TEXAS
Health and Human Services

Texas Vendor Drug Program
Pharmacy Provider Procedure Manual

Drug Policy

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1 Drug Coverage

VDP maintains the Texas Drug Code Index (TDCI), or formulary, which includes program-specific drug lists for:

- Medicaid
- Children's Health Insurance Program (CHIP)
- Children with Special Health Care Needs (CSHCN) Services Program
- Healthy Texas Women (HTW) Program
- Kidney Health Care (KHC) Program

MCO must adhere to the Medicaid and CHIP formularies.

Texas HHSC requires drug manufacturers to complete the ***Texas Drug Code Index Certification of Information*** (HHS Form 1326) to request the addition of drugs and products to the formulary. The request is for addition to the Medicaid formulary only. Manufacturers do not request addition to the CHIP, CSHCN, HTW, or KHC Programs.

Drugs classified with Drug Efficacy Study Implementation (DESI) values "5" or "6" are not covered.

2 Claim Requirements

2.1 Drug Format

Pharmacy claims are submitted with the following fields:

- 11-digit National Drug Code (NDC) in the "Product/Service ID" field (4Ø7-D7)
- '03' in the "Product/Service ID Qualifier" field (436-E1)

The NDC number submitted on the claim transaction must match the NDC number on the package or container dispensed

The 11-digit NDC number is composed of three segments:

- Labeler: 5-digit code assigned by the Food and Drug Administration (FDA) and identifies the drug manufacturer

- Product: 4-digit code assigned by the drug manufacturer and identifies the specific product
- Package: 2-digit code assigned by the manufacturer and identifies the package size

The correct format for pharmacy claim submission is an 11-digit number in a 5-4-2 format. Pharmacy staff must convert any other number, such as a 10-digit number in the 4-4-2, 5-3-2, or 5-4-1 format, before submittal. To correct the NDC place a leading zero (Ø) in either the labeler code, product code, or package size code to conform to the 5-4-2 format.

Refer to the "Multi-ingredient Compounds" section of the ***System Requirements*** chapter of this manual for instructions on how to identify the NDC on a multi-ingredient compounds claim.

2.2 Drug Unit of Measure

Pharmacy claims are submitted with billing units in the "Unit of Measure" field (6ØØ-28):

- Each (EA), used when the product is dispensed in discreet units
- Gram (GM), used when a product is measured by its weight
- Milliliter (ML), used when a product is measured by its liquid volume

Pharmacy staff should be aware of the correct billing units on certain medications to alleviate billing discrepancies, which can lead to potential audit risks. Quantity for milliliters and grams must be divisible by package size. Some products (such as Risperdal Consta, Humira, Enbrel, Lovenox, Neupogen, Pegasys, and Procrit) may have varying units depending on the NDC number.

Refer to the ***NCPDP B1 Transaction Payer Sheet*** for the acceptable unit of measure values on a single ingredient and multi-ingredient compound claim. Download the payer sheets from txvendordrug.com/about/manual/payer-sheets.

2.3 Day Supply

Pharmacy claims are submitted with the number of consecutive days covered by the prescription in the "Days Supply" field (4Ø5-D5). Incorrect reporting in this field may impact early refill edits or inaccurate drug use review warnings.

Pharmacy staff should divide the quantity by total dosage units per day to identify the correct day supply.

Table 1 - Maximum Days Supply By Program

Program	Maximum Day Supply
Medicaid	185 days
CHIP	Up to a 90 day supply
CSHCN	185 days
KHC	34 days unless Medicare is the primary payer; KHC will pay for a 90-day supply if Medicare allows a 90-day supply

2.4 Quantity Dispensed

Pharmacy claims are submitted with the amount dispensed by the pharmacy at point-of-sale in the "Quantity Dispensed" field (442-E7). Pharmacy staff must dispense the quantity prescribed or ordered by the prescribing provider except as limited by the policies and procedures described in this manual. When the actual quantity dispensed deviates from the prescribed quantity, pharmacy staff must submit for the amount dispensed. Incorrect reporting in this field may prompt drug companies to dispute the claim and cause rebate auditors to review the claim level data.

Drugs such as ear drops, eye drops or ointments, inhalers, and injectable products are packaged in sizes without a whole number. When submitting a claim for a drug packaged in a metric decimal-sized package (e.g. 10.2; 2.5; etc.), pharmacy staff should include the decimals on the claim and not round up.

Contact your software vendor for assistance with issues resolving whole number units on the package size and submitting decimal units.

2.5 Dispense as Written

Pharmacy staff must submit a value "1" in the "Dispense as Written (DAW) / Product Selection code" field (4Ø8-D8) when a prescribing provider wants a non-preferred brand name dispensed and hand writes the phrase "Brand Necessary," "Brand Medically Necessary," "Brand Name Necessary," or "Brand Name Medically Necessary" across the face of the prescription. The value of “1” will reimburse at the normal calculated cost, including comparison to the submitted "Usual and Customary Charge" and "Gross Amount Due" fields. The value of “1” is not needed if the brand drug prescribed has preferred status on the Texas Medicaid Preferred Drug List.

If an e-prescription is received by a pharmacy with “dispense as written” indicated but without the free text message ("Brand Medically Necessary") or additional note,

pharmacy staff must contact the prescriber for a new prescription. Submit the claim once the pharmacy receives the e-prescription with both data elements.

Failure of the pharmacy to produce electronic records indicating the proper DAW and “Brand Medically Necessary” in the free-text message for the prescription will result in the claim subject to recoupment. All non-electronic “Brand Medically Prescriptions” (for controlled and non-controlled substances), must continue to comply with current policy and Texas State Board of Pharmacy (TSBP) rules.

2.6 Prescription Splitting

The same drug in the same strength should be dispensed no more than once per month, per person. An exception to this is only for medications considered too unstable to be dispensed as a one-month supply. Pharmacies not compliant with this policy may be referred to the Texas HHS Office of Inspector General.

3 Claim Limitations

This section identifies claim limitations for claims processed by VDP (for traditional Medicaid, CSHCN, HTW, and KHC programs) or by the managed care organization. If no guidance is given for MCO processing, contact the MCO for plan-specific limitations.

3.1 Prescription Limits

3.1.1 Medicaid

People enrolled in Medicaid are limited to three (3) prescriptions per month except for:

- Children under the age of 21
- People enrolled in managed care
- People enrolled in eligibility waiver programs

Drugs and products not counted as part of the three-prescription limit include:

- Family planning drugs
- Flu vaccines
- Opioids for acute pain
- Diabetic supplies

- Smoking cessation products
- Home health supplies
    - Refer to the ***Home Health Supplies*** chapter of this manual for more information about these products
- Mosquito repellents
    - Refer to the ***Mosquito Repellant*** chapter of this manual for a list of these products

3.1.1.1 Medicaid

Payment for up to a six-month supply may be allowed for adults with monthly prescription limitations dependent on the drug prescribed. Quantities should not exceed a one-month (34-day) supply for people with an unlimited number of prescriptions per month.

3.1.2 CHIP

People enrolled in CHIP have unlimited prescriptions.

3.1.3 CSHCN

People enrolled in the CSHCN Services Program have unlimited prescriptions. The CSHCN Program is limited by the availability of appropriated funds. Upon notification to eligible people and providers, services may be adjusted periodically depending upon the current availability of funds. If a person is dually-enrolled in Medicaid and CSHCN, the Medicaid benefit should be used first, including those people limited to 3 prescriptions per month.

3.1.4 KHC

The KHC program limits people to four (4) prescriptions per month. The number of prescriptions per month the program pays per person is based on available KHC funds, and the number of prescriptions covered may change depending on budget limitations. Notification will be sent 30 days in advance if the prescription number limitation changes.

3.2 Refill Limitations

Prescription refills are allowed based on the drug schedule outlined in Table 2.

Table 2 - Refill Limitations

DEA Schedule	Refill Limitations
No schedule	Original prescription plus 11 refills within 365 days from the date the original prescription was written.
Schedule 2	No refills
Schedule 3, 4, 5	Original prescription plus 5 refills within 185 days from the date the original prescription was written.

3.3 Refill Authorization

Refills may only be submitted when requested by the individual. Pharmacy staff must not bill Medicaid unless the person has requested the refill. This includes pharmacies using automated refill systems.

3.4 Partial Fills

No partial fill processing is allowed.

3.5 Refill Utilization

A refill is considered too soon, or early, if the person has not used at least 75% of the previous fill of the medication.

3.5.1 Traditional Medicaid & CSHCN

A refill for certain controlled substances, such as tramadol, is considered too soon if the person has not used at least 90% of the previous fill of the medication. Attention deficit hyperactivity disorder drugs and certain seizure medications are excluded from this requirement.

Refer to the **Formulary search** at txvendordrug.com/formulary/formulary-search, and select the "90% Utilization" filter to identify these drugs (also see section 4 below).

Claims not meeting the utilization threshold will reject with error code 79. A previous fill may have been from a different pharmacy.

3.5.2 Refill Too Soon Overrides

3.5.2.1 Vendor Drug Program

Contact the Pharmacy Benefits Access Help Desk to request an override. Justifications for an override may include a verifiable dosage increase or anticipated

prolonged absences from the state. Prescribing providers may be asked to verify the reason for the early refill by the pharmacy.

3.5.2.2 Managed care

Contact the MCO for specific requirements and processes related to dispensing early refills.

3.6 Dollar Limits

3.6.1 Vendor Drug Program

Claims are limited to $9,999.99. Contact the Pharmacy Benefits Access Help Desk for assistance with claims $10,000.00 and greater.

4 Formulary Search

The VDP formulary search at txvendordrug.com/formulary/formulary-search identifies drug coverage and pricing information. There are two separate searches, one for drugs and one for products including home health supplies and vitamins and minerals. Users enter a combination of the following:

- Brand or generic name of the product
- 11-digit NDC
- Preferred drug class
- Home health supply description

Additional filters are available:

- Search by a program (Medicaid, CHIP, CSHCN, HTW, or KHC)
- Drugs requiring non-preferred or clinical prior authorization
- Family planning drugs
- Drugs requiring 90% use before a refill
- Over the counter drugs
- Drugs identified as long-acting reversible contraception products
- Products designated as diabetic supplies

- Products designated as mosquito repellents

The search is updated once a week. Drugs removed from the formulary will show a termination date but remain on the search for 90 days.

5 Shortage

HHSC encourages pharmacy staff to notify Texas HHS about potential drug shortages impacting prescribing choice and pharmacy claim processing using the ***Drug Shortage Notification*** (HHSC Form 1315). The state encourages reporting of significant drug shortages affecting multiple pharmacies and distributors which will have a continuing adverse impact on people enrolled in Medicaid if not resolved promptly. Download the form from txvendordrug.com/resources/downloads.

The process ensures notification of alternatives to the shorted drug, the timeline of the shortage, and the drug's availability for use. Requestors should provide as much of the following information on the form, including:

- Reason for reporting the shortage
- The extent of shortage, if known
- Estimated length of issue timeline
- Product status change
- Change in status requiring new application or NDC change
- Alternatives
    - Published notices or resources (such as FDA, American Society of Health-System Pharmacists, etc.)

Referrals should recommend an alternative with a supply chain so extra demand will not cause another shortage.

6 Drug-Specific Requirements

This section identifies certain drug requirements for claims processed by Texas HHS (for traditional Medicaid, CSHCN, HTW, and KHC programs) or by MCOs. If no guidance is given for MCO processing, then the pharmacy staff should contact the MCO for claim submission requirements.

6.1 Anorexic Products

6.1.1 Vendor Drug Program

Prior approval is required for ages 21 years and over. Weight management diagnoses will be denied. Claims will reject with NCPDP error code 75 and include the message “Prior Authorization not on file. Contact Pharmacy Benefits Access” in the “Additional Message Information” field (526-FQ). VDP clinician staff determine coverage, and no form is required.

6.2 Anti-Fungal Products

6.2.1 Vendor Drug Program

6.2.1.1 Medicaid

People are limited to a 180-day supply per calendar year. Claims will reject with error code “76” and the message "Days Supply Limited per Year by Program. Contact Pharmacy Benefits Access" in the “Additional Message Information” field (526-FQ). VDP clinician staff determine coverage, and no form is required.

6.3 Biosynthetic Growth Hormone Products

6.3.1 Vendor Drug Program

6.3.1.1 Medicaid

Prior approval and documentation of appropriate diagnoses are required. Prior authorization criteria are available at txvendordrug.com/formulary/prior-authorization/ffs-clinical-pa. Refer to the "Pharmacy Prior Authorization" section of the ***Contact Information*** chapter of this manual to contact the Texas Prior Authorization Call Center.

6.3.1.2 CSHCN Services Program

Prior approval and documentation of appropriate diagnoses are required.

Prescribing providers complete the ***Growth Hormone Products Authorization Request*** (HHS Form 1312) and submit for review.

6.4 Blood Factor Products

6.4.1 Vendor Drug Program

6.4.1.1 Medicaid

Pharmacy staff must submit one compound claim when the drugs are of the same active ingredient, from the same drug manufacturer, and are the same drug formulation, intended for use together with each dose. The multi-ingredient compound claim should contain one line-item per NDC. Refer to the ***System Requirements*** chapter of this manual for claim submission requirements for multi-ingredient compounds.

6.4.1.2 CSHCN Services Program

Products are covered and used in the treatment of hemophilia. Claims are processed and paid by the TMHP.

6.5 Compound-only Products

6.5.1 Vendor Drug Program

Some drugs are only payable when submitted as part of a multi-ingredient compound claim. After searching for a drug using the website formulary search (section 4 above), refer to the drug details page and locate the "Compound-only Use by Program" segment. Not all drugs in a multi-ingredient compound claim are payable. Refer to the ***System Requirements*** chapter of this manual for instruction on how to receive payment for non-covered products part of a multi-ingredient compound claim.

6.6 Cough and Cold Products

Cough and cold combination products for children less than 2 years of age are not covered. This excludes single entity antihistamines. Other uses of cough and cold products for children less than 6 years of age are subject to clinical prior authorization. Products containing acetaminophen, ibuprofen, or narcotics for children less than 6 years of age are not covered.

Products require prior authorization if the product is not indicated for the person's age. Products containing a narcotic will require prior authorization if a child is between 6 and 12 years of age.

6.7 Cystic Fibrosis Treatment Products

6.7.1 Vendor Drug Program

6.7.1.1 Medicaid

Claims for Orkambi require clinical prior authorization. Refer to the Cystic Fibrosis Agents criteria at txvendordrug.com/formulary/prior-authorization/ffs-clinical-pa.

6.7.1.2 CSHCN Services Program

Claims for Cayston, Kalydeco, Pulmozyme, and inhaled tobramycin require prior authorization with documentation of appropriate diagnosis required.

Prescribing providers complete the ***Cystic Fibrosis Treatment Products Authorization Request*** (HHS Form 1143) and submit for review.

Pharmacy staff can perform an E1 eligibility verification transaction to find a person's most current period of approval for Tobramycin.

- Refer to the ***System Requirements*** chapter of this manual for information about claim transactions.
- Refer to the "Field Responses for an Accepted Eligibility Verification" in the ***NCPDP E1 Transaction Payer Sheet*** for further explanation about the response. Download the payer sheets from txvendordrug.com/about/manual/payer-sheets.

6.7.2 Managed care

The Orkambi clinical prior authorization is required. The Kalydeco clinical prior authorization is optional. Refer to the Cystic Fibrosis Agents criteria at txvendordrug.com/formulary/prior-authorization/mco-clinical-pa.

6.8 Enzyme Replacement Therapy Products

6.8.1 Vendor Drug Program

6.8.1.1 CSHCN Services Program

Claims will reject with NCPDP error code "75" and the message "Prior Authorization not on file. Contact Pharmacy Benefits Access" in the "Additional Message Information" field (526-FQ).

6.9 Erectile Dysfunction Products

Erectile dysfunction drugs are not a covered benefit of any program.

6.10 Family Planning Products

6.10.1 Vendor Drug Program

6.10.1.1 Medicaid

Certain family planning drugs are covered and do not count towards a person's three prescription-per-month limitation.

Refer to the website formulary search (section 4 above) and select the "Family Planning" filter to identify these drugs.

6.10.1.2 CSHCN Services Program

The prescribing physician must compose a letter of medical necessity (LMN) on office stationery. Pharmacy staff must submit the LMN by fax to the CSHCN Service Program.

6.10.2 Managed Care

6.10.2.1 CHIP

CHIP covers birth control for certain diagnoses. Contraceptives are only covered for non-contraceptive medical purposes. Contact the MCO for claim submission requirements.

6.11 Human Immunodeficiency Virus Products

6.11.1 CSHCN Services Program

CSHCN allows 60 days of drug coverage with prior authorization. Contact CSHCN to receive prior authorization. The 60-day timeframe provides coverage while the person enrolls and receives approval or denial from the Texas HIV Medications Program. Contact the Texas HIV Medication Program at 1-800-255-1090 or online at dshs.texas.gov/hivstd/meds/.

If the person is not eligible for the HIV program, the medications may be an ongoing benefit through the CSHCN Services Program if the person remains eligible.

6.12 Insulin and Insulin Syringes

6.12.1 Vendor Drug Program

6.12.1.1 Medicaid

Insulin syringes are a benefit only when the syringes are for insulin use. Insulin syringes prescribed for other injectable drugs should be billed as a Medical benefit through TMHP. Only the insulin counts toward the person's prescription-per-month

limit. The pharmacy may submit claims for insulin with a day supply based on stability rather than the actual dose.

6.12.1.2 KHC Program

Prescriptions for syringes and home health supplies count toward the KHC 4-prescription-per-month limit.

6.13 Influenza Vaccine

Refer to the **Formulary search** at txvendordrug.com/formulary/formulary-search, to identify these products (also see section 4 above).

6.13.1 Vendor Drug Program

Texas Medicaid considers the influenza season in the United States to be October through the end of May. Beginning Sept. 1, 2019, individual pharmacists may administer flu vaccines to people age seven and older in a pharmacy setting. The individual pharmacist administering the vaccine does not have to enroll with TMHP but must follow the TSBP rules related to certification to immunize and vaccinate

- *Refer to 22 TAC Section 295.15 (Administration of Immunizations or Vaccinations by a Pharmacist under Written Protocol of Physician)*

Administering Pharmacists are health care professionals licensed by the TSBP to practice as a pharmacist, have met and maintained the eligibility requirements outlined in law, and who have been certified by the TSBP to administer vaccines.

Administering pharmacists are under the supervision of a physician under Texas law. Pharmacists may administer immunizations or vaccinations only under a physician's written protocol authorizing the administration. Pharmacists are employed and remunerated by a pharmacy for their services. If the services are covered and reimbursable by the program, payment may be made to the pharmacy employing the licensed pharmacist.

6.13.2 Managed care

6.13.2.1 Medicaid and CHIP

During influenza season MCOs are required to allow pharmacies to bill for influenza vaccines provided to people aged seven and older in a pharmacy setting. MCOs must cover all influenza vaccines available on the Medicaid and CHIP formularies as part of the pharmacy benefit.

MCOs must reimburse pharmacies for the ingredient cost and applicable administration fees for flu vaccines.

Refer to the **Pharmacy MCO Assistance Chart** from the "Downloads" page at txvendordrug.com/resources/downloads for the pharmacy call center phone numbers for each MCO.

6.14 Long-Acting Injectables

Refer to the **Formulary search** at txvendordrug.com/formulary/formulary-search to identify drugs eligible for administration in a pharmacy (also see section 4 above).

6.14.1 Vendor Drug Program

6.14.1.1 Medicaid

Pharmacists may administer long-acting injectables (LAIs) in a pharmacy setting for people in Medicaid with a valid prescription. Individual pharmacists can administer medications under a physician's written protocol as authorized by state law.

- *Refer to Section 157.002 (General Delegation Of Administration And Provision Of Dangerous Drugs) of Texas Government Code. Refer to Texas Government Code at txvendordrug.com/about/rules/texas-government-code.*

The pharmacy, not the individual pharmacist, submits claims for these services using the standard pharmacy claim transaction and is reimbursed for an ingredient cost, dispensing fee, and administration fee for each LAI claim processed.

Refer to the ***NCPDP B1 Transaction Payer Sheet*** for the acceptable fields. Download the payer sheets from txvendordrug.com/about/manual/payer-sheets.

Administering pharmacists are health care professionals licensed by the TSBP to practice as a pharmacist, have met and maintained the eligibility requirements outlined in law, and have been certified by the TSBP to administer injectable drugs.

Administering pharmacists are under the supervision of a physician under Texas law. Pharmacists are employed and remunerated by a pharmacy for their services. If the services are covered and reimbursable by the program, payment may be made to the pharmacy employing the licensed pharmacist.

6.14.2 Managed care

6.14.2.1 Medicaid and CHIP

The pharmacy benefit allows pharmacists to administer long-acting injectable antipsychotics and opioid antagonists to treat a substance use disorder or opioid-use disorder.

MCOs must reimburse pharmacies for the ingredient cost, dispensing fee, and applicable administration fees for certain long-acting anti-psychotics, opiate dependence treatments, and emergency treatment for known or suspected opioid overdoses.

Refer to the **Pharmacy MCO Assistance Chart** from the "Downloads" page at txvendordrug.com/resources/downloads for the pharmacy call center phone numbers for each MCO.

6.15 Kidney Transplant Drugs

6.15.1 Vendor Drug Program

6.15.1.1 KHC Program

Kidney transplant drugs require prior authorization. Claims reject with error code "75" and the message "Call KHC Program (800) 222-3986" in the "Additional Message Information" field (526-FQ).

6.16 Long-Acting Reversible Contraception Products

Providers can prescribe and obtain long-acting reversible contraception (LARC) products are on the Medicaid and HTW formularies from certain specialty pharmacies for women enrolled in Medicaid (traditional and managed care) or the HTW Program.

Refer to the **Formulary search** at txvendordrug.com/formulary/formulary-search, and select the "LARC" filter to identify products available through the pharmacy benefit (also see section 4 below).

LARC products are only available through certain specialty pharmacies working with LARC manufacturers. Providers who prescribe and obtain LARC products through the specialty pharmacies listed will be able to return unused and unopened LARC products to the manufacturer's third-party processor.

Prescribing providers may continue to obtain LARC products through the existing buy-and-bill process.

6.17 Opioids

6.17.1 Limitations

For many people, substance use disorder starts after initially receiving opioid prescriptions for an episode of acute pain. To encourage the appropriate use of opioids and reduce the over-prescribing of opioids, Texas Medicaid has

implemented the requirements in this section. The requirements in this section do not apply to clients who are:

- Receiving hospice care or palliative care
- Being treated for cancer
- Residing in a long-term care facility
- Residing in a facility in which residents receive opioid substitution therapy for the treatment of opioid use disorder (OUD).

The requirements also do not apply to other clients that HHSC elects to exempt based on an objective, confirmable physical pathology known to cause severe chronic pain that is not ameliorated by other therapies and for which opioid treatment is appropriate (e.g., sickle cell disease). If diagnoses are not available in the medical data, prescribers can request exemptions on a case-by-case basis through the pharmacy prior authorization process.

6.17.2 Prospective Safety Edits

The Medicaid policies and processes listed below are conducted automatically during the pharmacy claims submission process.

6.17.2.1 Morphine Milligram Equivalents and Days' Supply Limits

Morphine milligram equivalents (MME) per day is used to compare the potency of one opioid to another. The clinical decision for the MME per day recommendations varies depending on the person's opioid use. Additionally, the Centers for Disease Control and Prevention (CDC) recommends starting opioid treatment with an immediate-release/short-acting formulation at the lowest effective dose instead of an extended-release/long-acting formulation.

A person is considered "opioid-naïve" if the client has taken opioids for a duration that is less than or equal to seven days in the last 60 days. For clients who are opioid- naïve, providers must submit a one-time prior authorization request for:

- An opioid prescription that exceeds a ten-day supply.
- A prescription for a long-acting opioid formulation.
- A claim or combination of claims in which the total daily dose of opioids exceeds 90

The one-time requirement for prior authorization does not apply to subsequent claims because the member will no longer be “opioid-naïve.” The duration of the prior authorization is equal to the days’ supply of the claim.

For clients who are not opioid naïve, prior authorization is required for opioid prescriptions if the total daily dose of opioids exceeds 90 MME. For those patients who may require a tapering plan, providers would determine the development and management of a person-specific course of therapy to help manage withdrawal symptoms. A prescriber may request a tapering plan through the pharmacy prior authorization process on a case-by-case basis. Prior authorization approvals last for six-months.

6.17.2.2 Days’ Supply Limits

Opioid prescriptions for the treatment of acute pain are rarely required for more than ten days. To reduce the risk of addiction and the diversion of unused opioids, opioid prescriptions for clients who are opioid naïve are limited to a maximum ten-day supply without prior authorization.

6.17.2.3 Fee-For-Service Three Prescription Limit

Prescriptions for opioids to treat acute pain for clients who are 21 years of age and older are exempt from the three-prescription-per-month limit for members in fee-for-service.

6.17.2.4 Prospective Drug Utilization Review Alerts

Medicaid returns prospective drug utilization review alerts for pharmacists on all claims when:

- opioids and benzodiazepines are used concurrently; and
- opioids and antipsychotics are used concurrently;

Refer to the "Prospective Drug Utilization Review" section of the **Drug Utilization Review** chapter of this manual for more information about alerts.

6.18 Makena

6.18.1 Vendor Drug Program

Makena (hydroxyprogesterone caproate injection) requires a clinical prior authorization.

Prescribing providers complete the ***Makena Clinical Prior Authorization Request*** (HHS Form 1345) and submit for review.

6.18.2 Managed care

Clinical prior authorization may be required. Providers and pharmacy staff should contact MCO for requirements and forms. Refer to the "Managed Care" section of the ***Contact Information*** chapter of this manual for form submission requirements.

6.19 Migraine Medications

6.19.1 Vendor Drug Program

Medications are limited to specific quantities per calendar month for each drug. Claims exceeding this limitation will reject with error code “76” and the message "Exceeds Max Product Quantity/Month – MI” in the “Additional Message Information” field (526-FQ).

6.20 Over the Counter Drugs

6.20.1 Vendor Drug Program

Medicaid, CSHCN, and KHC cover some over-the-counter (OTC) drugs, except for people residing in a nursing facility.

6.20.2 CHIP

Insulin, diabetic supplies, and mosquito repellant are the only covered OTC items.

6.21 Peritoneal Treatment Products

6.21.1 KHC Program

Peritoneal product claims will reject with NCPDP error code “75” and the message "Prior Authorization not on file, call the Pharmacy Benefit Access” in the “Additional Message Information” field (526-FQ).

6.22 Premium Preferred Generic Drugs

6.22.1 Vendor Drug Program

Pharmacies are reimbursed for an additional $0.50 incentive fee for dispensing premium preferred generic (PPG) drugs on Medicaid claims. The PPG amount appears in the "Incentive Amount Paid" field (521-FL) of the paid claim response. The incentive does not apply to $0.00 total payment amount claims. Refer to the ***Drug Pricing and Reimbursement*** chapter of this manual to learn more about state reimbursement calculation.

6.23 Pediculosis Treatment Products

6.23.1 Vendor Drug Program

Prescribing providers can write one prescription per person in an amount covering an entire family if a person is diagnosed with lice or scabies.

6.24 Prenatal Vitamins

6.24.1 Vendor Drug Program

Vitamins are limited to females under the age of 50, and claims will reject for improper age or gender:

- Error code 6Ø ("Product Not Covered for Patient Age – PN")
- Error code 61 ("Product Not Covered for Patient Gender – PN")

6.25 Specialty Drugs

6.25.1 Managed care

HHSC provides a quarterly specialty drug list (SDL) to MCOs identifying specialty drugs provided exclusively through the MCO's specialty pharmacy network.

6.25.2 Vendor Drug Program

Specialty drugs on the SDL may be covered as either an outpatient pharmacy benefit, a medical/physician benefit, or) both. For brand/generic availability, diagnosis restrictions, and billing information, of products covered as a medical/physician service, refer to the Texas Medicaid Provider Procedure Manual.

Refer to the "Texas Medicaid and Healthcare Partnership" section of the ***Contact Information*** chapter of this manual for form submission requirements.

6.26 Stadol

6.26.1 Vendor Drug Program

Stadol is limited to 10 milliliters (or 4 bottles) per calendar month. Claims exceeding this limitation will reject with NCPDP error code "76" ("Plan Limitations Exceeded") and the message "Exceeds Max Product Quantity/Month – ST" in the "Additional Message Information" field (526-FQ).

6.27 Synagis

Synagis is used to help prevent serious lung disease caused by a respiratory syncytial virus (RSV) in infants born prematurely and certain other children at high risk for severe lung disease from RSV. Refer to the Synagis page on the VDP website at txvendordrug.com/formulary/prior-authorization/synagis to learn more about seasonal requirements and schedules

RSV season dates are based on a person's county of residence. RSV appears earlier in some counties and remains active later in other counties. Texas HHS uses RSV statistics from prior years plus regular virology reports to determine the season's dates for each region and reserves the right to extend or end a season after subsequent review of RSV levels in each region. MCO medical directors can end the RSV season for their MCO, by service area, if they demonstrate to Texas HHSthe local virology has dropped below 10% positivity for two consecutive weeks.

6.27.1 Prior Authorization

6.27.1.1 Managed care

Prescribing providers and pharmacy staff should contact the MCO for prior authorization requirements and forms. Refer to the "Managed Care" section of the ***Contact Information*** chapter of this manual for contact instruction.

6.27.1.2 Vendor Drug Program

This is a two-step process:

1. Prescribing providers complete the Medicaid Synagis Authorization Request (HHS Form 1033) and send the form and a prescription for Synagis with refills and supporting information to the Medicaid-enrolled pharmacy.
2. The pharmacy staff submits the form to the Texas Prior Authorization Call Center. Refer to the "Pharmacy Prior Authorization" section of the Contact Information chapter of this manual for submission requirements.

6.27.1.3 CSHCN Services Program

This is a two-step process:

1. Prescribing providers complete the ***CSHCN Synagis Authorization Request*** (HHS Form 1055) and send the form and a prescription for Synagis with refills and supporting information to the CSHCN-enrolled pharmacy.
2. The pharmacy staff submits the form to the CSHCN Services Program. Refer to the "Pharmacy Prior Authorization" section of the ***Contact Information*** chapter of this manual for form submission requirements.

6.28 Tramadol with Codeine

6.28.1 Vendor Drug Program

Products containing tramadol and codeine are not available for children younger than 12. Medicaid claims, including multi-ingredient compound claims, will deny with NCPDP error code “60” (“Product/Service Not Covered For Patient Age”) and include the message “Not Covered For Under Years Of Age” in the “Additional Message Information” field (526-FQ).

6.29 Xenical

6.29.1 Vendor Drug Program

Xenical is available only for the treatment of hyperlipidemia and not approved for concurrent use with other cholesterol-lowering agents. Texas HHS clinician staff will determine coverage.

Prescribing providers complete the ***Xenical Authorization Request*** (HHS Form 1331) and submit for review.