



Chapter 11

Pharmacy



INTRODUCTION

The purpose of the pharmacy division is to manage the Medicaid Pharmacy program in the most efficient and comprehensive manner possible by researching, designing and implementing mechanisms to ensure appropriate, cost effective and quality therapy.

PHARMACY POLICY (RULES)

Here is a brief overview of Pharmacy rules**:

- Dispensing limitation: 34 days supply or if on maintenance list up to 100 units.
- Covered Drugs: Must have a Federal Drug Rebate Agreement.
- Excluded Categories: Fertility, cosmetic, weight loss/gain, nutritional supplements.
- Reimbursement - Use the lower of
 - federal upper limit on state maximum allowable cost;
 - EAC (AWP – 12%); or
 - Pharmacy’s Usual & Customary Cost.
- Dispensing Fee – Up to \$4.15.
- Copays:
 - \$1 for ≤ \$30; \$2 for > \$29.99.
 - Copayment is not required of
 - a. members younger than 21 years old;
 - b. members in nursing facilities and intermediate care facilities for the mentally retarded; or
 - c. pregnant women.
 - Copayment is not required for family planning services. Includes all contraceptives and services rendered.

**Pharmacy program rules change frequently. For the most up-to-date SoonerCare Pharmacy program rules, visit the OHCA Web site at <http://www.okhca.org/provider/policy/pdf/lib/chapter30.pdf>.

PRESCRIPTION DRUG BENEFIT

- Six Rxs per month with three brand name drug limit.
- Rxs that don’t count towards perscription limit are HIV antiretrovirals, Chemo, contraceptives.
- Long Term Care – no limit.
- Members under 21 - no limit.
- Waiver Advantage members.
 - Seven extra generics + Therapy Management if more is needed.

PRODUCT BASED PRIOR AUTHORIZATION (PBPA)

This program divides certain therapeutic categories of drugs into two or more levels called “Tiers.” Tier 1 medications are preferred

as the first step for treating a member's health condition. They are cost effective and are available without prior authorization (PA) from the OHCA. Members who do not achieve a clinical success with Tier 1 medications may obtain a Tier 2 or greater medication with a PA. Providers that have members with clinical exceptions may request a PA to skip the step therapy process and immediately receive Tier 2 or greater. For more information, please review the OHCA Web site at <http://www.okhca.org/providers/rx/pa>

DURABLE MEDICAL EQUIPMENT (DME)

The general guidelines concerning the documentation necessary to obtain a prior authorization for DME supplies is located at <http://www.okhca.org/providers/dme/paguidelines>. Please be sure that you use your DME provider number, not your pharmacy provider number, when billing DME claims. DME claims will not process through the pharmacy point-of-sale system. For a list of providers that are willing to bill for DME supplies, go to <http://www.okhca.org/providers/dme/dmeproviders>. If you are not a contracted DME provider and would like to be, please contact provider contracts at 800 522-0114, opt. 5, or download, complete, and return the contract forms to <http://www.okhca.org/providers/enrollment/dme-msc>.

PHARMACY LOCK-IN PROGRAM

When it is decided that a member meets specific criteria and should be placed in the Lock-in program, a pharmacy is assigned to that member and their eligibility file is updated to only pay claims at that pharmacy. Referrals are made to the Lock-In unit by several sources. These include: physicians, pharmacies, caseworkers and OHCA staff. Referrals can be made by phone, online or in writing. Pharmacy help desk technicians review members' claims when assisting callers with claim problems and will turn in any suspicious activity.

Lock-In Decision Process

Once a member is referred to the Lock-in program, the following information is verified and reviewed for each case.

1. Eligibility (members that are not eligible or have Medicare are not reviewed).
2. Medicare eligibility.
3. Paid pharmacy claims for past year.
4. Hospital claims for past year.
5. Full history of diagnosis summary.
6. List of prescriber specialties.

The lock-in process is started if the member meets the required criteria based on this information.

Cases that look questionable but do not fully meet the criteria generally result in a warning letter sent to members or monitoring of members. Warning letters are sent to members explaining that they are being monitored due to a high number of visits to different pharmacies. Cases that receive warnings are reviewed again in six months. If there is no improvement, the members are entered into the Lock-in program. If the behavior improves, the cases are closed. If a decision is made to monitor without a warning, the case is reviewed again in three months and a new decision is made based on behavior pattern.

OBNND's Web site reveals member who paid cash for Controlled substances

Safety Concerns Criteria List

Number of ER visits (3).

Number of different pharmacies (3).

Number of different prescribers/physicians (5) (combined).

Number of days supply of anxiolytics, antidepressants etc.

Diagnosis of drug dependency/ other diagnosis.

Number of hospital discharges (3).

Other information from past reviews.

Who To Call

-OHCA *Main number* - 800-522-0114 or 405-522-6205

-Pharmacy Help Desk, Opt 4 - Mon-Fri (8:30a – 7:00p), Saturday (9am-5pm) and Sunday (11am-5pm)