

Pharmacy Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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eManual Contents

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Medical Assistance Letters

MAL 595 (Preferred Drug List Changes Effective November 1, 2014)

Medical Assistance Letter (MAL) 595

October 23, 2014

TO: Eligible Pharmacy Providers and Prescribers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy

SUBJECT: Preferred Drug List Changes Effective November 1, 2014

Summary

This medical assistance letter (MAL) outlines changes to the Ohio Department of Medicaid (ODM) Preferred Drug List (PDL) that are effective on November 1, 2014.

Policy Guidance

The Ohio Medicaid PDL will be updated effective November 1, 2014. Drug classes were reviewed to determine those products that the Department considers "preferred" for individuals receiving coverage through Ohio Medicaid. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations, although step therapy may be required for some brand drugs. Products in these classes that are "non-preferred" are subject to PA.

A copy of the PDL is available on the Ohio Medicaid website at <http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/TheOhioMedicaidDrugProgram.aspx>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

Please be reminded that although managed care plans (MCPs) that serve Ohio Medicaid consumers cover prescription drugs listed on the Ohio Medicaid list of covered drugs, MCPs may have ODM-approved preferred drug lists/prior authorization requirements that are different from the fee-for-service policy described in this MAL. Please see <http://medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx> for information about Medicaid MCPs.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes. This table is not all-inclusive.

Drugs that will require Prior Authorization or Step Therapy beginning date of service 11/1/2014	
Drug class	Drug Name
Cardiovascular: Lipotropics	Antara, Tricor (use generic fenofibrate) Trilipix (use generic fenofibric acid)
Infectious Disease: Antivirals for HIV <i>Note: Patients on existing regimens will not need to change therapy.</i>	<i>PA required:</i> Stribild
Respiratory Agents: Self-Injectable Epinephrine	Auvi-Q Generic Epinephrine
Drugs that will <u>no longer require</u> a Prior Authorization beginning with date of service 11/1/2014	

Drug class	Drug Name
Central Nervous System: Antidepressants	Duloxetine
Genitourinary: Urinary Antispasmodics	Enablex Oxytrol Vesicare

Ohio Administrative Code rule [5160-9-12](#), "Ohio Department of Medicaid list of drugs covered without prior authorization" has been amended to support this initiative. This rule has been amended to update the list to reflect the new PDL, as well as delete coverage for drugs no longer covered by Medicaid and add drugs that are new to the market.

Access to Rules and Related Material

The main ODM web page includes links to valuable information about its services and programs; the address is <http://medicaid.ohio.gov/>.

The Ohio Department of Job and Family Services (ODJFS) maintains an "electronic manuals" web page of ODJFS and ODM rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODM e-mail subscription service at <http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>.

Additional Information

Pharmacies may contact the Technical Help Desk at Xerox:

Phone: 1-877-518-1545

Prescribers may request prior authorization through Xerox:

Phone: 1-877-518-1546 Fax: 1-800-396-4111

MAL 593 (Drug Review Process)

Medical Assistance Letter (MAL) 593

May 14, 2014

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Medicaid Director

SUBJECT: Drug Review Process

Summary

Ohio Administrative Code rule [5101:3-9-07](#), "Drug Review Process," has been amended to add Average Manufacturer Price (AMP) to the information that may be requested from a manufacturer or labeler and update the department name.

Access to Rules and Related Material

The main Ohio Department of Job and Family Services (ODJFS) web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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Additional Information

Pharmacies may contact the Technical Help Desk at Xerox for assistance:

Phone: 1-877-518-1545

Additional information about the Ohio Medicaid pharmacy program is available online:

<http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>

MAL 591 (Medicaid Pharmacy Coverage for Dual Eligibles Effective January 2014)

Medical Assistance Letter (MAL) 591

February 24, 2014

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy

SUBJECT: Medicaid pharmacy coverage for dual eligibles effective January 2014

Summary

This medical assistance letter (MAL) outlines changes to Medicaid pharmacy coverage for dual eligibles. The changes were effective on January 1, 2014.

Policy Guidance

Beginning January 1, 2014, barbiturates are covered by Medicare Prescription Drug Plans so may no longer be covered by Medicaid programs for people who are dually eligible for Medicare and Medicaid. These changes in coverage are required by federal statute in Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA).

Ohio Administrative Code (OAC) rules pertaining to the Medicaid program have been renumbered. Medicaid pharmacy rules that were previously numbered in Chapter 5101:3-9 of the OAC are now in chapter 5160-9. OAC rule [5160-9-12](#), "Ohio department of Medicaid (ODM) list of drugs covered without prior authorization," is being amended to support the change in federal policy relating to barbiturates. References to other OAC rules have been updated in the rule body. Changes to the appendix to this rule include removal of coverage of barbiturates for dual eligibles, addition of drugs new to the market, removal of drugs that are no longer marketed or that have been identified by the federal Centers for Medicare and Medicaid Services as non-payable, and changes to co-payment requirements.

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Prescribers may request prior authorization through Xerox:

Phone: 1-877-518-1546 Fax: 1-800-396-4111

MAL 587 (Preferred Drug List Changes Effective November 1, 2013)

Medical Assistance Letter (MAL) 587

October 16, 2013

TO: Eligible Pharmacy Providers and Prescribers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy

SUBJECT: Preferred Drug List Changes Effective November 1, 2013

Summary

This medical assistance letter (MAL) outlines changes to the Ohio Department of Medicaid (ODM) Preferred Drug List (PDL) that are effective on November 1, 2013.

Policy Guidance

The Ohio Medicaid PDL will be updated effective November 1, 2013. Drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations, although step therapy may be required for some brand drugs. Products in these classes that are "non-preferred" are subject to PA.

A copy of the PDL is available on the Ohio Medicaid website at <http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/TheOhioMedicaidDrugProgram.aspx>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

Please be reminded that although managed care plans (MCPs) that serve Ohio Medicaid consumers cover prescription drugs listed on the Ohio Medicaid list of covered drugs, MCPs may have ODM-approved preferred drug lists/prior authorization requirements that are different from the fee-for-service policy described in this MAL. Please see <http://medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx> for information about Medicaid MCPs.

Beginning in October, messages are sent back to pharmacies when a drug that will change to prior authorization status is dispensed. This gives the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. All prior authorization requests must be initiated by the prescriber or prescriber's staff. Prior authorization may be requested prior to November 1.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes. This table is not all-inclusive.

Drugs that will require Prior Authorization or Step Therapy beginning date of service 11/1/2013

Drug class	Drug Name
Cardiovascular: Chronic Stable Angina Treatments	<i>Step therapy required: patient must have had inadequate clinical response to preferred generic beta blockers or calcium channel blockers: Ranexa</i>
Central Nervous System: Anticonvulsants <i>Note: Patients on existing regimens will not need to change therapy.</i>	<i>Step therapy required: patient must have had inadequate clinical response to preferred alternatives:</i> Banzel Celontin Felbamate (generic of Felbatol)

	<p>Lamical ODT Lamotrigine ER (generic of Lamictal XR) Levetiracetam ER (generic of Keppra XR) Lyrica Onfi Oxtellar XR Peganone Potiga Sabril Stavzor Tiagabine (generic of Gabitril) Topiramate sprinkle cap (generic of Topamax sprinkle cap) Vimpat</p>
<p>Central Nervous System: Fibromyalgia and Neuropathic Pain <i>Note: Patients on existing regimens will not need to change therapy.</i></p>	<p><i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives or diagnosis of fibromyalgia: Lyrica</i></p>
<p>Endocrine: Oral Hypoglycemics</p>	<p><i>PA required:</i> Kombiglyze XR Onglyza</p>
<p>Endocrine: Osteoporosis - Bone Ossification Enhancers</p>	<p><i>PA required:</i> Miacalcin Fortical</p>
<p>Gastrointestinal: Pancreatic Enzymes</p>	<p><i>PA required: Pancreaze</i></p>
<p>Gastrointestinal: Ulcerative Colitis</p>	<p><i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i> Pentasa</p>
<p>Infectious Disease: Antivirals for HIV <i>Note: Patients on existing regimens will not need to change therapy.</i></p>	<p><i>PA required:</i> Aptivus Edurant Fuzeon Intelence Rescriptor Selzentry</p>
<p>Topical Agents: Androgens</p>	<p><i>PA required:</i> Axiron Fortesta</p>

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Drugs that will <u>no longer require</u> a Prior Authorization beginning with date of service 11/1/2013	
Drug class	Drug Name
Blood Agents: Platelet Aggregation Inhibitors	Brilinta Effient
Central Nervous System: Migraine	Rizatriptan ODT Rizatriptan
Genitourinary: Urinary Antispasmodics	Sanctura XR
Topical Agents: Anti-Parasitics	Sklice

In addition to the tables above, the preferred growth hormones have changed beginning with date of service November 1, 2013. All growth hormones require clinical prior authorization. Existing prior authorizations are valid until expiration; new patients and re-approvals will need to use a preferred product. Preferred growth hormones are Genotropin and Norditropin.

Ohio Administrative Code rule [5101:3-9-12](#), "Ohio Department of Medicaid list of drugs covered without prior authorization" has been amended to support this initiative. This rule has been amended to update the list to reflect the new PDL, as well as delete coverage for drugs no longer covered by Medicaid and add drugs that are new to the market.

Access to Rules and Related Material

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Phone: 1-877-518-1546 Fax: 1-800-396-4111

MAL 586 (Drug Utilization Review Program)

Medical Assistance Letter (MAL) 586

October 1, 2013

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Drug Utilization Review Program

Summary

Ohio Administrative Code rule [5101:3-9-04](#), "Pharmacy Services: Drug Utilization Review," has been amended to revise the drug compendia used for drug assessments to mirror federal regulations, and to update the name of the department.

Access to Rules and Related Material

The main Ohio Department of Job and Family Services (ODJFS) web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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MAL 584-A (Changes to Diabetic Supply Coverage and Billing)

Medical Assistance Letter (MAL) 584-A

June 24, 2013

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Medicaid Director

SUBJECT: Changes to Diabetic Supply Coverage and Billing

Summary

This medical assistance letter outlines changes to coverage and billing of diabetic supplies for the Ohio Medicaid program.

Policy Guidance

Ohio Administrative Code rule [5101:3-9-02](#), "Pharmacy services: medical supplies and durable medical equipment," sets forth coverage and billing of certain medical supplies by pharmacy providers.

Effective July 1, 2013, Ohio Medicaid has chosen Abbott Diabetes Care and Nipro Diagnostics as preferred manufacturers of diabetic blood testing supplies. Supplies from other manufacturers will be denied unless there is medical necessity for a non-preferred brand, determined through the prescriber prior authorization process.

The preferred products are:

Blood Glucose Monitor

Corresponding Test Strips

FreeStyle Freedom Lite Meter	FreeStyle Lite glucose test strips
FreeStyle InsuLinx Meter	FreeStyle InsuLinx glucose test strips
FreeStyle Lite Meter	FreeStyle Lite glucose test strips
Precision Xtra Meter	Precision Xtra glucose test strips Precision Xtra Beta ketone test strips
TRUEresult Meter	TRUEtest glucose test strips
TRUEtrack Meter	TRUEtrack glucose test strips

Beginning June 1, 2013, messages will be sent back to pharmacies through the point-of-sale system when supplies that will become "non-preferred" are dispensed. This will give pharmacies an opportunity to determine whether a new prescription will be needed to change the patient to a preferred product for the next dispensing.

Reimbursement for diabetic testing and injection supplies is changing from the current fee schedule rates to wholesale acquisition cost (WAC) + 7%, the same pricing methodology as most brand name drugs. The maximum quantity of glucose test strips that can be dispensed per month without prior authorization is changing to 100.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Medical Assistance (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

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Additional Information

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Phone: 1-877-518-1545

Additional information about the Ohio Medicaid pharmacy program is available online:

<http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>

MAL 584 (Changes to Diabetic Supply Coverage and Billing)

Medical Assistance Letter (MAL) 584

May 24, 2013

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Medicaid Director

SUBJECT: Changes to Diabetic Supply Coverage and Billing

Summary

This medical assistance letter outlines changes to coverage and billing of diabetic supplies for the Ohio Medicaid program.

Policy Guidance

Ohio Administrative Code rule 5101:3-9-02, "Pharmacy services: medical supplies and durable medical equipment," sets forth coverage and billing of certain medical supplies by pharmacy providers.

Effective July 1, 2013, Ohio Medicaid has chosen Abbott Diabetes Care and Nipro Diagnostics as preferred manufacturers of diabetic blood testing supplies. Supplies from other manufacturers will be denied unless there is medical necessity for a non-preferred brand, determined through the prescriber prior authorization process.

The preferred products are:

Blood Glucose Monitor

Corresponding Test Strips

FreeStyle Freedom Lite Meter	FreeStyle Lite glucose test strips
FreeStyle InsuLinx Meter	FreeStyle InsuLinx glucose test strips
FreeStyle Lite Meter	FreeStyle Lite glucose test strips
Precision Xtra Meter	Precision Xtra glucose test strips Precision Xtra Beta ketone test strips
TRUEresult Meter	TRUEtest glucose test strips
TRUEtrack Meter	TRUEtrack glucose test strips

Beginning June 1, 2013, messages will be sent back to pharmacies through the point-of-sale system when supplies that will become "non-preferred" are dispensed. This will give pharmacies an opportunity to determine whether a new prescription will be needed to change the patient to a preferred product for the next dispensing.

Reimbursement for diabetic testing and injection supplies is changing from the current fee schedule rates to wholesale acquisition cost (WAC) + 7%, the same pricing methodology as most brand name drugs. The maximum quantity of glucose test strips that can be dispensed per month without prior authorization is changing to 100.

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Phone: 1-877-518-1545

Additional information about the Ohio Medicaid pharmacy program is available online:

<http://ifs.ohio.gov/ohp/bhpp/meddrug.stm>

MAL 583 (Medicaid Pharmacy Coverage for Dual Eligibles Effective January 1, 2013)

Medical Assistance Letter (MAL) 583

January 2, 2013

TO: Eligible Pharmacy Providers and Prescribers
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medical Assistance

SUBJECT: Medicaid pharmacy coverage for dual eligibles effective January 1, 2013

Summary

This medical assistance letter (MAL) outlines changes to Medicaid pharmacy coverage for dual eligibles. The changes are effective on January 1, 2013.

Policy Guidance

Beginning January 1, 2013, barbiturates for the treatment of epilepsy, cancer, and chronic mental health conditions, and benzodiazepines are covered by Medicare Prescription Drug Plans so may no longer be covered by Medicaid programs for people who are dually eligible for Medicare and Medicaid. Ohio Administrative Code rule [5101:3-9-12](#), "Office of Medical Assistance List of Drugs Covered Without Prior Authorization," is being amended to support this change in federal policy. In addition, references to the Ohio Department of Job and Family Services are being changed to the Office of Medical Assistance.

These changes in coverage are required by federal statute in Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA).

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Medical Assistance (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

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Additional Information

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Pharmacies may contact the Technical Help Desk at Xerox (formerly ACS):

Phone: 1-877-518-1545

Prescribers may request prior authorization through Xerox (formerly ACS):

Phone: 1-877-518-1546 Fax: 1-800-396-4111

Providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling Xerox (formerly ACS): at (614) 985-4534.

MAL 582 (Pharmacy Program Changes Effective October 1, 2012)

Medical Assistance Letter (MAL) 582

September 27, 2012

TO: Eligible Pharmacy Providers and Prescribers
Directors, County Departments of Job and Family Services

FROM: John McCarthy, Director, Office of Medical Assistance

SUBJECT: Pharmacy Program Changes Effective October 1, 2012

Summary

This medical assistance letter (MAL) outlines changes to the Ohio Medicaid pharmacy program that are effective on October 1, 2012.

Policy Guidance

Change to Preferred Drug List (PDL)

The newest phase of the Ohio Medicaid PDL will be effective on October 1, 2012. The drug classes were reviewed to determine those products that the Office considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations, although step therapy may be required for some brand drugs. Products in these classes that are "non-preferred" are subject to prior authorization.

A "quick list" of preferred drugs is available at <http://ifs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

Please be reminded that although MCPs that serve Ohio Medicaid consumers cover prescription drugs listed on the Ohio Medicaid list of covered drugs, MCPs may have Office of Medical Assistance (OMA)-approved preferred drug lists/prior authorization requirements that are different from the fee-for-service policy described in this MAL. Please see <http://ifs.ohio.gov/OHP/bmhc/index.stm> for information about Medicaid MCPs. OMA and the MCPs are working closely to align prior authorization policies as much as possible to lessen confusion for prescribers and pharmacies.

Beginning in September, messages are sent back to pharmacies when a drug that will change to prior authorization status is dispensed. This gives the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. All prior authorization requests must be initiated by the prescriber or prescriber's staff. Prior authorization may be requested prior to October.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes. This table is not all-inclusive.

Drugs that will require Prior Authorization or Step Therapy beginning date of service 10/1/2012

Drug class	Drug Name
Analgesics: Opioids	<i>Step therapy required for all immediate-release, single-entity, CII tablets/capsules: patient must have prior therapy with combination products (codeine/hydrocodone/ oxycodone) or tramadol.</i> Codeine sulfate tabs Hydromorphone tabs Meperidine tabs

	<p>Methadone tabs</p> <p>Morphine sulfate tabs</p> <p>Oxycodone tabs and caps</p>
Blood Agents: Heparin-Related	Fondaparinux (generic of Arixtra)
Blood Agents: Oral Anticoagulants	Effient
Cardiovascular: Antiarrhythmics	Multaq
Cardiovascular: Pulmonary Arterial Hypertension	<p>Letairis</p> <p>Tracleer</p>
Cardiovascular: Lipotropic - Bile Acid Sequestrant	Welchol
Cardiovascular: Lipotropic	Zetia
Cardiovascular: Lipotropic	<p><i>Step therapy required: patient must have therapeutic trial of two preferred statins:</i></p> <p>Vytorin</p>
Central Nervous System: Alzheimer's	<p><i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i></p> <p>Exelon patch</p> <p>Namenda</p>
Central Nervous System: Migraine	<p><i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i></p> <p>Maxalt / Maxalt-MLT</p> <p>Frova</p>
Central Nervous System: Antipsychotics	<p><i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i></p> <p>Abilify</p> <p>Seroquel XR</p>
	<p><i>PA required:</i></p> <p>Saphris</p>
Central Nervous System: ADHD	<p><i>PA Required:</i></p> <p>Kapvay</p>
Central Nervous System: Fibromyalgia	<p><i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives or Lyrica:</i></p> <p>Cymbalta</p>

	Savella
Central Nervous System: Neuropathic Pain	<i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives or Lyrica:</i> Cymbalta
Endocrine: Oral Hypoglycemics	<i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i> Actos Duetact Actoplus Met / Actoplus Met XR
Gastrointestinal: Ulcerative Colitis	<i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i> Apriso Asacol Lialda
	<i>PA required:</i> Asacol HD
Genitourinary: Electrolyte Depletter Agents	<i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i> Magnebind Renagel
	<i>PA Required:</i> Fosrenol
Genitourinary: Urinary Antispasmodics	<i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i> Sanctura XR Vesicare
Infectious Disease: Oral Quinolones	Avelox
Infectious Disease: Hepatitis C	Ribasphere 400mg, 600mg
Ophthalmic Antibiotic and Antibiotic/Steroid Combinations	<i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i> Blephamide drops/ointment Ciloxan ointment

	<p>Poly-Pred drops Pred-G drops/ointment Tobradex ointment Tobrex ointment Vigamox drops</p>
	<p><i>PA required:</i> Moxeza neomycin/polymyxin/hydrocortisone drops</p>
Ophthalmic: Glaucoma	<p><i>Step therapy required: patient must have had inadequate clinical response to preferred generic alternatives:</i> Betimol</p>
Ophthalmic: NSAIDs	Bromday
Respiratory: COPD	Daliresp
Topical Agents: Corticosteroids	<p>alclometasone cream/ointment Apexicon-E cream betamethasone dipropionate augmented cream/ointment/lotion/gel betamethasone dipropionate cream/ointment betamethasone dipropionate lotion Capex shampoo clobetasol propionate cream/emollient base cream/foam/gel/lotion/ointment/shampoo Clobex lotion/shampoo/spray Cloderm Cordran tape Desonate gel Desonide lotion desoximetasone cream/gel/ointment fluticasone propionate lotion halobetasol propionate cream/ointment Halog cream/ointment hydrocortisone butyrate cream/ointment hydrocortisone valerate cream/ointment hydrocortisone/urea cream Kenalog aerosol spray Luxiq Olux-E foam</p>

	Pandel cream Pediaderm HC kit prednicarbate cream/ointment triamcinolone acetonide lotion Vanos cream
Topical Agents: Immunomodulators	<i>Step therapy required: patient must have had inadequate clinical response to topical corticosteroids:</i> Elidel
	<i>PA required:</i> Protopic

Drugs that will <u>no longer require</u> a Prior Authorization beginning with date of service 10/1/2012.	
Drug class	Drug Name
Cardiovascular: Angiotensin Receptor Blockers and Combinations	Avapro / Avalide Losartan / Losartan-HCT Z (generic for Cozaar/ Hyzaar)
Central Nervous System: Antipsychotics	<i>Long-acting, injectable antipsychotics may be billed through the pharmacy if they will be delivered to the provider office for administration:</i> Invega Sustenna Risperdal Consta Zyprexa Relprevv
Central Nervous System: Medication Assisted Treatment of Addiction	<i>Long-acting injectable may be billed through the pharmacy if it will be delivered to the provider office for administration:</i> Vivitrol
Infectious Disease: Oral Quinolones	levofloxacin
Topical Agents: Acne	Azelex

Two Ohio Administrative Code rules have been amended to support this initiative:

1. [5101:3-9-03](#), "Covered drugs and associated limitations"

This rule has been amended to allow pharmacies to bill for Invega Sustenna, Risperdal Consta, Zyprexa Relprevv, and Vivitrol through the pharmacy benefit under the following circumstances:

 - a. The drug will be administered by a qualified healthcare professional; and
 - b. The pharmacy and administering provider follow any special handling requirements; and
 - c. The pharmacy releases the product only to the administering provider's office and not directly to the patient, following all regulations for a prescription pick-up station required by the Ohio Board of Pharmacy (see <http://pharmacy.ohio.gov/lawsrules.htm>).

This rule has also been amended to allow over-the-counter fexofenadine products to be billed by the pharmacy for residents of nursing facilities.

2. [5101:3-9-12](#), "Ohio department of job and family services list of drugs covered without prior authorization"

This rule has been amended to update the list to reflect the new PDL, as well as delete coverage for drugs no longer covered by Medicaid and add drugs that are new to the market.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Medical Assistance (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

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To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

Additional Information

Questions pertaining to this letter should be addressed to:

Pharmacies may contact the Technical Help Desk at Xerox (formerly ACS):

Phone: 1-877-518-1545

Prescribers may request prior authorization through Xerox (formerly ACS):

Phone: 1-877-518-1546

Fax: 1-800-396-4111

Providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling Xerox (formerly ACS): at (614) 985-4534.

MAL 581 (Covered Drugs)

Medical Assistance Letter (MAL) 581

July 12, 2012

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Covered Drugs

Summary

Ohio Administrative Code (OAC) rule 5101:3-9-12 has been amended.

Rule [5101:3-9-12](#), "Ohio Department of Job and Family Services List of Drugs Covered Without Prior Authorization" sets forth the drugs covered by the Medicaid pharmacy program without prior authorization. The appendix of this rule has been amended for routine maintenance of the drug list. This includes adding drugs that are newly marketed and deleting drugs that are no longer available or have been excluded from coverage by the federal Centers for Medicare and Medicaid Services. No changes have been made to the rule body.

Access to Rules and Related Material

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Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516

Pharmacies may contact the Technical Help Desk at ACS for assistance with claims billing:

Telephone (877) 518-1545

MAL 579 (Changes to Pharmacy Billing Standard Effective January 1, 2012)

Medical Assistance Letter (MAL) 579

January 3, 2012

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Changes to Pharmacy Billing Standard Effective January 1, 2012

Summary

This medical assistance letter outlines pharmacy billing changes required beginning January 1, 2012.

Policy Guidance

Beginning January 1, 2012, Ohio Medicaid will move to the new pharmacy billing standard, National Council for Prescription Drug Plans (NCPDP) version D.0, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Pharmacy claims in NCPDP D.0 format are accepted beginning December 19, 2011, and required no later than March 31, 2012. Pharmacy providers may send test claims in NCPDP D.0 format using Processor Control Number (PCN) DROHACCP.

Paper claims submitted for processing after January 1, 2012, should be submitted using the NCPDP version D.0 Universal Claim Form (UCF).

Information about the NCPDP version D.0 standard, including ordering information for UCFs, is available from the NCPDP web page, www.NCPDP.org.

In addition to the claim format changes required by NCPDP version D.0, Ohio Medicaid will require two additional changes:

1. The Prescription Origin Code must be submitted in NCPDP field 419-DJ. Only values 1 through 5 will be accepted in this field. Information in this field will assist the program in tracking the use of electronic prescribing, as well as assist with identifying prescriptions to be audited for compliance with the tamper-resistant prescription requirement outlined in Ohio Administrative Code (OAC) rule 5101:3-9-06, "Prescription Billing and Recordkeeping Requirements."

NCPDP values for Prescription Origin Code with Ohio Medicaid-specific notes:

Value	Definition	Notes
Blank	Not Defined	Claim will deny for missing/invalid origin code (NCPDP Reject Code 33: Invalid Prescription Origin Code)
0	Not Known	Claim will deny for missing/invalid origin code (NCPDP Reject Code 33: Invalid Prescription Origin Code)
1	Written	Pharmacy provider should ensure compliance with tamper-resistant requirement
2	Telephone	
3	Electronic	
4	Facsimile	

5	Pharmacy	Allowed in situations described by NCPDP
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2. Compound claims for intravenous (IV) administration will receive the enhanced dispensing fee described in OAC 5101:3-9-05, "Reimbursement," only if a Systematized Nomenclature of Medicine (SNOMED) route of administration code specifying IV infusion is submitted on the claim. The SNOMED route codes that will trigger the higher dispensing fee are 47625008 (IV), 419993007 (IV peripheral), and 418114005 (IV central).

Billing instructions and the Ohio Medicaid NCPDP payer sheet are posted at <http://jfs.ohio.gov/ohp/bhpp/omdp/POS.stm>.

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Additional Information

Pharmacies may contact the Technical Help Desk at ACS for assistance:

Phone: 1-877-518-1545

Additional information about the Ohio Medicaid pharmacy program is available online:

<http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>

MAL 578 (Limited Family Planning Benefit - Pharmacy Coverage)

Medical Assistance Letter (MAL) 578

December 29, 2011

TO: Eligible Pharmacy Providers and Prescribers
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Limited Family Planning Benefit - Pharmacy Coverage

Summary

This medical assistance letter outlines pharmacy coverage that will be available to consumers enrolled in the limited family planning benefit beginning January 1, 2012.

Policy Guidance

Beginning January 1, 2012, eligible consumers may enroll in a limited family planning benefit through the Ohio Medicaid program. Eligibility information is contained in Ohio Administrative Code (OAC) rule 5101:1-41-40, and medical coverage information is contained in OAC 5101:3-21-02.3.

New OAC rule [5101:3-9-14](#) establishes pharmacy coverage for consumers enrolled in this program. The family planning benefit is limited to family planning (contraception) drugs and supplies, and family planning-related drugs used to treat sexually transmitted infections (STIs) other than human immunodeficiency virus (HIV) and hepatitis as outlined in the rule and its appendix.

Prescriptions issued by the prescriber for treatment of STIs diagnosed during a family planning visit must include a family planning diagnosis in the V25 series. The pharmacy claim must include the family planning diagnosis indicated on the prescription.

Pharmacy claims submitted for consumers enrolled in the limited family planning benefit should be submitted in the same manner as those submitted for fee-for-service Medicaid patients, as outlined in the billing instructions posted at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm> and described in OAC rules 5101:3-9-01 through 5101:3-9-06 and 5101:3-9-09.

Access to Rules and Related Material

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To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

Additional Information

Pharmacies may contact the Technical Help Desk at ACS for assistance:

Phone: 1-877-518-1545

Additional information about the Ohio Medicaid pharmacy program is available online:

<http://ifs.ohio.gov/ohp/bhpp/meddrug.stm>

MAL 576 (Pharmacy Program Changes Effective October 1, 2011)

Medical Assistance Letter (MAL) 576

October 4, 2011

TO: Eligible Pharmacy Providers and Prescribers
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Pharmacy Program Changes Effective October 1, 2011

Summary

This medical assistance letter outlines changes to the Ohio Medicaid Pharmacy program that will be effective on October 1, 2011.

1. Change in pharmacy billing and coverage for members of Medicaid-contracting managed care plans (MCPs)
2. Change to fee-for-service Medicaid Preferred Drug List (PDL)

Policy Guidance

1. Change in pharmacy billing and coverage for members of Medicaid-contracting MCPs

Beginning October 1, 2011, the Medicaid MCPs will resume responsibility for pharmacy coverage and payment for their members. Claims for pharmacy services for consumers enrolled in Medicaid-contracting MCPs should be billed to the appropriate MCP. Claims for managed care consumers submitted by pharmacy providers through ACS, the Medicaid fee-for-service claims processor, will deny with NCPDP edit 41: "submit bill to other processor." Additional messaging will instruct the pharmacy to bill the MCP, and identify the plan by name. The pharmacy should ask the consumer for the MCP identification card to identify the claims processing information and cardholder ID.

Please be reminded that although MCPs that serve Ohio Medicaid consumers cover prescription drugs listed on the Ohio Medicaid list of covered drugs, MCPs may have preferred drug lists and prior authorization requirements that are different from the fee-for-service policy described in this MAL. Please see <http://jfs.ohio.gov/OHP/bmhc/index.stm> for information about Medicaid MCPs. ODJFS and the MCPs are working closely to align prior authorization policies as much as possible to lessen confusion for prescribers and pharmacies.

Questions from pharmacies about contracting with and billing the MCPs should be directed to each plan. Links to each MCP's website are available at <http://jfs.ohio.gov/OHP/bmhc/index.stm>. Links to each MCP's pharmacy coverage information and a common prior authorization form that can be used with all MCPs are available at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>.

MCP Pharmacy Contact Information:

Plan Name	Pharmacy Billing and Contracting Phone	Pharmacy Billing and Contracting Website
AMERIGROUP Community Care	1-800-364-6331 (Caremark)	http://info.cvscaremark.com
Buckeye Community Health Plan	1-800-460-8988 (US Script)	http://www.usscript.com/index.php
CareSource	1-800-488-0134	http://www.caresource.com

Molina Healthcare of Ohio	1-800-642-4168	http://www.molinahealthcare.com
Paramount Advantage	1-800-763-5550 (Express Scripts)	http://www.express-scripts.com
UnitedHealthcare Community Plan of Ohio	1-877-305-8952 (Prescription Solutions)	http://www.uhccommunityplan.com
WellCare of Ohio	1-800-951-7719	http://ohio.wellcare.com

One OAC rule has been amended to support this initiative:

- [5101:3-9-02](#), "Pharmacy services: medical supplies and durable medical equipment"

This rule has been amended to remove references to billing for consumers enrolled in MCPs.

2. Change to fee-for-service Medicaid Preferred Drug List (PDL)

The newest phase of the Ohio Medicaid Preferred Drug List (PDL) will be effective on October 1, 2011. The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid fee-for-service consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

A "quick list" of preferred drugs is available at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

As previously mentioned, MCPs may have preferred drug lists and/or prior authorization requirements that are different from the fee-for-service policy described in this MAL.

Beginning in September, messages are sent back to pharmacies when a drug that will change to prior authorization status is dispensed. This gives the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. All prior authorization requests must be initiated by the prescriber or prescriber's staff. Prior authorization may be requested prior to October.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes.

This table is not all-inclusive.

Drugs that <u>will require Prior Authorization</u> beginning with date of service 10/1/2011	
Drug class	Drug Name
Analgesics: Gout	Colcris
Analgesics: Opioids	Kadian
	OxyContin and Oxycodone ER
Cardiovascular: Sympatholytic Antihypertensives	Reserpine
Cardiovascular: Angiotensin Receptor Blockers (ARB) and ARB combinations	All ARBs and ARB combinations will require step therapy: prior treatment with an ACE inhibitor. Patients currently on an ARB/ARB combination will not need to change.

Cardiovascular: Calcium Channel Blockers	Dynacirc CR
Cardiovascular: Lipotropics - Statins	Lescol, Lescol XL
Cardiovascular: Lipotropic-Calcium Channel Blocker Combination	Caduet
Central Nervous System: Antidepressants	Venlafaxine ER Tablet
Central Nervous System: Anti-Migraine	Frova
Central Nervous System: Medication Assisted Treatment	Buprenorphine and Subutex
	Suboxone
Central Nervous System: Parkinson's	Requip XL
	Stalevo
Endocrine: Amylin Analogs and Incretin Mimetics	Symlin, Byetta, and Victoza will require step therapy: prior treatment with a non-DPP-4 oral hypoglycemic or insulin. Patients currently on a Symlin, Byetta, or Victoza will not need to change.
Endocrine: Dipeptidyl Peptidase-4 (DPP-4) Inhibitors and DPP-4 combinations	All DPP-4 and DPP-4 combinations will require step therapy: prior treatment with a non-DPP-4 oral hypoglycemic or insulin. Patients currently on a DPP-4 or DPP-4 combination will not need to change.
Endocrine: Estrogen Agents	Angeliq
	Climara
	Climara Pro
	Divigel
	Elestrin
	Estrace vaginal cream
	Estraderm
	Estrasorb
	Evamist
	Femring
	Femtrace
	Vagifem
	Vivelle-Dot

Endocrine: Osteoporosis	Actonel
Gastrointestinal: Helicobacter Pylori Packages	Prevpac
	Pylera
Gastrointestinal: Ulcerative Colitis	Dipentum
	Pentasa
Genitourinary: Benign Prostatic Hyperplasia	Avodart
Genitourinary: Overactive Bladder	Enablex
Infectious Disease: Oral Cephalosporins	Cedax
Ophthalmic: Antihistamines	Alocril
	Alomide
Ophthalmic: Glaucoma	Lumigan
	Travatan Z
Otic	Coly-Mycin-S
Respiratory: Nasal	Nasonex
Topical Agents: Acne	Azelex
	Clindamycin pledgets
	Differin cream, gel, lotion
	Ziana
Topical Agents: Antifungals	Naftin cream
	Oxistat cream
	Vusion ointment
Topical Agents: Post-Herpetic Neuralgia	Lidoderm
Drugs that will <u>no longer require</u> a Prior Authorization beginning with date of service 10/1/2011.	
Drug class	Drug Name
Cardiovascular: Beta Blocker combinations	Metoprolol/Hydrochlorothiazide
Cardiovascular: Calcium Channel Blockers	Nifedipine immediate release
Cardiovascular: Lipotropics - Bile Acid	Cholestyramine Packets

Sequestrants	Cholestyramine Light Packets
Central Nervous System: Antipsychotics	Risperidone orally disintegrating tablet
Central Nervous System: Attention Deficit Hyperactivity Disorder	Intuniv
	Kapvay
Central Nervous System: Parkinson's	Pramipexole immediate release
Central Nervous System: Sedative-Hypnotics	Zaleplon
Central Nervous System: Skeletal Muscle Relaxants	Dantrolene
Endocrine: Estrogen Agents	Estradiol patch
Genitourinary: Overactive Bladder	Oxybutynin Extended Release
	Sanctura, Sanctura XR
Infectious Disease: Oral Cephalosporins	Cefaclor Extended Release
	Cefadroxil 1 gram tablet, suspension
Ophthalmic: Antibiotics	Ciloxan ointment
	Ofloxacin drops
Respiratory: Antihistamine-Decongestant Combination	Cetirizine-Pseudoephedrine
Respiratory: Nasal	Flunisolide
Topical Agents: Acne	Sodium Sulfacetamide-Sulfur 10%/5% lotion, suspension, wash
Topical Agents: Antifungals	Econazole cream

One OAC rule has been amended to support this initiative:

- [5101:3-9-12](#), "Ohio department of job and family services list of drugs covered without prior authorization"

This rule has been amended to update the list to reflect the new PDL, as well as delete coverage for drugs no longer covered by Medicaid and add drugs that are new to the market.

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To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

Additional Information

Questions pertaining to this letter should be addressed to:

Pharmacies may contact the Technical Help Desk at ACS for assistance:

Phone: 1-877-518-1545

Prescribers may request prior authorization for fee-for-service consumers through ACS:

Phone: 1-877-518-1546 Fax: 1-800-396-4111

Providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling ACS at (614) 985-4534.

MAL 575 (Pharmacy Reimbursement and Covered Drugs)

Medical Assistance Letter (MAL) 575

July 1, 2011

TO: Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Pharmacy Reimbursement and Covered Drugs

Summary

Ohio Administrative Code (OAC) rules 5101:3-9-05 and 5101:3-9-12 have been amended.

Rule [5101:3-9-05](#), "Reimbursement," sets forth the reimbursement methodology for the Medicaid pharmacy program. A change has been made to continue the dispensing fee for noncompounded drugs at \$1.80 beyond June 30, 2011.

Rule [5101:3-9-12](#), "Ohio Department of Job and Family Services List of Drugs Covered Without Prior Authorization" sets forth the drugs covered by the Medicaid pharmacy program without prior authorization. The [appendix](#) of this rule has been amended for routine maintenance of the drug list. This includes adding drugs that are newly marketed and deleting drugs that are no longer available or have been excluded from coverage by the federal Centers for Medicare and Medicaid Services. Several drugs have been moved from one drug class to another to better align with current classifications. These changes have been noted in both the new and previous drug class. No changes have been made to the rule body.

Access to Rules and Related Material

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Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

Pharmacies may contact the Technical Help Desk at ACS for assistance with claims billing:

Telephone (877) 518-1545

MAL 571 (Mandatory Prescriber NPI Submission December 20, 2010)

Medical Assistance Letter (MAL) 571

November 22, 2010

To: Pharmacy Providers
Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Re: Mandatory Prescriber NPI Submission December 20, 2010

The purpose of this Medical Assistance Letter (MAL) is to inform pharmacies that they are required to bill using the prescriber's National Provider Identifier (NPI) beginning December 20, 2010. Claims submitted with a prescriber ID other than NPI will be rejected beginning December 20, 2010, regardless of the date of service.

This MAL refers only to submission of pharmacy claims. The prescriber's NPI is required on all point-of-sale and paper claims submissions to Affiliated Computer Services (ACS), the pharmacy point-of-sale vendor, beginning December 20, 2010. Please see the updated payer sheet on our web site at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. The prescriber's NPI should be submitted in NCPDP version 5.1 segment Ø3 (Prescriber) in field #411-DB (prescriber ID), with field #466-EZ (prescriber ID qualifier) submitted as Ø1 (NPI).

Web Page:

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Questions:

Questions pertaining to pharmacy claims should be addressed to ACS:

Telephone 877-518-1545

MAL 569 (Changes to the Medicaid Preferred Drug List Effective October 1, 2010)

Medical Assistance Letter (MAL) 569

September 30, 2010

TO: All Providers of Pharmacy Services and Prescribers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Changes to the Medicaid Preferred Drug List Effective October 1, 2010

The newest phase of the Ohio Medicaid Preferred Drug List ([PDL](#)) will be effective on October 1, 2010. The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

A "quick list" of preferred drugs is available at <http://ifs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

As a reminder, all Ohio Medicaid consumers, including those enrolled in Medicaid managed care plans, use the same list of covered drugs and prior authorization policy.

Beginning in September, messages are sent back to pharmacies when a drug that will change to prior authorization status is dispensed. This gives the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. All prior authorization requests must be initiated by the prescriber or prescriber's staff. **Prior authorization may be requested prior to October.**

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes. This table is not all-inclusive.

Drugs that will require Prior Authorization beginning with date of service 10/1/2010

Drug Class	Drug Name
Cardiovascular Agents: Bile Acid Sequestrants	Colestipol granules
	Prevalite® powder packets
	Welchol® packets
Cardiovascular Agents: Statin/Niacin Combination	Advicor®
Central Nervous System: Anti-Migraine Agents	Axert®
	Imitrex® tablets (use sumatriptan)
	Relpax®
	Treximet®
Central Nervous System: Sedative-Hypnotics	Rozerem®
Endocrine Agents: Diabetes - Oral Therapy	Avandia®
	Avandamet®

	Avandaryl®
Endocrine Agents: Osteoporosis	Boniva®
Gastrointestinal Agents: Proton Pump Inhibitors	Nexium® capsules
Genitourinary Agents: Benign Prostatic Hypertrophy	Uroxatral®
Genitourinary Agents: Urinary Antispasmodics	Sanctura®
	Sanctura XR®
Ophthalmic Agents: Antihistamines	Ketotifen drops
Ophthalmic Agents: NSAIDs	Acular LS®
Otic Agents: Antibacterial/Steroid Combinations	Cipro HC®

Drugs that require a clinical Prior Authorization and will be non-preferred beginning with date of service 10/1/2010

Drug Class	Drug Name
Endocrine Agents: Growth Hormones	Nutropin®, Nutropin AQ®
	Saizen®

Drugs that will no longer require a Prior Authorization beginning with date of service 10/1/2010

Drug Class	Drug Name
Cardiovascular Agents: Fibric Acid Derivatives	Antara®
Endocrine Agents: Diabetes - Insulin	Relion® R, N, and 70/30
Gastrointestinal Agents: Proton Pump Inhibitors	Lansoprazole capsules
	Omeprazole tablets
	Prevacid 24HR®
	Prilosec OTC®
	Zegerid OTC®
Ophthalmic Agents: NSAIDs	Xibrom®
Respiratory Agents: Beta-Agonists	Proventil HFA®

Drugs that require a clinical Prior Authorization and will be preferred beginning with date of service 10/1/2010

Drug Class	Drug Name
Endocrine Agents: Growth Hormones	Norditropin®

	Omnitrope®
Respiratory Agents: Beta-Agonists	Foradil®

Providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling ACS at (614) 985-4534.

MAL 568 (Pharmacy Influenza Vaccine Administration and Tamper-Resistant Prescription Pad Requirements)

Medical Assistance Letter (MAL) 568

September 21, 2010

TO: All Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Pharmacy influenza vaccine administration and tamper-resistant prescription pad requirements

This letter provides information regarding changes to the following Ohio Administrative Code (OAC) rules:

[5101:3-9-03](#), "Covered Drugs and Associated Limitations"

[5101:3-9-05](#), "Reimbursement"

[5101:3-9-06](#), "Prescription Billing and Recordkeeping Requirements"

[5101:3-9-13](#), "Influenza Vaccine Administration" is being rescinded.

OAC 5101:3-9-13 regarding influenza vaccine administration is being rescinded because the rule specifies dates of service October 1, 2009 through May 31, 2010. The information in this rule is being incorporated into OAC rules 5101:3-9-03 and 5101:3-9-05 to continue payment of influenza vaccine administered at the pharmacy for future influenza seasons.

OAC 5101:3-9-06 is being amended to clarify that tamper-resistant prescription pads are required for all Ohio Medicaid prescriptions.

Web Page:

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To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461

Telephone 800-686-1516

MAL 565 (Change to Coverage of Prescription Drugs and Certain Supplies)

Medical Assistance Letter (MAL) 565

Attachment: Sample Ohio Medicaid Managed Care Plan ID Cards

January 26, 2010

TO: All Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Changes to Coverage of Prescription Drugs and Certain Supplies

This letter provides information regarding changes to coverage of prescription drugs for members of Medicaid Managed Care Plans (MCPs) and to coverage of certain medical supplies for all Ohio Medicaid consumers, including MCP members. To support these changes, amendments are being made to Ohio Administrative Code (OAC) rules [5101:3-9-02](#) (Pharmacy Services: Medical Supplies and Durable Medical Equipment) and [5101:3-9-09](#) (Consumer Co-Payments for Certain Pharmacy Medications). OAC rule [5101:3-10-17](#) (Blood Glucose Monitors [Glucometers] and Supplies) is being rescinded.

Beginning with date of service February 1, 2010, prescription drug coverage for members of Medicaid MCPs will transfer to the Medicaid fee-for-service program. Prescription drug claims for MCP members should be billed through the ODJFS pharmacy point-of-sale (POS) vendor, ACS, in the same way claims for Medicaid fee-for-service consumers are billed. This change means that all Medicaid consumers will have the same list of covered drugs and same prior authorization policy. Medicaid MCPs are no longer responsible for prescription drug coverage for their members. This change is only for prescription drugs that are administered in the patient's home, not for any drugs that are administered in a provider setting such as physician office, hospital outpatient department, clinic, dialysis center, or infusion center. Drugs administered in a home health setting should be billed through the fee-for-service pharmacy program.

This letter has information about the following topics:

1. Pharmacy billing procedures
2. New billing procedures for newborns who have not been assigned a Medicaid ID
3. Changes to billing of certain medical supplies
4. Drug coverage, transition period, and prior authorization
5. Emergency supply if prescriber is not available to request prior authorization
6. Co-payment requirements
7. Tamper-resistant prescription pad requirements
8. ODJFS web page

1. Pharmacy Billing Procedures

Beginning with claims for date of service February 1, 2010, prescription drug claims for all Medicaid consumers, including MCP members, should be billed through the fee-for-service POS vendor, ACS. The ID number submitted should be the 12-digit MMIS billing number. Copies of the MCP member ID cards showing the location of the MMIS billing number are on the attachment to this letter.

Claims should be submitted to ACS with the information contained in the payer sheet, available online at <http://ifs.ohio.gov/ohp/bhpp/omdp/POS.stm>, using BIN 610084, PCN DROHPROD, group OHMEDICAID, and the 12-digit MMIS billing number. For claims processing questions, call ACS at 1-877-518-1545.

Claim adjustments for MCP members for dates of service prior to February 1, 2010, should be sent to the pharmacy benefit manager that originally processed the claim.

2. New billing procedures for newborns who have not been assigned a Medicaid ID

Pharmacies should make every attempt to determine whether a child born to a mother who has Medicaid has been assigned a Medicaid ID. If the consumer does not have an ID card showing the newborn's MMIS billing ID, call ACS to determine if an ID number has been assigned. Beginning February 1, 2010, if a Medicaid ID has not been assigned for the baby, newborns will be covered for prescriptions for the first year after birth under their mother's Medicaid billing ID. The pharmacy should submit the claim for the newborn using the mother's Medicaid ID and the baby's date of birth. Pharmacies should encourage consumers to report newborns to the eligibility caseworker as soon as possible after the birth so they can be added to the case and assigned a Medicaid ID.

3. Changes To Billing of Certain Medical Supplies

OAC [5101:3-9-02](#), entitled " Pharmacy Services: Medical Supplies and Durable Medical Equipment" is being amended to change the way certain medical supplies are billed. Beginning with date of service February 1, 2010, only pharmacy providers will be able to bill for the supplies listed in the table below. These supplies should be billed using the NDC on the package through the pharmacy POS claim system, and can no longer be billed on a medical claim (CMS-1500 claim form or 837P EDI claim transaction). Claims that were billed to Medicare Part B or a Medicare Advantage plan as the primary payer are not affected by this change and will continue to be paid when billed on a medical claim.

The supplies affected by this change are listed in the table. The Healthcare Common Procedure Coding System (HCPCS) code is listed in the table for reference only. Beginning with date of service February 1, 2010, these supplies will be paid by the NDC number instead of the HCPCS code.

HCPCS Code	Description
A4206	Syringe with needle, sterile less than or equal to 1 cc
A4215	Needles only, sterile, any size, including pen needles
A4245	Alcohol wipes or swabs, box
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4252	Blood ketone test or reagent strip, each
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50
A4256	Normal, low high calibration solutions/chips (pkg)
A4258	Spring powered device for lancet
A4259	Lancets, per box of 100
E0607	Home blood glucose monitor complete
E2100	Blood glucose monitor with voice (PA required)
E2101	Blood glucose monitor with integrated lancing/blood sample (PA required)
S5560	Insulin delivery device, reusable pen; 1.5ml size
S5561	Insulin delivery device, reusable pen; 3ml size
A4614	Peak Expiratory Flow Rate Meter

A4627	Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler
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In addition to the products listed in the table, condoms (male or female) may be billed through the pharmacy POS billing system. For Medicaid fee-for-service consumers, condoms may also be billed by other providers, such as clinics and DME dealers, that are registered with ODJFS to bill medical supplies. For MCP members, check with the MCP for coverage of condoms through provider types other than pharmacies. Limits and reimbursements for these supplies that are billed through the pharmacy billing system are listed in Appendix A to OAC rule 5101:3-9-02.

Amendments are also being made to OAC rules [5101:3-10-03](#) (Medicaid Supply List) and [5101:3-1-60](#) (Medicaid Reimbursement) to remove coverage of these HCPCS codes from the medical benefit under the durable medical equipment (DME) fee-for-service program effective February 1, 2010.

4. Drug Coverage, Transition Period, and Prior Authorization

Beginning date of service February 1, 2010, prescription drug coverage for Medicaid MCP members will be the same as coverage for Medicaid fee-for-service consumers. All coverage is outlined in OAC chapter 5101:3-9. A transition period for MCP members will be in effect from February 1 through April 30, 2010. For claims within these dates of service, MCP members will be able to continue to receive medications that were filled under the MCP within the previous six months. If the drug claim for a MCP member requires prior authorization, the claim will be authorized during February, March, and April 2010 if the MCP member had a claim for the same drug during the previous six months. The MCP member will be notified that the drug that was filled requires prior authorization, but that they may continue to receive that drug through April 30, 2010. Beginning May 1, 2010, claims will deny at the pharmacy and the prescriber should either change to a drug that does not require prior authorization or request prior authorization.

Some MCPs required drugs administered in a nursing facility, drugs supplied through home infusion, and some other specialty medications to be billed through the medical benefit rather than the pharmacy benefit. In these cases, the pharmacy claims record is not available to ODJFS to be included in the transition period and the claim may deny at the pharmacy even though the consumer has received the drug in the previous six months. In these cases, the prescriber will need to request PA as outlined below.

Prior authorization may be requested by the prescribing provider or a member of the prescribing provider's staff by calling ACS at 1-877-518-1546 or sending a fax to 1-800-396-4111. A "quick list" of preferred drugs is available at <http://ifs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information. Pharmacy and medical providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling ACS at (614) 682-2034.

5. Emergency Supply If Prescriber Is Not Available To Request Prior Authorization

If a pharmacy claim is rejected at the pharmacy because prior authorization is required, and the prescriber's office is closed, the pharmacy may call ACS to request payment of up to a 72-hour supply of medication. This will give time for the prescriber to request prior authorization. This emergency override is available only when the prescriber's office is closed (evenings, holidays, and weekends).

6. Co-Payment Requirements

OAC [5101:3-9-09](#), entitled "Consumer Co-Payments for Certain Pharmacy Medications" is being amended to include MCP members in the co-payment program for prescription drugs. For most trade name prescriptions, consumers who are eligible for the Medicaid program will be subject to a \$2.00 co-payment for selected trade name medications, and a \$3.00 co-payment for drugs requiring prior authorization. There is no co-payment for generic drugs that do not require prior authorization. When a co-payment is applicable, the pharmacy provider is responsible for collecting the co-payment, and ODJFS will reduce the pharmacy's reimbursement by the amount of the co-payment whether or not the pharmacy provider collected the co-payment. Pharmacies using the POS claims system will receive notification of the co-payment at the time the claim is submitted.

Prescribing providers may be asked by Medicaid consumers to prescribe generic medications that will not be subject to co-payment. If providers can prescribe a clinically appropriate medication that can be safely substituted for the trade name drug, then the provider may offer that choice so the consumer can get a prescription that is not subject to co-payment.

Co-payments must not be charged by a pharmacy, and co-payments are not applicable, if the consumer is:

- under age 21, or
- pregnant or in the post-partum period (The post-partum period is the immediate post-partum period that begins on the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends), or
- in a nursing home or intermediate care facility for the mentally retarded, or
- receiving hospice care

Co-payments must not be charged by a pharmacy, and co-payments are not applicable, if:

- the prescription medication is a trade name medication the department has exempted from co-payment (e.g., the department has indicated the trade name medication should be dispensed rather than the generic), or
- the prescription is for family planning (contraceptive, oxytocic, or prenatal vitamin)

Medications that are administered to a consumer in a provider setting such as physician office, hospital outpatient department, clinic, dialysis center, or infusion center are not subject to co-payments. Medications administered in a home health setting are subject to co-payments.

Most Medicaid consumers who are pregnant or in the post-partum period are exempted from co-payment through the POS system based on their Medicaid eligibility category. However, some pregnant women may be charged a co-payment through the POS system if their eligibility is in a category that has not been automatically exempted. In this case, the pharmacy can override the co-payment requirement by submitting the value 2 in the "Pregnancy Indicator" field (NCPDP field 335-2C) on the pharmacy claim. The co-payment will be reduced to zero and the co-payment amount will not be deducted from the pharmacy payment.

Medicaid consumers residing in a nursing home or intermediate care facility for the mentally retarded are exempted from co-payment by the POS system based on the living arrangement recorded by the eligibility caseworker in the consumer's eligibility record. In the event that the living arrangement has not been updated by the eligibility caseworker, or in the event that a consumer is receiving hospice care, the pharmacy can submit the appropriate "Patient Location Code" (NCPDP field 307-C7) on the pharmacy claim. Patient location code values 3 (nursing home), 4 (long term/extended care), 7 (skilled care), or 11 (hospice), will override the co-payment requirement. The co-payment will be reduced to zero and the co-payment amount will not be deducted from the pharmacy payment.

Consumers subject to co-payment, who indicate that they are unable to pay their co-payment at the time their medication is dispensed, may indicate their inability to pay and obtain their prescription medication without paying the co-payment. The consumer remains liable for the co-payment and the pharmacy provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment.

If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid Medicaid co-payment imposed by the co-payment program from a prior transaction as an outstanding debt and may refuse service to a Medicaid consumer who owes the provider an outstanding debt. If the provider intends to refuse service to a Medicaid consumer who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services.

7. Tamper-Resistant Prescription Pad Requirements

The federal Medicaid statute prevents payments of prescriptions "for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad."

All prescriptions that are written by the prescriber and given to the patient or patient's representative to present to the pharmacy must be tamper-resistant. Prescriptions transmitted to the pharmacy via telephone,

fax, or e-prescribing, in accordance with Ohio Board of Pharmacy regulations, are exempt from this requirement.

To be considered tamper-resistant, a prescription form must contain all of the following three characteristics:

Required characteristic:	Examples include but not limited to:
One or more features designed to prevent unauthorized copying of a completed or blank prescription form	Text that appears when photocopied or scanned (e.g., "void" or "illegal") Microprint borders that cannot be copied
One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber	Erasure or use of solvents will discolor background Check-off boxes to indicate the quantity prescribed (e.g., 1-24, 25-49, 50-74, etc.) Quantity border characteristics (dispense quantity and refill number bordered by asterisks and optionally spelled out) for prescriptions generated by an electronic system
One or more features designed to prevent the use of counterfeit prescription forms	Thermochromic ink Sequentially numbered Security features and descriptions listed on the prescription

The tamper-resistant requirement applies in both of the following situations:

- All written prescriptions presented at the pharmacy, including prescriptions for over-the-counter, legend, and controlled drugs; and
- All written prescriptions when ODJFS pays any part of the claim, including when ODJFS is not the primary payer.

The tamper-resistant requirement does not apply in the following situations:

- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone, in accordance with Ohio Board of Pharmacy regulations;
- Orders for medications administered in a provider setting and billed by the administering provider (i.e., medications not billed through the pharmacy);
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper-resistant if the patient does not have the opportunity to handle the written order.

If a written prescription that is not tamper-resistant is presented at the pharmacy, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within 72 hours of dispensing. The pharmacist should use professional judgment to define an emergency situation. The replacement may be a compliant written prescription, a fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription. Alternatively, the pharmacy may verify the prescription by telephone. In this case, the verification must be documented on the prescription including the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

8. Web Page

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid. The web address for the Ohio Department of Job and Family Services is <http://www.jfs.ohio.gov>. The web address of the Office of Ohio Health Plans front page is <http://www.jfs.ohio.gov/ohp>. Information regarding pharmacy policies may be accessed from the department's web page by browsing to <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>.

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Questions

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

Questions pertaining to drug coverage or pharmacy claims should be addressed to ACS:

Telephone 877-518-1545

For a visit from an Educational Outreach Pharmacist to receive additional information about the Preferred Drug List (PDL), call the ACS office:

Telephone 614-682-2034

MAL 564 (Change to Pharmacy Reimbursement)

Medical Assistance Letter (MAL) 564

January 5, 2010

TO: All Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Change to Pharmacy Reimbursement

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule [5101:3-9-05](#), "Reimbursement."

Effective January 1, 2010, the dispensing fee for noncompounded drugs will change to \$1.80 as required by the state budget bill, Amended Substitute House Bill 1.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "Pharmacy Services";
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

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To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MAL 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies)

Medical Assistance Letter (MAL) 561

December 14, 2009

TO: All Eligible Prescribing Providers
All Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies

This letter provides information regarding changes to coverage of prescription drugs for members of Medicaid Managed Care plans (MCPs) and to coverage of certain medical supplies for all Ohio Medicaid consumers, including MCP members.

Beginning with date of service February 1, 2010, prescription drug coverage for members of Medicaid MCPs will transfer to the Medicaid fee-for-service (FFS) program. This change means that all Medicaid consumers will have the same list of covered drugs and same prior authorization policy. Medicaid MCPs are no longer responsible for prescription drug coverage for their members.

This change is only for prescription drugs that are administered in the patient's home, not for any drugs that are administered in a provider setting such as physician office, hospital outpatient department, clinic, dialysis center, or infusion center. Drugs administered in a home health setting should be billed through the fee-for-service pharmacy program. Some medical supplies, such as diabetic testing supplies, supplies for injection of insulin and other drugs, inhaler spacers, and peak flow meters, will only be able to be billed by pharmacies (including hospital pharmacies) and will no longer be covered when billed by any other provider type, including durable medical equipment (DME) dealers, clinics, or individual physician offices.

This letter also contains information about CyberAccess, a secure web site that allows Ohio Medicaid providers to review the Medicaid prescription claims history for their patients, review prescription prior authorizations, and send electronic prescriptions (e-prescribe) for their Medicaid patients.

Prescriptions billed through the FFS program may be subject to co-payments. In addition, the federal requirement for tamper-resistant prescription pads will now include prescriptions for members of MCPs because they will be billed to the FFS program. Each of these topics is explained in more detail below.

Drug Coverage, Transition Period, and Prior Authorization

Prescription drug coverage for Medicaid MCP members will be the same as coverage for Medicaid fee-for-service consumers. A transition period for MCP members will be in effect from February 1 through April 30, 2010. For claims within these dates of service, MCP members will be able to continue to receive medications that were filled under the MCP within the previous six months. If the drug claim for a MCP member requires prior authorization, the claim will be authorized during February, March, and April 2010 if the MCP member had a claim for the same drug during the previous six months that was covered by the MCP. The MCP member will be notified that the drug that was filled requires prior authorization, but that they may continue to receive that drug through April 30, 2010. Beginning May 1, 2010, claims will deny at the pharmacy and the prescriber should either change to a drug that does not require prior authorization or request prior authorization. The prescribing provider or a member of the prescribing prescriber's staff may request prior authorization by calling ACS at 1-877-518-1546 or sending a fax to 1-800-396-4111. A "quick list" of preferred drugs is available at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information. Providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling ACS at (614) 682-2034.

CyberAccess

The Ohio Department of Job and Family Services (ODJFS) has contracted with ACS, its pharmacy vendor, to provide the CyberAccess system. CyberAccess is a user-friendly, intuitive internet portal for providers to access clinical alerts and pharmacy information regarding their patients. Prescribers can also use the tool to verify a drug's prior authorization status and to send "e-prescriptions" to pharmacies.

The CyberAccess tool is a web-based, HIPAA-compliant portal for prescribers and/or their authorized staff with the ability to:

- Review two years of claims data (patient profile information) including eligibility information and prescribed drug history
- Identify potential care management concerns using criteria derived from an analysis of the patient's claims history, including best practices recommendations, potential drug-related problems, and disease management or disease-related concerns
- Electronically verify Preferred Drug List status, including determining if a drug requires prior authorization and if the patient meets approval criteria within the SmartPA automated prior authorization system,
- Electronically send prescriptions to pharmacies (e-prescribe)

This tool can help to improve patient care by allowing better coordination between prescribers, as well as enabling a provider to see at a glance all of the prescriptions filled through the Medicaid program to avoid duplication or interactions.

Any Medicaid-participating practice can register to use CyberAccess. Contact ACS at (614) 682-2034 for additional information and to request a visit from an educational outreach pharmacist who can demonstrate the website and register your practice.

Tamper-Resistant Prescription Pad Requirements

The federal Medicaid statute prevents payments of prescriptions "for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad."

All prescriptions that are written by the prescriber and given to the patient or patient's representative to present to the pharmacy must be tamper-resistant. Prescriptions transmitted to the pharmacy via telephone, fax, or e-prescribing, in accordance with Ohio Board of Pharmacy regulations, are exempt from this requirement.

To be considered tamper resistant, a prescription form must contain all of the following three characteristics:

Required characteristic:	Examples include but not limited to:
1. One or more features designed to prevent unauthorized copying of a completed or blank prescription form	Text that appears when photocopied or scanned (e.g., "void" or "illegal") Microprint borders that cannot be copied
2. One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber	Erasure or use of solvents will discolor background Check-off boxes to indicate the quantity prescribed (e.g., 1-24, 25-49, 50-74, etc.) Quantity border characteristics (dispense quantity and refill number bordered by asterisks and optionally spelled out) for prescriptions generated by an electronic system
3. One or more features designed to prevent the use of counterfeit prescription forms	Thermochromic ink Sequentially numbered Security features and descriptions listed on the prescription

The tamper-resistant requirement applies in both of the following situations:

- All written prescriptions presented at the pharmacy, including prescriptions for over-the-counter, legend, and controlled drugs; and
- All written prescriptions when ODJFS pays any part of the claim, including when ODJFS is not the primary payer.

The tamper-resistant requirement does not apply in the following situations:

- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone, in accordance with Ohio Board of Pharmacy regulations;
- Orders for medications administered in a provider setting and billed by the administering provider (i.e., medications not billed through the pharmacy);
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper resistant if the patient does not have the opportunity to handle the written order.

If a written prescription that is not tamper resistant is presented at the pharmacy, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within 72 hours of dispensing. The pharmacist should use professional judgment to define an emergency situation. The replacement may be a compliant written prescription, a fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription. Alternatively, the pharmacy may verify the prescription by telephone. In this case, the verification must be documented on the prescription including the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

Co-Payment Requirements

Consumers may be required to pay a co-payment for prescription drugs. Consumers who are eligible for the Medicaid program will be subject to a \$2.00 co-payment for most trade name prescriptions, and a \$3.00 co-payment for drugs requiring prior authorization. There is no co-payment for generic drugs that do not require prior authorization.

Prescribing providers may be asked by Medicaid consumers to prescribe generic medications that will not be subject to co-payment. If providers can prescribe a clinically appropriate medication that can be safely substituted for the trade name drug, then the provider may offer that choice so the consumer can get a prescription that is not subject to co-payment.

Co-payments must not be charged by a pharmacy, and co-payments are not applicable, if the consumer is:

- under age 21, or
- pregnant or in the post-partum period (The post-partum period is the immediate post-partum period that begins on the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends), or
- in a nursing home or intermediate care facility for the mentally retarded, or
- receiving hospice care

Co-payments must not be charged by a pharmacy, and co-payments are not applicable, if:

- the prescription medication is a trade name medication the department has exempted from co-payment (e.g., the department has indicated the trade name medication should be dispensed rather than the generic), or
- the prescription is for family planning (contraceptive, oxytocic, or prenatal vitamin)

Medications that are administered to a consumer in a provider setting such as physician office, hospital outpatient department, clinic, dialysis center, or infusion center are not subject to co-payments. Medications administered in a home health setting are subject to co-payments.

Consumers subject to co-payment, who indicate that they are unable to pay their co-payment at the time their medication is dispensed, may indicate their inability to pay and obtain their prescription medication without paying the co-payment. The consumer remains liable for the co-payment and the pharmacy provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment.

Changes To Billing of Certain Medical Supplies

Beginning with date of service February 1, 2010, only pharmacy providers will be able to bill for the supplies listed in the table below. These supplies should be billed using the NDC on the package through the pharmacy point-of-sale (POS) claim system, and can no longer be billed on a medical claim (CMS-1500 claim form or 837P EDI claim transaction). The supplies affected by this change are listed in the table. The Healthcare Common Procedure Coding System (HCPCS) code is listed in the table for reference only. Beginning with date of service February 1, 2010, these supplies should be billed by the NDC number instead of the HCPCS code.

HCPCS Code	Description
A4206	Syringe with needle, sterile less than or equal to 1 cc
A4215	Needles only, sterile, any size, including pen needles
A4245	Alcohol wipes or swabs
A4250	Urine test or reagent strips or tablets
A4252	Blood ketone test or reagent strip
A4253	Blood glucose test or reagent strips for home blood glucose monitor
A4256	Normal, low high calibration solutions/chips
A4258	Spring powered device for lancet
A4259	Lancets
E0607	Home blood glucose monitor complete
E2100	Blood glucose monitor with voice (PA required)
E2101	Blood glucose monitor with integrated lancing/blood sample (PA required)
S5560	Insulin delivery device, reusable pen; 1.5ml size
S5561	Insulin delivery device, reusable pen; 3ml size
A4614	Peak Expiratory Flow Rate Meter
A4627	Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler

In addition to the products listed in the table, for fee-for-service consumers, condoms (male or female) may be billed through the pharmacy POS billing system. Condoms may also be billed by other providers, such as clinics and DME dealers, that are registered with ODJFS to bill medical supplies. Check with the managed care plan for coverage of condoms through provider types other than pharmacies.

Pharmacy Billing Procedures

Beginning with claims for date of service February 1, 2010, prescription drug claims for all Medicaid consumers, including MCP members, should be billed through the fee-for-service POS vendor, ACS. The ID number submitted should be the MMIS billing number, which is included on the MCP member's MCP identification card.

Claims should be submitted to ACS with the information contained in the payer sheet, available online at <http://jfs.ohio.gov/ohp/bhpp/omdp/POS.stm>, using BIN 610084, PCN DROHPROD, and group OHMEDICAID. For claims processing questions, call ACS at 1-877-518-1545.

Web Page

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid. The web address for the Ohio Department of Job and Family Services is <http://www.jfs.ohio.gov>. The web address of the Office of Ohio Health Plans front page is <http://www.jfs.ohio.gov/ohp>. Information regarding pharmacy policies may be accessed from the department's web page by browsing to <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The web address for this "emanuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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- (2) Selecting the appropriate service provider type or handbook;
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Questions

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

Questions pertaining to prior authorization and prior authorization requests should be addressed to ACS:

Telephone 877-518-1546
Facsimile 800-396-4111

Questions pertaining to pharmacy claims should be addressed to ACS:

Telephone 877-518-1545

For a visit from an Educational Outreach Pharmacist to receive additional information about the Preferred Drug List (PDL) or for a demonstration of CyberAccess, call the ACS office:

Telephone 614-682-2034

MAL 559 (Medicaid Payment for Influenza Vaccine Administration at the Pharmacy)

Medical Assistance Letter (MAL) 559

October 8, 2009

TO: All Eligible Pharmacy Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Medicaid Payment for Influenza Vaccine Administration at the Pharmacy

This letter provides information about new Ohio Administrative Code (OAC) rule [5101:3-9-13](#), "Influenza Vaccine Administration," which authorizes Medicaid payment to pharmacies for administration of both H1N1 pandemic and seasonal influenza vaccine for dates of service October 1, 2009, through May 31, 2010. Payment for influenza vaccine administration will be made to pharmacies only for Medicaid consumers who do not reside in long-term care facility (LTCF).

Reimbursement for the H1N1 pandemic influenza vaccine will be limited to an administration fee of no more than \$10.00. The H1N1 pandemic influenza vaccine is supplied by the Ohio Department of Health at no cost to the provider, so no reimbursement will be made for the vaccine itself. Reimbursement for the seasonal influenza vaccine will include product cost and an administration fee of no more than \$10.00. No dispensing fee will be paid when the administration fee is billed. Influenza vaccine may be dispensed to LTCF residents for administration by LTCF staff. Claims for influenza vaccine dispensed to residents of LTCFs are eligible for a dispensing fee of \$0.50.

To bill for the administration fee, pharmacies should submit the following information as part of the claim submitted to the ODJFS point-of-sale claims vendor, using the National Council for Prescription Drug Programs (NCPDP) 5.1 claim format:

Field Number	Field Name	Value	Comment
111-AM	Segment Identification	08	DUR/PPS Segment
473-7E	DUR/PPS Code Counter	1	Number of occurrences
440-E5	Professional Service Code	MA	Medication Administered
111-AM	Segment Identification	11	Pricing Segment
438-E8	Incentive Amount Submitted	U&C	Usual and customary amount for vaccine administration

The administration fee paid to the pharmacy will populate in the claim response pricing segment 521-FL "Incentive Fee Paid."

Please be reminded that although managed care plans (MCPs) that serve Ohio Medicaid consumers may cover influenza immunizations, MCPs may have policies and billing requirements that are different from the fee-for-service policy described in this MAL. Please see <http://ifs.ohio.gov/ohp/bmhc/> for information about Medicaid MCPs.

Web Page:

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To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Pharmacies may contact the Technical Help Desk at ACS for assistance:

Phone: 1-877-518-1545

MAL 557 (Changes to the Fee-For-Service Preferred Drug List Effective October 1, 2009)

Medical Assistance Letter (MAL) 557

September 30, 2009

TO: All Providers of Pharmacy Services and Prescribers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Changes to the Fee-For-Service Preferred Drug List Effective October 1, 2009

The newest phase of the Ohio Medicaid Preferred Drug List (PDL) will be effective on October 1, 2009. The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

A "quick list" of preferred drugs is available at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

Please be reminded that although managed care plans (MCPs) that serve Ohio Medicaid consumers cover prescription drugs listed on the Ohio Medicaid list of covered drugs, MCPs may have ODJFS-approved preferred drug lists/prior authorization requirements that are different from the fee-for-service policy described in this MAL. Please see <http://jfs.ohio.gov/ohp/bmhc/> for information about Medicaid MCPs.

Beginning in September, messages are sent back to pharmacies when a drug that will change to prior authorization status is dispensed. This gives the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. All prior authorization requests must be initiated by the prescriber or prescriber's staff. Prior authorization may be requested prior to October.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes. This table is not all-inclusive.

Drugs that will require Prior Authorization beginning with date of service 10/1/2009

Drug class	Drug Name
Cardiovascular: Lipotropics	Crestor®
Central Nervous System: Skeletal Muscle Relaxants	Orphenadrine (generic of Norflex®)
	Orphenadrine Compound (generic of Norgesic®)
	Orphenadrine Compound Forte (generic of Norgesic Forte®)
Gastrointestinal Agents: Proton Pump Inhibitors	Prevacid® capsules
Genitourinary Agents: Urinary Antispasmodics	Detrol LA®
	Toviaz®

Infections Disease Agents: Hepatitis C	Rebetol® (use generic ribavirin)
Ophthalmic Agents: Antibiotic Drops	Quixin®
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	Cortisporin-TC®
	Pediotic®
	Floxin® Singles (use bottle)
Respiratory Agents: Beta-Adrenergic Agents	Maxair Autohaler®
	Xopenex® HFA, Nebulizer Solution
Respiratory Agents: Nasal Preparations	Nasacort AQ®
Topical Agents: Acne Preparations	Clindagel®
	Benzoyl Peroxide pads (generic of Oscion®, Triaz®)
	Benzoyl Peroxide Microspheres cream (generic of Neobenz Micro®)
	Benzoyl Peroxide-Urea cleanser, cream, gel, pads (generic of Zoderm®)
	Duac CS® kit, Duac® gel
	Atralin® gel
	Epiduo® gel
	Sodium Sulfacetamide and Sodium Sulfacetamide combinations products other than Klaron®
Topical Agents: Anti-Parasitics	Eurax® lotion
	Lindane lotion, shampoo
Drugs that will no longer require a Prior Authorization beginning with date of service 10/1/2009.	
Drug class	Drug Name
Central Nervous System: Antidepressants	Venlafaxine ER tablets
	Cymbalta®
Gastrointestinal Agents: Proton Pump Inhibitors	Omeprazole 10mg, 20mg capsules (generic of Prilosec®)
Genitourinary Agents: Urinary Antispasmodics	Sanctura®, Sanctura XR®
Infections Disease Agents: Hepatitis C	Ribavirin, Ribasphere® (generic of Rebetol®, Copegus®)
Ophthalmic Agents: Glaucoma	LumiganTM

Respiratory Agents: COPD Anticholinergic Agents	Ipratropium/Albuterol Nebulizer Solution (generic of Duoneb®)
Topical Agents: Acne Preparations	Klaron® lotion
Topical Agents: Anti-Fungals	Terbinafine cream (generic of Lamisil®)

Providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling ACS at (614) 682-2034.

MAL 550 (Changes to the Fee-For-Service Pharmacy Program Effective October 1, 2008)

Medical Assistance Letter (MAL) 550

September 23, 2008

TO: All Providers of Pharmacy Services and Prescribers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Changes to the Fee-For-Service Pharmacy Program Effective October 1, 2008

This letter provides information regarding three changes to the Ohio Medicaid Fee-For-Service Pharmacy Program that will be effective October 1, 2008:

1. Changes to the Preferred Drug List (PDL) and additional information regarding antidepressants and second generation antipsychotics
2. Duration of therapy limit for heparin-related preparations
3. Full implementation of the federal requirement for tamper-resistant prescription forms

1. Changes to the Preferred Drug List (PDL) and additional information regarding antidepressants and second generation antipsychotics

The newest phase of the Ohio Medicaid Preferred Drug List (PDL) will be effective on October 1, 2008. The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

A "quick list" of preferred drugs is available at <http://ifs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, PA request fax form, and Pharmacy & Therapeutics Committee information.

Please be reminded that although managed care plans (MCPs) that serve Ohio Medicaid consumers cover prescription drugs listed on the Ohio Medicaid list of covered drugs, MCPs may have ODJFS approved preferred drug lists/prior authorization requirements that are different from the fee-for-service policy described in this MAL. Please see <http://ifs.ohio.gov/ohp/bmhc/pro-man-care.stm> for information about Medicaid MCPs.

Beginning in September, messages are sent back to pharmacies when a drug that will change to prior authorization status is dispensed. This gives the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. All prior authorization requests must be initiated by the prescriber or prescriber's staff. Prior authorization may be requested prior to October.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes. This table is not all-inclusive.

Drugs that will require Prior Authorization beginning with date of service 10/1/2008	
Drug class	Drug Name
Cardiovascular: Alpha-Beta Blockers	Coreg® CR
CNS: Antidepressants *	Cymbalta®

	Emsam®
	Luvox® CR
	Marplan®
	Nardil®
	Parnate®
	Paroxetine ER (generic of Paxil® CR)
	Pexeva®
	Pristiq®
	Prozac® Weekly (use fluoxetine)
CNS: Second Generation Antipsychotics *	Abilify Discmelt®
	Clozapine (generic of Clozaril®)
	Clozaril®
	Fazaclo®
	Risperdal M-Tab® (use tablets)
	Zyprexa®, Zyprexa Zydis®
	Symbyax®
CNS: Parkinson's Agents	Tasmar®
	Apokyn®
	Mirapex®
	Azilect®
	Zelapar® ODT
CNS: Sedative-Hypnotics	Lunesta®
Endocrine: Osteoporosis	Fosamax Plus D®
Infectious Disease: Macrolides	Zmax® (use azithromycin)
Ophthalmic Agents: Antibiotic Drops and Ointments	Ciloxan® ointment (use drops)
	Iquix® drops
	Zymar® drops

	Azasite® drops
Ophthalmic Agents: NSAIDs	Nevanac® drops
Respiratory Agents: Second Generation Antihistamines	Alavert® and Alavert-D tablets
Drugs that will no longer require a Prior Authorization beginning with date of service 10/1/2008.	
Drug class	Drug Name
Genitourinary: Benign Prostatic Hypertrophy Agents	UroXatral®
Infectious Disease: Cephalosporins	Cefprozil tablets
Ophthalmic Agents: Antibiotic Drops and Ointments	Quixin®

* Additional information for Antidepressants and Second Generation Antipsychotics. **Patients who have been stabilized on an antidepressant or second generation antipsychotic drug will not be asked to change drugs.** If the patient has a Medicaid claim for the drug within the past 120 days, the system will automatically approve continuation of therapy. If there is not a claim in the previous 120 days, for example if the patient is new to Medicaid or has received samples, the prescriber may request prior authorization via phone or fax and state that the patient has been taking the requested drug. In addition, **physicians who are registered with ODJFS as having a specialty in psychiatry are exempt from prior authorization of the standard tablet/capsule dosage forms of antidepressants and second generation antipsychotics.** Alternate dosage forms (e.g., rapid dissolve tablets) may require prior authorization from any prescriber. Alternative dosage forms will be approved for patients who are unable or unwilling to swallow the standard tablet/capsule dosage form. **Psychiatrists may contact Provider Enrollment at 1-800-686-1516 to verify that their psychiatry specialty is on file with ODJFS.**

Providers may request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling ACS at (614) 682-2034.

2. Duration of therapy limit for heparin-related preparations

To promote prescribing of heparin-related preparations according to published clinical guidelines, a duration of therapy limit will be implemented to encourage a switch to oral warfarin therapy as soon as clinically appropriate for the patient. Heparin-related preparations are indicated for prophylaxis and treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), unstable angina, non-Q-wave myocardial infarction (MI), ST-segment elevated MI (STEMI), and treatment of symptomatic venous thromboembolism (VTE). Products affected by this duration of therapy limit are dalteparin (Fragmin®), enoxaparin (Lovenox®), fondaparinux (Arixtra®), and tinzaparin (Innohep®).

Guidelines from American College of Chest Physicians (ACCP) Conference on Antithrombotic and Thrombolytic Therapy recommend duration of treatment no longer than 35 days. In most cases, heparin or a heparin-related preparation is initiated as prophylaxis. Oral warfarin is given concurrently to overlap and the heparin/heparin-related therapy is discontinued after the international normalizing ratio (INR) is within the appropriate therapeutic range. Long-term treatment with warfarin generally continues.

At the pharmacy point of sale, the days supply of heparin-related preparations for the current claim will be added to the days supply of any heparin-related preparations billed in the previous 180 days. This duration of therapy applies only to claims billed through the pharmacy program, meaning claims for patients self-injecting at home or for patients residing in a long-term care facility. Inpatient hospital duration of therapy is not included in the limit.

If the patient's claims history indicates that duration of therapy with heparin-related preparations exceeds 35 days, the claim will deny at the pharmacy and the prescriber may request prior authorization. Prior authorization will be approved for patients with cancer (approvable for up to six months), pregnant women (approvable for up to 40 weeks, through due date), or patients unable to take oral warfarin (approvable up to six months).

3. Full implementation of the federal requirement for tamper-resistant prescription forms

As previously announced, Congress passed H.R. 2206, U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Public Law 110-28, which amends the federal Medicaid statute to prevent payment of prescriptions "for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." Beginning October 1, 2008, a prescription is required to have three tamper-resistant characteristics in order to be reimbursed by Ohio Medicaid. Beginning April 1, 2008, prescriptions were required to have only one tamper-resistant characteristic.

All prescriptions that are written by the prescriber and given to the patient or patient's representative to present to the pharmacy must be tamper-resistant. Prescriptions transmitted to the pharmacy via telephone, fax, or e-prescribing, in accordance with Ohio Board of Pharmacy regulations, are exempt from this requirement.

To be considered tamper resistant on October 1, 2008, a prescription form must contain all of the following three characteristics:

Required characteristic:		Examples include but not limited to:
1.	One or more features designed to prevent unauthorized copying of a completed or blank prescription form	Text that appears when photocopied or scanned (e.g., "void" or "illegal") Microprint borders that cannot be copied
2.	One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber	Erasure or use of solvents will discolor background Check-off boxes to indicate the quantity prescribed (e.g., 1-24, 25-49, 50-74, etc.) Quantity border characteristics (dispense quantity and refill number bordered by asterisks and optionally spelled out) for prescriptions generated by an electronic system
3.	One or more features designed to prevent the use of counterfeit prescription forms	Thermochromic ink Sequentially numbered Security features and descriptions listed on the prescription

The tamper-resistant requirement applies in both of the following situations:

- All written prescriptions presented at the pharmacy on or after April 1, 2008, regardless of the date the prescription was written, including prescriptions for over-the-counter, legend, and controlled drugs; and
- All written prescriptions when ODJFS pays any part of the claim, including when ODJFS is not the primary payer.

The tamper-resistant requirement does not apply in the following situations:

- Refills of written prescriptions presented at the pharmacy before April 1, 2008;

- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone, in accordance with Ohio Board of Pharmacy regulations;
- Prescriptions for which payment will be made by an ODJFS-contracting managed care plan (i.e., only prescriptions billed to the fee-for-service program must be tamper resistant);
- Orders for medications administered in a provider setting and billed by the administering provider (i.e., medications not billed through the pharmacy);
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper resistant if the patient does not have opportunity to handle the written order.

If a written prescription that is not tamper resistant is presented at the pharmacy on or after April 1, 2008, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within 72 hours of dispensing. The pharmacist should use professional judgment to define an emergency situation. The replacement may be a compliant written prescription, a fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription. Alternatively, the pharmacy may verify the prescription by telephone. In this case, the verification must be documented on the prescription including the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

If a consumer is determined to be retroactively eligible for Medicaid or Disability Medical Assistance coverage, and the pharmacy has filled a prescription for a date of service that falls into the retroactive eligibility period, the pharmacy must verify that the original prescription was tamper resistant, or must determine that the prescription is exempt from the requirements as stated above. If the original prescription was not tamper resistant or exempt from the requirements, the pharmacy may follow the procedures listed above to obtain a replacement tamper-resistant prescription or verify the prescription by phone, prior to billing the claim to ODJFS.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals>.

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider"
- (2) Selecting "Pharmacy Services"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Questions:

Pharmacies may contact the Technical Help Desk at ACS for assistance:

Phone: 1-877-518-1545

Prescribers may request prior authorization through ACS:

Phone: 1-877-518-1546 Fax: 1-800-396-4111

Psychiatrists may verify that their psychiatry specialty is on file with ODJFS by contacting Provider Enrollment:

Phone: 1-800-686-1516

Rule 5101:3-9-12, Ohio Department of Job and Family Services List of Drugs Covered Without Prior Authorization

MAL 547 (Mandatory Pharmacy NPI Submission May 23, 2008)

Medical Assistance Letter (MAL) 547

June 12, 2008

To: Pharmacy Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Mandatory pharmacy NPI submission May 23, 2008

The purpose of this Medical Assistance Letter (MAL) is to inform pharmacies who are enrolled as providers in the Ohio Medicaid program and do business with ODJFS that they are required to bill using their National Provider Identifier (NPI) beginning May 23, 2008.

This MAL refers only to submission of pharmacy (drug) claims. The pharmacy NPI is required on all point-of-sale and paper claims submissions to Affiliated Computer Services (ACS), the pharmacy point-of-sale vendor, beginning May 23, 2008. Please see the updated payer sheet on our web site at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. The pharmacy's NPI should be submitted in NCPDP version 5.1 field #201-B1 (service provider ID), with field #202-B2 (service provider ID qualifier) submitted as Ø1 (NPI). Claims submitted with a service provider ID other than NPI will be rejected beginning May 23, 2008.

The prescriber ID in fields #411-DB (prescriber ID) and #466-EZ (prescriber ID qualifier) may be submitted as either NPI (qualifier Ø1) or Medicaid ID (qualifier Ø5) until further notice. ODJFS asks that pharmacies collect and use prescriber NPIs when they are available, but will not deny claims using a prescriber's Medicaid ID until it is apparent that pharmacies have adequate access to prescriber NPIs.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

Questions pertaining to billing pharmacy claims should be addressed to:

ACS Technical Call Center

Toll free telephone number 1-877-518-1545

MAL 546 (Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms)

Medical Assistance Letter (MAL) 546

March 20, 2008

TO: All Providers of Pharmacy Services and Prescribers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule 5101:3-9-06, entitled "Prescription billing and recordkeeping requirements." This rule outlines requirements for pharmacies that bill ODJFS for prescriptions. This letter is being sent to both pharmacies and prescribers to specify the new requirement to use tamper-resistant prescription forms when executing a written prescription for a consumer enrolled in the Ohio Medicaid or Disability Medical Assistance programs and billed to the Ohio Department of Job and Family Services (ODJFS). The effective date for the tamper-resistant prescription requirement is April 1, 2008.

As previously announced, Congress passed H.R. 2206, U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Public Law 110-28, which amends the federal Medicaid statute to prevent payment of prescriptions "for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This federal law was scheduled to be effective October 1, 2007. On September 29, 2007, the President signed H.R. 3668, the "TMA, Abstinence Education, and QI Programs Extension Act of 2007." This bill delays the implementation of the tamper-resistant requirement until April 1, 2008. ODJFS will enforce this new federal implementation date.

All prescriptions that are written by the prescriber and given to the patient or patient's representative to present to the pharmacy must be executed on tamper-resistant paper. The use of ink, stamps, embossers, or other features added by the prescriber do not meet the tamper-resistant requirement. The tamper-resistant features must be integral to the prescription form.

Prescriptions transmitted to the pharmacy via telephone, fax, or e-prescribing, in accordance with Ohio Board of Pharmacy regulations, are exempt from this requirement.

To be considered tamper resistant on April 1, 2008, a prescription form must contain at least one of the following three characteristics:

	Required characteristic:	Examples include but not limited to:
1.	One or more features designed to prevent unauthorized copying of a completed or blank prescription form	Text that appears when photocopied or scanned (e.g., "void" or "illegal") Microprint borders that cannot be copied
2.	One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber	Erasure or use of solvents will discolor background Check-off boxes to indicate the quantity prescribed (e.g., 1-24, 25-49, 50-74, etc.)
3.	One or more features designed to prevent the use of counterfeit prescription forms	Thermochromic ink Sequentially numbered

To be considered tamper-resistant beginning October 1, 2008, a prescription form must contain all three characteristics.

The tamper-resistant requirement applies in both of the following situations:

- All written prescriptions presented at the pharmacy on or after April 1, 2008, regardless of the date the prescription was written, including prescriptions for over-the-counter, legend, and controlled drugs; and
- All written prescriptions when ODJFS pays any part of the claim, including when ODJFS is not the primary payer.

The tamper-resistant requirement does not apply in the following situations:

- Refills of written prescriptions presented at the pharmacy before April 1, 2008;
- Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone, in accordance with Ohio Board of Pharmacy regulations;
- Prescriptions for which payment will be made by an ODJFS-contracting managed care plan (i.e., only prescriptions billed to the fee-for-service program must be tamper resistant);
- Orders for medications administered in a provider setting and billed by the administering provider (i.e., medications not billed through the pharmacy);
- Orders for medications administered in a long-term care facility (LTCF), provided the order is written in the patient's medical record and given by medical staff directly to the pharmacy. A prescription for a LTCF resident is considered tamper resistant if the patient does not have opportunity to handle the written order.

If a written prescription that is not tamper resistant is presented at the pharmacy on or after April 1, 2008, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within 72 hours of dispensing. The pharmacist should use professional judgment to define an emergency situation. The replacement may be a compliant written prescription, a fax copy, or an electronically transmitted copy. The replacement should be filed with the original, non-tamper-resistant prescription. Alternatively, the pharmacy may verify the prescription by telephone. In this case, the verification must be documented on the prescription including the name of the prescriber or prescriber's office staff member verifying the prescription, date of verification, and identification of the pharmacy staff member requesting verification.

If a consumer is determined to be retroactively eligible for Medicaid or Disability Medical Assistance coverage, and the pharmacy has filled a prescription for a date of service that falls into the retroactive eligibility period, the pharmacy must verify that the original prescription was tamper resistant, or must determine that the prescription is exempt from the requirements as stated above. If the original prescription was not tamper resistant or exempt from the requirements, the pharmacy may follow the procedures listed above to obtain a replacement tamper-resistant prescription or verify the prescription by phone, prior to billing the claim to ODJFS.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider"
- (2) Selecting "Pharmacy Services"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu

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Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with a copy of the OAC rule by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions:

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MAL 539 (Federal Delay of Requirement for Use of Tamper-Resistant Prescription Pads)

Medical Assistance Letter (MAL) 539

October 19, 2007

TO: All Providers of Pharmacy Services and Prescribers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Federal delay of requirement for use of tamper-resistant prescription pads

This letter provides an update to the previously announced federal requirement for use of tamper-resistant prescription pads.

As previously announced, Congress passed H.R. 2206, U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Public Law 110-28, which amends the Medicaid statute to prevent payment of prescriptions "for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This federal law was scheduled to be effective October 1, 2007.

On September 29, the President signed H.R. 3668, the "TMA, Abstinence Education, and QI Programs Extension Act of 2007." This bill delays the implementation of the tamper-resistant requirement until April 1, 2008. ODJFS will enforce this new federal implementation date.

Please watch the Department's web site at <http://jfs.ohio.gov/ohp/bhpp/omdp/POS.stm> for updated information.

Questions:

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461
Toll Free Telephone Number 1-800-686-1516

MAL 535 (Changes to the Pharmacy Program Effective October 1, 2007)

Medical Assistance Letter (MAL) 535

September 6, 2007

TO: All Providers of Pharmacy Services and Prescribers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Changes to the Pharmacy Program Effective October 1, 2007

This letter provides information regarding three changes to the Ohio Medicaid Pharmacy Program that will be effective October 1, 2007:

1. Changes to the Preferred Drug List (PDL)
2. Step edit for Long-Acting Beta Agonist (LABA) and LABA-corticosteroid combination products
3. Federal requirement for use of tamper-resistant prescription pads

1. Changes to the Preferred Drug List (PDL)

The newest phase of the Ohio Medicaid Preferred Drug List will be effective in October 2007.

The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

Beginning in September, messages are sent back to pharmacies when a drug that will become "non-preferred" is dispensed. This gives the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. **Prescribers may request prior authorization prior to October.**

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed. The table below gives a summary of changes. This table is not all-inclusive.

Drugs which will require a Prior Authorization as of 10/3/2007. These are either new PDL classes or drugs which were previously preferred and will now require a Prior Authorization.

Drug class	Drug Name
Analgesic: Opioids-Long Acting Oral	Avinza®
Cardiovascular: Lipotropics-Fibric Acid Derivative	Fenofibrate (use Tricor® brand)
CNS: Sedative-Hypnotics: Non-Barbiturate	Ambien CR®
CNS: Smoking Deterrents	Nicotine Patches (use Nicoderm CQ® brand)
Genitourinary: Benign Prostatic Hypertrophy	Uroxatral®
Infectious Disease: Cephalosporins	Cefdinir tablets and suspension (use Omnicef® brand)

Infectious Disease: Onychomycosis	Grifulvin V®
Infectious Disease: Hepatitis C Ribavirins	Ribavirin (use Rebetol® brand)
Ophthalmic: Antihistamines & Mast Cell Stabilizers	Alamast®
Ophthalmic: Glaucoma	Betoptic S®
	Lumigan™
	Iopidine®
Respiratory: Beta-Adrenergic, Long Acting	Brovana™
Respiratory: Leukotriene Receptor Modifiers and Inhibitors	Zyflo®
Respiratory: Nasal Preparations	Veramyst™
Drugs which will no longer require a Prior Authorization effective 10/1/2007. These are either new PDL classes or drugs which previously required a Prior Authorization.	
Drug class	Drug Name
Analgesic: NSAIDs	Piroxicam
Cardiovascular: Angiotensin II Receptor Blocker	Benicar®
Cardiovascular: Angiotensin II Receptor Blocker/Diuretic	Benicar HCT®
Cardiovascular: Beta Blocker	Toprol XL®
Cardiovascular: Lipotropics-Statin	Pravastatin
	Simvastatin
CNS: Sedative-Hypnotics: Non-Barbiturate	Zolpidem
CNS: Smoking Deterrents	Nicotrol Nasal Spray®
Endocrine: Osteoporosis-Bisphosphonate	Actonel®
Infectious Disease: Onychomycosis	Griseofulvin Suspension
Infectious Disease: Anti-Fungal Topical	Vusion®
Ophthalmic: Antihistamines & Mast Cell Stabilizers	Alaway®
	Pataday™

A "quick list" of preferred drugs is available online at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list,

Provider Manual, PA request fax form, and P & T Committee information. Providers may call ACS to request a pocket-sized copy of the PDL.

Pharmacies may contact the Technical Help Desk at ACS for assistance:

Phone: 1-877-518-1545

Prescribers may request prior authorization through ACS:

Phone: 1-877-518-1546 Fax: 1-800-396-4111

2. Step edit for Long-Acting Beta Agonist (LABA) and LABA-corticosteroid combination products

To promote prescribing of asthma controller medications according to published clinical guidelines, a step edit will be implemented for LABA-containing products. LABAs are indicated for treatment of asthma when two controller medications are necessary. Products affected by this edit are arformoterol (Brovana®), formoterol (Foradil®), salmeterol (Serevent®), formoterol-budesonide (Symbicort®), and salmeterol-fluticasone (Advair®).

Patients who have previously used other controller therapy, such as inhaled corticosteroids, are systematically approved for a LABA-containing product by the Department's automated prior authorization system. The majority (75%) of patients who are prescribed a LABA-containing product have used prior controller therapy, so will be automatically approved for the LABA-containing product without the prescriber needing to request prior authorization.

Patients whose Ohio Medicaid claims history meets any one of the following criteria will be automatically approved for the LABA-containing product:

Criteria	Approval Length
>= 3 claims for LABA-containing product in previous 6 months	6 months
>= 1 claim for inhaled anticholinergic in previous 6 months	12 months
>= 3 claims for inhaled corticosteroid in previous 12 months	6 months
>= 3 claims for leukotriene modifier in previous 12 months	6 months
>= 3 claims for theophylline in previous 12 months	6 months
>= 3 claims for oral corticosteroid in previous 4 months	6 months

If the patient's claims history does not meet any of the above criteria, the claim will be denied at the pharmacy and the prescriber may request prior authorization. Approvable criteria for prescriber-initiated prior authorization include diagnosis of chronic obstructive pulmonary disease (COPD); diagnosis of moderate persistent or severe persistent asthma, or uncontrolled or partly controlled asthma; or patient score of less than or equal to 19 on the Asthma Control Test™.

Compliance and persistence with asthma controller medications is an important tool in management of asthma. Patients who refill their LABA-containing product at least three times in each rolling six months will be automatically approved to receive their LABA-containing product for an additional six months. If the patient fails to refill their prescription three times per six months, and does not meet any of the criteria in the table above, the claim will be denied at the pharmacy and the prescriber will need to request prior authorization. At the time of prior authorization request, the prescriber will be educated about the patient's refill history and encouraged to speak with their patient about the importance of compliance with controller medications.

3. Federal requirement for use of tamper-resistant prescription blanks

Congress passed HR2206, U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Public Law 110-28, which amends the Medicaid statute to prevent payment of prescriptions "for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This federal law is effective October 1, 2007. In

accordance with Ohio Administrative Code (OAC) rule 5101:3-9-06, "all records of prescriptions must comply with federal and state regulations." In addition, OAC rule 5101:3-1-17.2, Provider Agreement for Providers, reads "by signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules..."

The federal Centers for Medicare and Medicaid Services (CMS) released guidance on August 17, 2007, to clarify this provision.

To be considered tamper resistant on October 1, 2007, a prescription pad must contain at least one of the following three characteristics:

- 1) one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
- 2) one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
- 3) one or more industry-recognized features 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. At this time, CMS has not released specific information to clarify the exact nature of these "industry-recognized features." Information will be provided as it becomes available. Please watch the Department's web site at <http://ifs.ohio.gov/ohp/bhpp/omdp/POS.stm> for updated information.

This requirement applies to:

- all written prescriptions presented at the pharmacy on or after October 1, 2007, regardless of the date the prescription was written;
- written prescriptions for all outpatient drugs, including controlled, non-controlled, and over-the-counter drugs;
- written prescriptions for drugs provided in a long-term care facility (LTCF), including nursing facility or intermediate care facility for the mentally retarded (ICF-MR), if the prescription is billed separately from the facility's charge (most prescriptions for LTCF residents are billed separately);
- written prescriptions when Medicaid pays any part of the claim, including when Medicaid is not the primary payer; and
- written prescriptions billed to Medicaid after the date of service due to retroactive eligibility.

This requirement does not apply to:

- refills of written prescriptions presented at a pharmacy before October 1, 2007;
- e-prescriptions transmitted to the pharmacy in accordance with state law;
- prescriptions faxed to the pharmacy in accordance with state law;
- prescriptions communicated to the pharmacy by telephone by a prescriber in accordance with state law;
- prescriptions for which payment will be made by a Medicaid managed care entity (i.e., this requirement applies only to prescriptions written for patients who receive a monthly paper Ohio Medicaid card, not to prescriptions written for patients enrolled in a Medicaid managed health care organization); and
- orders for medications administered in a provider setting (e.g., physician office or hospital outpatient or emergency department) and billed by the administering provider.

If a patient presents a non-compliant written prescription, the pharmacy may provide an emergency fill of the drug if the prescriber provides the pharmacy with a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled.

Web Page and Paper Distribution:

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Providers may view documents online by:

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Questions:

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MAL 523 (Information Pharmacy Providers Must Know about NPI in Order to Get Paid)

Medical Assistance Letter (MAL) 523

May 9, 2007

To: Pharmacy Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Pharmacy Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform providers who are enrolled as pharmacy providers in the Ohio Medicaid program and do business with ODJFS that they are required to bill using a National Provider Identifier (NPI) beginning May 23, 2007. An NPI is a unique, ten-digit, entity type 1, identifier that pharmacy providers receive from the National Council for Prescription Drug Programs (NCPDP) or National Plan and Provider Enumeration System (NPPES).

This MAL refers only to submission of pharmacy (drug) claims through the point-of-sale system. For instructions about submitting claims for durable medical equipment/disposable medical supplies (DME/DMS), please refer to the Medicaid Handbook Transmittal Letter (MHTL) that will be sent to durable medical equipment (DME) providers. Pharmacies who have been using the same Medicaid provider ID to bill pharmacy and DME/DMS may use the same NPI to submit pharmacy and DME/DMS claims. However, DME/DMS claims must also include the Medicaid provider ID through December 31, 2007.

I. How must my NPI relate to my Medicaid legacy number?

If your company received this MAL, your company submitted claim(s) as a pharmacy provider to ODJFS at least once during the last twelve months. When pharmacy providers enroll to do business with ODJFS, they are issued a pharmacy provider Medicaid legacy number.

Pharmacy providers must submit only the non-individual NPI assigned to their pharmacy with the Ohio Medicaid legacy number that was issued to them as a pharmacy provider. Only one NPI number can be associated with your Ohio Medicaid legacy number. A pharmacy provider's NPI should never be submitted to ODJFS with a Medicaid legacy number that belongs to any other provider. Please be sure that the NPI you have reported to ODJFS is for your pharmacy business, not for an individual pharmacist.

II. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for pharmacy (drug) claims only. Please refer to the MHTL that will be sent to DME providers for information about billing DME/DMS.

The pharmacy NPI is required on all point-of-sale and paper claims submissions beginning May 23, 2007. Please see the updated payer sheet on our web site at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. The pharmacy's NPI should be submitted in NCPDP version 5.1 field #201-B1 (service provider ID), with field #202-B2 (service provider ID qualifier) submitted as 01 (NPI). Claims submitted with a service provider ID other than NPI may be rejected beginning May 23, 2007.

The prescriber ID in fields #411-DB (prescriber ID) and #466-EZ (prescriber ID qualifier) may be submitted as either NPI (qualifier 01) or Medicaid ID (qualifier 05) until further notice. ODJFS asks that pharmacies collect and use prescriber NPIs when they are available, but will not deny claims using a prescriber's Medicaid ID until it is apparent that pharmacies have adequate access to prescriber NPIs.

III. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires pharmacy providers to obtain an NPI, to use it on all standard transactions where a pharmacy provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that pharmacy provider in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

IV. Am I required to share my NPI number with ODJFS?

Yes, the pharmacy provider must disclose to ODJFS the NPI number that has been assigned to the pharmacy provider. If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid pharmacy provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: <http://jfs.ohio.gov/OHP/providers/npi.stm>.

V. Am I required to share my NPI with other entities?

Yes, as stated in Section V above, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the pharmacy provider in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

ODJFS appreciates the attention of the pharmacy providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

Questions pertaining to billing pharmacy claims should be addressed to:

ACS Technical Call Center

Toll free telephone number 1-877-518-1545

MAL 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516)

Medical Assistance Letter No [522](#) is maintained in the General Information e-book.

MAL 516 (November 9, 2006 - Employee Education About False Claims Recovery)

Medical Assistance Letter No [516](#) is maintained in the General Information e-book.

MAL 504 (Change in Pharmacy Point-of-Sale Vendor)

Medical Assistance Letter (MAL) No. 504

June 2, 2006

To: All Pharmacy Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Change in pharmacy point-of-sale vendor

Effective Saturday, July 1, 2006, Ohio Medicaid and Disability Medical Assistance (DMA) pharmacy claims will be processed by Affiliated Computer Services (ACS) State Healthcare. This information pertains only to claims for these two programs administered through ODJFS. Pharmacies will receive the new payer sheet and other information directly from ACS.

In order to facilitate this transition, all claim reversals and adjustments processed beginning June 1, 2006, must be completed within 14 days of original claim transmission. Reversals and adjustments beyond 14 days of the original claim transaction will not be allowed until after July 1, 2006 in order to facilitate conversion efforts. If a pharmacy attempts to reverse a claim they will receive the following message: "Reversal after 14D not allowed until 7/1."

Please also see the pharmacy page of the ODJFS web site at <http://jfs.ohio.gov/ohp/bhpp/omdp/pos.stm> for additional updates regarding this change. This page will be updated with any new information.

Phone numbers for the point of sale and prior authorization vendor will remain the same after the transition:

Technical call center: 1-877-518-1545

Prior authorization requests: 1-877-518-1546

Prior authorization fax: 1-800-396-4111

If you have questions for ACS regarding setting up your point-of-sale system for the transition, please contact ACS at provider.relations@acs-inc.com or fax to 1-888-335-8461 through June 30. Beginning July 1, contact the technical call center at 1-877-518-1545.

If you would like to be added to the ACS distribution list, please send your mailing address, fax number, and/or email address to ACS at provider.relations@acs-inc.com.

MAL 495 (Changes to the Medicaid Pharmacy Program: New Consumer Co-Payments and Medicare Part D)

Medical Assistance Letter (MAL) No. 495

December 23, 2005

To: All Pharmacy Providers and Providers who prescribe medication
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Changes to the Medicaid pharmacy program: New consumer co-payments and Medicare Part D

PRESCRIPTION COVERAGE CHANGES EFFECTIVE JANUARY 1, 2006

Two changes to the Medicaid pharmacy program will be implemented effective January 1, 2006. These changes are new consumer co-payments for selected trade name drugs and changes in coverage for dually eligible consumers because of the Medicare Part D prescription drug program. Details of these changes are presented below.

Consumer Co-Payments for Selected Trade Name Drugs

For most trade name prescriptions dispensed on and after January 1, 2006, consumers who are eligible for the Medicaid or the Disability Medical Assistance programs will be subject to a **\$2.00 co-payment for selected trade name medications**, with the exception of those exemptions outlined below. When a co-payment is applicable, the pharmacy provider is responsible for collecting the co-payment, and the department will reduce the pharmacy's reimbursement by the amount of the co-payment whether or not the pharmacy provider collected the co-payment. Pharmacies using the department's point-of-sale system will receive notification of the co-payment at the time the claim is submitted.

Co-payments **must not be charged** by a pharmacy, and co-payments are not applicable, if the consumer is:

- under age 21, or
- pregnant or in the post-partum period (The post-partum period is the immediate post-partum period that begins on the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends), or
- in a nursing home or intermediate care facility for the mentally retarded, or
- receiving hospice care

Co-payments **must not be charged** by a pharmacy, and co-payments are not applicable, if:

- the prescription medication is a trade name medication the department has exempted from co-payment (e.g., the department has indicated the trade name medication should be dispensed rather than the generic), or
- the prescription is for family planning (contraceptive, oxytocic, or prenatal vitamin)

Medications administered to a consumer in a hospital, emergency department, office, clinic, or other facility, are not subject to co-payments.

The \$3.00 co-payment for medications requiring prior authorization remains in effect.

Consumers subject to co-payment, who indicate that they are unable to pay their co-payment at the time their medication is dispensed, may indicate their inability to pay and obtain their prescription medication without paying the co-payment. The consumer remains liable for the co-payment and the pharmacy provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment.

If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid Medicaid co-payment imposed by the

co-payment program from a prior transaction as an outstanding debt and may refuse service to a Medicaid consumer who owes the provider an outstanding debt. If the provider intends to refuse service to a Medicaid consumer who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services.

Prescribing providers may be asked by Medicaid consumers to prescribe generic medications that will not be subject to co-payment. If providers can prescribe a clinically appropriate medication that can be safely substituted for the trade name drug, then the provider may offer that choice so the consumer can get a prescription that is not subject to co-payment.

This information pertains only to the Medicaid fee-for-service program. Medicaid-contracting managed care plans (MCPs) have the discretion to decide whether to impose a co-payment on their Medicaid members. Currently, MCPs have chosen not to impose co-payments on their members. If a MCP decides to impose a co-payment in the future in accordance with the Medicaid co-payment program, the MCP will notify contracting pharmacies, MCP members, and other applicable providers.

The department has promulgated rules to be effective January 1, 2006: 5101:3-1-09 entitled "Medicaid co-payment program [except for Medicaid consumers enrolled in the Medicaid managed health care program]" and 5101:3-9-09 entitled "Consumer co-payments for certain pharmacy medications (except for consumers enrolled in the Medicaid managed health care program)." Appendix A of rule 5101:3-9-12 lists drugs covered by the department without prior authorization. Beginning January 1, 2006, a co-payment indicator of "2" will indicate those medications subject to the \$2.00 co-payment.

Changes in Medicaid Prescription Coverage Due to Medicare Part D

Beginning January 1, 2006, drugs that are covered or may be covered under a Medicare Part D Prescription Drug Plan (PDP) will no longer be covered under the Medicaid program for a consumer who is eligible for both Medicare and Medicaid (dually eligible consumer). Dually eligible consumers have been automatically enrolled into a PDP by Medicare. The pharmacy should bill the appropriate PDP for these prescriptions.

Ohio Medicaid will continue to cover for dual eligibles drugs that cannot be covered under a Medicare PDP, based on federal law. These drugs include benzodiazepines, barbiturates, vitamins (except prenatal vitamins, fluoride, and potassium), cough suppressants, and selected over-the-counter drugs that do not have a therapeutic equivalent that may be covered under a Medicare PDP.

The department has promulgated rules to be effective January 1, 2006: 5101:3-9-03 entitled "Covered drugs and associated limitations," 5101:3-9-06 entitled "Prescription billing and recordkeeping requirements," and 5101:3-9-12 entitled "Ohio department of job and family services list of drugs covered without prior authorization." Appendix A of rule 5101:3-9-12 lists drugs covered by the department without prior authorization. Beginning January 1, 2006, an indicator "Y" in the column labeled "covered for dual eligible" will indicate those medications that will continue to be covered for consumers who have coverage under both Medicare and Medicaid.

Access to Ohio Administrative Code Rules

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This MAL, and the rules referenced herein, may be viewed as follows:

1. Select "Ohio Health Plans - Provider" (left column).
2. Select "Pharmacy Services" (right column).
3. Select "Medical Assistance Letters" (left column).

Providers will receive one hard copy of this letter, and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this letter with copies of Ohio Administrative Code rules 5101:3-1-09, 5101:3-9-03, 5101:3-9-06, 5101:3-9-09, and 5101:3-9-12, the Provider should complete the

attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-1516

Pharmacy Services - Ohio Administrative Code Rules

5160-9-01 Eligible Providers of Pharmacy Services

Formerly 5101:3-9-01 Eligible Providers of Pharmacy Services

MHTL 3336-11-03

Effective Date: August 2, 2011

Most Current Prior Effective Date: April 14, 2005

Three types of providers are eligible for reimbursement for pharmacy services: "pharmacy providers," "hospitals" with a ~~"prescribed drugs"~~ "pharmacy" category of service, and ~~"other providers"~~ "clinics" with a ~~"prescribed drugs"~~ "pharmacy" category of service.

- (A) A "pharmacy provider" designation and provider number can be obtained by a "terminal distributor of dangerous drugs," as defined in section 4729.01 of the Revised Code, who also:
- (1) Has a valid drug enforcement agency (DEA) number; and
 - (2) Has a licensed registered pharmacist in full and actual charge of a pharmacy; and
 - (3) Complies with ~~rule~~ eligible provider rules 5101:3-1-17 to 5101:3-1-17.2 5101:3-1-17.4 of the Administrative Code and signs a provider agreement ~~pursuant thereto~~ with the Ohio department of job and family services.
- (B) A "hospital" provider acting as a pharmacy in accordance with paragraphs (A)(1) to (A)(3) of this rule can obtain a ~~"prescribed drug"~~ "pharmacy" category of service and ~~provide~~ bill for self-administered take-home drugs.
- (C) ~~"Other providers" who~~ "Clinic" providers that have a valid medicaid provider agreement and have met the criteria under the Revised Code for dispensing pharmaceuticals but are not eligible to become a "pharmacy provider" as defined in paragraph (A) of this rule, are eligible to apply for a ~~"prescribed drug"~~ "pharmacy" category of service and bill for self-administered take-home drugs.

Effective: 08/02/2011

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 06/28/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 9/19/77, 12/21/77, 12/30/77, 7/8/78, 10/1/78, 5/9/86, 11/1/86, 10/1/87, 2/1/88, 1/13/89 (Emer), 4/13/89, 6/1/89, 7/1/94, 10/1/97, 2/3/00 (Emer), 5/1/00, 04/14/05

[MAL 584-A](#)

Effective Date: July 1, 2013

Most Current Prior Effective Date: [October 1, 2011](#)

5101:3-9-02 [Appendix A](#), Supplies Billed by Ohio Medicaid Pharmacy Providers.

- (A) Eligible pharmacies in the Ohio medicaid program may ~~also~~ bill for medical supplies and durable medical equipment in accordance with Chapter [5101:3-10](#) of the Administrative Code, with the following stipulations:
- (1) The provider must apply to the Ohio ~~department of job and family services (ODJFS)~~ department of medicaid (ODM) to be eligible to dispense medical supplies/durable medical equipment.
 - (2) All products require a prescription written by a practitioner authorized to prescribe. The prescription must be obtained by and kept on file at the pharmacy.
 - (3) The provider must use the same medicaid provider number as when billing for pharmaceuticals.
 - (4) The provider must be licensed, registered, or exempt from licensure or registration under Chapter 4761. of the Revised Code to bill for home medical equipment that is subject to regulation under Chapter 4752. of the Revised Code.
- (B) Invoices submitted for medical supplies/durable medical equipment must be billed on the appropriate invoice designated by ~~ODJFS~~ODM for those services.
- (C) Medical supplies, durable medical equipment, prosthetic, and orthotic devices may be billed by pharmacy providers in accordance with Chapter 5101:3-10 of the Administrative Code.
- (D) Only eligible providers of pharmacy services as described in rule [5101:3-9-01](#) of the Administrative Code are eligible to bill for the medical supplies listed in the appendix A to this rule, except as specified in paragraph (G) of this rule. Eligible providers of pharmacy services may bill for these items without applying to ~~ODJFS~~ODM to be eligible to dispense medical supplies/durable medical equipment as described in Chapter 5101:3-10 of the Administrative Code.
- (E) The quantity billed should be equal to the number of items dispensed (e.g., the quantity of test strips billed should be the number of individual test strips, not the number of boxes). The table in the appendix to this rule includes ~~six~~five columns to indicate supply item coverage and reimbursement.
- (1) Item description. This column describes the supply item.
 - (2) Medicaid coverage status. This column has one of two possible indicators for each item. "Y" indicates the item is covered by medicaid for all consumers and may be billed directly to ~~ODJFS~~ODM by the provider. "H" indicates that the item may be billed directly to ~~ODJFS~~ODM only for consumers who reside in their personal residence. For consumers residing in a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) as defined in section 5111.20 of the Revised Code, the supply is the responsibility of the NF or ICF-MR and reimbursed to the NF or ICF-MR through the facility per diem payment.
 - (3) Covered for dual eligible. This column indicates whether the supply is covered under the medicaid program for a consumer who is a dual eligible as defined in rule [5101:3-1-05](#) of the Administrative Code. "Y" indicates the supply is covered for a dual eligible. "N" indicates the supply is not covered for a dual eligible.
 - ~~(4) Prior authorization. This column indicates whether the supply requires prior authorization. "Y" means the supply requires prior authorization and prior authorization must be obtained by the prescriber from the ODJFS point-of-sale vendor.~~
 - ~~(5)~~(4) Maximum units. This column indicates the largest number of units of the supply that may be dispensed within the time period indicated. Claims submitted that exceed the maximum units

shall be denied. Denials may be overridden by ODJFSODM or its designee in cases where medical necessity has been determined through prior authorization obtained by the prescriber from the ODJFSODM point-of-sale vendor.

~~(6)~~(5) Reimbursement. This column indicates the medicaid maximum reimbursement per item as defined in rule 5101:3-1-60 of the Administrative Code. Supplies with "*" in this column indicate that reimbursement will be calculated in accordance with paragraph (B)(2) of rule 5101:3-9-05 of the Administrative Code.

(F) The supplies listed in the appendix A to this rule should be billed through the pharmacy point of sale claims system using the national drug code (NDC) on the container from which the product was dispensed. ~~Reimbursement shall be the lesser of the submitted charge or the calculated allowable. The calculated allowable is the medicaid maximum reimbursement indicated in appendix A to this rule multiplied by the number of units billed.~~

(1) Reimbursement shall be the lesser of the submitted charge or the calculated allowable. The calculated allowable is the medicaid maximum reimbursement as described in paragraph (E)(5) of this rule.

(2) Prior authorization may be requested by the prescriber or a member of the prescribing provider's staff if there is medical necessity for quantities above those stated in the appendix to this rule.

(G) Exceptions to pharmacy billing requirement.

(1) Contraceptive supplies listed in the appendix A to this rule may be billed by both pharmacy providers and providers eligible to bill in accordance with rule 5101:3-10-01 of the Administrative Code. Pharmacy providers shall bill these supplies in accordance with paragraph (F) of this rule.

(2) Supplies billed to medicare as the primary payer and crossed over to medicaid using the medicare crossover process described in paragraph (B) of rule 5101:3-1-05 of the Administrative Code may be billed by any provider eligible for the medicare crossover process.

(H) Preferred diabetic blood testing supplies

(1) Products from the following manufacturers have been selected as preferred diabetic blood testing supplies:

(a) "Abbott Diabetes Care"

(b) "Nipro Diagnostics"

(2) Products from manufacturers or distributors that have not been selected as preferred require prior authorization.

(a) Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

(b) The prescriber must document medical necessity for the non-preferred product and why a preferred product cannot be used.

(c) When a request for prior authorization is denied, the consumer will be informed in writing of the denial and the right to a state hearing.

Effective: 07/01/2013

R.C. 119.032 review dates: 04/16/2013 and 07/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 06/21/2013

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, section 309.30.30 of Am. Sub. H.B. 153, 129th G. A.

Prior Effective Dates: 4/7/77, 12/21/77, 5/9/86, 10/1/97, 8/30/01, 7/1/06, 2/1/10, 10/1/11

MAL 582

Effective Date: October 1, 2012

Most Current Prior Effective Date: October 1, 2010

(A) Covered drugs

Drugs covered by the Ohio medicaid pharmacy program are limited to those that are manufactured or labeled by companies participating in the federal medicaid rebate program, dispensed by duly enrolled providers, and fall into one of the following categories:

- (1) Legend and over-the-counter drugs listed in appendix A to rule [5101:3-9-12](#) of the Administrative Code.
- (2) Legend and over-the-counter drugs not included in appendix A to rule 5101:3-9-12 of the Administrative Code but that have been prior authorized by the Ohio department of job and family services (ODJFS) or its designee, in accordance with paragraph (C) of this rule.
- (3) Compounded prescriptions in accordance with paragraph (D) of this rule.

(B) Non-covered drugs

Drugs that fall into one of the following categories are non-covered by the Ohio medicaid pharmacy program:

- (1) Drugs for the treatment of obesity.
- (2) Drugs for the treatment of infertility.
- (3) Drugs for the treatment of erectile dysfunction.
- (4) DESI drugs or drugs that may have been determined to be identical, similar, or related.
- (5) Drugs that are covered or may be covered by medicare part D, when prescribed for a consumer who is eligible for medicare, unless medicaid coverage for a dual eligible is indicated in appendix A to rule 5101:3-9-12 of the Administrative Code.
- (6) Drugs being used for indications not approved by the food and drug administration unless there is compelling clinical evidence to support the experimental use.

(C) Prior authorization

Drugs not listed in appendix A to rule 5101:3-9-12 of the Administrative Code that are medically necessary for treatment require prior authorization; however, noncovered drugs listed in paragraphs (B)(1) to (B)(5) of this rule are not eligible for prior authorization.

- (1) Prior authorization of pharmacy services will be administered in compliance with section 1927 of the Social Security Act, including a response by telephone or other telecommunication device within twenty-four hours of receipt of a request for prior authorization, and provisions for the dispensing of a seventy-two-hour supply of a covered outpatient prescription drug in an emergency situation.
- (2) Drugs not listed in appendix A to rule 5101:3-9-12 of the Administrative Code may be covered with prior authorization if medical necessity is documented, the drug is not excluded per paragraphs (B)(1) to (B)(5) of this rule, and a drug listed in appendix A to rule 5101:3-9-12 of the Administrative Code cannot be used.
- (3) Prior authorization of drugs not listed in appendix A to rule 5101:3-9-12 of the Administrative Code must be obtained from ODJFS or its designee before the drug may be dispensed. All requests must be submitted either verbally by telephone or in writing by facsimile device.

- (a) Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization except as described in paragraph (C)(3)(b) of this rule.
 - (b) A pharmacist may request prior authorization for an alternative dosage form of a drug to be administered through a tube for patients who are tube fed, if no comparable drugs listed in appendix A to rule 5101:3-9-12 of the Administrative Code can be administered through a tube. A pharmacist may also request prior authorization of a seventy-two-hour supply of a covered outpatient prescription drug in an emergency situation if the prescribing provider or prescribing provider's staff is not available to request prior authorization.
- (4) Drugs in therapeutic classes that are covered or may be covered under medicare part D are not available for prior authorization for a consumer who is eligible for medicare. Prior authorization may be requested for drugs in drug classes or portions of drug classes that may be covered for a dual eligible as indicated in appendix A to rule 5101:3-9-12 of the Administrative Code and are subject to any stated limits.
 - (5) When a request for prior authorization is denied, the consumer will be informed in writing of the denial and the right to a state hearing.

(D) Compounded drugs

- (1) Compounded drugs must be submitted to ODJFS or its designee using each national drug code (NDC) that is a part of the compound.
- (2) Component drugs that are not in appendix A to rule 5101:3-9-12 of the Administrative Code will require prior authorization. If a prior authorization is not approved or if a component drug is not eligible for authorization (i.e., not manufactured or labeled by companies participating in the federal medicaid rebate program or excluded from direct reimbursement per paragraph (J) of this rule), the pharmacy provider may elect to receive payment only for those items in the compound that are directly reimbursed by ODJFS, in accordance with billing instructions issued by ODJFS or its designee.

(E) Dispensing limitations

- (1) Days supply
 - (a) Acute medications are limited to a thirty-four-day supply.
 - (b) Chronic maintenance medications are limited to a one-hundred-two-day supply.
- (2) Maximum quantity

Maximum prescription quantities are included in informational updates supplied to providers and represent the largest number of units per drug that may be dispensed at any one time for a single prescription or the largest number of units per drug per day (or other time period) of therapy.
- (3) Claims submitted that exceed either the days supply limit or maximum quantity limit shall be denied. Denials may be overridden by ODJFS or its designee in cases where medical necessity has been determined.

(F) Refill prescriptions

Refills requested before seventy-five per cent of the days supply has been utilized will be denied, other than in cases where the dosage of a drug has been increased and has a new prescription number. Denials may be overridden by ODJFS or its designee for the following documented reasons:

- (1) Previous supply was lost, stolen, or destroyed. ODJFS or its designee may limit the number of instances denials may be overridden in cases of suspected fraud or abuse, and may request additional documentation before an override is authorized.
- (2) Pharmacist entered previous wrong day supply.
- (3) Vacation or travel.

- (4) Multiple supplies of the same medication are needed, for example in a workshop setting.
- (5) Hospital or police kept the medication.
- (6) Brand or generic was ineffective and the patient was switched to generic or brand.

(G) Unit dose

Drugs may be dispensed in unit dose packaging, but if the NDC number for such packaging is not listed in the Ohio medicaid drug payment system, the NDC number of the closest comparable bulk package that is listed in the payment system must be used for billing purposes.

(H) Vaccines, inoculations, and immunizations, other than seasonal and pandemic influenza vaccines, are covered as a pharmacy benefit only for residents of nursing facilities (NF) or intermediate care facilities for the mentally retarded (ICF-MR) as defined in section 5111.20 of the Revised Code; otherwise these services will be reimbursed as physician services in accordance with Chapter [5101:3-4](#) of the Administrative Code. Seasonal and pandemic influenza vaccines may be billed by the pharmacy for medicaid consumers who are not residents of NFs or ICFs-MR if the vaccine will be administered at the pharmacy.

(I) Selected pharmaceuticals, including injectable drugs, are not covered as an outpatient pharmacy benefit if they are administered in a provider ~~setting, other than a NF or ICF-MR,~~ setting.

(1) Long-acting injectable pharmaceuticals used for substance dependence or mental health conditions may be billed by the pharmacy under the following circumstances:

- (a) The pharmaceutical is dispensed pursuant to a valid prescription; and
- (b) The pharmaceutical is labeled with the patient name; and
- (c) The pharmaceutical will be administered by a qualified healthcare professional in a provider setting; and
- (d) The pharmacy and administering provider follow any special handling requirements in the package labeling; and
- (e) The pharmacy releases the pharmaceutical only to the administering provider or member of the provider's staff, and has followed all regulations for a prescription pick-up station required by the Ohio state board of pharmacy. The pharmacy shall not dispense the pharmaceutical directly to the patient, caregiver, or patient's representative.

~~(1)~~(2) Pharmaceuticals not described in paragraph (I)(1) of this rule administered in the physician's office must be purchased by the physician's office and billed as a physician claim.

~~(2)~~(3) Pharmaceuticals administered in a provider setting, other than a NF or ICF-MR, and not described by paragraph (I)(1) of this rule, cannot be billed by the pharmacy.

(J) Selected over-the-counter drugs are not directly reimbursable when prescribed for consumers residing in a NF as defined in section 5111.20 of the Revised Code. Such drugs are the responsibility of the NF and reimbursed to the NF through the facility per diem. The over-the-counter drugs not separately reimbursable are those that are classified into the following drug classes:

- (1) Analgesics, including urinary analgesics;
- (2) Compounding vehicles and bulk chemicals;
- (3) Cough and cold preparations and antihistamines, except preparations containing ~~cetirizine~~ and cetirizine, fexofenadine, or loratadine;
- (4) Ear preparations;
- (5) Gastrointestinal agents, except histamine-2 receptor antagonists, proton pump inhibitors, and loperamide;
- (6) Hemorrhoidal preparations;
- (7) Nasal preparations;

- (8) Ophthalmic agents, except antihistamines;
- (9) Saliva substitutes;
- (10) Sedatives;
- (11) Topical agents, except antifungal and acne preparations; or
- (12) Vitamins and minerals, except prenatal vitamins and fluoride.

Effective: 10/01/2012

R.C. 119.032 review dates: 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 09/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.98

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.20, 5111.262, 5111.98

Prior Effective Dates: 4/7/77, 9/19/77, 12/21/77, 12/30/77, 7/8/78, 10/1/78, 5/9/86, 11/1/86, 10/1/87, 2/1/88, 1/13/89 (Emer), 4/13/89, 6/1/89, 7/1/94, 10/1/97, 2/3/00 (Emer), 5/1/00, 3/31/03 (Emer), 6/12/03, 10/16/03 (Emer), 1/1/04, 4/14/05, 10/15/05, 1/1/06, 7/1/06, 7/31/09 (Emer), 10/1/09 (Emer), 10/29/09, 12/29/09, 10/1/10

MAL 586

Effective Date: October 5, 2013

Most Current Prior Effective Date: September 17, 2007

- (A) Patient profiles, prospective drug utilization review, and patient counseling
- (1) Patient profiles, prospective drug utilization review, and patient counseling must be performed for medicaid patients by medicaid pharmacy providers in accordance with Chapter 4729-5 of the Administrative Code.
 - (2) Documentation and records required by Chapter 4729-5 of the Administrative Code must be maintained in accordance with rule 5101:3-1-17.2 of the Administrative Code.
 - (3) In addition to the prospective drug utilization review required in paragraphs (A)(1) to (A)(2) of this rule, the ~~Ohio department of job and family services (ODJFS)~~ Ohio Department of Medicaid (ODM) or its designee will also perform prospective drug utilization review at the time of claim adjudication and may deny claims that exceed limitations described in rule 5101:3-9-03 of the Administrative Code. Denials may be overridden by ~~ODJFS-ODM~~ or its designee in cases where medical necessity has been determined.
 - (4) Prospective drug utilization review will be performed for the purpose of identifying prescriptions that may not be therapeutically appropriate, as described in paragraphs (B)(1)(b) to (B)(1)(j) of this rule.
- (B) Retrospective drug utilization review
- (1) Retrospective drug utilization review shall be performed by ~~ODJFS-ODM~~ or its designee on an ongoing periodic basis to monitor the following:
 - (a) Therapeutic appropriateness;
 - (b) Overutilization;
 - (c) Underutilization;
 - (d) Appropriate use of generic products;
 - (e) Therapeutic duplication;
 - (f) Drug-disease state contraindications;
 - (g) Drug-drug interactions;
 - (h) Incorrect drug dosage;
 - (i) Incorrect duration of drug treatment; and
 - (j) Clinical abuse/misuse.
 - (2) The "Drug Utilization Review (DUR) board," defined in paragraph (C) of this rule, shall, in compliance with ~~section 1927 of the Social Security Act~~, 42 U.S.C. 1396r-8 (June 13, 2013), review and recommend criteria used for retrospective drug utilization using predetermined standards consistent with, but not limited to, any of the following:
 - (a) American hospital formulary service drug information;
 - (b) United States pharmacopeia drug information;
 - (c) American medical association drug evaluations; ~~and~~
 - (d) Drugdex information system; and

~~(d)~~(e) Peer-reviewed medical literature (that is, scientific, medical, and pharmaceutical publications in which original manuscripts are rejected or published after having been critically reviewed by unbiased independent experts).

(3) Remedial strategies shall be recommended by the DUR board and may be approved by ~~ODJFS~~ ODM for use when clinical concerns are identified based on the monitoring of items listed in paragraph (B)(1) of this rule.

(C) DUR board

(1) Membership

(a) The DUR board shall include health care professionals appointed by the medicaid director ~~of ODJFS~~ ODM who have recognized knowledge and expertise in one or more of the following:

- (i) Clinically appropriate prescribing of covered outpatient drugs;
- (ii) Clinically appropriate dispensing and monitoring of covered outpatient drugs;
- (iii) Drug use review, evaluation, and intervention; or
- (iv) Medical quality assurance.

(b) The DUR board shall be composed of four licensed and actively practicing physicians, at least one of which is a doctor of osteopathic medicine, four licensed and actively practicing pharmacists, and one nonvoting ~~ODJFS~~ ODM staff person. Candidates may be submitted for consideration by the professional health care associations.

(c) The chairperson of the DUR board shall be elected by the membership for a one-year term and must be one of the licensed professionals as specified in paragraph (C)(1)(b) of this rule.

(2) Terms

(a) Two of the original physician appointments and two of the original pharmacist appointments shall be for two years, with the remaining appointments being for one year. Subsequent appointments shall be for two years. The ~~ODJFS~~ ODM staff person shall be an ongoing member of the board.

(b) Vacancies shall be filled for the unexpired terms in the same manner as the original appointments.

(3) Duties

(a) The DUR board shall review and recommend criteria used in drug utilization review.

(b) The DUR board shall recommend multiple levels of interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews. Intervention programs shall include, in appropriate instances, at least:

- (i) Written, oral, or electronic reminders containing patient specified and/or drug specific information and suggested changes in prescribing or dispensing practices, communicated in a way to ensure the privacy of patient related information;
- (ii) Use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices; and
- (iii) Intensified review or monitoring of selected prescribers, dispensers, or patients. This may include, but not be limited to, referral to the appropriate licensure board or ~~ODJFS's~~ ODM surveillance and utilization review area.

- (c) Criteria and interventions utilized by ~~ODJFS~~-ODM shall be reported back to the DUR board. The DUR board shall reevaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, evaluate the success of the interventions, and recommend modifications as necessary.
 - (d) The DUR board shall develop an informational package on the nature of the drug utilization review program.
 - (e) The DUR board shall provide for active and ongoing educational outreach programs to educate practitioners on common therapy problems and quality improvement initiatives.
 - (f) The DUR board shall prepare an annual report for ~~ODJFS~~-ODM that includes:
 - (i) A description of the board's activities, including the nature and scope of the prospective and retrospective drug use review programs;
 - (ii) A summary of the interventions used;
 - (iii) An assessment of the impact of these educational interventions on quality of care; and
 - (iv) An estimate of the cost savings generated as a result of such program.
- (4) Meetings and compensation
- (a) The DUR board shall meet quarterly, unless ~~ODJFS~~-ODM determines additional meetings are necessary, to perform the duties described in paragraph (C)(3) of this rule.
 - (b) The portion of the DUR board meeting dealing with the consideration of criteria and general interventions shall be open to any interested party.
 - (c) The ~~ODJFS~~-ODM shall reimburse each board member, other than the ~~ODJFS~~-ODM staff person, one hundred fifty dollars per meeting.

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R.C. 119.032 review dates: 07/19/2013 and 10/01/2018

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MAL 575

Effective Date: July 1, 2011

Most Current Prior Effective Date: October 1, 2010

- (A) Reimbursement shall be the lesser of the submitted charge or the calculated allowable in accordance with paragraphs (B) to (C) of this rule. For medications that are subject to a co-payment, the amount reimbursed by the Ohio department of job and family services (ODJFS) will be decreased by the amount equal to the co-payment that is to be billed to the consumer in accordance with rule [5101:3-9-09](#) of the Administrative Code.
- (B) Determination of allowable pharmaceutical product cost
- (1) Maximum allowable cost (MAC) pharmaceuticals
- (a) Maximum allowable costs have been determined by the federal department of health and human services for selected drugs. ODJFS shall not make reimbursement for these products, in the aggregate, at a rate higher than the federal upper limit (FUL) prices.
- Drugs that have been identified in [appendix A](#) to rule [5101:3-9-12](#) of the Administrative Code as brand medically necessary (BMN) may only be dispensed without prior authorization when the prescriber has indicated "brand medically necessary" or "BMN" on the prescription.
- (b) ODJFS may establish a MAC for additional selected drugs where either bio-equivalency of the drugs has been established or bio-inequivalency of the drugs has not been established. Reimbursement for state MAC drugs shall be based on the sixty-fifth percentile of the estimated acquisition cost of all readily available generically equivalent drugs.
- (2) Estimated acquisition cost (EAC) pharmaceuticals
- (a) All products, other than those designated as MAC drugs, will be considered EAC drugs. Reimbursement will be based on the estimate of wholesale acquisition cost (WAC) determined by periodic review of pricing information from Ohio drug wholesalers, pharmaceutical manufacturers and a pharmacy pricing update service. Maximum reimbursement for these drugs will be WAC plus seven per cent for claims with dates of service on or after October 1, 2005.
- (b) In the event that WAC cannot be determined, ODJFS will define "EAC" as average wholesale price (AWP) minus 14.4 per cent for claims with dates of service on or after October 1, 2005.
- (3) No reimbursement of product cost will be paid for pandemic influenza vaccine that is provided by the Ohio department of health or other government entity at no charge to the provider.
- (C) Dispensing fees
- (1) Eligibility for a dispensing or administration fee
- (a) Only pharmacy and hospital providers as defined in rule [5101:3-9-01](#) of the Administrative Code are eligible to receive a dispensing or administration fee.
- (b) Providers eligible to provide pharmacy services in accordance with paragraph (C) of rule 5101:3-9-01 of the Administrative Code are eligible to receive reimbursement for only the product cost. No dispensing or administration fee shall be paid.
- (c) Dispensing fees for prescriptions, other than compounded drugs, dispensed to patients residing in nursing facilities (NF) or intermediate care facilities for the mentally retarded (ICF-MR) as defined in section 5111.20 of the Revised Code shall be limited to one

dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. In the event that multiple prescriptions within a single GCN are dispensed within a twenty-five day timespan, only the product cost will be reimbursed. Exceptions to the single dispensing fee are:

- (i) Cases where the physician has prescribed a second round of medication within the twenty-five day period.
- (ii) Cases where the physician has changed the dosage.
- (iii) Cases where the medication did not last for the intended days supply.
- (iv) Cases where the drug has been compromised by accident (e.g., contaminated or destroyed).
- (v) Controlled substances (limited to two dispensing fees per twenty-five days).

When medications are delivered to the patient from an emergency or similar supply held in reserve by the NF or ICF-MR, the pharmacy provider must dispense and bill for the total prescription as one dispensation with one fee and arrange for the orderly replacement to the emergency or similar supply from the total prescription. The pharmacy may not bill two prescriptions, one to replace the emergency or similar supply, and another to satisfy the balance of the patient's requirements.

(2) Noncompounded drugs, other than influenza vaccine

The dispensing fee for noncompounded drugs shall be ~~three dollars seventy cents for claims with dates of service through December 31, 2009, and~~ one dollar eighty cents for claims with dates of service on or after January 1, 2010 ~~2010, through June 30, 2011~~.

(3) Compounded drugs

- (a) All compounded drugs, including total parenteral nutrition, must be submitted with a compound code value of "2".
- (b) Infusion compounds include intravenous (IV) therapy for chemotherapy, pain management and antibiotics. Claims submitted for infusion compounds will receive a dispensing fee of ten dollars per day, with a maximum dispensing fee of seventy dollars.
- (c) Total parenteral nutrition claims will receive a dispensing fee of fifteen dollars per day, with a maximum dispensing fee of one hundred fifty dollars.
- (d) Compounded drugs that are not infusion compounds or total parenteral nutrition claims will receive a single six dollar dispensing fee per prescription.
- (e) For purpose of documentation for the Ohio board of pharmacy, providers must be able to retrieve and document all components of a compounded drug.

(4) Seasonal and pandemic influenza vaccine

- (a) When dispensed to a resident of a NF or ICF-MR, the dispensing fee for seasonal and pandemic influenza vaccine shall be fifty cents.
- (b) When dispensed to a medicaid consumer who is not a resident of a NF or ICF-MR, and the vaccine is administered at the pharmacy, the administration fee shall be ten dollars.

Effective: 07/01/2011

R.C. 119.032 review dates: 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

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MAL 568

Effective Date: October 1, 2010

Most Current Prior Effective Date: April 1, 2008

- (A) The pharmacy claim to the Ohio department of job and family services (ODJFS) or its designee, the pharmacy point-of-sale vendor, must reflect the actual national drug code (NDC) on the container from which the product was dispensed except for unit dose products that must be billed in accordance with paragraph (G) of rule 5101:3-9-03 of the Administrative Code.
- (B) All records of prescriptions must comply with federal and state regulations and shall be retained by the provider for a period of six years from the date of reimbursement of the claim and if an audit is initiated during this time, records must be retained until the audit is resolved.
- (C) For a pharmacy claim to be eligible for reimbursement by ODJFS, any prescription executed in written (and non-electronic) format must be executed on a tamper-resistant form.
 - (1) To be considered tamper resistant ~~between April 1, 2008, and September 30, 2008~~, a prescription form must contain ~~at least one~~ all of the following three characteristics:
 - (a) One or more features designed to prevent unauthorized copying of a completed or blank prescription form;
 - (b) One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber; ~~or~~ and
 - (c) One or more features designed to prevent the use of counterfeit prescription forms.
 - (2) The tamper-resistant requirement applies to all written prescriptions presented at the pharmacy when ODJFS pays any part of the claim, including when ODJFS is not the primary payer, in accordance with paragraphs (F) and (G) of this rule.
 - ~~(2) To be considered tamper resistant beginning October 1, 2008, a prescription form must contain all three of the features in paragraph (C)(1) of this rule.~~
 - ~~(3) The tamper-resistant requirement applies in both of the following situations:~~
 - ~~(a) All written prescriptions presented at the pharmacy on or after April 1, 2008, regardless of the date the prescription was written; and~~
 - ~~(b) All written prescriptions when ODJFS pays any part of the claim, including when ODJFS is not the primary payer, in accordance with paragraphs (F) and (G) of this rule.~~
 - ~~(4)~~(3) The tamper-resistant requirement does not apply in the following situations:
 - ~~(a) Refills of written prescriptions presented at the pharmacy before April 1, 2008;~~
 - ~~(b)~~(a) Prescriptions transmitted to the pharmacy via an electronic prescription transmission system, facsimile device, or telephone, in accordance with rules promulgated by the state board of pharmacy in agency 4729 of the Administrative Code;
 - ~~(c) Prescriptions for which payment will be made by an ODJFS-contracting managed care plan;~~
 - ~~(d)~~(b) Orders for medications administered in a provider setting and billed by the administering provider in accordance with paragraph (I) of rule 5101:3-9-03 of the Administrative Code; or
 - ~~(e)~~(c) Orders for medications administered in a ~~long-term care facility (LTCF), including~~ nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR), if the order is written in the patient's medical record and given by medical staff directly to the pharmacy.

The prescription is considered tamper resistant if the patient does not have opportunity to handle the written order.

~~(5)~~(4) If a written prescription that is not tamper resistant is presented at the pharmacy ~~on or after April 1, 2008~~, the pharmacy may fill the prescription on an emergency basis and obtain a compliant tamper-resistant replacement from the prescriber within seventy-two hours of dispensing.

- (a) A tamper-resistant replacement may be obtained via any of the following methods:
 - (i) Telephone verification from the prescriber or prescriber's staff, documented on the prescription with the name of the person at the prescriber's office verifying the prescription, date of verification, and identification of the pharmacist or pharmacy staff member requesting verification;
 - (ii) Obtaining a copy of the prescription from the prescriber via facsimile device;
 - (iii) Obtaining an electronic prescription from the prescriber; or
 - (iv) Obtaining a replacement written prescription from the prescriber on a tamper-resistant form.
- (b) The replacement tamper-resistant prescription shall be filed with the original, non-tamper-resistant prescription.
- (c) The dispensing pharmacist shall use professional judgment to define an emergency situation.

~~(6)~~(5) When it is determined that a consumer is retroactively eligible, and the consumer's original or refill prescription was filled during a period when the consumer is retroactively eligible, the pharmacy must ensure that the original prescription was tamper resistant before billing the pharmacy claim to ODJFS.

- (a) If the prescription meets the provisions of paragraph ~~(C)(4)~~ (C)(3) of this rule, the tamper-resistant requirement does not apply.
- (b) If the original prescription was not tamper resistant, the pharmacy may obtain a tamper-resistant replacement as described in paragraphs ~~(C)(5)(a) and (C)(5)(b)~~ (C)(4)(a) and (C)(4)(b) of this rule.

(D) The quantity of the product dispensed must be submitted in a metric decimal format for payment.

(E) Voids and reversals

(1) Return to stock

- (a) When patients fail to pick up their prescriptions, pharmacies must reverse the claim submitted to ODJFS as soon as possible. Reversing a claim within fourteen days will simplify claim reconciliation for providers.
- (b) When prescriptions have been dispensed to ~~residents~~ a resident of a ~~LTCF~~NF or ~~ICF~~MR and there is an unutilized portion of a legally redispensable drug remaining, the drug must either be:
 - (i) ~~Be destroyed~~ Destroyed; or
 - (ii) Returned to the pharmacy to be redispensed and the product cost, not including the dispensing fee, must be credited to ODJFS. This shall be done by voiding or reversing the original claim and submitting a new claim for the utilized amount plus dispensing fee.

(2) Voids, reversals, and replacement claims for other reasons

- (a) Original claims shall be submitted within three hundred sixty-five days of the date of service. Claims may be reversed, voided, or replaced (i.e., re-billed) at any time within the first three hundred sixty-five days after the date of service.

- (b) Claims may be reversed, voided, or replaced beyond three hundred sixty-five days after the date of service in the following circumstances:
 - (i) Adjudicated paid claims may be reversed and replaced (i.e., re-billed) beyond three hundred sixty-five days after the date of service if the adjudication date of the replacement claim is within ninety days after the date of original claim payment.
 - (ii) Adjudicated denied claims may be replaced (i.e., re-billed) beyond three hundred sixty-five days after the date of service if the adjudication date of the replacement claim is within ninety days after the date of adjudication of an original denied claim.
 - (iii) Adjudicated paid claims may be reversed or voided beyond three hundred sixty-five days after the date of service if the adjudication date of the reversal or void is within five hundred forty-five days after the date of original claim payment.

(F) Third party liability

- (1) In accordance with rules [5101:3-1-17.2](#) and [5101:3-1-08](#) of the Administrative Code, ODJFS is the payer of last resort.
- (2) ODJFS shall reimburse the difference between the third party payment and the medicaid calculated allowable minus any co-payments imposed by medicaid in accordance with rule [5101:3-1-09](#) of the Administrative Code. This shall be considered payment in full.

(G) Medicare part B-covered services

Drugs covered by medicare part B for dually eligible consumers must be billed to medicare. ODJFS shall reimburse the medicare part B cost sharing in accordance with rule [5101:3-1-05](#) of the Administrative Code.

(H) Medicare part D-covered services

Drugs that are covered or may be covered by medicare part D for dually eligible consumers must be billed to the appropriate medicare part D prescription drug plan (PDP) and are not covered by medicaid. Medicare cost sharing for medicare part D services is not reimbursable by ODJFS.

(I) Point-of-sale claims processing

- (1) Pharmacy claims must be billed through the electronic point-of-sale system provided by the ODJFS pharmacy point-of-sale vendor or using a paper claim format as approved by the pharmacy point-of-sale vendor.
- (2) ~~Effective July 1, 2006, batch~~ Batch process claims are not accepted.

Effective: 10/01/2010

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[MAL 593](#)

Effective Date: May 23, 2014

Most Current Prior Effective Date: [July 24, 2008](#)

- (A) For a drug to be considered for inclusion in the appendix A to rule ~~5101:3-9-12~~ 5160-9-12 of the Administrative Code, the following information may be requested from the manufacturer or labeler:
- (1) Trade name of the drug.
 - (2) Generic name of the drug.
 - (3) National drug code number (NDC).
 - (4) Package sizes available.
 - (5) Strengths.
 - (6) Therapeutic use(s).
 - (7) List of therapeutic ingredients.
 - (8) Direct, average wholesale price, **and** wholesale acquisition ~~cost~~ cost and average manufacturer price.
 - (9) Bioavailability and bioequivalency data.
 - (10) Letter(s) of approval of new drug application (NDA), or abbreviated new drug application (ANDA).
 - (11) Product labeling as approved by the food and drug administration.
 - (12) A statement of justification for inclusion in the appendix A to rule ~~5101:3-9-12~~ 5160-9-12 of the Administrative Code including cost effectiveness and relative merits.
- (B) Final determination by ~~ODJFS~~ the Ohio Department of Medicaid (ODM) of a drug's inclusion on or removal from the appendix A to rule ~~5101:3-9-12~~ 5160-9-12 of the Administrative Code will be based on a review and analysis of the information required in paragraph (A) of this rule in addition to an analysis of such factors as:
- (1) Specific attributes and/or benefits of the drug.
 - (2) Availability and cost effectiveness of the drug in relation to alternative products.
 - (3) Availability of bioequivalent generic products.
 - (4) Provision of a supplemental rebate payment for a drug that reduces the acquisition cost.

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MAL 565

Effective Date: February 1, 2010

Most Current Prior Effective Date: January 1, 2006

- ~~(A)~~ Beginning January 1, 2004 consumers eligible for the medicaid program (except for consumers who are members of a medicaid managed health care program) as defined in paragraph (C) of this rule, and consumers eligible for the disability medical assistance program as defined in rule 5101:3-23-01 of the Administrative Code, will pay a three dollar co-payment for prescription medications not found in appendix A of rule 5101:3-9-12 of the Administrative Code. This co-payment is required on prescription medications not found in appendix A of rule 5101:3-9-12 of the Administrative Code which are prior authorized on or after January 1, 2004. Prescriptions for medications prior authorized prior to January 1, 2004 which have unfilled periods extending beyond the January 1, 2004 effective date are not subject to co-payment.
- ~~(B)~~ Beginning January 1, 2006, consumers eligible for the medicaid program (except for consumers who are members of a medicaid managed health care program) as defined in paragraph (C) of this rule, and consumers eligible for the disability medical assistance program as defined in rule 5101:3-23-01 of the Administrative Code, will pay a two dollar co-payment for selected trade name drugs as indicated in appendix A of rule 5101:3-9-12 of the Administrative Code.
- (A) Consumers eligible for the medicaid program as defined in paragraph (B) of this rule will pay a three dollar co-payment for prescription medications not found in appendix A to rule 5101:3-9-12 of the Administrative Code, and a two dollar co-payment for selected trade name drugs as indicated in appendix A to rule 5101:3-9-12 of the Administrative Code.
- ~~(C)~~(B) Consumers subject to co-payment for medications are identified as adults eligible under the medicaid ~~and disability medical assistance programs~~ program, age twenty-one and over. Co-payment requirements as contained in this rule are also subject to the provisions of rules 5101:3-1-09 and 5101:3-1-60 of the Administrative Code.
- ~~(D)~~(C) Exclusions to the co-payment requirement for prescription medications as described in ~~paragraphs~~ paragraph (A) ~~and (B)~~ of this rule are described in rule 5101:3-1-09 of the Administrative Code and as follows:
- (1) Children. Prescriptions for medications given to eligible consumers under twenty-one years of ~~age,~~ age are excluded from co-payment. The Ohio department of job and family services (ODJFS) identifies those eligible consumers who are under age twenty-one through the ~~department's~~ ODJFS recipient master file (RMF) and excludes them from co-payment at the time the medication is dispensed. In the event that there is a dispute concerning the consumer's age, and the RMF and the client registry information system-enhanced (CRIS-E) are found to be in error, the consumer may be refunded any paid co-payment in accordance with rule 5101:3-1-60.2 of the Administrative Code.
 - (2) Pregnant women. Prescriptions for medications given to eligible pregnant women are excluded from co-payment during the woman's pregnancy and the post-partum period. The post-partum period is the immediate post-partum period ~~which that~~ begins on the last day of pregnancy and extends through the end of the month in which the sixty day period following termination of pregnancy ends. Pregnant women may declare their pregnancy or their sixty day post-partum period at the time their prescription medication is dispensed and they will not be charged a co-payment for their medication.
 - (3) Institutionalized individuals. Prescriptions for medication given to any eligible consumer who is a resident in a long term care facility are excluded from co-payment. ~~The department~~ ODJFS identifies residents of long term care facilities (those living in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) as defined in section 5111.20 of

the Revised Code) through the ~~department's~~ RMF and excludes them from co-payment at the time the medication is dispensed.

- (4) Hospice care. Prescriptions for medication given to any eligible consumer who is receiving hospice care are excluded from co-payment. ~~The department~~ ODJFS identifies consumers who are receiving hospice care in accordance with ~~paragraph (C) of rule 5101:3-56-03~~ Chapter 5101:3-56 of the Administrative Code.
- (5) Family planning. Prescriptions for medication given to an eligible consumer of child-bearing age for the purposes of family planning are excluded from co-payment. ~~The department~~ ODJFS identifies medications that qualify as family planning services in appendix A ~~of to rule 5101:3-9-12~~ of the Administrative Code and the ~~department's~~ ODJFS pharmacy point-of-sale vendor will exempt these medications from co-payment.
- (6) Emergency services. Medications administered to an eligible consumer during emergency care provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily part or organ, are not subject to co-payment.
- (7) Medications administered to an eligible consumer during a medical encounter provided in a hospital, clinic, office, or other facility, when the medication is a part of the evaluation and treatment of the condition, are not subject to co-payment.

~~(E)~~(D) Prescriptions for medication given to an eligible consumer during a medical encounter provided in the emergency department or other hospital setting, clinic, office, or other facility as a result of the evaluation and treatment of the condition, to be filled at a pharmacy located at the facility or at an outside location, are subject to co-payment under the conditions described in paragraphs ~~(A), (B), and (C)~~ (A) and (B) of this rule.

~~(F)~~(E) ~~No provider of pharmacy services may deny services, to a consumer who is eligible for the services, on account of the consumer's inability to pay the co-payment. Consumers who are unable to pay their co-payment may declare their inability to pay and obtain their medication without paying their cost sharing amount; they remain, however, liable for the co-payment. The provider may bill the consumer for the co-payment or may request payment for a prior uncollected co-payment, however, the consumer may not be denied subsequent services based on their failure to pay an outstanding co-payment except as described in paragraph (B)(5) of rule 5101:3-1-09 of the Administrative Code.~~ No provider of pharmacy services may deny medication to a consumer because the consumer is unable to pay the co-payment, if the consumer is eligible for medicaid coverage of the medication. Consumers who are unable to pay their co-payment may declare to the provider their inability to pay and obtain the medication without paying their co-payment. Consumers who declare their inability to pay remain liable for the co-payment. The provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment. The provider may not deny subsequent medications that may be covered by medicaid based on a consumer's failure to pay prior co-payments except as described in paragraph (B)(5) of rule 5101:3-1-09 of the Administrative Code.~~(G)~~

(F) In accordance with rule 5101:3-1-08 of the Administrative Code, providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third party. ~~The department~~ ODJFS shall reimburse the difference between the third party payment and the medicaid calculated allowable minus the ~~three dollar~~ applicable co-payment as defined in paragraph (A) of this rule.

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Prior Effective Dates: 1/1/04, 1/1/06

MAL 595

Effective Date: November 1, 2014

Most Current Prior Effective Date: February 24, 2014

5101:3-9-12 Appendix A

- (A) The drug products covered under the medicaid program without prior authorization are specified in the appendix to this rule. The table includes four columns to indicate drug coverage.
- (1) Drug class. This column describes the therapeutic class of drug.
 - (2) Drug name. This column names each drug covered under the medicaid program without prior authorization.
 - (3) Co-payment. This column indicates the medicaid co-payment that applies to each drug in accordance with rule [5160-9-09](#) of the Administrative Code. "2" indicates that a two dollar co-payment applies, "0" indicates that zero co-payment applies, and "*" indicates that the drug is only available without prior authorization for children who are exempt from co-payment requirements under rule 5160-9-09 of the Administrative Code. If the drug is prior authorized for an adult, the appropriate co-payment for prior authorized drugs will apply.
 - (4) Covered for dual eligible. This column indicates whether the drug is covered under the medicaid program for a consumer who is a dual eligible as defined in rule [5160-1-05](#) of the Administrative Code. "Y" indicates that the drug is covered for a dual eligible and "N" indicates that the drug is not covered for a dual eligible.
- (B) Revisions to the appendix to this rule shall be filed pursuant to Chapter 119. of the Revised Code unless the revisions are required to comply with rule [5160-9-03](#) of the Administrative Code, state statute, and/or federal statute or regulations relating to federal financial participation in the medicaid program.
- (C) Drugs not listed in the appendix to this rule that are classified in the following drug classes will not require prior authorization if the pharmacy claim indicates that the prescriber is a physician who has registered his or her psychiatry specialty with ODM, and when the dosage form of the drug prescribed is a standard tablet or capsule:
- (1) Selective serotonin reuptake inhibitor (SSRI);
 - (2) Alpha-2 receptor antagonist;
 - (3) Selective serotonin-norepinephrine reuptake inhibitor (SNRI);
 - (4) Selective norepinephrine and dopamine reuptake inhibitor (NDRI);
 - (5) Monoamine oxidase inhibitor, non-selective and irreversible;
 - (6) Antipsychotic, atypical, dopamine and serotonin antagonist;
 - (7) Antipsychotic, atypical, D2 partial agonist/5HT mixed;~~or~~
 - (8) SSRI and antipsychotic, dopamine and serotonin antagonist ~~combination.~~combination; or
 - (9) SSRI and serotonin receptor modulator antidepressant.

Effective: 10/27/2014

Five Year Review (FYR) Dates: 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 10/16/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5162.031, 5162.20, 5164.02, 5164.755, 5164.7510 Prior Effective Dates: 11/1/85 (Emer), 1/31/86, 5/1/86, 8/1/86, 11/1/86, 2/2/87 (Emer), 5/1/87, 8/1/87, 10/29/87 (Emer), 1/20/88 (Emer), 4/18/88, 8/6/88, 11/1/88, 1/19/89, 1/20/89 (Emer), 4/20/89, 6/9/89 (Emer), 8/3/89, 11/1/89, 2/1/90, 5/1/90, 8/1/90 (Emer), 11/1/90, 12/31/90 (Emer), 3/31/91, 8/22/91, 2/10/92, 7/11/92, 10/25/92, 4/1/93, 6/18/93, 11/11/93, 3/18/94, 8/25/94, 3/20/95, 5/25/95, 9/1/95, 2/1/96, 9/13/96, 3/22/97, 8/14/97, 1/23/98, 7/1/98, 1/1/99, 3/31/99, 7/1/99, 4/1/00, 11/12/00, 3/19/01, 8/30/01, 12/13/01, 3/21/02, 8/15/02, 11/22/02, 3/31/03 (Emer), 6/12/03, 9/30/03, 4/1/04, 10/1/04, 4/14/05, 10/1/05, 1/1/06, 7/1/06, 10/1/06, 7/10/07, 10/1/07, 3/20/08, 10/1/08, 7/1/09, 10/1/09, 10/1/10, 7/1/11, 10/1/11, 7/19/12, 10/1/12, 1/1/13, 11/1/13, 2/24/14

MAL 578

Effective Date: January 1, 2012

5101:3-9-14 Appendix A

(A) Definitions

- (1) "Family planning services" and "pregnancy prevention/contraceptive management services" are defined in rule 5101:3-21-02 of the Administrative Code.**
- (2) "Family planning-related services" are defined in rule 5101:3-21-02.3 of the Administrative Code.**

(B) Individuals who meet the eligibility criteria in rule 5101:1-41-40 of the Administrative Code have a limited medicaid benefit as described in rule 5101:3-21-02.3 of the Administrative Code. Pharmacy services are limited to the following:

(1) Pregnancy prevention/contraceptive management

(a) Drugs listed in appendix A to rule 5101:3-9-12 of the Administrative Code that are included in the following drug classes:

- (i) G8A - Contraceptives, oral; and**
- (ii) G8F - Contraceptive, transdermal; and**
- (iii) G9B - Contraceptives, intravaginal, systemic; and**

(b) Contraceptive supplies listed in appendix A to rule 5101:3-9-02 of the Administrative Code.

(2) Family planning-related drugs used to treat sexually transmitted infections (STIs) other than human immunodeficiency virus (HIV) and hepatitis that are listed in the appendix to this rule. These drugs are included in the recommended treatment regimens published by the federal centers for disease control and prevention.

(a) The appendix to this rule includes three columns to indicate drug coverage:

- (i) Drug class. This column describes the therapeutic class of drug.**
- (ii) Drug name. This column names each drug covered for treatment of STIs under the limited family planning benefit.**
- (iii) Co-payment. This column indicates the medicaid co-payment that applies to each drug in accordance with rule 5101:3-9-09 of the Administrative Code. "2" indicates that a two dollar co-payment applies, "0" indicates that zero co-payment applies.**

(b) The prescriber must include family planning diagnosis in the V25 series on all prescriptions issued for consumers enrolled in the limited family planning benefit for drugs used for the treatment of STIs.

(c) The pharmacy claim must include the family planning diagnosis indicated on the prescription.

(C) The provisions of rules 5101:3-9-01 to 5101:3-9-06 and 5101:3-9-09 of the Administrative Code apply to claims billed under the limited family planning benefit.

Effective: 01/01/2012

R.C. 119.032 review dates: 01/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 12/22/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.0112, 5111.02, 5111.021

Archived Medical Assistance Letters

MAL 514

Medical Assistance Letter (MAL) No. 514

Attachment:

[Ohio Medicaid Preferred Drug List](#)

October 5, 2006

To: All Providers of Pharmacy Services and Prescribers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Pharmacy Program Preferred Drug List

The newest phase of the Ohio Medicaid Preferred Drug List will be effective in October 2006.

The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

Beginning in September, messages were sent back to pharmacies when a drug that will become "non-preferred" is dispensed. This gave the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. **Prescribers may request prior authorization prior to the effective rollout date for a given category.**

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed.

The enclosed document has been provided for your convenience, listing only the preferred drugs in each category.

We appreciate your continued support of our efforts to maintain a quality, cost-effective pharmacy program.

Information about the Ohio Medicaid pharmacy program, including the approved drug list, Provider Manual, PA request fax form, and P & T Committee information can be found at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>.

Pharmacies may contact the Technical Help Desk at ACS for assistance:

Phone: 1-877-518-1545

Prescribers may request prior authorization through ACS:

Phone: 1-877-518-1546

MAL 505

Medical Assistance Letter (MAL) No. 505

Attachment:

JFS 03400, Health Plan Provider Update Request Form for MAL 505

July 7, 2006

To: All Pharmacy Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Changes to the Medicaid pharmacy program effective July 1, 2006

Five Ohio Administrative Code rules impacting pharmacy providers have been amended, effective July 1, 2006.

Rule 5101:3-9-02, entitled "Pharmacy services: Medical supplies and durable medical equipment," has been amended to update references relating to pharmacy billing of medical equipment and supplies. This amendment does not change any existing policies relating to billing of medical equipment and supplies. The provider must be licensed, registered, or exempt from licensure or registration under Chapter 4761. of the Revised Code to bill for home medical equipment that is subject to regulation under Chapter 4752. of the Revised Code.

Rule 5101:3-9-03, entitled "Covered drugs and associated limitations," has been amended to clarify that ODJFS or the pharmacy point-of-sale vendor may limit the number of denial overrides available in the event a consumer requests early refill of a prescription due to the previous supply being lost, stolen, or destroyed. ODJFS or the vendor may require additional documentation in cases when fraud or abuse is suspected.

Rule 5101:3-9-06, entitled "Prescription billing and recordkeeping requirements," has been amended to clarify policy regarding the time limits to bill, reverse, and replace claims. This rule has also been amended to require all claims to be billed using the electronic point-of-sale system. Batch process claims will not be accepted beginning July 1, 2006. Paper claims may be submitted in limited circumstances and only with prior approval from ODJFS or the pharmacy point-of-sale vendor.

Rule 5101:3-9-12, entitled "Ohio department of job and family services list of drugs covered without prior authorization," has been amended for routine maintenance of the drug list.

Access to Ohio Administrative Code Rules

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This MAL, and the rules referenced herein, may be viewed as follows:

Select "Ohio Health Plans - Provider".

Select "Pharmacy Services" (right column).

Select the desired MAL or rule in the drop-down box at the top of the screen.

Providers will receive one hard copy of this letter, and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this letter with copies of Ohio Administrative Code rules 5101:3-9-02, 5101:3-9-03, 5101:3-9-06, and 5101:3-9-12, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-state toll free telephone number 1-800-686-1516

MAL 499

Medical Assistance Letter (MAL) Number 499

Attachment:

[JFS 07116](#), Medicare Part D Co-Payment Resolution Request

February 1, 2006

To: All Pharmacy Providers
From: Barbara E. Riley, Director
Subject: Extension of Medicare Part D Co-Payment Assistance to Pharmacies Through February

On January 20, 2006, ODJFS released Medical Assistance Letter (MAL) 498 announcing co-payment assistance to pharmacies who serve dually eligible consumers. Governor Bob Taft has instructed ODJFS to extend this program for prescriptions filled through the month of February 2006.

As a reminder, we ask that pharmacies provide prescriptions to dually eligible consumers for the lower, correct co-payment even when the PDP reports a higher co-payment. In an effort to facilitate the dispensing of medication to dual eligibles whose PDPs indicate co-payments greater than \$5, without putting pharmacies at financial risk, the state will make up the difference between the co-payment reported by the PDP and the \$0-\$5 co-payment that the pharmacist charges the patient when it is determined that the patient is eligible for Ohio Medicaid in January or February 2006. While pharmacies are not obligated to participate, we appreciate your assistance in helping our dually eligible consumers. Requests should be made by fax using JFS Form [07116](#) (attached).

This program is available only for prescriptions filled for consumers who are both eligible for Ohio Medicaid and enrolled in a Medicare Part D Prescription Drug Plan (PDP) on the date of service. It is limited to prescriptions filled for dually eligible consumers with dates of service January 1 through February 28, 2006. Fax requests must be received by March 31, 2006, to be considered for payment. Pharmacies should continue to work with PDPs to receive correct reimbursement through the PDP's online point-of-sale system.

A revised JFS Form 07116 reflecting the changed dates is attached. Please follow all other instructions found in MAL 498. MAL 498 may be accessed on the internet at <http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Drug/>.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-1516

Fax (614) 995-5959

MAL 498

Medical Assistance Letter (MAL) Number 498

Attachment:

JFS Form [07116](#), Medicare Part D Co-Payment Resolution Request

January 20, 2006

To: All Pharmacy Providers
From: Barbara E. Riley, Director
Subject: Co-Payment Assistance to Pharmacies for January 2006 Transition to Medicare Part D Coverage

As you know, consumers eligible for both Medicare and Medicaid (dual eligibles) are now required to receive the majority of their prescriptions through a Medicare Part D Prescription Drug Plan (PDP). Under federal law, PDPs should not charge dual eligibles a co-payment higher than \$5. Due to data-sharing problems between the federal Centers for Medicare and Medicaid Services (CMS) and the PDPs, incorrect co-payment obligations for dual eligibles are being reported through PDPs' point-of-sale claim systems. As a result, some patients may not be able to obtain critical medications.

We ask that pharmacies provide prescriptions to dually eligible consumers for the lower, correct co-payment even when the PDP reports a higher co-payment. In an effort to facilitate the dispensing of medication to dual eligibles whose PDPs indicate co-payments greater than \$5, without putting pharmacies at financial risk, the state will make up the difference between the co-payment reported by the PDP and the \$0-\$5 co-payment that the pharmacist charges the patient when it is determined that the patient is eligible for Ohio Medicaid in January 2006. While pharmacies are not obligated to participate, we appreciate your assistance in helping our dually eligible consumers. Requests should be made by fax using JFS Form 07116 (attached).

This program is available only for claims with date of service January 1 through 31, 2006. Fax requests must be received by February 28, 2006, to be considered for payment.

Pharmacies are asked to follow these steps to be eligible for state payment of the difference in co-payment:

1. Verify that a patient has Medicaid coverage for the month of January by asking for the January Medicaid card.
2. If the consumer can provide the card, call the PDP and request that the correct \$0-\$5 co-payment be applied.
3. If the PDP refuses to correct the co-payment through their online point-of-sale system, and continues to indicate a higher co-payment, collect a co-payment of no more than \$2 for generic drugs or \$5 for brand name drugs.
4. Submit a fully completed JFS Form 07116 via fax to (614) 995-5959.

Requests for more than one prescription may be made by attaching the required information for each prescription (consumer name, Medicare HIC Number, Medicaid ID, PDP information, drug information, and financial information) in spreadsheet or list form. All pharmacy information must be included on the JFS Form 07116. All requests will be fully researched with the PDP and CMS before payment is made. This process may take up to 60 days. Pharmacies should continue to work with PDPs to receive correct reimbursement through the PDP's online point-of-sale system.

On behalf of Governor Bob Taft, ODJFS would like to thank the Ohio pharmacists who have continued to serve dually eligible consumers as they transition to Medicare Part D for their drug coverage. The complexity of the transition has resulted in many frustrations for pharmacists who are ultimately trying to assure that all consumers obtain their medication. We appreciate your efforts.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-1516

Fax (614) 995-5959

MAL 491

Medical Assistance Letter No. 491

Attachment:

[Ohio Medicaid Preferred Drug List](#)

September 28, 2005

To: All providers of pharmacy services and prescribers
Directors, County Departments of Job and Family Services

From: Barbara E. Riley, Director

Subject: Pharmacy Program Preferred Drug List

The newest phase of the [Ohio Medicaid Preferred Drug List](#) will be phased in over two weeks, October 5 and 12, 2005.

The drug classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

Beginning September 2, 2005, messages were sent back to pharmacies when a drug that will become "non-preferred" is dispensed. This will give the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. **Prescribers may request prior authorization prior to the effective rollout date for a given category.**

A pharmacist may request PA for a drug to be administered through a tube for patients who are tube fed, if drugs not requiring PA cannot be administered through a tube. All other requests for PA must be made by the prescriber.

Those classes listed on the enclosed PDL document will require PA for non-preferred products beginning with all new prescriptions or refills filled on or after the dates indicated on the "Phase-in Schedule" on page 4 of the PDL document. Preferred drugs for hepatitis C which had previously required PA will no longer require PA beginning October 1, 2005.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class may have changed.

The enclosed document has been provided for your convenience, listing only the preferred drugs in each category.

In addition, the Ohio General Assembly has passed legislation which prohibits reimbursement by the Ohio Medicaid program for drugs for the treatment of erectile dysfunction. Beginning October 15, 2005, Cialis, Levitra, Viagra, Edex, Caverject, Muse, and similar drugs will not be covered for erectile dysfunction.

We appreciate your continued support of our efforts to maintain a quality, cost-effective pharmacy program.

If you have additional questions or would like to schedule an educational visit, please call our vendor, First Health Services, at (614) 488-6472 or (614) 488-6475.

Information about the Ohio Medicaid pharmacy program, including the approved drug list, Provider Manual, PA request fax form, and P and T Committee information can be found at

<http://ifs.ohio.gov/ohp/bhpp/meddrug.stm>.

Pharmacies may contact the Technical Help Desk at First Health for assistance:

Phone: 1-877-518-1545

Prescribers may request prior authorization through First Health:

Phone: 1-877-518-1546

Fax: 1-800-396-4111

MAL 490

Medical Assistance Letter (MAL) No. 490

Attachment: JFS 03400, Health Plan Provider Update Request Form for MAL 490

September 28, 2005

To: All Providers of Pharmacy Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Pharmacy Reimbursement

The reimbursement methodology for estimated acquisition cost pharmaceuticals is being revised effective October 1, 2005, pursuant to Ohio Administrative Code rule 5101:3-9-05, Reimbursement.

For estimated acquisition cost (EAC) pharmaceuticals, the maximum reimbursement will change from wholesale acquisition cost (WAC) plus nine per cent for claims with a date of service through September 30, 2005 to WAC plus seven per cent for claims with a date of service thereafter. When WAC cannot be determined, the EAC calculation will change from average wholesale price (AWP) minus 12.8 per cent for claims with a date of service through September 30, 2005 to AWP minus 14.4 per cent for claims with a date of service thereafter.

This rule can be viewed at <http://emanuals.odjfs.state.oh.us/emanuals/medicaid>. If you do not have internet access, you may request a paper copy of the rule by completing and returning the attached form JFS 03400.

Information about the Ohio Medicaid pharmacy program, including the approved drug list, Provider Manual, PA request fax form, and P and T Committee information can be found at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-state toll free telephone number 1-800-686-1516

MAL 483

Medical Assistance Letter (MAL) No. 483

March 29, 2005

To: All Ohio Medicaid Pharmacy Providers and Prescribers of Medication
Directors, County Department of Job and Family Services
Directors, District Offices

From: Barbara E. Riley, Director

Subject: Updates to pharmacy rules

Effective April 14, 2005, the following pharmacy rules have been reviewed and changed as indicated below:

Rule 5101:3-9-01 of the Ohio administrative code entitled "Eligible Providers of Pharmacy Services" has been changed to update a rule reference and make grammatical revisions.

Rule 5101:3-9-03 of the Ohio administrative code entitled "Covered Drugs and Associated Limitations" has been changed to clarify language and make grammatical revisions.

Rule 5101:3-9-04 of the Ohio administrative code entitled "Pharmacy Services: Drug Utilization Review" has been changed to update rule citations, clarify the purpose and standards used during drug utilization reviews, and to make grammatical revisions.

Rule 5101:3-9-12 of the Ohio administrative code entitled "Ohio Department of Job and Family Services List of Drugs Covered Without Prior Authorization" has had the appendix changed for the routine maintenance of the drug list.

These rules can be viewed at <http://emanuals.odjfs.state.oh.us/emanuals/medicaid/>

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-state toll free telephone number 1-800-686-1516

MAL 473

Medical Assistance Letter No. 473

Ohio Medicaid Preferred Drug List

September 2, 2004

To: All providers of pharmacy services and prescribers
Directors, County Departments of Job and Family Services

From: Thomas J. Hayes, Director

Subject: Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation

In an effort to contain rising drug costs and encourage appropriate utilization of prescription drugs, the Ohio Medicaid pharmacy program has developed several initiatives to begin in October 2004.

Clinical Utilization Edits

Effective October 1, 2004, the Ohio Medicaid pharmacy program will implement clinical edits for certain prescription drugs. These edits will cause denial in the point of sale system.

Tablet splitting

Due to the low cost differential of certain strengths of antidepressant medications, prior authorization will be required for selected tablet strengths. This initiative may save as much as \$10 million annually.

- Lexapro 10mg, paroxetine 20mg, Paxil 20mg, and Zoloft 50mg tablets will not be available without prior authorization beginning October 1, 2004. Prescriptions for these strengths should be changed by the prescriber to have the patient to take 1/2 tablet of the higher strength.
- Lexapro 5mg, paroxetine 10mg, Paxil 10mg, and Zoloft 25mg will be limited to 1 tablet per day.
- Prescribers and pharmacies are encouraged to educate patients on proper technique to split tablets.
- Prior authorization for the restricted strengths is available for patients unable to split tablets due to physical or other limitations, or for patients requiring complicated dosing regimens during dose titrations.

PPI Clinical Criteria

Due to the high cost and utilization of Proton Pump Inhibitors, prior authorization will be required for dosages of more than one tablet/capsule per day. Patients age 21 and younger do not require prior authorization for preferred drugs at any dose.

- For diagnosis of H. Pylori, BID dosing may be authorized for 1 month
- For other diagnoses, including COPD, Dyspepsia, Gastritis, Gastroparesis, Symptomatic Uncomplicated GERD, Cystic Fibrosis Hyperacidity, Hiatal Hernia, Zenkers Diverticulum, Achalasia, Barrett's Esophagus, Carcinoma of GI tract, Crest Syndrome, Esophageal Varices, HIV/Transplant Patients on NTIs, Multi Endocrine Adenoma, Oncology Patients, Sarcoid, Scleroderma, Systemic Mastocytosis, Zollinger Ellison Syndrome
- Length of authorization: 1 year
- Criteria: Must have failed QD dosing

Prior authorization required

Due to high rates of off-label prescribing of some drugs, several topical preparations will require prior authorization beginning October 1, 2004.

- Aldara will require prior authorization for all patients to ensure it is used only for FDA-approved indications.

- Regranex will require prior authorization for all patients to ensure it is used only for FDA-approved indications. The quantity will be limited to one 15-gram tube per 28-day period.
- Vitamin A derivatives such as Avita, Azelex, Differin, Renova, Retin-A and Tazorac will require prior authorization for patients over 23 years of age to ensure they are used only for FDA-approved indications

High dose and quantity limits

Dosage limits will be enforced based on FDA guidelines and high dose will cause denial in the point of sale system.

- Actonel 35mg and Fosamax 35mg and 70mg will be limited to one (1) tablet per week.
- Ambien, Lipitor, Singulair, Sonata, and Zocor will be limited to one (1) tablet/capsule per day.
- Tramadol will be limited to eight (8) tablets (400mg) per day.
- Acetaminophen will be limited to 4000mg per day, in any combination of preparations.

Therapeutic duplication

Only one drug from each of the following categories may be dispensed in any three-week period:

- Antihistamines
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Proton Pump Inhibitors (PPIs)
- Sedative/hypnotics
- Selective Serotonin Reuptake Inhibitors (SSRIs)

Pharmacy overrides using standard NCPDP intervention and outcome codes will be permitted only for the therapeutic duplication and acetaminophen high dose edits. These overrides should only be used when the pharmacist believes it is clinically appropriate.

Preferred Drug List

The newest phase of the Ohio Medicaid Preferred Drug List will be phased in over a six-week period from October 6 through November 10, 2004.

The classes were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Products in these classes that are "non-preferred" are subject to prior authorization.

Beginning September 2, 2004, messages will be sent back to pharmacies when a drug that will become "non-preferred" is dispensed. This will give the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. Prescribers can request prior authorization prior to the effective rollout date for a given category.

Those classes listed on the enclosed PDL document will require PA for non-preferred products beginning with all new prescriptions or refills filled on or after the dates indicated on the "Phase-in Schedule" on the last page of the document.

Please note that while most of these categories have been part of the PDL in the past, the preferred drugs in each class have changed.

The enclosed document has been provided for your convenience, listing only the preferred drugs in each category.

We appreciate your continued support of our efforts to maintain a quality, cost-effective pharmacy program.

If you have additional questions or would like to schedule an educational visit, please call our vendor, First Health Services, at (614) 488-6472 or (614) 488-6475.

Information about the Ohio Medicaid pharmacy program, including the approved drug list, Provider Manual, PA request fax form, and P and T Committee information can be found at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>.

Pharmacies may contact the Technical Help Desk at First Health for assistance:

Phone: 1-877-518-1545

Prescribers may request prior authorization through First Health:

Phone: 1-877-518-1546

Fax: 1-800-396-4111

MAL 460

Medical Assistance Letter (MAL) No. 460

December 18, 2003

To: All Pharmacy Providers and Providers who prescribe medication
Directors, County Departments of Job and Family Services
Directors, District Offices

From: Thomas J. Hayes

Subject: Consumer co-payments for prescription medication requiring prior authorization

PRESCRIPTION COVERAGE CHANGE EFFECTIVE JANUARY 1, 2004

For prescriptions prior authorized on and after January 1, 2004, consumers who are eligible for the Medicaid or the Disability Medical Assistance programs will be subject to a **\$3.00 co-payment for the prior authorized medication**, with the exception of those exemptions outlined below. When a co-payment is applicable the pharmacy provider is responsible for collecting the co-payment, and the department will reduce the pharmacy's reimbursement by the amount of the co-payment.

Co-payments must not be charged by a pharmacy if the consumer is:

- under age 21, or
- pregnant or in the post-partum period (The post-partum period is the immediate post-partum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty day period following termination of pregnancy ends.), or
- in a nursing home or intermediate care facility for the mentally retarded, or
- receiving hospice care, or
- a member of a Medicaid managed care program.

Co-payments **must not be charged** by a pharmacy if:

- the prescription medication does not need to be prior authorized, or
- the prescription medication is a refill that was prior authorized before January 1, 2004, or
- the prescription is for family planning

Medications administered to a consumer in a hospital, emergency department, office, clinic, or other facility, are not subject to co-payments.

Consumers subject to co-payment, who indicate that they are unable to pay their co-payment at the time their medication is dispensed, may indicate their inability to pay and obtain their prescription medication without paying the co-payment. The consumer remains liable for the co-payment and the pharmacy provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment. However, consumers may not be denied subsequent services based on their inability to pay an outstanding co-payment.

Prescribing providers may be asked by Medicaid consumers to prescribe medication that does not require prior authorization so that the consumer's prescription will not be subject to co-payment. If providers can prescribe a clinically appropriate medication that can be safely substituted for the drug that requires prior authorization, then the provider may offer that choice so the consumer can get a prescription that is not subject to co-payment.

The department will be providing a poster describing the department's co-payment policy to each pharmacy. To facilitate the implementation of the department's co-payment policy, we ask that when pharmacies receive the poster they display it in a location that can be easily read by consumers. Consumers who have questions

about the poster or the policy may contact the Ohio Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The department has promulgated rule 5101:3-9-09 of the Ohio Administrative Code entitled "Consumer co-payments for certain pharmacy medications (except for consumers who are members of a medicaid managed care program)". This rule may be viewed at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid/Drug/>

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-1516

MAL 456

Medical Assistance Letter No. 456

Attachments:

[Ohio PDL Quick-Preferred Only Listing](#)

[PDL Combo II Listing \(preferred and non-preferred\)](#)

September 15, 2003

To: Ohio Medicaid Pharmacy Providers/Prescribers
From: Thomas J. Hayes, Director
Subject: Preferred Drug List (PDL) Information

<http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm>

<http://medlist.odjfs.state.oh.us>

Effective October 1, 2003 Ohio Medicaid will move to the second phase of the Preferred Drug List (PDL). The classes listed below were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid consumers. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Those products in these classes that are "non-preferred" are subject to prior authorization.

Beginning August 28, messages are being sent back to pharmacies when a drug that will become "non-preferred" is dispensed. This will give the pharmacy an opportunity to suggest to prescribers that they consider the use of an alternative "preferred" medication in the future, if appropriate. Prescribers can request a prior authorization prior to the effective rollout date for a given category.

Those classes listed below will require PA for "non-preferred" products beginning with all new prescriptions or refills filled on or after the dates indicated below:

October 1 - Insulins**, Oral Hypoglycemics

**Patients currently receiving insulins will be grandfathered and will not be required to change formulations.

October 8 - Lipotropics, Antifungals

October 20 - Anti-infectives (Cephalosporins, Fluoroquinolones, Macrolides), Anti-virals (for Herpes)

October 27 - Triptans

The enclosed documents have been included for your benefit. We encourage you to keep them available for quick reference.

- The list printed on color paper gives a listing of "preferred" drugs in each category. It has been arranged so you can fold to keep in your pocket.
- A more comprehensive list includes both "preferred" and "non-preferred" products in each class. This can be duplicated and hung on a wall or placed in a binder for reference.

The contact numbers for requesting a PA are as follows:

Telephone PA Requests 1-877-518-1546

Fax PA Requests 1-800-396-4111

Technical Calls 1-877-518-1545

These PDL documents can also be found on our website:

<http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm>

In the future there are plans to provide these documents as shareware that can be downloaded to a PDA from our website. As this becomes available, it will be posted to the site listed above.

A new searchable website has been added that allows you to search for drugs that are covered without prior authorization by searching on the drug name or NDC number. This can be accessed at <http://medlist.odjfs.state.oh.us>

If you have additional questions or would like to schedule an educational visit, please call our vendor, First Health Services, at 614-481-3519.

We appreciate your continued support of our efforts to maintain a quality, cost-effective pharmacy program.

MAL 439-A

Medical Assistance Letter No 439-A

Attachments:

[Ohio PDL Quick-Preferred Only Listing](#)

[PDL Combo II Listing](#)

March 6, 2003

To: Ohio Medicaid Pharmacy Providers
From: Tom Hayes, Director
Subject: Preferred Drug List (PDL) Information

<http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm>

Effective April 7, 2003 Ohio Medicaid will move to the next phase of pharmacy management - a Preferred Drug List (PDL). The classes listed below were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid recipients. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Those products in these classes that are "non-preferred" are subject to prior authorization.

What does this mean for you?

1. Patients currently on "**preferred**" products may continue on their current therapy.
2. Patients currently on "**non-preferred**" products, in order to be reimbursed by the department, need either be converted to a "preferred" product or have a prior authorization requested for the "non-preferred" product as described below.
 - Beginning in March, scripts filled for "non-preferred" products will have a message (soft-edit) sent back indicating that PA will be required within a month.
 - Please contact the prescriber of "non-preferred" products to determine if a "preferred" product can be prescribed.
 - If the prescriber does not believe a "preferred" product is an acceptable alternative, ask that First Health be contacted for prior authorization of the current therapy.

In order to maintain quality care for Ohio Medicaid recipients, the Department requests that you be proactive in encouraging prescribers to consider a "preferred" product when you receive a soft-edit in March. Prescribers can request a prior authorization prior to the effective rollout date for a given category.

All drugs in classes not listed below remain available as per current coverage. Those classes listed below will require PA for "non-preferred" products beginning with all new prescriptions or refills filled on or after the dates indicated below:

April 7 - PPIs, and H-2 Receptor Antagonists

April 14 - Narcotics, NSAIDs

April 21 - Nasal Steroids, Inhaled Steroids, Inhaled Beta-Agonists, 2nd Generation Antihistamines

April 28 - ACE Inhibitors, Angiotensin Receptor Antagonists, Beta-Blockers, Calcium Channel Blockers

May 5 - COX-IIs for patients under age 60 only

The enclosed documents have been included for your benefit. We encourage you to keep them available for quick reference.

- The list printed on color paper gives a listing of "preferred" drugs in each category. It has been arranged so you can make it a tri-fold to keep in your pocket.

- A more comprehensive list includes both "preferred" and "non-preferred" products in each class. This can be duplicated and hung on a wall or placed in a binder for reference.

Effective immediately, a new fax number has been implemented for requesting PA. The **new fax number is 1-800-396-4111**. The phone numbers have remained the same:

Technical Calls 1-877-518-1545 PA Requests 1-877-518-1546

These PDL documents can also be found on our website:

<http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm>

If you have additional questions or would like to schedule an educational visit, please call our vendor, First Health Services, at 614-481-3519.

We appreciate your continued support of our efforts to maintain a quality, cost-effective pharmacy program.

MAL 439

Medical Assistance Letter No. 439

January 22, 2003

TO: ALL PROVIDERS OF PHARMACY SERVICES
DIRECTORS, COUNTY DEPARTMENTS OF JOB AND FAMILY SERVICES
DIRECTORS, DISTRICT OFFICES

FROM: THOMAS J. HAYES, DIRECTOR

SUBJECT: PHARMACY PROGRAM UPDATES

For the existing Approved Drug List, Regular Updates, Provider Manual and Pand T Committee Information visit our Website at: <http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm>

ODJFS is beginning the next phase of the pharmacy benefit strategy to ensure quality patient care while reducing the unsustainable expenditure growth of this program. The development of a more refined preferred drug list (PDL) is essential in providing a cost effective, quality health care benefit. The **Preliminary PDL** can be viewed under the "Pharmacy and Therapeutics Committee" link. Watch for details as they develop. This phase of PDL development is scheduled to be completed in April 2003.

As a reminder, the technical help desk at First Health that pharmacists should call when needing assistance is 1-877-518-1545; and the Prior Authorization number that physicians should call at First Health to get an approval for a drug requiring prior authorization is 1-877-518-1546.

MAL 403-C

Medical Assistance Letter No. 403-C

September 9, 2002

TO: ALL PROVIDERS OF PHARMACY SERVICES
DIRECTORS, COUNTY DEPARTMENTS OF JOB AND FAMILY SERVICES
DIRECTORS, DISTRICT OFFICES

FROM: THOMAS J. HAYES, DIRECTOR

SUBJECT: PHARMACY PROGRAM UPDATES

- For information concerning the Approved Drug List, visit our web site at: <http://www.state.oh.us/scripts/odjfs/ohp/formulary/index.asp>
- The following labeler codes are being terminated effective September 30, 2002, as a result of federal initiative.

Labeler Codes Being Terminated Effective September 30, 2002 (result of federal initiative)			
Labeler Code	Labeler	Labeler Code	Labeler
00033	Syntex Laboratories	53124	Praxis Biologics.
00113	Perrigo Company	53404	Vintage Pharmaceuticals, LLC
00268	Center Laboratories	57294	SmithKline Beecham Corporation
00349	ParMed Pharmaceuticals, Inc.	58441	InSource, Inc.
00710	Pfizer Pharmaceuticals Group	58728	Peters Laboratories, Inc.
10797	Luitpold Pharmaceuticals	63254	EM Pharma
50057	Pharmaceutical Ventures, LTD	64909	Zoetica Pharmaceutical Corp.
52446	Qualitest Pharmaceuticals, Inc.		

Labeler Codes Being Terminated Effective September 30, 2002 (result of federal initiative)			
Labeler Code	Labeler	Labeler Code	Labeler
00033	Syntex Laboratories	53124	Praxis Biologics.
00113	Perrigo Company	53404	Vintage Pharmaceuticals, LLC
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00349	ParMed Pharmaceuticals, Inc.	58441	InSource, Inc.
00710	Pfizer Pharmaceuticals Group	58728	Peters Laboratories, Inc.
10797	Luitpold Pharmaceuticals	63254	EM Pharma
50057	Pharmaceutical Ventures, LTD	64909	Zoetica Pharmaceutical Corp.
52446	Qualitest Pharmaceuticals, Inc.		

- The following labeler codes are being terminated effective September 30, 2002, as a result of state initiative:

Labeler Codes Being Terminated Effective September 30, 2002 (result of state initiative)	
Labeler	Labeler

Labeler Codes Being Terminated Effective September 30, 2002 (result of state initiative)	
Labeler	Labeler

Code	
51660	OHM
54022	Vitaline
61748	Versapharm

MAL 436

Medical Assistance Letter No. 436

August 20, 2002

TO: ALL PROVIDERS OF PHARMACY SERVICES
DIRECTORS, COUNTY DEPARTMENTS OF JOB AND FAMILY SERVICES
DIRECTORS, DISTRICT OFFICES

FROM: THOMAS J. HAYES, DIRECTOR

SUBJECT: NEW PHARMACY RULE

Rule 5101:3-9-08 of the Ohio administrative code entitled "Long Term Care Pharmacy Best Practices Management Incentive Payment Program" is a new rule being adopted on an emergency basis on or about August 28, 2002, and proposed for adoption on a permanent basis.

This rule implements a voluntary, two-year program for pharmacy providers serving institutionalized medicaid consumers. This rule is being initiated to test the assumption that incentive based drug utilization management can reduce pharmacy expenditures for medicaid consumers living in nursing facilities and intermediate care facilities for the mentally retarded without compromising patient care.

Eligible pharmacies wishing to participate in this program must fill out and return a participation agreement found in Appendix A of the rule, postmarked no later than September 30, 2002, for participation in program year SFY2003 (July 1, 2002 - June 30, 2003). This participation agreement and the corresponding rule can be viewed at <http://www.state.oh.us/odjfs/OLS/pubhearings>.

Questions on this rule should be addressed to Tammie Stroup at (614) 466-6420.

Medicaid Handbook Transmittal Letters

MHTL 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01)

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-09-02](#) is maintained in the General Information e-book.