MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 12, 2008

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF OF COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATIONS

Changes to this chapter are the result of the recommendations of the Drug Use Review (DUR) Board meeting on January 24, 2008. Pursuant to NRS 422.403, the DUR Board manages step therapy and prior authorizations for prescription drugs. The DUR Board consists of six members (physicians and pharmacists) and is appointed by the Director of the Department of Health and Human Services.

The DUR Board specifically discussed and took action to update the clinical prior authorization criteria for drugs used to treat Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder in adults and children. The criteria was changed to allow for approval of these medications without a prior authorization under certain criteria. The clinical prior authorization criteria for growth hormone added IGF-1 testing. The clinical prior authorization criteria for hematopoietic agents (Epogen® and Procrit®, erythropoietin and Aranesp® darbepoetin) revises criteria.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL20/08	**MTL 21/03; 25/07; 02/07; 21/03**
CHAPTER 1200 – PRESCRIBED DRUGS	CHAPTER 1200 – PRESCRIBED DRUGS
Sec. 1200 Added "Nevada Check Up Manual Chapter 1000"	Deleted "Chapter 3700"
Sec. 1201 Added "8. Section 1927 of the Social Security Act requires the establishment of a Drug Use Review (DUR) board to monitor therapeutic appropriateness, use of generic products, overutilization and underutilization of drugs and quality of care consistent with protecting the health of	

program beneficiaries."

Sec. 1203.1B.2.d.4

Added "that Medicaid will only pay for controlled substance"	Deleted "the"
Added "controlled substance prescriptions"	Deleted "recipient can only obtain payment"
Added "pharmacy"	Deleted "of the recipients choice."
	Deleted "/provider"
	Deleted "the service"
	Deleted "provider"
	Deleted "at another facility"

Sec. 1205.1
Added "Medicaid Service Manuals:"
Added "Nevada Check Up Manual: Chapter 1000 Nevada Check Up Program"

Deleted "Chapter 3700 Nevada Check Up"

Sec. 1205.2.1.a

Deleted "Nevada"

Sec. 1205.2.1.b

Deleted "Belrose"

Appendix A.1.C
Added "Attention Deficit Disorder (ADD)/"

Added "ADD/"

Appendix A.1.C.1
Added "criteria is"

Deleted "are"

Appendix A.1.C.1.a.1
Added "long-acting"

Added "ADD/" twice in sentence

Added "be"

Appendix A.1.C.2
Added " 's"

Deleted "in order for Prior Approval of CNS Stimulants:"

Appendix A.1.C.2.a
Added "T"

Deleted "In the pediatric and adult

Added "must be"

population, t"

Deleted "and any comorbidty";

Deleted "at"

Appendix A.1.C.1.b
Added "conditions apply and"

Deleted "present and"

Added "1. Prescriptions for ADD/ADHD medications do not require prior authorizations for children five years of age, up to eighteen years of age, if the following conditions apply:

a. The medication is prescribed by a psychiatrist, and
b. One of the following ICD-9 codes is documented on the prescription: 314.0-314.9.

2. In all other cases, prior authorization is required. The following is required for prior authorization:"

Deleted "for Prior Approval of CNS Stimulants:"

Appendix A.1.C.1.b.2.a
Added "or examination"

Deleted "primary"

Added "within the past twelve months,"

Deleted "(e.g. fetal alcohol syndrome, thyroid disease) and examination within the past twelve months, or more recently, if the clinical condition has changed"

Added "a primary"

Added "of all of the following:"

Appendix A.1.C.1.b.2.a.1
Added bullet point "a"

Deleted "1."

Added "and"

Deleted "2. One of the following:"

Appendix A.1.C.1.b.2.a.2
Added bullet point "2."

Deleted "DMS-IV"

Added "DSM-IV"

Deleted "or"

Added "and"

Appendix A.1.C.1.b.2.a.3
Added bullet point "3."

Deleted "c."

Added "or guardian(s)."
Appendix A.1.C.1.b.3.

Deleted "3. The following two criteria must be met and documented in the recipient's

	medical record for adult and pediatric recipients in order for Prior approval of CNS Stimulants: a. In the pediatric and adult population, the decision to medicate for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) and any comorbidty based on problems that are persistent and sufficiently severe to cause functional impairment in one or more of the following social environments: at school, home, work or with peers, and b. Before treatment with pharmacological methods is instituted, other treatable causes have been ruled out."
Appendix A.1.C.1.c	
	Deleted "for Prior Approval of CNS Stimulants"
Appendix A.1.C.1.c.2.a Added "primary"	Deleted "(e.g. thyroid disease head trauma)"
Added "identify"	Deleted "P"
Added "(s)"	
Added "p"	
Appendix A.1.C.1.c.2.b Added "s"	
Appendix A.1.C.1.c.2.c Added "T"	Deleted "t"
Appendix A.1.C.1.c.2.d	
	Deleted "PA forms"
Appendix A.1.D Added "(GH)"	Deleted "All criteria must be met for children under 21 years of age. Adult cases will be reviewed on an individual basis."
Added "An FDA-approved indication for the diagnosis being treated is required."	
Appendix A.1.D.1.a Added "The following apply to all requests for children:"	Deleted "The following criteria must be met for children under 21 years of age: Deleted "Indications for growth hormone therapy in children are growth hormone deficiency, growth retardation secondary to chronic renal insufficiency up until renal

	transplantation and short stature of Turner's or Prader Willi syndrome"
Appendix A.1.D.1.a.1 Added "An evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for therapy."	Deleted "All other causes for short stature are ruled out"
Appendix A.1.D.1.a.2 Added "All other causes for short stature are ruled out."	Deleted "Bone Age Study results show less than sixteen years for boys, less than 14 years for girls; epiphysis open. Bone age is at least two years less than chronological age."
Appendix A.1.D.1.a.3 Added "Patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonatropic hormones." Added "Therapy will be approved for any one of the following:"	Deleted "Growth chart and declining growth velocity show growth less than fifth percentile. At least three documented measurements over the last six month period."
Appendix A.1.D.1.a.4 Added "Diagnosis of Turner's Syndrome.	Deleted "Evaluation by a Pediatric Endocrinologist or Pediatric Nephrologist with a recommendation for therapy."
Appendix A.1.D.1.a.5 Added "Diagnosis of Prader-Willi Syndrome."	Deleted "At lest two provocative stimuli tests to show failure to raise growth hormone level above 10nb (nanograms)/ml. Exception: Patients with Chronic Renal Insufficiency (CRI)."
Appendix A.1.D.1.a.6 Added "Patient has chronic renal insufficiency (defined as Creatinine Clearance between 5 and 75/ml/min/1.73m2)."	Deleted "Baseline blood tests abnormalities to be corrected."
Appendix A.1.D.1.a.7 Added "If the patient has evidence of hypothalamic-pituitary disease or structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation and meeting any one of the following: Patient has not undergone renal transplant. a. Has failed at least one GH stimulation test (peak GH level <10 nanograms	Deleted "Turner's and Prader Willi syndrome documented by karotyping."

(ng/ml).

b. At least one documented low IGF-1 level (below normal range for patients age – refer to range on submitted lab document).
c. Has deficiencies in three or more pituitary axes (i.e. TSH, LH, FSH, ACTH, ADH)."

Appendix A.1.D.1.a.8

Added "If the patient is a newborn infant and has evidence of hypoglycemia and either a low GH level (<20ng/ml) or a low for age IGF-1 or IGF Binding Protein #3 level (IGFPB#3) (no stimulation test required for infants)."

Deleted "No expanding intracranial lesion or tumor diagnosis."

Appendix A.1.D.1.a.9

Added "Children with a history of intrauterine growth restriction (small for gestational age (SGA)) who at age two years have a height at least two Standard Deviations (SD) below the mean for the patient's age and gender."

Deleted "MRI or CT scan of head done on patients with multiple pituitary hormone deficiencies or history of intracranial lesions."

Appendix A.1.D.1.a.10

Added " For Idiopathic Short Stature all of the following criteria must be met:

a. Bone age>2 SD below the mean for age, Epiphysis open.
b. Height >2.25 SD below the mean for age or >2 SD below the mid-parenteral height percentile or growth velocity <25th percentile for bone age.
c. At least one provocative stimuli test to show failure to raise the growth hormone level about 10ng/ml.
d. Exception to the requirement for stimuli testing: Patients meeting (10)(a) and (10)(b) above in addition to a documented low serum insulin-like growth factor 1 (IGF-1) and/or insulin-like growth factor binding protein #3 (IGFPB#3) will not be required to have stimuli testing.

Appendix A (1)(D)(1)(b)

Added "the"

Added "for children"

Added "all of"

Appendix A.1.D.1.b.1
Added "Bone age >2 below the mean for age. Epiphysis open."

Deleted "Bone age study shows less than sixteen years for boys, less than fourteen years for girls. Epiphysis open."

Appendix A.1.D.1.b.2
Added "centimeters"

Deleted "cm"

Added "the"

Appendix A.1.D.1.b.3

Deleted "adult"

Appendix A.1.D.1.c

Deleted "Covered ICD-9 codes:
Panhypotituitarism
Pituitary Dwarfism
Latrogenic pituitary disorders
Other disorders of the pituitary and other syndromes of diencepalohypophyseal origin
Other disorders of the pituitary gland and craniophryngeal duct
Chronic renal failure
Unspecified disorder resulting from impaired renal function
Gonadal dysgenesis/Turner's syndrome
759.81 Prader Willi syndrome

Appendix A.1.D.1.c.6

Deleted "adult"

Appendix A.1.D.1.d
Added "Indications for growth hormone therapy in adults are: Adults who were growth hormone deficient as children or adolescents. All of the following criteria must be met:"

Deleted "The following criteria must be met for adults 21 years of age and older."

Deleted "e.) Agents selected for treatment must have an FDA approved indication for the diagnosis being treated as stated in the package insert."

Appendix A.1.D.1.d.1-4
Revised and added new criteria

Appendix A.1.D.1.e.2.
Added "a. Patient has failed to adequately respond to dietary measures.
b. Patient has failed to respond or is intolerant to appetite-stimulating drugs, (e.g. Megace) and anabolic steroids.

c. Absence of a concurrent illness or medical condition other than HIV infection that would explain these findings."

Added "Prior Authorization will be given for 12 weeks."

Added "the Prior Authorization"

Added "Prior Authorization"

Appendix A.2

Deleted "PA Guidelines"

Appendix A.1.G
Added "This policy applies in all settings with the exception of inpatient facilities."

Added "also known as erythropoiesis stimulating agents (ESAs)

Added "one of"

Added "following"

Appendix A.1.G.1.a.1
Added specific criteria to "Coverage and Limitations"

Deleted "Approval will be given for the sue of Red Blood Cell Building Hematopoietics and Hemantinics if a diagnosis of anemia and the cause (e.g. chronic renal failure, myclosuppressive chemotherapy) is documented and confirmed by blood test."

Appendix A (1)(G)(2)(a, b, c, d, e, f, g, h)
Added title and definition of "Non-covered Indications:"

Added "Claims documenting doses exceeding the Center for Medicare and Medicaid Services (CMS's) maximum threshold for ESAs will be denied."

Added "Recent laboratory results are required for Prior Authorization, i.e., serum hemoglobin within seven days of Prior Authorization request."

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

PRESCRIBED DRUGS

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

1200 INTRODUCTION

The Nevada Medicaid Pharmacy Services program pays for medically necessary prescription services for eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions hereinafter specified.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Services.

This Chapter describes covered services, service limitations, and general reimbursement methodology.

This manual obsoletes all previous policy and procedure manuals, bulletins and policy news.

All Medicaid policies and requirements (such as prior authorizations, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in the Nevada Check Up Manual Chapter 1000.

1201 AUTHORITY

1. The Code of Federal Regulations (CFR), Title 42, Public Health, Chapter IV Center for Medicare and Medicaid Services, Subchapter C Medical Assistance Programs, Parts 430 through 456, states prescription drug coverage is an optional service under Title XIX.

2. The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandates additional preventive health care services for infants, children and young adults (newborn through age 20) eligible for Medicaid. These mandates provide that children and adolescents under age 21 receive follow-up services for a medically necessary condition discovered in a screening examination (EPDST) see Chapter 1500; this includes prescription services.

3. CFR Title 42 and Section 1927 of the Social Security Act, require states to provide for a Drug Utilization Review (DUR) program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results (SSA, Title 19, (g)(1)(A)).

4. Section 1927 of the Social Security Act allows a state to require a prior authorization on any covered outpatient drug, providing the prior authorization program complies with the requirements outlined in the act.

5. Chapter 422 of NRS amended by AB 384 to require the Department of Health and Human Services to; 1) develop a list of preferred prescription drugs, 2) manage prescription drug use through the use of prior authorization and step therapy, and 3) create the Pharmacy and Therapeutics Committee.

6. U.S. Troop Readiness, Veteran's Health Care, Katrina Recovery and Iraq Accountability Appropriations Act 2007, Section 7002(b) of the act requires Medicaid outpatient drugs (defined in Section 1927(k)(2) of the Social Security Act) will be reimbursable only if non-electronic written prescriptions are executed on a tamper-resistant prescription pad. To review the PDF version of this public law refer to: http://www.asafm.army.mil/cong/cbreps/docs/2007L/supp/07EsupPL.pdf

7. The Deficit Reduction Act of 2005 requires fee-for-service State Medicaid programs to capture and report National Drug Codes (NDC) for outpatient drugs in order for the state to receive federal financial participation.

8. Section 1927 of the Social Security Act requires the establishment of a Drug Use Review (DUR) board to monitor therapeutic appropriateness, use of generic products, overutilization and underutilization of drugs and quality of care consistent with protecting the health of program beneficiaries.

1202 DEFINITIONS

1202.1 ACTUAL ACQUISITION COST (AAC)

Actual Acquisition Cost (AAC) is the actual price paid by the pharmacy for a drug.

1202.2 ADMINISTRATION FEE

The Administration fee is the dollar amount established for administering covered pharmaceuticals.

1202.3 COMPOUND DRUGS

Compound means to form or make up a composite product by combining two or more different ingredients.

1202.4 DEPARTMENT OF JUSTICE (DOJ) PRICING

In 2000, the US Department of Justice (DOJ) and the National Association of Medicaid Fraud Control Units (NAMFCU) determine that some drug manufacturers were reporting inaccurate Average Wholesale Prices (AWPs) for some of their products. As a result, the DOJ and the NAMFCU compiled new pricing data gathered from several wholesale drug catalogs for approximately 400 national drug codes. The State Medicaid programs had the option to implement this revised pricing from the investigation. Nevada Medicaid chose to implement the pricing algorithm at the time of its inception. The pricing is reflective of the data file from the First Data Bank.

1202.5 DISPENSING FEE

Dispensing fee is the dollar amount established for dispensing covered pharmaceuticals.

1202.6 DRUG USE REVIEW (DUR) BOARD

A drug use review program that consists of prospective drug use review, the application of explicit predetermined standards, and an educational program. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and that they are not likely to result in adverse medical results. (CFR 456 I.B) The board consists of pharmacists and physicians.

1202.7 ESSENTIAL MEDICATIONS

Essential medications are those which are medically necessary to counteract severe pain and/or to sustain life, limb or eyesight. Restorative, rehabilitative, preventive, and

maintenance medications must have appropriate corresponding diagnoses in the patient's chart to be considered medically necessary.

1202.8 ESTIMATED ACQUISITION COST (EAC)

Estimated Acquisition Cost (EAC) is defined by Nevada Medicaid as average wholesale price less than 15 percent (AWP - 15%). EAC is based upon the original package or container size from which the prescription is dispensed.

1202.9 EXPERIMENTAL

A drug prescribed for a use that is not a medically accepted indication. The term medically accepted indication means any use of 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 citation included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

1202.10 FEDERAL UPPER LIMIT (FUL)

Under the authority of 45 CFR, Part 19, the Pharmaceutical Reimbursement Board of the U.S. Department of Health and Human Services has determined the maximum allowable ingredient costs. These limits apply to all Medicaid prescriptions unless exempted as "Medically necessary" by the prescriber (see 1203.1(B)(4) of this chapter). The upper limit for multiple source drugs meets the criteria set forth in federal regulations. This listing is now available on the CMS homepage at: http://www.cms.hhs.gov/FederalUpperLimits.

1202.11 GENERAL PUBLIC

General Public is defined as the patient group accounting for the largest number of non-Medicaid prescriptions from a pharmacy. This excludes patients who purchase or receive prescriptions through third party payers such as Blue Cross, Aetna, PAID, PCS, etc. If a pharmacy discounts prices to specified customers, (e.g. 10% discount to senior citizens) these lower prices should be excluded from usual and customary calculations unless they represent more than 50% of the store's prescription volume.

1202.12 INPATIENTS

Inpatients are those individuals receiving room, board, and medical care in a general or specialty hospital or nursing facility. Individuals living in Adult Group or Child Care Facilities are not considered inpatients. Persons who are bedfast and receiving home health care in a private residence are not considered inpatients.

1202.13 LEGEND DRUGS

Legend pharmaceuticals are those bearing the insignia "Rx only" on the label, and/or bearing statement "Caution: federal law prohibits dispensing without a prescription."

1202.14 MAINTENANCE DRUG

Maintenance Drug is defined as any drug used continuously for a chronic condition. Refer to Section 1203.1A(5)(c) of this Chapter.

1202.15 MAXIMUM ALLOWABLE COST (MAC)

Maximum Allowable Cost (MAC) is the lower of (1) the cost established by the Center for Medicare and Medicaid Services (CMS) for multiple source drugs that meet the criteria set forth in 42 CFR 447.332 and 1927 (f)(2) of the Act, or (2) the cost established by DHCFP for multiple source drugs under the State Maximum Allowable Cost.

1202.16 MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

A computer system designed to help managers plan and direct business and organizational operations.

1202.17 MULTIPLE SOURCE DRUGS

Multiple Source Drugs is defined in §1927 (k) (7) of the Social Security Act as, "covered outpatient drug for which there are two or more drug products which (I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutically Equivalence Evaluations"), (II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and (III) are sold or marketed in the State during the period."

1202.18 NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)

The National Council for Prescription Drug Programs, Inc. is a not-for-profit Standards Developmental Organization representing the pharmacy services industry.

1202.19 NATIONAL DRUG CODE (NDC)

The NDC is a unique three segment number assigned to each medication listed under Section 510 of the U.S. Federal Food, Drug, and Cosmetic Act. The first segment identifies the drug manufacturer, the second segment identifies the product, and the third segment identifies the package size.

1202.20 NON-LEGEND DRUGS

Non-legend pharmaceuticals are those not bearing the insignia "Rx only" on the label, and/or "Caution: federal law prohibits dispensing without a prescription." Non-legend pharmaceuticals may also be known as "over-the-counter" drugs.

1202.21 OBRA 90 DRUG REBATE

Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). The law was amended by the Veterans Health Care Act of 1992 which also requires a drug manufacturer to enter into discount pricing agreements with the Department of Veteran's Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid.

1202.22 PHARMACEUTICALS

Pharmaceuticals are any drug, compound, mixture, or preparations which the U.S. Food and Drug Administration has approved for medical use.

Controlled pharmaceuticals are those pharmaceuticals listed in the schedule of substances, controlled by the Drug Enforcement Administration and/or the State Board of Pharmacy.

1202.23 PHARMACY AND THERAPEUTICS (P & T) COMMITTEE

P & T Committee is established under NRS. The P&T Committee is comprised of physicians and pharmacist to (l) identify the prescription drugs that are included or excluded on the preferred drug list for Title XIX and Title XXI programs, (II) identify the therapeutic classes for review and clinical analysis, and (III) review at least annually the therapeutic classes on the preferred drug list.

1202.24 POINT OF SALE (POS)

Point of Sale is a computerized claims adjudication system allowing pharmacies real-time access to recipient eligibility, drug coverage, pricing and payment information, and prospective drug utilization review across all network pharmacies.

1202.25 PREFERRED DRUG LIST (PDL)

The PDL is a listing of preferred outpatient drugs within specific therapeutic categories that have been identified, reviewed, and approved by the Pharmacy and Therapeutics Committee.

1202.26 PROSPECTIVE DRUG UTILIZATION REVIEW (PRO-DUR)

Prospective Drug Utilization Review encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening.

1202.27 SCHOOL OF MEDICINE

The facility referred to in this chapter shall mean the University of Nevada School of Medicine, Reno and Las Vegas.

1202.28 SINGLE SOURCE DRUG

Single Source Drug is defined in SS 1927(k)(7) of the Social Security Act as, "a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application".

1202.29 STEP THERAPY

The process of beginning drug therapy for a medical condition with the safest and most effective lower risk drug therapy and progressing to other drug regimens only if medically necessary. Step therapy protocols are developed at a therapeutic class level, and approved through the Drug Use Review Board based upon clinical practice guidelines, without consideration of the cost of prescription drugs. Step therapy guidelines may be implemented through a prior authorization process, prospective Drug Use Review edits, and/or provider educational programs.

1202.30 SUPPLEMENTAL REBATES

Supplemental rebates are drug rebates collected from the manufacturer above the rebates collected under the OBRA 90 Drug Rebate Program. Section 927(a)(1) of the Social Security Act provides that "the Secretary may authorize a State to enter directly into agreements with a manufacturer." Per CMS, SMDL #02-014, "States may enter separate or supplemental drug rebate agreements as long as such agreements achieve drug rebates equal to or greater than the drug rebates set forth in the Secretary's national rebate agreement with drug manufacturers, which is published at 56 F.R.7049 (1991).

1202.31 TAMPER-RESISTANT PRESCRIPTION PADS

Effective April 1, 2008, pursuant to CMS SMDL # 07-012 a tamper-resistant prescription pad must contain at least one of the following three characteristics:

1. One or more industry-recognized feature(s) designed to prevent unauthorized copying of a complete or blank prescription form;
2. One or more industry-recognized feature(s) designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3. One or more industry-recognized feature(s) designed to prevent the use of counterfeit prescription forms.

No later than October 1, 2008, to be considered tamper resistant, a prescription pad must contain all of the foregoing three characteristics.

1202. 32 UNIT DOSE

A unit dose drug is that quantity of a drug which is packaged as a single dose by the manufacturer.

1202.33 USUAL CHARGE

A pharmacy may not charge Medicaid more than the general public.

1203 POLICY

Nevada Medicaid reimburses pharmacies for prescriptions dispensed to each Medicaid recipient, with a maximum of a 34 day supply. Maintenance medications have a maximum of 100 day supply.

1203.1 PHARMACEUTICALS

All legend and non-legend pharmaceuticals must be prescribed by a licensed physician, podiatrist, osteopath, dentist, advanced practitioner of nursing, or physician's assistant within the scope of their practice.

1203.1A COVERAGE AND LIMITATIONS

1. Covered:

The Nevada Medicaid Drug program will pay for the following prescribed pharmaceuticals with a written prescription and may be subject to restrictions (such as Prior Authorization, Quantity Limitations etc):

a. 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.

b. Legend and non-legend pharmaceuticals manufactured by companies participating in the federal Medicaid Drug Rebate Program, not on the excluded list (see below);

c. Preferred Drug List (PDL) is a list of covered outpatient drugs established upon recommendations from the P&T Committee. Reference Medicaid Operations Manual Chapter 200 for the P&T bylaws. Pharmaceuticals not on the preferred drug list, but within drug categories reviewed by the P & T Committee require prior authorization, unless exempt under NRS or federal law, excluded through recommendations of the P&T Committee or excluded by the Division of Health Care Financing and Policy.

1. New pharmaceutical products not within reviewed PDL categories and excluded under state plan are available under prior authorization guidelines until the P&T Committee can review the product or evidence.

2. Existing pharmaceutical products for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan, are available under prior authorization guidelines until the P&T Committee can review the new evidence.
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 a specific category based on clinical efficacy and safety, DHCFP or contractor may consider cost in determining which drugs are selected for inclusion on the PDL.
5. The Drug Use Review Board shall not be required to develop, review or approve prior authorization policies necessary for the operations of the PDL.

c. Pharmaceuticals prescribed for a medically accepted indication;
d. Family planning items such as diaphragms, condoms, foams and jellies.

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

2. 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. 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 Drug Efficacy Study and Implementation (DESI) program which has been found to be a less than effective or is Identical, Related or Similar (IRS) to the DESI drug. The DESI drug is identified by the Food and Drug Administration or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the 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 Food and Drug Administration (FDA) as to substance or diagnosis for which prescribed.

f. Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed. See definition 1202.7 of this Chapter. 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.

3. 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) 639.712 and 639.714.

b. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. (e.g. A prescription is written for 100 doses of a medication with directions of one tablet 3 times a day. This prescription is for a 34-day supply. A consistent refill would be expected in 30 days; an inconsistent refill date would be 20 days from the original fill.)

c. 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 (see Section 1203.1A(5)(c) of this Chapter) only.

4. Early Refills

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 prescription is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

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 (refer to the POS Manual for a list of acceptable overrides). This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

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.

5. Quantity of medication

The maximum quantity of medication per prescription payable by the Medicaid program is a 34 day supply. Exceptions are allowed for maintenance medications. (See Section 1203.1A(5)(c) of this Chapter.)

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 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
    11. Oral/Topical Contraceptives

6. Time Limits

Claims and adjustment requests must be submitted within the following time frames:

a. Claims not involving other third party payments must be received no later than 180 days after the date of service.
b. Claims involving other third party payers must be received no later than 1 year after the date of service. A copy of the Explanation of Benefits (EOB) from the other third party payer must be attached to the claim.
c. Claims returned by the Fiscal Agent for additional information or correction must be resubmitted to the Fiscal Agent within 180 days from the date on the return form.
d. Requests for adjustment to paid claims, including zero paid claims, must be received by the fiscal agent no later than the stale date time limits. Please refer to Chapter 100 Eligibility Coverage and Limitations for stale date limits.

e. Claims for persons who are retroactively determined eligible for Medicaid must be received no later than 180 days after the date of eligibility determination or the date of service, whichever is later.

f. Prior Authorization Request time requirements. In accordance with 42 CFR Section (d)(5)(A), all service request determinations will be issued by the Nevada Medicaid Quality Improvement Organization (QIO-like vendor) by telephone or other telecommunication device (fax) within 24 hours of the receipt of such request.

7. Emergency supply of medication

a. In an emergency situation, after QIO-like vendor working hours and weekends, dispensing of a 72-hour supply of those covered outpatient drugs that require prior authorization will be allowed.

b. Nevada Medicaid requires prior payment authorization for medications identified as requiring Prior Authorization (PA).

c. The physician must indicate the diagnosis on the prescription (preferably with an ICD-9 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

All coverage and limitation policies and rules, including any PA requirements, outlined in this chapter apply to Nevada Check Up recipients as well as Nevada Medicaid Fee for Service recipients. There are NO exceptions.

9. Immunizations

Nevada Medicaid recognizes the importance of preventative health care through vaccines and immunizations. Unless otherwise stated in this chapter, immunizations are covered without prior authorization. Reference Appendix A.

a. Childhood Immunizations: All childhood immunizations are covered without prior authorization under the Healthy Kids Program. Please reference Chapter 1500 “Healthy Kids Program” for more information and a list of covered immunizations.

b. Adult Immunizations: Adult immunizations such as tetanus, flu vaccine, and pneumococcal vaccine are covered without prior authorization. For a list of covered adult immunizations, please reference the Physician’s Fee Schedule under “Professional Rates” at: http://www.dhcfp.nv.gov/RatesUnit.htm

c. Human Papillomavirus (HPV) Vaccine: The HPV vaccine is available to all Medicaid eligible females age 9 years old up to and including 26 years, based on the US Food and Drug Administration (FDA) approved indications. These may be accessed by following the link:
http://www.fda.gov/cber/products/hpvmer060806.htm

1203.1B PROVIDER RESPONSIBILITY

1. Any pharmacy, pharmacist or prescribing practitioner who has a current license or registration, and who is licensed by his respective state, and who is free from any Pharmacy Board restriction by any state, may apply to become a participating provider under this program.

a. Each in-state pharmaceutical provider must have entered into a written contract, signed by the provider and/or his representative, with Nevada Medicaid to acquire participating status and must comply with federal, state and Medicaid regulations and procedures.

b. The pharmaceutical provider will maintain records for all prescriptions dispensed to eligible recipients as may be required.

1. The provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.
2. All fiscal records are to be maintained for a period of six years or as specified in federal regulation.

c. Application for participation may be made by phone or letter to the Nevada Medicaid Office at the location noted in the reference Section 1205.2.C. of this Chapter. Nevada Medicaid reserves the right to reject any request for participation.

d. A current list of providers may be obtained through Medicaid's Fiscal Agent.

2. UTILIZATION CONTROL

a. Prospective (Concurrent) Drug Utilization Review (Pro-DUR)
Pro-DUR functions will be carried out via the Point of Sale (POS) Systems. However, verification of eligibility by provider review of the recipient's current Medicaid card at the time of service remains a necessary responsibility of the provider.

1. Pro-DUR edits apply to POS claims and paper (UCF) claims.
2. LTC claims are subject to all Pro-DUR edits that apply to retail.

3. Providers may submit override codes using the NCPDP standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file.
4. No long term PA's are issued, codes must be entered each time errors occur.

Reference the provider manual provided by the Nevada Medicaid POS system contractor for more information on the current Pro-DUR edits and override procedures.

b. Retro Drug Utilization Review

Both recipient and provider profiles (i.e. claim payments) are reviewed to identify patterns of excess. Verification of receipt of services is ongoing on a sample basis. Providers may be audited on site.

c. Drug Utilization Review (DUR)

Nevada Medicaid policy and federal law allows the state appointed DUR committee to conduct review of the information compiled about individual clients and providers and allows the DUR committee to educate Medicaid providers about the changes in ambulatory therapeutics. Educational programs may include information such as drug interactions between medications that physicians have prescribed for the patients, and medications they are prescribing that are unnecessarily expensive. In this case, educational efforts will be directed to help providers improve their efficiency in the allocation of the finite resources available for Medicaid clients.

d. Eligibility

Eligibility for Medicaid services is verified by possession of a Medicaid card valid for the current month.

1. Medicaid cards printed "A" or "M" mean Qualified Medicare Beneficiary (QMB); "A" is eligible for full Medicaid Services; "M" is eligible only for Medicare deductible and co-insurance, no other Medicaid services. A recipient card marked with a "P" is eligible only for pregnancy-related services, no others.
2. When patients claim Medicaid eligibility but do not have a computer generated Medicaid card, eligibility may be verified through the Eligibility Verification System (EVS) or by contacting the appropriate Division of Welfare and Support Services District Office (see Section 1205).

3. Managed Care – HMO: All reimbursement is subject to the enrolled health plan limitations. Contact instructions are noted on each recipient's Medicaid card.
4. Lock-in Program: When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, the recipient may be "locked-in" to a pharmacy or provider. This means that Medicaid will only pay for controlled substance prescriptions/medical service at a single pharmacy/provider. An edit will be placed in the POS system that will not allow another pharmacy to bill for controlled substance prescriptions, and a Pro-DUR message will be given at the time of service to notify the pharmacy that the recipient is "locked-in".

3. GENERIC SUBSTITUTION

Per NRS 639.2583, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

a. Is less expensive than the drug prescribed by brand name;
b. Is biologically equivalent to the drug prescribed by brand name;
c. Has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and
d. Is of the same generic type as the drug prescribed by brand name the least expensive of the drugs that are available to him for substitution.

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

4. PRESCRIBER BRAND CERTIFICATION

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure for certification must comply with the following:

a. The certification must be in the physician's own handwriting.
b. Certification must be written directly on the prescription blank.
c. The phrase "Dispense as written" is required on the face of the prescription. For electronically transmitted prescriptions "Dispense as written" must be noted.

Not acceptable: A printed box on the prescription blank checked by the prescriber to indicate "brand necessary" or a handwritten statement transferred to a rubber stamp and then stamped on the prescription.

d. A prior authorization is not required unless subject to Section 1203.1(A)1-2 or Appendix A of this Chapter.

e. Certification is not required if a generic is not manufactured.

f. A fax copy/verbal order may be taken by the pharmacist from the physician but the pharmacy must obtain an original printed copy and keep on file.

1203.1C RECIPIENT RESPONSIBILITY

1. Recipient must report any changes that might affect Medicaid eligibility, such as changes in family income or a move to another country or state. They must also notify the Division of Welfare and Supportive Services District Office if they buy health insurance or become covered under another person's health insurance.

2. Recipient's are encouraged to receive prescriptions in one pharmacy of their choice for continuity of care. They must inform providers that they are a Medicaid recipient and show a Medicaid card prior to services. Recipients are also responsible for informing providers of any other insurance that may cover medical services.

3. If approved for Medicaid retroactively, recipients must notify providers of Medicaid eligibility on receipt of a Medicaid card.

4. Recipients are responsible for charges incurred during any time of ineligibility for Medicaid.

1203.1D SERVICE DELIVERY MODEL

For the rate and reimbursement methodology see Medicaid Services Manual Chapter 700, Rates. For POS claims refer to the First Health Pharmacy Billing Manual, and for MMIS claims refer to the First Health Nevada Medicaid Billing Manual at https://nevada.fhsc.com/

1. Institutional settings:

a. Medical/Surgical, Specialty and Psychiatric Hospitals – All pharmacy services are included in the daily per diem rate for inpatient services, which are billed thought MMIS.

b. Long Term Care

1. Nursing Facilities – Legend pharmaceutical services are excluded from the daily per diem facility rate. This includes compound prescriptions and

Total Parental Nutrition (TPN) solution and additives. Legend pharmaceuticals are billed directly by a licensed pharmacy through POS.

Non-legend pharmaceuticals are not separately reimbursable.

2. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) – Legend and non-legend pharmaceuticals are excluded from the facility rate. Pharmaceuticals are billed directly by a licensed pharmacy through POS.

2. Outpatient Pharmaceuticals

a. Covered outpatient drugs that are billed separately from medical services, in accordance with Section 1927 of the SSA.

1. Retail pharmacies, (billed through POS).

2. Home Infusion Therapy (HIT)/Free Standing Infusion Clinics, (billed through POS). Refer to Section 1203.2 of this Chapter.

3. Physician administered drugs, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

4. Hospital based outpatient clinics, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

b. Covered outpatient drugs that are not reimbursed separately in accordance with 1927(k)(2) of the SSA.

1. Ambulatory Surgical Centers (ASC)/Hospital-Based Ambulatory Infusion Centers, all pharmacy services are included in the facility rate. Pharmacy charges may not be billed separately, (billed through MMIS).

2. Emergency Rooms, all pharmacy services are included in the Emergency Room charges. “Take home” medications are also included in the facility rate and may not be billed separately, (billed through MMIS).

3. DISPOSABLE MEDICAL SUPPLIES

Please refer to Chapter 1300, Durable Medical Equipment (DME) for instructions on billing and any applicable limitations for these items.

4. UNIT DOSE (REPACKAGE AND RE-STOCK)

REPACKAGE: Nevada Medicaid provides reimbursement incentives for Long Term Care (LTC) providers who repackage non-unit dose pharmaceuticals. An additional $0.43 per claim is given on pharmaceuticals that are repackaged for unit dose dispensing. Pharmaceuticals that First Data Bank classifies as unit dose products are not covered for this policy.

This incentive is available only to pharmacies supplying long-term care inpatients. The pharmacy provider must apply to the QIO-like Vendor Pharmacy Department to enroll in this incentive program.

In accordance with the Centers for Medicare and Medicaid Services (CMS), State Medicaid Director Letter (SMDL) 06-005, repackaging of pharmaceuticals must be in compliance with the Nevada State Board of Pharmacy. In addition, nursing facilities must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuance of the prescription or transfer, discharge or death of a Medicaid beneficiary. This is to assure there is no double billing of the medication.

5. THIRD PARTY LIABILITY

Medicaid is always payer of last resort whenever any other resource is responsible for payment. "Third Party" means any individual entity on program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a state Medicaid plan. Other medical resources include, but are not limited to, Medicare, private insurance, self-insured plans, and workers compensation insurance. The exceptions to this rule are Indian Health Services, and Children with Special Health Care Needs (previously known as Crippled Children's Services), and state victims of crime. Medicaid is a prior resource to these programs.

Billing all other third party resources is mandated by federal and state law, and is one of the provisions of the Provider Agreement signed by participating Medicaid providers. In addition, a Medicaid provider cannot refuse to furnish Medicaid covered services to a Medicaid eligible individual due to potential Third Party Liability (TPL) for the services. However, if the provider does not participate in the recipient's Other Health Care (OHC) plan, the provider should refer the recipient to the OHC plan. Nevada Medicaid may deny payment for the OHC plan covered services if the recipient elects to seek treatment from a provider not authorized by the OHC plan. If

the Medicaid recipient voluntarily elects to receive Medicaid covered services from a provider who does not participate in the recipient's OHC plan, the recipient assumes the responsibility to pay for the services the same as a private pay only patient.

a. Coordination of Benefits (COB)

On-line COB (cost avoidance) is part of the Nevada Medicaid POS system.

1. If Nevada Medicaid is the recipient's secondary carrier, claims for COB will be accepted.
2. Nevada Medicaid is always the payer of last resort.
3. Other coverage will be identified by the presence of other carrier information on the recipient eligibility file.
4. If the recipient shows other coverage, the claim will be denied. The POS system will return a unique client-identified carrier code identifying the other carrier, the recipient's policy number and the carrier name in the additional message filed. It is possible that a recipient may have more than one active other carrier; in that case, the returned code will be from the first carrier, subsequent codes will be returned until fully exhausted. Providers will be required to submit this code OTHER PAYER ID (#340-7C) field as part of the override process.
5. Even if "no other insurance" is indicated on the eligibility file, the claim will be processed as a TPL claim if the pharmacy submits.
6. If other insurance is indicated on the eligibility file, the claim will be processed as a TPL regardless of what TPL codes the pharmacy submits.
7. In all cases, the Nevada Medicaid "allowed amount" will be used when calculating payment. In some cases, this may result in a "0" payment, when the insurance carrier pays more than the Medicaid "allowable amount".
8. In order to facilitate the TPL/COB process, Nevada Medicaid will allow providers to override "days supply limits" and/or "Drug Requires PA" conditions by entering a value of "5" (exemption from prescription limits) in the PA/MC CODE field (NCPCP #416DG) if there are no PA requirements on these drugs from the primary insurer.

b. Non-participating HMO Providers

1. Recipients, who have Medicaid and HMO coverage, including Medicare HMOs, must seek treatment and services through their preferred provider network or HMO. Nevada Medicaid is not liable to pay for HMO covered services if the recipient elects to seek treatment from a provider not authorized by the HMO. Unless the provider is an authorized provider of a recipient's health plan, the recipient should be

referred to the plan for covered treatment, or the provider should contact the HMO for treatment authorization.

2. Exceptions to Medicaid liability policy are:
   a. The service(s) is/are a non-covered benefit of the HMO plan;
   b. The service is an emergency and a participating provider is more than 25 miles away;
   c. The service is for family planning;
   d. The recipient resides outside the service area of the HMO; or
   e. The recipient's HMO coverage has been exhausted.

6. PHARMACY BILLING PROCESS

a. National Council for Prescription Drug Program (NCPDP) Standard Billing Units

Nevada Medicaid reimburses for outpatient pharmaceuticals according to NCPDP "Billing Unit Standard Format" guidelines. The standard provides for the billing of pharmaceuticals in one of three billing units for all drug products. These units are "each", "milliliter (ml)", and "gram (g)". The following guidelines are to be used when billing Nevada Medicaid for pharmaceuticals:

Tablets, Capsules, Suppositories, Pre-filled Syringes**:** must be billed by "each". For example, if 30 tablets of Metformin are dispensed, the quantity will be 30.

Liquids, Liquid Orals, Suspensions, Solutions, Opthalmic/Otic Solutions: must be billed by milliliters (mls). For example, if 560ml of guiafenesin is dispensed, the quantity entered will be 560.

PLEASE NOTE:

Ounces must be converted to ml (1 ounce = 30ml).
Liters must be converted to ml (1L = 1000ml).
Ointments, Bulk Powders: must be billed by grams. For example, if a two ounce tube of oxiconazole nitrate is dispensed, the quantity entered will be 60.

PLEASE NOTE:

Ounces must be converted to grams (1 ounce = 30g, ½ ounce = 15g).
Oral Contraceptives/Therapy packs: must be billed per "each" tablet dispensed, not the number of packages. For example, Ortho Tri-Cyclen is a 28-day dial pack, the quantity entered will be 28.

Transdermal Patches/Powder Packets: must be billed per "each" patch/packet dispensed, regardless of whether they are pre-packaged in a box or come in individual pouches/packets. For example, Catapress-TTS comes in a box of four patches. If two of these boxes are dispensed, the quantity entered will be eight.

Inhalers and Aerosols: must be billed as either grams or ml, as specified by the manufacturer on the labeling. For example a 90mcg(microgram)/inh Albuterol Inhaler has a total of 17gm in the canister. If one of these is dispensed, 17 will be quantity entered.

Topical Products: must be billed as either grams or ml, as specified by the manufacturer on the labeling.

PLEASE NOTE: Ounces must be converted to grams or ml.

1 ounce = 30ml
1 ounce = 30g

Reconstitutables (oral, otic, ophthalmic): must be billed per ml that are/will be in the bottle after reconstitution according to the manufacturer's instructions.

Liquid Injectables (vials, ampoules): must be billed by milliliters (ml). For example, if a 10ml vial of Novolin 70/30 is dispensed, the quantity entered will be 10.

Powdered Injectables (vials): must be billed by "each" vial given per dose. For example if the recipient receives Ampicillin 1g every 6 hours for 1 week, the quantity entered will be 1, as only one vial is used per dose (assuming a 1gm vial is used), and the # of doses entered will be 28 (4 per day x 7 days). PLEASE NOTE: If the product is supplied with a diluent, the quantity entered is only the number of powdered vials dispensed, the diluent is not factored in.

Intravenous Solutions: must be billed in ml administered per dose. For example, if a recipient receives 250ml of Normal Saline four times per day, the quantity entered will be 250, as that is the quantity per dose.

Blood Derived Products: products may vary in potency from batch to batch. Anithemophilic products must be billed as the number of antihemophilic units dispensed (each). Prolastin must similarly be billed as the number of milligrams dispensed (each).

Kits: defined as products with a least two different or discreet items (excluding diluents, applicators and activation devices) in the same package, intended for dispensing as a unit. Kits carry only a single NDC. Kits are intended to be dispensed as a unit and should be billed as a unit of each kit dispensed (each).

For further information, refer to the NCPDP Billing Unit Standard Format Official Release.

b. Provider Numbers

The state NABP provider number is to be used and entered when billing online using the POS system or when using the UCF.

7. STATE MAXIMUM ALLOWABLE COST (SMAC)

a. State Maximum Allowable Cost (SMAC) is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the Division of Health Care Financing and Policy (DHCFP), or Fiscal Agent.

1. DHCFP Fiscal Agent will perform ongoing market analysis to monitor pricing patterns and product availability.
2. DHCFP Fiscal Agent will perform monthly updates of the drugs subject to the SMAC.
3. All drugs subject to the SMAC and updates will be posted on the following website: http://nevada.fhsc.com

b. Providers may appeal the current SMAC for a pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current SMAC reimbursement.

1. The pharmacy must contact the Fiscal Agent technical call center to initiate the appeal.
2. Information needed to make a decision will include NDC number, manufacturer, drug name, strength, and price paid. A faxed copy of the actual invoice for the drug may be requested.
3. Inquiries not resolved by the technical call center are forwarded to the Fiscal Agent's SMAC Coordinator for investigation and resolution.
4. If it is determined the SMAC is negatively impacting access to care for recipients, the SMAC Coordinator has the authority to 1) adjust SMAC pricing for the particular claim being appealed, and 2) make changes to the SMAC pricing file.

5. Appeals will be responded to within three working days of the referral to the SMAC Coordinator.

1203.1E AUTHORIZATION PROCEDURES

PRIOR AUTHORIZATION (PA) REQUESTS: Physician's may request payment for exceptions to program limitations outlined in Section 1203.1A(1) of this Chapter and medications requiring prior authorization in Appendix A of this Chapter by forwarding a PA request to the Quality Improvement Organization (QIO-like vendor). The phone/fax number is located in Section 1205 of this Chapter.

1. When completing the PA providers must:
   a. Provide all relevant diagnoses.
   b. List all routine essential drugs being prescribed.
   c. The requesting physician must sign the PA and forward all copies to the QIO-like vendor. He/she will be advised by return copy of the decision. (A facsimile signature stamp is acceptable.)
   d. Unless otherwise indicated, by the QIO-like vendor, the PA is for no more than one 34-day supply of prescription for each authorized drug per month.

2. Prior Authorization Protocols:

   a. Alternate media (e.g. paper/UCF claims) are subject to all prior authorization types.
   b. LTC claims, regardless of the media type, are subject to all prior authorization types. Note that the POS system does not require a "PA Number" to be entered on a paper or electronic claim; the only requirement is that the PA record is activated in the system prior to the claim submission. The approved PA will be in the POS system and will be active for all pharmacies using the POS system, unless the recipient is "locked-in" to a particular pharmacy for abuse/misuse reasons.
   c. A prior authorization will typically be required to be requested and entered prior to the dispensing of the medication, however there may be situations in which an authorization request is considered after the fact (e.g. retroactive eligibility).

   d. For clinical prior authorizations in which a Clinical Call Centre PA Unit pharmacist or pharmacy technician requests information from the prescribing physician, the PA will deny if the doctor does not respond to a request for information within three working days.
   e. The Nevada Medicaid QIO-like vendor will send all denial of service letters.

f. For any prior authorization requests that are denied due to criteria not being met, the recipient (only) may appeal the decision. Reference Nevada Medicaid Chapter 3100 for the hearings process.

g. Standard protocols for "Emergency" or "72 Hour Fill" type of overrides will be used.

1203.2 INTRAVENOUS (IV) THERAPY PROVIDER TYPE 37

The purpose of IV therapy is to sustain life, reduce or eliminate infections, replace or provide necessary chemicals to maintain electrolyte balance or provide blood product or hemotherapeutics. IV therapy and treatment should only be used when the Medicaid recipient cannot use oral medications.

1. Billing Guidelines:

IV therapy is billed through the pharmacy POS system using the multi-ingredient functionality. A 37 provider number is required (Home Infusion Therapy Provider). The paper Multi-ingredient UCF may also be used if an exception is granted by the Division. Drug coverage edits and prior-authorization edits will be performed at the individual ingredient level.

The billing units used should be the NCPDP standards of "each", milliliters (ml) or grams(g). Please refer to section 1203.1(D)(8) of this Chapter for complete explanation of these standards.

For specific instructions related to billing via the POS system, refer to the Claims Processing Manual provider by the Nevada Medicaid QIO-like vendor or contact them by phone (see section 1205 Page 1 of this Chapter).

2. Dispensing Fees:

A daily dispensing fee of $22.40 will be applied to IV therapy claims for outpatient antibiotic therapy. For recipients in Long Term Care, a daily dispensing fee of $16.80 will be applied to the claim. This will be multiplied by the number of days the therapy was provided.

3. Supplies:

Supplies for IV therapy, Enteral Nutrition and Total Parenteral Nutrition (TPN) are billed through the DME program (under Provider Type 33). Please refer to Chapter 1300 (DME) for instructions on billing and any applicable limitations on these items.

4. Long Term Care:

a. Non-Billable Items

IV hydration therapy of standard fluids without additives (e.g., antibiotics, potassium, and heparin) as well as supplies associated with IV therapy, Enteral Nutrition, and TPN administration are included in Nevada Medicaid's Long Term Care / Nursing Facilities rate and may not be billed as a separate charge.

b. Billable Items

IV Drugs/TPN for recipients in Long Term Care facilities may be billed as a separate charge. Please refer to Chapter 500 (Nursing Facilities) of the Medicaid Service Manuals for further information on items which may be billed separately to Nevada Medicaid.

1204 HEARINGS

1204.1 Please reference Nevada Medicaid Services Manual, Chapter 3100 for the Medicaid Hearings process.

1205 REFERENCES AND CROSS REFERENCES

1205.1 PROVIDER SPECIFIC INFORMATION

Specific information about each provider type can be found in the following chapters:

Medicaid Services Manuals:

Chapter 100	Eligibility, Coverage and Limitations
Chapter 1300	DME, Prostheses and Disposable Supplies
Chapter 3100	Medicaid Hearings
Chapter 3300	Surveillance and Utilization Review Section (SURS)
Chapter 3600	Managed Care Organization

Nevada Check Up Manual:

Chapter 1000	Nevada Check Up Program

1205.2 CONTACTS

1. STATE OFFICES

a. Central Office
Division of Health Care Financing and Policy
Nevada Medicaid Office
1100 E. Williams Street
Carson City, Nevada 89701
Telephone: (775) 684-3600

b. District Offices

Nevada Division of Health Care Financing and Policy, Medicaid District Offices (DO's) are listed in various Medicaid pamphlets. Local telephone numbers are:

Carson City	(775) 684-3651
Elko	(775) 753-1191
Las Vegas	(702) 668-4200
Reno - Bible Way	(775) 688-2811

c. CDC Public Health Advisor
Immunization Program
Nevada Department of Health and Human Services
4150 Technology Way
Carson City, NV 89706
(775)684-5900

1205.3 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNIT
Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENT
First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT
First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

CHAPTER 1200-PRESCRIBED DRUGS
APPENDIX A-TABLE OF CONTENTS

1. DRUGS REQUIRING A PRIOR AUTHORIZATION

A. Proton Pump Inhibitors (PPI's)

PPI's are a covered Nevada Medicaid benefit for adult recipients with a diagnosis of Gastroesophageal Reflux Disease (GERD), or Peptic/Gastric Ulcer Disease (PUD), or Helicobacter Pylori or Hypersecretory Conditions (e.g. Barrett's Esophagus, Zollinger-Ellison) who meet the criteria for coverage.

1. Coverage and Limitations:

Approval will be given if the following are met and documented:

a. Gastric Esophageal Reflux Disease (GERD):
   1. Lifestyle modification has been attempted/the prescriber documents attempts to educate recipient on lifestyle modification. This should include, but is not limited to, dietary changes, avoiding tight clothing, smoking cessation, reduction of meal size, elevation of HOB, etc. Consider NSAID/ASA use and discontinue use or switch recipient to Cox 2 if appropriate; and,
   2. Over the Counter (OTC) antacid/acid suppression trial has been attempted. This must include trial of at least one OTC antacid and one OTC H2A in therapeutic dosage. Drug, dose, frequency and duration attempted must be documented on the Payment Authorization (PA) form. This trial, in conjunction with lifestyle modification, must be at least a four week trial.
      Approval of PPI will be for one year. A trial of H2A after each year for two weeks.

b. Peptic/Gastric Ulcer Disease (PUD):
   1. Diagnosis of active gastric or duodenal ulcer must be confirmed with endoscopy or upper Gastrointestinal (GI) series within the last 2 months.
      Documentation of attempt at/attempt to educate recipient regarding lifestyle modification must be present (see GERD for guidelines).
   2. Helicobactor pylori test has been administered. If results are positive, see H. pylori guidelines below.
      Approval of PPI will be for a 90-day time limit.

c. Hypersecretory Conditions (Barrett's Esophagus, Zollinger-Ellison etc) diagnosis must be confirmed with testing. Approval will be for a 12-month time period.

d. Helicobacter pylori (H. pylori)
   1. Must be confirmed with testing (e.g. serologic, HpSA) and,
   2. Combination therapy must be documented. Triple therapy (e.g. a bismuth salt, metronidazole and tetracycline or amoxicillin) or other

regimen that combines one or more anti-infective agents with a bismuth salt and/or an antisecretory agent should also be considered.
Approval of PPI will be for a one-month limit.

e. GI Bleed

1. Diagnosis of active GI bleed within the past month.
Approval will be for a one-month limit.
If a PPI is prescribed concurrently with an H2A by the same prescriber, it will be considered duplicate therapy and will not be approved.

2. Covered Products:
All pharmaceutical PPI agents where the manufacturer of the product participates in the CMS rebate program and is compliant with all other Nevada Medicaid regulations (e.g. DESI drug status, etc.).

2. PA Guidelines:

The PA must be initiated by the prescriber, except in long term care facilities where the attending nurse may initiate and certify the PA after a review of the recipient's chart has been completed.

PA form: Nevada Medicaid Prior Authorization Request for Proton Pump Inhibitors Form. PA forms are available at http://nevada.fhsc.com

B. Cox 2 Inhibitors

Cox 2 Inhibitors are a covered benefit of Nevada Medicaid for adult recipients who meet the criteria for coverage.

1. Coverage and Limitations:

FDA Approved Indications:

a. A diagnosis of osteoarthritis, degenerative joint disease, rheumatoid arthritis, dysmenorrheal, familial adenomatous polyposis (FAP) or acute pain in adults.
b. Upon diagnosis of an FDA approved indication, authorization will be given if the patient meets all of the following criteria:
1. Patient has no history of allergies to sulfonamides, aspirin or other NSAID's (non-steroidal anti-inflammatory drugs).

2. Patient has a documented history of gastro-intestinal bleeding, ulceration or perforation of the stomach, small intestine or large intestine or is being treated with oral corticosteroids or anticoagulants.
3. Patient has a documented treatment history and/or failure of at least two non-selective (traditional) NSAIDs.
4. Patient is currently NOT being treated daily with aspirin for cardio-prophylaxis.
5. Patient does NOT have a documented history of cardiac events (e.g. stroke, myocardial infarction, or has NOT undergone of coronary artery bypass graft procedure in the past 6 months) or major cardiac risk factors such as smoking, high blood pressure, diabetes or high cholesterol.
6. Physician has considered alternative treatment options (e.g. GI protective agent and non-selective NSAID such as acetaminophen, tramadol or a topical agent).
7. Length of treatment has not exceeded 6 months.

2. PA Guidelines:

The PA must be initiated by the prescriber, except in long term care facilities where the PA may be initiated and certified by the attending nurse after a review of the recipient's chart has been completed.

PA Form: Nevada Medicaid Prior Authorization Request for Cox II's form. PA forms are available at http://nevada.fhsc.com.

C. Agents used for the treatment of Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)

Agents, both stimulants and non-stimulants used for the treatment of ADD/ADHD are a covered Nevada Medicaid benefit for the treatment of pediatric, adolescent, and adult clients that meet the criteria for coverage.

1. Coverage and Limitations:

Approval for medications will be given at the therapeutics class level if the following criteria is met and documented:

a. General Criteria (Children and Adults)

1. Only one long-acting agent at a time may be used for the treatment of ADD/ADHD (applies to the entire ADD/ADHD/Stimulant Class); a 30-day transitional overlap in therapy will be allowed.

2. The following two criteria's must be met and documented in the recipient's medical record for adult and pediatric recipients.
   a. The decision to medicate for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) must be based on problems that are persistent and sufficiently severe to cause functional impairment in one or more of the following social environments: school, home, work or with peers, and
   b. Before treatment with pharmacological methods is instituted, other treatable causes have been ruled out.

b. Children (up to age 18 years)

In addition to the general criteria above, the following conditions apply and must be documented in the recipient's medical record.

1. Prescriptions for ADD/ADHD medications do not require prior authorizations for children five years of age, up to eighteen years of age, if the following conditions apply:
   a. The medication is prescribed by a psychiatrist, and
   b. One of the following ICD-9 codes is documented on the prescription: 314.0-314.9.
2. In all other cases, prior authorization is required. The following is required for prior authorization.

   a. An initial evaluation or examination has been done within the past twelve months by the treating physician, pediatrician, psychiatrist or neurologist documenting the developmental history, physical evaluation, medical history or a primary neurological diagnosis and of all the following:

      1. School information, Standardized Teachers Rating Scales testing reports such as TOVA (Test of Variables of Attention), achievement test, neuropsychological testing if indicated, Conner's scale, speech and language evaluation, and
      2. DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) symptoms of ADD or ADHD, presence or absence-child behavior checklist, development and context of symptoms and resulting impairment, including school, family and peers, DSM-IV symptoms of possible alternate or comorbid psychiatric diagnosis, history of psychiatric, psychological pediatric or neurological treatment for ADD or ADHD, and
      3. Family history including diagnosis of ADD and ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder and other anxiety disorders, past or

present family stressors, crises, any abuse or neglect, interview with parent(s) or guardian(s).

c. Adults (18 years and above)In addition to the general criteria above, the following must be present and documented in the recipient's medical record:

1. An initial evaluation-complete psychiatric assessment, present and past DSM-IV, symptoms of ADD or ADHD, history of development and context of symptoms and resulting past and present impairment, including academic achievement, learning disorder evaluation, and
2. One of the following:
   a. Medical history, medical or primary neurological diagnosis, identify medication(s) that could be causing symptoms (e.g. Phenobarbital, steroids), or
   b. History of other psychiatric disorder(s) and treatment, or
   c. DSM-IV symptoms of ADD and ADHD presence or absence, possible alternate comorbid psychiatric diagnosis (especially: personality disorder, mood disorder, depression or mania, anxiety disorder, dissociative disorder, tic disorder including Tourette's disorder and substance abuse disorder), or
   d. Family history including diagnosis of ADD or ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder, mood disorder and anxiety disorder, possible family stressors, any history of abuse or neglect.

Prior Authorization will be given for a 1 year time period.

PA Form: Nevada Medicaid Prior Authorization Request for CNS Stimulants Adult and Pediatric forms are available at http://nevada.fhsc.com

D. Growth Hormone

Growth Hormone (GH) therapy is a covered Nevada Medicaid benefit subject to Prior Authorization. An FDA-approved indication for the diagnosis being treated is required.

1. Coverage and Limitations:
   a. Children (up to age 21)
   The following apply to all requests for children:

   1. An evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for therapy.

2. All other causes for short stature are ruled out.
3. Patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonatropic hormones.

Therapy will be approved for any one of the following:

4. Diagnosis of Turner's Syndrome.
5. Diagnosis of Prader-Willi Syndrome.
6. Patient has chronic renal insufficiency (defined as Creatinine Clearance between 5 and 75/ml/min/1.73m2).

7. If the patient has evidence of hypothalamic-pituitary disease or structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation and meeting any one of the following:
   a. Has failed at least one GH stimulation test (peak GH level <10 nanograms (ng/ml).
   b. Had at least one documented low IGF-1 level (below normal range for patients age – refer to range on submitted lab document).
   c. Has deficiencies in three or more pituitary axes (i.e. TSH, LH, FSH, ACTH, ADH).
8. If the patient is a newborn infant and has evidence of hypoglycemia and either a low GH level (<20ng/ml) or a low for age IGF-1 or IGF Binding Protein #3 level (IGFPB#3) (no stimulation test required for infants).
9. Children with a history of intrauterine growth restriction (small for gestational age (SGA)) who at age two years have a height at least two Standard Deviations (SD) below the mean for the patient's age and gender.
10. For Idiopathic Short Stature all the following criteria must be met:
    a. Bone age>2 SD below the mean for age, Epiphysis open.
    b. Height >2.25 SD below the mean for age or >2 SD below the mid-parenteral height percentile or growth velocity <25th percentile for bone age.
    c. At least one provocative stimuli test to show failure to raise the grow hormone level above 10 ng/ml.
    d. Exception to the requirement for stimuli testing: Patients meeting (10)(a) and (10)(b) above in addition to a documented low serum insulin-like growth factor 1 (IGF-1) and/or insulin-like growth factor binding protein #3 (IGFPB#3) will not be required to have stimuli testing.

b. Criteria for the continuation of growth hormone therapy for children includes all of the following:

1. Bone age >2 SD below the mean for age. Epiphysis open.
2. Growth rate with treatment is at least two centimeters greater than the untreated rate. Copy of the growth chart must accompany forms.
3. Child has not reached the 25th percentile of normal height for gender.
4. No diagnosis of an expanding lesion or tumor formation.
5. Patient has not undergone renal transplant.

c. Reasons for Non-Coverage/Denial include, but are not limited to, the following:

1. Indications other than those specified in this policy;
2. Any condition(s) which is contraindicated and/or considered to be experimental;
3. Patients with expanding lesions or tumor formation;
4. Patients who have received renal transplantation; or
5. Patients who do not meet criteria as set by this policy.
6. Also, growth rate that is less than 2.0 cm/yr of untreated rate; growth that has reached the 25% of normal height for gender; bone age that is over recommended age for gender; or if epiphysis is closed.

An evaluation by a pediatric endocrinologist or a pediatric nephrologist is mandatory for initiation of growth hormone therapy and close monitoring either by a pediatric endocrinologist, pediatric nephrologist or the recipient's primary care physician is required throughout therapy.

Prior Authorization will be given for a 6 month time period for initiation of therapy, and 6-12 months for continuation of therapy, dependant upon the response of growth by the recipient.

d. Adults (age 21 and older)

Indications for growth hormone therapy in adults are:
Adults who were growth hormone deficient as children or adolescents.
All of the following criteria must be met:

1. The patient is evaluated by an endocrinologist.
2. Patient has a growth hormone deficiency either alone or with multiple hormone deficiencies (hypopituitarism), as a result of either disease of the pituitary or hypothalamus, or injury to either the pituitary or hypothalamus from surgery radiation therapy or trauma.

3. Patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonadotropic hormone. Patient has failed to respond to standard growth stimulation tests. Exception: Complete hypopituitarism.
4. Patient has failed a growth hormone stimulation test. Failure generally defined as a maximum peak of <5ng/ml.

e. HIV/AIDS Wasting or Cachexia.

Agents selected for treatment must have an FDA approved indication for the diagnosis being treated as stated in the package insert.

The following criteria must be met for the treatment of HIV/AIDS wasting or cachexia:

1. Patient must be stable on antiretroviral therapy and compliant with therapy.
2. Documented involuntary weight loss greater than 10% pre-illness baseline or a body mass index of <20KG/M2 (weight and diagnosis must be confirmed by faxed chart notes).
   a. Patient has failed to adequately respond to dietary measures.
   b. Patient has failed to respond or is intolerant to appetite-stimulating drugs, (e.g. Megace) and anabolic steroids.
   c. Absence of a concurrent illness or medical condition other than HIV infection that would explain these findings.
3. No active malignancy other than Kaposi's Sarcoma.

Prior Authorization will be given for 12 weeks.

If patient maintains or gains weight, is experiencing no adverse events, and is being monitored on a regular basis by the prescriber, approve the Prior Authorization for 12 additional weeks. Subsequent Prior Authorization approvals based on this criteria may be granted in 12 week increments.

f. Requests involving the following should be denied:

1. Indications other than those specified above.
2. Any condition that is considered contraindicated and/or considered to be experimental.
3. Patients who do not meet the criteria.

PA Form: Nevada Medicaid Prior Authorization Request for Growth Hormone Adult and Pediatric forms are available at http://nevada.fhsc.com.

E. Over-the-Counter Medications

Over-the-Counter medications are a covered Nevada Medicaid benefit subject to Prior Authorization.

1. Coverage and Limitations:

Two prescriptions per month within the same Standard Therapeutic Class (please see Appendix B for a list of Standard Therapeutic Classes) will be allowed without PA. Any more than two prescription requests for medications within the same therapeutic class will require PA.

A PA form must be submitted to the Nevada QIO-like vendor. The QIO-like vendor will request further information needed on a case by case basis to determine the necessity of the medication for the recipient.

Note: Insulin will be exempt from any PA requirements.

Approval will be for a one month time limit.

PA Form: Generic Nevada Medicaid Request for Prior Authorization form.

F. Duragesic ® (fentanyl transdermal) Patches

Transdermal fentanyl, a narcotic agonist analgesic, is indicated in the management of chronic pain in patients requiring continuous opioid analgesia for pain that cannot be managed by lesser means such as acetaminophen-opioid combinations, non-steroidal analgesics or PRN dosing with short-acting opioids. Transdermal fentanyl is a covered Nevada Medicaid benefit subject to Prior Authorization.

1. Coverage and Limitations:

Because serious or life-threatening hypoventilation could occur, fentanyl transdermal is contraindicated in management of acute or postoperative pain, mild or intermittent pain responsive to PRN or non-opioid therapy, or in doses exceeding 25 mcg/hr at the initiation of opioid therapy. Therefore, patients must meet the following two criteria in order to gain PA approval:

a. Patient cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteriodal analgesics, or PRN dosing with short-acting opioid.
b. Patient requires continuous opioid administration.

In addition the following guidelines apply:

a. Dosing interval 1 patch every 3 days; may be dosed every two days if failure to achieve pain relief is documented and clinical notes are provided to clinical call center.

b. Do not authorize if on long-acting narcotics. If recipient is switching to fentanyl and has a prior authorization for a long-acting narcotic, discontinue the prior authorization for the long-acting narcotic and inform the prescriber.

Prior approval will be given for a 6 month time period.

PA Form: generic Nevada Medicaid Request for Prior Authorization form.

G. Hematopoietic/Hematinic Agents

This policy applies in all settings with the exception of inpatient facilities.

Hematopoietics and Hematinics also known as erythropoiesis stimulating agents (ESAs) are a covered Nevada Medicaid benefit for recipients who meet one of the following criteria for coverage.

1. Coverage and Limitations:
   a. Achieve and maintain hemoglobin levels within the range of 10 to 12 gm/dl in one of the following conditions.
      1. Treatment of anemia secondary to myelosuppressive anticancer chemotherapy.
      2. Treatment of anemia related to zidovudine therapy in HIV-infected patients.
      3. Treatment of anemia secondary to end stage renal disease (ESRD).
   b. Epoetin alfa (Epogen® is indicated to reduce the need for allogenic transfusions in surgery patients when a significant blood loss is anticipated. It may be used to achieve and maintain hemoglobin levels within the range of 10 to 13 gm/dl. Darbepoetin Alfa (Aranesp®) does not have this indication.

2. Non-Covered Indications:
   a. Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis.
   b. Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML), or erythroid cancers.
   c. Anemia of cancer not related to cancer treatment.
   d. Any anemia associated only with radiotherapy.
   e. Prophylactic use to prevent chemotherapy-induced anemia.
   f. Prophylactic use to reduce tumor hypoxia.
   g. Patients with erythropoietin-type resistance due to neutralizing antibodies.
   h. Anemia due to cancer treatment if patients have uncontrolled hypertension.

   Claims documenting doses exceeding the Center for Medicare and Medicaid Services (CMS) maximum threshold for ESAs will be denied.

Prior approval will be given for a one month period. Recent laboratory results are required for Prior Authorization, i.e. serum hemoglobin within seven days of Prior Authorization request.

PA Form: Generic Nevada Medicaid Request for Prior Authorization form.

H. Anti-Fungal Oncychomycosis (Lamisil®, Sporanox®, Penlac®)

Anti-Fungal Onchomycosis are a covered benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

a. Do not authorize itraconazole if recipient has evidence of ventricular dysfunction.
b. Do not authorize terbinafine if recipient has pre-existing liver disease.
c. Positive KOH stain, positive PAS stain or positive fungal culture and any of the following:
    1. Recipient experiencing pain which limits normal activity
    2. Recipient has an iatrogenically-induced or disease associated immunosuppression
    3. Recipient has diabetes
    4. Recipient has significant peripheral vascular compromise
d. Length of Authorization:
    1. Lamisil® & Sporanox Fingernail: 6 weeks Toenail: 12 weeks
    2. Penlac® Initial: 3 months
       Follow-up: 3 months (Up to 12 months)

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

I. Altace ® (ramipril)

Altace is a covered benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Do not authorize if recipient is pregnant.

Authorization will be given if one of the following criteria are met and documented**:**

a. History of stroke
b. Recipient has peripheral vascular disease
c. History of coronary artery disease
d. Diabetes with microalbuminuria

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

J. Inhaled Insulin

Inhaled insulin is a covered benefit of Nevada Medicaid for adult recipients (18 years or older) who meet the criteria for coverage.

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

a. Type 1 Diabetes Mellitus
   1. Have an inability to self-administer injections of SC insulin or has a persistent fear of self administration of SC insulin and do not have a caregiver who can administer SC insulin, or
   2. Intolerance to SC insulin (e.g. allergic reactions, injection site reactions)
   3. And the required diagnoses exclusions and laboratory criteria below are met.
b. Type II Diabetes Mellitus who meet all of the following:
   1. Unresponsive/intolerant to treatment with lifestyle changes

2. Unresponsive/intolerant have contra-indications to at least two oral hypoglycemics within at least two separate therapeutic classes in any of the following classes. Note that a biguanide (e.g. metformin) must be one of the agents attempted/tried or contraindicated.
   a. Oral sulfonylureas
   b. Biguanides
   c. TZDs
   d. Meglitinides
   e. Alpha Glucosidase inhibitors
3. Intolerance or contra-indications to SC insulin (e.g. injection site reactions or allergic reaction) or inability to self-administer insulin or has a persistent fear of self-administration of SC insulin and without a care-giver who can administer insulin.

c. Inhaled insulin is contraindicated in recipients with the following conditions and will not be approved:

1. Current smokers
2. Patients who have discontinued smoking within the last 6 months (date of discontinuation must be verified). The patient must be completely free of smoking activity for at least 6 months for approval to be considered.
3. Patients with underlying lung disease (e.g. asthma, COPD)

d. The following laboratory criteria must be met:
1. Documented PFTs prior to initiation of therapy: (if not done then inhaled insulin will not be authorized)
2. FEV_1 or DL_{CO} must be greater than or equal to 70% of predicted
3. FEV_1 or DL_{CO} must be done after 6 months of therapy and then annually, at each subsequent measurement if there has been a confirmed decline of 20% of FEV_1 from baseline then inhaled insulin will not be authorized.

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Requests for Prior Authorization Form. PA forms are available at http://nevada.fhsc.com

K. Exenatide Injection (Byetta®)

Exenatide injection is a covered benefit of Nevada Medicaid for recipients (18 years or older) who meet the criteria for coverage.

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

a. Diagnosis of Type 2 Diabetes Mellitus
b. Current use of metformin, a sulfonylurea, or both
c. Documented failure to achieve glycemic control despite an appropriate trial of metformin and/or a sulfonylurea
d. Not to be used for weight loss
e. Approval will be for a six month period

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

L. Pramlinitide Injection (Symlin®)

Pramlinitide injection is a covered benefit of Nevada Medicaid for recipients (15 years or older who meet the criteria for coverage).

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

a. Diagnosis of Type 1 or Type 2 Diabetes Mellitus
b. Documentation that recipient has not achieved desired HbA1c despite optimal insulin therapy.
c. Documented HbA1c<9%
d. Patient is competent and has received diabetic education, able to self-administer drug, and willing to perform blood glucose monitoring.
e. Approval period of 6 months.
f. Exclusion Criteria
    1. HbA1c>9%
    2. Confirmed diagnosis of gastroparesis
    3. Use of drugs that alter GI motility
    4. Presence of hypoglycemia unawareness
    5. Use of alpha-glucosidase inhibitors (e.g. acarbose, miglitol)

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

M. Injectable Immunomodulator Drugs:

Amevive® (alefacept)	Kineret® (ankinra)
Enbrel® (etanercept)	Raptiva® (efalizumab)
Humira® (adalimumab)	Remicade® (infliximab)

Injectable immunomodulator drugs are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage:

1. Coverage and Limitations:
   Approval will be given if the following criteria are met and documented:

   a. Rheumatoid Arthritis (Enbrel®, Humira®, Remicade®, Kineret®):
      1. Diagnosis of rheumatoid arthritis, and
      2. Rheumatology consult with date, and
      3. Inadequate response or adverse reaction of a disease modifying antirheumatic drug (DMARDs) (cyclosporine, sulfasalzine, mercaptopurine, gold compounds or corticosteroids) and methotrexate, and
      4. Negative tuberculin test (Remicade®, Humira®,)

   b. Psoriatic Arthritis (Enbrel®, Remicade®):
      1. Diagnosis of psioratic arthritis, and
      2. At least 3 swollen joints, and
      3. At least 3 tender joints, and
      4. For Remicade®, inadequate response to any one non-steroidal anti-inflammatory drugs (NSAIDs) and to any one of the following disease-modifying anti-rheumatic drugs (DMARDs) (methotrexate, cyclosporine, sulfasalzine, mercaptopurine, gold compounds or corticosteroids).
      5. For Enbrel®: Inadequate response to methotrexate,
      6. Negative tuberculin test (Remicade®)

   c. Ankylosing Spondylitis (Enbrel®, Remicade®):
      1. Diagnosis of ankylosing spondylitis, and
      2. Inadequate response to Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and to any one of the Disease-Modifying Anti-Rheumatic Drugs (DMARDs) (methotrexate, cyclosporine, sulfasalzine, mercaptopurine, gold compounds or corticosteroids), and
      3. Negative tuberculin test (Remicade®)

   d. Juvenile Rheumatoid Arthritis (Enbrel®):
      1. Diagnosis of juvenile rheumatoid arthritis, and
      2. At least five swollen joints, and
      3. Three or more joints with limitation of motion and pain, tenderness, or both and
      4. Inadequate response to one Disease-Modifying Anti-Rheumatic Drug (DMARD)

   e. Plaque Psoriasis (Amevive®, Enbrel®, Raptiva®)
      1. Diagnosis of chronic, moderate to severe plaques psoriasis, and
      2. Prescribed by a dermatologist, and
      3. Failed to adequately respond to a topical agent, and

4. Failed to adequately respond to at least one oral treatment.

f. Crohn's Disease (Remicade®):
   1. Diagnosis of Crohn's Disease, and
   2. Failed to adequately respond to conventional therapy (e.g. sulfasalzine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine) or those with fistulizing Crohn's disease, and
   3. Negative tuberculin test.

g. Ulcerative Colitis (Remicade®):
   1. Diagnosis of moderate to severe ulcerative colitis, and
   2. Failed to adequately respond to one or more of the following standard therapies:
      a. Corticosteroids
      b. 5-aminosalicylic acid agents
      c. Immunosuppresants
   3. Negative tuberculin test.

2. PA Guidelines:

The Prior Authorization must be initiated by the prescriber.
PA Form: Nevada Medicaid Prior Authorization Request. PA forms are available at http://nevada.fhsc.com

N. TOPICAL IMMUNOMODULATORS

Elidel®
Protopic®
Topical Imunomodulators drugs are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

a. Patient must have a therapeutic failure with the use of a topical steroid.
b. Patient has a documented diagnosis of Atopic Dermatitis:
   1. Elidel®: for mild to moderate, for ages $\geq$ two years.
   2. Protopic® 0.03%; moderate to severe, for ages $\geq$ two years.
   3. Protopic® 0.1%; moderate to severe, for ages $\geq$ 18 years.
c. Not for chronic use.
d. Elidel® is not recommended for use on patients with Netherton's syndrome due to the potential for systemic absorption.
e. Not recommended for use in immunocompromised patients.

Quantity Limits

a. Elidel® 1% cream: 30g per 30 rolling days with a 25% tolerance for refills.
b. Protopic® 0.03% and 0.1% Ointment: 30 mg per 30 rolling days with a 25% tolerance for refills.

2. PA form: Generic Nevada Medicaid Request for Prior Authorization form.

O. 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.

1. Coverage and Limitations:

Authorization will be given to utilize a non-preferred drug if one of the following criteria is met:

a. Allergy to all preferred medications within the same class.
b. Contraindication to or drug-to-drug interaction with all preferred medications within the same class.
c. History of unacceptable/toxic side effects to all preferred medications within the same class.
d. Therapeutic failure of two preferred medications within the same class. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication.
e. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication.
f. Antidepressant Medication – Continuity of Care, Recipients discharged from acute mental health facilities on a non-preferred antidepressant will be allowed to continue on that drug for up to 90 days following discharge. After 90 days, the recipient must meet one of the above five (5) PDL Exception Criteria.

2. PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

2. DRUGS WITH QUANTITY LIMITATIONS

A. Long-Acting Narcotics

Long Acting Narcotics are a covered benefit of Nevada Medicaid, for recipients who meet the coverage criteria.

1. Coverage and Limitations:

Indications: Management of moderate-to-severe pain when continuous around-the-clock analgesic is needed for an extended period of time. Medications:

Brand Names	Generic Names	Dosage Strength	Dosage Form
Avinza®	Morphine Extended Release	30, 60, 90, 120mg	Capsules
Kadian®	Morphine Sustained Release	20, 30, 50, 80, 100mg	Capsules, sustained-Release pellets
MS Contin®	Morphine Controlled Release	15, 30, 60, 100, 200mg	Tablets
	Morphine Sulfate Extended Release	15, 30, 60, 100mg	Tablets
Oramorph®	Morphine Sulfated Controlled Release	15, 30, 60, 100mg	Tablets
Oxycontin®	Oxycodone Extended Release	10, 20, 40, 80mg	Extended Release Tablets

a. Oxycontin (including generic)
   1. Any dosing greater than three tablets per day of any one strength will require a prior authorization.
   2. No prior authorization is required for diagnosis of terminal cancer
b. MS Contin (including generic)
   1. Any dosing greater than three tablets per day of any one strength will require a prior authorization.
   2. No prior authorization is required for a diagnosis of terminal cancer.
c. Avinza
   1. Any dosing greater than one capsule per day of any one strength will require a prior authorization.
   2. No prior authorization is required for a diagnosis of terminal cancer.
d. Kadian
   1. Any dosing greater than two capsules per day of any one strength will require a prior authorization.
   2. No prior authorization is required for a diagnosis of terminal cancer
e. Please Note: The use of Long Acting Narcotics for acute/short term treatment of pain not within the quantity limits will not be approved.

Approval will be for a three month time limit.

2. PA Guidelines:

The PA must be initiated by the prescriber. The approved PAR must be available if requested.

PA Form: Generic Nevada Medicaid Request for Prior Authorized form.

B. Toradol® (ketorolac tromethamine) tablets

The pharmaceutical Toradal® is a covered benefit for recipients who meet the criteria for overage.

1. Coverage and Limitations:
Ketorolac is indicated for the short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level. It is not indicated for minor or chronic painful conditions. The following criteria must be met:

a. Oral treatment is indicated only as continuation therapy to IV/IM therapy.
b. Oral treatment is not to exceed 5 days.

A prescription for 20 or less tablets per month may be obtained without PA. If the prescription is for a quantity of more than 20 tablets in the past 6 months, a PA must be obtained through the Nevada Medicaid QIO-like vendor.

2. PA Guidelines:

The PA must be initiated by the prescriber. The approved PA must be available if requested.

PA Form: Generic Nevada Medicaid Request for Prior Authorization form.

C. Anti-migraine medications (triptans)

Serotonin 5-HT1 receptor agonists commonly referred to as "triptans" or anti-migraine medications are a covered benefit of Nevada Medicaid subject to quantity limitations.

1. Coverage and Limitations:

The number of tablets/doses allowed per month is restricted on triptans. Only one prescription of triptans per month is allowable without PA. Nevada Medicaid restricts the allowable number of tablets/doses per month per the following table:

Brand Name	Generic Name	Strength	Dosage Form	How Supplied	Limit Per Month
Amerge	Naratriptan	1mg	Tablet	9 tablets/package	9 tablets
		2.5mg	Tablet	9 tablets/package	9 tablets
Axert	Almotriptan	6.25mg	Tablet	6 tablets/package	6 tablets
		12.5mg	Tablet	6 tablets/package	6 tablets
Frova	Frovatriptan	2.5mg	Tablet	9 tablets/package	9 tablets
Imitrex	Sumatriptan	25mg	Tablet	9 tablets/package	18 tablets
		50mg	Tablet	9 tablets/package	9 tablets
		100mg	Tablet	9 tablets/package	9 tablets
		6mg	Injection	2 injections/package	4 injections
		5mg	Nasal Spray	6 units/package	12 units

		20mg	Nasal Spray	6 units/package	6 units
Maxalt	Rizatriptan	5mg	Tablet	6 tablets/package	12 tablets
		10mg	Tablet	6 tablets/package	12 tablets
Maxalt-MLT		5mg	Orally Disintegrating tablet	2 units of 3 tab/pack	12 tablets
		10mg	Orally Disintegrating tablet	2 units of 3 tab/pack	12 tablets
Zomig	Zolmitriptan	2.5mg	Tablet	6 tablets/package	12 tablets
		5mg	Tablet	3 tablets/package	6 tablets
Zomig ZMT		2.5mg	Orally Disintegrating tablet	6 tablets/package	12 tablets
		5 mg	Nasal Spray	6 units/package	12 tablets

An approved PA is required for any prescription exceeding the above outlined quantity limits.

Approval for additional medication beyond these limits will be considered only under the following circumstances:

a. The recipient's current medication history documents the use of prophylactic medications for migraine headache or the medical provider agrees to initiate such therapy with includes beta-blockers, tricyclic antidepressants, anticonvulsants, Selective Serotonin Reuptake Inhibitors (SSRIs) and/or calcium channel blockers, OR

b. The medical provider is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required monthly.

- Recipient's current medication history must NOT have MAO (Monoamine Oxidose) Inhibitors present for approval of Imitrex® (sumitriptan), Maxalt® (rizatriptan) or Zomig® (zolmitriptan).
- Recipients whose current medication history indicates the use of propranolol will NOT be granted prior authorization of Maxalt® (rizatriptan) 10mg tablet or 10mg orally disintegrating tablet.
- Prior authorization will NOT be given to patients with ischemic heart disease.

Approval for exceeding the quantity limits on triptans will be given for a two month time period.

2. PA Guidelines:

The PA must be initiated by the prescriber. The approved PA must be available if requested.

PA Form: Generic Nevada Medicaid request for Prior Authorization form.

D. <u>Smoking cessation products</u>

Smoking cessation products, including patches, gums, lozenges and inhalers, are a covered Nevada Medicaid benefit subject to quantity limitations.

1. Coverage and Limitations:

   Smoking cessation products are limited to two 90 day therapy sessions, using the route of their choice, per year. E. Actig ® (fentanyl citrate)

   Actig ® is a covered benefit for recipients that meet the coverage criteria.

1. Coverage and Limitations:
   a. Diagnosis of pain unresponsive to other therapy, and
   b. Failure of two short-acting narcotics.
   c. Limit: 4 units per day

2. PA Guidelines:
   PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

F. Xopenex ® (levalbuterol)

Xopenex ® is a covered benefit for recipients that meet the coverage criteria.

1. Coverage and Limitations:

   a. Authorization only for recipients experiencing side effects on one other beta-adrenergic agent of any formulation
   b. Authorization for patients whose cardiovascular status is considered to be in severe deteriorating condition.
   c. Xopenex 0.31mg and 0.63mg cannot be dosed more than every 6 hours or as needed.
   d. Xopenex 1.25mg cannot be dosed more than every 8 hours or as needed.
   e. Maximum quantity per month = 4 boxes (288ml)

2. PA Guidelines:

   PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

G. Sedative Hypnotics

Sedatives Hypnotics are a covered Nevada Medicaid benefit subject to quantity limitations.

1. Coverage and Limitations:

Quantity limit of 30 tablets per month of only one strength.

H. Inhaled Anticholinergic Agents

Inhaled anticholinergic agents are a covered benefit of Nevada Medicaid

1. General Criteria

a. Only one inhaled anticholinergic agent may be used in a 30 day period.

I. See table for Quantity Edits Approved at DUR Board 12-16-2004:

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

QUANTITY EDITS APPROVED AT DUR BOARD 12-16-2004

Quantity Edit					
December – 04					
Drug Name	HCL	GSN	NDC	Maximum Quantity Per RX	Reason
Anzemet 100mg		34750		2.0	Edit designed to ensure appropriate dose, duration of therapy and indication.
Anzemet 50mg		34749		4.0	Same
Emend 80mg		51911		1.0	Same
Emend 125mg		51912		2.0	Same
Kytril 1mg		21592		2.0	Same
Zofran ODT 4mg		41562		12.0	Same
Zofran ODT 8mg		41563		6.0	Same
Zofran 4mg		16392		12.0	Same
Zofran 8mg		16393		6.0	Same
Zofran 24mg		43230		1.0	Same
Zofran Solution		15869		1 bottle (50 ml)	Same
Copaxone 20mg Kit			00088115330	1.0	Provider should be billing each, not milligrams
Duoneb	009040			6 bottles per month	Maximum needed
Duragesic				15	Maximum allowed
Flovent Rotadisk 100mcg		19317		1 box per month	Maximum needed
Flovent Rotadisk 250mcg		19318		1 box per month	Same
Flovent Rotadisk 50mcg		19319		1 box per month	Same
Lovenox 30mg/0.3ml		19331		18.0	Maximum daily dose should be BID, therefore no more than 60 syringes should be dispensed per RX.
Lovenox 40mg/0.4ml		39482		24.0	Same
Lovenox 60mg/0.6ml		27993		36.0	Same
Lovenox 80mg/0.8ml		27994		48.0	Same
Lovenox 100mg/ml		27995		60.0	Same
Lovenox 120mg/0.8ml		44669		48.0	Same
Lovenox 150mg/ml		44668		60.0	Same
Neupogen	006070			15.0	Providers should be billing by each and not micrograms
Rebif	023353			6.0	To prevent overbilling for number of syringes dispensed instead of ml's
Serevent Diskus		31417		1 box (60 inhalations per month)	Maximum needed
Synagis 100mg Vial		40293		4.0	This was the largest correct quantity submitted since 01/01/04
Xopenex (All Strengths)		49871, 41849, 41848		4 boxes (288ml) per month	Maximum needed

3. MEDICATIONS WITH GENDER/AGE EDITS

A. Prenatal vitamins

1. Payable only for female recipients.

B. Oral/Topical Contraceptives

1. Payable only for female recipients.

C. Hormones

1. Estrogen – payable only for female recipients.

2. Progestins – payable only for female recipients.

3. Estrogen and Androgen Combinations – payable only for female recipients.

4. Estrogen/Progestin Combinations – payable only for female recipients.

5. Contraceptive Hormones – payable only for female recipients.

6. Transdermal Testosterone – payable only for male recipients.

7. Androgen Hormone Inhibitor – payable only for male recipients.

D. Vitamins with Fluoride

1. Payable only for recipients up to age 21 years.

E. Tretinoic Acid Cream/Ointment/Gel

1. Payable only for recipients up to age 21 years.

F. Synagis ® Palivizumaub

Synagis® (palivizumab) injection is a covered benefit of Nevada Medicaid for recipients under the age of 2 years who meet the criteria. A Prior Authorization is not required for recipients within the indications and limitations of coverage. For consideration outside these guidelines, a PA may be submitted with supporting medical justification documentation.

1. Coverage and Limitations:

Recipients must meet one of the following criteria:

a. Less than 2 years old at start of Respiratory Syncytial Virus (RSV) season, with Chronic Lung Disease (CLD) and have required medical therapy for their CLD within 6 months before the anticipated RSV season, OR
b. Premature infant with a gestational age of 28 weeks or less and is 12 months of age or less at the start of RSV season , OR
c. Premature infant with a gestational age or 29-32 weeks and is six months of age or less at the start of RSV season, OR
d. Premature infant with gestational age 32-35 weeks and is six months of age or less at the start of RSV season with one or more of the following risk factors:
    - passive smoke exposure
    - day care attendance
    - school age siblings
    - multiple birth
    - two or more individuals sharing a bedroom
    - birth within six months before onset of RSV season, OR
e. Less than 2 years of age with severe immunodeficiency disease.
f. Infants meeting criteria in the above 1, 2 or 3 and who also have asymptomatic acyanotic congenital heart disease.

The product must be administered between October 1st and April 30th. Only one dose (based on recipient weight) may be given in a 30 day period.

If Synagis is administered outside these guidelines without PA, the cost of the medication will be recouped from the pharmacy.

Approval will be given on a per RSV season basis.

2. PA Guidelines:

Provider Type 20: Submit a HCFA 1500 form with CPT code 90378 (enter one unit of this code for every 50mg, or portion thereof, of the drug administered-for example if 120mg was given, this code will have 3 units) and attach invoice. Enter CPT 90782 for administration code. Enter the appropriate diagnosis code.

Provider Type 28: Submit an online or UCF (Universal Claim Form) claim using the appropriate NDC. The quantity entered will be the number of vials administered per single dose. For example, if a recipient receives 120mg, bill for one 100mg vial and one 50mg vial.

Note: Providers may bill for one vial even if only part of the single-use vial was given to the recipient and the remainder of the drug was discarded. Safe handling guidelines per

manufacturer must be observed (e.g. shelf life, cold chain requirements). The smallest size vial to cover the dose must be used. For example, if the appropriate dose is 120mg, one 100mg vial and one 50mg vial should be used, the provider may not bill for two 100mg vials in this case.

G. Zelnorm ®

Zelnorm ® is a covered benefit subject to quantity and gender edits.

1. Coverage and Limitations:

   a. Gender: Female

2. Maximum treatment 12 weeks. A new prior authorization is required to continue therapy beyond 12 weeks.

4. ANTIRETROVIRALS

Antiretrovirals for the treatment of HIV (Human Immune deficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) are a covered benefit for Nevada Medicaid recipients. FDA approved Antiretrovirals whose manufacturers participate in the federal Drug Rebate Program and are not DESI drugs, are covered.

Please Note: Until 07/01/03 Anitretrovirals are excluded from the Medicaid HMO benefit package and will be provided to Medicaid HMO recipients under Medicaid Fee-for-Service. They are to be billed directly to Nevada Medicaid's Fiscal Agent.

Beginning 07/01/03, antiretrovirals will be part of coverage under Medicaid HMO benefit packages.

5. BLOOD GLUCOSE TESTING

Blood glucose monitors and testing supplies for home use are a covered Medicaid benefit. A written prescription with a diagnosis is required and must be kept on the premise of the provider for 37 months. A recipient or their caregiver must specifically request refills of glucose supplies before they are dispensed. The provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if a recipient has "authorized" in advance.

No Prior Authorization is required for the items in the outlined quantities below:

Lancets	200/month

Alcohol Swabs	200/month
Battery for Monitor	1/year
Blood Glucose Monitor	1 every 2 years (not to exceed $55/monitor)
Blood Glucose Strips	200/month
Insulin Syringes	100/month
Keto-Stix	100/month
Control Solution	1/month

For all other items/quantities in excess of those outlined above, a Prior Authorization must be obtained from the Nevada Medicaid QIO-like vendor.

Blood Glucose monitors with special features (e.g. voice synthesizers) require a Prior Authorization. For special blood glucose monitors, the recipient must be legally blind. A diagnosis, a statement from the physician of visual impairment, and manufacturers' invoice in required with the PA.

ICD-9 codes 250.00 through 250.93 (Diabetes Mellitus) or 648.0 (Diabetes Mellitus complicating pregnancy) will be covered. No coverage will be provided for any other ICD-9 code.

Blood glucose monitors and related supplies are billed on the NCPDP Universal Claim Form (UCF) or on-line through the POS (Point of Sale) system with the correct NDC number, complete description, including brand name and package size. Reimbursement is 90% of average wholesale price plus and handling and dispensing fee of $1.54 per prescription.

APPENDIX B
Standard Therapeutic Drug Classes

FIRST HEALTH AD HOC REPORTING SYSTEM
STANDARD THERAPEUTIC CLASSES

Standard Therapeutic Class	Description
00	MEDICAL SUPPLIES
01	ANTI-ULCER PREPS/GASTROINTESTI
02	EMETICS
03	ANTIDIARRHEALS
04	ANTISPASMODIC-ANTICHOLINERGICS
05	BILE THERAPY
06	LAXATIVES
07	ATARACTICS-TRANQUILIZERS
08	MUSCLE RELAXANTS
09	ANTIPARKINSON
10	CNS STIMULANTS
11	PSYCHOSTIMULANTS-ANTIDEPRESSAN
12	AMPHETAMINE PREPARATIONS
13	ALL OTHER ANTIOBESITY PREPS
14	ANTIHISTAMINES
15	BRONCHIAL DILATORS
16	COUGH PREPARATIONS/EXPECTORANT
17	COLD AND COUGH PREPARATIONS
18	ADRENERGICS
19	TOPICAL NASAL AND OTIC PREPARA
20	OPHTHALMIC PREPARATIONS
21	TETRACYCLINES
22	PENICILLINS
23	STREPTOMYCINS
24	SULFONAMIDES
25	ERYTHROMYCINS
26	CEPHALOSPORINS
27	OTHER ANTIBIOTICS
28	URINARY ANTIBACTERIALS
29	CHLORAMPHENICOL
30	ANTINEOPLASTICS
31	ANTIPARASITICS
32	ANTIMALARIALS
33	ANTIVIRALS
34	TB PREPARATIONS
35	TRIMETHOPRIM
36	CONTRACEPTIVES, NON-SYSTEMIC
37	VAGINAL CLEANSERS
38	GENERAL ANTIBACTERIALS AND ANT
39	DIAGNOSTICS
40	NARCOTIC ANALGESICS
41	NON-NARCOTIC ANALGESICS
42	ANTIARTHRITICS
43	ANESTHETICS GEN INHALANT
44	ANESTHETICS GEN INJECT

APPENDIX B
Standard Therapeutic Drug Classes

45	ANESTHETIC LOCAL TOPICAL
46	SEDATIVE BARBITURATE
47	SEDATIVE NON-BARBITURATE
48	ANTICONVULSANTS
49	ANTINAUSEANTS
50	CORTICOTROPINS
51	GLUCOCORTICOIDS
52	MINERALOCORTICOIDS
53	ALDOSTERONE ANTAGONISTS
54	ANTIDOTES
55	THYROID PREPS
56	ANTITHYROID PREPS
57	IODINE THERAPY
58	DIABETIC THERAPY
59	ANABOLICS
60	ANDROGENS
61	ESTROGENS
62	PROGESTERONE
63	SYSTEMIC CONTRACEPTIVES
64	OTHER HORMONES
65	LIPOTROPICS
66	CHOLESTEROL REDUCERS
67	DIGESTANTS
68	PROTEIN LYSATES
69	ENZYMES
70	RAUWOLFIAS
71	OTHER HYPOTENSIVES
72	VASODILATORS CORONARY
73	VASODILATORS PERIPHERAL
74	DIGITALIS PREPARATIONS
75	XANTHINE DERIVATIVES
76	OTHER CARDIOVASCULAR PREPS
77	ANTICOAGULANTS
78	HEMOSTATICS
79	DIURETICS
80	FAT SOLUBLE VITAMINS
81	WATER SOLUBLE VITAMINS
82	MULTIVITAMINS
83	FOLIC ACID PREPARATIONS
84	B COMPLEX WITH VITAMIN C
85	VITAMIN K
86	INFANT FORMULAS
87	ELECTROLYTES & MISCELLANEOUS N
88	HEMATINICS & BLOOD CELL STIMUL
89	ALLERGENS
90	BIOLOGICALS
91	ANTIPRURITICS
92	COAL TAR
93	EMOLLIENTS PROTECTIVES
94	FUNGICIDES
95	ALL OTHER DERMATOLOGICALS

APPENDIX B
Standard Therapeutic Drug Classes

96	HEMORRHOIDAL PREPARATIONS
97	OXYTOCICS
98	PARASYMPATHETIC AGENTS
99	MISCELLANEOUS