REVISION DATES: 10/1/2018; 3/22/2018; 2/16/2018; 12/29/2017; 10/13/2015; 05/31/2012

Covered Services

Medically necessary, cost-effective, and CMS Covered Outpatient Drugs prescribed by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner and dispensed by an AHCCCS registered licensed pharmacy are covered for members consistent with 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2 and for persons who have a diagnosis of Serious Mental Illness (SMI), pursuant to A.R.S. §36-550.

The AHCCCS Fee-For-Service (FFS) Acute/LTC Drug List and the AHCCCS FFS TRBHA Drug List contain CMS Covered Outpatient Drugs and medications that are preferred in specific therapeutic drug classes. These drug lists are also known as the AHCCCS FFS Drug Lists. The AHCCCS FFS Drug Lists contain medications that are listed in accordance with the AHCCCS Medical Policy Manual Policy 310-V Prescription Medications / Pharmacy Services.

The AHCCCS FFS Drug Lists are not all-inclusive lists of medications for AHCCCS members. Drug coverage includes all medically necessary, clinically appropriate, and cost-effective medications that are CMS Covered Outpatient Drugs, regardless of whether or not these medications are included on these lists.

Questions regarding pharmacy benefits and services may be directed to the AHCCCS Director of Pharmacy Services Program Administrator at (602) 417-4726 or to the Pharmacy Department's email at AHCCCSPharmacyDept@azahcccs.gov

Specific Parameters of the AHCCCS Pharmacy Benefit

The AHCCCS Pharmacy Program and its Pharmacy Benefit Manager (PBM):

1. Shall utilize a mandatory generic drug substitution policy unless AHCCCS has required the use of a brand name medication. The substitution of a generic drug in place of a brand name drug is required if the generic drug is available and contains the same active ingredient(s) and both products, the brand name and generic, are chemically identical in strength, dosage form and route of administration. Generic substitutions shall adhere to Arizona State Board of Pharmacy rules and regulations.

   Exceptions to this policy include:

   a. Members intolerant to a generic medication. The prescribing clinician shall submit a prior authorization request, providing clinical justification for the brand name medication, to the contracted PBM; and

b. AHCCCS has determined that the brand name medication is less costly to the program.

2. May utilize step therapy to ensure that the most clinically appropriate cost-effective drug is prescribed and tried by the member prior to prescribing a more costly clinically appropriate medication.

   Exceptions to this requirement include members enrolled in an AHCCCS Complete Care (ACC) health plan, who have been stabilized on a medication and are transitioning from a T/RBHA to a PCP for their behavioral health needs. The medication, prescribed by the behavioral health practitioner must be clinically appropriate and continued at the point of transition.

3. May utilize prior authorization to ensure clinically appropriate medication use. Requests submitted for prior authorization of a medication must be evaluated for clinical appropriateness based on the strength of the scientific evidence and standards of practice that include, but are not limited to, the following:

   a. Food and Drug Administration (FDA) approved indications and limits;
   b. Published practice guidelines and treatment protocols;
   c. Comparative data evaluating the efficacy, type and frequency of side effects, and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes;
   d. Member adherence impact;
   e. Drug Facts and Comparisons;
   f. American Hospital Formulary Service Drug Information;
   g. United States Pharmacopieia;
   h. DRUGDEX Information System;
   i. UpToDate;
   j. MicroMedex;
   k. Peer reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies; and
   l. Other reference sources.

All CMS Covered Outpatient Drugs that are not listed on the AHCCCS FFS Drug Lists may be eligible for coverage through the prior authorization process.

Prescribers may submit a prior authorization request to the AHCCCS FFS PBM, OptumRx, for review and coverage determination. The Prior Authorization Form can be found in:

- The FFS Provider Billing Manual as Exhibit 12-1 under the Pharmacy Services chapter.
- The IHS/Tribal Provider Billing Manual as Exhibit 10-1 under the Pharmacy Services chapter.

The PA form is also available on the AHCCCS website at www.azahccc.gov under the American Indian Section. Under this section click on Pharmacy and then go to Pharmacy Member Information-American Indian Health Program and the Drug Prior Authorization Form is listed under this section.

4. May cover an over-the-counter medication under the pharmacy benefit when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication.

5. Allows CMS Covered Outpatient Drugs dispensed by an IHS/638 facility pharmacy and submitted to the AHCCCS Administration for reimbursement at the All Inclusive Rate (AIR) to not be subject to prior authorization.

AHCCCS Pharmacy Benefit Exclusions

The following are excluded from coverage under the outpatient FFS pharmacy benefit:

1. DESI Drugs that are determined to be “less than fully effective” by the Food and Drug Administration;
2. Experimental/Research Drugs;
3. Cosmetic Drugs;
4. Cosmetic Drugs for Hair Growth;
5. Nutritional/Diet Supplements;
6. Blood and Blood Plasma Products;
7. Drugs and Products to Promote Fertility;
8. Drugs used for Erectile Dysfunction Drugs;
9. Drugs from manufacturers that do not participate in the FFS Medicaid Drug Rebate Program;
10. Diagnostic /Medical Supplies except:
    a. Syringes
    b. Needles
    c. Lancets
    d. Alcohol Swabs
    e. Blood Glucose Meters and Test Strips
    f. Inhaler Sprays
11. Intrauterine Devices

Pharmacy Drug Coverage Limitations

1. A new prescription or refill prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater;
   b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater; or
   c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies as outlined in AMPM 310-DD.
3. AHCCCS covers the following for AHCCCS members who are eligible to receive Medicare:
   a. Over the counter medications that are not covered as part of the Medicare Part D prescription drug program when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication; and
   b. A drug that is excluded from coverage under Medicare Part D by CMS and the drug is medically necessary and federally and state reimbursable.
4. Drugs personally dispensed by a physician or dentist, or other authorized prescriber are not covered. Exceptions may be granted upon application and approval by AHCCCS for registration as a pharmacy provider in geographically remote areas where there is no participating pharmacy.

AHCCCS Pharmacy Benefit Manager (PBM)

All FFS network pharmacy and KidsCare prescription claims must be submitted electronically at the point-of-sale to the AHCCCS FFS PBM, OptumRx.

The OptumRx Help Desk is available 24 hours per day and 365 days per year. For information or assistance with prescription claims, prior authorization, contracted network pharmacies, or the AHCCCS FFS Drug List, please contact the OptumRx Customer Service Help Desk at (855) 577-6310.

The OptumRx Prior Authorization Department's hours of operation are:

Monday through Friday: 7:00 AM – 6:00 PM Central Standard Time
Saturday: 8:00 AM – 4:30 PM Central Standard Time

For assistance with online claim submissions, contact the OptumRx Customer Service Help Desk at 855-577-6310.

Some medications on the AHCCCS Drug List require prior authorization approval from OptumRx. If a prescription claim rejects at the point-of-sale for "NDC Not Covered" or "Prior Authorization Required," the pharmacist should contact the prescribing clinician to request an alternative on the AHCCCS FFS Drug List. If there is not an available alternative medication, the pharmacist should inform the prescriber that a prior authorization request for the medication must be submitted to the PBM for review.

- All prior authorization requests must be submitted by the prescribing clinician to OptumRx.
- The OptumRx PA Request Form (See Exhibit 12-1) is to be faxed to **866-463-4838**.
- Prior Authorizations may be faxed 24 hours per day, 7 days per week, and 365 days per year.

After Hours PBM Instructions

After 5:00 p.m. on weekdays, on weekends, and holidays, please contact the OptumRx Customer Service Desk, at (855) 577-6310 for an override if the medication is for:

- A hospital discharge;
- Members transitioning from one level of care to another;
- Urgent care or emergency room prescriptions; and
- Other emergent situations.

Return of and Credit for Unused Medications

The AHCCCS FFS Program and its Contractors shall require the return of unused medications to the outpatient pharmacy from nursing facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge or death of a Medicaid member. A payment credit shall be issued for unused prescription medications by the outpatient pharmacy to the AHCCCS FFS PBM or the appropriate Contractor. The pharmacy may charge a reasonable restocking fee as agreed upon with the AHCCCS FFS Program and/or its PBM.

The return of unused prescription medication shall be in accordance with Federal and State laws. Arizona Administrative Code (A.A.C. R4-23-409) allows for this type of return and the redistribution of medications under certain circumstances.

Documentation must be maintained and must include the quantity of medication dispensed and utilized by the member. A credit must be issued to AHCCCS when the unused medication is returned to the pharmacy for redistribution.

Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications shall not be billed to AHCCCS. A.A.C. R9-22-209(C) provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician-administered drug is not covered because it's not medically necessary or prescribed.

A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

Prior Authorization Protocol for Smoking Cessation Aids

AHCCCS has established a prior authorization protocol for smoking cessation aids. Please refer to the AHCCCS Medical Policy Manual (AMPM) Policy 320-K, Tobacco Cessation Product Policy for additional information.

Vaccines and Emergency Medications Administered by Pharmacists

AHCCCS covers vaccines and emergency medication for adults without a prescription order when administered by a pharmacist, who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law A.R.S §32-1974.

IHS and 638 Pharmacies may bill the outpatient AIR one time which includes the vaccine and the administration of the vaccine.

For purposes of this section "Emergency Medication" means emergency epinephrine and diphenhydramine. "Vaccines" are limited to AHCCCS covered vaccines for adults as noted in the AHCCCS Medical Policy Manual (AMPM) Policy 310-M, Immunizations.

In addition to the requirements specified in A.R.S. § 32-1974, AHCCCS requires the following:

1. The pharmacy providing the vaccine must be an AHCCCS registered provider;
2. IHS and 638 Pharmacies must be registered with AHCCCS; and

3. The AHCCCS member receiving the vaccine must be age 19 years or older.

Prior Authorization Criteria for Direct Acting Antiviral Treatment for Hepatitis C

AHCCCS has established a prior authorization protocol for direct acting antiviral treatment for Hepatitis C. Refer to the AHCCCS Medical Policy Manual (AMPM) Policy 320-N, Hepatitis C (HCV) Prior Authorization Requirements for Direct Acting Antiviral Medication Treatment for further information.

Billing for Pharmacy Services

Prescription medications may be reimbursed by the AHCCCS Administration or the Fee-For-Service (FFS) Pharmacy Benefit Manager (PBM), OptumRx, depending upon the member's enrollment and filling pharmacy, which are detailed in the table below:

Program/Member Type	Enrollment in AIHP, AHCCCS Complete Care (ACC), Kidscare or TRBHA	Pharmacy Dispensing Medication	Claims Shall Be Submitted To:
Title XIX Members	AIHP, ACC and TRBHA	IHS/638 Pharmacies	AHCCCS Administration
Title XIX & XXI Members	AIHP and TRBHA	Non-IHS/638 PBM Network Pharmacies	FFS PBM - OptumRx
Title XIX & XXI Members	ACC	Non-IHS/638 PBM Network Pharmacies	The ACC Plan's PBM
Title XXI Members	Kidscare members enrolled in AIHP & TRBHA	All IHS/638 and non-IHS/638 PBM Network Pharmacies	FFS PBM – Optum Rx

The AIR may be billed for adults 19 years of age and older, when a prescription is filled at an IHS/638 facility pharmacy. The AIR for prescription services may be billed once daily, per member, per facility pharmacy. Up to five AIRs may be billed daily, per member, per facility and they must be qualifying non-duplicative visits.

In a case where more than one prescription is prescribed and filled on the same day, at the same facility, for the same member, the NDC codes for all of the filled prescriptions must be

included on that day's claim submission for the AIR, however, only one AIR shall be reimbursed.

Example: A member is seen at an IHS 638 facility and has a dental visit, a PCP visit, and is prescribed 1 medication during the dental visit for pain and 2 medications during the PCP visit. All visits occur at the same IHS 638 facility. The member has all 3 prescriptions filled on the same day.

In this scenario three AIRs may be billed for reimbursement. One AIR may be billed for each of the following:

- The dental visit;
- The PCP visit; and
- All 3 prescriptions.

The claim submitted for the three prescriptions must include all 3 NDC codes.

All Inclusive Rate (AIR) Claims Billing Specifications for Title XIX AHCCCS Members

IHS/638 pharmacies dispensing and billing prescription claims at the All Inclusive Rate (AIR) for Title XIX members shall submit prescription claims to the AHCCCS Administration on the UB-04 claim form (or 837I for electronic claims) or shall submit via the AHCCCS website. The claim form shall:

- Use revenue code 519 (Other Clinic).
- Enter the outpatient All Inclusive Rate (AIR) on the first service line of the claim (0519).
  Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge).
- Include the AIR in the Total Charges field (Field 47), on the 0001 line.

The AHCCCS Claims System will reimburse the pharmacy claim at the outpatient AIR rate.

All Inclusive Rate Claims Billing for Title XIX Dual Eligible Members

The All Inclusive Rate may be billed for Dual Eligibles, members that are enrolled in AHCCCS under Title XIX and also eligible for Medicare, for prescription claims when:

a. The medication is listed on the AHCCCS FFS Dual Eligible Drug List; and
b. The medication is excluded from coverage under Medicare Part D by CMS and the drug is medically necessary and federally and state reimbursable.

The AIR may be billed for Dual Eligibles for Medicare Part B drugs when the claim is submitted from IHS/638 Pharmacy requesting reimbursement as the secondary payer.

a. The Medicare Part B EOMB must be submitted with the claim that is submitted to the AHCCCS Administration for reimbursement.

The AIR shall not be reimbursed for:

a. Medications eligible for coverage under Medicare Part D.
b. Part B covered drugs, devices and syringes when they are not billed as a secondary claim for payer reimbursement.
c. Medicare Part D or Medicare Part B drugs, devices, and syringes when the member is eligible for Medicare and the member has opted out of Medicare Part D and/or Medicare Part B enrollment.

Claims for Title XXI KidsCare Members

Pharmacy claims for Title XXI (KidsCare) Members must be submitted to OptumRx, the FFS PBM, as described in this chapter.

KidsCare claims are not eligible for reimbursement at the All Inclusive Rate.

340B Reimbursement

A.R.S. §36-2930.03 requires:
1. 340B covered entities to submit AHCCCS Member point-of-sale prescription and physician-administered drug claims, that are identified on the 340B pricing file, whether or not the drugs are purchased under the 340B drug pricing program at the lesser of:
a. The actual acquisition cost, or
b. The 340B ceiling price.

2. Drugs dispensed to AHCCCS members by a 340B covered entity pharmacy shall be reimbursed a professional fee.

3. Drugs administered to AHCCCS members by a 340B covered entity provider shall not be reimbursed a professional fee.

4. The administration and its contractors shall not reimburse 340B Contracted Pharmacies for drugs that are purchased, dispensed or administered as part of or subject to the 340B drug pricing program.

Licensed hospitals and outpatient facilities that are owned or operated by a licensed hospital are excluded from this statute.
For additional details on claim submission and reimbursement refer to A.R.S. §36-2930.03

A.A.C. R-9-22-710(C) describes the reimbursement methodology to be used by AHCCCS and its Contractors for Federally Qualified Health Center (FQHC) and FQHC Look-Alike Pharmacies for 340B drugs as well as reimbursement for Contract Pharmacies that have entered into a 340B drug purchasing arrangement with any 340B entity. The Rule also specifies reimbursement for FQHC and FQHC Look-Alike Pharmacies for drugs, which are not part of the 340B Drug Pricing program. The rule is located on the A.A.C. R9-22-709.

Behavioral Health Medication Coverage

For information about prescription medication coverage for behavioral health please refer to the AMPM 310-V, Prescription Medications-Pharmacy Services, Section C.

Medication Prescribing for Opioid Use Disorder

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

The AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat Opioid Use Disorder (OUD). For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

For further information regarding MAT please refer to AMPM 510, Primary Care Providers.

REFERENCES

- The AHCCCS Medical Policy Manual (AMPM) can be found at https://www.azahcccs.gov/shared/MedicalPolicyManual/.
- Refer to AMPM 310-V Prescription Medications/Pharmacy Services for further information about pharmacy coverage.
- Refer to AMPM-510 Primary Care Providers for further information about Opioid Use Disorders and Medication Assisted Treatments.
- Refer to AMPM Policy 320-K, Tobacco Cessation Product Policy for further information about smoking cessation aids.
- Refer to AMPM 320-N, Hepatitis C (HCV) Prior Authorization Requirements for Direct Acting Antiviral Medication Treatment for further information about Direct Acting Antiviral Medication Treatments for Hepatitis C.
- Refer to AMPM Policy 320-M, Medical Marijuana for further information on medical marijuana.
- Section 1903(i)(10) of the Social Security Act as amended by Section 6033 of the Deficit Reduction Act of 2005
- Center for Medicare and Medicaid Services (CMS) State Medicaid Director Letter dated March 22, 2006
- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 1860D-2(e)(2)(A) as amended by Section 175.
- Arizona Revised Statute § 32-1974
- Arizona Administrative Code R-9-22-710

REVISION HISTORY

Date	Description of changes	Page(s)
10/1/18	Clarification added to the Covered Services section. • "Federally and state reimbursable medications" changed to "CMS Covered Outpatient Drugs." 1 • Added: "The AHCCCS Fee-For-Service (FFS) Acute/LTC Drug List and the AHCCCS FFS TRBHA Drug List contain CMS Covered Outpatient Drugs and medications that are preferred in specific therapeutic drug classes." The Specific Parameters of the AHCCCS Pharmacy Benefit section was updated. • "Managed care" changed to "AHCCCS Complete Care health plan." • "…and members who are being treated for anxiety, depression, ADHD and/or OUD" was removed. Clarification added to the Vaccines and Emergency Medications Administered by Pharmacists section. The Billing for Pharmacy Services grid has been updated to include information about where claims should be submitted for Title XIX and XXI members.	1 2 6 7
3/22/18	The FFS Pharmacy Exclusions section has been updated	3
2/16/18	Billing for Pharmacy Services grid added AIR Claims Billing Specifications for Title XIX Members section added AIR Claims Billing for Title XIX Dual Eligible Members section updated AIR Claims Billing Specifications for Title XXI Members section added Pharmacy department updates General formatting	7 8 8-9 9 All All
1/1/2018	Prior Authorization Criteria for Direct Acting Antiviral Treatment for Hepatitis C Section/Reference Added Behavioral Health Medication Coverage Section/Reference Added Medication Assisted Treatment (MAT) for the Treatment of OUD Section Added References Updated General formatting Updating of phone numbers and links	7 9 9-10 10 All All
10/13/2015	New formatting;	

	New PBM vendor effective 10/01/2015 New Exhibit 10-1 OptumRX Prior Authorization Form	All & Exh 10-1
12/31/2012	Section title alpha corrections	All
10/01/2012	New PBM vendor – MedImpact effective 10/01/2012	All