MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 24, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

This revision to Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs requires certain identified classes of maintenance drugs be dispensed in a 100-day (3-month) supply. Initial fills can be dispensed in quantities of less than three months (100 days). This does not include drugs dispensed in long term care facilities.

These changes are effective January 25, 2017

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 30712 Prescribed Drugs	MTL 26/15 Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1(6)(c)	**Coverage and Limitations**	Added (*) to numbers 1,2,4,5,6,7,9,10,11.
1203.1(6)(c) (1-11)	**Coverage and Limitations**	Added language that the drug classes identified with a (*) will be required to be dispensed in a 3-month (up to 100-day) supply.
1203.1(6)(c) (11)(a-b)	**Coverage and Limitations**	Added language that initial fills can be dispensed in quantities of less than 3-month (100 days). Added language that this requirement does not include skilled nursing facilities.

1203 POLICY

The Division of Health Care Financing and Policy (DHCFP), Nevada Medicaid, reimburses pharmacies and practitioners for legend (prescription) and non-legend (over the counter) pharmaceuticals dispensed or administered to Medicaid recipients. All prescribers must have a license as a healthcare practitioner, such as a physician, podiatrist, osteopath, dentist, Advanced Practice Registered Nurse (APRN), physician's assistant, etc., keeping within the scope of their practice. The DHCFP requires that pharmaceuticals are written, dispensed and prescribed in accordance with the Nevada State Board of Pharmacy regulations and enforcement.

1203.1 COVERAGE AND LIMITATIONS

1. Covered drugs are subject to prior authorization and/or quantity limits and the following:

    a. Section 1927(d)(1)(B)(i) of the Social Security Act (SSA) allows Medicaid to restrict coverage for an outpatient drug if the prescribed drug is not for a medically accepted indication. Section 1927(k)(6) defines a medically accepted indication as any use for a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia:

        1. American Hospital Formulary Service Drug Information;

        2. United States Pharmacopeia;

        3. DRUGDEX Information System; or

        4. Peer-reviewed medical literature.

    b. Pharmaceuticals must be manufactured by companies participating in the Federal Medicaid Drug Rebate Program.

    c. Medicaid is mandated by Federal statute to require all written (non-electronic) prescriptions for all outpatient drugs for Medicaid recipients to be on tamper-resistant prescription pads. This requirement does not apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber. Refer to Medicaid Services Manual (MSM) Addendum for more information on tamper-resistant prescription pads.

    d. The Preferred Drug List (PDL) is a list of preferred outpatient drugs established by the Pharmacy and Therapeutics (P&T) Committee. Reference Medicaid Operations Manual (MOM) Chapter 200 for the P&T bylaws. Pharmaceuticals not on the preferred drug list, but within drug classes reviewed by the P&T Committee, require prior authorization, unless exempt under Nevada Revised Statute (NRS) or

federal law or excluded through recommendations of the P&T Committee or excluded by the DHCFP.

1. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan or by NRS are covered without a Standard Preferred Drug List Exception prior authorization until or if the P&T Committee adds the drug class to the PDL and reviews the product or evidence.

2. New FDA approved drugs, or existing pharmaceutical products within reviewed PDL drug classes, for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan or by NRS, are covered with an approved Standard Preferred Drug List Exception prior authorization until the P&T Committee can review the new evidence or drug.

3. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.

4. If the P&T Committee determines that there are no significant differences between drugs within specific classes based on clinical efficacy and safety, the DHCFP or its Quality Improvement Organization (QIO)-like vendor may consider cost in determining which drugs are selected for inclusion on the PDL.

5. Due to the 76th Special Session and in accordance with Senate Bill (SB) 4, every therapeutic prescription drug that is classified as an anticonvulsant medication or antidiabetic medication that was covered by the Medicaid program on June 30, 2010 must be included on the PDL as a preferred drug. If a therapeutic prescription drug that is included on the list of preferred prescription drugs is prescribed for a clinical indication other than the indication for which it was approved as of June 30, 2010, the Committee shall review the new clinical indication for that drug in accordance with Section 1203 of this chapter.

6. Due to the 76th Special Session and in accordance with SB 4, the P&T Committee must prefer atypical and typical antipsychotic medications that are prescribed for the treatment of a mental illness, anticonvulsant medications and antidiabetic medications for a patient who is receiving services pursuant to Medicaid if the patient:

    a. was prescribed the prescription drug on or before June 30, 2010, and takes the prescription drug continuously, as prescribed, on and after that date; and

b. maintains continuous eligibility for Medicaid.

Reference Appendix A for coverage and limitations of medications with special criteria.

2. Standard Preferred Drug List Exception Criteria

Drugs that have a "non-preferred" status are a covered benefit for recipients if they meet the coverage criteria.

a. Coverage and Limitations

1. Allergy to all preferred medications within the same class;

2. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;

3. History of unacceptable/toxic side effects to all preferred medications within the same class;

4. Therapeutic failure of two preferred medications within the same class;

5. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication;

6. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a Food and Drug Administration (FDA)-approved indication;

7. Psychotropic Medication – Continuity of Care.

Recipients discharged from an institution on non-preferred psychotropic medication(s), their drugs will continue to be covered by Medicaid for up to six months to allow the recipient time to establish outpatient mental health services.

8. For atypical or typical antipsychotic, anticonvulsant and antidiabetic medications the recipient demonstrated therapeutic failure on one preferred agent.

b. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms/aspx

3. Excluded

The Nevada Medicaid Drug Rebate program will not reimburse for the following pharmaceuticals:

a. Agents used for weight loss.

b. Agents used to promote fertility.

c. Agents used for cosmetic purposes or hair growth.

d. Yohimbine.

e. Drug Efficacy Study and Implementation (DESI) list "Less than Effective Drugs": In accordance with current policy, federal financial participation is not allowed for any drug on the Federal Upper Limit (FUL) listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the DESI program which has been found to be a less than effective or is Identical, Related or Similar to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

This includes pharmaceuticals designated "ineffective" or "less than effective" (including identical, related or similar drugs) by the FDA as to substance or diagnosis for which prescribed.

f. Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed. Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

g. Agents used for impotence/erectile dysfunction.

4. Refills

A refill is a prescription subject to the limitations below:

a. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to Nevada Administrative Code (NAC) Chapter 639.

b. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. If a prescription is for a 34-day supply, a consistent refill would be filled in 30 days; an inconsistent refill date would be filled in 20 days

from the original fill. Lost Medications. Nevada Medicaid does not pay for replacement of lost, stolen or otherwise destroyed medications even if a physician writes a new prescription for the medication. It is the responsibility of the recipient to replace these medications. Prior authorization may be granted in life-threatening situations and for maintenance medications only. See Maintenance Medications in this section for more information on maintenance medications.

5. Early Refills

a. Nevada Medicaid only pays for up to a 34-day supply of medications (100-day supply for maintenance medications) for recipients each month. A prescription refill will be paid for by Nevada Medicaid only when 80% of the non-controlled substance prescription, and 90% of the controlled substance prescription, is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

b. In the instance that a recipient will be out of town when a refill is due, the pharmacist may enter the appropriate override code to allow an early refill. This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

c. Medicaid will not pay for an early prescription refill when gross negligence or failure to follow prescriber's prescription instructions has been displayed by the recipient.

6. Maintenance medications

Exceptions to the 34-day supply of medications are allowed for maintenance medications.

a. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)

b. Prescription quantities may be reviewed; in those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

c. The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, ~~may be~~ a 100-day (3-month) supply.

The following drug categories are considered maintenance medications:

1. Antianginals*;
2. Antiarrhythmics*;
3. Anticonvulsants;
4. Antidiabetics*;
5. Antihypertensives*;
6. Cardiac Glycosides*;
7. Diuretics*;
8. Thyroid preparations;
9. Estrogens*;
10. Progesterone*; and
11. Oral/Topical Contraceptives*.

a. Drug classes identified with (*) are required to be dispensed in a 3-month (up to 100 day) supply, except for initial fills which can be dispensed in quantities of less than three months (100 days).

b. This requirement does not include skilled nursing facility pharmacies

7. Emergency supply of medication

a. In an emergency situation, dispensing of up to a 96-hour supply of covered outpatient drugs that require prior authorization will be allowed.

b. Nevada Medicaid requires prior payment authorization for medications identified as requiring prior authorization.

c. The physician must indicate the diagnosis on the prescription (preferably with an International Classification of Disease (ICD) code) to support the use of the emergency policy.

d. As a follow-up to the dispensing of the emergency supply of medication, the provider must contact the QIO-like vendor, to obtain a verbal verification number.

8. Nevada Check Up (NCU)

All coverage and limitation policies and rules, including any prior authorization requirements, outlined in this chapter apply to NCU recipients as well as Nevada Medicaid Fee-for-Service (FFS) recipients. There are NO exceptions.