are available on-call after normal business hours. Prior Authorization requests may be made telephonically, via facsimile, or in writing via U.S. mail, to:

OptumRx
Prior Authorization Department
PO Box 25183
Santa Ana, CA 92799

Clinical and PA Support	866-525-5827
Fax Line	888-491-9742

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802.3 Denial of Requests

Any request, which cannot be approved by the agent, will be communicated at the time of the request to the requester. Appeals of denied requests must be submitted to the agent within ten (10) business days of the denial. The appeal must be reviewed and the requesting provider notified of the results within seven (7) business days of the receipt of the appeal, unless additional information is required. In this case, the decision must be made within seven (7) days of receipt of the additional information.

If an appeal is denied by the agent, a provider may request a 2nd level appeal by DCH within ten (10) business days. 2nd level appeals must be faxed to OptumRx at 888-491-9742. OptumRx will prepare the appeal for DCH's consideration.

802.4 Requests Returned for Additional Documentation

Any prior approval request that cannot be approved due to insufficient information will be returned to the physician for additional information. Prescribers have (3) business days to provide additional information requested.

PART II - CHAPTER 900

SCOPE OF SERVICE

901. General

Effective January 1, 1991, payment for pharmaceutical services is limited to those products of manufacturers who offer rebates to the states as required by the Omnibus Reconciliation Act of 1990. The Division covers the products of all manufacturers who offer such rebates with certain exceptions. The drugs or classes of drugs listed below represent those the Division has elected to exclude from coverage (as allowed by federal law).

901.1 Non-Covered Drugs

- A) Agents used for anorexia weight loss or weight gain.
- B) Agents used to promote fertility.
- C) Agents used for cosmetic purposes or hair growth.
- D) Drugs identified by the Centers for Medicare and Medicaid Services (CMS) as less than effective (DESI), as provided under Section 1927(k)(2).
- E) Legend Prescription Vitamins and Mineral Products with the following exceptions:
 - a. Covered Legend Vitamin and Mineral Products include:
 - i. Prenatal vitamins for women
 - ii. Fluoride preparations that are not in combination with other vitamins
 - iii. Carnitor
 - iv. Folic Acid 1mg
 - v. Vitamin B 12 injection
 - vi. Vitamin and Mineral Products for recipients <21 years of age
- F) Nonprescription drugs with the following exceptions:

NOTE: all covered OTC drugs require a prescription.

- a) Enteric coated aspirin (covered under per diem for nursing home members)
- b) Ibuprofen suspension for members < 21 years of age
- c) Diphenhydramine
- d) Insulin
- e) Meclizine
- f) Select generic over-the-counter (OTC) non-sedating antihistamines, H-2 Receptor antagonists, topical antifungals and proton pump inhibitors.
- H) Legend agents when used for the symptomatic relief of cough and colds for members 21 years of age and over
- I) Agents prescribed for any indication that is not medically accepted.
- J) Drugs that are not listed in the CMS DDR system or do not have a signed rebate agreement
- K) Any Medicare Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

- L) Non-FDA approved drugs
- M) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

Please see Section 801.3 for a description of covered OTC ESRD drugs.

901.2 Rebateable Manufacturers

The list can also be found at www.mmis.georgia.gov > Pharmacy > Other Documents

901.3 Quantity and Monetary Thresholds

The Department will pay for up to a maximum of a (30) day supply of medication calculated at maximum therapeutic levels established by Department of Community Health.

Claims greater than \$3000 - require an administrative review when submitting on POS or paper before override and payment are granted.

901.4 Co-Payment

Effective with dates of service on or after July 1, 2001, the Department will impose a nominal co-payment for each preferred generic or preferred brand drug of \$.50 dispensed by the pharmacy.

Category	Co-Payment
Preferred Generic	\$0.50
Preferred Brand	\$0.50
Non-Preferred Brand Or Non-Preferred Generic	Under \$10.00 = \$0.50 \$10.01-\$25.00 = \$1.00 \$25.01-\$50.00 = \$2.00 \$50.01 or more = \$3.00

Medicaid members under age twenty-one (21), pregnant women, institutionalized individuals and hospice care members are not required to pay this co-payment. Emergency services and family planning services are also exempt from this co-payment. Members enrolled in the Breast and Cervical Cancer eligibility groups are also excluded from copayment.

902. Medical Assistance Eligibility Certification

Member Eligibility Verification:

Each member should present an Identification Card when getting a prescription filled. The new member cards will serve a dual purpose for medical & prescription covered services. Eligibility can also be determined by accessing the DXC Technology web portal at www.mmis.georgia.gov and becoming a registered user.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Member ID# 123456789012
Member, Joe Public
Card Issuance Date: 12/01/11

Primary Care Physician:
Dr. Jane Q Public
285 Main Street
suite 2859
Atlanta, GA 30303
Phone: (123) 123-1234 x 1234

Plan: Georgia Better Health Care

After Hours: (123) 123-1234 x 1234

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Verify eligibility at www.mmis.georgia.gov

If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.

Payor: For Non-Managed Care Members
Customer Service: 1-800-766-4456 (Toll Free)

DXC Technology	OptumRx	Mail RX Drug Claims to:
P.O. Box 105200	Rx BIN-001553	OptumRx
Tucker, GA 30085-5200	Rx PCN-GAM	P.O. Box 29044
Prior Authorization: GMCF	OptumRx Prior Auth	Hot Springs, AR 71903
P. O. Box 105329	1-866-525-5827	RX Provider Help Line
Atlanta, GA 30348		1-866-525-5826

This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.

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If a person claims to be a Georgia Medicaid Member and does not have a card, submit the claim online, then if you receive a “*Missing/Invalid Cardholder ID*” rejection code, verify eligibility by contacting the OptumRx Call Center at 866-525-5826.

Eligibility must be verified before dispensing any medication through POS or direct contact with OptumRx.

NOTE:
Presentation of the card does not guarantee eligibility or reimbursement.

902.1 Specialty or Secondary Pharmacy Providers (Home Health, Biologicals, I.V. Therapy)

Specialty pharmacy providers do not provide for all the member's medication needs. Specialty or secondary providers must verify eligibility and drug coverage before each dispensing. As a reminder, diluents, heparin locks or flushes within the same generic category will require an administrative override to adjudicate. Multiple vials and/or sizes of the same medication will require an administrative override. An administrative override is not intended to bypass the non rebateable rejection, but instead is intended to override any DUR rejections that may post when a provider has to submit multiple claims for the same product on the same date of service (when multiple vials and/or package sizes are dispensed).

The determination of covered outpatient drugs under the Medicaid Drug Rebate Program generally depends on whether the drug has been approved as a prescription drug by the FDA under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act. While the FDA approved certain heparin flush syringes as prescription drugs under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act, others were issued device approvals. Those that were issued device approvals do not meet the definition of a covered outpatient drug as defined in Section 1927(k) of the Social Security Act and are therefore not eligible for Medicaid coverage under the Drug Rebate Program. Those manufacturers participating in the Medicaid Drug Rebate Program that have received FDA approval under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act for their heparin syringes are:

- Hospira (labeler code 00409)
- Abbott (labeler code 00074)
- American Pharmaceutical Partners (labeler code 63323)
- Baxter Health Care (labeler code 00338 and 00641)

903. Service Limitations

Minimum Quantities Payable - These drugs need not be dispensed in one-month quantities provided that the amount prescribed or ordered is not more than is usually and customarily prescribed or ordered, and the amount is consistent with accepted health care practice in the community. Effective February 1, 2011, any drug ordered or prescribed and taken regularly and continuously thirty (30) days or more is considered maintenance medication.

NOTE:

The division defines a one-month supply as (30) thirty days

Maintenance medication must be dispensed in one-month quantities after the initial thirty (30) days is over. The only exception to this regulation is for Controlled Substances designated Schedule II, Schedule III, Schedule IV, Temodar, estrogen replacement patches, Clozapine, oral antibiotics, Prempro/Premphase, all Fosamax, Boniva, Actonel weekly and oral contraceptives as defined in Code Title 16-13, Article 26

These products need not be dispensed in one-month quantities provided that the amount prescribed or ordered is not more than is usually and customarily prescribed or ordered, and the amount is consistent with accepted health care practice in the community.

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903.1 Duplicate Dispensing

The Division will not pay any provider a second dispensing fee for the same drug for the same member in the same month of service. In the event that a member requires a second prescription for the same drug in the same month of service, the provider will be reimbursed **only** for the cost of the drug.

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Oral and IV antibiotics, DEA Schedule II, III, IV or V, oral contraceptives, Prempro/Premphase, all Fosamax, Boniva, Actonel weekly, Temodar, Estrogen replacement patches and Clozapine are exempt from this policy.

904. Emergency Prescriptions

With a written or oral prescription from the member's physician indicating the need for a drug due to an emergency situation or condition, the pharmacist may use the emergency billing code or submit a written request for payment to the Division **to override the member's co-pay only**. This emergency billing code will not override member eligibility, prior authorizations that are required, quantity limits exceeded, or refills-too-soon. The Division defines an emergency prescription as one in which:

A short-term (no more than thirty days) drug therapy is needed immediately for the treatment of an acute condition.

Emergency prescriptions must meet the following conditions:

- A log shall be maintained for each emergency or pharmacist generated override that provides at least the following information: date, patient name, and prescription number. Please see signature log requirements in the Outpatient Pharmacy Billing Appendix. These records will be subject to review by the Division.
- The emergency prescription must not have been dispensed based on a blanket physician authorization; and
- Maximum (6) emergency overrides per member per calendar year
- Abuse of the emergency prescription procedure code will subject a provider to adverse action.
- **99888** has been assigned for use as the drug code number for each emergency prescription billed. All five digits, 99888, must be entered in field (462-EV)

“Prior Authorization Number Submitted”. This code requires “04” in PA Type-Code field (461-EW) on the claim. This code does not override member eligibility, prior authorizations that are required, quantity limits exceeded, or refills-too-soon.

905. Pharmaceutical Services Rendered in Nursing Facility

In providing pharmacy services and drugs to patients in nursing facilities, pharmacies must meet all requirements and special conditions for participation. Pharmacists should refer to Appendix C for the applicable sections of the Policies and Procedures for Nursing Facility Services manual that describes drugs that must be furnished to members by the nursing facility.

Pharmacists servicing Nursing Homes and Long Term Care Facilities as a Vendor or Consultant must be licensed in the State of Georgia as required by the Georgia State Board of Pharmacy Rules, Chapter 480-24-.02. Authority Ga.L.1974, pp. 221-270; O.C.G.A. Secs. 26-4-37, 26-4-53.

Effective **January 1, 2006**, full benefit dual-eligibles will receive fee for service payment only for the drugs listed in Appendix C of this manual.

905.1 Unit Dose

The Division defines unit dose packaging as individual doses of drugs that preserve the identity and integrity of the medication from packaging to patient consumption. Each dose of oral medication is packaged in a sealed, tamper-proof container and carries full disclosure labeling.

Products labeled “For Institutional Use Only” and identified by the Center for Medicare and Medicaid Services (CMS) or the manufacturer, as entities **NOT** a part of the rebate program, are **NOT covered by Medicaid** and should **NOT** be billed to the Division. These drugs will deny with a “non-rebateable/non-covered” drug edit through the POS system.

905.2 Drugs Covered in the Nursing Home Per-Diem

Over-the-Counter (OTC) Drugs and Related Items - Each nursing facility shall as part of nursing and routine services supply clinically necessary over-the-counter drugs and related items to be used for members as ordered by the attending physician without additional charge to the Division, the member, or the member’s representative.

Each item must be available in adequate supply to assure the member’s timely receipt of the items as ordered. Those items will be provided generically or in a brand of the nursing facility’s choosing unless the doctor has a clinically necessary reason to choose a particular brand. The resident may only be charged for over-the-counter drugs if, after being informed of the options, he or she chooses to purchase a specific brand for non-clinical reasons from his/her personal needs allowance.

The items to be supplied by the nursing facility shall include, but shall not be limited to the following:

- Stool Softener and Laxative
 - Magnesium Hydroxide Liquid (Milk of Magnesia)
 - Glycerin Suppositories
 - Stool Softener
 - Bulk Laxative
 - Stimulant Laxative
- Antidiarrheal
 - Non-legend antidiarrheal product
- Antacid
 - Antacids
- Analgesic/Antipyretic
 - Acetaminophen - tablets, liquid, suppositories
 - Aspirin - tablets, suppositories
- Ophthalmic
 - Artificial tears in multi-dose containers labeled for specific patients' use
- Diluents/Irrigants
 - Normal saline
 - Sterile water
- Treatment Solutions
 - Chlorhexidine gluconate (Hibiclens)
 - Rubbing Alcohol
 - Povidone-iodine 10% (Betadine)
 - Hydrogen Peroxide 3% (Peroxide)
- Vaccines

- Influenza Vaccine
- Hepatitis B Virus Vaccine (ICF-MR only)
- Other
 - Other clinically necessary non-legend drugs ordered by the physician for which there is no substitute covered by Medicaid.

906. Pharmacy Consultant Services

The Division requires that there be pharmacy consultant services in nursing facilities as a condition of participation in Medicaid. The furnishing of pharmacy consultant services and payment for these services should not be confused with the filling of prescriptions for covered prescribed drugs and payment for them. For pharmacy consultant services, payment is made by the long-term care facility for a service to the institution. Reimbursement is not available for such services from the Pharmacy Services program.

907. Drug Utilization Review (DUR)

Effective July 1, 1992, the Division will implement a DUR program designed to monitor the use of prescription drugs by Medicaid members. The goal of the program is to identify potential drug therapy problems to providers and seek their assistance in resolving them. As a part of this program, two additional pieces of information are needed on the pharmacy claim. These are (1) the identity of the prescribing practitioner and (2) the number of days the medication should last, based on the prescriber's directions for use.

907.1a National Provider Identification Number (NPI) for Georgia Medicaid

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health and Human Services to meet the HIPAA health care provider identification mandate. It replaces all existing health care provider identifiers including numbers assigned by Georgia Medicaid on standard HIPAA transactions. It will be the number used to identify providers nationally.

Effective with dates of service on or after May 23, 2008, use of the Georgia Medicaid dummy physician license number is strictly prohibited. All pharmacy claims submitted with a dummy physician license number will reject at the Point of Sale (POS). Paper claims submitted using the dummy physician license number will also reject.

To obtain the NPI of a prescriber not on file, please visit:

<https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind>

or

Please, see the NPI-FAQ Guide located in Billing Section G of this manual.

Medicaid Enrollment Required for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

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Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating (i.e., rendering) provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

To comply with the requirement, medical residents may obtain an NPI and Medicaid provider ID in order to prescribe outpatient prescription medications. Pharmacies may submit the NPI of the medical resident who has signed the prescription on the pharmacy claim in the prescriber ID field. Alternatively, facilities may continue to use a prescription that is countersigned by the attending or supervising physician if they do not wish to enroll their residents and those claims should be billed under the attending's NPI number in the prescribing provider field. Medical residents may only prescribe; they may not order, refer or bill other services.

Beginning October 1, 2013, pharmacy claims will be denied if the prescribing provider is not enrolled as an OPR or rendering provider with DCH.

A provider may enter the following information to bypass the OPR reject, but a limited amount of overrides will be available per member:

- Field 461-EU PRIOR AUTHORIZATION TYPE CODE = Ø1 – Prior Authorization
- Field 462-EV PRIOR AUTHORIZATION NUMBER SUBMITTED = 44444444444 – Ordering Prescribing or Referring (OPR) Provider Override

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at <http://dch.georgia.gov/publications>

Type of Prescriber	Eligible for Medicaid Provider ID	Required Signature on Prescription	Required NPI# on Claim for Legend Drugs	Required NPI# on Claim for Controlled Drugs
Nurse Practitioner	Yes	Nurse Practitioner	Nurse Practitioner NPI#	Nurse Practitioner NPI# (CIII, IV, V drugs only)
Physician Assistant	Yes	Physician Assistant	Physician Assistant NPI#	Physician Assistant NPI# (CIII, IV, V drugs only)

- Search to see if a provider is enrolled at www.mmis.georgia.gov → Provider Enrollment → Provider Contract Status (enter the NPI or Medicaid Provider # in the Provider ID section to search)
- Access a provider listing at www.mmis.georgia.gov – Provider Information – Reports (Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing)

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907.2 Day Supply

This three digit numerical field will indicate the number of days the medication should last based on the prescriber's directions for use.

For example, a prescription for a medication to be taken twice a day with a quantity of sixty (60) would be a thirty (30) day supply. Prescriptions written and dispensed with nonspecific directions, such as "PRN" or "As Directed" and prescriptions for topical preparations, aerosol inhalers or nitroglycerin should be billed as a 30-day supply. Please see Section 602.8.

907.3 Prospective Drug Review

Beginning January 1, 1993, the pharmacists dispensing drugs to Medicaid members shall perform a review of drug therapy before each prescription is filled or delivered to the member. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindication, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

907.4 Patient Counseling

As a part of prospective drug review, pharmacists dispensing drugs to Medicaid members must meet the standards established for patient counseling by the Georgia State Board of

Pharmacy in 480-31.01 and OBRA 90' federal legislation.. That is, the pharmacist must offer to discuss with each Medicaid member or caregiver of such individual in person, whenever practicable, or by toll-free-telephone for long distance calls matters which, in the exercise of the pharmacist's professional judgment, he/she deems significant including the following:

- A) The name and description of the drug
- B) The dosage form, dose, route of administration and duration of drug therapy
- C) Intended use of the drug and expected action
- D) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur
- E) Techniques for self-monitoring drug therapy
- F) Proper storage
- G) Prescription refill information
- H) Action to be taken in the event of a missed dose
- I) Comments from the pharmacist relevant to the individual's drug therapy including any other information peculiar to the specific patient or drug
- J) Compliance and persistence counseling

907.5 Patient Profiles

A patient record system shall be maintained by all pharmacies for patients for whom prescription drug orders are dispensed. The pharmacist or his/her designee shall record and maintain all of the following information:

- A) Full name of the patient for whom the drug is intended.
- B) Address and telephone number of the patient.
- C) Date of birth and gender.
- D) Known allergy, drug reactions, idiosyncrasies and chronic conditions.
- E) A list of all prescription drug orders obtained by the patient at the pharmacy where the prescription drug order is being filled within the preceding five (5) years. This list shall contain at a minimum, the following elements: Prescription number, name and strength of drug,

date and quantity dispensed, name of the prescriber, and the initials of the dispensing pharmacist.

- F) Appropriate comments from the pharmacist relevant to the individual's drug therapy including any other information peculiar to the specific patient or drug. A patient profile shall be maintained for a period of not less than five (5) years from the date of the last entry in the profile record. This profile may be on paper or on a computer.

907.6 Refusal of Consultation

A pharmacist is not required to provide consultation when the member or caregiver of such member refuses such consultation. The pharmacist must document the refusal of consultation by having the member or caregiver sign a preprinted statement acknowledging the refusal. Such statements may be maintained with the member's prescription or on a log that identifies the member, the prescription and the date dispensed.

908. Hospice Related Services

Medicaid members who elect to enroll in the Hospice program receive all care related to their terminal illness from the hospice. Prescriptions filled for these members relating to the terminal illness are to be paid by the hospice and should not be billed to the Medicaid drug program. Pharmacy hospice claims do not require paper or attachments and can be billed through POS effective 10/1/2000.

However, should the Medicaid hospice patient require covered drugs that do NOT relate to the terminal illness, these prescriptions may be billed to Medicaid with some restrictions.

Effective 03/23/2010, children less than 21 years of age will no longer be required to forego curative care when electing hospice. They may concurrently receive palliative and curative treatment related to the terminal illness. All palliative treatment is to be provided by the hospice provider through hospice services reimbursed by Medicaid. Pharmacy services prescribed as curative treatment for children less than 21 years of age will also be paid by Medicaid when eligibility for concurrent care criteria is met. Providers wishing to prescribe drugs for curative treatment from the list of medications below should use the pharmacy services PA process to request an exception.

DCH considers the following drugs palliative in nature and therefore ineligible for coverage in the outpatient pharmacy program for hospice members. These include but are not limited to:

- analgesics
- antibiotics*
- antidepressants*

- anti-emetics
- antifungals
- antihistamines for sleep
- anxiolytics
- appetite stimulants
- folic acid, multivitamins, iron
- hematopoetics (Procrit, Epogen, etc.)
- HIV drugs
- hypnotics
- interferons
- laxatives
- megestrol
- anti-migraine drugs
- muscle relaxants
- non-steroidal anti-inflammatory agents
- oncology drugs
- sedatives
- stool softeners

*approval on a case-by-case basis.

909. Member Hearing Request

Please refer to Part I Policies and Procedures for Medicaid/PeachCare for Kids Manual, Chapter 500

PART II - CHAPTER 1000 BASIS FOR REIMBURSEMENT

These policies are in accordance with federal regulation 42 CFR 447.331 and 447.332.

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1001. Reimbursement

For claims with fill dates on or after April 1, 2017, the reimbursement methodology used will be contingent on if the product dispensed is a specialty drug.

The Professional Dispensing Fee (PDF) will be set to \$10.63.

Reimbursement for specialty drugs dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

- A) Select Specialty Pharmacy Rate (SSPR) plus the Professional Dispensing Fee (PDF),
or
- B) National Average Drug Acquisition Cost (NADAC) plus the Professional
Dispensing Fee (PDF), or
- C) Georgia Estimated Acquisition Cost (GEAC) plus the Professional Dispensing Fee
(PDF), or
- D) Georgia Maximum Allowable Cost (GMAC) plus the Professional Dispensing Fee
(PDF), or
- E) Federal Upper Limit (FUL) plus the Professional Dispensing Fee (PDF), or
- F) Provider submitted charges (including Usual and Customary Charges)

Reimbursement for non-specialty drugs, which have an active National Average Drug Acquisition Cost (NADAC) price on file, dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

- A) National Average Drug Acquisition Cost (NADAC) plus the Professional Dispensing
Fee (PDF), or
- B) Georgia Maximum Allowable Cost (GMAC) plus the Professional Dispensing Fee
(PDF), or
- C) Federal Upper Limit (FUL) plus the Professional Dispensing Fee (PDF), or
- D) Provider submitted charges (including Usual and Customary Charges)

Reimbursement for non-specialty drugs, which do not have an active National Average Drug Acquisition Cost (NADAC) price on file, dispensed under the Georgia Medical Assistance program shall not exceed the lowest of:

- A) Georgia Estimated Actual Acquisition Cost (GEAC) plus the Professional Dispensing Fee (PDF), or
- B) Georgia Maximum Allowable Cost (GMAC) plus the Professional Dispensing Fee (PDF), or
- C) Federal Upper Limit (FUL) plus the Professional Dispensing Fee (PDF), or
- D) Provider submitted charges (including Usual and Customary Charges)

NOTE: Between May 15, 2002 – June 30, 2005 a 50-cent generic incentive dispensing fee was paid to providers.

Determining Usual and Customary Charges

The Division defines usual and customary as the lowest price routinely offered to any segment of the general public. For example, if a pharmacy offers discounts to Senior Citizens or children, the same discounted price must be billed to the Division. Likewise, a pharmacy that provides prescription refills at no charge must not bill the Division for a refill provided to a Medicaid member. Donations or discounts provided to a charitable organization or fees charged to or paid by federal or state funded programs are not considered usual and customary charges.

Georgia Maximum Allowable Cost (GMAC) Price List and Disputes

A complete Georgia Maximum Allowable Cost (GMAC) Price List is updated on a quarterly basis and is available online under www.mmis.georgia.gov → Pharmacy → Pricing List. Any changes to GMAC prices within the quarter are also posted online to this same location. Any disputes to current GMAC prices may be submitted by completing a Pricing Appeal Form and faxing it along with a copy of an invoice received within 30 days of the appeal date to OptumRx at 1-888-292-4814. A copy of the MAC Pricing Appeal Form may be found online under <https://ga-providerportal.optum.com> → click the link for Pricing Appeal Form.

Other pricing disputes may be submitted to OptumRx by accessing the Pricing Appeal Form online and following the same process as mentioned for GMAC pricing disputes.

Please note: The submission of a pricing appeal does not guarantee a change in pricing.

Select Specialty Pharmacy Rates (SSPR)

Effective July 1, 2012, the Georgia Department of Community Health implemented Select Specialty Pharmacy Rates (SSPR) resulting in a change to the reimbursement for Medicaid and PeachCare for Kids™ Fee-for-service pharmacy claims.

Select Specialty Pharmacy Rate (SSPR) is the Actual Acquisition Cost (AAC) for select specialty pharmaceuticals based on the product dispensed and the Department's ability to ensure access to the medication at that reimbursement level. All other established payment methodologies and rules continue to apply. Products identified by the

Department as Specialty Pharmaceuticals and subject to this reimbursement change include but are not limited to the agents used in the treatment of the following conditions:

- Rheumatoid Arthritis/Crohn's Disease/Psoriasis
- Multiple Sclerosis
- Neutropenia
- Hepatitis
- Anemia
- Growth Hormone Deficiency
- Cystic Fibrosis
- Respiratory Syncytial Virus (RSV) Prevention
- Pulmonary Hypertension
- Hemophilia
- Cancer
- Orphan Diseases
- HIV

No less than quarterly, the Department reviews the appropriateness of the reimbursement methodology for Specialty pharmaceuticals and Hemophilia Blood Factor-related products and adjusts the reimbursement rate if needed to ensure recipients' access to the medications is maintained.

For a current list of Select Specialty Pharmacy Rates (SSPR) please refer online to www.mmis.georgia.gov → Pharmacy → Pricing List → SSPR → Select Specialty Pharmacy Rates (SSPR)

1001.1 Recoupment Resulting from Audit Findings

Recoupments of any disputed funds shall only occur after final internal disposition of the audit, including the appeals process as set forth in The Pharmacy Audit Bill of Rights Section 11, subsection (d). Only documentation that was submitted during the audit process will be considered for review. For other appeals information please refer to Part I Policies and Procedures for Medicaid/PeachCare for Kids Manual, Chapter 500.

1002. Brand Necessary/Innovator Drugs/Mandatory Generic Dispensing

Medicaid requires A-Rated generic drug dispensing when generics are available unless otherwise specified. Brand name drugs for products that have a Federal Upper Limit (FUL) are subject to prior approval. **The only exceptions to this policy are Brand Tegretol, Brand Dilantin and preferred brand drugs that are listed on the Preferred Drug List (PDL).**

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To receive prior approval for the innovator product of a MAC drug, the following circumstance must prevail:

- A) The generic equivalents have caused an allergic reaction, and this fact has been documented by the prescribing physician by letter or on the GA Watch Form. The GA Watch form is included in appendix G, Outpatient Pharmacy Billing. The form or letter documenting the specific allergic reaction must be provided to OptumRx

1003. DAW - Product Selection Code (PSC)

DCH does not accept DAW/PSC codes with the exception of DAW/PSC = 1 for brand name Dilantin and Tegretol. The physician must have hand-written on the face of the prescription "Brand Necessary".

The State of Georgia does not prohibit substitution of any multisource products. Please be advised that the use of the DAW Code 7 is considered to be inappropriate for Georgia Medicaid.

APPENDIX A

DRUGS AND THERAPY CLASSES REQUIRING PRIOR APPROVAL

Rev. 10/15 Prior approval is required before the dispensing of certain drugs and classes of drugs. OptumRx can authorize clinical prior approvals when criteria is met for members without a Medicaid I.D. number in the database. The requestor must provide at a minimum, the member's Social Security Number and date of birth. OptumRx can also accept requests for prior approval from pharmacies not currently enrolled in Medicaid. The dispensing pharmacy must supply their NCPDP number.

The Medicaid Preferred Drug list including drugs and therapeutic classes requiring prior approval can be viewed at

www.mmis.georgia.gov → Pharmacy → Other Documents

Please contact the DXC Technology call center to obtain a hard copy of the PDL at 1-800-766-4456 or 770-325-9600.

Rev. 10/15 Please note that the Preferred Drug List and Quantity Level Limit list is subject to change without notice. Contact OptumRx 866-525-5826 to determine the coverage status or quantity level limit of any covered drug.

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs), Cyclooxygenase-2 (COX-2) Inhibitors, and Meloxicam

The prior approval request for NSAIDs, including meloxicam, must include confirmation of trials with a combined total of (2) multiple source NSAIDS. The prior approval request for a COX-2 inhibitor must include claim history confirmation of the use of (2) generic NSAIDS for at least 14 consecutive days of therapy each.

Samples and OTC usage will not be considered as a trial. Once an approval has been issued, brands of NSAIDs or COX-2s may be interchanged without a new request within the approved time period of twelve months. All COX-2s and NSAIDs have quantity level limits (QLL) in place.

Brand Name Innovator Products of Multiple Source Generics

Effective July 1, 1996, all brand name drugs for products that have a Federal Upper Limit (FUL) are subject to prior approval unless otherwise specified. Exceptions to this rule can be found under Section 1002 Brand Necessary/Innovator Drugs/Mandatory Generic Dispensing.

Drugs with Age and/or Gender Limitations

The brand and generic forms of the following drugs or drug classes are covered with limitations based upon age and/or gender and require Prior Authorization.

- Xenical up to age 21
- Prenatal vitamins for women
- Vitamin and Mineral Products for recipients < 21 years of age
- Ibuprofen suspension for members < 21 years of age
- Diclegis for women
- Cough and cold products for recipients < 21 years of age

APPENDIX B

DRUGS WITH THERAPY LIMITATIONS or QUANTITY LEVEL LIMITS

Therapy Limitations

A number of drugs have limits on the length of time they may be prescribed, dispensed and covered by Medicaid without prior approval. Each type of limitation is defined separately below and the quantity level limit (QLL) listing follows Appendix B of this section.

1. Legend Histamine-2 (H2) Receptor Antagonists

Effective February 1, 2002, legend generic H2 receptor antagonists will be available without therapy limits. Quantity level limits will be set at a month's supply based on the dose and frequency of administration. Mandatory generic dispensing is required where applicable. See the current GMAC list located on the Department's web site at www.mmis.georgia.gov → Pricing List → GMAC List.

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2. Prescription Limitation For Narcotics

Beginning April 1, 2013, the Department of Community Health is lowering its narcotic prescription limitation for Georgia Medicaid Fee-for-Service (FFS) members from 6 to 5 fills per month. Thus, Georgia Medicaid FFS members will be limited to 5 fills per month of narcotic prescriptions without a written letter of medical necessity. Cancer and hospice patients are exempt from the limit. Please refer all prior authorization requests to OptumRx (formerly SXC) at 1-866-525-5827.

3. Benzodiazepines

Effective October 1, 2008, select benzodiazepines are covered for all adults without an annual prescription limitation.

Therapeutic Duplication (TD) Edits and Quantity Level Limits (QLL) for Select Benzodiazepines and Sedative Hypnotics

Effective October 1, 2008, the Department implemented therapeutic duplication edits and new QLLs for select benzodiazepines and sedative hypnotics. Therapeutic duplication (TD) edits are activated within each category of the anxiolytic benzodiazepines and sedative hypnotic benzodiazepines (see Table 1).

Table 1

Therapeutic Duplication Edit **only (1) product from each class allowed without PA**	
Anxiolytic Benzodiazepines	Sedative Hypnotic Benzodiazepines
alprazolam, chlordiazepoxide, clorazepate, diazepam, lorazepam and oxazepam	estazolam, flurazepam, temazepam and triazolam

A (TD) edit will post if claims for more than one drug in a 30-day period are processed within each of the benzodiazepine categories. Also, a quantity level limit (QLL) of 18 per 30 days across the sedative hypnotics (benzodiazepine and non-benzodiazepine) will be enforced (see Table 2).

Table 2

Sedative Hypnotic Group – Quantity Level Limit of (18) per 30 days (QLL applied across entire group for a combined total of 18 per 30 days)
estazolam, flurazepam, temazepam, triazolam, zolpidem ER/Ambien CR, Lunesta, Rozerem, zaleplon/Sonata and zolpidem/Ambien

The QLL edit will look for a combined quantity total of 18 per 30 days within the sedative hypnotic group. **Requests to override the (TD) or (QLL) edits will require a prior authorization (PA).** Providers may request a PA from the OptumRx Clinical Call Center at 1-866-525-5827.

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4. Other Drugs With Limitations

Toradol (injectable and tablets) - Limited to one (5) day supply per rolling month.

5. Drugs or Devices with Quantity or Day Supply Limitations

Effective April 1, 1995, all prescriptions for **Ambien** will be limited to a maximum quantity of eighteen (18) per rolling month.

Effective October 1, 2009, all prescriptions for oral **Triptans** will be limited to (9) tablets per rolling month. These include, but are not limited to: **Imitrex, Amerge, Maxalt, Zomig, Frova, Axert and Relpax**. Please review the Preferred Drug List on the GHP Technology Web Portal at www.mmis.georgia.gov → Pharmacy → Other Documents → Preferred Drug List (PDL).

Effective July 1, 1999, all prescriptions for **Imitrex** injections will be limited to (4) units per rolling month.

Effective July 1, 1999, all prescriptions for **Imitrex Nasal Spray** will be limited to (6ml) per rolling month.

Effective July 1, 1999, all prescriptions for **Migranal Nasal Spray** will be limited to (6) spray units (24ml) per rolling month.

Effective October 1, 1999, all prescriptions for **Sonata** will be limited to a maximum of eighteen capsules (18) per rolling month.

Effective October 1, 2000, all **Relenza** therapy will be limited to (20) doses per rolling month. These prescriptions are available only to members ≥ 7 years old. Relenza therapy is restricted to two (2) courses of therapy every twelve (12) months.

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Effective October 1, 2000, all prescriptions for **Tamiflu** will be limited to (5) days of therapy per (6) months. For institutional settings, Tamiflu will be limited to (21) days of therapy per (6)

months. All therapy is restricted to (2) courses every twelve (12) months.

Effective October 1, 2000, all prescriptions for the following will be limited to (1) Rx per rolling month: **EpiPens (including EpiPen Jr.) , AnaKit and Plan B.**

Effective June 1, 2002, all **Stadol Nasal Spray** will be limited to a maximum quantity of two (2) spray units (6ml) per rolling month.

Effective February 1, 2005, all prescriptions for **Lunesta** will be limited to a maximum of eighteen tablets (18) per rolling month.

Effective October 1, 2005, all prescriptions for **Rozerem** will be limited to a maximum of eighteen tablets (18) per rolling month.

Rev. 04/19 **6. Members Requiring Diabetic Supplies & Insulin**

Effective October 1, 2013, only select Abbott Diabetes Care brand blood glucose monitors, test strips, and ketone strips are covered through the manufacturer and are available to Medicaid members requiring diabetic supplies. A list of covered diabetic supplies is located on the GHP Web Portal at www.mmis.georgia.gov under Pharmacy→ Other Documents→ Covered Diabetic Supplies.

Blood Glucose Monitors

As of October 1, 2010, the Outpatient Fee-For-Service (FFS) Pharmacy Program no longer reimburses providers for blood glucose monitors. Covered blood glucose monitors by Abbott Diabetes Care should be adjudicated directly to the manufacturer for reimbursement.

A 2nd blood glucose monitor is available for Georgia Medicaid FFS & PeachCare for Kids Members who are in school and 18 years of age and younger.

Rev. 04/19 **Abbott Diabetes Care Blood Glucose Monitors**

- **No Charge Meter Coupons:** Abbott Diabetes Care sales representatives distributed no-charge meter cards to network pharmacy stores that provide a unique ID number and billing instructions. If your store has an urgent need for meter adjudication cards you may call **Abbott Diabetes Care Customer Service at 1-888-522-5226 (24-hour service).**
- Georgia Medicaid FFS/PeachCare for Kids Members can receive a free FreeStyle Lite or FreeStyle Freedom Lite meter by calling Abbott Diabetes Care at 1-866-224-8892, or order online at www.choosefreestyle.com and entering offer code YXRFAQEK.
- For product training, please call Abbott Diabetes Care Customer Service at 1-888-522-5226 (24-hour service).
- To process claims for FreeStyle and Precision brand blood glucose monitors for Georgia Medicaid members, please use the below code, which is part of the Abbott Free Meter Program. This code must be accompanied by a blood glucose monitor prescription.

Dispense one FreeStyle Lite (NDC 99073-0708-05), FreeStyle Freedom Lite (NDC 99073-0709-14), or Precision Xtra (NDC 57599-8814-01) meter at no charge to the patient.

RxBIN: 610020
Group#: 99992432
Universal Member ID: ERXGAMED

For assistance with processing an Abbott meter please contact TrialCard at 1-866-740-8343. Their hours of operation are as followed:

Monday – Friday: 24 hours
Saturday: 8am – 7pm ET
Sunday: 9am – 5pm ET

- Any blood glucose monitor dispensed pursuant to the terms of this code is dispensed as a sample and shall not be submitted to any third-party payer, public, or private for reimbursement.

Lancet Devices, Lancets, Syringes and Pen Needles

Effective October 1, 2013, a maximum allowed unit price will be set for the following products as indicated on the table below:

Product Name	Unit Price
LANCET DEVICES	\$ 5.33
LANCETS	\$ 0.09
INSULIN SYRINGES	\$ 0.10
INSULIN PEN NEEDLE	\$ 0.24

- Insulin Syringes - 120 per rolling month, without prior approval.
- Insulin Pen Delivery Systems and Cartridge – require Prior Approval for ≥ 21 years old. The quantity level limit is (1) insulin pen delivery system per rolling year.
- Lancets - 150 per rolling month, without prior approval
- Lancet Device – one (1) device per calendar year, without prior approval
- FreeStyle and Precision Blood Glucose Test Strips – 150 per rolling month, without prior approval
- Pen Needles – 100 per rolling month, without prior approval
- Urine Glucose Test Strips - 100 per rolling month, without prior approval

Durable Medical Equipment (DME) Diabetic Supply Transition

Effective **November 1, 2011**, The Georgia Department of Community Health (DCH) transitioned the following Durable Medical Equipment (DME) diabetic supplies: insulin syringes, pen needles, lancing device, lancets, blood glucose monitoring strips, and blood glucose monitors to the Georgia Medicaid Fee-For-Service (FFS) Outpatient Pharmacy Program. The following supplies are no longer reimbursable under the DME Program Category of Service (COS) 320:

DME SUPPLY	CODE
Lancet	A4259
Glucose Strips	A4253
Monitor	E2100 (w/integrated voice synthesizer)

Only the insulin infusion pump (E0784) and its supplies (A4230, A4231, A4232, K0101, K0602, K0603 and K0604) continue to be reimbursed under the DME program.

Diabetic supplies are only available through enrolled Georgia Medicaid FFS Outpatient Pharmacies when prescribed by a physician. Georgia licensed pharmacies, when enrolled, are simultaneously assigned to COS 300 and 321. Only providers eligible to enroll in COS 300 and 321 are eligible to dispense approved FFS insulin syringes, pen needles, lancing device, lancets, blood glucose monitoring strips, and blood glucose monitors to non-nursing home Medicaid PeachCare diabetic patients.

Claims submitted by pharmacies for FFS members are processed by the Pharmacy Benefit Manager (PBM), OptumRx (COS 300), except for blood glucose monitors which are processed directly through the manufacturer. All claims (including blood glucose monitors) submitted by pharmacies for crossover members (dual eligible) are processed by DXC Technology through the Medicaid Management Information System (MMIS) (COS 321).

Only dual eligible members are eligible to continue to receive services from DME suppliers.

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7. Members Requiring Spacers and Peak Flow Meters

Effective January 1, 1999, asthmatic children (<21) may receive spacers and peak flow meters under Pharmacy Services per the following:

One (1) spacer per calendar year – GMAC effective December 1, 2015, of \$50.00 a spacer plus a dispensing fee.

One (1) peak flow meter per lifetime – GMAC effective July 1, 2007, of \$20.00 a meter plus a dispensing fee.

8. Generic OTC Drug Coverage-Products Previously Available as Legend Only

Effective on or after September 1, 2004, the following generic over-the-counter (OTC) drugs and/or classes will be covered with a prescription.

- **Low-Sedating Antihistamines & Combination Products:**

- OTC generic **loratadine** and generic **loratadine-D** combination products are covered for all members.

OTC generic **certirizine tablets** and OTC/RX generic **certirizine syrup** are covered for all members.

9. Smoking Deterrent Products

Smoking deterrent products are covered with a prescription. All smoking deterrent products are covered up to a maximum duration of 24 weeks (168 days) per year 12 weeks at a time. Preferred OTC medications (generic nicotine gum, lozenges and patches) do not require prior authorization (PA) for the 1st 12 weeks. All other smoking deterrent products require prior authorization for the 1st 12 weeks and the 2nd 12 weeks.

We appreciate your continued participation in the Georgia Medicaid & Peach Care for Kids Programs.

Georgia Medicaid Quantity Level Limits****Please note that this list is subject to change without notice****

DRUG PRODUCT	MAXIMUM QUANTITY
Abilify, all strengths	60 tablets per 30 days
Abilify ODT 10mg, 15 mg	60 tablets per 30 days
Abilify Oral Solution 1 mg/mL	720 mL per 30 days
Abilify Maintena	1 vial per 30 days
Abilify Mycite, all strengths	1 box (30 tablets; 7 wearable sensors) per 30 days
Absorica	60 capsules per 30 days
Abstral, all strengths	240 tablets per 30 days
Acanya	50 grams per 30 days
Accolate	60 tablets per 30 days
Acebutolol (Sectral)	90 capsules per 30 days
Aceon	60 tablets per 30 days
Acetazolamide ER (Diamox Sequels) 500mg	60 capsules per 30 days
Aciphex	30 tablets per 30 days
Aciphex Sprinkles 5 mg	30 capsules per 30 days
Aciphex Sprinkles 10 mg	60 capsules per 30 days
Actemra Subcutaneous	3.6 mL per 30 days
Actimmune injection	12 vials (6 mL) per 28 days
Actiq Lozenge	90 lozenges per 30 days
Activella	28 tablets per 28 days
Actonel 5, 30mg	30 tablets per 30 days
Actonel 35mg	5 tablets per 30 days
Actonel 150mg	1 tablet per 30 days
Actoplus Met	90 tablets per 30 days
Actoplus Met XR	30 tablets per 30 days
Actos	30 tablets per 30 days
Acular Eye Drops	12 mL per 30 days
Acular LS Ophthalmic Solution	5 mL per 30 days
Acuvail	10 vials (4 mL) per 30 days
Adcirca 20mg	60 tablets per 30 days
Adderall XR	90 capsules per 30 days
Adempas	90 tablets per 30 days
Adlyxin Starter Pack	1 pack (6 mL) per liftemine
Adlyxin Maintenance Pack	1 pack (6 mL) per 28 days
Admelog	45 mL per 30 days
Advair Diskus	60 (1 diskus) per 30 days
Advair HFA	12 grams (1 inhaler) per 30 days
Advicor 500/20, 1000/40mg	30 tablets per 30 days
Advicor 750/20, 1000/20mg	60 tablets per 30 days
Adzenys XR, all strengths	30 tablets per 30 days
Afinitor and Afinitor Disperz	28 tablets per 28 days
Aimovig, all strengths	1 auto-injector pen per 28 days
AirDuo, all strengths	1 canister (60 metered doses) per 30 days
Ajovy	1 syringe (1.5 mL) per 30 days
Akynzeo	1 capsule per 30 days
Alamast	10 mL per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Albuterol HFA (Proventil HFA, Ventolin HFA, ProAir HFA)	2 inhalers per 30 days
Albuterol nebulized solution (Accuneb, Proventil, Ventolin)	175 unit dose vials per 30 days
Albuterol RespiClick (ProAir)	2 inhalers per 30 days
Alecensa	240 capsules per 30 days
Alinia suspension	1 bottle per 30 days
Alinia tablets	6 tablets per 30 days
Allegra 30mg ODT	60 tablets per 30 days
Allegra-D	60 tablets per 30 days
Allegra-D 24	30 tablets per 30 days
Allegra Oral Suspension, 30 mg/5 mL	300 mL per 30 days
Allzital	360 tablets per 30 days
Alocril	5 mL per 30 days
Alomide	10 mL per 30 days
Alphagan P (brimonidine) 0.1%, 0.15%	1 bottle per 30 days
Alprazolam (Xanax)	90 tablets per 30 days
Alrex Eye Drops	10 mL per 30 days
Altace 1.25mg	60 tablets per 30 days
Altace 2.5, 5, 10mg	90 tablets per 30 days
Altinac	45 grams per 90 days
Altoprev	30 tablets per 30 days
Altreno	45 grams (1 tube) per 30 days
Alunbrig 30mg	60 tablets per 30 days
Alunbrig 90mg	30 tablets per 30 days
Alunbrig 180mg	30 tablets per 30 days
Alunbrig Titration Pack	1 pack (30 tablets) per lifetime
Alvesco 80mcg, 160mcg	12.2 grams (2 inhalers) per 30 days
Ambien/CR, Edular, Intermezzo, Lunesta, Rozerem, Sonata	18 pills per 30 days
Amerge, Axert, Frova, Imitrex, Maxalt, Relpax, sumatriptan, Treximet and Zomig tablets	9 tablets per 30 days
Amevive 7.5, 15mg	4 injections per 30 days for 12 weeks
Amethyst (Lybrel)	28 tablets per 28 days
Amicar oral solution	1920 mL per 30 days
Amicar oral tablets, all strengths	480 tablets per 30 days
Amitiza 8, 24mcg	60 capsules per 30 days
Amoxicillin suspension (Amoxil, Trimox)	600 mL (200/400mg/5mL) or 900 mL (125/250mg/5mL) per 30 days
Amoxicillin/Clavulanate suspension (Augmentin, Augmentin ES, Amoclan)	600 mL (200/400mg/5mL) or 900 mL (125/250mg/5mL, 600/5mL) per 30 days
Amoxicillin/Clavulanate suspension (Augmentin) 250/62.5mg/5mL	700 mL per 30 days
Amphetamine Salts (Adderall)	180 tablets per 30 days
Ampyra 10mg	60 tablets per 30 days
Amturnide, all strengths	30 tablets per 30 days
Anastrozole (Arimidex) 1mg	30 tablets per 30 days
Androderm 2, 4mg	30 patches per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Androgel 1% (12.5mg) gel pump	150 grams (1 package) per 30 days
Androgel 1% (50mg) gel packets	300 grams (60 packets) per 30 days
Androgel 1% (25mg) gel packets	150 grams (60 packets) per 30 days
Androgel 1.62% (20.25mg) gel pump	150 grams (2 bottles) per 30 days
Androgel 1.62% (20.25mg/1.25gm) gel packets	37.5 grams (30 packets) per 30 days
Androgel 1.62% (40.5mg/2.5gm) gel packets	150 grams (60 packets) per 30 days
Angeliq, all strengths	28 tablets (1 pack) per 28 days
Anoro Ellipta	60 blisters per 30 days
Antara 30mg, 43mg	60 capsules per 30 days
Antara 90mg, 130mg	30 capsules per 30 days
Anzemet 50, 100mg	5 tablets per 30 days
Apidra	45 mL per 30 days
Aplenzin 174, 348, 522mg	30 tablets per 30 days
Aptensio XR	30 capsules per 30 days
Aptiom 200, 400, 800mg	30 tablets per 30 days
Aptiom 600mg	60 tablets per 30 days
Aranesp	4 vials/syringes per 30 days
Arava	30 tablets per 30 days
Arcalyst	4 vials per 28 days
Arcapta Neohaler	30 capsules per 30 days
Aricept (donepezil) 5mg, 23mg	30 tablets per 30 days
Aricept (donepezil) 10mg	60 tablets per 30 days
Aricept (donepezil) ODT 5mg	30 tablets per 30 days
Aricept (donepezil) ODT 10mg	60 tablets per 30 days
Arikayce	28 vials (235.2 mL) per 28 days
Aristada 441 mg/1.6 mL	1.6 mL (1 syringe) per 30 days
Aristada 662 mg/2.4 mL	2.4 mL (1 syringe) per 30 days
Aristada 882 mg/3.2 mL	3.2 mL (1 syringe) per 30 days
Aristada 1064 mg/3.9 mL	3.9 mL (1 syringe) per 56 days
Aristada Initio	2.4 mL (1 syringe) per year
Arixtra Syringe	11 syringes per 30 days
Armonair Resplick	1 inhaler (60 metered doses) per 30 days
Arnuity Ellipta, all strengths	30 actuations (1 inhaler) per 30 days
Arymo ER, all strengths	90 tablets per 30 days
Asmanex HFA	13 grams per 30 days
Asmanex Twisthaler 220mcg #14	1 inhaler per 30 days
Asmanex Twisthaler 220 mcg #30, #60, #120	2 inhalers per 30 days
Asmanex Twisthaler 110mcg #30	1 inhaler per 30 days
Astagraf XL 0.5mg	30 capsules per 30 days
Astagraf XL 1mg, 5mg	120 capsules per 30 days
Astelin Nasal Spray	1 bottle (30mL) per 30 days
Astepro	1 bottle (30mL) per 30 days
Atacand 32mg	30 tablets per 30 days
Atacand 4, 8, 16mg	60 tablets per 30 days
Atacand HCT	30 tablets per 30 days
Atelvia 35mg	4 tablets per 30 days
Atenolol (Tenormin)	90 tablets per 30 days
Atenolol/chlorthalidone (Tenoretic)	60 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Atralin 0.05% gel	45 grams per 30 days
Atovaquone (Mepron)	300 mL per 30 days
Atovaquone/proguanil (Malarone) 250/100 mg	30 tablets per lifetime
Atovaquone/proguanil (Malarone) 62.5/25 mg	90 tablets per lifetime
Atrovent 0.03% nasal spray (ipratropium)	2 bottles per 30 days
Atrovent 0.06% (ipratropium)	1 bottle per 30 days
Atrovent HFA	25.8 grams (2 inhalers) per 30 days
Aubagio	28 tablets per 28 days
Auryxia	360 tablets per 30 days
Austedo, all strengths	60 tablets per 30 days
Avalide 300mg/12.5mg	30 tablets per 30 days
Avalide 150mg/12.5mg	60 tablets per 30 days
Avandamet	60 tablets per 30 days
Avandaryl 4mg/1mg, 4mg/2mg	60 tablets per 30 days
Avandaryl 4mg/4mg	30 tablets per 30 days
Avandia 2, 4, 8mg	30 tablets per 30 days
Avapro	30 tablets per 30 days
Avelox	21 tablets per 30 days
Avelox ABC Pack	15 tablets per 30 days
Avinza 120mg	90 capsules per 30 days
Avinza 30, 45, 60, 75, 90 mg	30 capsules per 30 days
Avodart	30 capsules per 30 days
Avonex, Avonex AD	4 vials per 30 days
Avycaz	42 vials per 14 days
Axert	See Amerge
Axiron	2 bottles (180mL) per 30 days
Azithromycin 100mg/5mL Suspension (Zithromax Suspension)	30 mL per 30 days
Azithromycin 1g/packet (Zithromax)	2 packets per 30 days
Azithromycin 200mg/5mL Suspension (Zithromax Suspension)	90 mL per 30 days
Azithromycin 250mg (Zithromax)	12 tablets per 30 days
Azithromycin 500mg (Zithromax)	6 tablets per 30 days
Azithromycin (Zithromax) 600mg	30 tablets per 30 days
Azor 5/20, 5/40, 10/20, 10/40mg	30 tablets per 30 days
Bactroban (mupirocin) cream	45 grams per 30 days
Bactroban (mupirocin) ointment	44 grams per 30 days
Bactroban Nasal	10 grams per 30 days
Balcoltra	35 tablets per 28 days
Balversa, all strengths	60 tablets per 30 days
Banzel 200mg	480 tablets per 30 days
Banzel 400mg	240 tablets per 30 days
Banzel suspension	2,400mL per 30 days
Baraclude	30 tablets per 30 days
Baraclude solution	600 mL per 30 days
Basaglar	45 mL per 30 days
Baxdela oral tablets	28 tablets per 30 days
Beconase AQ	50 grams (2 inhalers) per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Belbuca (buprenorphine)	60 films per 30 days
Belsomra	See Ambien
Benazepril (Lotensin)	60 tablets per 30 days
Benazepril/HCT 10/12.5mg, 20/12.5mg (Lotensin HCT)	60 tablets per 30 days
Benazepril/HCTZ 20/25mg (Lotensin HCT)	120 tablets per 30 days
Benicar	30 tablets per 30 days
Benicar HCT	30 tablets per 30 days
Benlysta solution for subcutaneous injection	4 syringes (4 mL) per 28 days
BenzaClin	1 jar or bottle per 30 days
BenzaClin Kit	1 kit per 30 days
BenzE Foam 5.3%	60 grams per 30 days
Benznidazole, all strengths	120 tablets per 30 days
Bepreve 1.5%	1 bottle per 30 days
Besivance	5 mL per 30 days
Betaseron	15 vials per 30 days
Betaxolol 10mg (Kerlone)	60 tablets per 30 days
Betaxolol 20mg (Kerlone)	120 tablets per 30 days
Bethkis	224 mL per 56 days
Bevyxxa, all strengths	30 capsules per 30 days
Beyaz	28 tablets per 28 days
Bevespi	10.7 grams (1 inhaler) per 30 days
Bidil	180 tablets per 30 days
Biktarvy	30 tablets per 30 days
Bimatoprost 0.03%	7.5 mL per 75 days
Binosto	4 tablets per 30 days
Bisoprolol 10mg (Zebeta)	60 tablets per 30 days
Bisoprolol 5mg (Zebeta)	30 tablets per 30 days
Bisoprolol/HCTZ (Ziac)	60 tablets per 30 days
Blood glucose meter	1 meter per lifetime
Blood glucose test strips (FreeStyle, Precision)	150 test strips per 30 days
Blood ketone test strips (Precision)	30 strips per 30 days
Boniva 150mg	1 tablet per 30 days
Boniva 2.5mg	30 tablets per 30 days
Boniva syringe	1 syringe per 90 days
Bonjesta	60 tablets per 30 days
Bosulif 100mg	120 tablets per 30 days
Bosulif 400mg	30 tablets per 30 days
Bosulif 500mg	30 tablets per 30 days
Braftovi, all strengths	180 capsules per 30 days
Breo Ellipta	60 blisters per 30 days
Brilinta	60 tablets per 30 days
Brimonidine 0.2%	1 bottle per 30 days
Brintellix	30 tablets per 30 days
Brisdelle	30 capsules per 30 days
Briviact oral tablets, all strengths	60 tablets per 30 days
Briviact oral solution	600 mL per 30 days
Briviact intravenous solution	40 mL per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Bromfenac 0.09%	5 mL per 30 days
Bryhali, all strengths	2 tubes (200 g total) per 28 days
Budesonide SR (Entocort EC)	90 capsules per 30 days
Bunavail (buprenorphine/naloxone) 2.1/0.3 mg	30 films per 30 days
Bunavail (buprenorphine/naloxone) 4.2/0.7 mg, 6.3/1 mg	60 films per 30 days
Buphenyl tablets 500mg	1,200 tablets per 30 days
Buphenyl powder 250g	750g per 30 days
Bupropion (Wellbutrin)	120 tablets per 30 days
Bupropion ER 100, 150mg (Wellbutrin SR)	90 tablets per 30 days
Bupropion SR 200mg (Wellbutrin SR)	60 tablets per 30 days
Buproban/bupropion [smoking deterrent] SR 150mg (Zyban)	60 tablets per 30 days
Butorphanol Nasal Spray (Stadol)	2 bottles per 30 days
Butrans (buprenorphine)	4 patches per 28 days
Bydureon vials	4 vials per 28 days
Bydureon prefilled syringe	1 box (4 pens) per 28 days
Bydureon BCise Auto-Injector	4 syringes (3.4 mL) per 28 days
Byetta	1 pen per 30 days
Bystolic 2.5, 5, 10mg	30 tablets per 30 days
Bystolic 20mg	60 tablets per 30 days
Byvalson	30 tablets per 30 days
Cabergoline 0.5mg (Dostinex)	10 tablets per 30 days
Cabometyx 20, 60mg	30 tablets per 30 days
Cabometyx 40mg	60 tablets per 30 days
Caduet tablets (all strengths)	30 tablets per 30 days
Calquence	60 capsules per 30 days
Cambia 50mg	9 packets per 30 days
Campral	180 tablets per 30 days
Capresla 100mg	60 tablets per 30 days
Capresla 300mg	30 tablets per 30 days
Captopril 100mg	120 tablets per 30 days
Captopril 12.5, 25, 50mg	60 tablets per 30 days
Captopril/HCTZ 25/15mg, 25/25mg, 50/15mg	60 tablets per 30 days
Captopril/HCTZ 50/25mg	120 tablets per 30 days
Carac	30 grams per 30 days
Carbamazepine SR/ER (Tegretol XR) 100mg	480 tablets per 30 days
Carbamazepine SR/ER (Tegretol XR) 200mg	240 tablets per 30 days
Carbamazepine SR/ER (Tegretol XR) 400mg	120 tablets per 30 days
Cardene SR 30mg	120 capsules per 30 days
Cardene SR 45 mg	90 capsules per 30 days
Cardene SR 60mg	60 capsules per 30 days
Cardizem LA	30 tablets per 30 days
Carisoprodol 250mg	180 tablets per 30 days
Carisoprodol 350mg	120 tablets per 30 days
Carospir	600 mL per 30 days
Carvedilol 25mg	120 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Carvedilol 3.125, 6.25, 12.5mg	90 tablets per 30 days
Casodex 50mg	30 tablets per 30 days
Catapres TTS Patches	5 patches per 30 days
Cathflo Activase	8 mg (4 vials) per 30 days
Cayston inhalation 75mg/mL	84 mL per 56 days
Cedax (ceftibuten)	10 tablets per 30 days
Cedax (ceftibuten) Suspension (90mg/5mL)	240 mL per 30 days
Cefaclor Liquid (Ceclor Liquid)	400 mL per 30 days
Cefaclor	60 tablets per 30 days
Cefadroxil 1g (Duricef)	20 tablets per 30 days
Cefadroxil 250mg/5mL, 500mg/5mL (Duricef)	2 bottles per 30 days
Cefadroxil 500mg (Duricef)	40 tablets per 30 days
Cefpodoxime suspension	2 bottles per 30 days
Cefpodoxime tablets	56 tablets per 30 days
Cefprozil (Cefzil)	40 tablets per 30 days
Cefprozil Suspension 125mg/5mL (Cefzil)	300 mL per 30 days
Cefprozil Suspension 250mg/5mL (Cefzil)	200 mL per 30 days
Ceftin (cefuroxime) Suspension 125mg/mL	300 mL per 30 days
Ceftin (cefuroxime) Suspension 250mg/5mL	200 mL per 30 days
Cefuroxime 125mg (Ceftin)	20 tablets per 30 days
Cefuroxime 250, 500mg (Ceftin)	40 tablets per 30 days
Celebrex 100mg	30 tablets per 30 days
Celebrex 200mg	60 tablets per 30 days
Cenestin, all strengths	30 tablets per 30 days
Cephalexin (Keflex)	40 tablets-capsules per 30 days
Cephalexin liquid (Keflex)	2 bottles per 30 days
Cerdelga	56 capsules per 28 days
Cesamet	30 capsules per 30 days
Cetirizine 5, 10mg	30 tablets per 30 days
Cetirizine syrup	300 mL per 30 days
Chantix 0.5mg	112 tablets per 28 days
Chantix 1mg	56 tablets per 28 days
Chantix Starting Month Pak	53 tablets (1 pack) per 28 days
Chantix Continuing Month Pak	56 tablets (1 pack) per 28 days
Chlordiazepoxide (Librium)	120 capsules per 30 days
Cholbam 50mg	120 capsules per 30 days
Cholbam 250mg	120 capsules per 30 days
Cialis 2.5, 5mg for Benign Prostatic Hyperplasia	30 tablets per 30 days
Ciclodan 0.77% Kit	544 grams (1 kit) per 30 days
Ciclodan 8% Kit	34.6 mL (1 kit) per 30 days
Cimduo	30 tablets per 30 days
Cimetidine 200, 400, 800mg (Tagamet)	60 tablets per 30 days
Cimetidine Liquid (Tagamet)	1,200 mL per 30 days
Cimzia Kits 200mg/mL	1 kit (2 syringes or 2 vials) per 30 days
Cimzia Starter Kit (50474-0710-81)	1 kit per lifetime
Ciprofloxacin ER 1000mg	14 tablets per 30 days
Ciprofloxacin ER 500mg	3 tablets per 30 days
Ciprodex	15 mL per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Ciprofloxacin (Cipro)	60 tablets per 30 days
Ciprofloxacin Ophthalmic (Ciloxan)	10 mL per 30 days
Ciprofloxacin Suspension 10% (Cipro)	2 bottles per 30 days
Ciprofloxacin Suspension 5% (Cipro)	2 bottles per 30 days
Citalopram 10mg (Celexa)	30 tablets per 30 days
Citalopram 20, 40mg (Celexa)	30 tablets per 30 days
Citalopram 10mg/5mL (Celexa)	600 mL per 30 days
Clarinet Syrup	300 mL per 30 days
Clarinet/Clarinet Reditabs	30 tablets per 30 days
Clarinet-D 12	60 tablets per 30 days
Clarinet-D 24	30 tablets per 30 days
Clarithromycin (Biaxin)	28 tablets per 30 days
Clarithromycin ER (Biaxin XL)	14 tablets per 30 days
Clarithromycin Suspension (Biaxin Suspension)	200 mL per 30 days
Climara Pro Patches	4 patches per 28 days
Clindacin PAC Kit	1 kit per 30 days
Clindamycin palmitate granules for oral solution (Cleocin Pediatric) 75mg/5mL	1,400 mL per 30 days
Clindesse	5.8 grams per 30 days
Clobex Spray 59 mL	236 mL (4 bottles) per 30 days
Clobex Spray 125 mL	250 mL (2 bottles) per 30 days
Clocortolone (Cloderm)	90 grams per 30 days
Clodan Kit	1 kit per 30 days
Clonazepam (Klonopin)	90 tablets per 30 days
Clopidogrel (Plavix)	30 tablets per 30 days
Clorazepate (Tranxene)	90 tablets per 30 days
Clozapine 25, 100mg (Clozaril)	270 tablets per 30-days
Clozapine 50mg	180 tablets per 30 days
Clozapine 200mg	120 tablets per 30 days
Coartem	24 tablets per 30 days
Codeine/APAP 325mg (Tylenol No. 3)	360 tablets per 30 days
Codeine/APAP 650mg combinations (Vopac)	180 tablets per 30 days
Colchicine, Colcrys	40 capsules or tablets per 30 days
Combigan 0.2:0.5% ophthalmic solution	1 bottle per 30 days
Combivent Respimat	4 grams (1 inhaler) per 30 days
Combivir	60 tablets per 30 days
Cometriq Kit 60mg	84 capsules per 28 days
Cometriq Kit 100mg	56 capsules per 28 days
Cometriq Kit 140mg	112 capsules per 28 days
Complera	30 tablets per 30 days
Comtan (entacapone)	240 tablets per 30 days
Concerta	90 tablets per 30 days
Conzip 100, 200, 300mg	30 capsules per 30 days
Copaxone 20mg/mL	1 kit per 30 days
Copaxone 40mg/mL	12 mL per 30 days
Copiktra, all strengths	56 capsules per 28 days
Cordran Tape	2 rolls per 30 days
Coreg 3.125, 6.25, 12.5mg	90 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Coreg 25mg	120 tablets per 30 days
Coreg CR, all strengths	30 tablets per 30 days
Corlanor	60 tablets per 30 days
Corvite	30 tablets per 30 days
Corzide	30 tablets per 30 days
Cosentyx	2 mL per 28 days
Cosopt	10 mL per 30 days
Cosopt PF	60 containers per 30 days
Cotellic	63 tablets per 28 days
Cotempla XR ODT 8.6 mg, 17.3 mg	30 tablets per 30 days
Cotempla XR ODT 25.9 mg	60 tablets per 30 days
Covera HS	30 tablets per 30 days
Cozaar	30 tablets per 30 days
Creon 3000 units	6990 capsules per 30 days
Creon 6000 units	3500 capsules per 30 days
Creon 12000 units	1750 capsules per 30 days
Creon 24000 units	875 capsules per 30 days
Creon 36000	584 capsules per 30 days
Cresemba capsules	68 capsules per 30 days
Crestor	30 tablets per 30 days
Cromolyn ophthalmic (Crolom)	10 mL per 30 days
Cromolyn oral concentrate	2,400 mL per 30 days
Cuvposa 1mg/5mL oral solution	1,350 mL per 30 days
Cyanocobalamin injection	30 mL per 90 days
Cyclobenzaprine (Flexeril, Fexmid) 5, 7.5, 10mg	63 tablets per 30 days
Cyclobenzaprine ER (Amrix) 15, 30mg	30 capsules per 30 days
Cycloset	180 tablets per 30 days
Cymbalta, all strengths	60 capsules per 30 days
Cystaran	60 mL per 28 days
Daklinza, all strengths	28 tablets per 28 days
Daliresp	30 tablets per 30 days
Dalvance	3 vials per 30 days
Daurismo 25 mg	60 tablets per 30 days
Daurismo 100 mg	30 tablets per 30 days
Daytrana	30 patches per 30 days
Degarelix 80mg	1 vial per 28 days
Degarelix 120mg	1 vial per lifetime
Delstrigo	30 tablets per 30 days
Delzicol	180 capsules per 30 days
Depo-Provera	1 injection per 90 days
Descovy	30 tablets per 30 days
Desoxyn	150 tablets per 30 days
Desvenlafaxine extended-release	30 tablets per 30 days
Detrol	60 tablets per 30 days
Detrol LA	30 capsules per 30 days
Dexedrine SA	120 capsules per 30 days
Dexilant 30, 60mg	30 capsules per 30 days
DexPack (Zema-Pak)	2 packs per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Detroamphetamine 15 mg, 20 mg, 30 mg (Zenzedi)	60 tablets per 30 days
Dextroamphetamine other strengths (Dexedrine, Zenzedi)	120 tablets per 30 days
Diacomit, all strengths	180 capsules/packets per 30 days
Diastat Acudial	10 boxes per 30 days
Diazepam ampules (Valium)	10 ampules per 30 days
Diazepam oral concentrate	60 mL per 30 days
Diazepam oral solution	300 mL per 30 days
Diazepam syringes (Valium)	15 syringes per 30 days
Diazepam tablets (Valium)	120 tablets per 30 days
Diazepam vials (Valium)	10 vials per 30 days
Diclegis	120 tablets per 30 days (360 tablets per pregnancy)
Differin Cream/Gel	45 grams per 60 days
Differin Lotion	1 bottle per 30 days
Difcid	20 tablets per 30 days
Diltiazem capsules (Cardizem CD/LA, Dilacor XR, Tiazac)	30 capsules per 30 days
Diltiazem ER 120mg (Cardizem SR, Dilacor XR, Tiazac)	60 capsules per 30 days
Diltiazem tablets (Cardizem)	120 tablets per 30 days
Diovan 320mg	30 tablets per 30-days
Diovan 40, 80, 160mg	60 tablets per 30 days
Diovan HCT	30 tablets per 30 days
Disulfiram (Antabuse) 250mg	60 tablets per 30 days
Disulfiram (Antabuse) 500mg	30 tablets per 30 days
Ditropan XL 5, 10, 15mg	60 tablets per 30 days
Divigel, all strengths	30 packets per 30 days
Divista	30 capsules per 30 days
Doptelet	15 tablets per 30 days
Doribax 250, 500mg	42 vials per 30 days
Doryx MPC 120mg	60 tablets per 30 days
Dovato tablets	30 tablets per 30 days
Dovonex 60mg	60 mg per 30 days
Dovonex 120gm	120 grams per 30 days
Doxepin cream	90 g per 30 days
Doxycycline delayed-release (Doryx) 50mg	120 tablets per 30 days
Doxycycline delayed-release (Doryx) 75, 100, 150mg	60 tablets per 30 days
Doxycycline delayed-release (Doryx) 200mg	30 tablets per 30 days
Duac (clindamycin/benzoyl peroxide)	45 grams per 30 days
Duavee	30 tablets per 30 days
Duetact	30 tablets per 30 days
Duexis	90 tablets per 30 days
Dulera 100/5, 200/5mcg	13 grams (1 inhaler) per 30 days
DuoNeb 3mL vial	205 vials (pkg size 3) per 30 days
Dupixent	8 mL (1200 mg) per 28 days
Durezol 0.05%	10 mL per 30 days
Durlaza	30 capsules per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Dutoprol, all strengths	60 tablets per 30 days
Duzallo, all strengths	30 tablets per 30 days
Dyanavel	240 mL per 30 days
Dymista	23 grams (1 bottle) per 30 days
Dynabac	28 tablets per 30 days
Dynacirc 2.5, 5mg	60 capsules per 30 days
Dynacirc CR 5, 10mg	60 tablets per 30 days
Edarbi 40, 80mg	30 tablets per 30 days
Edarbyclor, all strengths	30 tablets per 30 days
Edluar	See Ambien
Edurant	30 tablets per 30 days
Effexor XR 37.5, 75mg	90 capsules per 30-days
Effexor XR 150mg	60 capsules per 30 days
Effient 5, 10mg	30 tablets per 30 days
Egrifta 1mg	60 vials per 30 days
Egrifta 2mg	30 vials per 30 days
Electrolyte Soln/PEG (Colyte/Golytely/Nulytely/Peg 3350/ OCL/Trilyte)	4,000 mL per 30 days
Elestat	5 mL per 30 days
Elidel	200gm per 30 days
Eliquis	60 tablets per 30 days
Ella	1 tablet per 30 days
Emadine	5 mL per 30 days
Embeda, all strengths	60 tablets per 30 days
Emend 125mg	1 capsule per 30 days
Emend 80mg	2 capsules per 30 days
Emend 40mg	1 capsule per 30 days
Emend Trifold Pack	1 pack per 30 days
Emend powder for oral suspension	3 unit-of-use packages per 30 days
Emflaza oral tablets, all strengths	30 tablets per 30 days
Emflaza oral suspension	20 mL per 30 days
Emgality	2 pens (2 mL) per 30 days
Emsam	30 patches per 30 days
Enablex	30 capsules per 30 days
Enalapril (Vasotec)	90 tablets per 30 days
Enalapril/HCTZ 10/25mg (Vaseretic)	120 tablets per 30 days
Enalapril/HCTZ 5/12.5mg (Vaseretic)	60 tablets per 30 days
Enbrel 25mg	8 injections per 30 days
Enbrel 50mg (including Enbrel Mini)	4 injections per 30 days
Endari	180 packets (900 grams) per 30 days
Enjuvia, all strengths	30 tablets per 30 days
Enstilar	120 grams per 30 days
Entresto, all strengths	60 tablets per 30 days
Epaned, all formulations	150 mL per 30 days
Epclusa	28 tablets per 28 days
Epidiolex	600 mL per 30 days
Epiduo	45 grams per 60 days
Epiduo Forte	45 grams per 60 days

DRUG PRODUCT	MAXIMUM QUANTITY
Epinephrine injection (Adrenaclick, Auvi-Q, EpiPen, EpiPen Jr.)	4 pens per 30 days
Eplerenone (Inspra) 25, 50mg	60 tablets per 30 days
Erivedge	28 capsules per 28 days
Epivir-HBV	30 tablets per 30 days or 600 mL per 30 days
Erleada	120 tablets per 30 days
Erythromycin Base (E-Mycin, ERYC, ERY-TAB, PCE)	80 tablets per 30 days
Erythromycin Ethylsuccinate (E.E.S. 400)	80 tablets per 30 days
Erythromycin Ethylsuccinate liquid (ERYPED 200, ERYPED 400 , E.E.S. 400)	600 mL per 30 days
Erythromycin Stearate (Erythrocin)	80 tablets per 30 days
Erythromycin w/ Sulfisoxazole Suspension (Pediazole)	400 mL per 30 days
Esbriet	270 capsules/tablets per 30 days
Estazolam (Prosom)	18 tablets per 30 days
Estrace Vaginal	2 packages per 30 days
Estradiol Transdermal (Alora, Climara, Esclim, Estraderm, Vivelle/Vivelle-Dot)	1 package per 28 days
Estradiol replacement (Vivelle/Vivelle-Dot)	1 patch per 180 days
Estrogel pump	93 grams per 30 days
Etidronate 200, 400mg (Didronel)	150 tablets per 30 days
Eucrisa	60 grams per 60 days
Eurax	120 mL or 120g per 30 days
Evekeo	180 tablets per 30 days
Evenity	1 box (2.34 mL; 2 syringes) per 30 days
Evista (raloxifene)	30 tablets per 30 days
Evotaz	30 tablets per 30 days
Evoxac (cevimeline)	90 capsules per 30 days
Evzio	0.8 mL (2 pens) per 1 year
Exalgo 8mg	30 tablets per 30 days
Exalgo 12mg	150 tablets per 30 days
Exalgo 16mg	120 tablets per 30 days
Exelon Transdermal	30 patches per 30 days
Exemestane (Aromasin)	30 tablets per 30 days
Exforge	30 tablets per 30 days
Exforge HCT	30 tablets per 30 days
Exjade, all strengths	360 tablets per 30 days
Extavia 0.3mg/3mL	1 box (15 vials) per 30 days
Extina	100 grams per 30 days
Fabior	100 grams per 150 days
Factive	7 tablets per 30 days
Famotidine 20mg (Pepcid)	120 tablets per 30 days
Famotidine 40mg (Pepcid)	60 tablets per 30 days
Famotidine 40mg/5mL oral suspension (Pepcid)	300 mL per 30 days
Famvir 125mg	21 tablets per 30 days
Famvir 250mg	60 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Famvir 500mg	21 tablets per 30-days
Fanapt, all strengths	60 tablets per 30 days
Fanapt Titration Pack	1 pack per 30 days
Farxiga 5, 10mg	30 tablets per 30 days
Farydak	9 capsules per 28 days
FazaClo 25mg, 100mg	270 tablets per 30 days
FazaClo 150mg	180 tablets per 30 days
FazaClo 200mg	120 tablets per 30 days
Felbamate (Felbatol) 400, 600mg	180 tablets per 30 days
Felbamate (Felbatol) 600 mg/5 mL	900 mL per 30 days
Felodipine 10mg (Plendil)	30 tablets per 30 days
Felodipine 2.5mg, 5mg (Plendil)	60 tablets per 30 days
Femcon FE	28 tablets per 28 days
FemHRT	28 tablets per 28 days
Femring	1 per dispensing/4 per year
Fenofibrate 134 and 200mg	30 capsules per 30 days
Fenofibrate 54mg (Lofibra)	90 tablets per 30 days
Fenofibrate 67mg (Lofibra)	60 capsules per 30 days
Fenoglide 120mg	30 tablets per 30 days
Fenoglide 40mg	90 tablets per 30 days
Fenoprofen 600mg	120 tablets per 30 days
Fentanyl Patches (Duragesic Patches)	25 patches per 30 days
Fentora	90 tablets per 30 days
Feraheme 510mg/17mL	2 vials per 30 days
Ferriprox	420 tablets per 30 days
Ferrlecit	300 mL per 30 days
Fetzima	30 capsules per 30 days
Fetzima Titration Pack	28 capsules per lifetime
Fexofenadine 180mg (Allegra)	30 tablets per 30 days
Fexofenadine 30, 60mg (Allegra)	60 tablets/capsules per 30 days
Fiasp	45 mL per 30 days
Fibricor 35, 105mg	30 tablets per 30 days
Finacea	50 grams (1 tube or can) per 30 days
Finacea Plus Kit	1 kit per 30 days
Finasteride (Proscar)	30 tablets per 30 days
Fioricet (butalbital/acetaminophen/cafeine)	180 pills per 30 days
Fioricet with Codeine (butalbital/acetaminophen/cafeine/codeine)	180 pills per 30 days
Firazyr	3 mL per 30 days
Firdapse tablets	240 tablets per 30 days
First Vancomycin Compound Kits	300 mL per 30 days
Flagyl ER 750mg	7 tablets per 30 days
Flarex Eye Drops	15 mL per 30-days
Flavoxate (Urispas)	240 per 30 days
Flomax	60 capsules per 30 days
Flovent / HFA 110 mcg	24 grams (2 inhalers) per 30 days
Flovent / HFA 220 mcg	36 grams (3 inhalers) per 30 days
Flovent / HFA 44 mcg	21.2 grams (2 inhalers) per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Fluconazole 150mg (Diflucan)	1 tablet per 30 days
Flunisolide Nasal Spray (Nasarel)	75 mL per 30 days
Fluocinolone oil (Derma-Smooth)	118.28 mL per 30 days
Fluorometholone Drops (Eflone, FML Forte, Fluor-op, Flarex)	15 mL per 30 days
Fluorometholone Eye Drops (Eflone)	15 mL per 30 days
Fluoxetine 10mg (Prozac, Sarafem)	60 capsules/tablets per 30 days
Fluoxetine 20mg (Prozac, Sarafem)	90 capsules/tablets per 30 days
Fluoxetine 20mg/5mL (Prozac)	600 mL per 30 days
Fluoxetine 40mg (Prozac)	60 capsules per 30 days
Fluphenazine Decanoate 25mg/mL (5mL vial) (Prolixin)	15mL per 30 days
Flurazepam (Dalmane)	18 capsules per 30 days
Flurbiprofen Ophthalmic (Ocufen)	3 mL per 30 days
Fluticasone 16 gram (Flonase AQ)	1 bottle per 30 days
Fluticasone lotion (Cutivate)	120 mL per 30 days
Fluvoxamine 25 mg	30 tablets per 30 days
Fluvoxamine 50mg	60 tablets per 30 days
Fluvoxamine 100mg	90 tablets per 30 days
FML S.O.P. Ointment	4 grams per 30 days
Focalin	60 tablets per 30 days
Focalin XR 5mg, 10mg, 15mg, 20mg	60 capsules per 30 days
Focalin XR 25mg, 30mg, 35mg, 40mg	30 capsules per 30 days
Folic Acid 1mg	150 tablets per 30 days
Foradil (12 blisters) + inhaler	1 package per 30 days
Foradil (18 blisters) + inhaler	1 package per 30 days
Foradil (60 blisters) + inhaler	1 package per 30 days
Fortamet ER 500mg	150 tablets per 30 days
Fortamet ER 1000mg	60 tablets per 30 days
Forteo 20mcg	1 pen per 28 days
Fortesta	2 bottles (120 grams) per 30 days
Fosamax 35 and 70mg	4 tablets per 30 days
Fosamax 5, 10, and 40 mg	30 tablets per 30 days
Fosamax (alendronate) 70mg/75mL	300 mL per 30 days
Fosamax D	4 tablets per 30 days
Fosinopril	60 tablets per 30 days
Fragmin syringes	28 syringes per 30 days
Fragmin vials	3 vials per 30 days
Fragmin 95,000 IU/3.8 mL vial	6 vials per 30 days
Frova	See Amerge
Fulphila	2 syringes (1.2 mL) per 30 days
Fulyzaq	60 tablets per 30 days
Fuzeon Convenience Kit	1 kit per month
Fycompa 2mg	60 tablets per 30 days
Fycompa, all other strengths	30 tablets per 30 days
Fycompa oral suspension	720 mL per 30 days
Gabitril (tiagabine) 2mg, 12mg	120 tablets per 30 days
Gabitril (tiagabine) 4mg	240 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Gabitril (tiagabine) 16mg	90 tablets per 30 days
Gablofen injection, all strengths	2 syringes (40 mL) per 30 days
Galafold	14 capsules per 28 days
Gattex	1 kit per 30 days
Gelnique 3%	92 grams per 30 days
Gelnique 10%	30 sachets per 30 days
Gemfibrozil (Lopid)	60 tablets per 30 days
Generess FE	28 tablets per 28 days
Genvoya	30 tablets per 30 days
Geodon	60 capsules per 30 days
Giazo	180 tablets per 30 days
Gilenya	30 capsules per 30 days
Gilotrif	30 tablets per 30 days
Gleevec, all strengths	60 tablets per 30 days
Glipizide/metformin (Metaglip)	120 tablets per 30 days
Glumetza 500mg	30 tablets per 30 days
Glumetza 1000mg	60 tablets per 30 days
Glyburide/Metformin (Glucovance)	120 tablets per 30 days
Glyburide 5mg	120 tablets per 30 days
Glyburide 1.25mg, 2.5mg	60 tablets per 30 days
Glycate	90 tablets per 30 days
Glycopyrrolate syringes	30 syringes (30 mL) per 30 days
Glynase (glyburide micronase) 1.5mg, 3mg, 6mg	60 tablets per 30 days
Glyxambi	30 tablets per 30 days
Gocovri, all strengths	60 capsules per 30 days
GoNitro sublingual powder	36 packets (1 box) per 30 days
Gralise Starter Kit	1 kit per lifetime
Gralise 300 mg, 600 mg	90 tablets per 30 days
Granisteron	10 tablets per 30 days
Granisteron Solution	30 mL per 30 days
Granix 300 mcg vial	30 mL per 30 days
Granix 300 mcg pre-filled syringe	15 mL per 30 days
Granix 480 mcg	24 mL per 30 days
Grastek	30 tablets per 30 days
Grifulvin V (griseofulvin microsize) 500mg	60 tablets per 30 days
Gris-Peg (griseofulvin ultramicrosize) 125, 250mg	90 tablets per 30 days
Halonate Kit	1 kit per 30 days
Haloperidol Decanoate 100mg/mL - 1mL per vial (Haldol Decanoate)	5 mL per 30 days
Haloperidol Decanoate 100mg/mL - 5mL per vial (Haldol Decanoate)	5 mL per 30 days
Haloperidol Decanoate 50mg/mL - 1mL per vial (Haldol Decanoate)	10 mL per 30 days
Haloperidol Decanoate 50mg/mL - 5mL per vial (Haldol Decanoate)	10 mL per 30 days
Harvoni	28 tablets per 28 days
Helidac	224 pills (14 cards, 1 box) per 30 days
Hemangeol	120 mL per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Hemlibra, all strengths	4 vials per 30 days
Hepsera	30 tablets per 30 days
Hetlioz	30 capsules per 30 days
Horizant 300, 600mg	60 tablets per 30 days
H.P. Acthar	6 vials (30 mL) per 30 days
Humalog	45 mL per 30 days
Humalog Kwikpen	45 mL per 30 days
Humira 10mg	1 kit per 30 days
Humira 20mg, 40mg	2 syringes per 30 days
Humira Crohn's Starter Kit	1 kit per lifetime
Humira Psoriasis Starter Kit	1 kit per lifetime
Humulin	45 mL per 30 days
Humulin R 500 units/mL	20 mL per 30 days
Humulin R 500 units/mL KwikPen	24 mL per 30 days
Hycet	2,700 mL per 30 days
Hydrocodone/APAP 325mg combinations (Lortab, Xodol, Norco 5)	360 tablets per 30 days
Hydrocodone/APAP 500mg combinations (Lortab, Co-gesic, Vicodin)	240 tablets per 30 days
Hydrocodone/APAP 650mg combinations (Lorcet Plus, Vicodin HP)	180 tablets per 30 days
Hydrocodone/APAP 750mg combinations (Vicoden ES)	150 tablets per 30 days
Hydrocortosone acetate cream (Proctosol-HC)	2 times package size per 30 days
Hysingla ER	30 tablets per 30 days
Hyzaar	30 tablets per 30 days
IB Stat Oral Spray	14 bottles (420mL) per 30 days
Ibrance	21 capsules per 28 days
IC Kits	1 kit per 30 days
Iclusig 15mg	60 tablets per 30 days
Iclusig 45mg	30 tablets per 30 days
Idhifa, all strengths	30 tablets per 30 days
Ilaris 180mg/vial	2 vials (360mg) per 28 days
Ilaris 150mg/vial	2 vials (300mg) per 28 days
Ilevro	1.7 mL per 30 days
Imbruvica, all strengths	30 capsules/tablets per 30 days
Imitrex (sumatriptan) 25 and 50 mg tablets	See Amerge
Imitrex 5 and 20 mg Nasal Spray	6 nasal spray devices per 30 days
Imitrex Syringe (Injection)	2 kit (4 syringes) per 30 days
Imitrex 6mg/0.5mL (2.5mL vial)	1 vial per 30 days
Impavido	84 capsules per 28 days
Incivek	168 tablets per 28 days
Incruse Ellipta	30 packs per 30 days
Inderal LA 160mg	30 capsules per 30 days
Inderal LA 60, 80, 120mg	60 capsules per 30 days
Infergen 9mcg	12 vials per 30 days
Infergen 15mcg	30 vials per 30 days
Ingrezza, all strengths	30 capsules per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Ingrezza, titration pack	1 pack (28 capsules) per lifetime
Injectafer	30 mL per 30 days
Inlyta 1mg	180 tablets per 30 days
Inlyta 5mg	60 tablets per 30 days
Innopran XL 120mg	60 capsules per 30 days
Innopran XL 80mg	30 capsules per 30 days
Inova 4%, 8%, all kits	1 kit per 30 days
Insulin cartridges, pens, vials	45 mL per 30 days
Insulin pen device	1 pen per year
Insulin syringes	120 syringes per 30 days
Intelence 25mg, 100mg	120 tablets per 30 days
Intelence 200mg	60 tablets per 30 days
Intermezzo	See Ambien
Intron A, 50 million units	14 vials per 28 days
Intron A, all strengths except 50 million unit vial	5 vials per 28 days
Intuniv, all strengths	30 tablets per 30 days
Invega 1.5mg, 3mg, 9mg	30 tablets per 30 days
Invega 6mg	60 tablets per 30 days
Invega Sustenna, all strengths	1 syringe per 30 days
Invega Trinza, all strengths	1 syringe per 90 days
Inveltys	2 bottles (5.6 mL) per 30 days
Invokana 100mg	60 tablets per 30 days
Invokana 300mg	30 tablets per 30 days
Invokamet	60 tablets per 30 days
Invokamet XR	60 tablets per 30 days
Irenka	90 capsules per 30 days
Iressa	30 tablets per 30 days
Iron Dextran (InFed)	60 mL per 30 days
Isentress 25mg, 100mg	180 tablets per 30 days
Isentress 100mg powder	60 packets per 30 days
Isentress 400mg	60 tablets per 30 days
Isentress HD	60 tablets per 30 days
Isotretinoin	60 capsules per 30 days
Itraconazole 100mg (Sporanox)	60 capsules per 30 days
Jadenu 90mg	300 tablets per 30 days
Jadenu 180mg	330 tablets per 30 days
Jadenu 360mg	270 tablets per 30 days
Jadenu Sprinkle Granules 90mg	300 pouches per 30 days
Jakafi, all strengths	60 tablets per 30 days
Jalyn	30 capsules per 30 days
Janumet, all strengths	60 tablets per 30 days
Janumet XR 50/500mg, 100/1000mg	30 tablets per 30 days
Janumet XR 50/1000mg	60 tablets per 30 days
Januvia, all strengths	30 tablets per 30 days
Jardiance	30 tablets per 30 days
Jentadueto, all strengths	60 tablets per 30 days
Jentadueto XR 2.5/1000mg	60 tablets per 30 days
Jentadueto XR 5/1000mg	30 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Jublia	4 mL per 30 days
Juluca	30 tablets per 30 days
Juvisync, all strengths	30 tablets per 30 days
Juxtapid, all strengths	28 capsules per 28 days
Jynarque, all strengths	56 tablets per 28 days
Kadian 100 mg	90 capsules per 30 days
Kadian 10, 30, 50, 60, 80mg, 200mg	30 capsules per 30 days
Kadian 20mg	120 capsules per 30 days
Kadian 100mg	90 capsules per 30 days
Kadian 200mg	30 capsules per 30 days
Kaletra 80mg:20mg/mL oral solution	480 mL per 30 days
Kaletra 133.3:33.3mg softgels	240 capsules per 30 days
Kaletra 200:50mg tablets	180 capsules per 30 days
Kaletra 100:25mg tablets	240 tablets per 30 days
Kalydeco	56 tablets per 28 days
Kalydeco powder packet, all strengths	56 packets per 28 days
Kapspargo, all strengths	60 capsules per 30 days
Kapvay 0.1mg	120 tablets per 30 days
Kapvay Dose Pack	60 tablets (1 pack) per 30 days
Karbinal ER	1200 mL per 30 days
Kazano	60 tablets per 30 days
Keppra XR 500mg	180 tablets per 30 days
Keppra XR 750mg	120 tablets per 30 days
Kerydin	4 mL per 30 days
Ketek	20 tablets per 30 days
Ketocon Plus Kit	1 kit per 30 days
Ketodan Kit	544 grams (1 kit) per 30 days
Ketorolac (Toradol)	20 tablets per 30 days
Ketorolac 15mg/mL injection (Toradol)	40 mL per 30 days
Ketorolac 30mg/mL injection (Toradol)	20 mL per 30 days
Ketorolac 60mg/2mL injection (Toradol)	20 mL per 30 days
Keveyis	120 tablets per 30 days
Kevzara, all strengths and formulations	2 syringes (3 mL) per 28 days
Kineret	30 injections per 30 days
Kisqali	63 tablets per 28 days
Kisqali Femara 200 Dose	49 tablets per 28 days
Kisqali Femara 400 Dose	70 tablets per 28 days
Kisqali Femara 600 Dose	91 tablets per 28 days
Kitabis Pak	280 mL per 56 days
Kombiglyze XR 2.5/1000mg	60 tablets per 30 days
Kombiglyze XR 5/500, 5/1000mg	30 tablets per 30 days
Korlym	120 tablets per 30 days
Krintafel	2 tablets per year
Kristalose packets 10gm	30 packets (1 carton) per 30 days
Kristalose packets 20gm	60 packets (2 cartons) per 30 days
Kuvan, all strengths	120 tablets/packets per 30 days
Kynamro	4 mL (4 syringes) per 28 days
Labetolol 100mg (Trandate)	150 per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Labetolol 200, 300mg (Trandate)	120 per 30 days
Lamictal chewable tablets, all strengths	480 chewable tablets per 30 days
Lamictal tablets, all strengths	90 tablets per 30 days
Lamivudine (Epivir) 150 mg	60 tablets per 30 days
Lamivudine (Epivir) 300 mg	30 tablets per 30 days
Lamivudine HBV (Epivir HBV) 100mg	30 tablets per 30 days
Lancets	150 lancets per 30 days
Lancet device	1 device per year
Lantus	45 mL per 30 days
Lastacaft 0.25%	3 mL (1 bottle) per 30 days
Latrix XM 45%	240 mL per 30 days
Latuda 20 mg, 40 mg, 60 mg, 120 mg	30 tablets per 30 days
Latuda 80 mg	60 tablets per 30 days
Lenvima 4 mg	90 capsules per 30 days
Lenvima 8 mg therapy pack	60 capsules per 30 days
Lenvima 10 mg therapy pack	30 capsules per 30 days
Lenvima 12 mg therapy pack	90 capsules per 30 days
Lenvima 14 mg therapy pack	60 capsules per 30 days
Lenvima 18 mg therapy pack	90 capsules per 30 days
Lenvima 20 mg therapy pack	60 capsules per 30 days
Lenvima 24 mg therapy pack	90 capsules per 30 days
Lescol 20 mg	30 capsules per 30 days
Lescol 40 mg	60 capsules per 30 days
Lescol XL 80 mg	30 tablets per 30 days
Letairis	30 tablets per 30 days
Letrozole (Femara)	30 tablets per 30 days
Leukine	30 vials per 30 days
Levaquin solution	280 mL per 30 days
Levaquin tablets	14 tablets per 30 days; if QLL exceeded, refer to prior authorization criteria
Levatol 20mg	60 tablets per 30 days
Levemir	45 mL per 30 days
Levetiracetam (Keppra) 500mg/5mL injection	150 mL (30 vials) per 30 days
Levorphanol tablets, all strengths	120 tablets per 30 days
Levothyroxine injections	30 vials per 30 days
Lexapro 5, 10, 20mg	30 tablets per 30 days
Lexapro 5mg/5mL	600 mL per 30 days
Letairis 5, 10mg	30 tablets per 30 days
Lidoderm 5% patches	90 patches (3 boxes) per 30 days
Lindane	60 mL per 30 days
Linzess	30 capsules per 30 days
Lioresal IT	4 kits per 30 days
Lipitor	30 tablets per 30 days
Lipofen 150mg	30 capsules per 30 days
Lipofen 50mg	90 capsules per 30 days
Liptruzet	30 tablets per 30 days
Lisinopril 10, 20, 30, 40mg (Prinivil, Zestril)	60 tablets per 30 days
Lisinopril 2.5, 5mg (Prinivil, Zestril)	60 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Lisinopril/HCTZ (Prinizide, Zestoretic)	60 tablets per 30 days
Livalo 1, 2, 4mg	30 tablets per 30 days
Lo Loestrin FE	28 tablets (1 pack) per 28 days
Lo Minastrin FE	28 tablets (1 pack) per 28 days
Lodosyn (carbidopa)	120 tablets per 30 days
Lokelma	90 packets per 30 days
Lonhala Magnair	60 vials (60 mL) per 30 days
Lonsurf 15 mg/6.14 mg	107 tablets per 28 days
Lonsurf 20 mg/8.19 mg	80 tablets per 28 days
Loprox 0.77% Kit	90 grams per 30 days
Loratadine (Alavert, Claritin, Tavist ND, various)	30 tablets per 30 days
Loratadine Syrup (Alavert, Claritin)	300 mL per 30 days
Loratadine/PSE (Claritin-D 12-hr, Alavert-D 12-hr)	60 tablets per 30 days
Loratadine-D (Claritin-D 24-hour)	30 tablets per 30 days
Lorazepam syringes (Ativan)	5 syringes per 30 days
Lorazepam tablets (Ativan)	120 tablets per 30 days
Lorazepam vials (Ativan)	5 vials per 30 days
Lorbrena 25 mg	90 tablets per 30 days
Lorbrena 100 mg	30 tablets per 30 days
Lorzone 375, 750mg	120 tablets per 30 days
LoSeasonique	91 tablets (1 pack) per 91 days
Lotemax 0.5% gel	5 grams per 30 days
Lotemax 0.5% ointment	3.5 grams per 30 days
Lotemax 0.5% suspension	15 mL per 30 days
Lotemax SM gel	5 grams per 30 days
Lotrel 2.5/10, 5/10, 5/20, 5/40, 10/20, 10/40mg	30 capsules per 30 days
Lotronex 0.5, 1mg	60 tablets per 30 days
Lovastatin 10mg (Mevacor)	30 tablets per 30 days
Lovastatin 20, 40mg (Mevacor)	60 tablets per 30 days
Lovaza	120 capsules per 30 days
Lovenox 30mg/0.3mL syringe	18 mL (60 syringes) per 30 days
Lovenox 40mg/0.4mL syringe	24 mL (60 syringes) per 30 days
Lovenox 60mg/0.6mL syringe	36 mL (60 syringes) per 30 days
Lovenox 80mg/0.8mL, 120mg/0.8mL syringes	48 mL (60 syringes) per 30 days
Lovenox 100mg/1mL, 150mg/1mL syringes	60 mL (60 syringes) per 30 days
Lovenox 300mg/3mL syringe	180mL (60 syringes) per 30 days
Lovenox vial	7 vials per 30 days
Lumigan 0.01%, 0.03%	7.5 mL per 102 days
Lunesta	See Ambien
Lupron Depot-Ped 7.5 mg, 15 mg 1 month kit	1 kit per 30 days
Lupron Depot 11.25mg 3 month kit	1 kit per 90 days
Lupron Depot 22.5mg 3 month kit	1 kit per 90 days
Lupron Depot 30mg 4 month kit	1 kit per 120 days
Lupron Depot 45mg 6 month kit	1 kit per 180 days
Lupron Depot 11.25, 30mg 3 month kits	1 kit per 90 days
Luxiq (betamethasone aerosol)	100 grams per 30 days
Luvox CR 100mg, 150mg	60 capsules per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Luzu	60 grams per 30 days
Lynparza capsule	448 capsules per 28 days
Lynparza tablets	120 tablets per 30 days
Lyrica 25, 50, 75, 100, 150, 200, 225mg	90 capsules per 30 days
Lyrica 300mg	60 capsules per 30 days
Lyrica Oral Solution	900 mL per 30 days
Lyrica CR, all strengths	30 tablets per 30 days
Lysteda 650mg	30 tablets per 30 days
Makena vial	5 mL (1 vial) per 35 days
Makena auto-injector	4 syringes (4.4 mL) per 28 days
Maprotiline 25mg	60 tablets per 30 days
Maprotiline 50, 75mg	90 tablets per 30 days
Mavenclad tablets	10 tablets per 28 days; 20 tablets per 365 days
Mavik	60 tablets per 30 days
Mavyret	28 tablets per 28 days
Maxair Autohaler 14 gram	1 inhaler per 30 days
Maxalt/Maxalt-MLT 5 and 10mg	See Amerge
Maxaquin	14 tablets per 30 days
Maxidex Eye Drops	15 mL per 30 days
Mayzent, 0.25 mg tablets	120 tablets per 30 days
Mayzent, 2 mg tablets	30 tablets per 30 days
Meloxicam 7.5, 15mg (Mobic)	30 tablets per 30 days
Meloxicam Suspension (Mobic Suspension)	300 mL per 30 days
Mekinist 0.5mg	90 tablets per 30 days
Mekinist 2mg	30 tablets per 30 days
Mektovi	180 tablets per 30 days
Menostar	4 patches per 28 days
Mephyton	30 tablets per 30 days
Mestinon	750 tablets per 30 days
Metadate CD	60 capsules per 30 days
Methadone 5mg, 10mg	250 tablets per 30 days
Methadone oral solution, 5mg/5mL, 10mg/5mL	1,250 mL per 30 days
Methylergonovine (Methergine)	28 tablets per 30 days
Methylphenidate 5mg/5mL oral solution (Methylin)	450 mL per 30 days
Methylphenidate 10mg/5mL oral solution (Methylin)	900 mL per 30 days
Methylphenidate (Methylin, Ritalin)	90 tablets per 30 days
Methylphenidate ER (Metadate ER, Methylin ER, Ritalin SR, Ritalin LA)	60 tablets per 30 days
Methylpred Pak (Medrol Dose Pak)	2 packs per 30 days
Metoprolol 100mg (Lopressor)	120 tablets per 30 days
Metoprolol 25, 50mg (Lopressor)	150 tablets per 30 days
Metoprolol 37.5, 75 mg (Lopressor)	60 tablets per 30 days
Metoprolol/HCTZ (Lopressor HCT)	120 tablets per 30 days
Metrogel	60 grams per 30 days
Metozolv 5mg, 10mg	120 tablets per 30 days
Miacalcin injection 200 u/mL	2 mL per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Miacalcin nasal spray 200 u/dose	4 mL per 30 days
Micardis	30 tablets per 30 days
Micardis HCT	60 tablets per 30 days
Monistat Dual-Pak	1 box per 30 days
Migranal nasal spray 4 mg/mL	6 ampules/spray units (24mL) per month
Millipred DP Pak	2 packs per 30 days
Minastrin 24 FE	28 pills per 28 days
Minocycline 50mg (Dynacin)	56 tablets per 30 days
Minocycline SR (Solodyn), all strengths	30 tablets per 30 days
Minolira, all strengths	30 tablets per 30 days
Mirapex ER, all strengths	30 tablets per 30 days
Mircera prefilled syringes, all strengths	4 prefilled syringes (1.2 mL) per 28 days
Mirena	1 system per year
Mirtazapine (Remeron)	30 tablets per 30 days
Mirtazapine Rapdis (Remeron SolTab)	30 tablets per 30 days
Moexipril 15mg (Univasc)	120 tablets per 30 days
Moexipril 7.5mg (Univasc)	90 tablets per 30 days
Mometasone (Elocon)	90 grams per 30 days
Morgidox Kits	1 kit per 30 days
MorphaBond ER, all strengths	90 tablets per 30 days
Morphine Sulfate SA 15, 30, 60, 100mg (MS Contin, Oramorph SR)	90 tablets per 30 days
Morphine Sulfate SA 200 mg (MS Contin, Oramorph SR)	120 tablets per 30 days
Motegrity tablets, all strengths	30 tablets per 30 days
Moxatag 775mg ER tablets	10 tablets per 30 days
Moxeza 0.5%	3 mL (1 bottle) per 30 days
Movantik	30 tablets per 30 days
Moviprep	1 box per 30 days
Mulpleta	7 tablets per 30 days
Multaq	60 tablets per 30 days
Myalept	30 vials per 30 days
Mycamine injection, all strengths	30 vials per 30 days
Mycobutin (rifabutin)	60 capsules per 30 days
Mycophenolate sodium (Myfortic) 180mg	180 tablets per 30 days
Mycophenolate sodium (Myfortic) 360mg	120 tablets per 30 days
Mydayis, all strengths	30 capsules per 30 days
Myrbetriq	30 tablets per 30 days
Mytesi	60 tablets per 30 days
Nadolol (Corgard)	90 tablets per 30 days
Naftin 1%	60 grams per 30 days
Naftin 2%	45 grams per 30 days
Nalfon 200mg	120 capsules per 30 days
Nalfon 400mg	240 capsules per 30 days
Namenda 5, 10mg	30 tablets per 30 days
Namenda oral solution	300 mL per 30 days
Namenda Titration Pak	49 tablets (1 pack) per lifetime
Namenda XR	30 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Namenda XR Titration Pak	28 tablets (1 pack) per lifetime
Namzaric, all strengths	30 capsules per 30 days
Namzaric Titration Pack	28 capsules (1 pack) per lifetime
Naprelan 375, 500mg	90 tablets per 30 days
Naprelan 750mg	60 tablets per 30 days
Naprelan Dose Pak	1 pack per 30 days
Nasacort AQ	1 bottle per 30 days
Nasarel 0.025%	75 mL per 30 days
Nasonex 50 mcg nasal spray	1 bottle per 30 days
Natazia	28 tablets per 28 days
Natesto	22 grams (3 tubes) per 30 days
Natpara	2 cartridges (1 package) per 28 days
Natroba	2 bottles (240mL) per 30 days
NebuPent	1 container (inhaler)
Nefazodone 100, 150, 200mg (Serzone)	90 per 30 days
Nefazodone 50, 250mg (Serzone)	60 per 30 days
Neomycin/Polymyxin/HC Ophthalmic Drops (Cortisporin)	2 times package size per 30 days
Neomycin/Polymyxin/HC Otic Drops (Cortisporin)	2 times package size per 30 days
Neosynalar Kit	315 grams (1 kit) per 30 days
Nephrocaps QT	30 tablets per 30 days
Nerlynx	180 tablets per 30 days
Nesina	30 tablets per 30 days
Neuac Kit	130 grams (1 kit) per 30 days
Neulasta	2 syringes per 30 days
Neumega	21 vials per 30 days
Neupogen	30 vials/syringes per 30 days
Neupro, all strengths	30 patches per 30 days
Nexavar	120 tablets per 30 days
Nexium 20, 40mg	30 capsules per 30 days
Nexium Granules all strengths	30 packets per 30 days
Nexium IV 20, 40mg	10 vials per 30 days
Next Choice	2 tablets per 30 days
Niaspan 500mg	30 tablets per 30 days
Niaspan 750mg, 1,000mg	60 tablets per 30 days
Nicardipine (Cardene)	90 capsules per 30 days
Nicotine gum (Nicorette)	330 gums per 30 days
Nicotine lozenge (Commit)	360 lozenges per 30 days
Nicotine inhaler (Nicotrol Inhaler)	336 cartridges (2 inhalers) per 30 days
Nicotine nasal spray (Nicotrol NS)	40mL per 28 days
Nicotine transdermal patch (Nicoderm CQ)	28 patches per 28 days
Nicotine transdermal patch kit	56 patches (1 kit) per 84 days
Nifedipine 10, 20mg (Procardia)	90 capsules per 30 days
Nifedipine ER 30mg (Adalat CC, Procardia XL)	60 tablets per 30 days
Nifedipine ER 60mg (Adalat CC, Procardia XL)	60 tablets per 30 days
Nifedipine ER 90mg (Adalat CC, Procardia XL)	60 tablets per 30 days
Nimodipine (Nimotop) 30mg	222 capsules per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Ninlaro	3 capsules per 28 days
Nislodipine SR 20mg	90 tablets per 30 days
Nislodipine SR 30mg, 40mg	60 tablets per 30 days
Nislodipine SR (Sular) 8.5mg, 17mg, 25.5mg, 34mg	30 tablets per 30 days
Nitro-Dur (nitroglycerin transdermal)	30 patches per 30 days
Nitrofurantoin oral suspension	600 mL per 30 days
Nitrolingual (nitroglycerin spray)	2 bottles per 30 days
NitroMist (nitroglycerin aerosol)	2 bottles per 30 days
Nivestym	30 vials/syringes per 30 days
Nizatidine (Axid) 150mg	60 capsules per 30 days
Nizatidine (Axid) 300mg	30 capsules per 30 days
Nizatidine (Axid) oral soln 15mg/mL	600 mL per 30 days
Noctiva	3.8 grams (1 bottle) per 30 days
Noroxin	56 tablets per 28 days
Northera 100, 200 mg	90 capsules per 30 days
Northera 300 mg	180 capsules per 30 days
Norvasc 2.5, 5, 10mg	30 tablets per 30 days
Norvir oral powder	360 packets per 30 days
Novolin	45 mL per 30 days
Novolog	45 mL per 30 days
Noxafil suspension	600 mL per 30 days
Noxafil tablets	93 tablets per 30 days
Nucynta 50, 75, 100mg	180 tablets per 30 days
Nucynta ER, all strengths	60 tablets per 30 days
Nuedexta 20/10mg	60 capsules per 30 days
Nuplazid 17 mg	60 tablets per 30 days
Nuplazid 10mg, 34 mg	30 capsules/tablets per 30 days
Nuessa	5 grams per 30 days
Nuvigil 50, 150, 200, 250mg	30 tablets per 30 days
Nuzyra tablets	30 tablets per 30 days
Nymalize	2,520 mL per 30 days
Odefsey	30 tablets per 30 days
Odomzo	30 capsules per 30 days
Ofev	60 capsules per 30 days
Ofloxacin	56 tablets per 30 days
Ofloxacin Ophthalmic (Ocuflox)	10 mL per 30 days
Oleptro 150mg	75 tablets per 30 days
Oleptro 300mg	30 tablets per 30 days
Olumiant	30 tablets per 30 days
Olux/Olux-E (clobetasol foam)	100 grams per 30 days
Olysio	28 capsules per 28 days
Omeclamox Pak	80 pills (10 cards, 1 box) per 30 days
Omeprazole (Prilosec) 10, 20, 40mg	30 capsules per 30 days
Omeprazole/sodium bicarbonate	30 capsules per 30 days
Omniaris Nasal Suspension	1 bottle per 30 days
Omnicef	40 tablets per 30 days
Omnicef Suspension	2 bottles per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Onexton	50 grams per 30 days
Onfi 5, 20mg	60 tablets per 30 days
Onfi 10mg	90 tablets per 30 days
Onfi Suspension	480 mL per 30 days
Onglyza 2.5, 5mg	30 tablets per 30 days
Onmel	28 tablets per 28 days
Onsolis, all strengths	120 films per 30 days
Onzetra	16 nosepieces/capsules per 30 days
Opana	30 tablets per 30 days
Opana ER	60 tablets per 30 days
Opsumit	30 tablets per 30 days
Optivar	6 mL per 30 days
Oracea	30 capsules per 30 days
Oralair	30 tablets per 30 days
Oravig 50 mg	14 tablets per 30 days
Orencia prefilled syringes	4 syringes per 28 days
Orencia 125 mg/mL auto-injector	4 mL (auto-injector syringes) per 28 days
Orenitram 0.125 mg, 0.25 mg	180 tablets per 30 days
Orenitram 1 mg	240 tablets per 30 days
Orenitram 2.5 mg	120 tablets per 30 days
Orenitram 5 mg	60 tablets per 30 days
Orilissa, all strengths	56 tablets per 28 days
Orkambi tablets, all strengths	112 tablets (1 box) per 28 days
Orkambi granules, all strengths	56 packers per 28 days
Ortho Evra	3 patches (1 box) per 28 days
Ortho Evra replacement patch	1 replacement patch with proof of fill for 1 box (3 patches) within past 60 days (3 replacement patches per 365 days)
Ortho Tri-Cyclen (Tri-Privifem, Tri-Sprintec, Trinessa)	28 tablets per 28 days
Ortho Tri-Cyclen Lo	28 tablets per 28 days
Oseni	30 tablets per 30 days
Osmolex ER, all strengths	30 tablets per 30 days
Otezla	60 tablets per 30 days
Otezla Starter Pack	55 tablets (1 pack) per lifetime
Otrexup, all strengths	1.6 mL per 28 days
Otovel	7 mL (2 boxes) per 30 days
Ovide	60 mL per 30 days
Oxandrolone (Oxandrin) 2.5 mg	120 tablets per 30 days
Oxandrolone (Oxandrin) 10 mg	60 tablets per 30 days
Oxazepam (Serax)	120 capsules per 30 days
Oxcarbazepine (Trileptal) oral susp 300mg/5mL	1,200 mL per 30 days
Oxcarbazepine (Trileptal) 150, 300mg	180 tablets per 30 days
Oxcarbazepine (Trileptal) 600mg	120 tablets per 30 days
Oxecta 5mg	600 tablets per 30 days
Oxecta 7.5mg	480 tablets per 30 days
Oxervate ophthalmic solution	3 boxes (21 mL) per 30 days; limit 2 fills per 365 days

DRUG PRODUCT	MAXIMUM QUANTITY
Oxtellar XR 150, 300mg	30 tablets per 30 days
Oxtellar XR 600mg	120 tablets per 30 days
Oxybutynin 5mg (Ditropan)	120 tablets per 30 days
Oxybutynin syrup 5mg/5mL (Ditropan)	600 mL per 30 days
Oxycodone	240 tablets/capsules per 30 days
Oxycodone 5mg/5mL oral solution	2,400 mL per 30 days
Oxycodone 20mg/mL concentrate	420 mL per 30 days
Oxycodone CR, ER (OxyContin, all strengths)	60 tablets per 30 days
Oxycodone/APAP 325mg combinations (Perloxx, Endocet, Percocet, Roxicet)	360 tablets per 30 days
Oxycodone/APAP 400mg combinations (Magnacet)	300 tablets per 30 days
Oxycodone/APAP 500mg combinations (Roxicet 5/500, Tylox)	240 tablets per 30 days
Oxycodone/APAP 650mg combinations (Endocet 10/650, Percocet 10/650)	180 tablets per 30 days
Oxytrol	8 patches (1 box) per 30 days
Ozempic	2 pens (3 mL)
Palynziq, all strengths	60 mL per 30 days
Pancreaze 2600 units	300 capsules per 30 days
Pancreaze 4200 units	5000 capsules per 30 days
Pancreaze 10500 units	2000 capsules per 30 days
Pancreaze 16800 units	1250 capsules per 30 days
Pancreaze 21000 units	1000 capsules per 30 days
Paroxetine 10mg (Paxil)	30 tablets per 30 days
Paroxetine 10mg/5mL (Paxil)	600 mL per 30 days
Paroxetine 20, 30mg (Paxil)	60 tablets per 30 days
Paroxetine 40mg (Paxil)	30 tablets per 30 days
Paroxetine ER (Paxil CR) 12.5, 25, 37.5 mg	60 tablets per 30 days
Pataday 0.2%	2.5 mL (1 bottle) per 30 days
Patanase	1 bottle per 30 days
Patanol 0.1%	5 mL (1 bottle) per 30 days
Pazeo	2.5 mL per 30 days
Peak Flow Meters	1 per lifetime
Pediaderm AF	144 grams (1 kit) per 30 days
Pediaderm HC Kit	1 kit per 30 days
Pediaderm TA Kit	115 grams (1 kit) per 30 days
Pedipirox-4 Nail Kit	1 kit per 30 days
Pegasys 180mcg/0.5mL syringes	2 mL (4 syringes) per 30 days
Pegasys 180mcg/1mL vials	4 mL (4 vials) per 30 days
Pegasys Kit	1 kit per 30 days
Pegasys Proclick 135, 180mcg/0.5mL syringes	2 mL (4 syringes) per 30 days
Peg-Intron / RediPen 50, 80, 120, 150mcg	5 kits per 30 days
Pen needles	100 pen needles per 30 days
Pennsaid 1.5%	600 mL per 30 days
Pennsaid 2%	224 grams per 30 days
Pentazocine/APAP 650mg combinations (Talacen)	180 tablets per 30 days
Perforomist 20mcg/2mL Inh Solution	60 vials per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Permethrin 1% lotion	60 mL per 30 days; 240mL per year
Permethrin 5% cream	60 grams per 30 days; 240 grams per year
Perseris, all strengths	1 syringe per 30 days
Pexeva 10mg	30 tablets per 30 days
Pexeva 20, 30mg	60 tablets per 30 days
Pexeva 40mg	30 tablets per 30 days
Phenelzine (Nardil)	180 tablets per 30 days
Picato 0.015%	3 tubes per 30 days
Picato 0.05%	2 tubes per 30 days
Pifeltro	60 tablets per 30 days
Pindolol	120 per 30 days
Plan B	2 tablets per 30 days
Plan B One Step	1 tablet per 30 days
Plegridy	1 mL (2 syringes) per 28 days
Plegridy Starter Pack	1 mL (1 pack) per lifetime
Plenvu	1 box per 30 days
Polyethylene glycol 3350 – 255gm (Miralax/Glycolax)	2 containers per 30 days
Polyethylene glycol 3350 – 527gm (Miralax/Glycolax)	1 container per 30 days
Polyethylene glycol 3350 packets (Miralax/Glycolax packets)	36 packets (3 cartons) per 30 days
Pomalyst	21 capsules per 28 days
Ponstel (mefenamic acid)	28 capsules per 30 days
Potassium citrate extended-release (Urocit-K) 5mEq, 10mEq	280 tablets per 30 days
Potassium citrate extended-release (Urocit-K) 15mEq	120 tablets per 30 days
Potiga, all strengths	90 tablets per 30 days
Praluent	2 mL (2 pens/syringes) per 28 days
Pramipexole (Mirapex), all strengths	90 tablets per 30 days
Pradaxa	60 capsules per 30 days
PrandiMet 1/500, 2/500mg	150 tablets per 30 days
Prandin 0.5mg, 1mg	120 tablets per 30 days
Prandin 2mg	240mg tablets per 30 days
Pravastatin (Pravachol)	30 tablets per 30 days
Prednisolone acetate/sodium phosphate ophthalmic solution/suspension (Omnipred, Pred Forte, Pred Mild)	15 mL per 30 days
Premarin, all strengths	30 tablets per 30 days
Premarin Vaginal Cream	1 tube per 30 days
Premphase	28 tablets per 28 days
Prempro	28 tablets per 28 days
Prepopik	2 packets (1 box) per 30 days
Prestalia	30 tablets per 30 days
Prevacid/Prevacid Solutab (lansoprazole) 15mg	30 pills per 30 days
Prevacid/Prevacid Solutab (lansoprazole) 30mg	30 pills per 30 days
Prevpac	14 cards (1 box) per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Prevymis, all strengths	28 tablets per 28 days
Prezcobix	30 tablets per 30 days
Prilosec for Oral Suspension, 2.5mg and 10mg	60 packets per 30 days
Pristiq	30 tablets per 30 days
ProCentra Oral Solution, 5mg/5mL	1,800 mL per 30 days
Prolensa	3 mL per 30 days
Promacta oral tablets, all strengths	30 tablets per 30 days
Promacta powder for suspension	120 packets per 30 days
Propafenone ER (Rythmol SR) 225, 325, 425mg	60 capsules per 30 days
Propranolol 10mg (Inderal)	150 tablets per 30 days
Propranolol 20, 40, 60, 80mg (Inderal)	120 tablets per 30 days
Propranolol drops 80mg/mL	60 mL per 30 days
Propranolol soln 4mg/mL	500 mL per 30 days
Propranolol/HCTZ (Inderide)	60 tablets per 30 days
Protonix	30 tablets per 30 days
Protonix Granules for Oral Suspension	30 packets per 30 days
Protonix injection	10 vials per 40 days
Protopic	120 grams per 30 days
Provigil	90 tablets per 30 days
Prozac Weekly 90mg	5 capsules per 30 days
Pulmicort Respules 0.25mg/2mL	120 ampules per 30 days
Pulmicort Respules 0.5mg/2mL	60 ampules per 30 days
Pulmicort Respules 1mg/2mL	30 ampules per 30 days
Pulmicort Flexhaler 90, 180mcg	2 inhalers per 30 days
Pulmozyme	60 vials (150 mL) per 30 days
Purixan	300 mL per 30 days
Prudoxin cream	90 g per 30 days
Pylera	120 capsules per 30 days
Qbrexys	1,200 mL per 30 days
Qbrexza	30 pledgets per 30 days
Qnasl	10.6 grams (1 bottle) per 30 days
Qnasl Children's	4.9 grams (1 bottle) per 30 days
Qtern	30 tablets per 30 days
Qualaquin	42 capsules per lifetime
Quartette	91 tablets per 91 days
Qudexy XR 25, 50, 100, 150mg	30 capsules per 30 days
Qudexy XR 200mg	60 capsules per 30 days
QuilliChew ER 20, 30mg	60 tablets per 30 days
QuilliChew ER 40mg	30 tablets per 30 days
Quillivant XR	2 bottles per 30 days
Quinapril 10, 20mg (Accupril)	90 tablets per 30 days
Quinapril 5, 40mg (Accupril)	60 tablets per 30 days
Quinapril/HCTZ 10/12.5mg, 20/12.5mg (Accuretic)	60 tablets per 30 days
Quinapril/HCTZ 20/25mg (Accuretic)	120 tablets per 30 days
Quixin	5 mL per 30 days
QVAR 40, 80mcg	8.7 grams (1 inhaler) per 30 days
QVAR RediHaler	2 canisters (21.1 grams) per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Ragwitek	30 tablets per 30 days
Ranitidine 150mg (Zantac)	120 tablets per 30 days
Ranitidine 300mg (Zantac)	60 tablets per 30 days
Rapamune oral solution	1200 mL per 30 days
Rapamune oral tablets	600 tablets per 30 days
Rapaflo 4mg, 8mg	30 capsules per 30 days
Rasuvo 7.5 mg/0.15 mL	0.60 mL per 28 days
Rasuvo 10 mg/0.20 mL	0.80 mL per 28 days
Rasuvo 12.5 mg/0.25 mL	1 mL per 28 days
Rasuvo 15 mg/0.30 mL	1.20 mL per 28 days
Rasuvo 17.5 mg/0.35 mL	1.40 mL per 28 days
Rasuvo 20 mg/0.40 mL	1.60 mL per 28 days
Rasuvo 22.5 mg/0.45 mL	1.80 mL per 28 days
Rasuvo 25 mg/0.50 mL	2 mL per 28 days
Rasuvo 27.5 mg/0.55 mL	2.20 mL per 28 days
Rasuvo 30 mg/0.60 mL	2.40 mL per 28 days
Ravicti	525 mL per 30 days
Rayaldee	60 capsules per 30 days
Rayos 1mg	30 tablets per 30 days
Rayos 2mg	60 tablets per 30 days
Rayos 5mg	360 tablets per 30 days
Rebif 22 and 44 mcg	15 syringes per 30 days
Rebif Titration Pack	1 package/4.2mL per 30 days
Reclast 5mg/100mL Injection	1 vial per year
Rectiv	30 grams per 56 days
Regranex 0.01% Gel 2, 7.5, and 15gm	2 tubes per 30 days
Relenza	20 blisters per 6 months
Relexxii	30 tablets per 30 days
Relistor 8mg/0.4mL	30 syringes per 30 days with a lifetime therapy limit of 120 days
Relistor 12mg/0.6mL	30 vials per 30 days with a lifetime therapy limit of 120 days
Relistor Kit	4 kits per 30 days
Relistor oral tablets	90 tablets per 30 days
Relpax	See Amerge
Remicade	3 vials per 30 days
Renagel	600 tablets per 30 days
Renvela tablets 800mg	600 tablets per 30 days
Renvela powder 0.8g, 2.4g	90 packets per 30 days
Repatha	3 mL per 30 days
Repatha Pushtronex System	3.5 mL (1 cartridge) per 30 days
Requip XL 2, 4, 6mg	30 tablets per 30 days
Requip XL 8, 12mg	60 tablets per 30 days
Rescula	15 mL per 60 days
Restasis	60 vials per 30 days
Retin-A Micro	60 grams per 90 days
Retin-A Micro 0.06% and 0.08% Pump	50 grams per 30 days
Revatio	90 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Revatio suspension	180 mL per 30 days
Revlimid, all strengths	30 capsules per 30 days
Rexulti 0.25mg	90 tablets per 30 days
Rexulti 0.5, 1, 2, 3, 4mg	30 tablets per 30 days
Rhinocort Aqua 32 mcg (120 actuations)	17.2 grams (2 bottles) per 30 days
Rhopressa	1 bottle (2.5 mL) per 28 days
RibaPak 600mg/day	56 tablets per 28 days
Rilutek	120 tablets per 30 days
Riomet	765 mL per 30 days
Risperdal 1mg/mL Solution	2 bottles per 30 days
Risperdal, all strengths	90 tablets per 30 days
Risperdal Consta	3 syringes per 30 days
Risperal M-TAB 0.5mg	60 tablets per 30 days
Risperdal M-TAB 1, 2, 3, 4mg	90 tablets per 30 days
Risperidone 0.25mg ODT	60 tablets per 30 days
Ritalin LA, all strengths	30 capsules per 30 days
Rosadan Kit	1 kit per 30 days
Rowasa Kit	4 kits per 28 days
RoxyBond, all strengths	240 tablets per 30 days
Rozerem	See Ambien
Rubraca, all strengths	120 tablets per 30 days
Rydapt	224 capsules per 28 days
Rytary, all strengths	300 capsules per 30 days
RyVent	120 tablets per 30 days
Ryzolt 100, 200, 300mg	30 tablets per 30 days
Sabril 500mg tablets	180 tablets per 30 days
Sabril 500mg powder	180 packets per 30 days
Safyral	28 tablets (1 pack) per 28 days
Simbrinza	24 mL per 60 days
Samsca 15mg	30 tablets per lifetime
Samsca 30mg	60 tablets per lifetime
Sancuso 3.1mg/24hr	2 patches per 30 days
Sanctura 20mg tablet	60 tablets per 30 days
Sanctura 60mg XR capsules	30 capsules per 30 days
Saphris 2.5, 5, 10mg	60 tablets per 30 days
Sarafem 20mg Capsules, 4 blister packs of 7	14 capsules per 28 days
Sarafem 15mg Tablets, 4 blister packs of 7	14 tablets per 28 days
Sarafem 10mg Tablets, 4 blister packs of 7	14 tablets per 28 days
Savaysa	30 tablets per 30 days
Savella 12.5, 25, 50, 100mg	60 tablets per 30 days
Seasonale	4 packs per year
Seasonique	4 packs per year
Seebri	60 capsules per 30 days
Segluromet, all strengths	60 tablets per 30 days
Selzentry oral solution	4 bottles (920 mL) per 30 days
Serevent Diskus 28 blisters	1 package per 30 days
Serevent Diskus 60 blisters	1 package per 30 days
Seroquel	90 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Seroquel XR 50mg	150 tablets per 30 days
Seroquel XR 150mg	30 tablets per 30 days
Seroquel XR 200mg	90 tablets per 30 days
Seroquel XR 300, 400mg	60 tablets per 30 days
Sertraline 25mg (Zoloft)	60 tablets per 30 days
Sertraline 50, 100mg (Zoloft)	90 tablets per 30 days
Sertraline Oral Concentrate, 20mg/mL (Zoloft)	450 mL per 30 days
Signifor	60 mL (60 ampules) per 30 days
Signifor LAR, all strengths	1 vial per 28 days
Silenor 3mg, 6mg	30 tablets per 30 days
Siliq	4 syringes (6 mL) per 28 days
Simcor 500/20mg, 500/40mg, 1000/40mg	30 tablets per 30 days
Simcor 750/20mg, 1000/20mg	60 tablets per 30 days
Simponi 50 mg/0.5 mL injection	1 syringe (0.5mL) per 30 days
Simponi 100mg/1mL injection	1 syringe (1.0mL) per 30 days
Simvastatin (Zocor)	30 tablets per 30 days
Singulair	30 tablets per 30 days
Singulair chewable	30 tablets per 30 days
Singulair granules 4mg/packet	30 packets per 30 days
Sirturo	188 tablets per 24 weeks
Sitavig	2 tablets per 30 days
Sivextro tablets	6 tablets per 30 days
Sivextro vials	6 vials per 30 days
Skelaxin (metaxalone) 800mg	120 tablets per 30 days
Sklice	117 grams (1 tube) per 30 days
Skyrizi	2 syringes (1.66 mL) per 84 days
Solaraze	100 grams per 30 days
Soliqua	15 mL (1 pack) per 30 days
Solosec	1 packet per 30 days
Somavert	30 vials per 30 days
Sonata	See Ambien
Soolantra	45 grams per 30 days
Soriatane 10mg	120 capsules per 30 days
Soriatane 17.5mg, 22.5mg, 25mg	60 capsules per 30 days
Sorilux	120 grams per 30 days
Sotalol 240mg (Betapace, Sorine)	90 tablets per 30 days
Sotalol 80, 120, 160mg (Betapace, Sorine)	60 tablets per 30 days
Sotalol AF (Betapace AF)	60 tablets per 30 days
Sotylice	2000 mL per 30 days
Sovaldi	28 tablets per 28 days
Spacer Device	1 per year for recipients 21 or less
Spectracef 200mg	20 tablets per 30 days
Spectracef 400mg	28 tablets per 30 days
Spirolactone (Aldactone) 25, 50, 100mg	120 tablets per 30 days
Spiriva Cap Handihaler – 90 caps	1 pkg per 90 days
Spiriva Cap Handihaler – 30 caps	1 pkg per 30 days
Spiriva Cap Handihaler – 6 caps	5 pkgs per 30 days
Spiriva Cap Handihaler – 5 caps	6 pkgs per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Spiriva Respimat	4 grams (1 inhaler) per 30 days
Sporanox Oral Solution, 10mg/mL	1,120 mL per 30 days
Spritam, 250, 500, 1000 mg	60 tablets per 30 days
Spritam 750 mg	120 tablets per 30 days
Sprix	5 bottles per 30 days
Sprycel 20mg	180 tablets per 30 days
Sprycel 50, 70, 80mg	60 tablets per 30 days
Sprycel 100, 140mg	30 tablets per 30 days
Starlix (nateglinide) 60mg, 120mg	90 tablets per 30 days
Steglatro, all strengths	30 tablets per 30 days
Steglujan, all strengths	30 tablets per 30 days
Stelara 45 mg/0.5 mL	0.5 mL (1 syringe) per 28 days
Stelara 90 mg/mL	1 mL (1 syringe) per 28 days
Stiolto Respimat	4 grams (1 inhaler) per 30 days
Stivarga	84 tablets per 28 days
Strattera	90 capsules per 30 days
Streptomycin injections	60 vials per 30 days
Striant	60 buccal systems per 30 days
Stribild	30 tablets per 30 days
Striverdi Respimat	4 grams (1 inhaler) per 30 days
Subsys, all strengths	120 boxes per 30 days
Subutex (buprenorphine) 2mg, 8mg tablets	60 tablets per 30 days
Suboxone (buprenorphine/naloxone) Film 4/1mg	30 films per 30 days
Suboxone (buprenorphine/naloxone) Film or Tablet 2/0.5mg	60 films or tablets per 30 days
Suboxone (buprenorphine/naloxone) Film or Tablet 8/2mg	90 films or tablets per 30 days
Suboxone (buprenorphine/naloxone) Film 12/3mg	60 films per 30 days
Suclear	2,480mL (1 box) per 30 days
Sumavel Dosepro	2mL (4 syringes) per 30 days
Sumaxin pads	60 pads per 30 days
Sumaxin wash	473 mL in 30 days
Sumatriptan	See Imitrex
Suprax suspension 100mg/5mL, 200mg/5mL	200 mL per 30 days
Suprax suspension 500mg/5mL	60 mL per 30 days
Suprax chewable tablets 100mg, 200mg	28 tablets per 30 days
Suprax tablets and capsules 400mg	14 pills per 30 days
Suprep	354 mL (1 box) per 30 days
Sutent	28 tablets per 28 days
Symbicort Aerosol	10.2 grams (1 inhaler) per 30 days
Symbyax 12/25mg, 12/50mg, 6/50mg	60 capsules per 30 days
Symbyax 6/25mg	90 capsules per 30 days
Symbyax 3/25mg	30 capsules per 30 days
Symdeko	56 tablets per 28 days
Symfi	30 tablets per 30 days
Symfi Lo	30 tablets per 30 days
Symlinpen 60	6 mL per 30 days
Symlinpen 120	10.8 mL per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Sympazan, all strengths	60 films per 30 days
Symtuza	30 tablets per 30 days
Synagis 100mg	2 vials per 30 days
Synagis 50mg	1 vial per 30 days
Synalar TS Kit	1 kit per 30 days
Synalgos-DC	240 capsules per 30 days
Syndros oral solution	4 bottles (120 mL) per 30 days
Synjardy	60 tablets per 30 days
Synjardy XR 5/1000mg, 12.5/1000mg	60 tablets per 30 days
Synjardy XR 10/1000mg, 25/1000mg	30 tablets per 30 days
Synribo	28 vials per 28 days
Taclonex ointment	100 grams per 30 days
Taclonex suspension	120 grams per 30 days
Tafinlar	120 capsules per 30 days
Tagrisso	30 tablets per 30 days
Takhzyro	4 mL (2 vials) per 30 days
Taltz	1 mL (1 syringe) per 28 days
Talzenna 0.25 mg	90 capsules per 30 days
Talzenna 1 mg	30 capsules per 30 days
Tamiflu 45, 75 mg	10 capsules per 6 months
Tamiflu 30 mg	20 capsules per 6 months
Tamiflu 6mg/mL oral suspension	120mL per 6 months
Tanzeum	1 box (4 pens) per 28 days
Tarceva 25 mg	90 tablets per 30 days
Tarceva 100, 150 mg	30 tablets per 30 days
Targretin gel, -softgel	2 times package size per 30 days
Tarka 1/240, 2/180, 2/240, 4/240mg	30 tablets per 30 days
Tasigna 50, 150, 200mg	120 capsules per 30 days
Tavalisse, all strengths	60 tablets per 30 days
Taytulla	28 capsules (1 pack) per 28 days
Tazorac	100 grams per 150 days
Tecfidera 120mg	60 capsules per lifetime
Tecfidera 240mg	60 capsules per 30 days
Tecfidera Starter Pack	60 capsules (1 pack) per lifetime
Technivie	56 tablets per 28 days
Teflaro 400, 600mg	28 vials per 30 days
Tegsedi	4 pre-filled syringes (6 mL) per 28 days
Tekamlo, all strengths	30 tablets per 30 days
Tekturna 150, 300mg	30 tablets per 30 days
Tekturna HCT, all strengths	30 tablets per 30 days
Temazepam (Restoril)	18 capsules per 30 days
Temodar	10 capsules per 30 days
Terbinex Kit	1 kit per 30 days
Terconazole (Terazol 3)	3 (1 box) per 30 days
Terconazole 0.4% (Terazol 7 Cream)	1 tube (of the 45 gram) per 30 days
Terconazole 0.8% (Terazol 3 Cream)	1 tube (of the 20 gram) per 30 days
Testim 1% (50mg) gel	300 grams (60 tubes) per 30 days
Teveten 400mg	60 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Teveten 600mg	30 tablets per 30 days
Teveten HCT	30 tablets per 30 days
Thalomid capsule, all strengths	60 capsules per 30 days
Tibsovo	60 tablets per 30 days
Tiglutik oral suspension	600 mL per 30 days
Timolol maleate (Blocadren) 20mg	90 tablets per 30 days
Timolol maleate (Blocadren) 10mg	60 tablets per 30 days
Tindamax	21 tablets per 30 days
Tivicay, all strengths	60 tablets per 30 days
Tivorbex	90 capsules per 30 days
Tobi/tobramycin nebulizer solution	280 mL per 56 days
Tobi Podhaler	224 capsules per 56 days
TobraDex ointment	7 grams (2 tubes) per 30 days
TobraDex suspension	20 mL per 30 days
TobraDex ST suspension	20 mL per 30 days
Tobramycin injection	15 vials (450 mL) per 30 days
Tolak	40 grams per 30 days
Tolsura	120 capsules per 30 days
Topicort ointment 0.05%	60 grams per 30 days
Topicort spray 0.05%	100 mL per 60 days
Toprol XL	90 tablets per 30 days
Toujeo	45 mL per 30 days
Toviaz 4, 8mg	30 tablets per 30 days
Tracleer	60 tablets per 30 days
Tracleer 62.5, 125mg	60 tablets per 30 days
Tracleer 32 mg tablet for oral suspension	112 tablets per 28 days
Tradjenta	30 tablets per 30 days
Tramadol (Ultram)	240 tablets per 30 days
Tramadol/APAP (Ultracet)	40 tablets per 30 days
Travatan Z	5 mL per 60 days
Trazodone 300mg (Desyrel)	60 tablets per 30 days
Trazodone 50, 100, 150mg (Desyrel)	120 tablets per 30 days
Trelegly Ellipta	1 inhaler (30 inhalations) per 30 days
Trelstar LA Injection	1 injection per 60 days
Tremfya	1 syringe (1 mL) per 56 days
Tresiba	45 mL per 30 days
Tretinoin (Retin-A, Avita)	60 grams per 90 days
Tretin-X	1 packages per 30 days
Treximet, all strengths	See Amerge
Trianax 0.05% ointment	85 grams per 30 days
Triazolam (Halcion)	18 tablets per 30 days
Tribenzor, all strengths	30 tablets per 30 days
Tricor 134, 145 and 160mg	30 tablets per 30 days
Tricor 48mg	90 tablets per 30 days
Triglide 160mg	30 tablets per 30 days
Triglide 50mg	90 tablets per 30 days
Trilipix 45mg	60 capsules per 30 days
Trilipix 135mg	30 capsules per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Triumeq	30 tablets per 30 days
Trizivir	60 tablets per 30 days
Trogarzo	19 mL per 28 days
Trokendi XR 25mg, 50mg, 100mg	30 capsules per 30 days
Trokendi XR 200mg	60 capsules per 30 days
Trulance	30 tablets per 30 days
Trulicity	2 mL (4 pens) per 28 days
Truvada, all strengths	30 tablets per 30 days
Tudorza Pressair	1 inhaler per 30 days
Tybost	30 tablets per 30 days
Tykerb tablets	180 tablets per 30 days
Tyvaso Starter Kit	1 kit per lifetime
Tyvaso Refill Kit	1 kit per 28 days
Twynsta, all strengths	30 tablets per 30 days
Uceris	30 tablets per 30 days
Uceris foam	66.8 grams per 28 days
Udencya	2 syringes (1.2 mL) per 30 days
Ulesfia	454 grams per 30 days
Uloric 40, 80mg	30 tablets per 30 days
Ultram ER	30 tablets per 30 days
Umecta PD emulsion, suspension	1 bottle per 30 days
Uniretic	60 tablets per 30 days
Uptravi (excluding 200 mcg)	60 tablets per 30 days
Uptravi 200 mcg	140 tablets per 30 days
Uptravi Titration Pack	200 tablets (1 pack) per lifetime
Urea Nail Kit	1 kit per 30 days
Urine Test Strips and Urine Glucose Test Strips	100 test strips per 30 days
Urogesic Blue	120 tablets per 30 days
Uroxatral	30 tablets per 30 days
Utibron	60 capsules per 30 days
Valchlor	60 grams per 30 days
Valcyte oral solution 50mg/mL	540 mL per 30 days
Valcyte oral tablets	120 tablets per 30 days
Valtrex	30 caplets (tablets) per 30 days
Vancomycin (Vancocin) 125mg, 250mg	80 capsules per 30 days
Vanos (fluocinonide)	120 grams per 30 days
Varubi	2 tablets (1 pack) per 28 days
Vascepa	240 capsules per 30 days
Vecamyl	300 tablets per 30 days
Vectical 5gm, 100gm	1 tube in 30 days
Velphoro	180 tablets per 30 days
Veltassa	30 packets per 30 days
Veltin	60 grams per 60 days
Vemlidy	30 tablets per 30 days
Venclexta starter pack	42 tablets (1 box) per lifetime
Venclexta 10mg	60 tablets per 30 days
Venclexta 50mg	30 tablets per 30 days
Venclexta 100mg	120 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Venlafaxine 25, 37.5mg (Effexor)	90 tablets per 30 days
Venlafaxine 50, 75, 100mg (Effexor)	120 tablets per 30 days
Venlafaxine ER tablets 37.5, 75mg	90 tablets per 30 days
Venlafaxine ER tablets 150mg	60 tablets per 30 days
Venlafaxine ER tablets 225mg	30 tablets per 30 days
Venofer	150 mL per 30 days
Ventavis 10mcg/mL	270 mL per 30 days
Ventavis 20mcg/mL	270 mL per 30 days
Veramyst nasal spray	1 bottle per 30 days
Verapamil IR tablets (Calan)	120 tablets per 30 days
Verapamil ER capsules (Verelan, PM)	30 capsules per 30 days
Verapamil ER tablets/capsules (Calan SR, Isoptin SR, Covera HS)	60 tablets/capsules per 30 days
Versacloz	540 mL per 30 days
Verzenio, all strengths	56 tablets per 28 days
Vescepa	120 capsules per 30 days
Vexol Eye Drops	10 mL per 30 days
Viadur Implant Kit	1 per rolling year
Viberzi	60 tablets per 30 days
Victoza 18mg/3mL pen	9 mL per 30 days
Victrelis	336 tablets per 28 days
Vigamox	3 mL per 30 days
Viibryd Starter Kit	1 kit per lifetime
Viibryd 10, 20, 40mg	30 tablets per 30 days
Viekira Pak	112 tablets per 28 days
Viekira XR	84 tablets per 28 days
Vimovo 375/20mg, 500/20mg	60 tablets per 30 days
Vimpat 50, 100, 150, 200mg	90 tablets per 30 days
Vimpat 200 mg/20 mL injection	10 vials (200 mL) per 30 days
Vimpat 10mg/mL oral solution	1,200 mL per 30 days
Viramune 200mg 14-Day Starter Pack	1 pack per lifetime
Viramune 200mg	60 tablets per 30 days
Viramune suspension	1,200 mL per 30 days
Viramune XR 100mg	90 tablets per 30 days
Viramune XR 400mg	30 tablets per 30 days
Viread, all strengths	30 tablets per 30 days
Viroptic (trifluridine) 1%	15 mL (2 bottles) per 30 days
Vitekta	30 tablets per 30 days
Vitrakvi 25 mg capsules	180 capsules per 30 days
Vitrakvi 100 mg capsules	60 capsules per 30 days
Vitrakvi 20 mg/mL oral solution	300 mL per 30 days
Vivitrol	1 vial per 30 days
Vivlodex	30 capsules per 30 days
Vizimpro, all strengths	30 tablets per 30 days
Vosevi	28 tablets per 28 days
Votrient 200mg	120 tablets per 30 days
Vraylar, all strengths	30 capsules per 30 days
Vytorin	30 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Vyvanse, all strengths	30 capsules per 30 days
Vyvanse chewable, all strengths	30 chewable tablets per 30 days
Vyzulta	1 bottle (5 mL) per 30 days
Welchol 625mg	210 tablets per 30 days
Welchol 3.75g	30 packets per 30 days
Wellbutrin XL 150mg	90 tablets per 30 days
Wellbutrin XL 300mg	30 tablets per 30 days
Xadago, all strengths	30 tablets per 30 days
Xalatan	2.5 mL per 30 days
Xalkori 200, 250mg	60 capsules per 30 days
Xarelto 2.5 mg	60 tablets per 30 days
Xarelto, all other strengths	30 tablets per 30 days
Xarelto Starter Pack	51 tablets (1 pack) per lifetime
Xartemis XR	120 tablets per 30 days
Xatmep	1 bottle (120 mL) per 30 days
Xeljanz, all strengths	60 tablets per 30 days
Xeljanz XR	30 tablets per 30 days
Xeloda tablets, all strengths	240 tablets per 30 days
Xelpros	1 bottle (2.5 mL) per 30 days
Xenazine 12.5mg	120 tablets per 30 days
Xenazine 25mg	60 tablets per 30 days
Xerese	5 grams per 30 days
Xermelo	84 tablets per 28 days
Xhance	240 actuations (32 mL) per 30 days
Xifaxan 200mg	9 tablets per 30 days
Xifaxan 550mg	60 tablets per 30 days
Xigduo XR 5/500, 10/500, 10/1000 mg	30 tablets per 30 days
Xigduo XR 5/1000 mg, 2.5/1000 mg	60 tablets per 30 days
Ximino, all strengths	30 capsules per 30 days
Xodol 5mg/300mg	360 tablets per 30 days
Xodol 7.5mg/300mg, 10mg/300mg	180 tablets per 30 days
Xofluza, all strengths	2 tablets per 30 days
Xolegel 15gm, 45gm	45 grams per 30 days
Xopenex	120 units (5 boxes or 360mL) per 30 days
Xoponex HFA	30 grams (2 inhalers) per 30 days
Xospata	90 tablets per 30 days
Xyosted, all strengths	3 auto-injector syringes (2 mL) per 28 days
Xyrem	540 mL per 30 days
Xtampza ER, all strengths	60 capsules per 30 days
Xtandi	120 capsules per 30 days
Xultophy	15 mL (5 pens/1 box) per 30 days
Xyzal tablet, 5mg	30 tablets per 30 days
Xyzal oral solution, 2.5mg/5mL	300 mL per 30 days
Yaz (Gianvi)	28 tablets per 28 days
Yonsa, all strengths	30 tablets per 30 days
Yosprala, all strengths	30 tablets per 30 days
Yupelri	30 vials (90 mL) per 30 days
Zamicet	2,025mL per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Zantac syrup	1,200 mL per 30 days
Zarxio	30 syringes per 30 days
Zavesca	90 capsules per 30 days
Zecuity	4 patches per 30 days
Zejula	90 tablets per 30 days
Zelboraf	240 tablets per 20 days
Zembrace	4 mL (8 syringes) per 30 days
Zenpep 3,000 units	360 capsules per 30 days
Zenpep 5,000 units	810 capsules per 30 days
Zenpep 10,000 units	1,020 capsules per 30 days
Zenpep 15,000 units	720 capsules per 30 days
Zenpep 20,000 units	1,050 capsules per 30 days
Zenpep 25,000 units	1,050 capsules per 30 days
Zenpep 40,000 units	660 capsules per 30 days
Zepatier	28 tablets per 28 days
Zetia 10 mg	30 tablets per 30 days
Zetonna	6.1 grams (1 canister) per 30 days
Ziagen	60 tablets per 30 days
Ziana	60 grams per 60 days
Zinbryta	1 mL (syringe) per 30 days
Zioptan	30 containers per 30 days
Zipsor 25 mg	120 capsules per 30 days
Zirgan 0.15%	1 tube (5g) per 30 days
Zmax	1 bottle per 30 days (3 Rxs per year)
Zofran (ondansetron) 24 mg	1 tablet per 30 days
Zofran (ondansetron) 4 and 8 mg	60 tablets per 30 days
Zofran (ondansetron) solution, 4 mg/5mL	150 mL per 30 days
Zohydro ER, all strengths	60 capsules per 30 days
Zolpimist oral spray 5mg	7.7 mL (1 bottle) per 60 days
Zolvit	2,025 mL per 30 days
Zomig 2.5, 5mg/ Zomig ZMT	See Amerge
Zomig 2.5, 5mg Nasal Spray	6 nasal spray devices per 30 days
Zonalon cream	90 g per 30 days
Zontivity	30 tablets per 30 days
Zortress 0.25 mg	60 tablets per 30 days
Zortress 0.5 mg	240 tablets per 30 days
Zortress 0.75 mg	120 tablets per 30 days
Zortress 1 mg	60 tablets per 30 days
Zorvolex	90 capsules per 30 days
Zovirax cream 5%	5 grams per 30 days
Zovirax ointment 5%	30 grams per 30 days
ZTlido	90 patches per 30 days
Zubsolv (buprenorphine/naloxone) 0.7 mg/0.18 mg	30 tablets per 30 days
Zubsolv (buprenorphine/naloxone) 1.4 mg/0.36 mg	90 tablets per 30 days
Zubsolv (buprenorphine/naloxone) 5.7 mg/1.4 mg, 8.6 mg/2.1 mg	60 tablets per 30 days
Zubsolv (buprenorphine/naloxone) 2.9 mg/0.71 mg, 11.4 mg/2.9 mg	30 tablets per 30 days

DRUG PRODUCT	MAXIMUM QUANTITY
Zurampic	30 tablets per 30 days
Zydelig	60 tablets per 30 days
Zyflo, Zyflo CR 600mg	120 tablets per 30 days
Zykadia	Min: 60 capsules per 30 days Max: 150 capsules per 30 days
Zymaxid 0.5%	2.5 mL per 30 days
Zypitamag, all strengths	30 tablets per 30 days
Zyprexa, Zyprexa-Zydis 2.5, 5, 7.5, 10, 15mg	60 tablets per 30 days
Zyprexa, Zyprexa-Zydis 20mg	30 tablets per 30 days
Zyprexa Relprevv 210, 300mg	2 vials per 30 days
Zyprexa Relprevv 405mg	1 vial per 30 days
Zytiga, all strengths	120 tablets per 30 days
Zyvox 600mg	28 tablets per 30 days
Zyvox Injection, 2mg/mL	8,400 mL per 30 days
Zyvox Oral Suspension, 100mg/5mL	6 bottles per 30 days

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APPENDIX C

COVERED NURSING FACILITY SERVICES

Covered Services

The approved reimbursement rate established by the Division of Medical Assistance is an inclusive rate to cover the following:

- A) Nursing facility residents are allowed to retain from their income each month “a monthly personal needs allowance - which is reasonable in amount for clothing and other personal needs of the individual while in an institution.” 43 USCA, Section 396a (q) (1) (A). The personal need allowance is currently set at \$50.00 per month.
- B) Nursing facility covered services. In addition to other services and items required by the Division’s policy, the following services and items shall be provided by the nursing facility at no additional charge to the Division, the member, or the member’s representative:
 - 1) Patient’s room and board (including special diets and special dietary supplements used for tube or oral feedings, when specifically prescribed by a physician). Insofar as possible, privacy shall be accorded a member with a terminal illness; however, this shall not be interpreted to require a private room.
 - 2) Laundry (including personal laundry).
 - 3) Nursing and routine services:

Routine services include all nursing services and supplies and other supplies and equipment related to the day-to-day care of the patient. Items of service which are covered in routine services regardless of the condition of the patient include, but are not limited to the following:

- Nursing services (excluding private duty nurses)
- Medical social services
- Physical therapy
- Speech therapy
- Restorative nursing care
- Hand feedings
- Enemas
- Assistance in personal care and grooming
- Nursing supplies and dressings

- Extra Linen
- Laboratory procedures not requiring laboratory personnel
- Tray service
- Durable medical equipment (such as, but not limited to, beds, bedrails, walkers, wheelchairs) excluding specialized equipment for individual use
- Incontinency care
- Incontinency pads, diapers, and sanitary pads
- Special mattresses and pads

Routine personal hygiene items and services including, but not limited to:

Shampoo, hair conditioner, comb, brush, bath soap, non-legend disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, petroleum jelly, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, towels, washcloths, hospital gowns, nail care, hair care, bathing, and shaving.

Over-the-Counter (OTC) Drugs and Related Items:

- Each nursing facility shall as part of nursing and routine services supply clinically necessary over-the-counter drugs and related items to be used for members as ordered by the attending physician without additional charge to the Division, the member, or the member's representative. Each item must be available in adequate supply to assure the member's timely receipt of the items as ordered. These items will be provided generically or in a brand of a nursing facility's choosing unless the doctor has a clinically necessary reason to choose a particular brand.
- The resident may only be charged for over-the-counter drugs if, after being informed of the options, he or she chooses to purchase a specific brand for non-clinical reasons from his/her personal needs allowance. The items to be supplied by the nursing facility shall include, but shall not be limited to the following:
 - Stool Softener and Laxative
 - Magnesium Hydroxide Liquid (Milk of Magnesia)
 - Glycerin Suppositories
 - Stool Softener
 - Bulk Laxative

- Stimulant Laxative
- Antidiarrheal
 - Non-legend antidiarrheal product
- Antacid
 - Antacid
- Analgesic/Antipyretic
 - Acetaminophen - tablets, liquid, suppositories
 - Aspirin - tablets, suppositories
- Ophthalmics
 - Artificial tears in multi-dose containers labeled for specific patients' use
- Diluents/Irrigants
 - Normal saline
 - Sterile water
- Treatment Solutions
 - Chlorhexidine gluconate (Hibiclens)
 - Rubbing Alcohol
 - Povidone-iodine 10% (Betadine)
 - Hydrogen Peroxide 3% (Peroxide)
- Vaccines
 - Influenza Vaccine
 - Hepatitis B Virus Vaccine (ICF-MR only)
- Other
 - Other clinically necessary non-legend drugs ordered by the physician for which there is no substitute covered by Medicaid.

C) Drugs Eligible For Coverage By Full Benefit Dual Eligibles Receiving Medicare
Part D Benefits

Effective January 1, 2006, full-dual eligibles may receive Medicaid fee for service payment for only the following drugs and/or therapeutic categories. All therapy, quantity and service limits as well as prior approval requirements remain in effect.

- Cyancobalamin Injection
- Generic Megace Suspension*
- Folic Acid 1mg
- Hep-Lock Saline Flush
- Legend prenatal vitamins for women
- Legend Injectable Iron
- Diphenhydramine
- Generic permethrin lotion 1%, pyrantel pamoate
- OTC generic Loratadine and Loratadine D-, OTC Certirizine tablets and syrup
- Enteric coated aspirin
- Meclizine
- ESRD vitamins and antacids:

Calcium Carbonate, Aluminum Hydroxide, calcium acetate, sodium bicarbonate. Calcium Carbonate with Glycine, Calcium Lactate, Docusate Calcium, Docusate Sodium, Niacin, Pyridoxine Hydrochloride, Thiamine Hydrochloride, Legend Vitamin D products, Vitamin B Complex (All Require Prior Approval)

Members < 21 years old may receive all medications listed above as well as the following drugs and/or therapeutic categories. All therapy, quantity and service limits as well as prior approval requirements remain in effect.

- Cough and cold products
- Vitamin E
- Children's Multiple Vitamins in combination with Fluoride
- OTC Multi-Vitamins and Multi-Vitamins with Iron (chewable or liquid drops)
- Legend Vitamin & Mineral Products
- Ibuprofen Suspension

Please Note: All covered OTCs require a Prescription

*Generic Megace is covered for the duals unless its use is for anorexia, or an unexplained, significant weight loss in patients with a diagnosis of acquired immunodeficiency syndrome (AIDS).

APPENDIX D MEDICARE CROSSOVER CLAIMS

Effective for dates of service on and after May 11, 2012, payments for Medicare coinsurance and deductible obligations for dual eligible Medicare/Medicaid members, including Qualified Medicare Beneficiaries (QMB), will be limited to the Medicaid maximum allowable amount. This reimbursement structure is consistent with the public notice issued by the Department of Community Health (DCH) dated August 30, 2000. The August 30th public notice is summarized below:

If Medicaid approves the claim; the Medicaid reimbursement amount is determined as follows:

1. The Medicare coinsurance and deductible amount for the claim is compared to the Medicaid maximum allowable amount minus the Medicare payment. The Medicaid payment will be the lesser of these amounts less applicable TPL and copayments.
2. If Medicaid approves the claim, a payment of the lesser of the coinsurance and deductible up to the Medicaid maximum allowable amount for the claim will be made.
3. If the Medicare payment on the claim is equal to or greater than what Medicaid would have allowed for the claim; Medicaid will pay at \$0.00.

A copy of the public notice issued on August 30, 2000 and/or applicable calculation examples are available upon request. Please submit your request along with any questions to crossoverissues@dch.ga.gov.

Rev. 04/16 CO-PAYMENT

Effective April 1, 2016, dual eligible Medicare/Medicaid members, including Qualified Medicare Beneficiaries (QMB) are exempt from co-payment.

Thank you for your continued participation in the Medicaid program.

APPENDIX E CO-PAYMENT FOR PHARMACY

Effective with dates of service on or after July 1, 2001, the Department will impose a nominal co-payment for each preferred generic or preferred brand drug of \$.50 dispensed by the pharmacy.

Category	Co-Payment
Preferred Generic	\$0.50
Preferred Brand	\$0.50
Non-Preferred Brand	Under \$10.00 = \$0.50
Or	\$10.01-\$25.00 = \$1.00
Non-Preferred	\$25.01-\$50.00 = \$2.00
Generic	\$50.01 or more = \$3.00

Medicaid members under age twenty-one (21), pregnant women, institutionalized individuals and hospice care members are not required to pay this co-payment. Emergency services and family planning services are also exempt from this co-payment.

The Medicaid members listed below are not required to pay the co-payment.

- Members who are under twenty-one years of age
The member's age will be determined systematically during claims processing.
- Members who reside in a nursing facility
For new nursing facility members not yet identified on the card, providers should enter **(11111)** in the prior authorization number field on the claim and enter an "04" in field 461-EU (Prior authorization Type Code). This number will prevent the reduction of co-payment from the claim.
- Members who are pregnant
For newly diagnosed pregnant women, providers may indicate this exemption by placing **(22222)** in the prior authorization number field on the claim and enter an "04" in field 461-EU (Prior authorization Type Code).
- Members enrolled in hospice care
Hospice members are identified on the Medicaid card; no entry on the claim is required by providers.
- All emergency prescriptions are exempt from co-payment
The entry of the emergency number **(99888)** in the prior authorization number field and entry of an "04" in field 461-EU (Prior authorization Type Code) will exempt the prescription from co-payment. This code will not override drugs that require member eligibility, prior authorization, quantity level limit, or refill-too-soon approvals.

6. All family planning prescriptions are exempt from Co-payment
All oral and/or injectable contraceptives are exempt from co-payment. These prescriptions are identified systematically by their therapeutic category and the co-payment will not be deducted.
7. All Breast and Cervical Cancer AID Category Members, AID category (245 & 800) Only
Effective January 1, 2007, all members of the Breast and Cervical Cancer Aid category are exempted from co-payment. Utilizing the NCPDP (5.1) claim standard, enter (08) in field (#461 EU) to bypass drug co-payment for Breast and Cervical Cancer aid category members, not properly identified through POS adjudication. Please note that this only applies to members eligible in AID categories (245 and 800).

Effective with dates of service on or after July 1, 2005, the Division is implementing a tiered member co-payment scale on all evaluation and management codes (99201-99499), including Ophthalmic visits--as described in 42CFR447.54. See co-payment scale below:

Payment for the service chargeable	Maximum co-payment to member
\$10 or less	\$.50
\$10.01 to \$25	\$1.00
\$25.01 to \$50	\$2.00
\$50.01 or more	\$3.00

§ The member co-payment will be deducted from each evaluation and management procedure code billed unless the member is included in one of the exempted, which include:

1) Pregnant women; 2) Nursing Home Facility residents; and 3) Hospice Care members.

§ The co-payments does not apply to emergency or family planning services.

§ The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the co-payment.

A co-payment will be deducted from each prescription billed unless the member has been identified in an exempt group as defined above. Providers should continue to submit their usual and customary charge for each prescription billed to the Division. Do not deduct the co-payment from your submitted charges to the Division.

Providers who agree to provide pharmacy services to Medicaid members by accepting their Eligibility card, or by filing a request for prior approval for a member, are obligated to file the claim to Medicaid and accept Medicaid reimbursement as payment in full.

The provider may not deny services to any member on account of such member's inability to pay the co-payment. A member's inability to pay the co-payment does not eliminate his or her liability for such co-payment.

The application of co-payment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of co-payment.

The services subject to the co-payment and the co-payment amount are listed below.

Service	Co-Payment
Inpatient Hospital	\$12.50
Physicians	\$2.00
Home Health	\$3.00
Rural Health	\$2.00
Nurse Practitioners	\$2.00
Drugs	\$.50
	\$1.00
	\$2.00
	\$3.00
Non-Emergency Transportation	\$1.00
Durable Medical Equipment	\$3.00
Optometry	\$1.00
Orthotics and Prosthetics	\$3.00
Ambulatory Surgical Centers	\$3.00
Podiatry	\$2.00
Physician Assistants	\$2.00

CO-PAYMENTS FOR PEACHCARE FOR KIDS

Effective for services provided on or after April 1, 2012, the Department of Community Health will implement co-payments for covered services to PeachCare for Kids members six years of age and older.

The co-payments are subject to fee-for-service rates. They will be deducted from the amount paid on each claim filed.

Co-pays are not required for children who are American Indians or are Alaska Natives. The provider cannot deny services to any eligible PeachCare for Kids member because of the member's inability to pay the co-payment. The provider should check member eligibility In order to identify those individuals who may be responsible for the co-payment. If you have questions, contact DXC Technology Provider Services Contact Center at (770) 325-9600 or (800) 766-4456.

Listed below are the PeachCare for Kids co-payment amounts:

ILLUSTRATIVE CO-PAYMENTS	
Pharmacy - Preferred Drugs	\$0.50
Pharmacy - Non-Preferred Drugs	Cost Based
COST BASED CO-PAYMENTS	
Cost of Service	Co-Payment
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

APPENDIX F
STATEMENT OF PARTICIPATION

The new Statement of Participation is available in the Provider Enrollment Application Package.

Phone your request to: (800) 766-4456

APPENDIX G
OUTPATIENT PHARMACY BILLING
OUTPATIENT PHARMACY BILLING TABLE OF CONTENTS

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OPTUMRX PHARMACY PROVIDER

Rev. 10/15

SUPPORT PHONE NUMBERS AND HOURS

For all online inquiries including claims processing, eligibility prior approval or online messaging, contact

OptumRx Technical Support

866-525-5826

24/7/365

Prior Authorization and Clinical Support,

866-525-5827

Intended for Physicians/Pharmacist use

24/7/365

OPTUMRX-GDCH Paper Claims

PO Box 29044

Hot Springs, AR 71903

OptumRx FAX Number for Georgia Medicaid

888-491-9742

GEORGIA HEALTH PARTNERSHIP (GHP)

Provider Correspondence

DXC Technology
P.O. Box 105200
Tucker, GA 30085-5201

Provider Enrollment

Includes Pharmacy Providers
www.mmis.georgia.gov → Provider
Enrollment
FAX: 1-866-483-1044

Prior Authorization & Pre-Certification

GHP
P.O. Box 105329
Atlanta, GA 30348

Electronic Data Interchange (EDI)

Includes:

- Asynchronous
- Web portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/
- Internet Protocol (TCP/IP)
- 1-877-261-8785

Provider Inquiry Numbers:

770-325-9600 (Metro area)
800-766-4456 (Toll free)

OptumRx– web address

<https://ga-providerportal.optum.com>

GHP – web address

The web contact address is [http:// www.mmis.georgia.gov](http://www.mmis.georgia.gov)

ONLINE TRANSMISSION INFORMATION

In order to participate in the Medicaid provider network, you must be able to submit claims electronically to OptumRx. For providers who need to get online, OptumRx has a list of software vendors that offer software and/or hardware products for online claim submission. Contacting a software vendor should be your first step. The second step is to contract with a switching company. Your software vendor may offer recommendations for a compatible switching company. Please contact OptumRx Provider Relations at 866-525-5826 if you have questions.



GA Medicaid FFS/PeachCare for Kids OptumRx

PAYER SPECIFICATION SHEET REVISED OCTOBER 23, 2017

BIN #: 001553
States: All GA willing Providers
Destination: OptumRx / RxClaim
Accepting: Claim Billing, Claim Rebill, and Claim Reversals
Format: NCPDP Version D.Ø
Effective: 1/1/2012

****Start of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet****

Field Legend for Columns			
Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Transaction Header Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	Required for B1 & B3 Transactions.

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	ØØ1553	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1,B2, or B3 only	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	GAM	M	

Transaction Header Segment			Claim Billing/Claim Rebill	
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
109-A9	TRANSACTION COUNT	Up to 4 allowed	M	Ø1 – Ø4 (up to 4 transactions per B1 & B3 transmission) accepted; Only Ø1 for B2 transaction
202-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 National Provider ID (NPI)	M	
201-B1	SERVICE PROVIDER ID	National Provider ID (NPI)	M	
401-D1	DATE OF SERVICE	CCYYMMDD	M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Use value for Switch's requirements.	M	If submitting claim without a Switch, populate with blanks.

Insurance Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	Required for B1 & B3 Transactions

Insurance Segment Segment Identification (111-AM) = "Ø4"				Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
302-C2	CARDHOLDER ID	Enter member's 12 digit ID from Medicaid ID card	M	<i>Payer Requirement:</i> Required
312-CC	CARDHOLDER FIRST NAME		RW	<i>Payer Requirement:</i> Not required, captured if sent
313-CD	CARDHOLDER LAST NAME		RW	<i>Payer Requirement:</i> Not required, captured if sent
314-CE	HOME PLAN		RW	<i>Payer Requirement:</i> Not required, captured if sent
524-FO	PLAN ID		RW	<i>Payer Requirement:</i> Not required, captured if sent
309-C9	ELIGIBILITY CLARIFICATION CODE		RW	<i>Payer Requirement:</i> Not required, captured if sent
301-C1	GROUP ID		RW	<i>Payer Requirement:</i> Not required, captured if sent
303-C3	PERSON CODE		RW	<i>Payer Requirement:</i> Not required, captured if sent
306-C6	PATIENT RELATIONSHIP CODE		RW	<i>Payer Requirement:</i> Not required, captured if sent

Patient Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	Required for B1 & B3 Transactions

Patient Segment Segment Identification (111-AM) = “Ø1”				Claim Billing/Claim Rebill
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
331-CX	PATIENT ID QUALIFIER		RW	<i>Payer Requirement:</i> Not required, captured if sent
332-CY	PATIENT ID		RW	<i>Payer Requirement:</i> Not required, captured if sent
3Ø4-C4	DATE OF BIRTH		R	<i>Payer Requirement:</i> Required
3Ø5-C5	PATIENT GENDER CODE		RW	<i>Payer Requirement:</i> Not required, captured if sent
31Ø-CA	PATIENT FIRST NAME		RW	<i>Payer Requirement:</i> Not required, captured if sent
311-CB	PATIENT LAST NAME		RW	<i>Payer Requirement:</i> Not required, captured if sent
322-CM	PATIENT STREET ADDRESS		RW	<i>Payer Requirement:</i> Not required, captured if sent
323-CN	PATIENT CITY ADDRESS		RW	<i>Payer Requirement:</i> Not required, captured if sent
324-CO	PATIENT STATE / PROVINCE ADDRESS		RW	<i>Payer Requirement:</i> Not required, captured if sent
325-CP	PATIENT ZIP/POSTAL ZONE		RW	<i>Payer Requirement:</i> Not required, captured if sent
326-CQ	PATIENT PHONE NUMBER		RW	<i>Payer Requirement:</i> Not required, captured if sent
333-CZ	EMPLOYER ID		RW	<i>Payer Requirement:</i> Not required, captured if sent
335-2C	PREGNANCY INDICATOR		RW	<i>Payer Requirement:</i> Not required, captured if sent
384-4X	PATIENT RESIDENCE		RW	<i>Payer Requirement:</i> Not required, captured if sent

Claim Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	Required for B1 & B3 Transactions
This payer supports partial fills	X	

Claim Segment Segment Identification (111-AM) = “Ø7”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<i>Imp Guide:</i> For Transaction Code of “B1”, in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing). <i>Payer Requirement:</i> Only value of “1” is accepted
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	<i>Payer Requirement:</i> Supports 12-digit Rx# Example: ØØØØØ1234567 (leading zeros)

Claim Segment Segment Identification (111-AM) = “Ø7”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø1 – UPC Ø2 – HRI Ø3 – NDC	M	<i>Payer Requirement:</i> Ø1 – Universal Product Code (UPC) Ø2 – Health Related Item (HRI) Ø3 – National Drug Code (NDC)
4Ø7-D7	PRODUCT/SERVICE ID		M	<i>Payer Requirement:</i> 12-digit UPC Code 10-digit HRI Number 11-digit NDC Number
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	<i>Imp Guide:</i> Required if the “completion” transaction in a partial fill (Dispensing Status (343-HD) = “C” (Completed)). Required if the Dispensing Status (343-HD) = “P” (Partial Fill) and there are multiple occurrences of partial fills for this prescription.
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	<i>Imp Guide:</i> Required if the “completion” transaction in a partial fill (Dispensing Status (343-HD) = “C” (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = “P” (Partial Fill) and there are multiple occurrences of partial fills for this prescription.
458-SE	PROCEDURE MODIFIER CODE COUNT	Maximum count of 1Ø.	RW	<i>Imp Guide:</i> Required if Procedure Modifier Code (459-ER) is used. <i>Payer Requirement:</i> Not required, captured if sent

Claim Segment Segment Identification (111-AM) = “Ø7”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
459-ER	PROCEDURE MODIFIER CODE		RW	<i>Imp Guide:</i> Required to define a further level of specificity if the Product/Service ID (4Ø7-D7) indicated a Procedure Code was submitted. Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> Not required, captured if sent
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 – Not a Compound 2 – Compound	R	<i>Payer Requirement:</i> Use “1” if product not a compound or “2” if product is a compound
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø – No Product Selection Indicated 1 – Substitution Not Allowed by Prescriber	R	<i>Payer Requirement:</i> Use ‘1’ only for limited products. Do not use 2, 3, 4, 5, 6, 7, 8 or 9
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		RW	<i>Payer Requirement:</i> Not required, captured if sent
419-DJ	PRESCRIPTION ORIGIN CODE	Ø – Not Known 1 – Written 2 – Telephone 3 – Electronic 4 – Facsimile 5 – Pharmacy	R	<i>Payer Requirement:</i> Required
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used.

Claim Segment Segment Identification (111-AM) = “Ø7”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø8 – Process Compound For Approved Ingredients 2Ø – 340B Purchased Drug	RW	<i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø). <i>Payer Requirement:</i> Ø8=Process compound for Approved Ingredients 2Ø = Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 34ØB of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)).
3Ø8-C8	OTHER COVERAGE CODE	Ø – Not Specified 1 – No other coverage 2 – Other coverage exists- payment collected 3 – Other Coverage Billed – claim not covered 4 – Other coverage exists – payment not collected 8 – Claim is billing for patient financial responsibility only (co-pay/coinsurance)	RW	<i>Imp Guide:</i> Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits.
429-DT	SPECIAL PACKAGING INDICATOR		RW	<i>Payer Requirement:</i> Not required, captured if sent
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER		RW	<i>Imp Guide:</i> Required if Originally Prescribed Product/Service Code (455-EA) is used.
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		RW	<i>Imp Guide:</i> Required if the receiver requests association to a therapeutic, or a preferred product substitution, or when a DUR alert has been resolved by changing medications, or an alternative service than what was originally prescribed.

Claim Segment Segment Identification (111-AM) = “Ø7”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
446-EB	ORIGINALLY PRESCRIBED QUANTITY		RW	<i>Imp Guide:</i> Required if the receiver requests reporting for quantity changes due to a therapeutic substitution that has occurred or a preferred product/service substitution that has occurred, or when a DUR alert has been resolved by changing quantities.
454-EK	SCHEDULED PRESCRIPTION ID NUMBER		RW	<i>Payer Requirement:</i> Not required, captured if sent
6ØØ-28	UNIT OF MEASURE		RW	<i>Payer Requirement:</i> Not required, captured if sent
418-DI	LEVEL OF SERVICE		RW	<i>Payer Requirement:</i> Not required, captured if sent
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø1 – Prior Authorization Ø4 – Exemption from Copay and/or Coinsurance Ø8 – Payer Defined Exemption	RW	<i>Payer Requirement:</i> Ø1 – Ordering Prescribing or Referring (OPR) Provider Override* Ø4 – Emergency Fill Indication* Ø4 – New Nursing Facility Members* Ø4 – Newly DX Pregnant Women* Ø8 – Member is diagnosed with Breast or Cervical Cancer* *Note: 462-EV must be submitted with a following appropriate code
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	<i>Payer Requirement:</i> 4444444444 – Ordering Prescribing or Referring (OPR) Provider Override 99888 – Emergency Fill Indication 11111 – New Nursing Home Indicator 22222 – Newly DX pregnant woman ØØØØØ – Breast or Cervical Cancer diagnosis
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID		RW	<i>Imp Guide:</i> Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary. Required if Intermediary Authorization ID (464-EX) is used.

Claim Segment Segment Identification (111-AM) = “Ø7”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
464-EX	INTERMEDIARY AUTHORIZATION ID		RW	<i>Imp Guide:</i> Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary.
343-HD	DISPENSING STATUS		RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription.
995-E2	ROUTE OF ADMINISTRATION		RW	<i>Payer Requirement:</i> Required if 4Ø6-D6 Compound Code is a “2”
996-G1	COMPOUND TYPE	Ø1 – Anti-infective Ø2 – Ionotropic Ø3 – Chemotherapy Ø4 – Pain management Ø5 – TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition Ø6 – Hydration Ø7 – Ophthalmic 99 – Other	RW	<i>Payer Requirement:</i> Required if 4Ø6-D6 Compound Code is a “2” Ø1 = Anti-infective – a medicinal product intended to treat pathogens such as bacteria, viruses, fungi or parasites Ø2 = Ionotropic – a medicinal product intended to correct irregular heart rhythms Ø3 = Chemotherapy – a medicinal product intended to treat cancer Ø4 = Pain management – a regimen of therapy intended to ameliorate mild to severe discomfort Ø5 = TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition – products intended to provide nourishment by central or peripheral veins for patients with compromised digestive tracts Ø6 = Hydration – a product intended to restore body fluids Ø7 = Ophthalmic – a product intended to be applied to or instill in the surface of the eye 99 = Other – not defined by other available codes

Pricing Segment	Check	Claim Billing/Claim Rebill
This Segment is always sent	X	Required for B1 & B3 Transactions

Pricing Segment Segment Identification (111-AM) = "11"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	INGREDIENT COST SUBMITTED		R	Payer Requirement: Required
412-DC	DISPENSING FEE SUBMITTED		RW	Payer Requirement: Not required, captured if sent
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	Payer Requirement: Not required, captured if sent
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Payer Requirement: Not required, captured if sent
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	Imp Guide: Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. Payer Requirement: Not required, captured if sent
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	Imp Guide: Required if Other Amount Claimed Submitted (480-H9) is used. Payer Requirement: Not required, captured if sent
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	Payer Requirement: Not required, captured if sent
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	Payer Requirement: Required in applicable locations.
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	Payer Requirement: Required in applicable locations.
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	Imp Guide: Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used.
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	Imp Guide: Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	Payer Requirement: Required
430-DU	GROSS AMOUNT DUE		R	Payer Requirement: Required
423-DN	BASIS OF COST DETERMINATION		RW	Payer Requirement: Not required, captured if sent

Pricing Segment Segment Identification (111-AM) = “11”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED		RW	Payer Requirement: Not required, captured if sent

Pharmacy Provider Segment	Check	Claim Billing/Claim Rebill
This Segment is situational – Not required	X	

Pharmacy Provider Segment Segment Identification (111-AM) = “Ø2”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
465-EY	PROVIDER ID QUALIFIER		RW	Imp Guide: Required if Provider ID (444-E9) is used. Payer Requirement: Not required, captured if sent
444-E9	PROVIDER ID		RW	Payer Requirement: Not required, captured if sent

Prescriber Segment	Check	Claim Billing/Claim Rebill
This Segment is situational	X	Required for B1 & B3 Transactions

Prescriber Segment Segment Identification (111-AM) = “Ø3”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 – NPI	R	Imp Guide: Required if Prescriber ID (411-DB) is used. Payer Requirement: Required.- Use only Ø1 National Provider ID (NPI)
411-DB	PRESCRIBER ID		R	Payer Requirement: National Provider ID (NPI) – Required
427-DR	PRESCRIBER LAST NAME		RW	Payer Requirement: Not required, captured if sent
498-PM	PRESCRIBER PHONE NUMBER		RW	Payer Requirement: Not required, captured if sent

Prescriber Segment Segment Identification (111-AM) = “Ø3”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER		RW	Payer Requirement: Not required, captured if sent
421-DL	PRIMARY CARE PROVIDER ID		RW	Payer Requirement: Not required, captured if sent
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME		RW	Payer Requirement: Not required, captured if sent

Coordination of Benefits/Other Payments Segment	Check	Claim Billing/Claim Rebill
This Segment is situational	X	Required for secondary and tertiary claims.
		Required for B1 & B3 Transactions
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = “Ø5”				Claim Billing/Claim Rebill
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)				
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	Ø1 if other payer was Primary Ø2 if other payer was Secondary Ø3 if other payer was Tertiary
339-6C	OTHER PAYER ID QUALIFIER		RW	Imp Guide: Required if Other Payer ID (34Ø-7C) is used. Payer Requirement: Complete if present
34Ø-7C	OTHER PAYER ID		RW	Imp Guide: Required if identification of the Other Payer is necessary for claim/encounter adjudication. Payer Requirement: Complete if present

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = “Ø5”				Claim Billing/Claim Rebill
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)				
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
443-E8	OTHER PAYER DATE		RW	<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. <i>Payer Requirement:</i> Same as Imp Guide
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 3.	RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used. <i>Payer Requirement:</i> Required if (3Ø8-C8) Other Coverage Code is 2; # of claims paid
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used. <i>Payer Requirement:</i> Required if (3Ø8-C8) Other Coverage Code is 2
431-DV	OTHER PAYER AMOUNT PAID		RW	<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. <i>Payer Requirement:</i> Required if (3Ø8-C8) Other Coverage Code is 2; COB amount
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used. <i>Payer Requirement:</i> Complete if present
472-6E	OTHER PAYER REJECT CODE		RW	<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing. <i>Payer Requirement:</i> Complete if present
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. <i>Payer Requirement:</i> Required if (3Ø8-C8) Other Coverage Code is 8

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)				
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø5 - Amount of Copay (518-FI) as reported by previous payer. Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6 - Patient Pay Amount (5Ø5-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7 - Amount of Coinsurance (572-4U) as reported by previous payer. Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection.	RW	<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. <i>Payer Requirement:</i> Required if (3Ø8-C8) Other Coverage Code is 8
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	<i>Imp Guide:</i> Required if necessary for patient financial responsibility only billing. <i>Payer Requirement:</i> Required if (3Ø8-C8) Other Coverage Code is 8; co-pay or coinsurance from COB

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = “Ø5”				Claim Billing/Claim Rebill
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)				
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	<i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used. <i>Payer Requirement:</i> Not required, captured if sent
393-MV	BENEFIT STAGE QUALIFIER		RW	<i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used. <i>Payer Requirement:</i> Not required, captured if sent
394-MW	BENEFIT STAGE AMOUNT		RW	<i>Imp Guide:</i> Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. <i>Payer Requirement:</i> Not required, captured if sent

DUR/PPS Segment	Check	Claim Billing/Claim Rebill
This Segment is situational	X	

DUR/PPS Segment Segment Identification (111-AM) = “Ø8”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	<i>Imp Guide:</i> Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE		RW	<i>Payer Requirement:</i> Required if segment used.
44Ø-E5	PROFESSIONAL SERVICE CODE		RW	<i>Payer Requirement:</i> Required if segment used.
441-E6	RESULT OF SERVICE CODE		RW	<i>Payer Requirement:</i> Required if segment used.
474-8E	DUR/PPS LEVEL OF EFFORT		RW	<i>Payer Requirement:</i> Complete if present

DUR/PPS Segment Segment Identification (111-AM) = “Ø8”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
475-J9	DUR CO-AGENT ID QUALIFIER	Ø1 – Universal Product Code (UPC) Ø2 – Health Related Item (HRI) Ø3 – National Drug Code (NDC) 2Ø – International Classification of Diseases (ICD9)	RW	<i>Imp Guide:</i> Required if DUR Co-Agent ID (476-H6) is used. <i>Payer Requirement:</i> Not required. Values Ø1, Ø2, Ø3, and 2Ø accepted
476-H6	DUR CO-AGENT ID		RW	<i>Payer Requirement:</i> Complete if present. Encouraged if code DC, DD, ID, MC, TD in 439-E4

Compound Segment	Check	Claim Billing/Claim Rebill
This Segment is situational	X	Use when Compound Code (4Ø6-D6) value of 2 is sent in the Claim Segment
		Required for B1 & B3 Transactions

Compound Segment Segment Identification (111-AM) = “1Ø”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Ø1 – Capsule Ø2 – Ointment Ø3 – Cream Ø4 – Suppository Ø5 – Powder Ø6 – Emulsion Ø7 – Liquid 1Ø – Tablet 11 – Solution 12 – Suspension 13 – Lotion 14 – Shampoo 15 – Elixir 16 – Syrup 17 – Lozenge 18 – Enema	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1 – Each 2 – Grams 3 – Milliliters	M	

Compound Segment Segment Identification (111-AM) = “1Ø”				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	<i>Payer Requirement:</i> Count of compound product IDs (both active and inactive) in the compound mixture submitted.
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 – National Drug Code (NDC)	M	<i>Payer Requirement:</i> Ø3 – NDC Required
489-TE	COMPOUND PRODUCT ID		M	<i>Payer Requirement:</i> NDC of each ingredient
448-ED	COMPOUND INGREDIENT QUANTITY		M	<i>Payer Requirement:</i> Quantity of each ingredient
449-EE	COMPOUND INGREDIENT DRUG COST		R	<i>Payer Requirement:</i> Required
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	ØØ – Default Ø1 – AWP (Average Wholesale Price) Ø2 – Local Wholesaler Ø3 – Direct Ø4 – EAC (Estimated Acquisition Cost) Ø5 – Acquisition Ø6 – MAC (Maximum Allowable Cost) Ø7 – Usual & Customary Ø8 – 34ØB Price Ø9 – Other 1Ø – ASP (Average Sales Price) 11 – AMP (Average Manufacturer Price) 12 – WAC (Wholesale Acquisition Cost) 13 – Special Patient Pricing	R	<i>Payer Requirement:</i> Required
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 1Ø.	RW	<i>Payer Requirement:</i> Not required, captured if sent
363-2H	COMPOUND INGREDIENT MODIFIER CODE		RW	<i>Payer Requirement:</i> Not required, captured if sent

Clinical Segment	Check	Claim Billing/Claim Rebill
This Segment is situational	X	Only for B1 or B3 Transactions if required for specific claim.

Clinical Segment Segment Identification (111-AM) = "13"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.	RW	<i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø1=International Classification of Diseases (ICD9)	RW	<i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used. <i>Payer Requirement:</i> Value Ø1=International Classification of Diseases (ICD9) accepted
424-DO	DIAGNOSIS CODE		RW	<i>Payer Requirement:</i> Effective 10/01/11, submit the ICD-9 code of 299.0 for pediatric members ages 5-16 using risperidone for irritability associated with autism.

**** End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet****

**** Start of Request Claim Reversal (B2) Payer Sheet ****

Field Legend for Columns			
Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of “Required” for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	“Required when”. The situations designated have qualifications for usage (“Required if x”, “Not required if y”).	Yes

Question	Answer
What is your reversal window?	90 Days

CLAIM REVERSAL TRANSACTION

Transaction Header Segment	Check	Claim Reversal
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	ØØ1553	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	GAM	M	
1Ø9-A9	TRANSACTION COUNT	Up to 1 allowed	M	Only 1 allowed for B2 transaction
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 National Provider ID (NPI)	M	
2Ø1-B1	SERVICE PROVIDER ID	National Provider ID (NPI)	M	
4Ø1-D1	DATE OF SERVICE	CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Use value for Switch’s requirements.	M	If submitting claim without a Switch, populate with blanks.

Insurance Segment	Check	Claim Reversal
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = “Ø4”				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø2-C2	CARDHOLDER ID	Enter member’s 12 digit ID from Medicaid ID card	M	
3Ø1-C1	GROUP ID		RW	<i>Imp Guide:</i> Required if needed to match the reversal to the original billing transaction.

Claim Segment	Check	Claim Reversal
This Segment is always sent	X	

Claim Segment Segment Identification (111-AM) = “Ø7”				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<i>Imp Guide:</i> For Transaction Code of “B2”, in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is “1” (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	<i>Payer Requirement:</i> Supports 12-digit Rx# Example: ØØØØØ1234567 (leading zeros)
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø1 – UPC Ø2 – HRI Ø3 – NDC	M	<i>Payer Requirement:</i> Ø1 – Universal Product Code (UPC) Ø2 – Health Related Item (HRI) Ø3 – National Drug Code (NDC)
4Ø7-D7	PRODUCT/SERVICE ID		M	<i>Payer Requirement:</i> 12-digit UPC Code 10-digit HRI Number 11-digit NDC Number
4Ø3-D3	FILL NUMBER		RW	<i>Imp Guide:</i> Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day.
3Ø8-C8	OTHER COVERAGE CODE		RW	<i>Imp Guide:</i> Required if needed by receiver to match the claim that is being reversed.

Pricing Segment	Check	Claim Reversal
This Segment is always sent	X	

Pricing Segment Segment Identification (111-AM) = "11"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
43Ø-DU	GROSS AMOUNT DUE		R	Payer Requirement: Required

Coordination of Benefits/Other Payments Segment	Check	Claim Reversal
This Segment is situational	X	

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	Ø1 if other payer was Primary Ø2 if other payer was Secondary Ø3 if other payer was Tertiary

DUR/PPS Segment	Check	Claim Reversal
This Segment is situational	X	

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"				Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	Imp Guide: Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE		RW	Payer Requirement: Required if segment used.
44Ø-E5	PROFESSIONAL SERVICE CODE		RW	Payer Requirement: Required if segment used.
441-E6	RESULT OF SERVICE CODE		RW	Payer Requirement: Required if segment used.

**** End of Request Claim Reversal (B2) Payer Sheet ****

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) are excluded from the payer sheet.

ELIGIBILITY VERIFICATION (E1) TRANSACTION DATA ELEMENTS

- This client does NOT SUPPORT eligibility verification transactions.

PRIOR AUTHORIZATION (P1, P2, P3) TRANSACTION DATA ELEMENTS

- This client does NOT SUPPORT prior authorization transactions.
- The use of the Prior Authorization Segment is NOT SUPPORTED.

INFORMATION (N1, N2, N3) TRANSACTION DATA ELEMENTS

- This client does NOT SUPPORT informational transactions.

CONTROLLED SUBSTANCE REPORTING (C1, C2, C3) TRANSACTION DATA ELEMENTS

- This client does NOT SUPPORT controlled substance reporting transactions

PARTIAL FILL TRANSACTION REPORTING

- Partial Fill transactions are handled per NCPDP standard

COORDINATION OF BENEFITS REPORTING

- Use of COB Segment data elements is required when alternate insurance exists

COUPON REPORTING

- USE OF THE COUPON SEGMENT DATA ELEMENTS is NOT SUPPORTED
- Submit value of coupon in COB Segment's Other Payer Amount field.

MULTIPLE-INGREDIENT COMPOUND CLAIMS SUBMISSION

- The COMPOUND SEGMENT for multi-ingredient compound claims is supported
- Single-ingredient compound claims are not accepted by this client.

DUPLICATE CLAIM

- Denial reason of 88 DUPRX will post for a duplicate prescription filled at a different pharmacy. Please call the Technical Help Desk if you need more information on the other script causing the conflict.

GENERAL INFORMATION

Live Date:	January 1, 2007 (Version D.Ø Effective 01/01/12)	
Maximum prescriptions per transaction:	4	
Technical assistance, help desk:	(866) 525-5826	OptumRx
Clinical Prior Authorization support:	(866) 525-5827	OptumRx
Toll Free Prior Authorization Fax Number:	(888)-491-9742	OptumRx
Vendor certification required:	No	
Pharmacy Registration with Payer Required:	Yes	
Switch Support:	NDC Health Emdeon/WebMD, eRx, ENVOY, QS1	

NCPDP Version D.0 Implementation
Georgia Department of Community Health

- Effective January 1, 2012, GDCH will begin accepting claims via the HIPAA compliant NCPDP Version D.0 standard transaction.
- Please call the OptumRx Technical call center @1-866-525-5826 with OptumRx for questions specific to NCPDP Version D.0.

MEMBER ELIGIBILITY VERIFICATION

Each member should present an Identification Card when getting a prescription filled. The new member cards will serve dual purpose for medical & prescription card.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Member ID #: 123456789012
Member: Joe Q Public
Card Issuance Date: 12/01/02

Primary Care Physician:
Dr. Jane Q Public
285 Main Street
Suite 2859
Atlanta, GA 30303
Phone: (123) 123-1234 X1234

Plan: Georgia Better Health Care

After Hours: (123) 123-1234 X1234

Verify eligibility at www.mmis.georgia.gov

If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.

Payor: For Non-Managed Care Members
Customer Service: 1-800-766-4456 (Toll Free)

DXC Technology P.O. Box 105200 Tucker, GA 30085-5200 Prior Authorization: GMCF P. O. Box 105329 Atlanta, GA 30348	OptumRx Rx BIN-001553 Rx PCN-GAM OptumRx Prior Auth 1-866-525-5827	Mail RX Drug Claims to: OptumRx P.O. Box 29044 Hot Springs, AR 71903 RX Provider Help Line 1-866-525-5826
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This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.

Rx BIN #/PCN #/Group
Number: Required
Information to process claim

Rx Provider # for
Technical Assistance

If a person claims to be a Georgia Medicaid Member and does not have a card, submit the claim online, then if you receive a “Missing/Invalid Cardholder ID” rejection code, verify eligibility by contacting the OptumRx Call Center at 866-525-5826

Eligibility must be verified before dispensing any medication through POS or direct contact with OptumRx. Presentation of the card does not guarantee eligibility or reimbursement.

GENERAL CLAIM SUBMISSION POLICIES

Rev. 10/15

- All claims must be submitted online with the pharmacy provider's Most Favored Nations Rate in the Gross Amount Due field.
- All claims must be submitted to a primary payer when Medicaid is secondary. The secondary claim transmitted to Medicaid through OptumRx must include the applicable Other Coverage Code and the Primary Paid Amount as returned by the primary payer. (See section on Coordination of Benefits/Billing.)
- All claims must be submitted with the actual NDC of the medication dispensed. Non-standard NDCs are prohibited by the HIPAA Standard.
- All claims must be submitted with an appropriate Prescriber ID on all claims. The required identifier is the NPI. Failure to submit the complete and accurate required Prescriber identifier will result in a rejected claim (See section 907.1 of Policy Manual).
- All paper claims should be submitted on a Universal Claim Form (UCF) DAH 2 pt.
- The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at <http://dch.georgia.gov/publications>
- Search to see if a provider is enrolled at <https://www.mmis.georgia.gov/portal/default.aspx>

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

- Access a provider listing at
<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx>

Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

Georgia Medicaid FFS Tamper Resistant Prescription Pad (TRPP)-Pharmacy Update

On October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) tamper-resistant prescription law took effect requiring all handwritten and/or computer generated (by an electronic medical record (EMR) or ePrescribing applications) printed prescriptions for fee-for-service Medicaid patients contain at least one industry recognized feature from each of the three categories of tamper resistance.

The Georgia Department of Community Health (DCH) Office of the Inspector General Program Integrity division is required to enforce this federal requirement. Any payment made for a prescription that does not comply with this requirement will be recouped by the Department. The Center for Medicare and Medicaid Services (CMS) strongly supports both e-prescribing and the use of tamper-resistant prescription pads as methods to reduce instances of unauthorized, improperly altered, and counterfeit prescriptions.

Review of CMS Requirements for TRPP:

Required tamper-resistant characteristics include one or more industry-recognized features designed to:		Examples include but are not limited to:
1	Prevent unauthorized copying of a completed or blank prescription form	• High security watermark on reverse side of blank • Thermochromic ink technology • Photocopied prescription blanks show the word “Copy,” “Illegal,” or “Void.”
2	Prevent erasure or modification of information written on the prescription by the prescriber	• Tamper-resistant background ink shows erasures or attempts to change written information
3	Prevent the use of counterfeit prescription forms	• Duplicate or triplicate blanks

Summary of features that could be used on a tamper-resistant pad/paper in compliance with the CMS guidelines

Category 1 – Copy Resistance: One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription form.	
Feature	Description
“Void,” “Illegal,” or “Copy” pantograph <u>with or without</u> Reverse “Rx”	The word “Void,” “Illegal,” or “Copy” appears when the prescription is photocopied. Except where state law mandates the word “Void” or “Illegal” – it is recommended that the pantograph show the word “Copy” if the prescription is copied. The pantograph should be placed so as not to obscure the security feature description contained on the prescription, the patient and prescriber demographics, or the medication and directions. Some pantographs can be problematic because when the prescription is copied, the resulting “void” or other wording that appears makes the underlying prescription difficult to read. These types of pantograph should be avoided. Providers may wish to ask their pad vendor about hollow “VOID” pantograph lettering which is less likely to obscure the information. The Reverse Rx disappears when photocopied at a light setting – thus making the pantograph more effective in copy resistance. The pantograph may be used with a reverse Rx, but Reverse Rx is not effective as a feature by itself.
Micro printing – To be effective, this feature must be printed in 0.5 font or less making it illegible to the pharmacist when copied	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.
Thermochromic ink	Ink changes color with temperature change.
Coin-reactive ink	Ink changes color when rubbed by a coin.
<u>Watermarking</u> Security back print (artificial watermark) Digital watermarks Watermarking on special paper	Printed on the back of prescription form. The most popular wording for the security back print is “Security Prescription” or the security back print can include the states name. Can only be seen when viewed at an angle. Weak digital watermarks cannot be read if copied and strong digital watermarks provide digital rights management/“proof” of origin when copied. Special paper contains a watermark that can be seen when backlit.

Category 2 – Erasure / Modification Resistance: One or more industry-recognized features designed to prevent the erasure or modification of information written / printed on the prescription by the prescriber.	
Features to Prevent Erasure	Description
An erasure revealing background (erasure resistance)	Background that consists of a solid color or consistent pattern that has been printed onto the paper. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase, the consistent background color will look altered and show the color of the underlying paper.
Toner Receptor Coating / Toner Lock or Color Lock paper (erasure resistance for computer generated prescriptions printed with a laser printer) OR Chemically reactive paper (erasure resistance for hand written prescriptions)	Special printer paper that establishes a strong bond between laserprinted text and paper, making erasure obvious. Note – this is NOT necessary for inkjet printers – as the ink from inkjet printers is absorbed into normal “bond” paper. If exposed to chemical solvents, oxidants, acids, or alkalis that can be used to alter the prescription, the chemically reactive paper will react and leave a mark visible to the pharmacist.
Features to Prevent Modification	Description
Quantity check off boxes and refill indicator (circle or check number of refills or NR)	In addition to the written quantity on the prescription, quantities are indicated in ranges. It is recommended that ranges be in 25’s with the highest being “151 and over”. The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid. The refill indicator indicates the number of refills on the prescription. Refill numbers must be used to be a valid prescription.
Pre-printed language on prescription Paper Example: “Rx is void if more than XXX Rx’s on paper”	Reduces ability to add medications to the prescription. Line must be completed for this feature to be valid. Computer printer paper can accommodate this feature by printing, “This space intentionally left blank” in an empty space or quadrant.
Quantity and Refill Border and Fill (this is the recommended for computer generated prescriptions)	Quantities and refill # are surrounded by special characters such as an asterisks to prevent modification, e.g. QTY **50** Value may also be expressed as text, e.g. FIFTY, (optional).

Category 3 – Counterfeit Resistance: One or more industry-recognized feature designed to prevent the use of counterfeit prescription forms.	
Feature	Description
Security features and descriptions listed on prescriptions – this feature is strongly recommended on all prescriptions	Complete list of the security features on the prescription paper for compliance purposes. This is strongly recommended to aid pharmacists in identification of features implemented on prescription.
Thermochromic ink	Ink changes color with temperature change.
Encoding techniques (bar codes)	Bar codes on prescription. Serial number or Batch number is encoded in a bar code.
Security Thread	Metal or plastic security threads embedded in paper as used in currency.

Best Practices for Tamper Resistant Printed Prescriptions (Handwritten)

Category 1	A) Photocopied “COPY”, “ILLEGAL”, or “VOID” Pantograph
Category 2	A) An Erasure revealing background (resists erasures and alterations) B) Quantity check off boxes C) Refill indicator (circle number of refills or “NR”)
Category 3	A) Security features and descriptions listed on the prescription

Best Practices for Tamper Resistant Printed Prescriptions

Front

(Handwritten)

Back

Void or Copy Pantograph: displays "VOID" or "ILLEGAL" on a color copy of an Rx. It will appear on a wide range of copier settings. (Cat. 1)

SPRINGHAVEN MEDICAL PRACTICE
1234 HEALTH CENTER DRIVE
DAYTON, OH 45408
PHONE 1-937-221-1234 • FAX 1-937-434-5678

JOHN R. SMITH, M.D.
Lic: 123456 • DEA: XX1234567
NPI: 2222222222

HELEN C. DOE, M.D.
Lic: 123456 • DEA: XX1234567
NPI: 2222222222

PATIENT'S FULL NAME _____ SEX _____ DATE OF BIRTH ____/____/____

ADDRESS _____ DATE ____/____/____

Rx **Preprinted Text Fields:** Quantity check boxes, refill indicators, and preprinted limitations or guidelines make the Rx harder to modify. (Cat.2)

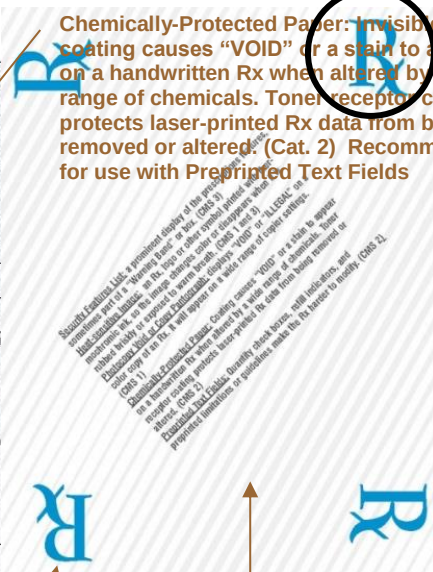
Refills: ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 151 and over

TEST AREA: Refills 1 2 3 4 No Refills Void After _____

DEA #: _____

VALID FOR CONTROLLED SUBSTANCES

Chemically-Protected Paper: Invisible coating causes "VOID" or a stain to appear on a handwritten Rx when altered by a wide range of chemicals. Toner receptor coating protects laser-printed Rx data from being removed or altered. (Cat. 2) Recommended for use with Preprinted Text Fields



Heat-sensitive Image: An Rx, logo, or other symbol printed with Thermochromic ink, so the image changes color or disappears when it is rubbed briskly or exposed to warm breath. (Cat. 1 and 3)

Example of a Color Copied Prescription

Hollow Pantograph: VOID or ILLEGAL is designed to not obscure or block vital information. Often showing strongest intensity at the "top" or the document. These pantographs generally do not "pop" on a black and white fax

Best Practices for Tamper Resistant Printed Prescriptions (Generated by an EMR)

Example A

Washington Medical Group 555 Pennsylvania Ave, Washington DC 20001 202-222-2222 (Fax) 202-222-1111	
Name Jane Q. Public	Date 06/29/2008
Addr 123 Main Street	DOB 07/04/1960
City Washington, DC 20001	Ph: 202-555-5555

HYDROCHLOROTHIAZIDE 12.5 MG CAPS One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE

Disp ***30*** THIRTY (2)
Refill ***3*** THREE

Security Features: (*) bordered & spelled quantities, microprint signature line visible at 5x or > magnification that must show THIS IS AN ORIGINAL PRESCRIPTION & the description of features (3)

(1) John Smith, MD
NPI# 1111111111

Category #1 – Copy Resistance: Microprint signature line*

Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out)

Category #2 – Modification / Erasure Resistance: Printed on “toner-lock” paper

Category #3 – Counterfeit Resistance: Listing of security features

*Microprint Line viewed at 5x magnification

THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION

Example B

The Center for Women's Health
555 Pennsylvania Ave, Washington CT 20001
202-222-2222 (Fax) 202-222-1111

(1) Rx

Name Jane Q. Public
Addr 123 Main Street
City Washington, CT 06597

Date 06/29/2008
DOB 07/04/1960
Ph: 860 -555-5555

HYDROCHLOROTHIAZIDE 12.5 MG (1) One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE

Disp ***30*** THIRTY (2)
Refill ***3*** THREE

Security features include: (*) bordered and spelled quantities, a void pantograph and reverse Rx (when copied - the prescription will say "COPY" and the "Rx" in the upper right corner will NOT be visible), and this description of features. (3)

John Smith, MD
NPI# 1111111111

Category #1 – Void/Illegal/Copy Pantograph with or without Reverse Rx

Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out)

Category #2 – Modification / Erasure Resistance: Printed on “toner-lock” paper for laser printed prescriptions, and on plain bond paper for inkjet printed prescriptions

Category #3 – Counterfeit Resistance: Listing of security features

Georgia Department of Community Health • Program Integrity Division

**Tamper Resistant Prescriptions
PROVIDER COMPLIANCE REFERRAL FORM**

On October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) tamper-resistant prescription law took effect requiring that all handwritten and/or computer generated (by an electronic medical record (EMR) or ePrescribing applications) printed prescriptions for fee-for-service Medicaid patients contain at least one industry recognized feature from each of the three categories of tamper resistance.

This form is designed to assist the Department in coordinating educational efforts for non-compliant prescribing providers. Questions about this form or its use should be directed to the Program Integrity Division at (404) 463-5273.

Fill in the information and fax to: **(770) 344-4257**.

Submitting Pharmacy should provide the following information for non-compliant prescribers (* denotes required information):

Prescriber Name*:	
Prescriber License Number*:	
Prescriber NPI Number*:	
Phone Number: (include area code)	
Street Address:	
City, State, Zip:	

Prescriber Name*:	
Prescriber License Number*:	
Prescriber NPI Number*:	
Phone Number: (include area code)	
Street Address:	
City, State, Zip:	

Prescriber Name*:	
Prescriber License Number*:	
Prescriber NPI Number*:	
Phone Number: (include area code)	
Street Address:	
City, State, Zip:	

Submitting Pharmacy*: _____ Date: _____
GA Medicaid Provider #*: _____
Phone # (incl. area code): _____

Additional Resources

http://www.cms.gov/DeficitReductionAct/30_GovtInfo.asp



****Ages 2 and under Prevacid Compound requests- please contact OptumRx directly for approval at 1-866-525-5827.
Completion of this form is NOT required.****
Requests for Proton Pump Inhibitors (PPI) additionally require a completed PPI Prior Authorization Form available from:
www.mmis.georgia.gov → Pharmacy → Prior Approval Process → Proton Pump Inhibitor Prior Authorization Form

MEMBER Last Name															MEMBER First Name														
MEMBER ID number															MEMBER Date of Birth														
PRESCRIBER Last Name															PRESCRIBER First Name														
PRESCRIBER NPI#																													
PRESCRIBER Phone															PRESCRIBER Fax														
PRESCRIBER Address																													

1 Member Diagnosis	2 Compound Requested

4 Ingredient Name	5 11 digit NDC	6 Quantity	7 Unit (e.g. mls)
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
6.	6.	6.	6.
7.	7.	7.	7.
8.	8.	8.	8.
9.	9.	9.	9.
10.	10.	10.	10.

8 Pharmacy Name	9 Pharmacy NABP
10 Pharmacy Phone	11 Pharmacy Facsimile
12 Pharmacist Signature and Date	

*****Updated 09/10/12*****

Rev. 04/12

Compounded Prescriptions

Reimbursement for all drugs is contingent upon dispensing a drug that is manufactured by a company who has a signed rebate agreement for that drug with the Centers for Medicare and Medicaid Services (CMS) **and** the member's eligibility at the time of service.

Rev. 07/17 Effective July 17, 2017, compound requests for select compounded ingredients (in addition to compounds for omeprazole, lansoprazole and common TPN ingredients) will no longer require a Prior Authorization (PA). Any ingredient utilized outside of the select ingredients will still require a PA. Please review your final claim submission to determine if any ingredients still require PA. Other non-rebateable and non-covered OTC ingredients continue to be not covered in all compounds.

Rev. 07/17 Compounded products are covered for members less than 21 years of age when the physician documents that the drug is medically necessary. Common TPN ingredients may be covered for patients over the age of 21. All compounded prescriptions are non-preferred products.

To be considered for reimbursement, each component of the compound must:

- Have a valid and published NDC
- Be a covered benefit
- Be a drug that is manufactured by a company who has a signed rebate agreement for that drug with the Centers for Medicare and Medicaid Services (CMS)

Compounded Prescription Billing

Compounded prescriptions must be submitted electronically using the following guidelines:

- At least one of the components in the compound must be a federal legend drug
- NCPDP Partial Fill functionality is not allowed

Rev. 07/17

Compounded Prescription Prior Approval

- Effective July 17, 2017, compound requests for select compounded ingredients (**in addition** to compounds for omeprazole, lansoprazole and common TPN ingredients) will no longer require a Prior Authorization (PA). Any ingredient utilized outside of the select ingredients will still require a PA. Please review your final claim submission to determine if any ingredients still require PA. Other non-rebateable and non-covered OTC ingredients continue to be not covered in all compounds.
- The prescriber is required to submit a request for Prior Approval using the "Georgia Medicaid Fee-for-Service Multi-Ingredient Compound Drug Prior Authorization Form" via fax to OptumRx at 888-491-9742.

Rev. 04/17

- The compound PA request form requires the prescriber to justify the absence of commercially available products containing the same or similar ingredients to achieve the same therapeutic outcome.

Reimbursement

- Ingredient line item reimbursement will be paid using the methodology detailed in Section 1001.

Submission Clarification Code

- If one or more ingredients submitted in the compound is not covered, the claim will reject. Normal drug coverage edit 7Ø (NDC not covered) will be applied to each line item submitted within the compound, but quantity level limit rules (QLL) will be ignored.
- The provider may decide to accept payment excluding the non-covered ingredient(s). In the Submission Clarification Code (42Ø-DK) field, a value “Ø8” is resubmitted on a rejected compound prescription when the provider decides to accept payment for all other ingredients, except those not covered by the plan.
- A Submission Clarification Code value of “Ø8” will allow a claim to continue processing if at least one ingredient is covered

This billing reference has been created for use in conjunction with the *NCPDP Telecommunication Standard Implementation Guide Version D.Ø*. It should not be considered a replacement for the *NCPDP Telecommunication Standard Version D.Ø Implementation Guide*, but rather used as an additional source of information.

Compound Claim Submissions

- Must submit a minimum of 2 ingredients – single-line compounds are not accepted.
 - The Department does not consider simple admixtures e.g., Vancomycin and Normal Saline a compounded prescription, and they should not be billed using this process.
- A maximum of 25 ingredients are allowed per compound prescription

When submitting a compound claim, use the following Claim and Pricing Segment fields:

Field	Field Name	Description
4Ø6-D6	Compound Code	Submit compound claims using value ‘2’ in this field.
4Ø7-D7	Product/Service ID	Defaults to zero. Enter as “Ø” on the claim segment to identify the claim as a multi-ingredient compound.
436-E1	Product/Service ID Qualifier	Defaults to “ØØ”. The Product/Service ID must contain a value of “Ø” and Product/Service ID Qualifier must contain a value of “ØØ” when used for multi-ingredient compounds.
442-E7	Quantity Dispensed	Enter the quantity of the entire multi-ingredient product.
354-NX	Submission Clarification Code Count	Required if Submission Clarification Code (42Ø-DK) is used.
42Ø-DK	Submission Clarification Code	A value of “Ø8” will allow a claim to continue processing if at least one ingredient is covered.
995-E2	Route of Administration	When used in multiple ingredient processing, this field contains the route of administration of the complete compound mixture.
4Ø9-D9	Ingredient Cost Submitted	Sum of all individual ingredient costs.

The Compound Segment must be submitted on all compound claims which includes the following fields:

Field	Field Name	Description
450-EF	Compound Dosage Form Description Code	The dosage form of the complete compound mixture.
451-EG	Compound Dispensing Unit Form Indicator	The total compound metric decimal quantity expressed as Eaches, Grams, or Milliliters. Describes the units' form of the entire compound, such as 1Ø each, 3Ø grams, or 1ØØØ milliliters.
447-EC	Compound Ingredient Component Count	A count of each ingredient (both active and inactive) in the compound mixture submitted. The Compound Ingredient Counter Number is incremented for each ingredient submitted.
488-RE	Compound Product ID Qualifier	Code qualifying the type of product dispensed. Qualifies 'Compound Product ID' (489-TE).
489-TE	Compound Product ID	Product identification of an ingredient used in a compound. Qualified by 'Compound Product ID Qualifier' (488-RE).
448-ED	Compound Ingredient Quantity	The quantity in metric decimal format of the product included in the compound mixture.
449-EE	Compound Ingredient Drug Cost	The ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in field 448-ED.
490-UE	Compound Ingredient Basis of Cost Determination	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.

Compound Transaction Claim Example

Tetracycline 500mg cap, Nystatin 1000000u/ml Susp, Diphenhydramine 50mg cap

Field	Field Name	Value	Comments
101-A1	BIN Number	ØØ1553	
102-A2	Version/Release Number	DØ	DØ Transaction Format
103-A3	Transaction Code	B1	Rx Billing
104-A4	Processor Control Number	GAM	
109-A9	Transaction Count	1	One occurrence
202-B2	Service Provider ID Qualifier	Ø1	National Provider ID (NPI)
201-B1	Service Provider ID	123456789	
401-D1	Date of Service	20120201	February 1, 2012
110-AK	Software Vendor/Certification ID	ØØØØØØØØØØ	Use value for Switch's requirements. If submitting claim without a Switch, populate with blanks.
111-AM – Segment Identification – Ø1 – Patient Segment			
304-C4	Date of Birth	1997092Ø	September 20, 1997
111-AM – Segment Identification – Ø4 – Insurance Segment			
302-C2	Cardholder ID	123456789Ø12	Enter member's 12 digit ID from Medicaid ID card
111-AM – Segment Identification – Ø7 – Claim Segment			

Field	Field Name	Value	Comments
455-EM	Rx/Service Reference Number Qualifier	1	Rx Billing
402-D2	Rx/Service Reference Number	123456789102	12-digit Rx number
436-E1	Product/Service ID Qualifier	03	NDC
407-D7	Product/Service ID	000000000000	0 Default NDC for Compounds
442-E7	Quantity Dispensed	120000	120.000ml
403-D3	Fill Number	1	First dispensing for Rx
405-D5	Days Supply	3	3-Day Supply
406-D6	Compound Code	2	Compounded Rx
408-D8	DAW/Product Selection Code	0	Substitution allowed
414-DE	Date Prescription Written	20120201	February 1, 2012
354-NX	Submission Clarification Code Count	1	Required if Submission Clarification Code (420-DK) is used.
420-DK	Submission Clarification Code	08	Process covered ingredients
995-E2	Route of Administration	11	Oral
111-AM – Segment Identification – 10 – Compound Segment			
450-EF	Compound Dosage Form Description Code	11	Solution
451-EG	Compound Dispensing Unit Form Indicator	3	Milliliters
447-EC	Compound Ingredient Component Count	03	3 Ingredients
488-RE	Compound Product ID Qualifier	03	NDC
489-TE	Compound Product ID	00591223501	Tetracycline Capsule 500mg
448-ED	Compound Ingredient Quantity	12.00	12 capsules
449-EE	Compound Ingredient Drug Cost	\$1.20	
490-UE	Compound Ingredient Basis of Cost Determination	01	AWP
488-RE	Compound Product ID Qualifier	03	NDC
489-TE	Compound Product ID	00603148158	Nystatin 100000unit/ml Susp
448-ED	Compound Ingredient Quantity	120.000	120.000ml
449-EE	Compound Ingredient	\$8.40	

Field	Field Name	Value	Comments
	Drug Cost		
490-UE	Compound Ingredient Basis of Cost Determination	Ø1	AWP
488-RE	Compound Product ID Qualifier	Ø3	NDC
489-TE	Compound Product ID	ØØ9042Ø5661	Diphenhydramine 5Ømg cap
448-ED	Compound Ingredient Quantity	24.ØØ	24 capsules
449-EE	Compound Ingredient Drug Cost	\$4.6Ø	
490-UE	Compound Ingredient Basis of Cost Determination	Ø2	Local Wholesaler
111-AM – Segment Identification – 11 – Pricing Segment			
409-D9	Ingredient Cost Submitted	\$14.2Ø	Sum of all individual ingredient costs
426-DQ	Usual and Customary Charge	\$28.ØØ	
430-DU	Gross Amount Due	\$18.83	

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TPN Billing

- When billing a TPN, the quantity of any component billed must be consistent with the actual quantity used unless the component is drawn from a single dose container.
- In the event the component utilized is drawn from a single dose container, the package size must be consistent with the smallest commercially available package size from which the dose can be obtained. However, if doses are withdrawn from a single dose container by a closed-system compounding device, the quantity billed should be reflective of the actual quantity utilized or justification for full package size billing must be noted on the prescription.
- All other policy requirements for the billing of compound claims also applies.

IMPORTANT NOTICE

PARTIAL FILL

Effective 10/16/2003, DCH began supporting Partial Fill transactions on point-of-sale claims.

What is a Partial Fill Claim?

Partial Fill claims occur when a pharmacy attempts to fill a script and determines that there is not enough of the drug in stock to provide the entire prescribed quantity/days supply. The Partial Fill functionality accommodates the need to fill a prescription partially on one day and complete the dispensing on a different date.

What unique fields are used in a Partial Fill transaction?

OptumRx will accept a Partial Fill transaction from a pharmacy using NCPDP vDØ to process claims for Medicaid and PeachCare for Kids. The unique fields used in a Transaction Code B1, Billing, Partial Fill transaction:

Partial Fill Field Name	Field Description
Dispensing Status 343-HD	The code in this field indicates that the quantity dispensed is an initial partial fill “P” or the completion of a partial fill “C” .
Associated Prescription/Service Date 456-EP	Date of the initial transaction in a partial fill. Used when submitting the “completion” transaction.
Associated Prescription Service/Reference Number 456-EN	The prescription or service reference number of the initial transaction in a partial fill. Used when submitting the “completion” transaction.
Quantity Intended to be Dispensed 344-HF	The metric decimal quantity that would have been dispensed if adequate inventory were available. This field is used only in association with a “P” or “C” in the Dispensing Status field. NOTE: If populating this field, an assumption is made that the “Days Supply intended to be Dispensed” is also sent.
Days Supply Intended to be Dispensed 345-HG	Days supply for the metric decimal quantity that would have been dispensed if adequate inventory was available. This field is used only in association with a “P” or “C” in the Dispensing Status field.

How will OptumRx edit a Partial Fill transaction?

If you decide to use the Partial Fill transaction, the following information describes how OptumRx will edit that transaction:

- 1) The Intended field information will be edited in order to notify the pharmacy when the intended days supply or quantity would cause the claim to reject if the claim had been submitted as a full claim
- 2) The Actual Days Supply and Quantity will be edited according to the member's benefit
- 3) The Completed Claim will be edited based on balancing exactly to the Intended Days Supply, Quantity, and NDC of the Partial Claim. If these fields do not balance or the NDC does not match, the claim will reject
- 4) The Completed Claim will be edited against the files that existed during the partial fill date of service (e.g. the member was eligible during the partial fill date filled, the member is still eligible). The exception would be if a member is retro-terminated, if the retro-term date encompasses the Partial Fill Claim date of service, the claim will reject
- 5) The Partial and Completed Claim will be counted as one filled script
- 6) The Refill Too Soon and Quantity Level Limit edits will apply to the Partial and Completed Claim since a full claim could be filled between these two transactions
- 7) Ample supply editing will be based on the fill date of the Partial Claim
- 8) A Completed Claim does not need to be submitted in order to fill a subsequent full claim

How will the claim be priced and the member co-pay determined?

- 1) The claim will be priced and a co-pay assigned based on the Intended Days Supply and Quantity
- 2) The claim will be priced based on the final cost calculation of the Intended Quantity
- 3) The Partial and Completed Claim will be prorated based on the Actual Days Supply and Quantity dispensed on each claim
- 4) The member will pay a prorated co-pay based on the actual quantity dispensed
- 5) The pharmacy will receive a prorated dispensing fee based on the actual quantity dispensed for both the partial and completed claim. This was necessary in order to accurately balance the payable amount to the pharmacy and the member co-pay between the two claims

<u>Questions:</u> OptumRx 1-866-525-5826

PHARMACY PROVIDER AGREEMENT INFORMATION

For Pharmacy Provider Agreement requests, contact DXC Technology Provider Relations Dept:

DXC Technology

Provider Services Contact Center

PO Box 105200
Tucker, GA 30085-5200
1-800-766-4456 or 770-325-9600

Pharmacy Additions/Deletions or Address Changes

DXC Technology must be notified, in writing, when a chain or independent requests to add, change, or delete a Pharmacy in the GA Medicaid Network. Only claims from enrolled Pharmacies will be accepted.

Mail to:

DXC Technology
P O Box 105200
Tucker, Georgia 30085-5200

PHARMACY AUDIT INFORMATION

OptumRx maintains an ongoing Pharmacy audit program as a service to our plan Sponsors as well as to assist network Pharmacies in complying with the terms of their Pharmacy Provider Agreement.

For up to five years from the date a prescription is dispensed to a Georgia Medicaid Member, the Pharmacy must permit OptumRx or a third party authorized by OptumRx to inspect, review, audit, and reproduce, during regular business hours and without charge, any business, financial, and prescription record maintained by the Pharmacy pertaining to the member or the Pharmacy Provider Agreement. The Pharmacy must cooperate and participate with OptumRx in any and all quality assurance procedures, peer review, credentialing processes, audit systems, and any complaint resolution procedures established by OptumRx.

DCH AUDIT TIPS

DCH does not seek recovery on any prescription whose days supplied is consistent with the quantity prescribed and/or the quantity remaining on the prescription including all valid refills as long as such days supply does not exceed (30) days and provided through the most appropriate package size. Please review Section 104.2 of Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual. Bulk packages such as but not limited to inhalers, ophthalmics, otics, kits, etc. who due to their packaging cannot be divided or dispensed in an exact quantity to fulfill the prescribed days supply, should be handled as follows:

- If the quantity dispensed is sufficient for less than a (30) day supply, the days supplied on the claim should be consistent with the quantity dispensed and the directions on the prescription +/- 25% of the days such quantity should last.
- If the quantity dispensed provides greater than a (30)-day supply given the directions on the prescription and the most appropriate commercially available package size, the days supply on the claim should be not less that (30) days.
- In each case, DCH will continue to monitor utilization for patterns that may be considered to be fraudulent or inappropriate.
- In each case, DCH will monitor to assure the pharmacy dispenses the product in the commercially available package size that is closest to the quantity needed for the directions on the prescription.

AUDIT TRIGGERS

The OptumRx audit program is supported by continuous in-house analysis of statistical dispensing triggers. These triggers include, but are not limited to:

- Generic, Multi-Source Brand, and Single Source Brand fill rates
- Generic substitution
- Dispense As Written (DAW) code usage
- Average claim amount
- Quantity dispensed versus days supply and FDA guidelines
- Days supply versus quantity dispensed and FDA guidelines
- Usual and Customary retail prices
- Reversals
- Compounding
- Formulary Compliance
- Prescriber Profiling

Other non-statistical audit triggers include, but are not limited to:

- Referral from plan Members
- Referral from plan Sponsors
- Random selection

AUDIT PROGRAMS

NorthStar HealthCare Consulting, (NHC), the sub-contractor for OptumRx, utilizes the following types of audit programs. This list is not intended to be all-inclusive:

- Onsite Audits: The NHC auditor visits the Pharmacy to perform a comprehensive review of claim and quality assurance documentation, procedures, and credentialing.
- Written Desk Audits: Targeted documentation is requested from the Pharmacy and reviewed with in-house Pharmacy dispensing information.
- Next Day Online Desk Audits: Online claims from the previous day are automatically flagged utilizing predetermined criteria and subjected to audit procedures.
- Physician Audits: Targeted Pharmacies, Members and claims are comprehensively verified by the prescribing physician.
- Member Audits: Prescription receipt and specific claim information are substantiated through Member contacts.

On-site audits are normally scheduled with two weeks notice. However, under certain circumstances, less or no advance notice may be given.

If any claim was paid based on incorrectly submitted data, OptumRx will disallow reimbursement for that claim.

AUDIT GUIDELINES

- Quantities Dispensed: Always submit the quantity prescribed, and submit the **exact** calculation of days supply per the Prescriber's dosing instructions. "As directed" or "PRN" Prescriber directions must be clarified with Prescriber or Member. Verifying pharmacist must document and initial the information on the prescription.
- Dispense As Written Codes: Submission of DAW 1 code must be supported by hard copy prescription documentation on the original prescription, the telephone order, or prescription update, and is subject to local regulations. OptumRx will disallow reimbursement for any claim submitted with missing or incorrect DAW Codes.
- Signature Logs: All prescription claims paid by OptumRx are subject to signature log verification. Claims not properly supported by documentation verifying receipt of the medication will be reversed on audit (see example signature log).
- Compliance with Audit Procedures: Failure to comply with any OptumRx quality assurance or audit process will result in reversal of all applicable paid claims and may result in termination of the Pharmacy Provider Agreement.
- Audit Response: Pharmacies are given the opportunity to respond to audit findings within 30 days from receipt of the final audit report. OptumRx at its sole discretion, may consider certain follow-up documentation. Findings regarding missing or incorrect Dispense as Written Codes, days supply or quantity, and Usual and Customary Retail Pricing are not subject to response.
- Only the following will be accepted as documentation to correct audit discrepancies, if applicable for "clerical error" corrections:
 - Submitting the claim under the incorrect physician
 - Non-correctable; the prescription was misfiled
 - Missing date on original or phoned-in prescription
 - Re-written prescription from physician
 - Unsigned Physician's order
 - Re-written prescription from physician
 - On phoned-in prescription that are missing the name of the agent calling it in and/or the hand-written initials of the RPh who took the call
 - Re-written prescription from physician

- Incomplete signature log; meaning if any of the policy required information is missing
 - Signed patient attestation
- Eye Drops: Georgia Medicaid uses the conversion standard of (16 drops/ml) for the purpose of dose calculations.

PROVIDER RELATIONS AUDIT & COMPLIANCE POST AUDIT DISPUTE FORM

PHARMACY NABP #: _____

DATE OF AUDIT: _____

Prescription #(s) Audited _____

OptumRx maintains an ongoing pharmacy compliance and review program. OptumRx is committed to working with you to continuously increase the overall quality of our Provider Networks. You have been the subject of a recent quality assurance audit. If you do not agree with results of the audit, we want you to have the opportunity to present additional information you feel may be relevant to the audit results. Please complete this form, providing your reasoning below for disputing the audit findings, and attach any documentation supporting your stance. Please be sure to include a photocopy of the original prescription(s) hard copy. Please fax this documentation to our secure Audit e-fax server at # 1-877-295-0836, Northstar LLC, Attach additional sheets if necessary.

SIGNATURE LOG REQUIREMENTS

Each Pharmacy must maintain a signature log for all claims in chronological order as prescriptions are received by the Member, including off-site delivery, with the following information:

RETAIL SAMPLE

Name of Patient	Fill Date	Rx Number	Signature of Member (or Legal Representative)	Date Rx is picked up
John Doe	1/2/97	123456	J. Doe	1/3/97

The signature log must be kept for five years from the date a prescription is dispensed.

LONG TERM CARE FACILITIES

When picked up at the LTC facility:

- Patient Name
- Prescription number(s)
- Date(s) of Service
- Member or member's legal representative's signature or representative of the facility
- Date picked up
- Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.

When delivered to a facility:

- Patient Name
- Prescription number(s)
- Date(s) of Service
- Facility delivered to
- Date of delivery
- Name of person who received delivery
- Documentation of administration through a medication administration record or other method is required for members who do not self-administer their medications.

Medication Delivery Report

Sample

Facility: _____

Date Received: _____

Nursing Station: _____

Patient Name	RX Number	Date Filled

Received By: _____

GRIEVANCE REQUEST FORM

Pharmacy _____
NCPDP _____
Audit Number _____

In order to file a grievance, the following must be submitted: a copy of the prescription in question; any and all other supporting documentation that you would like for the committee to review, and an explanation of the rationale for the dispute. Upon review of the documentation, the committee will provide notification of their decision via mail.

Please provide the rationale in the section below, with as much **detail** as possible. Please print clearly (if you need additional space please feel free to provide extra pages). If you prefer, you may attach a typed written report.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

Upon completion of the form, please fax all documentation to (678) 672-4196.
If you have any additional questions please feel free to contact NHC at (678) 672-4206.

Thank you for your cooperation,

Program Compliance Director
NorthStar HealthCare Consulting

COORDINATION OF BENEFITS (COB) BILLING

Effective 6/1/01, Georgia Department of Community Health (GDCH) implemented Coordination of Benefits (COB). In order to implement COB, an online environment was created which allows pharmacy providers to submit claims through the NCPDP v D.Ø compliant Point of Sale (POS) processing system.

In those cases where members have private insurance coverage, the provider must attempt to exhaust all third party benefits prior to submitting a claim to the Department of Community Health. Claims with private insurance must be submitted to Medicaid within twelve (12) months from the date of service. The POS processing system will reject claims when the recipient has primary coverage with another insurance carrier and Medicaid as secondary coverage.

Online Processing Steps

If the recipient has primary coverage other than Medicaid you will receive **Rejection 41 “Submit Bill to Other Processor or Primary”** with the following messages:

Free Form Text Message:

OC: “Primary Carrier Group #”, “Primary Name”, Telephone: XXX-XXX-XXXX

Example: OC: APFG, Principal Financial Group, 800-888-8888

Additional Message:

Questions regarding primary coverage call DXC Technology: 800-766-4456, in Atlanta area 770-325-9600.

Bill the claim to the appropriate primary carrier and then online to GDCH using the following Other Coverage Codes for processing.

Other Coverage Codes:

Value	NCPDP Definition	Practical Use	Medicaid Payment Type
Ø	Not specified by patient	Primary Claim	Primary
1	No other coverage	Primary Claim	Primary
2	Other coverage exists/billed-payment collected	Secondary claim submitted to Medicaid as payment was received from primary payer	Secondary
3	Other Coverage Billed – claim not covered	Primary claim rejected for plan benefit coverage reasons	Primary
4	Other coverage exists-payment not collected	Primary Paid Amount = \$0–member Co-pay reflects 100% of Primary Allowed Amount.	Primary
8	Claim is billing for patient financial responsibility only	Primary claims’ copay charged	Secondary

Tertiary Claims

If multiple primary carriers exist you will receive Rejection 41 with the following messages:

Free Form Text Message:

“Multi-Rx Plans-Ask PT for all Rx Cards”

Additional Message:

Questions regarding primary coverage call DXC Technology: 800-766-4456, in Atlanta area 770-325-9600.

If your system does not allow for tertiary claims processing you may bill GDCH on paper and attach a copy of each EOB or pharmacy screen print/profile reflecting payment or denial.

Common online rejections you will see:

Rejection Code	NCPDP Definition
DV	Missing/invalid other payer amount paid
13	Missing/invalid other coverage code
41	Submit bill to other processor or primary payer

Paper Processing Steps:

Paper processing is allowed if your pharmacy system does not allow for online processing of Medicaid secondary or tertiary claims.

If the carrier returns payment for the claim, the pharmacy provider must include EOB from primary carrier or a pharmacy screen print/profile with primary carrier detail that should include: the primary amount billed, primary amount paid, and recipient amount paid (co-pay/deductible), and remaining amount due that is being billed to GDCH.

If the other carrier denied the claim, attach the denial statement from the other insurance carrier to your claim form for processing.

If no response is received from the insurance carrier, attach the Coordination of Benefits Confirmation Statement to the back of your claim for payment.

Old UCF Fields:

UCF Field	Instructions
Ingredient Cost	Submit lower of MFN or U&C (exclusive of DF)
Dispensing Fee	Submit MFN rate
Tax	Leave blank
Total price	Total of IC, DF, and Tax (above fields)
DED Amount	Submit Other Payer Co-pay Amount with OCC 2
Balance	Submit Net Amount Due from Other Payer “Other Payer Amount”
Other Third Party Coverage	Check no if applicable, if yes, write in the appropriate Other Coverage Code (1-8) rather than check the box.

New UCF Fields:

Non-COB Transaction	
UCF Field	Instructions
Ingredient Cost	Same as online claim amount (exclusive of DF)
Dispensing Fee	Leave blank
Incentive Amount	Leave blank
Other Amount Submitted	Leave blank
Tax	Leave blank
Gross Amount Due	Ingredient Cost Submitted + Dispensing Fee Submitted
Patient Paid Amount	Leave blank
Other Payer Amount Paid	Leave blank
Net Amount Due	Leave blank
Other Coverage Code	Other Coverage Code of Ø or 1 as this is a non-COB transaction

New UCF Fields:

COB Transaction – Primary Insurance Paid a Portion of the Claim	
UCF Field	Instructions
Ingredient Cost	Same as online claim amount (exclusive of DF)
Dispensing Fee	Leave blank
Incentive Amount	Leave blank
Other Amount Submitted	Leave blank
Tax	Leave blank
Gross Amount Due	Ingredient Cost Submitted + Dispensing Fee Submitted
Patient Paid Amount	Leave blank
Other Payer Amount Paid	“Total Amount Paid” from previous payer
Net Amount Due	“Gross Amount Due” – “Other Payer Amount Paid”
Other Coverage Code	Other Coverage Code of 2 – Other coverage exists/billed-payment collected

New UCF Fields:

COB Transaction – Co-Pay Only Billing	
UCF Field	Instructions
Ingredient Cost	Same as online claim amount (exclusive of DF)
Dispensing Fee	Leave blank
Incentive Amount	Leave blank
Other Amount Submitted	Leave blank
Tax	Leave blank
Gross Amount Due	Ingredient Cost Submitted + Dispensing Fee Submitted
Patient Paid Amount	Leave blank
Other Payer Amount Paid	Leave blank
Other Payer-Patient Responsibility Amount	“Patient Pay Amount” from previous payer
Net Amount Due	“Gross Amount Due” – “Other Payer-Patient Responsibility Amount”
Other Coverage Code	Other Coverage Code of 8 – Claim is billing for patient financial responsibility only

Please mail paper claims to:
GME Paper Claims –OptumRx
Attn: Pharmacy Claims Rte# GME-01
PO Box 29044
Hot Springs, AR 71903

COB Billing Tips

Review the Medical Assistance Eligibility Certification for third party carrier information each time service is requested.

Always bill third-party insurance carriers first. Use the information provided online, prior to billing Medicaid. If the member denies having Primary coverage, the member or pharmacy should contact DXC Technology to correct any incorrect information returned in the online message. The pharmacy provider may bill the claim online to OptumRx once the primary carrier information has been updated.

If DXC Technology is not able to correct the primary carrier information within (3) business days, then the pharmacy provider may process the claim using the appropriate Other Coverage Code.

All Pharmacy providers must maintain all records and proof that Medicaid was the payor of last resort. Any claims unable to be validated may be reversed upon audit.

All documentation should be retained for a period of no less than five years for compliance review purposes

The recipient name and third party payments on the EOB should match what is entered on the claim. If dollar amounts do not match, use the COB Confirmation Statement to give a detailed explanation of third party payment.

Do not use a highlighter on claim forms or other documents. All claims are microfilmed, and highlighted areas are darkened and illegible when claim copies are retrieved for review.

Write “**COB**” in bold letters on the attachments.

Enter *only* third party payments in the “Balance” or “Other Payer Amount Paid” block of the claim form.

Bill **Medicare** first for diabetic supplies and any drug products covered by Medicare.

Medicare crossover claims are transmitted to DCH directly from the COBC. Pharmacies who bill Georgia Medicaid for Medicare Part-B Rx drugs must submit claims via X12 837 Professional format or paper. Presently, Georgia Medicaid does not support the NCPDP Version D.0 Batch format for **Crossover Claims**. To submit claims via the X12 837P format, providers must contact DXC Technology-EDI at 877-261-8785.

All paper claims and/or correspondence should be submitted to DXC Technology at the following address:

DXC Technology
P.O. Box 105200
Tucker, GA 30085-5200

Bill only one calendar month of service per claim. Span billing over one calendar month will result in a denied claim.

Please note: If the COBC receives a Medicare Part B pharmacy claim in the NCPDP D.0 format for Georgia Medicaid, they must send it out in the NCPDP D.0 format. Since Georgia Medicaid does not support this format, the claim will not crossover and we will not receive it.

COMMON COORDINATION OF BENEFITS (COB) QUESTIONS

Question #1: When do I file a claim with a third party insurer for a Medicaid recipient?

Answer: A claim must be filed when there is information indicating that the recipient has other 3rd party coverage. The enrolled provider must make reasonable efforts to collect funds from third parties. Reasonable efforts include, but are not limited to:

Requesting the third party ID card from the recipient or asking them to identify any third party benefits.

Filing claim(s) online or via UCF with the appropriate third parties prior to filing with Medicaid.

If all online billing methods have failed, the pharmacy provider must submit claims via UCF that include an EOB from primary carrier or a pharmacy screen print/profile with primary carrier details including primary amount billed, primary amount paid, and recipient amount paid (co-pay/deductible).

Question #2: When we receive payment, how do I bill Medicaid?

Answer: Submit the claim online using Other Coverage Code 2 and indicate the Net Amount Due from the Other Carrier in the Other Payer Amount field or submit the claim via UCF using the before mentioned procedure.

Question #3: If I receive no third party payment, how do I bill Medicaid?

Answer: Answer: Submit the claim online using the appropriate Other Coverage Code (3 and 4) or submit the claim via UCF using the previously mentioned procedure.

Question #4: How long do I have to file my third party claim to Medicaid?

Answer: When eligible members have other insurance coverage, you have up to one (1) year from the date of service to send your claim to OptumRx for payment.

Question #5: How should we bill compounds?

Answer: Bill Compounds online for primary and secondary processing. If the primary carrier is not online, the provider must bill the primary carrier via paper first and then bill Medicaid online or via paper. Compounds are not covered for persons over the age of 21 for the Georgia Medicaid Pharmacy Program. Compounds may be covered for members <21 years old and require prior approval. Common TPN ingredients may be covered for patients over the age of 21. Refer to the Policy Manual for more information regarding the Compound Policy.

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Question #6: What if the primary carrier is not online?

Answer: If the primary carrier is not online, the provider must bill the primary carrier via paper first and then bill Medicaid online or via paper once the primary payer's response is received.

Question #7: What if the pharmacy provider is not in the network for the primary carrier?

Answer: If the provider does not participate in the patient's managed care plan, the provider should direct the recipient to a participating pharmacy.

Question #8: What if my payment from the other carrier meets or exceeds the Medicaid payable amount?

Answer: The online claim will be returned payable with all dollar fields filled with zeros to indicate no payment returned with the message "Other Carrier Payment Meets or Exceeds Payable".

Question #9: What if recipient states they no longer have the other coverage that is listed in the online message?

Answer: Bill the other coverage first, using the information provided online, prior to billing Medicaid. If the recipient denies having Primary coverage the recipient or pharmacy should contact DXC Technology (1-800-766-4456 or 770-325-9600) to correct any incorrect information returned in the online message. The pharmacy provider may bill the claim online to OptumRx once the primary carrier information has been updated.

If DXC Technology is not able to correct the primary carrier information please escalate your inquiry to the OptumRx Technical Call Center at 1-866-525-5826. If the claim rejects from the primary carrier listed in the online message due to the recipient not being eligible, the pharmacy provider may contact DXC Technology (1-800-766-4456 or 770-325-9600) or escalate the inquiry to the OptumRx Technical Call Center at 1-866-525-5826.

Question #10: What if the pharmacy submits a claim to the primary carrier and it pays, but when it is submitted to Medicaid they receive drug not covered rejection or prior authorization required rejection?

Answer: If the claim rejects from Georgia Medicaid for "Drug Not Covered," Georgia Medicaid will not approve the claim and the pharmacy provider should collect the applicable co-pay.

Prior Authorization may be obtained by calling OptumRx. Prior Authorization will be considered pursuant to the policy requirements. If Prior Authorization is denied under Georgia Medicaid policy requirement, the pharmacy provider should collect the applicable co-pay.

Question #11: What if the primary payer allows a 60 day supply but Medicaid only allows a 30 day supply?

Answer: The claim will reject for NCPDP Reject 76 - Plan Limitations Exceeded. The secondary message will state the Max Day Supply that is allowed by Georgia Medicaid is 30. If the member has active Deeming Waiver, NOW, COMP or SSI-Disabled Aid category and primary insurance that covers a 90-day supply, an override may be obtained by contacting the PBM call center to exceed the maximum day supply of 30.

Question #12: Primary carrier is mail order only, does the provider still bill Primary carrier first?

Answer: The present system will not specifically identify a pharmacy plan as “mail order only.” Provider must bill the identified carrier and if claim is denied for that reason, bill Medicaid using OCC3. GDCH will review and verify claims submitted with OCC3 for the denial reasons and if plan is determined to be “Mail order only,” will apply the “pay and chase” methodology as necessary.

Question #13: Will providers be allowed a 2nd dispensing fee on COB claims for the same drug filled previously in the same month?

Answer: The policy will remain as is.

Question #14: If the provider receives “claim too old” from the Primary carrier, can the provider bill Medicaid as primary?

Answer: No.

Question #15: If the provider is not participating in the primary carrier’s network because there is large differential between the Medicaid Allowed Amount and the Primary carrier’s network rate, will the provider be forced to join the network and pass that price on for Most Favored Nations pricing?

Answer: No, providers are not required by Medicaid to participate in any private managed care plan, but may choose to do so. If the provider does not participate in the patient’s managed care plan, the provider should direct the recipient to a participating pharmacy.

Question #16: If the primary claim is returned with 100% co-pay, should the primary claim be reversed?

Answer: No, providers should submit the claim to Medicaid with OCC4. GDCH will review and verify claims submitted with OCC4 and will apply the “pay and chase” methodology as necessary.

SAMPLE BUSINESS CASES

Use Case	1	Title	Flat Copay, Brand Drug, No MAC
Field Name		Value	
Primary Carrier Pricing			
AWP		\$ 100	
U&C		\$ 98	
Submitted		\$ 100	
Primary Allowed/Contracted		\$ 91 (89 + 2)	
Primary Copay		\$ 15	
Primary Net Amt Due		\$ 76	
OptumRx Secondary Pricing			
U&C		\$ 98	
Submitted		\$ 100	
Gross Amount Due		\$ 91	
Medicaid State Rate Maximum		\$ 91 (89 + 2)	
Medicaid Copay		\$ 0.50	
Other Coverage Code		2	
Medicaid Allowed		\$ 91	
Other Payer Amount		\$ 76	
OptumRx Compute			
Ingr. Cost		\$ 15 (91 – 76)	
Dispensing Fee		\$0	
Tax		\$0	
Copay		\$0.50	
OptumRx Total Amt Due		\$14.50 (15 - .50)	
Basis of Reimbursement		09	
Notes			

Use Case	2	Title	Flat Copay, Brand Drug, No MAC
Field Name		Value	
Primary Carrier Pricing			
AWP		\$ 100	
U&C		\$ 98	
Submitted		\$ 100	
Primary Response		REJECTED	
OptumRx Secondary Pricing			
U&C		\$ 98	
Submitted		\$ 100	
Gross Amount Due		\$ 88	
Medicaid State Rate Maximum		\$ 93.63 (89 + 4.63)	
Medicaid Copay		\$ 0.50	
Other Coverage Code		1 or 3	
Medicaid Allowed		\$ 88	
Other Payer Amount		\$ 0	
OptumRx Compute			
Ingr. Cost		\$ 88	
Dispensing Fee		\$0	
Tax		\$0	
Copay		\$0.50	
OptumRx Total Amt Due		\$87.50	
Basis of Reimbursement		09	
Notes			

Use Case	3	Title	Flat Copay, MAC Drug
Field Name		Value	
Primary Carrier Pricing			
AWP		\$ 100	
U&C		\$ 98	
Submitted		\$ 100	
Primary Allowed/Contracted		\$ 91 (89 + 2)	
Primary Copay		\$ 15	
Primary Net Amt Due		\$ 76	
OptumRx Secondary Pricing			
U&C		\$ 98	
Submitted		\$ 100	
Gross Amount Due		\$ 91	
Medicaid State Rate Maximum		\$ 54.63 (50 + 4.63)	
Medicaid Copay		\$ 0.50	
Other Coverage Code		2	
Medicaid Allowed		\$ 54.63 (MAC)	
Other Payer Amount		\$ 76	
OptumRx Compute			
Ingr. Cost		\$ 0	
Dispensing Fee		\$0	
Tax		\$0	
Copay		\$0	
OptumRx Total Amt Due		\$0	
Basis of Reimbursement		09	
Payable Message		Other Carrier Payment Meets or Exceeds Payable	
Notes		Primary Paid Amount meets or exceeds the Medicaid Allowed so all cost fields will be returned with \$0 payable and the payable message Other Carrier Payment Meets or Exceeds Payable.	

When reversing secondary claims:

- Please submit the Other Coverage Code (3Ø8-C8) value used on the original online COB claim submission when reversing secondary claims.
- Omission of the Other Coverage Code will cause the primary COB claim to be reversed. You must submit the applicable Other Coverage Code value if you desire to reverse the secondary COB claim. These OCC valid values are 1 through 8 as listed below.
- For your reference, please review NCPDP's Data Dictionary field guide regarding the Other Coverage Code values that OptumRx supports:

Field	Name of Field	Values and Definitions of Field Codes indicating whether or not the patient has other insurance coverage	Medicaid Payment Type
3Ø8-C8	Other Coverage Code	Ø = Not specified by patient	Primary
3Ø8-C8	Other Coverage Code	1 = No other coverage	Primary
3Ø8-C8	Other Coverage Code	2 = Other coverage exists/billed-payment collected	Secondary
3Ø8-C8	Other Coverage Code	3 = Other Coverage Billed – claim not covered	Primary
3Ø8-C8	Other Coverage Code	4 = Other coverage exists-payment not collected	Primary
3Ø8-C8	Other Coverage Code	8 = Claim is billing for patient financial responsibility only	Secondary



IMPORTANT NOTICE

ONLINE COORDINATION OF BENEFITS (COB)

Georgia Department of Community Health

- Effective immediately for providers submitting NCPDP Version D.0 claims, please submit the Other Coverage Code (308-C8) value used on the original online COB claim submission when reversing secondary claims.
- Omission of the Other Coverage Code will cause the primary COB claim to be reversed. You must submit the applicable Other Coverage Code value if you desire to reverse the secondary COB claim. These OCC valid values are 1 through 8 as listed below.
- For your reference, please review NCPDP's Data Dictionary field guide regarding the Other Coverage Code values that OptumRx supports:

Field	Name of Field	Values and Definitions of Field Codes indicating whether or not the patient has other insurance coverage	Medicaid Payment Type
308-C8	Other Coverage Code	Ø = Not specified by patient	Primary
308-C8	Other Coverage Code	1 = No other coverage	Primary
308-C8	Other Coverage Code	2 = Other coverage exists/billed-payment collected	Secondary
308-C8	Other Coverage Code	3 = Other Coverage Billed – claim not covered	Primary
308-C8	Other Coverage Code	4 = Other coverage exists-payment not collected	Primary
308-C8	Other Coverage Code	8 = Claim is billing for patient financial responsibility only	Secondary

Please remember this communication applies only to NCPDP Version D.0 claims.



**Proton Pump Inhibitor Prior Authorization Form
Fee-for-Service Medicaid/PeachCare for Kids**

PHONE #: 866-525-5827

FAX #: 888-491-9742

Note: If the Following Information is NOT filled in completely, correctly, or legibly the PA process can be delayed. **(One form per member please)**

MEMBER Last Name 	MEMBER First Name
MEMBER ID number 	MEMBER Date of Birth
PRESCRIBER Last Name 	PRESCRIBER First Name
PRESCRIBER NPI# 	
PRESCRIBER Phone 	PRESCRIBER Fax
PRESCRIBER Address 	

Medication Requested _____ Strength _____

Directions _____ Dosage Form _____

Duration of Therapy Requested _____ Compound Y N G-tube Y N

Diagnosis/Indication – Please do not include documentation that is not requested on this form.

Please circle which diagnosis/indication that applies to member:

- a. Barrett's Esophagus
- b. Peptic Ulcer Disease (PUD)/ Duodenal ulcer/ Gastric ulcer
- c. Erosive Esophagitis
- d. Gastroesophageal reflux disease (GERD) without complications
- e. GERD with complications- please specify: _____
- f. H. Pylori
- g. Zollinger Ellison (ZE) Syndrome
- h. Pancreatitis
- i. Cerebral Palsy
- j. Cancer
- k. Crohn's Disease
- l. Cystic Fibrosis
- m. Multiple endocrine adenomas
- n. Systemic mastocytosis
- o. Patient was recently discharged from the hospital (within the last 60 days) for an upper GI bleed, hemorrhage, perforation, or obstruction and was already started on PPI therapy in the hospital
- p. Gastric Bypass Surgery
- q. Premature infant with GERD and feeding difficulties

Please specify other diagnosis/complicated disease state:

H2 receptor antagonist use history:

Drug _____ **Strength** _____ **Directions** _____

Dates used: from _____ **to** _____ **Failed due to:** _____

Drug _____ **Strength** _____ **Directions** _____

Dates used: from _____ **to** _____ **Failed due to:** _____

Physician Signature: _____

Contact Person _____

OptumRx will provide a response within 1 business day upon receipt.

This facsimile transmission contains legally privileged and confidential information intended for the parties identified below. If you have received this transmission in error, please immediately notify us by telephone and return the original message to P.O. Box 3214; Lisle, IL 60532-8214. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

revised 9/3/2015



**Non-Preferred Statin Request Form
Fee-for-Service Medicaid/PeachCare for Kids**

FAX: 1-888-491-9742
PHONE: 1-866-525-5827

TODAY'S DATE: _____

Note: If the following information is NOT filled in completely, correctly, and/or legibly the appeal process will be delayed. **(One form per Member please)**

MEMEBER Last Name												MEMBER First Name											
MEMBER ID number												MEMBER Date of Birth											
PRESCRIBER Last Name												PRESCRIBER First Name											
PRESCRIBER NPI#																							
PRESCRIBER Phone												PRESCRIBER Fax											
PRESCRIBER Address																							

Medication Requested: _____ Strength _____ Directions --

A COPY OF THE MEMBER'S LIPID PANELS MUST BE INCLUDED WHEN SUBMITTING
(both Pre-Treatment LDL Value/Date and Current LDL Value/Date are required to complete the review)

Diagnoses	Yes	No	Unknown
Coronary Heart Disease (CHD)			
Diabetes Mellitus			
Carotid Artery Disease			
Peripheral Arterial Disease			
Abdominal Aortic Aneurysm			
Previous Coronary Event (Myocardial Infarction, Angina, Arrhythmia)			
Risk Factors	Yes	No	Unknown
Age: M >45yrs, F >55yrs			
Hypertension (≥130/≥85 mmHg or on HTN medication)			
HDL cholesterol: M <40 mg/dL, F <50 mg/dL			
Family history of premature CHD in first degree relative: M <55yrs, F <65yrs			
Cigarette smoking			
Metabolic Syndrome	Yes	No	Unknown

*****EFFECTIVE JANUARY 1, 2006 ALL MEDICARE B DRUGS FOR MEDICARE B OR MEDICARE D ELIGIBLE MEMBERS MUST BE SUBMITTED TO EITHER MEDICARE, A MEDICARE PDP, OR A MEDICARE ADVANTAGE PLAN. CLAIMS SUBMITTED TO MEDICAID FOR A MEDICARE PART B DRUG OR SUPPLY WILL DENY FOR THESE MEMBERS. THE DENIAL CANNOT BE OVERRIDEN WITH AN ‘OTHER COVERAGE**

Tips for Medicare Billing:

Claims submitted to OptumRx for the drugs listed above will be denied for dually eligible members. You will receive the standard NCPDP error message #41, **“Submit Bill to Other Processor,”** followed by **“Submit to Medicare.”**

Bill Medicare electronically using Point of Sale software or by paper using the CMS 1500 available at **www.medicare.gov**. Complete billing codes and coverage criteria can be found at **www.palmettogba.com**. DCH encourages providers to access this site.

Once the Medicare claim has been processed, Medicare will automatically submit the balance of your claim as a “crossover” to DXC Technology electronically. DXC Technology will pay the coinsurance and/or deductible as allowed by Medicare. The provider should only collect the usual Medicaid copay where applicable.

You will receive a Medicare remittance notice from Medicare indicating one of the three following codes for your claim status:

- “A” code means that the claim was accepted for processing but either a payment or denial will be forthcoming.
- “R” code means that more information or additional paperwork is needed to complete processing of the claim.
- “D” code means that the claim was processed but denied.

Please see the attached flow chart on G-74 for further explanation of the crossover claim from Medicare to Medicaid.

To order copies of the CMS 1500 claim form, send your request in writing, including your provider number, the return address for the forms to be sent, and the quantity needed to DXC Technology via fax at 866-483-1044 or via mail to:

DXC Technology
P.O. Box 105200
Tucker, Georgia 30085-5200

For information on Medicare billing workshops, visit **www.palmettogba.com**. Click on provider, DME, Publication & Information, and then Advisory.

For the Palmetto GBA **Helpdesk**, call **1-866-238-9650**.

Directions on How to Obtain Medicare Enrollment Materials:

Via the Internet:

www.palmettogba.com/registration.nsf

Click on National Supplier Clearinghouse

Select option: publication & information

Select HCFA Form 855 DME POS

Via mail or phone:

National Supplier Clearinghouse

P.O. Box 100142

Provider Enrollment

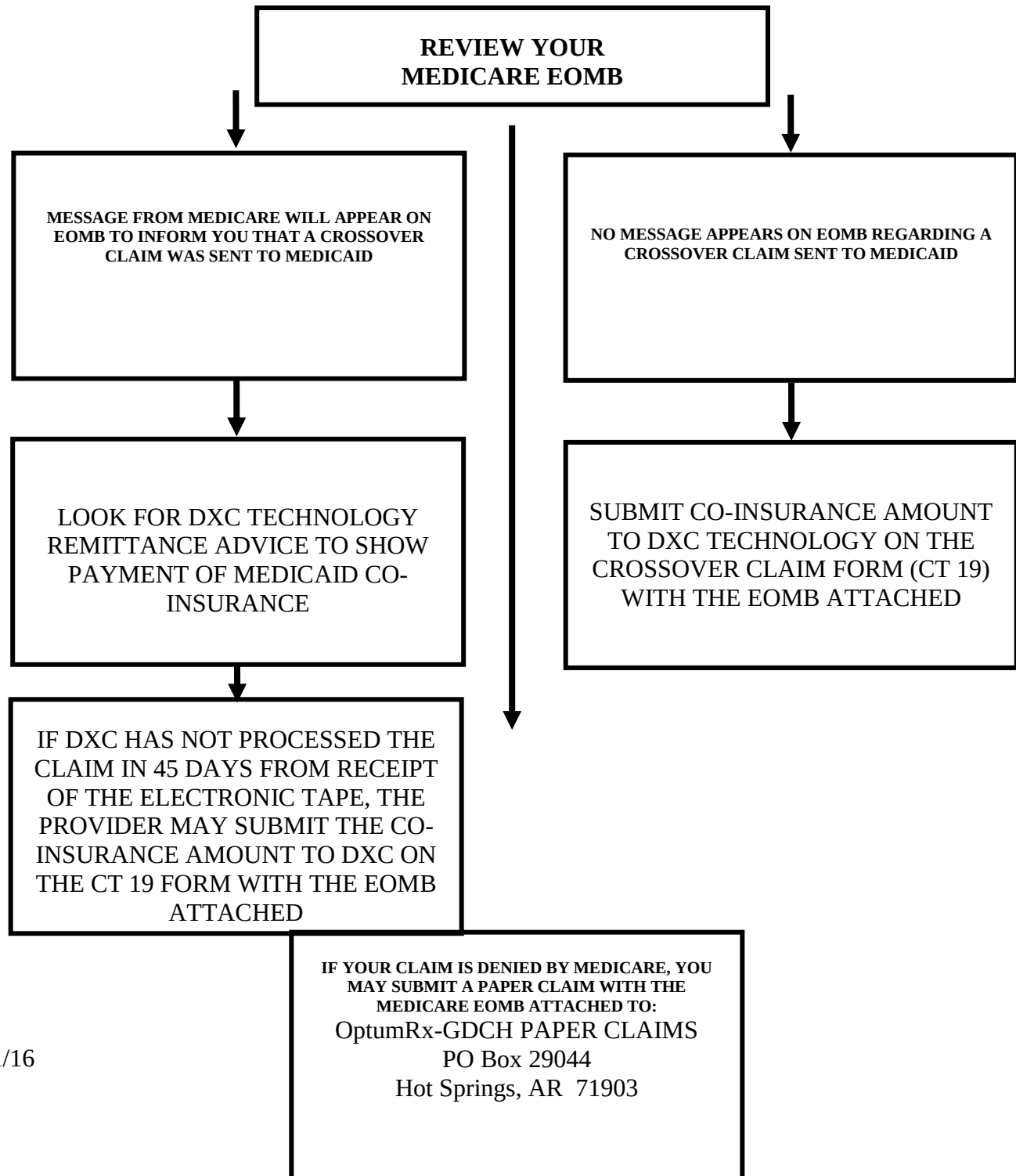
Columbia, SC 29202-3142

1-866-238-9652, press “0”, ask for Medicare Part B Provider Application

Options for Obtaining Medicare Billing Software Include:

1. Contact your software vendor to see if specific Medicare software is available
2. Contact Palmetto GBA to inquire about their software available at 1-866-749-4301
3. Visit www.palmettogba.com. Click on Other Medicare Partners. Click on EDI.

NOTE:
Medicare policy states that enrolled providers must bill Medicare for all covered drugs or supplies for eligible members. It should be noted that Medicare policy supersedes DCH requirements.



Rev. 01/16



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



Georgia Watch Form

Fee-for-Service Medicaid & PeachCare for
Kids

Prior Authorization
Claims Processing
Phone: (866) 525-5827
P.O. Box 25183
Santa Ana, CA 92799

FAX TO: 888-491-9742

Today's Date _____

Note: All of the following requests for information must be answered completely, correctly, and legibly, otherwise the authorization process will be delayed.

First, Middle, Last

Member Full Name _____

Member ID# _____ Member DOB ____ / ____ / ____

Medication Requested _____ Strength _____ Dosage Form _____

Quantity _____ Directions _____

Generic products tried? (Circle one) NO or YES *If yes, list the names of the manufacturers of generic products tried.*

1. _____ 2. _____ 3. _____

What was the patient's response to each generic product? (A response description **MUST** be given.)

Product Name

Response

1. ☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other

Response description:

2. ☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other

Response description:

3. ☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other

Response description:

Please print legibly

Physician's Name _____

Physician's Signature _____

Required

NPI # _____

Physician Address _____

Physician Phone _____ Physician Fax _____

Medical Office Contact _____ Signature _____

Any additional information pertaining to this drug request should be included and attached to this form.

The documentation accompanying this facsimile may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are notified that any disclosure, copying, distribution or action taken in reference to the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Confidential

UNIVERSAL CLAIM FORMS

Copyright © by NCPDP 1977, 1979, 1980, 1981, 1982, 2000
NCPDP UNIVERSAL CLAIM FORM (UCF)

CARDHOLDER
I.D. _____ **GROUP**
I.D. _____

CARDHOLDER
NAME L/F/M **PLAN**
NAME _____

PATIENT
NAME L/F/M **OTHER**
COVERAGE CODE (1) _____ **PERSON**
CODE (2) _____

PATIENT
DATE OF BIRTH MM DD CCYY **PATIENT (3)**
GENDER CODE _____ **PATIENT (4)**
RELATIONSHIP CODE _____

PHARMACY
NAME _____ **QUAL (5)**

ADDRESS _____ **SERVICE**
PROVIDER I.D. _____

CITY _____ **PHONE NO.** ()

STATE & ZIP CODE _____ **FAX NO.** ()

WORKERS COMP. INFORMATION
EMPLOYER
NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CARRIER
I.D. (6) _____ **EMPLOYER**
PHONE NO. _____

DATE OF
INJURY MM DD CCYY **CLAIM (7)**
REFERENCE I.D. _____

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN	DATE OF SERVICE	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
		MM DD CCYY	MM DD CCYY			

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE
MM DD CCYY				

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN	DATE OF SERVICE	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
		MM DD CCYY	MM DD CCYY			

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE
MM DD CCYY				

FOR OFFICE USE ONLY

**ATTENTION RECIPIENT
PLEASE READ
CERTIFICATION
STATEMENT ON
REVERSE SIDE**

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES

Rev. 04/12

Universal Claim Forms can be obtained by contacting Moore North American at 1-800-635-9500. UCF version named (DAH 2 pt.) meets NCPDP vD.0 requirements and is preferred for Georgia Medicaid Pharmacy claim submissions.

(BACK)

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnostic code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/FPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

- | | | |
|--|--|---|
| 0=Not Specified | 1=No other coverage identified | 2=Other coverage exists-payment collected |
| 3=Other coverage exists-this claim not covered | 4=Other coverage exists-payment not collected | 5=Managed care plan denial |
| 6=Other coverage denied-not a participating provider | 7=Other coverage exists-not in effect at time of service | 8=Claim is billing for a copy |

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

- 0=Not Specified 1=Male 2=Female
- 4. PATIENT RELATIONSHIP CODE**
- 0=Not Specified 1=Cardholder 2=Spouse
3=Child 4=Other

4. PATIENT RELATIONSHIP CODE

- 0=Not Specified 1=Cardholder 2=Spouse
3=Child 4=Other

5. SERVICE PROVIDER ID QUALIFIER

- | | | |
|--|-------------------|--|
| 03-Service Provider ID Qualifier | | |
| 01-National Provider Identifier (NPI) | 02-Blue Cross | |
| 04-Medicare | 05-Medicaid | |
| 07-NCPPDP Provider ID | 08-State License | |
| 10-Health Industry Number (HIN) | 11-Federal Tax ID | |
| 13-State Issued | 14-Plan Specific | |
| Blank/Not Specified | | |
| 03-Blue Shield | | |
| 06-UPIN | | |
| 09-Champus | | |
| 12-Drug Enforcement Administration (DEA) | | |
| 98-Other | | |

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

- Blank=Not Specified 1=Rx billing 2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

- | | | |
|---|--|---|
| 00=Blank/Not Specified | 00=Not Specified | 01=Universal Product Code (UPC) |
| 02=Health Related Item (HRI) | 03=National Drug Code (NDC) | 04=Universal Product Number (UPN) |
| 05=Department of Defense (DOD) | 06=Drug Use Review/Professional Pharm. Service (DUR/PPS) | 07=Common Procedure Terminology (CPT4) |
| 08=Common Procedure Terminology (CPTS) | 09=HCFA Common Procedure Coding System (HCPCS) | 10=Pharmacy Practice Activity Classification (PPAC) |
| 11=National Pharmaceutical Product Interface Code (NAPPI) | 12=International Article Numbering System (EAN) | 13=Drug Identification Number (DIN) |
| 99=Other | | |

11. PRIOR AUTHORIZATION TYPE CODE

- | | | |
|--|--|----------------------------|
| 0=Not Specified | 1=Prior authorization | 2=Medical Certification |
| 3=EPSTD (Early Periodic Screening Diagnosis Treatment) | 4=Exemption from copay | 5=Exemption from Rx limits |
| 6=Family Planning Indicator | 7=Aid to Families with Dependent Children (AFDC) | 8=Payer Defined Exemption |

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. **DUR/PROFESSIONAL SERVICE CODES:** Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

14. BASIS OF COST DETERMINATION

- | | | |
|---------------------|---------------------------------|-------------------------------------|
| Blank=Not Specified | 00=Not Specified | 01=AWP (Average Wholesale Price) |
| 02=Local Wholesaler | 03=Direct | 04=EAC (Estimated Acquisition Cost) |
| 05=Acquisition | 06=MAC (Maximum Allowable Cost) | 07=Usual & Customary |

15. PROVIDER ID QUALIFIER

- | | |
|--|---------------------------------------|
| 01=Drug Enforcement Administration (DEA) | 02=State License |
| 03=Social Security Number (SSN) | 04=Name |
| 06=Health Industry Number (HIN) | 05=National Provider Identifier (NPI) |
| | 99=Other |

16. DIAGNOSIS CODE QUALIFIER

- | | | |
|---|--|--|
| Blank=Not Specified | 00=Not Specified | 01=International Classification of Diseases (ICD9) |
| 02=International Classification of Diseases (ICD10) | 03=National Criteria Care Institute (NDCC) | 04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED) |
| 05=Common Dental Term (CDT) | 06=Medi-Span Diagnosis Code | 07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) |

17. OTHER PAYER ID QUALIFIER

- | | | |
|----------------------------------|---|---------------------------------|
| Blank=Not Specified | 01=National Payer ID | 02=Health Industry Number (HIN) |
| 03=Bank Information Number (BIN) | 04=National Association of Insurance Commissioners (NAIC) | 09=Coupon |
| 99=Other | | |

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM

[illegible]

**COMPLETION OF THE NCPDP PHARMACY PROVIDER UCF
(UNIVERSAL CLAIM FORM)
Version (DAH 2pt.) preferred**

(Items not required by Georgia DMA are not included in these instructions)

Rev. 10/15

Once forms are completed, please mail them to:

OptumRx-GDCH Paper Claims

PO Box 29044

Hot Springs, AR 71903

This section provides specific instructions for completing the NCPDP-UCF form. A sample invoice is included for your reference.

Item 1 Pharmacy Provider Information

Pharmacy/Provider Name

Pharmacy/Provider NCPDP# or Medicaid Provider# or NPI # (must use qualifier when using NPI)

Item 2 Date of Service

The following information must be included:

- Date of Service (including month, date and year)

Item 3 Recipient

The following information must be included:

- Recipient ID#
- Recipient DOB
- Recipient Name

Item 4 Prescriber Information

The following information must be included:

- NPI number

Item 5 (COB)

The following information must be included:

- Indicate “YES” if the recipient has insurance other than Medicaid

Item 6 Prescription Number

The following information must be included:

- Enter the prescription number, not to exceed seven digits, assigned by the pharmacy to identify individual prescriptions

Item 7 National Drug Code

The following information must be included:

- This field must contain eleven characters consisting of labeler, product and package size.

Item 8 Quantity

The following information must be included:

- Enter the metric quantity of the drug dispensed.

Item 9 Charges

The following information must be included:

- Ingredient cost
- Dispensing fee
- Total price
- Deductible or copay amount
- Balance due

Item 10 Prior Authorization

The following information must be included:

- Enter any clinical authorization numbers or automated override codes that might apply to the prescription (enter them anywhere on the form). For example, 11111, 22222, 99888, 987987987.

Item 11 Provider's Pharmacist's Signature

The following information must be included:

- Provider or Pharmacist's signature

REFUND ADJUSTMENTS AND REVERSALS

Reversing a Paid Claim (Pharmacy Initiated)

If a provider experiences an inaccurate claim payment, a reversal and resubmission may be processed online to OptumRx. Reversals of paid claims must occur within ninety (90) days of claim pay date. If the provider has questions or needs assistance with a reversal, please contact the OptumRx Pharmacy Help Desk at 866-525-5826.

Reversals may also be required in the event certain changes are made retroactive. At that time, the Department will send a communication requesting that providers reverse and resubmit their claims.

Remittance Advice

An Adjustment Request is processed by OptumRx and may result in an increase or decrease of payment. The adjustment appears as either a positive or negative amount above the summary section of the Remittance Advice.

If the adjustment is a Positive amount, it will be indicated below the last processed claim on the Remittance Advice. This amount will increase the payment to the Pharmacy.

If the adjustment is a Negative amount, it will be indicated below the last processed claim on the Remittance Advice. The amount will reduce the amount of payment. If the Negative Adjustment is more than the total processed paid claims, this will result in a credit to the Pharmacy. This credit will be applied against future processed paid claims through OptumRx.

Filing Limitation

Claim Reversal requests must be received within three (3) months from the first day of the month following the month in which the claim to be reversed was paid. The payment month is reflected in the date located in the top right hand corner of the Remittance Advice page.

Adjustment of Inaccurate Medicare/Medicaid Payments

To appeal the amount paid for services to Medicaid/Medicare members, notify the appropriate Medicare Fiscal Intermediary of your appeal. (Any additional payments is through both Medicare and Medicaid). If the payments are made to an incorrect provider or are above the amount due, return the erroneous checks or issue refunds to Medicare and to Medicaid for their respective shares. Any erroneous Medicaid payments or refunds due the DCH must be forwarded to the following address

Table 10.2 Addresses for all Erroneous Medicaid Payments or Refunds

Provider	Hospital
Bank of America Lock Box 277941 Atlanta, GA 30384	Bank of America Lock Box 406867 Atlanta, GA 30384

Atypical Antipsychotic Prior Authorization Request Form
Fee-for-Service Medicaid/PeachCare for Kids
PHONE #: 866-525-5827
FAX #: 888-491-9742

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed. **Please complete one form per member.**

MEMBER Last Name 	MEMBER First Name
MEMBER ID number 	MEMBER Date of Birth
PRESCRIBER Last Name 	PRESCRIBER First Name
PRESCRIBER NPI# 	
PRESCRIBER Phone 	PRESCRIBER Fax
PRESCRIBER Address 	

Medication(s) Requested: _____ **Strength:** _____ **Directions:** _____

_____ **Strength:** _____ **Directions:** _____

Is this a tapering off dose for discontinuation? ☐ Yes ☐ No **Dosage Form:** _____
Compound ☐ Yes ☐ No

What is the member's diagnosis? ☐ Depressive Episodes of Bipolar Disorder ☐ Mixed or Manic Episodes of Bipolar Disorder ☐ Schizophrenia/Schizoaffective Disorder ☐ Suicidal Behavior associated with Schizophrenia/Schizoaffective Disorder ☐ Treatment-Resistant Schizophrenia/Schizoaffective Disorder
☐ Pervasive Developmental Disorder (PDD)/Autism/Irritability associated with Autism/PDD ☐ Major Depressive Disorder ☐ Treatment-Resistant Major Depressive Disorder ☐ Major Depressive Disorder with Psychosis ☐ Chronic Aggression ☐ Oppositional Defiant Disorder
☐ Tourette's Syndrome ☐ Tics
☐ Other (specify): _____

Is the member being referred to a psychiatrist and awaiting an appointment? ☐ Yes ☐ No
Date of appointment: _____
Psychiatrist: _____

What is the member's age in years? ☐ ≥18 ☐ 10-17 ☐ 6-9 ☐ 5 ☐ <5

Is there a monitoring plan/will the member be monitored for evaluating safety and effectiveness of the medication? ☐ Yes ☐ No

If the member is younger than FDA-approved age for medication(s) requested, please complete Section E (page 3).

Medication Generic Name (Brand Name)	Under FDA-Approved Age
Aripiprazole (Abilify/Abilify Discmelt)	<6 years of age for autism/PDD irritability; <10 years of age for bipolar; <13 years of age for schizophrenia; <18 years of age for MDD

Aripiprazole long-acting injection (Abilify Maintena)	<18 years of age
Clozapine (Clozaril, FazaClo, Versacloz)	<18 years of age
Iloperidone (Fanapt)	<18 years of age
Ziprasidone (Geodon)	<18 years of age
Paliperidone (Invega)	<12 years of age
Paliperidone long-acting injection (Invega Sustenna)	<18 years of age
Lurasidone (Latuda)	<18 years of age
Risperidone (Risperdal/Risperdal M-Tab)	<5 years of age for autism/PDD irritability; <10 years of age for other diagnoses
Risperidone long-acting injection (Risperdal Consta)	<18 years of age
Asenapine (Saphris)	<18 years of age
Quetiapine immediate-release (Seroquel)	<10 years of age
Quetiapine extended-release (Seroquel XR)	<18 years of age for MDD; <13 years for schizophrenia; <10 years for bipolar
Olanzapine/fluoxetine (Symbyax)	<18 years of age
Olanzapine (Zyprexa/Zyprexa Zydis)	<13 years of age
Olanzapine long-acting injection (Zyprexa Relprevv)	<18 years of age

NOTE: Section A or B must be completed.

C H E C K O N E A O R B	☐ A. The member has been established on the requested medication	
	1. How long has the member been taking the requested medication? ☐ <2 weeks ☐ ≥2 weeks	
	2. Has the member shown improvement in symptoms while on the requested medication?	
	☐ Yes ☐ No	
	If yes, please check one or more boxes below for areas of improvement:	
	☐ delusions	☐ excitement
	☐ grandiosity	☐ hostility
	☐ suspiciousness/persecution	☐ blunted affect
	☐ passive/apathetic social withdrawal	☐ poor rapport
	☐ difficulty in abstract thinking	☐ lack of spontaneity and flow of conversation
☐ stereotyped thinking	☐ suicidal thoughts	
☐ other _____	☐ depressive symptoms	
☐ B. The member has never taken the requested medication		
1. Which preferred medication(s) has the member tried? (check all that apply)		
☐ Abilify Dates: _____ ☐ Latuda Dates: _____ ☐ Olanzapine Dates: _____		
☐ Risperidone Dates: _____ ☐ Quetiapine IR Dates: _____ ☐ Ziprasidone Dates: _____		
☐ Olanzapine/Fluoxetine Dates: _____ ☐ None		
2. Reason preferred agents are not appropriate for this member. (complete for each applicable drug in the following table)		

Drug	Reason inappropriate choice for member
Abilify	
Latuda	
Olanzapine	
Olanzapine/Fluoxetine	
Risperidone	
Quetiapine IR	
Ziprasidone	

3. For Abilify, Seroquel XR, Symbyax (for major depressive disorder only): Reason antidepressant monotherapy is not adequate for this member. (complete for each drug/class in the following table)

Drug	List medication name, response, and dates of therapy
SNRIs (desvenlafaxine [Pristiq], duloxetine [Cymbalta], venlafaxine [Effexor/XR])	
SSRIs (citalopram [Celexa], escitalopram [Lexapro], fluvoxamine [Luvox], fluoxetine [Prozac], paroxetine [Paxil], or sertraline [Zoloft])	
Other Antidepressants (bupropion, mirtazapine, trazodone; list may not be all inclusive)	

☐ **C. An orally disintegrating dosage formulation or non-preferred solution is being requested.**

1. What prevents the member from taking the regular oral dosage form?

☐ Dysphagia ☐ Compliance monitoring required

☐ Other (specify): _____

☐ **D. Abilify Maintena, Risperdal Consta, Invega Sustenna, or Zyprexa Relprevv is being requested.**

1. Has the member tried oral Abilify (if Abilify Maintena is being requested), oral risperidone or oral Invega (if Risperdal Consta is being requested), oral Invega, oral risperidone, or Risperdal Consta (if Invega Sustenna is being requested), or oral Zyprexa (if Zyprexa Relprevv is being requested) or does the member have a history of noncompliance with oral medications and is unable to receive a trial of the appropriate oral atypical antipsychotic before starting long-acting therapy with injection or is the member unable to swallow or use orally disintegrating tablets?

☐ Yes Date of last therapy: _____ ☐ No

2. Is the prescribing physician a psychiatrist or has a psychiatrist been consulted?

☐ Yes ☐ No

3. Where will the medication be administered?

☐ Home health or other outpatient pharmacy setting by a trained health care professional

☐ Long-term care facility

☐ CSB (Community Service Board health center)

☐ Physician's office or clinic**

☐ Other (specify): _____

** If you are requesting for authorization for administration in a physician's office or clinic other than a CSB, please go to the Registered User portion of the Georgia Health Partnership website at www.mmis.georgia.gov/portal to request a PA from Physician

Section E: In the space below, please provide letter of medical necessity and any additional information you deem clinically relevant in evaluating the prior authorization request.

Physician Signature: _____

Contact Person: _____ **Phone:** _____

OptumRx Sample Remittance Advice

4 → Payer JREUSXC SYC TEST PAYOR

Payee 1443073 MEDICINE SHOPPE PHAR 0408 **5**

1 → Pharmacy: 1443073 **2** MEDICINE SHOPPE PHARMACIES
8907 W BURLINGTON AVE
BROOKFIELD, IL 60513 2034

7 → Rx Nbr Refill Member ID

0430014	01	SXC0003
0430015	01	SXC0003
0430016	01	SXC0004
0430017	01	SXC0004
0430018	01	SXC0004
0430019	01	SXC0004
0430020	01	SXC0005

8 → Pharmacy Total Claims Paid: 7

9 → Claims Reversed: 0

 Total Count: 7

19 **20** **21**

6 → Check Number 40002 1/17/02

Batch Number 2200 1/17/02 **3** Report 1/16/02

Submitted		Approved						
Filled	Usual/Cost	Sub Cost	App Cost	Fee	Tax	Incentive	Pat Paid	Amount Paid
1/04/2002	\$100.00	\$100.00	\$182.80	\$0.00	\$0.00	\$0.00	\$0.15	\$182.6
1/04/2002	\$100.00	\$100.00	\$254.60	\$0.00	\$0.00	\$0.00	\$0.15	\$254.4
1/04/2002	\$100.00	\$100.00	\$254.60	\$0.00	\$0.00	\$0.00	\$0.15	\$254.4
1/04/2002	\$100.00	\$100.00	\$254.60	\$0.00	\$0.00	\$0.00	\$0.15	\$254.4
1/04/2002	\$100.00	\$100.00	\$254.60	\$0.00	\$0.00	\$0.00	\$0.15	\$254.4
1/04/2002	\$100.00	\$100.00	\$141.33	\$0.00	\$0.00	\$0.00	\$0.15	\$141.1
1/04/2002	\$100.00	\$100.00						
7	\$700.00	\$700.00	\$1,483.86	\$0.00	\$0.00	\$0.00	\$1.05	\$1,482.8
0	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.0
7	\$700.00	\$700.00	\$1,483.86	\$0.00	\$0.00	\$0.00	\$1.05	\$1,482.8

12 **13** **14** **15** **16** **17** **18**

10 **11**

22

Remittance Advice Legend			
1 Pharmacy Number	7 Rx Number	13 Approved Cost	19 Paid Claim Count
2 Pharmacy Name, Address	8 Refill Code	14 Dispense Fee	20 Reversed Claim Count
3 Remittance Advice Date	9 Member ID	15 State Tax	21 Total Claim Count
4 Payer	10 Fill Date	16 Incentive Fee	22 Total Amount Due
5 Payee	11 U&C Amount	17 Copay Amount	
6 Check Number	12 Submitted Cost	18 Amount Due Pharmacy	



Important Update- Banner Notification

12/04/2006

Effective January 1, 2007, OptumRx (formally SXC Health Solutions, Inc.) will become the pharmacy benefits manager for the GA Medicaid Fee-For-Service (FFS) Outpatient Pharmacy Program. In this role, OptumRx will be responsible for providing services to the FFS Outpatient Pharmacy Program that are currently provided by Express Scripts, Inc. DCH is working with both companies to ensure a seamless transition of services to your pharmacy.

The following BIN and PCN combination are required to successfully transmit claims effective January 1, 2007. No group number will be required for the transmission of a claim to OptumRx.

****REVISED****

BIN: 001553

PCN: GAM

There will be two dedicated pharmacy call lines; one line for Technical Support and one line for Clinical and Prior Authorization Support. They are as follows:

Technical Support

866-525-5826

Clinical and Prior Authorization Support

866-525-5827

For the processing of manual claims, please forward them to the following address:

**OptumRx
Claims Processing
PO Box 29044
Hot Springs, AR 71903**



RxProvider/Prescriber Portal is Web-based interface utilized by physicians and pharmacists to obtain information on a member to assist in providing more accurate, timely and cost efficient prescription treatment.

Accessing The Site

The Provider Portal can be accessed by visiting <https://ga-providerportal.optum.com>. Physicians and Pharmacists are required to register using the registration form on the login page of the Portal.

Registration

Registration is a one-time process. To enter the Portal after a User ID and Password has been assigned, simply enter the information on the login page and click "Sign In".

Main Page

The main page contains short cut links to frequently requested information. The top horizontal menu bar will always be visible to quickly access information within the Portal.

Member Search

A search for members can be performed by entering the Member ID, Last Name and Birth Date. When a member is found the following information is displayed:

- Member ID
- Member Name
- Birth Date
- Gender
- Eligibility from and thru dates

Claim Detail

The details of the claim detail screen for a member include:

- Fill Date
- RxNumber
- Claim Status
- Group ID
- Product ID
- Product Description
- Prescriber Name
- Pharmacy Name
- Days Supply
- Quantity
- Bin
- PCN
- Reject Code if applicable
- Reject Message if applicable

Guidelines and Forms

The Guidelines and Forms section of the Portal contains information to assist Providers with member care and prescription management.



Banner Messages

Updated Banner Messages are loaded to this page to provide timely notifications that affect provider groups.

The Resources

The resources section of the Portal contain links to outside resources such as; HIPAA, PeachCare for Kids site and provider association sites.

Remittance Summary

*Pharmacies Only

The Remittance Summary page displays the Remittance History. Searches can be done by date range and check number. Clicking on the check number outlines the following:

- Submitted Amount
- Approved Amount
- Taxes and Fees
- Patient Pay
- Amount Due
- And Sums of the above



Provider Portal New User Request

A separate Provider Portal Access Identification form is required for each User requested.
Please provide identifying information for the one individual that should be receiving access to the Provider Portal.

Provider Information			
I am a:	☐ Pharmacist	NCPDP:	Payee ID Internal Use Only
	☐ Pharm Other	NCPDP:	Payee ID Internal Use Only
	☐ Physician	MD State License:	DEA Number (if applicable):
	☐ Other Provider	Type	Description:
	NPI For Practice Location:		
Medicaid ID			
User Name:			
	Last	First	MI
Pharmacy or Clinic Name:			
Address:			
	Street Address		
	City	State	ZIP Code
Phone:		Alt. Phone:	
E-mail:			

To the best of my knowledge the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health Division of Medical Assistance for the purpose of Accessing the Provider Portal. I understand that falsification; omission or misrepresentation of any information in this document will result in a denial of access to the Portal, possible closure of current provider members and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions.

I understand that my signature certifies that I am authorized to make binding decisions on behalf of the Provider/Facility listed above.

Medicaid/PeachCare Provider Signature: _____

Date: _____

Email (preferred) the completed registration form to GAMProvider.PortalTeam@Optum.com or Fax to 1-888-292-4814.

Provider Enrollment FAQs

Each individual practitioner in a group must enroll to receive a provider number.

Q: How long does it take to process an enrollment application?

A. The enrollment process should be completed within four to six weeks after we receive the complete application. Be sure to attach the supporting documentation required. Any omissions or missing forms will cause the application to be returned.

Q. Can I fax my applications for processing?

A. No. Applications must contain original, not copied signatures.

Q. *Since I am a new applicant, what provider number should I enter on my EFT Agreement?*

A. Leave the provider number blank. DXC Technology will enter the provider number for new providers. An Electronic Funds Transfer (EFT) Agreement is required for all providers.

Q. Should I send my application via express or certified mail?

A. That would be your choice. Because of the volume of incoming mail, sending applications through certified mail helps to ensure proper delivery. It also serves as your proof of submission, provides a mechanism for tracking and guarantees quicker delivery. The mailing address is DXC Technology Provider Enrollment Unit, PO Box 105200, Tucker, GA 30085-5200. Applications are processed in the order they are received.

Q: I was told that my application required a site visit. Why is that?

A: The Department conducts site visits to ensure that members receive quality care in a medical environment that provides easy access, clean treatment rooms and qualified staff. In the present environment, applications may be approved pending a future site visit.

Note: Facilities that are certified by the Department of Human Resources; Office of Regulatory Services will not be site audited by Georgia Medicaid.

Q. How will I be notified of my new provider number?

A. A system generated DXC Technology notification letter is sent to the provider once the application is approved. The letter is mailed to the address listed on the application. Any corrections should be addressed to DXC Technology immediately.

Q. Should I hold claims until I receive confirmation of my provider number?

A. Yes. The division will not reimburse you for services rendered before the effective date of enrollment. The effective date of enrollment is the first day of the month in which the application is received or the date of licensure/certification (whichever is later).

Q: My old provider number is closed. How do I get it re-opened?

A: If your number has been suspended for inactivity, you may submit a written request to re-activate the number. If your number has been terminated for inactivity (no claims filed for more than 16 months), then you must submit a new application package.

Q: I am an individual practitioner and have (or had) a provider number at one location. I am now going to work from another location or open my own practice. What forms do I need to submit?

A: You should submit an additional location application package. If you will no longer be working from your previous location, please notify Provider Enrollment of the effective date to close that previous number.

Q: There has been a change to my practice information. What do I need to do to notify the Department of the change?

A: If your phone number(s), Legal name, Payee name, etc. changes, you will need to complete and submit a Change of Information form or a signed request on your letterhead listing the information to be corrected.

Q: My Company is buying an existing Medicaid provider. Will we need to apply for a new Medicaid number? (*Facilities Only*)

A: Any enrolled provider that becomes a different legal entity or is replaced in the program by another provider must give the Department at least 10 days prior written notice. Possible circumstances include dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger or joint venture.

At the same time, the successor provider must also submit a new Provider Enrollment Application package to become effective at the time of the change. Medicaid will require a new application package if the facility is required to submit a change of ownership application to Medicare.

Q: I am a Georgia Medicaid provider that is interested in submitting claims electronically. What is the procedure for signing up?

A: Please contact DXC Technology EDI Helpdesk at (877) 261-8785, Monday – Friday 8:00am – 5:00pm or visit the website at <http://www.mmis.georgia.gov>.

Q: I am building a new facility. When should I submit my application?

A: You should submit an application when the facility is ready for business. The site has to be visited before your application can be approved.

Out of State Providers

The Department enrolls medical practitioners within 50 miles of the Georgia state border as in-state providers. Providers whose physical location is more than 50 miles from the Georgia border may be enrolled as Out-of-State providers under the circumstances outlined below.

Out-of-state providers may be reimbursed for covered services provided to eligible Georgia members while out-of-state if the claim is received within twelve months from the month of service, and if at least one of the following conditions is met:

- a) The service was prior authorized by the Division; or
- b) The service was provided as a result of an emergency or life-endangering situation occurring out of state.

Out-of-state claims submitted for reimbursement must have a copy of the authorization letter from the Department attached if services were prior authorized **or** medical justification if the services were due to an emergency or life-endangering situation. Requests for prior approval or questions regarding out-of-state services must be directed to:

GMCF
P. O. Box 105329
Atlanta, GA 30348
1-800-766-4456

Please request a Provider Enrollment Application or enrollment documents by one of the methods listed below:

Phone: (800) 766-4456 or in metro Atlanta, (770) 325-9600

Download: <http://mmis.georgia.gov> → Provider Information → Documents and Forms

E-mail: <http://mmis.georgia.gov>, click on “Contact Us”

Or Apply

Online: <http://mmis.georgia.gov>, “Provider Information” then “Enroll as an Individual”

Facsimile: 1-866-309-0935

GA Medicaid Fee-for-Service Pharmacy Provider NPI FAQs
****REVISED April 1, 2013****

1. ***Is the pharmacy NPI required for electronic pharmacy claims?***

YES, Pharmacy NPI is required for electronic pharmacy claims effective May 1, 2008. Submit the ID qualifier '01' (NPI) in field 202-B2 and the pharmacy NPI (Service Provider ID) in field 201-B1.

2. ***Is the prescriber NPI required for electronic pharmacy claims?***

Effective May 23, 2008, only the Prescriber NPI will be allowed when processing electronic pharmacy claims. Between May 1, 2008 and May 22, 2008, the prescriber NPI or the prescriber's state license number may be used. Dummy ID numbers will no longer be valid with the exception of GHS300 (Grady Hospital, Clinics, ER) and AOH300 (All other Hospitals, Clinics or Emergency Rooms) between May 1 and May 22. Effective May 23, ONLY NPI will be accepted for electronic claims. Submit the ID qualifier '01' for prescriber NPI in NCPDP field 466-EZ and the prescriber NPI in field 411-DB.

Rev. 01/15

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating (i.e. rendering) provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

To comply with the requirement, providers who do not have NPIs or who are not authorized to enroll as a Medicaid or CHIP provider must provide the NPI of the supervising or attending physician on the order, prescription, or referral. Medical residents may obtain an NPI and Medicaid ID in order to prescribe outpatient prescription medications. Alternatively, facilities may continue to use a prescription that is countersigned by the attending or supervising physician if they do not wish to enroll their residents. Medical residents may only prescribe; they may not order, refer or bill other services.

Type of Prescriber	Eligible for Medicaid Provider ID	Required Signature on Prescription	Required NPI# on Claim for Legend Drugs	Required NPI# on Claim for Controlled Drugs
Nurse Practitioner	Yes	Nurse Practitioner	Nurse Practitioner NPI#	Nurse Practitioner NPI# (CIII, IV, V drugs only)
Physician Assistant	Yes	Physician Assistant	Physician Assistant NPI#	Physician Assistant NPI# (CIII, IV, V drugs only)

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at <http://dch.georgia.gov/publications>
- Search to see if a provider is enrolled at <https://www.mmis.georgia.gov/portal/default.aspx>

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

- Access a provider listing at <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx>

Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

3. ***I have used Dummy IDs for some hospital/emergency room physicians, Dentists, Podiatrists, Out of State Physicians, Optometrists and new physicians granted a license number within 60 days. What ID should I use for those prescribers?***
All prescribers should have their own NPI. You may look up a prescriber's NPI at <http://www.hmedata.com/npi.asp> If appropriate, GHS300 and AOH300 will be accepted between May 1, 2008 - May 22, 2008 **only**.
4. ***What should I do if I have a prescriber's correct and verified NPI but the claim is still rejecting.***
Contact OptumRx Customer Service: 1-866-525-5826.

5. *How can I process a pharmacy claim if the prescriber doesn't have a NPI?*

Providers who do not have NPIs or who are not authorized to enroll as a Medicaid or CHIP must apply the NPI of the supervising or attending physician to the claim.

6. *What is the NPI requirement for paper claims? (Universal Claim Form)*

The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating (i.e. rendering) provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

7. *Where can a pharmacy or prescriber obtain an NPI?*

An NPI can be obtained on-line at:

<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>

or a paper copy of the application can be obtained by phone, e-mail, or mail.

- Phone: 1-800-465-3203 or TTY 1-800-692-2326
- E-mail: customerservice@npientumerator.com
- Mail:
NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

We appreciate your continued participation in the Georgia Medicaid program. If you have any questions, please contact OptumRx Customer Service at 1-866-525-5826.

Please share this information with appropriate staff. If you are the corporate office of a chain pharmacy, please provide this information to each of your stores located in Georgia.

**Division of Medical Assistance
Pharmacy Services Unit 404-656-4044**

COUGH AND COLD PREFERRED DRUG LIST (PDL) INFORMATION

Effective November 1, 2008, the Medicaid Fee-for-Service Program will implement a Cough and Cold Preferred Drug List (PDL). Coverage applies to member's less than 21 years of age. This PDL listing is available online at www.dch.georgia.gov/pharmacy (Preferred Drug Lists → Related Links: Cough and Cold Preferred Drug List) and on the Georgia Medicaid Web Portal at: www.mmis.georgia.gov (Pharmacy→Other Documents).

Cough and Cold Preferred Drug List Frequently Asked Questions

Why did the Department of Community Health develop a Preferred Drug List (PDL) for cough and cold products?

Due to recent state level budgetary constraints, DCH has been asked to assist by further managing the outpatient pharmacy drug spend. Additionally, many of the products within this class have similar combinations, albeit with slightly varying product strengths. The abundance of similar products coupled with the Department's fiscal responsibilities lead to the simplification of covered products within this class.

Who is eligible to receive the products covered on the Cough and Cold PDL?

Medicaid Fee for Service (FFS) Members aged less than 21.

How were products selected for inclusion onto the PDL?

Products were selected for inclusion on the PDL based upon several factors including available formulations, utilization as well as cost effectiveness. It is DCH's intent to continually update the PDL based upon several factors including rebate status, cost effectiveness, and availability.

Why were over-the counter (OTC) products not included on the Cough and Cold PDL?

Medicaid is funded by both state and federal funds. Generally, federal matching funds are not provided for OTC items as set forth in the Centers for Medicare and Medicaid Services (CMS) guidelines for state Medicaid programs unless authorization is approved in advance. DCH does plan to seek approval for coverage of these items. Hence, pending CMS approval, coverage may be allowed for OTC items.

Why were some products included on the Cough and Cold PDL that are no longer being manufactured or marketed?

The Department is aware that some of the products contained within the PDL may no longer be stocked by all pharmacies. However, the Department's policy does allow for the submission of claims for products that are inactive or no longer available until they become obsolete and the residual supply in dispensing pharmacies has been exhausted. Therefore, pharmacies who have stock of these medications available may still submit claims for adjudication, up to 18 months past the inactive date as reported by the manufacturer.

Given the recent FDA guidance regarding the use of cough and cold products in children, why did the Department develop a Cough and Cold PDL?

The Cough and Cold PDL was developed with many factors in mind including coverage for those members less than 21 years of age. Further, the Department does not have a position regarding the use of these products in any patient population. However, should a prescriber decide to initiate therapy with a product within this class, we have provided a simplified PDL from which to select reimbursable items.

How do you get prior authorization for a product not listed on the Cough and Cold PDL?

Only those products contained within the PDL are eligible for coverage. The Department plans to continually update and revise the PDL as needed.

Where may I find the most up to date Cough and Cold PDL?

This PDL listing is available online at www.dch.georgia.gov/pharmacy (Preferred Drug Lists → Related Links: Cough and Cold Preferred Drug List) and on the Georgia Medicaid Web Portal at: www.mmis.georgia.gov (Pharmacy→Other Documents).

APPENDIX H

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

 Amerigroup Community Care 800-249-0442 www.myamerigroup.com	 CareSource 888-901-0014 www.caresource.com
 Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	 WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
PeachCare for Kids®	Aged, Blind and Disabled
Parent/Caretaker with Children	Nursing home
Children under 19	Long-term care (Waivers, SOURCE)
Women's Health Medicaid (WHM)	Federally Recognized Indian Tribe
Transitional Medicaid	Georgia Pediatric Program (GAPP)
Refugees	Hospice

Planning for Healthy Babies	Children's Medical Services program
Resource Mothers Outreach	Medicare Eligible
Newborns	Supplemental Security Income (SSI) Medicaid
	Medically Needy

Georgia Families

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid as well as new services. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs as well as expanded access to plans and providers, giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education.

All four CMOs are State-wide.

The Department of Community Health has contracted with four CMOs to provide these services: Amerigroup Community Care, CareSource, Peach State Health Plan and WellCare. Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at **www.georgia-families.com** or call **1-800-GA-ENROLL** (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

<i>COE</i>	<i>DESCRIPTION</i>
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended

135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB <= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

APPENDIX I



Information for Providers Serving Medicaid Members in the Georgia Families 360SM Program

Rev. 07/18

Georgia Families 360SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360SM Every member in Georgia Families 360SM is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov