COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

This section provides the terms and conditions under which prescription services will be paid by the Medicaid program and a description of the authorized benefits for eligible beneficiaries.

Terms and Conditions

Licensed Prescribers

Payment will be made for prescription services only when issued by a licensed prescribing practitioner who has an active Medicaid prescriber number. (Refer to Section 37.5.6 - Prescribers for detailed information about prescribers).

Eligible Beneficiaries

The Medicaid program will only reimburse pharmacy claims when the beneficiary is eligible on the date of service. Pharmacy claims submitted with a date of service after a beneficiary's date of death are not allowed. (Refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on Medicaid eligibility).

Rebate Agreements

In accordance with Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the Medicaid program will pay only for those drug products for which the pharmaceutical company has entered into a federal rebate agreement with the U.S. Department of Health and Human Services (DHHS).

NOTE: The listing of Medicaid drug federal rebate participating pharmaceutical companies can be accessed at: www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf. This listing is updated periodically and is posted on the Louisiana Medicaid website. **Providers should take note of the effective dates of the labeler codes.**

Coverage will be provided for those drug products labeled by the pharmaceutical companies that have entered into a rebate agreement. As new pharmaceutical companies enter into rebate agreements, labeler codes will be added.

The therapeutic categories, e.g., cough and cold preparations, anorexics and cosmetic drugs, will remain non-payable. The *Medicaid Drug Federal Rebate Participation Pharmaceutical*

Companies listing and additional information can be accessed at: www.lamedicaid.com/Provweb1/Forms/Drug_appendices/APNDC.pdf or by visiting Section 37.5.1 of this manual chapter.

Medically Accepted Indications

A drug must be medically necessary and prescribed for medically accepted indications to be eligible for reimbursement.

As defined by Section 1927(k)(6) of the Social Security , the term "medically accepted indication" means any use for a covered outpatient drug which is approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Act or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: *American Hospital Formulary Service Drug Information, United States Pharmacopeia – Drug Information* (or its successor publications), and *DRUGDEX Information System.*

Drug Utilization Review

OBRA '90 also requires that states have a Drug Utilization Review (DUR) program in place and that this program assures that prescriptions are appropriate, are medically necessary and not likely to result in adverse medical results. The DUR program must include prospective drug review, retrospective drug review, and an educational program. (Refer to Section 37.5.12 - Patient Counseling, DUR for detailed information regarding DUR).

Patient Counseling Requirement

The Louisiana Board of Pharmacy's regulations require patient counseling, patient profiles, and prospective drug review, in accordance with OBRA '90.

Patient Counseling Documentation

Section 1927(g)(2)(ii)(I) of OBRA '90 requires that the pharmacist offer to discuss with each Medicaid beneficiary or a caregiver, in person whenever practicable, or by toll-free telephone for long distance calls, matters which, in their professional judgment, the pharmacist deems significant. Such counseling is subject to standards for counseling in accordance with the Louisiana Board of Pharmacy Regulations at LAC, 46:LIII, §517. Such counseling is to be provided unless refused by the beneficiary or caregiver. The Pharmacy Program will require counseling documentation for all prescriptions reimbursed by Louisiana Medicaid. According to

the patient counseling standards in the OBRA'90, patient counseling begins with, and focuses on providing information related to the immediately prescribed drug. The only documentation required is a "yes" or "no" checked on the form next to the patient's signature to indicate whether they accepted the offer to provide this information. Counseling records must be retained in the pharmacy for five years from the date of payment and must be readily retrievable upon audit.

NOTE: Refer to Section 37.5.12 of this manual chapter for detailed information.

Pharmacy Signature and Delivery Logs

Pharmacy providers must obtain a signature from the patient or caregiver confirming the receipt of the prescription(s). This applies to all prescription pick-ups, home and facility deliveries. Claim submission is not proof that the prescription(s) or prescription order was actually furnished.

Pharmacy Pick-up

1. Signature log documentation should include the prescription number(s) and the date the prescription was picked up. If multiple prescriptions are being picked up at one time, a single signature will be sufficient for all of the patient's prescriptions;

2. Electronic signatures for receipt are permitted only if retrievable upon audit and kept on file by the pharmacy;

3. Obtaining a signature to confirm receipt of prescription(s) can be part of a counseling log; and

4. Signature confirmation must be maintained by the dispensing pharmacy for five years from the date of payment and must be retrievable upon audit.

Facility Delivery/Mail Order/Specialty

1. A signature is required at the time of delivery;

2. Signature documentation must also include the list of prescription number(s) and date the medication(s) was/were delivered. A single signature will be sufficient for all the medication in the delivery;

3. Electronic signatures for receipt or electronic tracking slips for delivery are permitted only if retrievable on audit;

4. A waiver signature form is not an acceptable practice and such forms will not serve as confirmation of delivery; and

5. Confirmation of the delivery must be maintained by the pharmacy for five years from the date of payment and must be retrievable on audit. Delivery industry tracking receipts that contain a signature (e.g., FedEx, UPS, and USPS) qualify as a signature for receipt of delivery.

Home Delivery

1. If a pharmacy provider chooses to have a pharmacy representative deliver prescription(s) to a beneficiary' s home, the pharmacy should inform the beneficiary or designee of the pharmacy's delivery schedule, verify the date and location for the delivery, and notify the beneficiary or designee that a signature will be required at the time of delivery; and

2. The pharmacy representative will obtain a signature from the beneficiary or their designee confirming the delivery. A waiver signature form is not an acceptable practice, and such forms will not serve as confirmation of delivery. Delivery confirmation must be maintained by the pharmacy for five years from the date of payment and must be retrievable upon audit. Electronic signatures for receipt are permitted only if retrievable and kept on file by the pharmacy.

Prescription Duration

Scheduled narcotic prescriptions must be filled within six (6) months of the date issued, excluding Schedule II narcotic prescriptions. Schedule II narcotic prescriptions will expire 90 days after the date of issue in accordance with the Louisiana Board of Pharmacy regulations. Prescriptions for non-controlled substances expire after 11 authorized refills or one year after the date prescribed, whichever occurs first.

Prescription Transfers

The transfer of prescriptions, including those for Schedule III-V narcotics, must be in accordance with the Louisiana Board of Pharmacy regulations.

Date of Service

The date of service is based on the adjudication process. The pharmacy staff should evaluate any prospective warnings or alerts based on internal software, or the Louisiana Program response generated during the claim submission. Based on this clinical review, the date the prescription was adjudicated is the service date except when long-term care eligibility determination is delayed.

Prescription Refills

Prescription refills can be provided if they are authorized specifically by the prescribing practitioner. Prescriptions for non-controlled substances have a one-year expiration and an 11-refill maximum from the date prescribed, whichever occurs first.

Refills for Scheduled III-V narcotics have a six (6) month expiration and a five refill maximum from the date prescribed, whichever occurs first.

No refills are allowed on Schedule II prescriptions.

National Drug Code

In order to be reimbursed for a pharmacy claim, prescribed items must have an assigned National Drug Code (NDC).

Prescriptions Received via Telecommunication

Most prescriptions are acceptable when received by telephone or other telecommunication device in accordance with state and federal regulations. Providers must file and log prescriptions received via telecommunication as they would any other written or electronic prescriptions.

Tamper Resistant Prescription Policy

Written, non-electronic prescriptions for Medicaid beneficiaries are required to be written on tamper-resistant pads.

The "Transitional Medical Assistance (TMA), Abstinence Education and QI Program Extension Act of 2007" (H.R. 3668) and the "U.S. Troop Readiness, Veterans' Health Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007" (H.R. 2206) states that all

handwritten prescriptions or those printed from an electronic medical record (EMR), or an ePrescribing application must contain all three characteristics listed below. Exceeding these guidelines is permissible if:

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; and

3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

This provision applies to all written (non-electronic) prescriptions for outpatient drugs including over-the-counter drugs reimbursed by Pharmacy Program, regardless of whether Medicaid is the primary or secondary payer.

It is the responsibility of the prescriber to obtain and purchase tamper-resistant prescription pads.

NOTE: The *Table of Tamper Resistant Prescription Criteria and Examples* can be accessed in Section 37.5.12 at:
www.lamedicaid.com/Provweb1/manuals/App_L_Tamper_Res_Prescription.pdf

Excluded Prescriptions

The tamper-resistant requirement does not apply to prescriptions which are communicated by the prescriber to the pharmacy electronically, verbally or by facsimile.

Confirming Non-Compliant Prescriptions

If a prescription does not meet the requirements for tamper-resistance, pharmacies may obtain verbal confirmation and document appropriately. The pharmacy does not need to speak with the prescriber directly. They may receive confirmation from a nurse or administrative staff person who has authority to act on behalf of the prescriber.

Emergency Fills

Emergency fills with non-compliant written prescriptions are permissible as long as the prescriber provides a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled. If an emergency fill is confirmed with a verbal order, the pharmacist must document the call on the face of the written prescription.

Authorized Benefits

Provided below are the authorized medications and/or supplies which are payable under Louisiana Medicaid.

NOTE: Refer to "Quantity Limitations" in this section and Section 37.3 - Reimbursement Services for detailed information regarding authorized benefits.

Legend Drugs

Legend drugs are drugs that require a prescription or that have the following statement on the label, "Caution: Federal law prohibits dispensing without a prescription." Medicaid reimbursement is available for most legend drugs that are dispensed in outpatient settings.

NOTE: Refer to "Non-Covered Services" in this section for detailed information regarding legend drugs.

Legend Vitamin and Mineral Products

Only the following legend vitamin and mineral products will be reimbursed by the Pharmacy Program:

Vitamin B 12 preparations	Vitamin E preparations	Pediatric vitamin preparations
Vitamin A preparations	Vitamin K preparations	Legend prenatal vitamins for pregnant and lactating beneficiaries
Vitamin B preparations	Calcium replacement	Magnesium salt replacement
Vitamin B1 preparations	Folic Acid preparation	Prescription strength fluoride as a single entity
Vitamin B6 preparations	Geriatric vitamin preparations	Urinary pH modifiers (Phosphorus)
Vitamin C preparations	Multivitamin preparations	

Vitamin D preparations	Niacin preparations	

Injectable Drugs

Reimbursement is provided for most injectable drugs for outpatient beneficiaries when supplied by community pharmacies, long-term care (LTC) pharmacies, and home infusion pharmacies that are enrolled as Medicaid providers.

Some antibiotic and oncologic injections administered in practitioners offices and clinics are reimbursed through the Professional Services Program.

Non-Legend Drugs

Only a limited number of non-legend or over-the-counter (OTC) drugs can be reimbursed by the Louisiana Medicaid program. For Medicaid reimbursement, these drugs must be prescribed by licensed practitioners. **Providers must bill the NDC from the actual package dispensed**. **Also, the drug manufacturer must participate in the federal rebate program.**

The following non-legend drugs are covered when an authorized prescriber has written a prescription:

1. Insulin;
2. Sodium chloride solution for inhalation therapy;
3. Contraceptives, topical;
4. Urinary pH modifiers; and
5. Other non-legend drugs that have Pharmacy Program approval.

Non-Legend Items and Supplies

Only a limited number of non-legend items and supplies can be reimbursed by the Medicaid Program. In order to receive Medicaid reimbursement, these items and supplies must be prescribed by licensed practitioners. (**Providers must bill the NDC from the actual package dispensed):**

1. OTC Vitamin D preparations;

2. OTC Vitamin E preparations;
3. OTC Niacin preparations;
4. OTC Calcium replacement agents;
5. OTC Magnesium replacement agents;
6. OTC Phosphate replacement agents;
7. OTC Iron replacement agents;
8. Normal saline and heparin flushes;
9. Disposable needles and syringes used to administer insulin;
10. Test strips for determining blood glucose levels;
11. Lancets;
12. Urine test strips (e.g., Clinitest® and Clinistix®);
13. Family planning items; and
14. Other non-legend items and supplies that have Pharmacy Program approval.

Total Parenteral Nutrition

Total Parenteral Nutrition (TPN) and associated supplies and equipment are covered services in the Pharmacy Program. (Refer to Section 37.5.10 - Total Parenteral Nutrition for additional information).

Medication Administration

Enrolled pharmacies may be reimbursed for the administration of select adult vaccines and the COVID vaccine. Pharmacists who have the "Authority to Administer" authorized by the Louisiana Board of Pharmacy may administer vaccines. (Refer to Section 37.5.11 - Medication Administration for detailed information).

Non-Covered Services

Drugs Excluded From Coverage

The following drugs and/or therapeutic categories are excluded from Medicaid coverage:

1. Select agents when used for anorexia, weight loss, or weight gain with the exception of orlistat (Xenical);

2. Select agents when used to promote fertility except vaginal progesterone when used for high-risk pregnancy to prevent premature births;

3. Select agents when used for symptomatic relief of cough and colds except prescription antihistamine and antihistamine/decongestant combination products;

4. Select prescription vitamins and mineral products except:

Vitamin B 12 preparations	Vitamin E preparations	Pediatric vitamin preparations
Vitamin A preparations	Vitamin K preparations	Legend prenatal vitamins for pregnant and lactating beneficiaries
Vitamin B preparations	Calcium replacement	Magnesium salt replacement
Vitamin B1 preparations	Folic Acid preparation	Prescription strength fluoride as a single entity
Vitamin B6 preparations	Geriatric vitamin preparations	Urinary pH modifiers (Phosphorus)
Vitamin C preparations	Multivitamin preparations	
Vitamin D preparations	Niacin preparations	

5. Select nonprescription drugs except OTC antihistamines and antihistamine/decongestant combinations, OTC naloxone, polyethylene glycol 3350, and OTC medications listed in the U.S. Preventive Service Task Force A and B Recommendations.

Otherwise Restricted Drugs include the following:

1. The state will cover agents when used for cosmetic purposes or hair growth only when the state has determined that use to be medically necessary;

2. Select drugs for erectile dysfunction except when used for the treatment of conditions, or indications approved by the FDA, other than erectile dysfunction;

3. Compound prescriptions (mixtures of two or moe ingredients; the individual drugs will continue to be reimbursed);

4. Drug Efficacy Study Implementation (DESI) Drugs (refer to those drugs that the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness);

5. Experimental drugs;

6. Medications which are included in the reimbursement to a facility, i.e. hospitals, skilled nursing facility for beneficiaries receiving benefits under Part A of Title XVIII, mental hospitals, or some other nursing facilities; and

7. Vaccines covered in other programs. The state will cover select adult vaccines in the pharmacy program.

Durable Medical Equipment

The Medicaid Pharmacy Program will reimburse continuous glucose monitors and other diabetic supplies as a pharmacy benefit. Preferred products and prior authorization (PA) criteria for continuous glucose monitors will be posted on the Single Preferred Drug List (PDL).

The following diabetic supplies with be reimbursed as a pharmacy benefit only:

1. Diabetes glucose meters;

2. Diabetic test strips;

3. Continuous glucose meters;

4. Transmitters and sensors;
5. External insulin pumps (i.e. Omnipod and V-Go);
6. Control solution;
7. Ketone test strips
8. Lancets and devices;
9. Pen needles;
10. Re-usable insulin pens; and
11. Syringes.

Prior Authorization and Single Preferred Drug List

The Medicaid Program administers a PA process for pharmacy services. This process utilizes a single PDL for selected therapeutic classes. Drugs included on the PDL are preferred. Drugs in these classes that are not included on the PDL require prescribers to obtain PA.

PDL Provider Notification

Lists of covered drug products, including those that require PA, will be posted on the Louisiana Medicaid website.

Prior Authorization Process General Information

The PA process provides for a turn-around response by either telephone or other telecommunications device within 24 hours of a PA request. In emergency situations, providers may dispense a minimum of a 72 hour or a three day supply of medication**.**

Prior Authorization and Single PDL Information Site

The *Louisiana Medicaid Single PDL/Non-Preferred Drug List (NPDL)* and the *Louisiana Uniform Prescription Drug Prior Authorization Form* and its instructions can be accessed at:

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf or by visiting Section 37.5.5 of this manual chapter.

Who Can Obtain Prior Authorization

The prescribing practitioner is responsible for obtaining PA for non-preferred agents, agents which require clinical PA or where PAs are otherwise required. Pharmacist or beneficiary calls/requests will not be accepted. The prescribing practitioner must have and provide their valid individual Louisiana Medicaid prescribing provider number to obtain PA. Only individual provider numbers will be accepted.

The prescribing practitioner may obtain the PA by one of the following:

1. Electronic prior authorization (E-PA);
2. Telephone;
3. Facsimile; or
4. Mail.

NOTE: Refer to the Section 37.5.4 – Contact Information for access to additional information on PA. In addition, refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

The Prior Authorization Unit's (PAU's) hours of operation are 8:00 am to 6:00 pm Central Time, Monday through Saturday.

NOTE: National Provider Identifier (NPI) numbers that are assigned to a group are not allowed to prescribe or obtain a PA. If a prescribing practitioner does not have an individual prescriber number, refer to Section 37.5.6 - Prescribers for detailed information.

Prior Authorization Request Form

The Louisiana Uniform Prescription Drug PA Form must be used by the prescriber to request a PA. The form and its instructions can be accessed at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf or by visiting Section 37.5.5 of this manual chapter.

Emergency Procedures

Prescriptions indicating emergency situations shall be dispensed in a minimum quantity of a three day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.** The beneficiary's practitioner must contact the PAU (RxPA) to request authorization to continue the medication past the emergency supply, and a new prescription must be issued.

This process may be used when the RxPA Unit is closed (Sundays; Monday – Saturday before 8:00 am and after 6:00 pm) or when the PA system is unavailable. The pharmacist may also use professional judgment in situations that would necessitate an emergency supply.

The prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription if hard copy, or if the prescription is called in to the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency Rx" on the hard copy prescription. When the pharmacist determines the prescription is an emergency, the pharmacist must indicate "Emergency by Pharmacist" on the hard copy prescription.

NOTE: The Point of Sale (*POS) User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed claim submission and processing information.

Beneficiaries are exempt from paying co-payments for emergency situations.

Monitoring of emergency prescriptions/beneficiaries is conducted on an ongoing basis through management reports, pharmacy provider audits, and other monitoring programs to review the number of and the reasons for these prescriptions.

Hospital Discharge Prescriptions for Atypical Antipsychotic Agents

When a beneficiary is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if it is a hard copy, that the prescription is a "Hospital Discharge". If the prescription is called in to the pharmacy, the "Hospital Discharge" status of the prescription must be communicated to the pharmacist who must indicate "Hospital Discharge" on the hard copy prescription.

In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is a "Hospital Discharge" prescription, the pharmacist must indicate "Hospital Discharge on the hard copy prescription.

Claims for "Hospital Discharge" prescriptions needing PA will be submitted using the same process used for an emergency override.

Prescriptions for "Hospital Discharge" products shall be dispensed in a minimum quantity of a three-day supply, and refills for the dispensing of the non-preferred products are not permitted. The beneficiary's practitioner must contact the RxPA Unit to request authorization to continue the medication past the "Hospital Discharge" supply, and a new prescription must be issued.

Prescriptions Issued Prior to the Effective Dates of Prior Authorization

The PA process does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to a drug's effective date of PA.

Beneficiaries with Retroactive Eligibility

Drugs that are not on the PDL are sometimes dispensed to patients who are awaiting Medicaid eligibility determinations. Pharmacy providers will be reimbursed for these claims when the date of service falls within the beneficiaries' retroactive time period. The retroactive time period is defined as the time period between the first date of eligibility and the date that the beneficiary's eligibility is placed on the beneficiary file. Pharmacy providers shall submit these claims electronically.

Important Facts

When a beneficiary elects to self-pay for an original prescription which requires PA, attempts to have Medicaid pay for the refill of this prescription will result in the pharmacy claim being denied.

If an approved PA exists in the system, the pharmacy claim will bypass the PA edit and continue with existing POS edits. If an approved PA does not exist, the pharmacy claim will be denied through the POS system.

An approved PA does not guarantee payment of the claim by Medicaid. It only indicates that the drug has been approved as a course of treatment within the Medicaid Program. All existing POS claim edits will continue to be applied.

The PA process does not verify a beneficiary's Medicaid eligibility. It only verifies that the beneficiary is "on file" (i.e., has a valid Medicaid ID number on file – not that the beneficiary is eligible on the date of service). Beneficiary eligibility will continue to be verified by the Pharmacy POS subsystem or through the Medicaid Eligibility Verification System (MEVS) or Recipient Eligibility Verification System (REVS) automated beneficiary eligibility systems.

Only practitioners' individual prescriber numbers are accepted to request PA of a non-preferred drug. Any provider number other than an individual prescribing provider number **WILL NOT** be accepted to prior authorize non-preferred drugs.

Clinical Authorization

There are certain medications that require clinical authorization. Clinical authorization is a prescriber initiated request for authorization on a selected number of drugs.

Prescribers must complete the *Louisiana Uniform Prescription Drug Prior Authorization Form* in full. The clinical authorization criteria can be used as a reference when completing the form. Clinical authorization requests should be faxed or mailed to the RxPA Unit. (Refer to Section 37.5.4 – Contact Information in this manual chapter for contact information).

NOTE: Refer to the Single PDL to access the clinical authorization drug list, forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Monthly Service Limit

Limit

Medicaid reimburses up to four prescriptions per calendar month per beneficiary. Claims including those for emergency prescriptions and PA prescriptions that are in excess of four per calendar month per beneficiary will be denied.

Exceptions to Limit

The following federally mandated beneficiary groups are exempt from the 4 prescriptions per calendar month limitations:

1. Persons under 21 years of age;

2. Persons who are residents of long-term care institutions, such as nursing homes and Individuals with Intellectual Disabilities (ICF/IID) facilities; and

3. Beneficiaries who are pregnant.

Limit Override Procedures

The four prescriptions per month limit can be exceeded when the prescriber determines an additional prescription is medically necessary and communicates the following information to the pharmacist on the hard prescription, by telephone or other telecommunications device:

1. "Medically necessary override; and

2. Valid diagnosis code that directly relates to each drug prescribed that is over the four prescription limit (an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM, or its successor) literal description is not acceptable).

The prescriber should use the Electronic Clinical Drug Inquiry (e-CDI) in their clinical assessment of the beneficiary's disease state or medical condition and the current drug regimen before making a determination that more than four prescriptions per calendar month is required by the beneficiary. (Refer to Section 37.5.4 for details on how to access the e-CDI).

Printed statements without the prescribing practitioner's signature, check-off boxes or stamped signatures are not acceptable documentation.

An acceptable statement and diagnosis code are required for each prescription in excess of four for each calendar month.

Pharmacists and prescribers are required to maintain documentation to support the override of a prescription limitation.

NOTE: Refer to Section 37.5.1 to access the *POS User Guide* to obtain detailed billing instructions and override procedures at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Drugs with Special Payment Criteria/Limitations

Coverage of some drugs is limited to special criteria being met. These are explained below.

NOTE: Refer to Section 37.5.8 - Claim Submission for detailed override information as well as Section 37.5.1 to access the *POS User Guide* for detailed billing instructions, where applicable, at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Age and Gender Restricted Drugs

Certain drugs have age and gender restrictions placed on them. For further assistance, providers should contact the Gainwell Provider Helpdesk (Refer to Section 37.5.4 for contact information).

Acne Agents

Pharmacy claims for select acne agents have a quantity limit, age requirements, and/or clinical authorization requirement.

Clinical information (acne severity) is required for all topical acne agents.

All agents are limited to use in beneficiaries who are younger than 21 years of age when used for acne. Trifarotene (Aklief®) is limited to beneficiaries who are at least 9 years of age.

Pharmacy claims submitted with a diagnosis code for psoriasis (L40*) will bypass the age restriction for tazarotene cream or tazarotene gel.

** Any number or letter or combination of **UP TO 4** numbers and letters of an assigned ICD-10-CM diagnosis code*

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at:
http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Allergen Extracts

Pharmacy claims for allergen extracts may be subject to clinical authorization/PA, physician prescriber requirements, age requirements, diagnosis code requirements, and an auto-injectable epinephrine prescription requirement for reimbursement.

Select allergen extracts are listed in the following chart:

Generic Name (Brand Name Example)
Grass Pollen Allergen Extract (Timothy Grass) Sublingual Tablet (Grastek®)
House Dust Mite Allergen Extract Sublingual Tablet (Odactra™)
Mixed Grass Allergen Extracts Sublingual Tablet (Oralair®)
Peanut (*Arachis hypogaea*) Allergen Powder Capsule; Packet (Palforzia®)
Ragweed Pollen Allergen Extract Sublingual Tablet (Ragwitek®)

Physician Prescriber Requirements for Allergen Extracts

Prescribers of allergen extracts must have a specialty of 1) Allergy, 2) Otology, Laryngology, Rhinology, or 3) Ophthalmology, Otology, Laryngology, Rhinology for reimbursement.
NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Auto-Injectable Epinephrine Requirement for Allergen Extracts

Pharmacy claims for allergen extracts require a pharmacy claim for an auto-injectable epinephrine product within the last year for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Alzheimer's Agents

Select agents for the treatment of Alzheimers disease require clinical authorization or PA. The following chart lists select agents for the treatment of Alzheimer's disease.

Generic Name (Brand Name Example)
Aducanumab-avwa (Aduhelm™)*
Donepezil ODT, Tablet (Aricept®)
Donepezil Transdermal Patch (Adlarity®)
Galantamine ER Capsule, Solution, Tablet
Lecanemab-irmb (Leqembi™)*
Memantine Solution, Tablet, Dose Pack (Namenda®, Namenda®Titration Pack)
Memantine ER Capsule, Dose Pack (Namenda XR®, Namenda XR® Titration Pack)
Memantine/Donepezil ER Capsule (Namzaric®)
Rivastigmine Capsule
Rivastigmine Transdermal Patch (Exelon®)

* Aducanumab-avwa (Aduhelm™) and lecanemab-irmb (Leqembi™) require a drug specific clinical authorization form.

Antiemetic/Antivertigo Agents

Pharmacy claims for select antiemtic/antivertigo agents may be subject to the following:

1. Clinical authorization/PA;

2. Behavioral health clinical authorization for ages less than 7 years (for prochlorperazine);

3. Diagnosis code requirement; and

4. Quantity limit.

The following bypass conditions apply for antiemtic/antivertigo agents:

1. Prochlorperazine pharmacy claims that are submitted with a diagnosis code for severe nausea or vomiting will bypass the Behavioral Health Clinical Authorization requirement for children younger than 7 years of age; and

2. Ondansetron ODT and ondansetron tablet pharmacy claims that are submitted with a diagnosis code for cancer or palliative end-of-life care will bypass the quantity limit.

Select antiemetic/antivertigo agents are listed in the following chart.

Generic Name (Brand Name Example)	Generic Name (Brand Name Example)
Amisulpride Vial (Barhemsys®)	Metoclopramide Solution, Tablet, Vial (Reglan®)
Aprepitant Capsule, Pack, Powder for Oral Suspension (Emend®)	Metoclopramide Nasal (Gimoti®)
Aprepitant Vial (Aponvie®, Cinvanti®)	Netupitant/Palonosetron HCl Capsule (Akynzeo®)
Dimenhydrinate Vial	Ondansetron ODT, Solution, Tablet, Vial
Dolasetron Mesylate (Anzemet®)	Ondansetron Oral Film (Zuplenz®)
Doxylamine/Pyridoxine Tablet (Bonjesta®, Diclegis®)	Ondansetron Ampule, Syringe
Dronabinol Oral (Marinol®)	Palonosetron Vial (Aloxi®)
Fosaprepitant Dimeglumine Vial (Emend®	Prochlorperazine Rectal, Tablet, Vial (Compro®)
Fosnetupitant/Palonosetron Vial (Akynzeo®)	Promethazine Ampule, Rectal, Suppository, Syrup, Tablet, Vial (Phenergan®)
Granisetron ER Syringe, Tablet, Vial (Sustol®)	Rolapitant Tablet (Varubi®)
Granisetron Transdermal Patch (Sancuso®)	Scopolamine Transdermal (Transderm-Scop®)
Meclizine Tablet (Antivert®)	Trimethobenzamide Capsule, Vial (Tigan®)

The following **antiemetic/antivertigo** agent will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Ondansetron (Zofran®) ODT, Tablet (solid oral dosage forms)	30 tablets/30 days

Amifampridine (Firdapse®)

Pharmacy claims for amifampridine (Firdapse®) are subject to the following:

1. Clinical authorization;

2. Diagnosis code requirement; and

3. Maximum daily dose.

The maximum daily dose for amifampridine (Firdapse®) is listed in the chart below.

Generic Name (Brand Name)	Maximum Daily Dose
Amifampridine (Firdapse®)	80 mg/day

Amyotrophic Lateral Sclerosis

Pharmacy claims for amyotrophic lateral sclerosis (ALS) agents require an appropriate diagnosis code entered at POS.

Select amyotrophic lateral sclerosis (ALS) agents are listed in the following chart.

Generic Name (Brand Name Example)
Edaravone (Radicava®; Radicava ORS®)
Riluzole (Rilutek®; Tiglutik™; Exservan™)
Sodium Phenylbutyrate and Taurursodiol (Relyvrio™)
Toferson (Qalsody™)

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Androgenic Agents

Select androgenics may be subject to the following:

1. PA; and

2. Diagnosis code requirement.

Select androgenic agents are listed in the following chart:

Generic Name (Brand Name Example)
Methyltestosterone Capsule (Methitest®)
Testosterone Gel, Gel Pump, Nasal, Oral, Transdermal (Androgel®, Natesto®, Androderm®)
Testosterone Cypionate IM Injection (Depo-Testosterone®)
Testosterone Enanthate SQ Injection (Xyosted®)
Testosterone Implant Pellet (Testopel®)
Testosterone Undecanoate Capsule, Injection (Jatenzo®, Aveed®)

Pharmacy claims for androgenic agents require an appropriate diagnosis code entered at POS for beneficiaries who are younger than 18 years of age. Pharmacy claims which are submitted with a diagnosis code associated with gender dysphoria or gender reassignment (F64*, Z87.890) will deny.

* – any number or letter or combination of **UP TO 4** numbers and letters of an assigned ICD–10–CM diagnosis code.

Anthelmintics

Select anthelmintics require PA.

Pharmacy claims for ivermectin (Stromectol®) have a diagnosis code requirement at POS.

Anti-Anxiety Drugs

Select anti-anxiety drugs may be subject to the following POS edits:

1. PA;
2. Age limit;
3. Behavioral health clinical authorization for age less than 7 years;
4. Quantity limit;
5. Concurrent use;

6. Prior use;

7. Therapeutic duplication; and

8. Diagnosis code requirements.

Select anti-anxiety drugs are listed in the following chart:

Generic Name (Brand Name Example)
Alprazolam ER tablet. ODT, tablet (Xanax®, Xanax XR®)
Alprazolam Intensol Concentrate ®
Buspirone
Chlordiazepoxide
Chlordiazepoxide/Clidinium (Librax®)
Clorazepate (Tranxene T-Tab®)
Diazepam Intensol Concentrate, Solution, Syringe, Tablet, Vial (Valium®)
Lorazepam ER capsule, tablet (Loreev XR ™; Ativan®)
Lorazepam Intensol Concentrate ®
Meprobamate
Oxazepam

Age Requirement

The following anti-anxiety agents are limited for use in beneficiaries who meet specific age requirements as listed in the chart.

Generic Name (Brand Name Example)	Age Limit
Alprazolam XR tablet (Xanax XR®)	> or = 18 years
Alprazolam ODT (Niravam®)	> or = 18 years
Lorazepam ER capsule (Loreev XR®)	> or = 18 years

Behavioral Health Clinical Authorization For Ages Less Than 7 Years

Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents, EXCEPT meprobamate, when requested for beneficiaries who are younger than 7 years of age.

Quantity Limit

The following anti-anxiety agents will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit Per Rolling 30 Days
Alprazolam (Xanax®)	90 units
Alprazolam ER (Xanax XR®)	30 units
Alprazolam ODT (Niravam ™)	90 units
Chlordiazepoxide	90 units
Clorazepate (Tranxene T-Tab®)	90 units
Diazepam (Valium®)	90 units
Lorazepam (Ativan®)	90 units
Lorazepam ER (Loreev XR™)	90 units
Oxazepam (Serax®)	90 units

Quantity limits will be bypassed for clonazepam (Klonopin®), clorazepate (Tranxene®), and diazepam (Valium®) when an acceptable diagnosis code is submitted.

Acceptable diagnosis codes that will bypass the edit are:

ICD-10-CM Diagnosis Code	Description
P90	Convulsions in Newborn
G40.*	Epilepsy, Seizures
R56.*	Other Convulsions

Concurrent Use

Incoming benzodiazepine pharmacy claims will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for a buprenorphine-containing product used to treat opioid dependence.

Incoming benzodiazepine pharmacy claims will deny when the beneficiary has an active prescription for an opioid analgesic

Pharmacy claims for selected anxiolytics, when submitted with a seizure-related diagnosis code will bypass the behavioral-health clinical authorization requirement, the restriction on concurrent use with opioids, and quantity limits.

Pharmacy claims submitted with a diagnosis code for cancer or palliative end-of-life care will bypass the restriction on concurrent use of benzodiazepines with opioids.

Prior Use

An incoming pharmacy claim for lorazepam (Loreev XR™) will deny if there is no evidence of a pharmacy claim for **ONE** of the following in the most recent 30-day period:

1. A quantity of at least 90 lorazepam immediate-release tablets; **OR**
2. Any quantity of lorazepam (Loreev XR™).

Therapeutic Duplication

Pharmacy claims for anti-anxiety agents will deny at POS with a therapeutic duplication if there is an active claim for another anti-anxiety agent, with oxybate ((Xyrem®) and with oxybate salts (Xywav™).

Diagnosis Code Requirements

Pharmacy claims for alprazolam ER and alprazolam ODT require an appropriate diagnosis code.

NOTE: Refer to the Diagnosis Code Policy chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Analeptics: Armodafinil (Nuvigil®), Modafinil (Provigil®), Pitolisant (Wakix®), and Solriamfetol (Sunosi®)

Age Restriction

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when the beneficiary is 16 years of age or younger**.**

Pharmacy claims for solriamfetol (Sunosi®) and pitolisant (Wakix®) will deny at POS when the beneficiary is less than 18 years old.

Diagnosis Code Requirements

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) require an appropriate diagnosis code documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.by the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis is required for claim submission. The appropriate diagnosis codes are listed in the chart:

Medication	Description of Diagnosis	ICD-10-CM Diagnosis Code
Armodafinil (Nuvigil®); Modafinil (Provigil®)	Obstructive Sleep Apnea	G47.33
	Circadian rhythm sleep disorder, shift work type	G47.26
	Narcolepsy	G47.4*
Solriamfetol (Sunosi™)	Obstructive Sleep Apnea	G47.33
	Narcolepsy	G47.4*
Pitolisant (Wakix®)	Narcolepsy	G47.4*

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Therapeutic Duplication

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the beneficiary's file for either armodafinil (Nuvigil®) or modafinil (Provigil®).

Therapeutic Duplication with Stimulants

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the beneficiary's file for other stimulants or atomoxetine (Strattera®).

Pharmacy claims for solriamfetol (Sunosi®) or pitolisant (Wakix®) will deny at POS when there is an active claim on the beneficiary's file for either solriamfetol (Sunosi®), pitolisant (Wakix®), modafinil (Provigil®) or armodafinil (Nuvigil®). Also, modafinil (Provigil®) and armodafinil (Nuvigil®) should deny at POS when there is an active claim on the beneficiary's file for either solriamfetol (Sunosi®) or pitolisant (Wakix®).

Pharmacy claims for solriamfetol (Sunosi®) or pitolisant (Wakix®) will deny if there is an active claim on the beneficiary's file for another stimulant or atomoxetine (Strattera®).

Pharmacy claims for dextroamphetamine (Xelstrym™) will deny if there is an active claim on the beneficiary's file for solriamfetol (Sunosi™) or pitolisant (Wakix®) and vice versa.

Pharmacy claims for dextroamphetamine (Xelstrym™) will deny if there is an active claim on the beneficiary's file for modafinil (Provigil) or armodafinil (Nuvigil) and vice versa.

Concurrent Use with Sedative Hypnotics

Pharmacy claims for armodafinil (Nuvigil®) and modafinil (Provigil®) will deny at POS when there is an active claim on the beneficiary's file for a sedative hypnotic.

If in the professional judgment of the prescriber a determination is made which necessitates therapy with modafinil (Provigil®) or armodafinil (Nuvigil®) and a sedative hypnotic, the pharmacist may override this edit. After consultation with the prescriber to verify the necessity of both agents, the pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason for concurrent therapy. The reason for service code, professional service code and result of service code used in submitting the claim must also be documented on the hardcopy prescription or in the pharmacy' electronic recordkeeping system.

Pharmacy claims for solriamfetol (Sunosi®) or pitolisant (Wakix®) will deny if there is an active claim on the beneficiary's file for a sedative hypnotic. Pharmacy claims for a sedative hypnotic will deny if there is an active claim on the beneficiary's file for solriamfetol (Sunosi®) or pitolisant (Wakix®).

Antibiotic-Otic Agents

Select antibiotic- otic agents are listed in the following chart.

Generic Name (Brand Name Example)
Ciprofloxacin Solution
Ciprofloxacin/Dexamethasone Susp (Ciprodex®)
Ciprofloxacin/Fluocinolone Acetonide Solution (Otovel®)
Ciprofloxacin/Hydrocortisone Suspension (Cipro HC Otic®)
Colistin/Neomycin/Thonzonium/Hydrocortisone Suspension (Cortisporin® TC)
Neomycin/Polymyxin B/Hydrocortisone Solution, Suspension
Ofloxacin Solution

Pharmacy claims for select antibiotic otic agents may be subject to the following:

1. PA; and

2. Quantity limit.

Select antibiotic-otic agents are listed in the following chart.

Generic Name (Brand Name Example)
Ciprofloxacin Solution
Ciprofloxacin/Dexamethasone Susp (Ciprodex®)
Ciprofloxacin/Fluocinolone Acetonide Solution (Otovel®)
Ciprofloxacin/Hydrocortisone Suspension (Cipro HC Otic®)
Colistin/Neomycin/Thonzonium/Hydrocortisone Suspension (Cortisporin® TC)
Neomycin/Polymyxin B/Hydrocortisone Solution, Suspension
Ofloxacin Solution

Pharmacy claims for the following **antibiotic-otic** agent will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Ciprofloxacin HCl 0.2% Otic Solution	2 packs of 14 single-use containers per 30 days

Anticoagulants

Prescriptions for select anticoagulants are subject to the following clinical edits for reimbursement:

1. Quantity limits; and

2. Duration of therapy.

Quantity Limits

The quantity limits for anticoagulant agents are listed in the chart below:

Generic	Representative Brand	Dosage Form	Quantity Limit
Apixaban	Eliquis®	Tablet	60 units/30 days
Apixaban Starter Pack	Eliquis® Starter Pack	Tablet Dose Pack	1 unit/365 days
Dabigatran Etexilate Mesylate	Pradaxa®	Capsule	60 units/30 days
Dalteparin Sodium	Fragmin®	Vial/Syringe	60 units/30 days
Edoxaban Tosylate	Savaysa®	Tablet	30 units/30 days
Enoxaparin Sodium	Lovenox®	Vial/Syringe	60 units/30 days
Fondaparinux Sodium	Arixtra®	Syringe	30 units/30 days
Rivaroxaban 2.5mg	Xarelto®	Tablet	60 units/30 days
Rivaroxaban 10mg, 15mg & 20mg	Xarelto®	Tablet	30 units/30 days
Rivaroxaban Starter Pack	Xarelto® Starter Pack	Tablet Dose Pack	1 unit/365 days
Rivaroxaban	Xarelto® Oral Suspension	Suspension	4 bottles (155ml each)/ 31 days

Duration of Therapy

The duration of therapy for select anticoagulant agents are listed in the chart below:

Generic	Representative Brand	Maximum Duration of Therapy*
Dalteparin	Fragmin®	35 days
Enoxaparin	Lovenox®	35 days
Fondaparinux Sodium	Arixtra®	35 days

*Maximum 35-day course of therapy within a 90-day period

Antidepressant Medications

Prescriptions for antidepressant medications will require an approved clinical authorization for beneficiaries under 6 years of age. Pharmacy claims for antidepressant medications will be checked for therapeutic duplication.

Therapeutic Duplication

Pharmacy claims for a tricyclic antidepressant will deny if there is an active claim on the beneficiary's file for a tricyclic antidepressant.

Pharmacy claims for selective serotonin reuptake inhibitors (SSRIs) will deny if there is an active claim on the beneficiary's file for a SSRI.

Antihistamine/ Decongestant Products

Antihistamine/decongestant products may require a PA for reimbursement.

Antihistamine/decongestant products are subject to a therapeutic duplication with each other and with other sedating antihistamines at POS.

The program, in accordance with the Social Security Act Section 1927 (d)(2), excludes drugs or classes of drugs containing cough and cold agents when those products are prescribed for the treatment of cough and cold.

Select covered antihistamine and antihistamine/decongestant products are listed in the following chart.

Generic Name (Brand Name Example)
Cetirizine Capsule OTC, Chewable Tablet OTC, Solution OTC, Solution Rx, Tablet OTC (Zyrtec)
Cetirizine/Pseudoephedrine Tablet OTC (Zyrtec-D)
Chlorpheniramine Maleate Tablet
Chlorpheniramine/Pseudoephedrine Liquid (Lohist-D)
Clemastine Fumarate Syrup, Tablet
Cyproheptadine Syrup, Tablet
Desloratadine ODT, Tablet (Clarinex®)
Desloratadine/Pseudoephedrine ER Tablet (Clarinex-D®)

Fexofenadine Suspension OTC, Tablet OTC (Allegra)
Fexofenadine/Pseudoephedrine Tablet OTC (Allegra-D)
Levocetirizine Solution, Tablet, Tablet OTC (Xyzal)
Loratadine Chewable Tablet OTC, ODT OTC, Solution OTC, Tablet OTC (Claritin)
Loratadine/Pseudoephedrine Tablet OTC (Claritin-D)

Therapeutic Duplication

Pharmacy claims for first and/or second generation antihistamines and antihistamine-decongestant products will deny if there is an active claim on the beneficiary's file for another first and/or second generation antihistamine or antihistamine-decongestant product. A change in therapy from an antihistamine to an antihistamine-decongestant or the reverse will have override provisions.

Exclusions

Claims for diphenhydramine, hydroxyzine HCL, and hydroxyzine pamoate are excluded from the therapeutic duplication.

After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic recordkeeping system the following:

1. The reason the prescribing provider chose to override the therapeutic duplication; and

2. The National Council for Prescription Drug Program (NCPDP) DUR override codes used in submitting the claim.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits" in this section for policy regarding first and second generation antihistamines and combination agents included in the therapeutic duplication edit.

Anti-Fungal

Pharmacy claims for select oral antifungal agents will be subject to the following:

1. Prior or clinical authorization; and

2. Quantity limit.

Select anti-fungals are listed in the following chart:

Generic Name (Brand Name Example)
Clotrimazole Troche
Fluconazole Suspension, Tablet (Diflucan®)
Flucytosine Capsule
Griseofulvin Suspension, Tablet, Ultramicrosize Tablet
Ibrexafungerp Citrate Tablet (Brexafemme™)
Isavuconazonium Capsule (Cresemba®)
Itraconazole Capsule, Solution (Sporanox®)
Itraconazole Capsule (Tolsura®)
Ketoconazole Tablet
Miconazole Buccal Tablet (Oravig®)
Nystatin Tablet
Oteseconazole Capsule (Vivjoa™)
Posaconazole Suspension, Suspension Packet, Tablet (Noxafil®)
Terbinafine Tablet
Voriconazole Suspension, Tablet (Generic; Vfend®)

Anti-Infective, Anti-Fungal, and Corticosteroids

Pharmacy claims for select anti-infective, anti-fungal, and corticosteroids have quantity limits.

Medication	Dosage Form	Quantity Limit
Ciclopirox Olamine 0.77%	Suspension	60ml/30 days
Ciprofloxacin HCl 0.2%	Otic Solution	2 packs of 14 singles/30 days
Clobetasol Propionate 0.05%	Cream	100gm/30 days

Clobetasol Propionate 0.05%	Ointment	120gm/30 days
Clobetasol Propionate 0.05%	Solution	100ml/30 days
Doxycycline Hyclate / Monohydrate	Capsule	60 caps of any strength/30 days
Econazole Nitrate 1%	Cream	85gm/30 days
Gentamicin Sulfate 0.3%	Ophthalmic Ointment	3.5gm/30 days
Gentamicin Sulfate 0.3%	Ophthalmic Solution	5ml/30 days
Gentamicin Sulfate 0.1%	Cream	30gm/30 days
Gentamicin Sulfate 0.1%	Ointment	30gm/30 days
Itraconazole 100mg	Capsule	120 caps/30 days
Itraconazole 100mg	Capsule Pulsepak	1 pack (28 caps) / 28 days
Itraconazole 65mg	Capsule	120 caps/30 days
Ketoconazole 2%	Shampoo	120ml/30 days
Ketoconazole 2%	Cream	60gm/30 days
Mupirocin 2%	Cream	30gm/30 days
Mupirocin 2%	Ointment	22gm/30 days
Nystatin 100,000 units/gm	Cream	60gm/30 days
Nystatin 100,000 units/gm	External Powder	120mg (Two 60mg bottles)/30 days
Nystatin 100,000 units/gm	Ointment	60gm/30 days

Antimigraine Agents- CGRP Antagonists

Pharmacy claims for select antimigraine agents-CGRP antagonists may be subject to clinical or PA and quantity limits.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

The quantity limits for select CGRP antagonists are listed in the following chart:

Medication-Generic (Brand)	Quantity Limit
Atogepant (Qulipta)	30 tablets/30 days
Eptinezumab-jjmr (Vyepti™)	3 single dose vials (300mg)/90 days
Erenumab-aooe (Aimovig®) - 70mg, 140mg single dose syringe	3 single dose syringes/90 days

Fremanezumab-vfrm (Ajovy®) - 225mg single dose syringe	3 single dose syringes/90 days
Galcanezumab-gnlm (Emgality®) - 100mg single dose syringe	3 single dose syringes/30 days
Galcanezumab-gnlm (Emgality®) - 120mg single dose pen/syringe	7 single dose syringes/180 days
Rimegepant (Nurtec® ODT)	16 tablets/30 days
Ubrogepant (Ubrelvy™)	16 tablets/30 days

Antiretroviral Agents – HIV/AIDS

Pharmacy claims for select antiretroviral agents – HIV/AIDS require a diagnosis code and are monitored for therapeutic duplication.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Antipsychotic Agents

Pharmacy claims for select antipsychotic medications are subject to the following:

1. Diagnosis Code Requirement;
2. Age Requirements;
3. Quantity limits;
4. Maximum daily dose;
5. Prior use; and
6. Therapeutic Duplication.

Diagnosis Code Requirement on All Antipsychotic Medications

Prescriptions for antipsychotic agents require appropriate diagnosis codes.

The numeric diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Pharmacy claims for antipsychotic medications that have a missing or invalid diagnosis code will deny at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

If the prescriber does not indicate a diagnosis code, and the pharmacist determines the beneficiary cannot wait to receive the medication, the pharmacy provider may override the denial. The pharmacist must document "Emergency" on the hard copy prescription or in the pharmacy's electronic recordkeeping system and the reason for the emergency.

Antipsychotic agents are also subject to prospective DURs when a third antipsychotic agent is submitted for payment.

Age Requirements for Antipsychotic Medications

Select antipsychotic agents have age requirements. Pharmacy claims for pimavanserin (Nuplazid®) is limited to use in beneficiaries who are at least 18 years old.

Maximum Daily Dose for Antipsychotic Medications

The following antipsychotic agents are subject to a maximum daily dose limit as listed in the chart below.

Generic – Brand Example	**Age (Years)**						
<5		**5**	**6-9**	**10-12**	**13-15**	**16-17**	**18 and older**
Aripiprazole – Abilify®	5mg	20mg	20mg	20mg	30mg	30mg	30mg
Aripiprazole – Abilify® MyCite®	0mg	0mg	0mg	0mg	0mg	0mg	30mg

Asenapine – Saphris®	0mg	0mg	0mg	20mg	20mg	20mg	20mg
Asenapine Transdermal - Secuado®	0mg	0mg	0mg	0mg	0mg	0mg	7.6mg
Brexpiprazole – Rexulti®	0mg	0mg	0mg	0mg	0mg	4mg	4mg
Cariprazine – Vraylar®	0mg	0mg	0mg	0mg	0mg	4.5mg	6mg
Vraylar® Therapy Pack	0mg	0mg	0mg	0mg	0mg	4.5mg	6mg
Clozapine – Clozaril®, FazaClo®, Versacloz®	0mg	0mg	0mg	0mg	0mg	0mg	900mg
Iloperidone – Fanapt®	0mg	0mg	0mg	0mg	0mg	16mg	24mg
Lurasidone – Latuda®	0mg	0mg	0mg	80mg	80mg	80mg	160mg
Olanzapine – Zyprexa®	10mg	20mg	20mg	20mg	30mg	30mg	40mg
Olanzapine/Fluoxetine – Symbyax®	0mg	0mg	0mg	12mg/50mg	12mg/50mg	12mg/50mg	18mg/75mg
Paliperidone – Invega®	3mg	6mg	6mg	6mg	9mg	9mg	12mg
Quetiapine – Seroquel®	100mg	600mg	600mg	600mg	1000mg	1000mg	1200mg
Risperidone – Risperdal®	3mg	6mg	6mg	6mg	8mg	8mg	16mg
Ziprasidone – Geodon®	30mg	60mg	60mg	60mg	120mg	120mg	200mg

Quantity Limits

Pharmacy claims for selected antipsychotic medications have quantity limits.

Antipsychotic Oral/Transdermal Agents Quantity Limit Chart

The following antipsychotic oral/transdermal agents are subject to a quantity limit as listed in the chart below.

Medication –Generic (Brand)	Quantity Limit
Asenapine (Secuado®)	30 patches per 30 days
Lurasidone (Latuda®) Tablet 20mg, 40mg, 60mg & 120mg	30 tablets per 30 days
Lurasidone (Latuda®) Tablet 80mg	60 tablets per 30 days
Olanzapine/Samidorphan (Lybalvi)	30 tablets per 30 days
Pimavanserin (Nuplazid™) 10 mg	30 tablets per 30 days
Pimavanserin (Nuplazid™) 34 mg	30 capsules per 30 days

Antipsychotic Injectable Agents Quantity Limit Chart

The following antipsychotic injectable agents are subject to quantity limit as listed in the chart below.

Medication-Generic (Brand)	Quantity Limit
Aripiprazole (Abilify Asimtufii®)	1 unit every 56 days
Aripiprazole (Abilify Maintena®)	1 unit every 28 days
Aripiprazole Lauroxil (Aristada®) 441 mg; 662 mg; 882 mg syringe	1 unit every 28 days
Aripiprazole Lauroxil (Aristada®) 1064mg syringe	1 unit every 56 days
Aripiprazole Lauroxil (Aristada® Initio™) 675mg syringe	Limited to 1 unit per 18-month period
Olanzapine (Zyprexa Relprevv®) 210mg & 300mg60 tablets per 30 days	2 units every 28 days
Olanzapine (Zyprexa Relprevv®) 405mg	1 unit every 28 days
Paliperidone Palmitate (Invega Hafyera®)	1 unit every 180 days
Paliperidone Palmitate (Invega Sustenna®)	Initiation: 2 units in 14 days; Maintenance: 1 unit every 28 days
Paliperidone Palmitate (Invega Trinza®)	1 unit every 84 days
Risperidone (Perseris™)	1 unit every 28 days
Risperidone (Risperdal Consta®)	2 units every 28 days
Risperidone Microspheres (Rykindo®)	2 units every 28 days
Risperidone (Uzedy™) 50mg; 75mg; 100mg; 125mg syringe	1 unit every 28 days

Risperidone (Uzedy™) 150mg; 200mg; 250mg syringe	1 unit every 56 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Therapeutic Duplication

Pharmacy claims for a beneficiary with an active oral antipsychotic prescription on file will deny when an additional pharmacy claim for a second oral antipsychotic prescription is submitted.

Pharmacy claims for a beneficiary with an active injectable antipsychotic prescription on file will deny when an additional pharmacy claim for a second injectable antipsychotic prescription is submitted.

Therapeutic Duplication of Olanzapine/Samidorphan (Lybalvi™) with Another Oral Antipsychotic Medication

An incoming pharmacy claim for olanzapine/samidorphan (Lybalvi™) will deny with a therapeutic duplication if there is an active claim for another oral antipsychotic medication on file. Conversely, a claim for another oral antipsychotic medication will deny with a therapeutic duplication if there is an active claim for olanzapine/samidorphan (Lybalvi™) on file.

Therapeutic Duplication of Paliperidone Palmitate (Invega Hafyera™) with Another Injectable Antipsychotic Medication

An incoming pharmacy claim for paliperidone palmitate (Invega Hafyera™) will deny with a therapeutic duplication, if there is an active claim for another injectable antipsychotic medication on file. Conversely, a claim for another injectable antipsychotic medication will deny with a therapeutic duplication, if there is an active claim for paliperidone palmitate (Invega Hafyera™) on file.

Prior Use Requirement Antipsychotic Agents

Select antipsychotic agents have a prior use requirement at POS.

Pharmacy claims for cariprazine (Vraylar®) have a prior use requirement of a previous claim for cariprazine **OR** a preferred generic oral antipsychotic within the previous 365 days.

Pharmacy claims for lurasidone (Latuda®) have a prior use requirement of a previous claim for lurasidone **OR** a preferred generic oral antipsychotic within the previous 365 days.

An incoming pharmacy claim for paliperidone palmitate (Invega Hafyera™) will require a previous claim for any **ONE** of the medications listed below including the requested medication:

1. Four (4) claims for Invega Sustenna® in the previous 120-day period; **OR**
2. One (1) claim for Invega Trinza® in the previous 90-day period; **OR**
3. One (1) claim for Invega Hafyera™ in the previous 365 days.

Prior Use Requirement Antipsychotic Injectables Chart

These agents require evidence in pharmacy claims indicating established tolerance with previous use of an oral or injectable form.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Asthma/COPD- Immunomodulators

Pharmacy claims for select immunomodulators require PA.

Atidarsagene Autotemcel (Lenmeldy™)

Pharmacy claims for atidarsagene autotemcel (Lenmeldy™) require a clinical authorization.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) Agents

Prescriptions for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD agents will require an appropriate diagnosis code for reimbursement. Pharmacy claims for select ADD/ADHD medications will be subject to quantity limits. ADD/ADHD will be checked for therapeutic duplication.

The numeric diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Pharmacy claims for ADD and ADHD medications that have a missing or invalid diagnosis code will deny at POS.

When beneficiaries are established on ADD/ADHD medications, but the diagnosis codes submitted are not included in the table of covered diagnoses, prescribing providers may call the RxPA Unit (Refer to Section 37.5.4 for contact information.)

NOTE: Refer to the link to access the *POS User Guide* for detailed billing instructions at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Therapeutic Duplication

Pharmacy claims for ADD/ADHD medications will be subject to a therapeutic duplication.

An incoming pharmacy claim for a short-acting ADD/ADHD medication will deny when there is an active claim on file for another short-acting ADD/ADHD medication. An incoming claim for a long-acting ADD/ADHD medication will deny when there is an active claim on file for another long-acting ADD/ADHD medication.

An incoming pharmacy claim for an ADD/ADHD medication will deny when there is an active claim on file for another ADD/ADHD medication written by a different prescriber.

Therapeutic Duplication of Serdexmethylphenidate/ Dexmethylphenidate (Azstarys™) with Another Long-Acting ADD/ADHD Medication

An incoming pharmacy claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) will deny with a therapeutic duplication if there is an active claim for another long-acting ADD/ADHD medication on file. Conversely, a claim for long-acting ADD/ADHD medication will deny with a therapeutic duplication if there is an active claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) on file.

Therapeutic Duplication of Serdexmethylphenidate/ Dexmethylphenidate (Azstarys™) with Another Short-Acting ADD/ADHD Medication

An incoming pharmacy claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) will deny with a therapeutic duplication if there is an active claim for another short-acting ADD/ADHD medication on file. Conversely, a claim for short-acting ADD/ADHD medication will deny with a therapeutic duplication if there is an active claim for serdexmethylphenidate/dexmethylphenidate (Azstarys™) on file.

Therapeutic Duplication of Xelstrym™ with another Long-Acting Stimulant or Related Medication for ADHD

Pharmacy claims for dextroamphetamine (Xelstrym™) will deny if there is an active claim on the beneficiary's file for any other long-acting stimulant and related medication for ADHD and vice versa.

Behavioral Health Medications for Beneficiaries 7 Years of Age and Younger

Pharmacy claims for behavioral health medications for beneficiaries 7 years of age and younger require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Clinical Authorization for ADD/ADHD Medications for Beneficiaries Less Than 7 years of Age

Pharmacy claims for ADD/ADHD medications for beneficiaries less than 7 years of age require an approved clinical authorization for reimbursement.

Benign Prostatic Hyperplasia (BPH) Treatment Agents

Pharmacy claims for benign prostatic treatment agents may be subject to the following:

1. PA;
2. Diagnosis code requirement; and

3. Duration of therapy.

Select benign prostatic treatment agents are listed in the following chart:

Generic Name (Brand Name Example)
Alfuzosin ER Tablet
Doxazosin ER Tablet, Tablet (Cardura XL®; Cardura®)
Dutasteride Capsule (Avodart®)
Dutasteride/Tamsulosin Capsule (Jalyn®)
Finasteride (Proscar®)
Finasteride/Tadalafil (Entadfi®)
Silodosin Capsule (Rapaflo®)
Tadalafil (Cialis®)
Tamsulosin Capsule (Flomax®)
Terazosin Capsule

Pharmacy claims for the BPH treatment agents listed in the following chart require an appropriate diagnosis code entered at POS for beneficiaries who are younger than 18 years of age.

Generic Name (Brand Name Example)
Dutasteride (Avodart®)
Finasteride (Proscar®)

Pharmacy claims for BPH treatment agents listed in the following chart require an appropriate diagnosis code for beneficiaries at any age.

Generic Name (Brand Name Example)
Finasteride/tadalafil (Entadfi®)
Tadalafil (Cialis®)

Pharmacy claims for the following **BPH** treatment agents are limited to a duration of therapy.

Generic Name (Brand Name Example)	Maximum Duration of Therapy
Finasteride/tadalafil (Entadfi®)	26 weeks
Tadalafil 2.5mg or 5mg (Cialis®) when used with finasteride (Proscar®)	26 weeks

Beremagene geperpavec-sydt (Vyjuvek™)

Pharmacy claims for beremagene geperpavec-sydt (Vyjuvek™) require an approved clinical authorization for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Birch triterpenes (Filsuvez®)

Pharmacy claims for birch triterpenes (Filsuvez®) require a clinical authorization for reimbursement.

Budesonide (Eohilia™)

Pharmacy claims for budesonide (Eohilia™) will be subject to the following:

1. Age Requirement;
2. Diagnosis Code; and
3. Duration of Therapy Edit.

Pharmacy claims for budesonide (Eohilia™) have diagnosis code and age requirement of 11 years of age or older on the date of service.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Prescriptions for budesonide (Eohilia™) will deny when the duration of therapy exceeds 12 weeks.

Cannabidiol (Epidiolex®)

Pharmacy claims for cannabidiol (Epidiolex®) have a prior use requirement (in a previous 365-day period) of the following:

1. **ONE** paid claim for cannabidiol (Epidiolex®); **OR**

2. A paid claim in the previous 365 days for at least **TWO** of the following agents (brand/generic or preferred/non-preferred formulations) below:

   a. Clobazam;

   b. Felbamate;

   c. Lamotrigine;

   d. Levetiracetam;

   e. Rufinamide;

   f. Topiramate; and

   g. Valproate derivatives.

Carisoprodol

Pharmacy claims for carisoprodol will deny when the quantity exceeds 90 tablets per rolling 90 days. The quantity limit is cumulative and applies to all strengths and combinations of carisoprodol. The pharmacy claim will deny as exceeding the program's maximum allowed. **There are no provisions for overrides**.

Cefiderocol (Fetroja)

Pharmacy claims for cefiderocol (Fetroja®) have a clinical authorization requirement.

Chorionic Gonadotropin (Novarel®, Pregnyl®)

Pharmacy claims for chorionic gonadotropin (Novarel®, Pregnyl®) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Clotting Factor Products

Clotting factor products administered in an outpatient setting will **only** be reimbursed as a pharmacy benefit, not as a medical/professional benefit.

Select clotting factors products are reimbursed in the pharmacy program, exluding Hemlibra.

Brand name examples of clotting factor products are listed in the following chart.

Advate®	Feiba®	Nuwiq®
Adynovate®	Fibryga®	Obizur®
Afstyla®	Hemofil®	Profilnine®
Alphanate®	Humate®	Rebinyn®
Alphanine®	Idelvion ®	Recombinate™
Alprolix®	Ixinity®	Riastap Vial®
Altuviiio®	Jivi®	Rixubis®
Balfaxar®	Kcentra®	Sevenfact®
Benefix®	Koate®	Tretten®
Coagadex®	Kogenate®	Vonvendi®
Corifact®	Kovaltry®	Wilate®
Eloctate®	Novoeight®	Xyntha®
Esperoct®	Novoseven®	

Codeine

Pharmacy claims for products containing codeine have an age limit for reimbursement. The acceptable age limits are listed in the chart:

Description	Age (Y=Year)
Codeine (Single Ingredient)	≥18 Y
Codeine Combination Product	≥12 Y

Collangenase Topical (Santyl®)

Prescriptions for collagenase topical (Santyl®) will have a quantity limit of 7 90 gram tubes per prescription, for a total of 630 grams.

Contraceptive Agents

Medicaid health plans are required to allow a six month supply (180 days supply) of contraceptive drugs to be obtained at one time by the beneficiary when the beneficiary has used the same contraceptive drugs for at least 6 consecutive months prior to receiving a 6-month supply, unless the following applies:

1. The beneficiary requests a smaller supply; OR

2. The prescribing provider instructs for the beneficiary to receive a smaller supply.

Drospirenone/Ethinylestradiol/Levomefolate Calcium (Beyaz®)

Pharmacy claims for Drospirenone/Ethinyl Estradiol/Levomefolate Calcium (Beyaz®) require an appropriate diagnosis code for reimbursement. Claims submitted with diagnosis codes for cosmetic indications will deny.

Etonogestrel (Nexplanon®)

Pharmacy claims for Etonogestrel (Nexplanon®) will be limited to one implant every 2 years.

If the prescriber chooses to exceed the quantity limit for Etonogestrel (Nexplanon®), the pharmacist may override the limit after consultation with the prescribing practitioner. The pharmacist must document the NCPDP override codes and reason for the override on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Etonogesetrel/Ethinyl Estradiol Vaginal Ring (Nuvaring®)

Prescription claims for Etonogestrel/Ethinyl Estradiol vaginal ring (Nuvaring®) for quantities of four and greater will deny. There is no provision for override as these claims exceed the program maximum of a 100 unit doses.

In addition, there will be a valid days' supply range dependent on the quantity billed:

1. If quantity = 1, then Days' Supply must be 21 to 28;

2. If quantity = 2, then Days' Supply must be 42 to 56; and

3. If quantity – 3, then Days' Supply must be 63 to 84.

Pharmacists are allowed to override the denial on days' supply after consultation with the prescriber.

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Oral Contraceptive Agents

Oral contraceptive agents will have an age limit of 12-55 years of age per program policy for legacy Medicaid.

Pharmacy claims for oral contraceptive agents are subject to an **educational alert** encouraging the submission of a diagnosis code at POS. The acceptable diagnosis codes for oral contraceptives as a family planning benefit or for menstrual disorders are listed in the chart.

ICD-10-CM Diagnosis Code	Diagnosis Description
Z30*	Encounter for oral contraceptive management
F32.81	Premenstrual dysphoric disorder
N92*	Excessive, frequent and irregular menstruation

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code.

Medroxyprogesterone Acetate Injectable

Prescription claims for Medroxyprogesterone Acetate injectable for female beneficiaries billed with a quantity of one and a days' supply less than 84 will deny. Quantities of two and greater

will not be payable with no provision for override as they exceed the program maximum of a 100 unit doses.

Claims for Medroxyprogesterone Acetate sub-q 104 injectable for female beneficiaries, billed with a quantity of 0.65 and a days' supply less than 84, will deny. Quantities of 1.3 and greater will not be payable, with no provision for override, as they exceed the program maximum of a 100 unit doses.

Pharmacists are allowed to override the denial on days' supply after consultation with the prescriber.

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Norelgestromin /Ethinyl Estradiol Transdermal Patches (Ortho-Evra) ®)

Reimbursement of these contraceptive transdermal patches when dispensed using the package size of three must be billed in multiples of three. If the quantity billed is not a multiple of three, the claim will deny. There are no provisions for override.

Corticotropin (Acthar® Gel, Cortropin™ Gel)

Pharmacy claims for corticotropin (Acthar® Gel, Cortropin™ Gel) require an approved clinical authorization for reimbursement.

Cytokine and Cell-Adhesion Molecule (CAM) Antagonists

Prescriptions for cytokine and cell-adhesion molecule (CAM) antagonists may require the following for reimbursement:

1. Clinical authorization or PA; and/or
2. Quantity limit.

The quantity limits for select cytokine and CAM antagonists are listed in the chart.

Generic (Brand Example)	Quantity Limit
Adalimumab (Humira®) 10mg, 20mg, 40mg	4 injections per 28 days

Adalimumab (Humira®) 80mg	2 injections per 28 days
Etanercept (Enbrel®)	Starting Dose – 8 injections per 28 days for 3 months (if applicable)
	Maintenance Dose – 4 injections per 28 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Cystic Fibrosis Agents

Pharmacy claims for select agents for the treatment of cystic fibrosis may require PA.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Danicopan (Voydeya®)

Pharmacy claims for danicopan (Voydeya®) require a diagnosis code for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Deferiprone (Ferriprox)

Pharmacy claims for deferiprone (Ferriprox) will require an approved diagnosis code for chronic iron overload due to blood transfusions (E83.111) entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
https://ldh.la.gov/assets/HealthyLa/PDL/7.30.2020/Louisiana.Medicaid.ICD-10.Chart.docx

Deferasirox (Exjade ®, Jadenu®)

Pharmacy claims for deferasirox (Exjade®, Jadenu®) are subject to diagnosis code requirements and age limitations.

Beneficiaries 2 years of age and less

Pharmacy claims for deferasirox (Exjade®, Jadenu®) will deny for beneficiaries 2 years of age or less.

Beneficiaries 2-9 years of age

Pharmacy claims for deferasirox (Exjade®, Jadenu®) require a valid diagnosis code for reimbursement. The diagnosis code must be documented on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Beneficiaries 10 years of age and older

Pharmacy claims for deferasirox (Exjade®, Jadenu®) require a valid diagnosis code for reimbursement. The diagnosis code must be documented on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

The appropriate diagnosis codes for deferasirox (Exjade®) are listed in the chart:

Covered Indications at POS	ICD-10-CM Diagnosis Code
2-9 years of age	
Chronic iron overload due to blood transfusion	E83.111
10 years of age and older	
Chronic iron overload due to blood transfusion	E83.111
Chronic iron overload in non-transfusion-dependent thalassemia (NTDT) syndromes	D56.0, D56.1, D56.5, D56.8, D57.4*

* - any number or letter or combination of UP TO 4 numbers and letters of an assigned ICD-10-CM diagnosis code

Dermatology-Atopic Dermatitis Immunodulators

Pharmacy claims for atopic dermatitis immunodulators may require a clinical authorization or PA.

Pharmacy claims for crisaborole (Eucrisa®) have a quantity limit and prior use requirement.

Crisaborole Ointment (Eucrisa®) is subject to a quantity limit of 300 gm per rolling 365 days.

Pharmacy claims for crisaborole ointment (Eucrisa®) or ruxolitinib (Opzelura™), requires prior use of at least **ONE** paid claim in the previous 180 days for:

1. Drug [crisaborole ointment (Eucrisa®) or ruxolitinib cream (Opzelura™)];
2. Topical corticosteroid; **OR**
3. Topical calcineurin inhibitor.

Point of Sale Bypass Diagnosis for Opzelura® (Ruxolitinib) Prior Drug Use Requirement

Pharmacy claims submitted for ruxolitinib (Opzelura®), when submitted with a diagnosis code for nonsegmental vitiligo (L80), will bypass the POS prior drug use requirement for ruxolitinib (Opzelura®), which requires prior use of ruxolitinib (Opzelura®), a topical corticosteroid, or topical calcineurin inhibitor.

Desmopressin (Nocdurna®)

Pharmacy claims for desmopressin (Nocdurna®) have a quantity limit.

Generic Name	Brand Name	Quantity Limit
Desmopressin	Nocdurna®	30 tablets/day

Diabetic Testing Supplies

The Pharmacy Program reimburses claims for prescribed diabetic testing supplies. Diabetic testing supplies will have a diagnosis code requirement and quantity limit.

Diagnosis Description	ICD-10-CM Diagnosis Code	Quantity Limit
Diabetes Due to Other Conditions or Causes	E08*, E09*, E013*	100/102 Test Strips/90 days and 100/102 Lancets/90 days

Type 2 Diabetes Mellitus	E11*	
Type 1 Diabetes Mellitus	E10*	200/204 Test Strips/30 days and 200/204 Lancets/30 days
Gestational Diabetes; Diabetes Mellitus in Pregnancy	O24.4*; O24*	
Long-Term (Current) Use of Insulin (Insulin Treated Non-Type 1 Diabetes Mellitus)	Z79.4*	

*any number or letter or combination of UP TO FOUR numbers or letters of an assigned ICD-10-CM diagnosis code.

All diabetic supply claims submitted to Medicaid will deny when beneficiaries are Medicare Part B eligible. Medicare Part B covers diabetic supplies for all diabetic beneficiaries regardless of insulin requirements. Pharmacy providers shall submit these claims to the Medicare durable medical equipment regional carrier (DMERC). These claims will then automatically cross over to the Medicaid fiscal intermediary (FI) for payment of the coinsurance and deductible amounts, where applicable.

Diabetic supplies and glucometers for long-term care beneficiaries are not covered in the Medicaid Pharmacy Program or through PA because they are covered in the nursing facility per diem rate.

It is allowable for Medicare Part B to be billed if the long-term care beneficiary is eligible for the benefit. Medicaid is not obligated to pay the coinsurance and deductible if the items are included in the Medicaid per diem. The Medicaid FI will automatically deny any crossover claims for diabetic supplies for long-term care beneficiaries.

NOTE: Refer to Section 37.5.7 - Medicare Prescription Drug Coverage for detailed information.

Dextromethorphan/Quinidine (Nuedexta®)

Pharmacy claims for dextromethorphan/quinidine (Nuedexta®) are subject to the quantity limit listed in the chart.

Generic Name	Brand Name	Quantity Limit
Dextromethorphan/Quinidine	Nuedexta®	60 tablets/30 days

Diroximel Fumarate (Vumerity®)

Pharmacy claims for diroximel fumarate (Vumerity®) are subject to the quantity limit listed in the chart.

Generic Name	Brand Name	Quantity Limit
Diroximel Fumarate	Vumerity®	1 starter bottle (106 capsules)/365 days
		1 maintenance bottle (120 capsules)/30 days

Dichlorphenamide (Keveyis®)

Pharmacy claims for dichlorphenamide are subject to a quantity limit of 120 tablets/30 days.

Dofetilide (Tikosyn®)

Pharmacy claims for dofetilide (Tikosyn®) have a clinical authorization requirement.

Doxepin Cream (Prudoxin®, Zonalon®)

Pharmacy claims for doxepin cream will be subject to the following edits:

1. Diagnosis code requirement;
2. Age limit;
3. Quantity limit; and
4. Therapeutic duplication.

Diagnosis Code Requirement

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon®) require a diagnosis code. The acceptable diagnosis codes are listed in the chart.

Generic Name	Brand Name	Description of Diagnosis	ICD-10-CM Diagnosis Code
Doxepin Cream	Prudoxin®, Zonalon®	Atopic Dermatitis	L20*
		Lichen Simplex Chronicus	L28.0

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Age Limit

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon®) will deny when the beneficiary is less than 18 years old.

Quantity Limit

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon® will have a quantity limit of 45 grams per rolling 30 days.

Therapeutic Duplication

Pharmacy claims for doxepin cream (Prudoxin®, Zonalon®) will deny with a therapeutic duplication if there is an active claim on the beneficiary's file for doxepin cream (Prudoxin®, Zonalon®).

Duchenne Muscular Dystrophy

Pharmacy claims for select Duchenne Muscular Dystrophy agents require an approved clinical authorization.

Generic Name (Brand Name Example)
Casimersen (Amondys 45®)
Delandistrogene Moxeparvovec-rokl (Elevidys™)
Eteplirsen (Exondys 51®)
Golodirsen (Vyondys 53®)
Viltolarsen (Viltepso®)

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL, which gives drug specific clinical authorization criteria and instructions.

Eculizumab (Soliris®)

Pharmacy claims for eculizumab (Soliris®) require a diagnosis code for reimbursement.

ICD-10-CM Diagnosis Code*	Diagnosis Description
D59.3	Hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis Optica Spectrum Disorder (NMOSD)
G70.0	Myasthenia Gravis

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Epinephrine Injection (Generic, EpiPen®, and EpiPen Jr®)

Prescriptions for epinephrine injection have the following quantity limits for reimbursement.

Medication	Quantity Limit
Epipen® (Brand and Generic) Epipen Jr® (Brand and Generic)	4 boxes of 2 syringes (8 syringes total) per rolling 365 days

Esketamine Intranasal (Spravato®)

Pharmacy claims for esketamine intranasal (Spravato®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Elagolix (Orilissa ®)

Pharmacy claims for elagolix (Orilissa®) require an approved clinical authorization for reimbursement.

Empagliflozin/Linagliptin/Metformin HCl (Trijardy®)

Pharmacy claims for empagliflozin/linagliptin/metformin HCl (Trijardy®) are subject to the following:

1. Prior use requirement;
2. Quantity limits; and
3. Therapeutic Duplication.

Prior Use Requirement

An incoming claim for empagliflozin/linagliptin/metformin (Trijardy® XR), will deny if there is no evidence of one of the following in paid claims:

1. At least a 90-day supply of ONE of the following in the previous 180-day period:
   a. Metformin AND either a DPP-4 or an SGLT2;
   b. A combination product of DPP-4/metformin or SGLT2/metformin; or
   c. At least a 60-day supply of empagliflozin/linagliptin/metformin (Trijardy® XR) in the previous 90-day period.

Quantity Limit

Pharmacy claims for empagliflozin/linagliptin/metformin HCl (Trijardy XR®) have the following quantity limits listed in the chart:

Generic Name	Brand Name	Quantity Limit
Empagliflozin/linagliptin/ metformin HCl	Trijardy® XR 10/5/1000	30 tablets / 30 days
	Trijardy® XR 25/5/1000	30 tablets / 30 days
	Trijardy® XR 5/2.5/1000	60 tablets / 30 days
	Trijardy® XR 12.5/2.5/1000	60 tablets / 30 days

Therapeutic Duplication

A pharmacy claim for empagliflozin/linagliptin/metformin HCl (Trijardy XR®) will deny at POS when there is an active claim on the beneficiary's file for another DPP-4 inhibitor or a SGLT2 Inhibitor. Conversely, a claim for a DPP-4 inhibitor or a SGLT2 Inhibitor will deny at POS when there is an active claim on the beneficiary's file for empagliflozin/linagliptin/metformin HCl (Trijardy XR®).

Fabry (-Anderson) Disease Agents

Pharmacy claims for Fabry (-Anderson) Disease agents will be subject to the following:

1. Diagnosis code requirement and

2. Therapeutic duplication.

Select Fabry (-Anderson) Disease agents are listed in the following chart.

Generic Name (Brand Name Example)
Agalsidase beta (Fabrazyme®)
Migalastat (Galafold™)
Pegunigalsidase alfa-iwxj (Elfabrio®)

Fecal Microbiota Spores, Live-brpk (Vowst™)

Pharmacy claims for fecal microbiota spores, live-brpk (Vowst™) require a PA.

Fertility Agents

Fertility preparations, when they are used solely for the treatment of infertility, are not reimbursable. The drugs include Clomiphene citrate tablets 50mg, Urofollitropin ampules 75IU, and Menotropins ampules 150IU and 75IU.

Fidanacogene Elaparvovec-dzkt (Beqvez™)

Pharmacy claims for fidanacogene elaparvovec-dzkt (Beqvez™) require a PA.

Givosiran (Givlaari®)

Pharmacy claims for Givosiran (Givlaari®) have a clinical authorization requirement.

Ganaxolone (Ztalmy®)

Pharmacy claims for ganaxolone (Ztalmy®) may be subject to the following:

1. Diagnosis code requirement;
2. Clinical authorization; and
3. Prior use.

If there is no evidence of prior use of ganaxolone (Ztalmy®) or two different anticonvulsant medications (brand or generic/preferred or non-preferred) within the previous 365 days, pharmacy claims submitted for ganaxolone (Ztalmy®) will deny.

Granulocyte Colony Stimulating Factor Agents (GCSF)

Pharmacy claims for Granulocyte Colony Stimulating Factor (GCSF) agents will be subject to the following:

1. Prior or clinical authorization.

Select Granulocyte Colony Stimulating Factor (GCSF) agents are listed in the following chart.

Generic Name (Brand Name Example)
Eflapegrastim-xnst (Rolvedon™)
Filgrastim (Neupogen®)
Filgrastim-aafi (Nivestym®)
Filgrastim-ayow (Releuko®)
Filgrastim-sndz (Zarxio®)
Pegfilgrastim (Neulasta®)
Pegfilgrastim-apgf (Nyvepria®)

Generic Name (Brand Name Example)
Eflapegrastim-xnst (Rolvedon™)
Pegfilgrastim-bmez (Ziextenzo®)
Pegfilgrastim-cbqv (Udenyca®)
Pegfilgrastim-fpgk (Stimufend®)
Pegfilgrastim-jmdb (Fulphila®)
Pegfilgrastim-pbbk (Fylnetra®)
Sargramostim (Leukine®)
Tbo-filgrastim (Granix®)

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Growth Factor Agents

Pharmacy claims for Growth Factor agents require PA. Growth Factor agents are listed in the following chart.

Generic Name (Brand Name Example)
Mecasermin Subcutaneous (Increlex®)
Tesamorelin Acetate Subcutaneous (Egrifta SV®)
Vosoritide Vial (Voxzogo™)

Growth Hormone

Prescriptions for Growth Hormone will be reimbursed when:

1. The prescriber has obtained an approved clinical authorization; and

2. An acceptable diagnosis code has been submitted with the pharmacy claim.

Diagnosis Code Requirement

Pharmacy claims for Growth Hormone will require an acceptable diagnosis code for reimbursement.

Select Growth Hormone agents are listed in the following chart:

Generic Name (Brand Name Examples)
Lonapegsomatropin-tcgd (Skytrofa®)
Somatropin Cartridge, Syringe (Genotropin®)
Somatropin Pen (Norditropin® FlexPro®)
Somatropin Cartridge, Vial (Omnitrope®, Saizen®)
Somatropin Vial (Serostim®, Zomacton®, Zorbtive®)
Somapacitan-beco (Sogroya®)
Somatrogon-ghla (Ngenla®)

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Hepatitis C Virus Direct-Acting (DAA) Antiviral Agents

Hepatitis C Direct Acting Antiviral Agent(s) may be subject to PA and quantity limits.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Hemophilia Agents

Pharmacy claims for select hemophilia agents may be subject to the following:

1. Prior/clinical authorization; and

2. Diagnosis code requirement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/non-preferred agents, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Hereditary Angioedema (HAE) Agents

Pharmacy claims for Hereditary Angioedema agents require an approved clinical pre-authorization for reimbursement. The select HAE agents are as follows:

1. Berotralstat Hydrochlorode (Orladeyo);
2. C1 Inhibitor, Human Injection (Berinert®);
3. C1 Inhibitor, Human Injection (Cinryze®);
4. C1 Inhibitor, Human Injection (Haegarda®);
5. C1 Inhibitor (Recombinant) Injection (Ruconest®);
6. Ecallantide Injection (Kalbitor®);
7. Icatibant Acetate Subcutaneous (Generic);
8. Icatibant Acetate Injection (Firazyr®); and
9. Lanadelumab Injection (Takhzyro®).

Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Inhaled Antibiotics

Pharmacy claims for inhaled antibiotic agents may require the following:

1. PA; and
2. Diagnosis code requirement.

Select inhaled antibiotic agents are listed in the following chart:

Generic Name (Brand Name Example)
Amikacin inhalation suspension (Arikayce®)
Aztreonam solution (Cayston®)
Tobramycin nebulizer solution, inhaler (Bethkis®, Kitabis Pak®, Tobi®)

Imiquimod

Pharmacy claims for imiquimod require a diagnosis code. (See chart below).

Generic-Brand Example	Diagnosis	ICD-10-CM Diagnosis Code
Imiquimod – Zyclara® 2.5%	Actinic Keratosis	L57.0
Imiquimod – Zyclara® 3.75%	Actinic Keratosis	L57.0
	External Genital Warts (Condylomata Acuminata)	A63.0
Imiquimod – Aldara® 5%	Actinic Keratosis	L57.0
	External Genital Warts (Condylomata Acuminata)	A63.0
	Superficial Basal Cell Carcinoma	C44.•1*

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Immune Globulin (Human)

Pharmacy claims for select Immune Globulin (Human) agents have a clinical authorization requirement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Immunomodulators, Lupus

Pharmacy claims for immunomodulators for the treatment of lupus may require PA.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Immunosupressive Agents

Pharmacy claims for immunosuppressive agents may be subject to a prior or clinical authorization.

Select immunosuppressive agents are listed in the following chart.

Generic Name (Brand Name Example)
Avacopan Capsule (Tavneos™)
Azathioprine Tablet (Azasan®; Imuran®)
Belumosudil Tablet (Rezurock™)
Cyclosporine Capsule, Solution (Sandimmune®)
Cyclosporine Capsule, Softgel, Solution – MODIFIED (Neoral®)
Everolimus Tablet (Generic; Zortress®)
Mycophenolate Mofetil Capsule, Suspension, Tablet (CellCept®)
Mycophenolic Acid as Mycophenolate Sodium (Myfortic®)
Sirolimus Solution, Tablet (Rapamune®)
Tacrolimus Capsule, Granule Packet (Prograf®)
Tacrolimus ER Capsule (Astagraf ® XL)
Tacrolimus ER Tablet (Envarus® XR)

Incretin Mimetic/Enhancers

Prescriptions for incretin mimetic/enhancers may be subject to the following:

1. Age requirement;
2. Diagnosis code requirement;
3. Prior or clinical authorization;
4. Prior use [empagliflozin/linagliptin/metformin (Trijardy® XR)];

5. Quantity limits;

6. Maximum daily dose limits; and

7. Terapeutic duplication.

Age Requirement

The following chart list the age requirements for select incretin mimetic/enhancers.

Generic (Brand Example)	Minimum Age
Dulaglutide (Trulicity®)	10 years
Exenatide (Bydureon® BCise™)	10 years
Exenatide (Byetta®)	18 years
Liraglutide (Victoza®)	10 years
Semaglutide (Ozempic®, Rybelsus®)	18 years
Tirzepatide (Mounjaro®)	18 years

Diagnosis Code Requirement

Pharmacy claimes for select incretin mimetic/enhancers require a diagnosis code.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Prior or Clinical Authorization

Pharmacy claims for select incretin mimetic/enhancers may require a prior or clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Prior Use for Empagliflozin/Linagliptin/Metformin (Trijardy® XR)

Pharmacy claims for empagliflozin/linagliptin/metformin (Trijardy® XR) will be subject to prior use verification that there has been one of the following:

1. At least a 90-day supply of **ONE** of the following in the previous 180-day period:
    a. Metformin **AND either** a DPP-4 **or** an SGLT2; **OR**
    b. A combination DPP-4/metformin **or** SGLT2/metformin.
2. At least a 60-day supply of empagliflozin/linagliptin/metformin (Trijardy® XR) in the previous 90-day period.

Quantity Limit

The quantity limits for select incretin mimetics/enhancers are listed in the chart below:

Generic Name (Brand Name Example)	Quantity Limit
Dulaglutide (Trulicity®)	1 syringe per week
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 5 mg / 2.5 mg / 1000 mg	60 tablets per 30 days
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 10 mg / 5 mg / 1000 mg	30 tablets per 30 days
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 12.5 mg / 2.5 mg / 1000 mg	60 tablets per 30 days
Empagliflozin/Linagliptin/Metformin (Trijardy® XR) 25 mg / 5 mg / 1000 mg	30 tablets per 30 days
Semaglutide (Rybelsus®)	30 tablets per 30 days
Tirzepatide (Mounjaro™)	1 syringe per week

Maximum Daily Dose Limit

The maximum dose for select incretin mimetic/enhancers are listed in the chart.

Medication (Brand Name Example)	Maximum Dose
Alogliptin (Nesina®)	25mg/day
Alogliptin/Metformin (Kazano®)	25mg/2000mg per day
Alogliptin/Pioglitazone (Oseni®)	25mg/45mg per day
Exenatide (Bydureon®, Bydureon® BCise™)	2mg/week
Exenatide (Byetta®)	20mcg/day
Linagliptin (Tradjenta®)	5mg/day
Linagliptin/Metformin (Jentadueto®, Jentadueto XR®)	5mg/2000mg per day
Liraglutide (Victoza®)	1.8mg/day
Pramlintide (Symlin®)	Type 1 diabetes: 60mcg SQ immediately prior to each major meal
	Type 2 diabetes: 120mcg SQ immediately prior to each major meal
Saxagliptin (Onglyza®)	5mg/day
Saxagliptin/Metformin ER (Kombiglyze XR®)	5mg/2000mg per day
Semaglutide (Ozempic®)	2mg/week
Sitagliptin (Januvia®)	100mg/day
Sitagliptin/Metformin (Janumet®, Janumet XR®)	100mg/2000mg per day
Sitagliptin (Zituvio™)	100mg/day

*Authorization at POS is required to exceed maximum doses.

Therapeutic Duplication

1. GLP-1 receptor agonists are monitored at the pharmacy POS for duplication of therapy with other GLP-1 receptor agonists or DPP-4 inhibitors;

2. DPP-4 inhibitors are monitored at the pharmacy POS for duplication of therapy with other DPP-4 inhibitors or GLP-1 receptor agonists;

3. Empagliflozin/Linagliptin/Metformin (Trijardy® XR) is monitored at the pharmacy POS for duplication of therapy with DPP-4 inhibitors. Conversely, DPP-4 inhibitors are monitored at the pharmacy POS for duplication of therapy with empagliflozin/linagliptin/metformin (Trijardy® XR); and

4. Empagliflozin/Linagliptin/Metformin (Trijardy® XR) is monitored at the pharmacy POS for duplication of therapy with SGLT2s. Conversely, SGLT2s are

monitored at the pharmacy POS for duplication of therapy with empagliflozin/linagliptin/metformin (Trijardy® XR).

Inotersen (Tegsedi®)

Pharmacy claims for inotersen (Tegsedi®) require a diagnosis code. The diagnosis code must be documented on the prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Generic Name	Brand Name	Diagnosis	ICD-10-CM Diagnosis Code
Inotersen	Tegsedi®)	Polyneuropathy of hereditary transthyretin-mediated amyloidosis	E85.1

Interferons

Select interferons have a diagnosis code requirement. (See chart below).

Generic-Brand Example	Diagnosis	ICD-10-CM Diagnosis Code
Interferon Alfa–2B Recombinant – Intron A®	AIDS–Related Kaposi's Sarcoma	C46.*
	Chronic Hepatitis B	B18.0, B18.1
	Chronic Hepatitis C	B18.2
	External Genital Warts (Condylomata Acuminata)	A63.0
	Follicular Lymphoma	C82.*
	Hairy Cell Leukemia	C91.4*
	Melanoma	C43.*

Interferon Gamma–1B – Actimmune®	Chronic Granulomatous Disease	D71
	Malignant Osteopetrosis	Q78.2
Peginterferon Alfa–2A – Pegasys®	Chronic Hepatitis B	B18.0, B18.1
	Chronic Hepatitis C	B18.2
Peginterferon Alfa–2B – Sylatron®	Melanoma	C43.*

*any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Ivermectin (Stromectol®)

Pharmacy claims for ivermectin (Stromectol®) require an approved diagnosis code for reimbursement at POS.

Ketorolac

Pharmacy claims for oral forms of ketorolac will deny for a quantity greater than 20 or the day supply is greater than five days as exceeding the program's maximum allowed. The pharmacist may override the denial after consultation with the prescriber. The prescriber must supply the diagnosis code and the rationale for using greater than a five day supply of ketorolac. The diagnosis code is required for the claim submission.

NOTE: The *POS User Guide* can be accessed by visiting Section 37.5.1 for detailed billing instructions and override procedures at:
www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf

Lasmiditan (Reyvow®)

Pharmacy claims for lasmiditan (Reyvow®) have a quantity limit of 8 tablets per 30 days.

Lefamulin (Xenleta™)

Pharmacy claims for lefamulin (Xenleta™) have a clinical authorization requirement.

Leniolislab (Joenja®)

Pharmacy claims for leniolislab (Joenja®) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

L-glutamine oral powder (Endari®)

Pharmacy claims for l-glutamine oral powder (Endari®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Linezolid (Zyvox®)

Prescriptions for linezolid (Zyvox®) injections, tablets, and oral suspension will only be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Lipotropics

Pharmacy claims for select lipotropics may require the following:

1. Clinical authorization or PA; and

2. Quantity limit.

Select lipotropics are listed in the following chart:

Generic Name (Brand Name Example)
Alirocumab (Praluent®)
Bempedoic Acid Tablet (Nexletol™)
Bempedoic Acid and Ezetimibe Tablet (Nexlizet™)
Cholestyramine/Aspartame Packet, Powder
Cholestyramine/Sucrose Packet, Powder (Questran®)
Colesevelam Powder Pack, Tablet (Welchol®)
Colestipol Granules, Tablet (Colestid®)

Evinacumab-dgnb Vial (Evkeeza®)
Evolocumab Auto-Injector, Catridge, Prefiled Syringe (Repatha®)
Ezetimibe (Zetia®)
Fenofibrate Capsule Micronized, Capsule, Tablet, Tablet Nanocrystallized (Tricor®)
Fenofibric Acid Tablet (Fibricor®)
Fenofibric Acid Choline Capsule (Trilipix®)
Gemfibrozil Tablet (Lopid®)
Icosapent Ethyl Capsule (Vascepa®)
Inclisiran Syringe (Leqvio®)
Lomitapide Capsule (Juxtapid®)
Omega-3-acid Ethyl Esters Capsule (Lovaza®)

Select lipotropics have quantity limits as listed in the following chart:

Medication (Generic – Brand Example)	Quantity Limit
Alirocumab (Praluent®)	2 injections (2ml) per 28 days
Evolocumab (Repatha®) 140mg/ml	2 injections (2ml) per 28 days
Evolocumab (Repatha®) 420mg/3.5ml	2 injections (7ml) per 28 days
Inclisiran (Leqvio®)	3 injections (4.5mls) per 365 days
Lomitapide (Juxtapid®)	60 capsules per 30 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Lumateperone (Caplyta™)

Prescriptions for lumateperone (Caplyta™) are subject to the following edits:

1. Clinical authorization;
2. Diagnosis Code Requirement;
3. Maximum Daily Dose; and
4. Therapeutic Duplication.

Clinical Authorization Requirement

Pharmacy claims submitted for lumateperone (Caplyta™) will require a clinical authorization for beneficiaries 0-5 years old.

Diagnosis Code Requirement

Pharmacy claims for lumateperone (Caplyta™) require a valid diagnosis code at POS.

Diagnosis	ICD-10-CM Diagnosis Code
Schizophrenia	F20.*

* any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Maximum Daily Dose Limit

Pharmacy claims submitted for lumateperone (Caplyta™) for beneficiaries 6-17 years old will deny.

Pharmacy claims submitted for lumateperone (Caplyta™) for beneficiaries 18 years old or older will deny when the dose exceeds 42mg/day.

Therapeutic Duplication

Pharmacy claims for lumateperone (Caplyta™) will deny if the beneficiary has an active prescription on file for a traditional or atypical oral antipsychotics. Pharmacy claims submitted for a traditional or atypical oral antipsychotic will deny if the beneficiary has an active prescription on file for lumateperone (Caplyta™).

Myasthenia Gravis Agents

Pharmacy claims for Myasthenia Gravis agents require a diagnosis code.

Select Myasthenia Gravis agents are listed in the following chart.

Generic Name (Brand Name Example)
Efgartigimod alfa-fcab (Vyvgart®)
Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart® Hytrulo)
Rozanolixizumab-noli (Rystiggo®)

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Mavacamten (Camzyos™)

Pharmacy claims for mavacamten (Camzyos™) will be subject to the following:

1. Clinical authorization; and

2. Quantity limit.

Quantity Limit

Pharmacy claims for mavacamten (Camzyos™) are subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Mavacamten (Camzyos™)	30 capsules per 30 days

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL, which gives drug specific Clinical Authorization criteria and instructions.

Mitapivat (Pyrukynd®)

Pharmacy claims for mitapivat (Pyrukynd®) require an approved clinical authorization for reimbursement.

Mosquito Repellents

Prescriptions for mosquito repellents are covered to decrease the risk of exposure to the Zika virus. Mosquito repellent coverage will be limited to Medicaid beneficiaries:

1. Who are pregnant; or

2. Of childbearing years (women and men 14-44 years of age) who are trying to conceive.

A prescription will be required to cover one of the following products:

Product Name	Ounces	Bill As
Cutter Backwoods 25 percent Spray	6 oz.	170 g
Cutter Skinsations 7 percent Spray	6 oz.	177 mL
OFF! Family Care 15 percent Spray	2.5 ounces	71 g
OFF! Deep Woods Dry 25 percent Spray	4 ounces	113 g
OFF! Deep Woods 25percent Spray	6 ounces	170 g
OFF! Active 15 percent Spray	6 ounces	170 g
Repel Sportsmen 25 percent Spray	6.5 ounces	184 g
Repel Sportsmen Max 40 percent Spray	6.5 ounces	184 g
Natrapel 20 percent Picaridin	5 ounces	177 mL
Sawyer Insect Repellent 20 percent Picaridin	4 ounces	118 mL

Quantity Limit

One bottle of mosquito repellent will be covered every rolling 30 days.

Age Restriction

Pharmacy claims for mosquito repellents have an age limit of 14 to 44 (of childbearing) years of age.

Multiple Sclerosis (MS) Treatment Agents

Prescriptions for Multiple Sclerosis treatment agents may require the following:

1. Clinical authorization or PA; and
2. Quantity limit.

Select MS treatment agents will be subject to the quantity limit as listed in the chart below:

Generic Name (Brand Name Example)	Quantity Limit
Diroximel fumerate (Vumerity)	120 capsules per 30 days

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Nedosiran (Rivfloza™)

Pharmacy claims for nedosiran (Rivfloza™) require an approved clinical authorization.

Naloxone

Pharmacy claims for naloxone have a quantity limit requirement for reimbursement. Refer to the chart below.

Generic (Brand Example)	Quantity Limit
Naloxone Nasal Spray (Narcan®)	4 units/30 days
Naloxone Nasal Spray (Kloxxado™)	4 units/30 days
Naloxone Injectable Solution/Cartridge 0.4mg/ml	4 units/30 days
Naloxone Injectable Solution Syringe 1mg/ml	4 units/30 days
Naloxone Injectable Solution (5ml, 10ml, 20ml) 1mg/ml	1 unit/30 days
Naloxone Injectable Solution (10ml) 0.4mg/ml	1 unit/30 days
Naloxone Injectable Solution (Zimhi™)	4 syringes (2ml)/30 days

Nicotine Transdermal Patches, Gum and Spray

Select nicotine transdermal patches, nicotine polacrilix gum, and nicotine spray are covered.

Nintedaib (Ofev®)

Pharmacy claims for nintedaib (Ofev®) have a clinical authorization requirement and quantity limit of 60 capsules/30 days.

Omaveloxolone (Skyclarys™)

Pharmacy claims for omaveloxolone (Skyclarys™) will be subject to the following:

1. Clinical Authorization; and

2. Quantity Limit.

The quantity limit for omaveloxolone (Skyclarys™) is listed in the following chart:

Generic Name (Brand Example)	Quantity Limit
Omaveloxolone (Skyclarys™) capsule	90 capsules/30 days

Orlistat

Medicaid will provide reimbursement to outpatient pharmacies for orlistat prescriptions based on the following criteria:

1. Patient is 12 years of age or older;

2. The prescription is for a maximum of 90 capsules **and** 30 days' supply;

3. The beneficiary has a documented current body mass index (BMI) of 27 or greater and the prescriber had identified the BMI, in their handwriting, on the dated prescription or a dated and signed attachment to the prescription or the BMI is entered by the pharmacist in the pharmacy's electronic record keeping system after it is communicated by the prescriber;

4. The beneficiary has other risk factors warranting the use of Orlistat and the prescriber has identified an approved diagnosis code in their handwriting, on the dated prescription or a dated and signed attachment to the prescription; and

5. There are no provisions for override of the prospective drug utilization edits, i.e., early refill (ER) and duplicate drug (ID) editing.

The beneficiary has a diagnosis for other risk factors warranting the use of orlistat (Xenical®) and the prescriber has identified an approved diagnosis code.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Onasemnogene Abeparvovec Injection (Zolgensma®)

Pharmacy claims for onasemnogene abeparvovec injection (Zolgensma®) require a clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Oxybate Salts (Calcium, Magnesium, Potassium, and Sodium) Oral, (Xywav®)

Pharmacy claims for oxybate salts (calcium, magnesium, potassium and sodium) oral, (Xywav™) require clinical authorization and may be subject to a therapeutic duplication.

Incoming prescriptions for oxybate salts (calcium, magnesium, potassium and sodium) oral, (Xywav™) will deny with a therapeutic duplication when there is an active prescription on the beneficiary's file for a CNS depressant medication, whether as a single entity or as a component of a combination product. An active prescription is a prescription in which the days' supply has not expired. Alternately, incoming prescriptions for a CNS depressant medication will deny with a therapeutic duplication when there is an active prescription on the beneficiary's file for oxybate salts (calcium, magnesium, potassium and sodium) oral, (Xywav™).

Palivizumab (Synagis®)

Prescriptions for palivizumab (Synagis®) will only be reimbursed when prescriptions meet the following criteria:

1. The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Respiratory Syncytial Virus Season

Louisiana's respiratory syncytial virus (RSV) activity may be followed during the RSV season by frequently accessing the Center for Disease Control's website. (Refer to Section 37.5.4 for web address). The RSV season in Louisiana begins November 1st and ends March 31st.

Age Restriction

Palivizumab claims for beneficiaries who are 24 months of age or younger on November 1st of the current RSV season meet the POS age requirement.

Early Refill

Palivizumab claims will only process for payment every 28 days. When a pharmacy submits a claim for Synagis® and there is an active paid Synagis® claim on file, the incoming claim will deny. An active prescription is a prescription in which the days' supply has not expired.

Maximum Number of Doses Allowed

Claims billed for Synagis® outside the allowable number of doses will deny, except in an extended RSV Season*. Based upon the diagnosis code submitted, a maximum of five doses of Synagis® will be reimbursed each RSV season. If the initial dose is given in October, the fifth and final dose should be given in February. If initial dose is given in November, the fifth and final dose should be given in March.

NOTE: *In an extended RSV season, the number of allowed doses reimbursable, is increased to accommodate dosing outside the usual RSV season.

Medical Reconsideration for Palivizumab (Synagis®)

Medical reconsideration of a denied clinical authorization decision may be requested by the prescribing practitioner. Medical reconsideration requires completion of the Palivizumab Request for Reconsideration Form.

Palivizumab Criteria ICD-10-CM Code and Medication List

NOTE: Any accepted diagnosis code listed on the Palivizumab Clinical Authorization Form must have supporting documentation attached. Supporting documentation is supplemental information submitted to support the patient meeting the criteria and may include copies of progress notes, hospital discharge notes, pediatric cardiologist consult notes, chart notes, pharmacy profiles, etc.

NOTE: Refer to the Diagnosis Code Policy Chart at:
https://ldh.la.gov/assets/HealthyLa/PDL/7.30.2020/Louisiana.Medicaid.ICD-10.Chart.docx

Penicillamine (Cuprimine®, Depen®)

Pharmacy claims for penicillamine (Cuprimine®, Depen®) have quantity limits. The quantity limits are listed in the chart.

Generic Name	Brand Name	Quantity Limit
Penicillamine	Cuprimine®	240 capsules/30 days
	Depen®	240 tablets/30 days

Pituitary Suppressive Agents

Pharmacy claims for pituitary suppressive agents may require a PA and/or a diagnosis code at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Pompe Disease Agents

Pharmacy claims for Pompe Disease Agents require a diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Potassium Binders

Pharmacy claims for select potassium binder agents may require the following:

1. PA; and

2. Quantity limit.

Select Potassium binder agents are listed in the following chart:

Generic Name (Brand Name Example)
Patiromer (Veltassa®)*
Sodium Polystyrene Sulfonate Powder

Sodium Zirconium Cyclosilicate (Lokelma®)

Pharmacy claims for the following **potassium binder** agent will be subject to a quantity limit as listed in the chart.

Generic Name (Brand Name Example)	Quantity Limit
Patiromer (Veltassa®)	30 packets/30 days

Progestational Agents

Pharmacy claims for progestational agents may be subject to the following:

1. PA;
2. Day Supply; and
3. Diagnosis code requirement.

Select progestational agents are listed in the following chart:

Generic Name (Brand Name Example)
Hydroxyprogesterone Caproate IM Injection*
Medroxyprogesterone Acetate IM, SQ Injection (Depo-Provera®)*
Medroxyprogesterone Acetate Tablet (Provera®)*
Norethindrone Acetate Tablet (Aygestin®)*
Progesterone Capsule, IM Injection (Prometrium®)*
Progesterone, Micronized Capsule,Vaginal Gel (Crinone®)

Select progestational agents dispensed with the following quantities are limited to specific days supply as listed in the chart:

Generic Name (Brand Name Example)	Quantity Dispensed	Days Supply
Medroxyprogesterone Acetate Injection (Depo-Provera®)	1 ml	84 days*

Medroxyprogesterone Acetate SQ Injection (Depo-Provera®)	0.65 ml	84 days**

Progesterone injectable agents require a diagnosis code.

Medication (Brand Example)	Diagnosis Description	Diagnosis Code
Progesterone Injectable	A diagnosis code is required on pharmacy claims for all ages. Pharmacy claims submitted with certain age-specific diagnosis codes **will deny**.	Diagnosis **must** be submitted but **cannot** be: F64* or Z87.890 if beneficiary is younger than 18 years old N97* if beneficiary is any age

Pyrimethamine (Daraprim®)

Prescriptions for pyrimethamine (Daraprim®) will be reimbursed when:

1. The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Schedule II Narcotic Agents

All prescriptions for Schedule II narcotic agents require a diagnosis code indicating the reason for use documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code must be written on the hardcopy prescription by the prescribing practitioner or by the pharmacist in the pharmacy's electronic record keeping system after consultation with the prescriber.

Except for methadone, when the prescribing practitioner does not indicate a diagnosis code on the prescription and when the prescriber cannot be reached, a denial for a missing diagnosis code may

be overridden if the pharmacist determines that the beneficiary cannot wait to receive the medication.

Schedule II narcotic agents are also subject to prospective DURs which address quantity limits.

NOTE: Refer to "Prospective Drug Utilization Policies/Limits/Edits" in this section for further information.

Fentanyl Buccal and Sublingual Agents

Claims for fentanyl buccal and sublingual agents (Abstral®, Actiq®, Fentora® and Onsolis®) **must** contain a cancer-related diagnosis code in order for the claim to process for payment through the POS System.

Acceptable diagnosis codes are as follows:

ICD-10-CM Code Range	Description
C00.*-C96*	Cancer

Buccal and sublingual agents are subject to prospective DURs which address quantity limits.

Diagnosis Code Requirement

Pharmacy claims for fentanyl nasal solution (Lazanda®) and fentanyl sublingual liquid (Subsys®) require an appropriate diagnosis code documented on the hardcopy prescription by either the prescriber or pharmacist. The pharmacist may document the diagnosis code after electronic or verbal consultation with the prescribing practitioner on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Age Restriction

Claims for fentanyl nasal solution (Lazanda®) and fentanyl sublingual liquid (Subsys®) will deny when the beneficiary is 17 years of age or younger.

Methadone

All prescriptions for methadone must have a diagnosis code for payment. There are no provisions for an override of methadone when a diagnosis code is omitted. Methadone products when used for the treatment of opioid addiction in detoxification or maintenance programs shall only be dispensed by opioid treatment programs certified by the Substance Abuse and Mental Health Services Administration.

Prescriptions for methadone will be reimbursed when the prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Morphine ER (Avinza®)

When the cumulative daily dosage for Morphine ER (Avinza®) exceeds the maximum daily dosage, the claim will deny. The maximum daily dosage for this agent is 1600mg per day. There is no provision for override through the POS system for Morphine ER (Avinza®) when the maximum daily dosage is exceeded.

Oxycodone/Acetaminophen 7.5/325mg (Xartemis XR®)

Prescriptions for oxycodone/acetaminophen (Xartemis XR®) require an appropriate diagnosis code documented on the hard copy prescription by the prescriber or pharmacist. The pharmacist may document the diagnosis code after electronic or verbal consultation with the prescribing practitioner on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Pharmacy claims for oxycodone/acetaminophen (Xartemis XR®) have a quantity limit of 30 units every 15 days within a 30-day period.

Paroxetine Mesylate (Brisdelle®)

Pharmacy claims for paroxetine mesylate (Brisdelle®) require submission of a valid diagnosis code at POS for reimbursement. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The following table lists the acceptable diagnosis codes for paroxetine mesylate (Brisdelle®).

Medication	ICD-10-CM Diagnosis Code*	Diagnosis Description
Paroxetine Mesylate (Brisdelle®)	E28.310	Moderate to severe vasomotor symptoms associated with menopause
	E89.41	
	N95.1	

Patisiran (Onpattro®)

Pharmacy claims for patisiran (Onpattro®) require a diagnosis code. The diagnosis code must be documented on the prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Generic Name	Brand Name	Diagnosis	ICD-10-CM Diagnosis Code
Patisiran	Onpattro®	Polyneuropathy of hereditary transthyretin-mediated amyloidosis	E85.1

Perampanel (Fycompa®)

Age Limit

Pharmacy claims for perampanel (Fycompa®) will deny for beneficiaries under four years of age.

After consultation with the prescriber to verify the necessity of prescribing perampanel (Fycompa®) for a beneficiary under four years of age, the pharmacist may override the age restriction. The reason for service code, professional service code and result of service code used in submitting the claim must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Pirfenidone (Esbriet®)

Pharmacy claims for pirfenidone (Esbriet®) have a clinical authorization requirement and quantity limit of 90 capsules or tablets/30 days.

Pulmonary Arterial Hypertension (PAH)

Pharmacy claims for agents for the treatment of pulmonary arterial hypertension have the following edits:

1. Diagnosis code requirement;
2. Quantity limit; and
3. Monitoring for drug-drug interaction.

Pulmonary arterial hypertension treatment agents require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

The quantity limit for agents for the treatment of pulmonary arterial hypertension are listed in the chart below.

Medication	Quantity Limit
Ambrisentan Tablet (Letairis®)	30 tablets per 30 days
Bosentan Tablet for Suspension (Tracleer®)	120 tablets per 30 days
Bosentan Tablet (Tracleer®)	60 tablets per 30 days
Iloprost Inhalation Solution (Ventavis®)	9 cartons per 30 days

Macitentan Tablet (Opsumit®)	30 tablets per 30 days
Macitentan and Tadalafil (Opsynvi®)	30 tablets per 30 days
Riociguat Tablet (Adempas®)	90 tablets per 30 days
Selexipag Dose Pack (Uptravi®)	1 dose pack per 365 days
Selexipag Tablet (Uptravi®)	60 tablets per 30 days
Sildenafil Oral Suspension (Liqrev®)	1 bottle (122ml) per 20 days
Sildenafil Powder for Oral Suspension (Revatio®)	1 bottle (112ml) per 19 days
Sildenafil Tablet (Revatio®)	90 tablets per 30 days
Sotatercept-csrk (Winrevair™)	2 bottles (300ml) per 30 days
Tadalafil Tablet (Alyq™; Adcirca®)	60 tablets per 30 days
Tadalafil Suspension (Tadliq®)	2 bottles (300ml) per 30 days
Treprostinil ER Tablet Titration Kit (Month 1, 2, 3) (Orenitram®)	1 of each kit per 365 days
Treprostinil Inhalation Solution Starter Kit with Device (Tyvaso®)	1 starter kit per 2 years
Treprostinil Inhalation Solution Refill Kit (Tyvaso®)	1 refill kit per 28 days
Treprostinil Inhalation Powder Titration Kit (Tyvaso DPI™)	1 titration kit per 365 days
Treprostinil Inhalation Maintenance Kit (Tyvaso DPI™)	1 kit per 28 days

Drug-Drug Interaction

Pharmacy claims for macitentan/tadalafil, sildenafil and tadalafil are monitored at the pharmacy POS for a drug-drug interaction with nitrates.

1. Incoming prescriptions for macitentan/tadalafil, sildenafil or tadalafil will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for a nitrate; and

2. Incoming prescriptions for a nitrate will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for macitentan/tadalafil, sildenafil or tadalafil.

Quinine Sulfate

Pharmacy claims for quinine sulfate (Qualaquin®) 324mg have a quantity limit of

42 capsules/7 day supply per 365 days.

Ravulizumab-cwvz (Ultomiris®)

Pharmacy claims for ravulizumab-cwvz (Ultomiris®) require an appropriate ICD-10-CM diagnosis code for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at: www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Resmetirom (Rezdiffra ™)

Pharmacy claims for resmetirom (Rezdiffra™) require a clinical authorization.

Risdiplam (Evrysdi™)

Pharmacy claims for risdiplam (Evrysdi™) have a quantity limit and clinical authorization requirement.

Generic Name	Brand Name	Quantity Limit
Risdiplam	Evrysdi™	160 ml (2-80 ml bottles)

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Ritlecitinib (Litfulo™)

Pharmacy claims for ritlecitinib (Litfulo™) require an approved clinical authorization for reimbursement.

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL, which gives drug specific clinical authorization criteria and instructions.

Ropeginterferon alfa-2b-njf (Besremi®)

Pharmacy claims for ropeginterferon alfa-2b-njf (Besremi®) require an appropriate diagnosis code for reimbursement.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Roflumilast (Daliresp®)

Pharmacy claims for roflumilast (Daliresp®) require an approved clinical authorization for reimbursement.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Selumetinib (Koselugo™)

Pharmacy claims for selumetinib (Koselugo®) have a clinical authorization requirement and quantity limit of 120 capsules/30 days.

Semaglutide (Rybelsus®)

Pharmacy claims for semaglutide (Rybelsus®) are subject to a prior use and quantity limit edit.

Pharmacy claims for semaglutide (Rybelsus®) will have a quantity limit of 30 tablets/30 days. Pharmacy claims for semaglutide (Rybelsus®) will require previous use of metformin or a paid claim for semaglutide (Rybelsus®) or another Incretin Mimetic Enhancers. An incoming claim for semaglutide (Rybelsus®) will deny if there is no evidence of a paid claim(s) for at least 90 days of metformin therapy in the previous 180-day period or if there is no evidence of paid

claims of at least 60 days of semaglutide (Rybelsus®) or other Incretin Mimetic/Enhancers within the previous 90 days.

Short-Acting Beta$_2$ Agonist Inhalers

Prescriptions for short- acting beta$_2$ agonist inhalers (SABAs) (i.e albuterol, levalbuterol, and pirbuterol):

1. Require an appropriate diagnosis code; and

2. Are subject to a maximum quantity of six short-acting beta$_2$ agonist inhalers per calendar year.

Diagnosis Code Requirement

The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone or facsimile.

Diagnosis codes which bypass the 6 inhaler limit are noted below:

Generic – Brand Example	Diagnosis Description	ICD-10-CM Diagnosis Code(s)
Albuterol – ProAir HFA®, ProAir RespiClick®, ProAir Digihaler®, Proventil HFA®, Ventolin HFA® **YQ** Levalbuterol – Xopenex HFA® **YQ** *Yearly Quantity Limit (YQ)*	Bronchitis, not specified	J40
	Chronic Airway Obstruction	J44.9
	Cystic Fibrosis	E84.*
	Emphysema	J43.*
	Obstructive Chronic Bronchitis, Chronic Obstructive Asthma	J44.*

* – any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code.

Pharmacy claims that do not indicate a diagnosis code on the prescription and the prescriber cannot be reached; a denial for a missing diagnosis code may be overridden by the pharmacist entering the emergency override.

Quantity Limit

If the prescriber chooses to exceed the quantity limit, the prescriber must provide the reason why the limit needs to be exceeded. The pharmacist may override the limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record-keeping system the following:

1. The prescriber's reason why the limit needs to be exceeded; and

2. The NCPDP DUR override codes used in submitting the claim.

If the prescriber cannot be reached, the pharmacist may override the quantity limit by entering the emergency override. The pharmacist must document "Emergency" on the hardcopy prescription and the reason for entering the emergency override.

Therapeutic Duplication

Pharmacy claims billed for concurrent use of different SABAs will deny with a therapeutic duplication. After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication. This consultation is necessary to confirm that:

1. The prescriber is aware of the current active SABA claim; and

2. The addition of a different SABA is necessary (i.e., a change in therapy).

To bill concurrent therapy with different SABAs, the pharmacist must document on the hardcopy prescription or the pharmacy's electronic recordkeeping system the following:

1. The reason why an additional SABA was requested by the prescriber; and

2. The NCPDP DUR override codes used in submitting the claim.

NOTE: Refer to 'Drugs with Special Payment Criteria/Limitations' in this section for further policy regarding short-acting beta$_2$ agonist inhalers.

Sickle Cell Anemia Treatment Agents

The following sickle cell anemia treatment agents may require PA:

Generic Name (Brand Name)
Crizanlizumab-tmca Infusion (Adakveo®)
Exagamglogene autotemcel (Casgevy™)
Hydroxyurea Capsule (Generic; Droxia®)
Hydroxyurea Tablet (Siklos®)
L-glutamine Powder Pack (Generic; Endari™)
Lovotibeglogene autotemcel (Lyfgenia®)

Skeletal Muscle Relaxants

Pharmacy claims for skeletal muscle relaxants that contain codeine (carisoprodol-aspirin-codeine) will deny at the POS if the beneficiary is less than 12 years of age.

Pharmacy claims for skeletal muscle relaxants are subject to a quantity limit. (See chart below.)

Medication	Quantity Limit per 30 days
Baclofen 10mg	120 Units
Baclofen 20mg	120 Units
Cyclobenzaprine 5mg	90 Units
Cyclobenzaprine 7.5mg	90 Units
Cyclobenzaprine 10mg	90 Units
Cyclobenzaprine 15mg	30 Units
Cyclobenzaprine 30mg	30 Units
Tizanidine 2mg	90 Units
Tizanidine 4mg	90 Units
Tizanidine 6mg	180 Units

Smallpox and Monkeypox Live Vaccine (Jynneos)

The administration of the Smallpox and Monkeypox, Live Vaccine (Jynneos) is covered in the pharmacy program. The federal government covers the ingredient cost.

Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combination Products

Prescriptions for Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and combination products will be reimbursed when:

1. The prescriber has obtained an approved clinical authorization.

Prior Use of Metformin Required (SGLT2 Inhibitors Only)

An incoming pharmacy claim for a SGLT2 inhibitor will require evidence of previous use of metformin or a paid claim for the requested medication or another medication within the same therapeutic class.

An incoming claim for a SGLT2 inhibitor will deny if there is not a paid claim(s) for at least 90 days of metformin therapy OR there is no evidence of at least 60 days of paid claims for the requested medication (or another SGLT2 inhibitor).

Exception: Pharmacy claims submitted for dapagliflozin (Farxiga®) and empagliflozin (Jardiance®) will bypass the POS prior drug use requirement for metformin and SGLT2 when submitted with an appropriate bypass diagnosis code of heart failure (I50*) or chronic kidney disease (N18*).

NOTE: ** can be any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code.*

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Sodium Oxybate (Xyrem®)

Clinical Pre-Authorization

Pharmacy claims for sodium oxybate (Xyrem®) will be reimbursed when the prescriber has obtained an approved clinical authorization. A diagnosis of narcolepsy or cataplexy must be submitted in the clinical authorization process.

Therapeutic Duplication

Pharmacy claims for sodium oxybate (Xyrem®) will deny when the beneficiary has an active claim on file for a CNS depressant. Claims for CNS depressants will deny when the beneficiary has an active claim on file for sodium oxybate (Xyrem®).

CNS depressant medications include the following agents, whether given as a single entity or as a component of a combination product:

Alprazolam	Dantrolene	Metaxalone	Quazepam
Baclofen	Diazepam	Methadone	Ramelteon
Buprenorphine	Dihydrocodeine	Methocarbamol	Remifentanil
Buspirone	Doxepin	Midazolam	Secobarbital
Butabarbital	Estazolam	Morphine	Sufentanil
Butalbital	Eszopiclone	Nalbuphine	Suvorexant
Butorphanol	Fentanyl	Opium	Tapentadol
Carisoprodol	Flurazepam	Orphenadrine	Tasimelteon
Chlordiazepoxide	Hydrocodone	Oxazepam	Temazepam
Chlorzoxazone	Hydromorphone	Oxycodone	Tizanidine
Clonazepam	Levorphanol	Oxymorphone	Tramadol
Clorazepate	Lorazepam	Paregoric	Triazolam
Codeine	Meperidine	Pentazocine	Zaleplon
Cyclobenzaprine	Meprobamate	Phenobarbital	Zolpidem

The therapeutic duplication edit for sodium oxybate (Xyrem®) and CNS depressants can be overridden in emergency circumstances. These claims will require consultation and approval from the prescribing provider to override the therapeutic duplication. After consultation with the prescribing provider, the pharmacist may override the therapeutic duplication with the emergency override. The pharmacist must document "**Emergency**" on the hardcopy prescription and the reason why the prescribing provider choose to override the therapeutic duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Somatropin

Pharmacy claims for Somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin®, Nutropin AQ®, Omnitrope®, Saizen®, Serostim®, Tev-Tropin®, and Zorbtive®) require an

appropriate diagnosis code for reimbursement. The numeric code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile.

There are no overrides for this edit. However, the pharmacist may contact the prescriber for a valid diagnosis code and resubmit the claim.

The following chart addresses acceptable diagnosis code(s) which are in accordance with the reimbursement criteria for somatropin.

ICD-10-CM Diagnosis Code(s)	Diagnoses
N25.0	Growth failure in children associated with: Renal insufficiency or chronic kidney disease
Q87.1	Noonan Syndrome
Q87.1	Prader-Willi Syndrome
Q96	Turner Syndrome
P05.1	Small for gestational age at birth (fetal growth retardation) who fail to manifest catch-up growth or with no catch-up growth
R62.52	Short Stature in children (idiopathic or SHOX deficiency) 1. Short stature 2. Lack of expected normal physiological development in childhood
E23.0	Pituitary dwarfism
E23.0	Panhypopituitarism
E23.1, E89.3	Iatrogenic pituitary disorders
K90.2, K91.2	(Zorbitive® only) Short Bowel Syndrome in patients receiving specialized nutritional support: 1. Blind Loop Syndrome 2. Other unspecified post-surgical nonabsorption
R64	(Serostim® only) HIV-associated cachexia or wasting

Spinal Muscular Atrophy Agents

The following spinal muscular atrophy agents may require prior or clinical authorization.

Generic Name (Brand Name)
Nusinersen (Spinraza®)*
Onasemnogene abeparvovec-xioi (Zolgensma®)
Risdiplam (Evrysdi®)

***** *Nusinersen (Spinraza®) has a drug specific clinical authorization form.*

Quantity Limit

Risdiplam (Evrysdi™) is limited to a maximum quantity of 160ml (2-80ml bottles) every 24 days.

Statin Agents

Pharmacy claims for select statin agents may be subject to the following:

1. PA; and
2. Therapeutic duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Sulfonylurea Agents

Pharmacy claims for sulfonylurea agents may be subject to the following:

1. PA; and
2. Therapeutic duplication.

Sulfonylurea agents may be subject to a therapeutic duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Suvorexant (Belsomra®)

Pharmacy claims for suvorexant (Belsomra®) are subject to a maximum daily dosage limit of 20 mg/day.

Tafamidis (Vyndaqel®, Vyndamax®)

Pharmacy claims for tafamidis (Vyndaqel®, Vyndamax®) have a quantity limit.

Generic Name	Brand Name	Quantity Limit
Tafamidis	Vyndaqel®	120 capsules/30 days
Tafamidis	Vyndamax®	30 capsules/30days

Tasimelteon (Hetlioz®)

Prescription claims for tasimelteon (Hetlioz®) may be subject to the following clinical edits:

1. Clinical Authorization;
2. Quantity Limit;
3. Maximum Daily Dose; and
4. Therapeutic Duplication.

Clinical Authorization for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) will be reimbursed at POS when the prescriber has obtained an approved clinical authorization.

Override provisions should be addressed through the Clinical Authorization process.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Maximum Dose for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) have a maximum daily dose of 20mg/day. There are no override provisions through the POS system using NCPDP service codes.

Therapeutic Duplication for tasimelteon (Hetlioz®)

Pharmacy claims for tasimelteon (Hetlioz®) will deny at POS if there is an active claim for another sedative-hypnotic agent.

After consultation with the prescriber to verify the necessity of the therapeutic duplication, the pharmacist may override the therapeutic duplication.

The pharmacist must document the override codes on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

Quantity Limit for tasimelteon (Hetlioz LQ™)

Pharmacy claims for tasimelteon (Hetlioz LQ™) have a maximum quantity of 158 mls per 31 days.

Tazarotene (Tazorac®)

Pharmacy claims for Tazarotene (Tazorac®) require an appropriate diagnosis code for reimbursement. The prescribing provider must document the diagnosis code on the hard copy prescription or may communicate the diagnosis code to the pharmacist electronically, via telephone, or facsimile.

The acceptable diagnosis codes are:

ICD-10-CM Code	Description
L40*	Psoriatic Arthritis

* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Pharmacy providers may direct questions to the Provider Help Desk concerning overrides for this edit. (Refer to Section 37.5.4 for contact information).

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Tedizolid Phosphate (Sivextro®)

Prescriptions for tedizolid phosphate (Sivextro®) will be reimbursed when:

1. The prescriber has obtained an approved clinical pre-authorization.

Teplizumab-mzwv(Tzield™)

Pharmacy claims for teplizumab-mzwv (Tzield™) require an approved clinical authorization for reimbursement.

Tesamorelin (Egrifta®)

Pharmacy claims for tesamorelin (Egrifta®) require a diagnosis code. The diagnosis code must be documented on the prescription or in the pharmacy's electronic recordkeeping system. The pharmacist can document the diagnosis code after electronic or verbal consultation with the prescribing practitioner.

Tiotropium Bromide (Spiriva Respimat®)

Pharmacy claims for tiotropium bromide (Spiriva Respimat®) will require a diagnosis code.

Medication	Description of Diagnosis	ICD-10 Code
Spiriva Respimat® 1.25 mcg (tiotropium bromide)	Asthma	J45*
Spiriva Respimat® 2.5 mcg (tiotropium bromide)	COPD	J44*

*any number or letter or combination of UP TO 4 numbers and letters of an assigned ICD-10_CM diagnosis code.

Tolvaptan (Samsca®)

Pharmacy claims for tolvaptan (Samsca®) have quantity limits. The quantity limits for tolvaptan (Samsca®) are listed in the chart.

Generic Name	Brand Name	Quantity Limit
Tolvaptan	Samsca® 15mg	30 tablets/30 days
	Samsca® 30 mg	60 tablets/30 days

Tramadol

Pharmacy claims for tramadol–containing products have the following edits:

1. Age Limit;
2. Clinical Authorization; and
3. Maximum Daily Dose.

Description	Age (Y=Year)
Tramadol	≥12 Y
Tramadol Combination Product	≥12 Y

Pharmacy claims for tramadol and tramadol combination products will deny at POS if the beneficiary is less than 12 years of age.

Pharmacy claims for tramadol-containing products submitted for beneficiaries 12-17 years of age without an approved clinical authorization will deny.

Generic Name	Maximum Dose per Day	Age
Tramadol Immediate Release	400 mg/day	<76 years
Tramadol Immediate Release	300 mg/day	>75 years

Tramadol Extended Release	300 mg/day	
Tramadol/Acetaminophen	8 tablets/day	

Trientine Tetrahydrochloride (Cuvrior™)

Pharmacy claims for trientine tetrahydrochloride (Cuvrior™) will be subject to the following:

1. Clinical authorization; and
2. Quantity limit.

The quantity limit for trientine tetrahydrochloride (Cuvrior™) is listed in the following chart.

Generic Name (Brand Example)	Quantity Limit
Trientine Tetrahydrochloride (Cuvrior™)	300 tablets/30 days

Trifarotene (Aklief®)

Pharmacy claims for trifarotene (Aklief®) will deny at POS when the beneficiary is younger than 9 years of age or older than 20 years of age.

Triptans

Pharmacy claims for triptans for beneficiaries under 18 years of age will require a valid diagnosis code for reimbursement. Triptans are identified in the following chart:

Generic Name	Representative Brand(s)
Almotriptan	Axert®6
Eletriptan	Relpax®
Frovatriptan	Frova®
Naratriptan	Amerge®
Rizatriptan	Maxalt®, Maxalt MLT®

Generic Name	Representative Brand(s)
Sumatriptan	Alsuma®, Imitrex®, Sumavel®, Zecuity®
Zolmitriptan	Zomig®, Zomig ZMT®

The acceptable ICD-10-CM diagnosis codes for triptans in beneficiaries less than 18 years of age are as follows:

Drug-Brand Example	Diagnosis	ICD-10-CM Diagnosis Code
Almotriptan – Axert® Eletriptan – Relpax® Frovatriptan – Frova® Naratriptan – Amerge® Rizatriptan – Maxalt®, Maxalt MLT® Sumatriptan [Oral, Nasal] – Imitrex®, Onzetra Xsail®, Tosymra® Sumatriptan [Injection] – Zembrace SymTouch® Zolmitriptan – Zomig®, Zomig ZMT®	Migraine	G43.0*, G43.1*, G43.7*
Sumatriptan [Injection] – Imitrex®, Sumavel®	Migraine	G43.0*, G43.1*, G43.7*
	Cluster Headache, Acute	G44.009

Trofinetide (Daybue™)

Pharmacy claims for trofinetide (Daybue™) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Urea Cycle Disorder Agents

Pharmacy claims for Urea Cycle Disorder agents may require a prior or clinical authorization.

Select Urea Cycle Disorder agents are listed in the following chart.

Generic Name (Brand Example)
Carglumic Acid (Carbaglu®)
Glycerol Phenylbutyrate (Ravicti®)
Sodium Phenylbutyrate Pellet (Pheburane®, Olpruva™)
Sodium Phenylbutyrate Powder, Tablet (Buphenyl®)

Note: Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL for preferred/non-preferred agents, drug specific clinical authorization criteria and instructions.

Vaccines (Adult)

Louisiana Medicaid will reimburse enrolled **pharmacies** for select adult vaccines and the COVID vaccine administered by a pharmacist with the "Authority to Administer" authorized by the Louisiana Board of Pharmacy. Adult vaccine reimbursement includes reimbursement for the ingredient cost and administration fee.

Counseling for Vaccines

Counseling for vaccines will be reimbursed for beneficiaries less than 21 years old when the vaccine is administered and criteria has been met.

The following criteria must be followed to receive reimbursement for vaccine counseling:

1. Confirm that the patient is not currently "up-to-date" with vaccine dosing, as recommended by the Advisory Committee on Immunization Practices (ACIP) or Centers for Disease Control and Prevention (CDC);

2. Confirm vaccination status in the Louisiana Immunization Network for Kids Statewide (LINKS), whenever possible;

3. Confirm patient consent of the parent, guardian or caregiver (if appropriate) to receive the counseling and vaccine;

4. Document the type and Brand of the vaccine or booster;

5. Confirm the Medicaid beneficiary is (for counseling reimbursement):

    a. From 3-20 years old for COVID vaccine;

    b. From 3-20 years old for influenza vaccine; or

    c. From 3-20 years old for all other vaccines:

NOTE: PREP Act allowance for ages 3-6 years until January 1, 2030 for COVID and influenza vaccines.

6. Counsel the patient, along with their parent, guardian, or caregiver (if appropriate) on the safety and effectiveness of vaccines;

7. Answer any questions that the patient or parent, guardian, or caregiver has regarding vaccination;

8. Counsel the patient, along with their parent, guardian, or caregiver (if appropriate) for a minimum of five minutes; and

9. Administer the vaccine.

Pharmacist Requirements

For adult vaccine reimbursement, the pharmacist shall:

1. Be registered with the Louisiana Board of Pharmacy with the "Authority to Administer" vaccines;

2. Be registered as a Louisiana Medicaid provider;

3. Inform the individual that the administration of an immunization or vaccine is not to be construed as being in lieu of an annual preventive visit with the individual's primary care or family physician;

4. Access the Louisiana Immunization Network for Kids (LINKS) prior to immunization administration, if possible, to verify appropriate utilization according to the Advisory Committee on Immunization Practices (ACIP) to prevent duplication, unnecessary doses, inappropriate age, etc.;

5. Report each immunization to the Louisiana Department of Health (LDH), Office of Public Health's LINKS at the time of the immunization or as soon as reasonably possible, thereafter;

6. Report all adverse events observed or which are reported to the pharmacist to the Vaccine Adverse Events Reporting System, or its successor program; and further, the pharmacist shall refer the patient with an adverse event to appropriate medical care;

7. Report certain data elements to the CDC for each COVID vaccine administered within 24 hours of administration, as a vaccination Provider;

8. Ensure that pharmacy technicians and/or state-authorized pharmacy interns administering COVID vaccines meet PREP Act qualifications. The qualified pharmacy technicians and/or state-authorized pharmacy interns act under the supervision of a qualified pharmacist. The supervising qualified pharmacist of qualified pharmacy technicians and/or state-authorized interns must comply with CDC, state, and federal requirements for COVID vaccine administration; and

9. Request the name of a patient's primary care provider prior to the administering of any immunization. The pharmacist shall notify the primary care provider, by written or electronic communication, as soon as reasonably possible that the immunization was administered.

All 340B pharmacies carved-in to Medicaid may bill vaccines and the administration fee for adults (19 years and older) at POS as a pharmacy benefit.

There will be no copay assessed on adult vaccine claims. Third party billing policy will apply and Medicaid will be the payer of last resort.

Pharmacy claims for vaccines will bypass POS edits for the four prescription monthly limit and pharmacy Lock-In.

The following chart lists select adult vaccines with age limits covered when administered by a pharmacist as a pharmacy claim:

Vaccines	Brand Name Examples	Age Limit
BCG LIVE	BCG (TICE Strain)	≥ 19 years
COVID	Various Brands	*
H. influenzae Type B Conjugate	Hiberix	≥ 19 years
Hepatitis A Adult	Vaqta®, Havrix®	≥ 19 years
Hepatitis A – Hepatitis B Adult	Twinrix®	≥ 19 years
Hepatitis B Adult (recombinant adjuvanted)	Heplisav-B®	≥ 19 years
Hepatitis B Adult (recombinant)	Engerix-B®, *Recombivax HB*®	≥ 19 years
Hepatitis B vaccine [trivalent (recombinant)]	PreHevbrio®	≥ 19 years
HPV – Human Papillomavirus 9-valent	Gardasil®9	19-45 years
Influenza Vaccine	Various Brands	*
Japanese Encephalitis	Ixiaro	≥ 19 years
Measles, Mumps & Rubella	M-M-R®II, Priorix®	≥ 19 years
Meningococcal (Groups A, B, C, W, and Y)	Penbraya	10-25 years
Meningococcal Conjugate (Groups A, C, Y and W-135)	Menveo®, Menactra®, MenQuadfi®	≥ 19 years
MENB – Meningococcal Group B	Trumenba®, Bexsero®	≥ 19 years
Pneumococcal – 13-valent	Prevnar 13™	≥ 19 years
Pneumococcal – 15-valent	Vaxneuvance™	≥ 19 years
Pneumococcal – 20-valent	Prevnar 20™	≥ 19 years
Pneumococcal Polysaccharide (23-valent)	Pneumovax®23	≥ 19 years

Poliomyelitis	Ipol	≥ 19 years
Rabies Vaccine	Imovax®, RabAvert®	≥ 19 years
RSV Vaccine, Pref A and Pref B	Abrysvo	≥ 60 years
RSVPREF3 Antigen	Arexvy Kit, Arexvy Vial	≥ 60 years
Smallpox and Monkeypox	Jynneos	*
Tetanus and Diphtheria Toxoids	TDVAX®, *Tenivac*®	≥ 19 years
Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis	Adacel®, Boostrix®	≥ 19 years
Varicella	Varivax®	≥ 19 years
Yellow Fever	Stamaril, YF-Vax	≥ 19 years
Zoster Vaccine Recombinant, adjuvanted	Shingrix®	≥ 18 years

*There are select age ranges for specific vaccines based on the package insert.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

COVID Vaccine

The COVID vaccines are covered by the Louisiana Medicaid pharmacy program. The at home administration of the COVID vaccine is not a covered service effective May 12, 2023. The COVID vaccine administration by pharmacist will be covered for beneficiaries 3 years of age and older in accordance with current prescribing information and PREP ACT guidelines until January 1, 2030.

COVID Oral Agents

Pharmacy claims for nirmatrelvir/ritonavir (Paxlovid®) used in the treatment of COVID are covered.

Nirmatrelvir/ritonavir (Paxlovid®) is subject to the following quantity limit and age requirements.

Drug	Quantity Limit	Age Requirement
nirmatrelvir/ritonavir (Paxlovid®)	30 tablets/5 days	≥12 years

COVID Over-the-Counter (OTC) At Home Tests

COVID OTC at home diagnostic tests are not covered. Reimbursement for COVID OTC tests ended September 30, 2024.

Vamorolone (Agamree®)

Pharmacy claims for vamorolone (Agamree®) require an approved clinical authorization.

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

Prescriptions for Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors: deutetrabenazine (Austedo®), tetrabenazine (Xenazine®), and valbenazine (Ingrezza®) will be reimbursed when:

1. The prescriber has obtained an approved clinical authorization.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Velmanase alfa-tycv (Lamzede®)

Pharmacy claims for velmanase alfa-tycv (Lamzede®) require an appropriate diagnosis code entered at POS.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Zoledronic Acid (Reclast®)

Pharmacy claims for zoledronic acid (Reclast®) are subject to the quantity limit listed in the chart.

Generic Name	Brand Name	Quantity Limit
Zoledronic Acid	Reclast®	1 vial/365 days

Zuranolone (Zurzuvae™)

Pharmacy claims for zuranolone (Zurzuvae™) require a PA and are subject to the quantity limits listed in the chart below.

Medication (Brand Example)	Quantity Limit
Zuranolone (Zurzuvae™) 20 mg	28 capsules per 14 days
Zuranolone (Zurzuvae™) 25 mg	28 capsules per 14 days
Zuranolone (Zurzuvae™) 30 mg	14 capsules per 14 days

Diagnosis Code Requirement for Selected Medications

Prescriptions for selected medications require a diagnosis code for reimbursement for both FFS Medicaid and the MCOs. The diagnosis code should be documented on the hardcopy prescription by the prescriber or pharmacist. The pharmacist may document the diagnosis code on the hardcopy prescription or in the pharmacy's electronic recordkeeping system after electronic or verbal consultation with the prescribing practitioner.

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Prospective Drug Utilization Policies/Limits/Edits

Pharmacy claims are processed utilizing prospective DUR system which consists of criteria set forth by the state-established DUR board which monitors for inappropriate use of medications and identifies potential drug conflicts. It is designed to work alongside the POS claims processing and eligibility systems, displaying alert messages, based on severity level, to alert of any possible harmful effects that a medication may have on a patient. The alerts generated are caused by various

combinations of interactions between a beneficiary's condition, beneficiary's historical drug prescription records on file and the current medications prescribed for them.

Professional judgment regarding appropriate drug use is the responsibility of the pharmacist. Improper use of DUR override codes by pharmacy staff may result in the disallowance of these override codes and administrative sanctions by Medicaid and the Board of Pharmacy.

Prospective DUR monitors:

1. Duration of therapy;
2. Early refill;
3. Duplicate drug therapy;
4. Pregnancy and FDA Category X drugs;
5. Therapeutic duplication;
6. Drug to drug interaction;
7. Unnecessary drug therapy;
8. Age and gender restrictions;
9. Maximum dosage;
10. Quantity Limits; and
11. Drugs to diagnosis.

NOTE: Refer to Section 37.5.12 for an overview of Patient Counseling, DUR.

Histamine (H_2) Antagonists

Pharmacy claims for H_2 antagonists may be subject to a PA.

NOTE: Refer to Section 37.5.5 of this manual chapter to access the Single PDL, which is inclusive of the preferred/NPDL, clinical authorization list, drug specific forms, criteria, and POS edits at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Proton Pump Inhibitors (PPIs)

Pharmacy claims for proton pump inhibitors (PPIs) may be subject to following:

1. Prior or clinical authorization;
2. Duration of therapy;
3. Quantity limit; and
4. Therapeutic duplication.

Select proton pump inhibitors (PPIs) are listed in the following chart.

Generic Name (Brand Name Example)
Dexlansoprazole Capsule (Dexilant®)
Esomeprazole Capsule, Suspension (Nexium®)
Lansoprazole Capsule, ODT (Prevacid®, Prevacid SoluTab®)
Omeprazole Capsule Rx, Granules for Suspension (Prilosec®)
Omeprazole/Sodium Bicarbonate Oral Suspension (Konvomep®)
Omeprazole/Sodium Bicarbonate Rx Capsule, Packet (Zegerid®)
Pantoprazole Suspension, Tablet (Protonix®)
Rabeprazole Tablet (AcipHex®)

Duration of Therapy

Pharmacy claims for all PPIs are subject to a duration of therapy limit of **180 days** in a rolling **365-day period**.

Duration of Therapy Exemptions

The following conditions are exempt from the duration of therapy limit:

1. Beneficiaries under 6 years of age; OR

2. Beneficiaries receiving pancreatic enzymes; OR

3. Pharmacy claims submitted with an appropriate bypass diagnosis code.

Diagnosis Codes Exempt from the Duration of Therapy Limit for PPIs

Select diagnosis codes are exempt and bypass the duration of therapy edit for PPIs. (See the following chart for the listing).

Diagnosis	ICD-10-CM Diagnosis Code(s)
Abscess of Esophagus	K20.8
Angiodysplasia of Stomach and Duodenum (with OR without Mention of Hemorrhage)	K31.81*
Atrophic Gastritis with Hemorrhage	K29.41
Barrett's Esophagus	K22.7*
Cerebral Palsy (*new Aug 2019)*	G80*
Chronic Pancreatitis	K86.0, K86.1
Congenital Tracheoesophageal Fistula	Q39.1, Q39.2
Cystic Fibrosis	E84.*
Eosinophilic Esophagitis	K20.0
Eosinophilic Gastritis	K52.81
Gastrointestinal Hemorrhage	K92.2
Gastrointestinal Mucositis (Ulcerative)	K92.81
Malignant Mast Cell Tumors	C96.2*
Multiple Endocrine Adenomas	D44.0, D44.2, D44.9
Tracheoesophageal Fistula	J86.0, J95.04
Ulcer of Esophagus with OR without Bleeding	K22.1*
Zollinger-Ellison Syndrome	E16.4

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

Quantity Limit

Pharmacy claims for PPIs will be subject to a quantity limit as listed in the chart:

Generic Name (Brand Name Example)	Quantity Limit per 30 Days
Dexlansoprazole Capsule (Dexilant®)	30 capsules
Esomeprazole Capsule (Nexium®)	30 capsules
Esomeprazole Granules for Oral Suspension (Nexium®)	1 carton of 30 packets
Lansoprazole Capsule (Prevacid®)	30 capsules
Lansoprazole ODT (Prevacid® SoluTab®)	30 tablets
Omeprazole Capsule/Tablet (Prilosec®)	30 capsules/tablets
Omeprazole Granules for Oral Suspension (Prilosec®)	1 carton of 30 packets
Omeprazole/Sodium Bicarbonate Capsule (Zegerid®)	30 capsules
Omeprazole/Sodium Bicarbonate Packet (Zegerid®)	30 packets
Omeprazole/Sodium Bicarbonate Suspension (Konvomep™)	600 ml
Pantoprazole Granules for Oral Suspension (Protonix®)	1 carton of 30 packets
Pantoprazole Tablet (Protonix®)	30 tablets
Rabeprazole Sprinkle Capsule (AcipHex® Sprinkle™)	30 capsules
Rabeprazole Tablet (AcipHex®)	30 tablets

Therapeutic Duplication

Pharmacy claims for PPIs will deny at POS with a therapeutic duplication if there is an active claim for another PPI on the beneficiary's file.

Early Refill

The Medicaid Program denies pharmacy claims for early refills if the patient has requested the same medication at the same pharmacy prior to 85 percent of medication being utilized. This translates into a five day window based on a 30-day supply.

Prescriptions for narcotic analgesics will deny for an early refill edit when less than 90 percent of the medication had been utilized. This translates into a two day window based on a 30-day supply.

Pharmacists must enter the actual days' supply for each pharmacy claim. If the number of days is not apparent, an estimate must be given based on professional judgment.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a beneficiary's request for medication earlier than previously reported in the estimated days' supply.

The pharmacist must document the circumstances on the prescription hard copy.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Duplicate Drug Therapy

A claim denial will occur if the beneficiary attempts to obtain the same drug (form and strength) from a different pharmacy sooner than is anticipated based on the estimated days' supply.

After consultation with the physician, beneficiary and/or the POS help desk, the provider must determine whether there are extenuating circumstances which substantiate the dispensing of a duplicate claim.

The pharmacy provider shall record documentation of circumstances and specific contacts for the override.

For those isolated instances when one pharmacy has billed a claim, and special circumstances prevented the beneficiary from receiving the prescription from the pharmacy originally billing the claim an override is allowed. An override should only be used if the second pharmacy attempting to bill a claim for the same ingredient for the same beneficiary and cannot have the first claim reversed by the original billing pharmacy. A notation to that effect must be written on the hardcopy prescription or in the pharmacy's electronic record keeping system. Pharmacy claims submitted with an override code are subject to the pharmacy audit process.

When both duplicate drug therapy and early refill clinical events occur, reimbursement will not be made. These situations indicate multiple pharmacy shopping patterns.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Pregnancy and FDA Category X Drugs

The Medicaid Program denies pharmacy claims with FDA Pregnancy Category for pregnant women. Pharmacy claims submitted for a drug in this category for beneficiaries with a co-payment designation of pregnancy will be denied.

The specific drugs that are currently included in FDA Pregnancy Category X are listed below. The Medicaid Program may add drugs to these lists as new drugs appear on the market or as FDA indications change.

There is no override option for these claims.

Pregnancy and FDA Category D Drugs

Pharmacy claims submitted with FDA Pregnancy Category D drugs will receive an educational edit in the response from the Medicaid Program. These claims will not deny.

Prior Drug Use

Pharmacy claims for select drugs will require prior use of other drug(s) before reimbursement.

Olmesartan/amlodipine/hydrochlorothiazide (Tribenzor®) and amlodipine/valsartan/hydrochlorothiazide (Exforge HCT®) will require prior drug use of two drug therapies from these select drug classes: calcium channel blockers, angiotensin receptor blockers, and/or diuretics. If previous claims for drugs in two of these three drug classes (calcium channel blockers, angiotensin receptor blockers, and/or diuretics) are not identified, the pharmacy claim will deny.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Therapeutic Duplication

The Medicaid Program denies pharmacy claims for oral formulations of drugs in the following classes and specific drugs if the beneficiary has an active paid claim on file for another drug in the

same therapeutic class. An active prescription is a prescription in which the days' supply has not expired.

If an override is determined appropriate after contacting the prescriber, additional documentation of the reason for service code, professional service code and result of service code is required on the hard copy prescription or in the pharmacy's electronic record keeping system. Additional requirements may be associated with certain drug classes or specific drugs.

First Generation Antihistamine

Brompheniramine Maleate	Carbinoxamine Maleate
Clemastine Fumarate	Cyproheptadine HCL

If a first generation antihistamine is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

Second Generation Antihistamine

Cetirizine HCL	Desloratadine
Fexofenadine HCL	Levocetirizine Dihydrochloride
Loratadine	

If a second generation antihistamine is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

First Generation Antihistamine-Decongestant

Pseudoephedrine HCL/Brompheniramine	Psuedoephedrine HCL/Triprolidine HCL
Phenylephrine/Diphenhydramine	Pseudoephedrine HCL/Chlorpheniramine

If a first generation antihistamine-decongestant product, is given with another first and/or second generation antihistamine or antihistamine-decongestant product, he claim will deny due to a therapeutic duplication.

Second Generation Antihistamine-Decongestant

Cetirizine HCL/Pseudoephedrine	Fexofenadine/Pseudoephedrine

Loratadine/Pseudoephedrine	Desloratadine/Pseudoephedrine

If a second generation antihistamine-decongestant product, is given with another first and/or second generation antihistamine or antihistamine-decongestant product, the claim will deny due to a therapeutic duplication.

Claims for diphenhydramine, hydroxyzine HCl, and hydroxyzine pamoate are not included in the antihistamine edits for therapeutic duplication.

Angiotensin Converting Enzyme (ACE) Inhibitors and ACE Inhibitor/Diuretic Combinations

Benazepril HCl	Lisinopril/Hydrochlorothiazide
Benazepril HCl/Hydrochlorothiazide	Moexipril HCl
Captopril	Moexipril/Hydrochlorothiazide
Captopril/Hydrochlorothiazide	Perindopril Erbumine
Enalapril Maleate	Quinapril HCl
Enalapril/Hydrochlorothiazide	Quinapril/Hydrochlorothiazide
Fosinopril Sodium	Fosinopril Sodium
Fosinopril/Hydrochlorothiazide	Ramipril
Lisinopril	Trandolapril

ACE Inhibitors/Calcium Channel Blocker Combinations

Benazepril/Amloipine	Trandolapril/Verapamil HCl

Angiotensin Receptor Antagonists (ARB) and ARB/Diuretic Combinations

Candesartan Cilexetil	Losartan/Hydrochlorothiazide
Candesartan/Hydrochlorothiazide	Olmesartan Medoxomil
Eprosartan Mesylate	Olmesartan/Hydrochlorothiazide
Eprosartan/Hydrochlorothiazide	Telmisartan
Irbesartan	Telmisartan/Hydrochlorothiazide
Irbesartan/Hydrochlorothiazide	Valsartan
Losartan Potassium	Valsartan/Hydrochlorothiazide

ARB/Calcium Channel Blocker Combinations

Olmesartan Medoxomil/Amlodipine	Valsartan/Amlodipine

Beta-Adrenergic Blocking Agents and Beta-Adrenergic Blocking Agent/Diuretic Combinations

Acebutolol HCl	Nadolol
Atenolol	Nadolol/Bendroflumethiazide
Atenolol/Chlorthalidone	Nebivolol HCl
Betaxolol HCl	Penbutolol Sulfate
Bisoprolol Fumarate	Pindolol
Bisoprolol/Hydrochlorothiazide	Propranolol HCl
Carvedilol	Propranolol/Hydrochlorothiazide
Carvedilol CR	Sotalol AF
Labetalol HCl	Sotalol HCl
Metoprolol ER	Timolol Maleate
Metoprolol Tartrate	Timolol/Hydrochlorothiazide
Metoprolol/Hydrochlorothiazide	

Calcium Channel Blockers

Amlodipine	Nifedipine
Diltiazem	Nimodipine
Felodipine	Nisoldipine
Isradipine	Verapamil
Nicardipine	

Calcium Channel Blocker/Antihyperlipemia Agent Combination

Amlodipine/Atorvastatin Calcium

Potassium Replacement

Potassium Acetate	Potassium Bicarbonate/Citric Acid
Potassium Chloride	Potassium Citrate

Tricyclic Antidepressants

Amitriptyline HCl	Imipramine Pamoate
Amoxapine	Maprotiline HCl
Clomipramine HCl	Nortriptyline HCl
Desipramine HCl	Protriptyline HCl
Doxepin HCl	Trimipramine Maleate
Imipramine HCl	

Selective Serotonin Reuptake Inhibitors

Citalopram HBr	Paroxetine HCl
Escitalopram Oxalate	Paroxetine Mesylate
Fluoxetine HCl	Sertraline HCl
Fluvoxamine Maleate	

Antipsychotic Agents (Typical and Atypical)

Prescriptions for antipsychotic agents will deny for therapeutic duplication when the beneficiary has two active antipsychotic prescriptions on their file. The pharmacist must document on the hard copy prescription the reason the prescriber required the beneficiary to receive a third antipsychotic agent.

Note: Refer to "Drugs with Special Payment Criteria/Limitations" in this section for further policy regarding antipsychotic agents.

Typical Antipsychotic Agents

Chlorpromazine	Pimozide
Fluphenazine	Thioridazine
Haloperidol	Thiothixene
Loxapine	Trifluoperazine
Molindone	
Perphenazine	

Atypical Antipsychotic Agents

Aripiprazole	Lurasidone
Asenapine	Olanzapine
Brexpiprazole	Paliperidone
Cariprazine	Quetiapine
Clozapine	Risperidone
Iloperidone	Ziprasidone

Antipsychotic /Selective Serotonin Reuptake Inhibitor Combinations

Pharmacy claims for olanzapine/fluoxetine will deny when there are two active prescriptions for antipsychotic agents on the beneficiary's file or when there is one active prescription for a selective serotonin reuptake inhibitor (SSRI) on the beneficiary's history file.

Olanzapine/Fluoxetine

Anti-Anxiety Agents

Alprazolam	Hydroxyzine
Buspirone	Lorazepam, Lorazepam XR
Chlordiazepoxide	Meprobamate
Chlorazepate	Oxazepam
Diazepam	

The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic recod keeping system the reason an additional anti-anxiety agent was requested by the prescriber.

An additional anti-anxiety agent may be submitted without a therapeutic duplication when the beneficiary has a diagnosis of seizures. The diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system, after written or verbal consultation with the prescriber and submitted electronically for the override.

Acceptable diagnosis codes are:

ICD-10-CM Diagnosis Code(s)	Description
P90	Convulsions in Newborn
G40.*	Epilepsy, Seizures
R56.*	Other Convulsions

Sedative Hypnotic Agents

Estazolam	Temazepam
Eszopiclone	Triazolam
Flurazepam HCl	Zaleplon
Quazepam	Zolpidem Tartrate

Attention Deficit Disorder (ADD) Agents

Armodafinil	Guanfacine
Atomoxetine	Lisdexamfetamine
Dexmethylphenidate	Methylphenidate
Dextroamphetamine	Modafinil
Dextroamphentamine/amphetamine	

An incoming pharmacy claim for any of the above ADD agents will deny when there is an active paid claim for any of these agents on the beneficiary's file written by a different prescriber.

Non-Steroidal Anti-Inflammatory Agents

Celecoxib	Ibuprofen	Meloxicam
Diclofenac Potassium	Ibuprofen/Hydrocodone Bitartrate	Nabumetone
Diclofenac Sodium	Ibuprofen/Oxycodone	Naproxen
Diclofenac Sodium/Misoprostol	Indomethacin	Naproxen Sodium
Diflunisal	Ketoprofen	Naproxen/Lansoprazole
Etodolac	Ketorolac Tromethamine	Oxaprozin
Fenoprofen Calcium	Meclofenamate Sodium	Piroxicam
Flurbiprofen	Mefenamic Acid	Tolmetin Sodium

Short-Acting Beta$_2$ Agonist Inhalers

Albuterol	Pirbuterol
Levalbuterol	

Pharmacy claims billed for concurrent use of different short-acting beta$_2$ agonist inhalers (SABAs) will deny with a therapeutic duplication.

Note: Refer to 'Drugs with Special Payment Criteria/Limitations' in this section for further policy regarding short-acting beta$_2$ agonist inhalers.

Short-Acting Opiate Agents

Buprenorphine*	Hydrocodone/APAP
Buprenorphine/Naloxone*	Hydrocodone/Ibuprofen
Butorphanol Tartrate	Hydromorphone HCl IR
Codeine Phosphate	Levorphanol Tartrate
Codeine Phosphate/APAP	Meperidine HCl
Codeine/ASA	Methadone HCl
Codeine Sulfate	Morphine Sulfate IR
Codeine/APAP/Caffeine/Butalbital	Oxycodone HCl IR
Codeine/ASA/Caffeine/Butalbital	Oxycodone/APAP
Codeine/Carisoprodol/ASA	Oxycodone ASA
Dihydrocodeine/APAP/Caffeine	Oxycodone/Ibuprofen
Fentanyl Ciltrate Buccal	Oxymorphone
Pentazocine/APAP	Tramadol HCl
Pentazocine/Naloxone	Tramadol HCl/APAP

NOTE: Concurrent prescriptions for opioid analgesics with buprenorphine agents may only be overridden when issued by the same physician.

Long-Acting Opiate Agents

Fentanyl Transdermal	Oxycodone HCl CR
Morphine Sulfate CR	Oxymorphone ER

Proton Pump Inhibitors

Esomerprazole	Omeprazole/Soduim Bicarbonate
Lansoprazole	Pantoprazole
Omeprazole	Rabeprazole

Sulfonylureas

A pharmacy claim for a sulfonylurea will deny if there is an active claim on the beneficiary's file for another sulfonylurea.

The Department may add drugs to these lists as new drugs appear on the market.

NOTE: Refer to Section 37.5.8 - Claim Submission and Processing Payments for override information as well as the *POS User Guide* accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing information.

Drug/Drug Interaction

There may be some situations where adverse interactions could potentially occur between two drugs. In these instances the UniDUR system denies one or both of these claims.

Prescriptions for nitrates will deny when there is an active prescription for Sildenafil (Revatio®) or Tadalafil (Adcirca®) on the beneficiary's drug history file. Conversely, prescriptions for Sildenafil (Revatio®) and Tadalafil (Adcirca®) will deny when there is an active prescription for nitrates on the drug history file.

Upon consultation with the prescriber, the pharmacist may override this interaction. The pharmacist must document the reason the prescriber required the beneficiary to receive a nitrate and Sildenafil (Revatio®) or Tadalafil (Adcirca®). In addition, documentation of the reason for service code, professional service code and result of service code is required on the hardcopy prescription or in the pharmacy's electronic record keeping system. These DUR codes are required for the claim submission.

Unnecessary Drug Therapy

Selective Cox-2 Inhibitor

Pharmacy claims for the selective COX-2 inhibitor, celecoxib (Celebrex®) will deny for "drug use not warranted" if they are not submitted with an appropriate diagnosis code and reason for treatment documented on the hard prescription.

The FDA issued a public health advisory which stated that use of a COX-2 selective agent may be associated with an increased risk of serious cardiovascular events, especially when it is used for long periods of time or in very high-risk settings (e.g. immediately after heart surgery).

The FDA made the following interim recommendations:

1. Practitioners prescribing Celecoxib (Celebrex®) should consider this emerging information when weighing the benefits against risks for individual patients. Patients who are at a high risk of gastrointestinal (GI) bleeding, have a history of intolerance to non-selective NSAIDs or are not doing well on non-selective NSAIDs may be appropriate candidates for COX-2 selective agents; and

2. Individual patient risk for cardiovascular events and other risks commonly associated with NSAIDs should be taken into account for each prescribing situation.

As a result of this public health advisory and to help ensure the safety and well-being of Medicaid beneficiaries, the prescribing practitioner must include:

1. The condition being treated with the COX-2 selective agent by indicating the diagnosis code of the treated condition on all new prescriptions written for a COX-2 selective agent; and

2. The reason a COX-2 selective agent is used rather than a non-selective NSAID (e.g. treatment failure or history of a GI bleed).

The diagnosis code and the rationale for the choice of a COX-2 selective agent must be documented on the hardcopy prescription or in the pharmacy's electronic record keeping system after consultation with the prescriber. The diagnosis code and the rationale may be submitted as an attachment to the original prescription via facsimile.

A prescription written for a COX-2 selective agent for a Medicaid beneficiary will only process without an override when the following conditions are met:

1. A diagnosis code indicating the reason for treatment is documented and submitted; and

2. When one of the following conditions exists:

    a. Beneficiary has current prescription for H2 receptor antagonist;

    b. Beneficiary has current prescription for proton pump inhibitor;

    c. Beneficiary has current prescription for warfarin;

    d. Beneficiary has current prescriptions indicating chronic use of oral steroids; or

    e. Beneficiary is 60 years of age or older.

If, in the professional judgment of the prescriber, a determination is made which necessitates therapy with a COX-2 selective agent, the pharmacist may override this edit. The pharmacy provider must supply the reason for service code, professional service code and result of service code with the POS submission of the claim and have the information recorded on the hardcopy prescription or in the pharmacy's electronic record keeping system.

NOTE: Refer to Section 37.5.8 - Claim Submission and Processing Payments for override information as well as the *POS User Guide* accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing information.

Maximum Dosage

Atypical Antipsychotic Agents

Pharmacy claims for doses of antipsychotic agents which exceed the maximum recommended doses will deny.

NOTE: Refer to Antipsychotic Agents of this section for the age limits and dosage schedules for antipsychotic agents.

The prescriber may choose to override an age or dosage limit for an antipsychotic medication. Overrides for antipsychotic medications can be addressed by the provider contacting the RxPA Unit. When the pharmacist cannot reach the prescriber or the RxPA Unit is closed, the pharmacist, using their professional judgment, may deem the filling of the antipsychotic prescription to be an "emergency." In these emergency cases, the pharmacist must indicate "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system and override the age or dosage limit.

Agents Containing Acetaminophen or Aspirin

Due to the potential of hepatotoxicity, claims billed with a dosage of acetaminophen that exceeds four grams per day will deny. Claims for products containing aspirin will deny payment when the maximum daily dosage billed exceeds four grams per day. Please note that patients may also be consuming over the counter products that contain either acetaminophen or aspirin.

The maximum regimens apply to both brand name and generic products. As new products are added to the drug file, maximum daily dosages will apply.

Overrides for the (high dose) denial are only acceptable when the prescriber is consulted and approval is given. A notation stating the reason and the codes used to override the claim should be noted on the hardcopy prescription or in the pharmacy's electronic record keeping system.

It is imperative that pharmacists use their professional judgment to determine an appropriate days' supply based upon the directions noted by the prescriber.

Suspending Agents

Pharmacy claims for the following select suspending agents are reimbursable:

Generic Name	Trade Name1
Compounding Vehicle Suspension No. 19	Mx-Sol Blend; Ora Blend

Compound Vehicle Suspension SF No. 20	Ora Plus
Compounding Vehicle No. 8	Ora Sweet
Compound Vehicle Sugar Free No. 9	Ora Sweet SF

Sedative Hypnotic Agents

Pharmacy claims which exceed the maximum daily dosage limit for selected sedative hypnotic agents will deny at POS.

The maximum daily doses for the selected sedative hypnotic agents are as follows:

Generic Name	Brand Name	Maximum Dose Per Day
Daridorexant	QuvivqTM	50mg/day
Doxepin (sedative-hypnotic only)	Silenor®	6 mg/day
Estazolam	Prosom®	2 mg/day
Eszopiclone	Lunesta®	3 mg/day
Flurazepam	Dalmane®	30 mg/day
Lemborexant	Dayvigo®	10mg/day
Quazepam	Doral®	15 mg/day
Ramelteon	Rozerem®	8 mg/day
Suvorexant	Belsomra®	20mg/day
Tasimelteon	Heltioz®	20mg/day
Temazepam	Restoril®	30 mg/day
Triazolam	Halcion®	0.5 mg/day

Generic Name	Brand Name	Maximum Dose Per Day
Zaleplon	Sonata®	20 mg/day
Zolpidem IR tablet	Ambien®	10 mg/day
Zolpidem SL tablet	Edluar®	10 mg/day
Zolpidem oral spray	Zolpimist®	10 mg (2sprays)/day
Zolpidem ER tablet	Ambien CR®	12.5 mg/day
Zolpidem SL tablet	Intermezzo®	1.75mg/day (female)
Zolpidem SL tablet	Intermezzo®	3.5 mg/day (male)

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdfor by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Pharmacy claims for the following sedative hypnotics will be subject to thequantity limits listed in the chart below:

Generic Name (Brand Name Example)	Naïve 7-day supply per rolling 30 days[1]	Chronic Use 15-day supply per 30 rolling days[2]
Daridorexant (Quviviq™)	7 tablets	15 tablets
Doxepin Tablet (Silenor®)	7 tablets	15 tablets
Estazolam Tablet (ProSom®)	7 tablets	15 tablets
Eszopiclone Tablet (Lunesta®)	7 tablets	15 tablets
Flurazepam Capsule (Dalmane®)	7 capsules	15 capsules
Lemborexant (Dayvigo®)	7 tablets	15 tablets
Ramelteon Tablet (Rozerem®)	7 tablets	15 tablets
Suvorexant Tablet (Belsomra®)	7 tablets	15 tablets
Temazepam Capsule (Restoril®)	7 capsules	15 capsules
Triazolam Tablet (Halcion®)	7 tablets	15 tablets
Zaleplon Capsule (Sonata®)	7 capsules	15 capsules
Zolpidem IR (Ambien®)	7 tablets	15 tablets
Zolpidem ER (Ambien CR®)	7 tablets	15 tablets

Generic Name (Brand Name Example)	Naïve 7-day supply per rolling 30 days[1]	Chronic Use 15-day supply per 30 rolling days[2]
Zolpidem Sublingual (Edluar®; Intermezzo®)	7 tablets	15 tablets

[1] Oral sedative hypnotics for a naïve beneficiary have a 7 day supply per rolling 30 days. Naïve is defined as having no paid claims for a sedative hypnotic in the previous 60 days.

[2] Oral sedative hypnotics for chronic use have a 15 day supply per rolling 30 days. Chronic use is defined as having a paid claim for a sedative hypnotic in the previous 60 days.

Additional information for oral sedative hypnotics:

1. Pharmacy claims for all sedative/hypnotic agents (except dexmedetomidine, tasimelteon capsule and zolpidem tartrate oral spray) are limited to:

    a. A quantity of 7 per rolling 30 days for beneficiaries who have no sedative/hypnotic pharmacy claims in the previous 60-day period;

    b. A quantity of 15 per rolling 30 days for beneficiaries who have any sedative/hypnotic pharmacy claim in the previous 60-day period; and

    c. Tasimelteon (Hetlioz LQ™) is limited to a maximum quantity of 158 ml per 31 days.

Exclusions for quantity limit edits for oral sedative hypnotics:

1. Pharmacy claims submitted with an ICD-10-CM diagnosis code of palliative care (Z51.5) in **NCPDP field 424-DO** will bypass the quantity limit; and

2. Pharmacy claims submitted for tasimelteon capsule (Hetlioz®) and zolpidem tartrate oral spray (ZolpiMist®) are excluded.

Sedative hypnotics are monitored at POS for duplication of therapy with other sedative/hypnotic agents.

Tapentadol (Nucynta®)

When the cumulative daily dosage for Tapentadol (Nucynta®) exceeds the maximum daily dosage of 700mg per day, the claim will deny.

If the prescribing practitioner chooses to exceed the maximum daily dosage, the prescribing practitioner must provide the reason why the daily dosage limit needs to be exceeded. The pharmacist may override the dosage limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic recordkeeping system the reason for service code, professional service code and result of service code with the POS submission.

Agents containing Tramadol

Pharmacy claims for doses of agents containing Tramadol which exceed the maximum recommended doses will deny.

The maximum daily doses for agents containing Tramadol are as follows:

Generic Name	Maximum Dose per Day	Age
Tramadol Immediate Release	400mg/day	<76 years
Tramadol Immediate Release	300mg/day	>75 years
Tramadol Sustained Release	300mg/day	
Tramadol/Acetaminophen	8 tablets/day	

If the prescribing practitioner chooses to exceed the maximum daily dosage, the prescribing practitioner must provide the reason why the daily dosage limit needs to be exceeded. The ***pharmacist may override the dosage limit after consultation with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason why the daily dosage limit needs to be exceeded. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record

keeping system the reason for service code, professional service code and result of service code with the POS submission.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Tramadol/Celecoxib (Seglentis®)

Pharmacy claims for tramadol/celecoxib (Seglentis®) will have the following POS edits:

1. Age limit;
2. Concurrent Use;
3. Drug-Drug Interaction;
4. Maximum Daily Dose;
5. Morphine Milligram Equivalent (MME) Limit;
6. Quantity limit; and
7. Therapeutic Duplication.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Botulinum Toxins OnabotulinumtoxinA (Botox®), IncobotulinumtoxinA (Xeomin®), RimabotulinumtoxinB (Myobloc®)

Quantity Limit

Pharmacy claims for onabotulinumtoxinA (Botox®) will have quantity limits of 6 units every rolling 84 days for the 100 unit vial and 3 units every rolling 84 days for the 200 unit vial. Pharmacy claims for incobotulinumtoxinA (Xeomin®) will have quantity limits of 400 units every rolling 84 days.

Diagnosis Code Requirement

Prescriptions for onabotulinumtoxinA (Botox®) and incobotulinumtoxinA (Xeomin®) require an appropriate diagnosis code documented on the hard copy prescription by either the prescriber or pharmacist. The diagnosis code may be communicated to the pharmacist electronically, via telephone, or facsimile. After consultation with the prescriber, the pharmacist must document the diagnosis code on the hard copy prescription or in the pharmacy's electronic recordkeeping system. The diagnosis code is required for the claim submission.

Acceptable Diagnosis Codes for OnabotulinumtoxinA (Botox®)

ICD-10-CM Diagnosis Code(s)	Description
L74.510	Axillary Hyperhidrosis
G24.5	Blepharospasm
G24.3	Cervical Dystonia
G43.7*	Chronic Migraine (Prophylaxis)
N32.81	Overactive Bladder
H49*, H50*, H51*	Strabismus
G35	Upper or Lower Limb Spasticity Associated with Multiple Sclerosis (Relapsing)
G80.0, G80.1, G80.2, G80.4, G80.8, G80.9	Upper or Lower Limb Spasticity Associated with Cerebral Palsy
G81.1*	Upper or Lower Limb Spasticity Associated with Spastic Hemiplegia
G82.53	Upper or Lower Limb Spasticity Associated with Complete Quadriplegia
G82.54	Upper or Lower Limb Spasticity Associated with Incomplete Quadriplegia
G83.0	Upper Limb Spasticity Associated with Diplegia of Upper Limb
G83.1*, G83.2*, G83.3*	Spasticity Associated with Monoplegia of Upper or Lower Limb

ICD-10-CM Diagnosis Code(s)	Description
L74.510	Axillary Hyperhidrosis
G24.5	Blepharospasm
G24.3	Cervical Dystonia
G43.7*	Chronic Migraine (Prophylaxis)
N32.81	Overactive Bladder
H49*, H50*, H51*	Strabismus
I69.•31, I69.•32, I69.•33, I69.•34, I69.•39, I69.•41, I69.•42, I69.•43, I69.•44, I69.•49	Spasticity Associated with Monoplegia of Upper or Lower Limb due to Late Effects Cerebrovascular Disease
S06.1*, S06.2*, S06.3*, S06.4*, S06.5*, S06.6*, S06.8*, S06.9*	Upper or Lower Limb Spasticity Associated with Intracranial Injury of Other and Unspecified Nature (Traumatic Brain Injury)
S14.0*, S14.1•5*, S14.1•6*, S14.1•7*	Upper or Lower Limb Spasticity Associated with Spinal Cord Injury without Evidence of Spinal Bone Injury
N36.44, N31.9	Urinary Incontinence (Detrusor Overactivity Associated with Neurological Disease)

* - any number or letter or combination of UP TO FOUR numbers and letters of a valid ICD-10-CM diagnosis code
• - any ONE number or letter of a valid ICD-10-CM diagnosis code

Acceptable Diagnosis Codes for IncobotulinumtoxinA (Xeomin®)

ICD-10-CM Diagnosis Code(s)	Description
G24.5	Blepharospasm
G24.3	Cervical Dystonia
K11.7	Chronic Sialorrhea
G35	Upper Limb Spasticity (ULS) Associated with Multiple Sclerosis (Relapsing)
G80.0, G80.1, G80.2, G80.4, G80.8, G80.9	Upper Limb Spasticity (ULS) Associated with Cerebral Palsy
G81.1*	Upper Limb Spasticity (ULS) Associated with Spastic Hemiplegia
G82.53	Upper Limb Spasticity (ULS) Associated with C5-C7 Complete Quadriplegia
G82.54	Upper Limb Spasticity (ULS) Associated with C5-C7 Incomplete Quadriplegia
G83.0	Upper Limb Spasticity (ULS) Associated with Diplegia of Upper Limb
I69.□31, I69.□32, I69.□33, I69.□34, I69.□39	Upper Limb Spasticity (ULS) Associated with Monoplegia of Upper Limb due to Late Effects of Cerebrovascular Disease
I69.□51, I69.□52, I69.□53, I69.□54, I69.□59	Upper Limb Spasticity (ULS) Associated with Hemiplegia due to Late Effects of Cerebrovascular Disease
S06.1*, S06.2*, S06.3*, S06.4*, S06.5*, S06.6*, S06.8*, S06.9*	Upper Limb Spasticity (ULS) Associated with Intracranial Injury of Other and Unspecified Nature (Traumatic Brain Injury)
G83.2*	Upper Limb Spasticity (ULS) Associated with Monoplegia of Upper Limb
S14.0*, S14.1□5, S14.1□6, S14.1□7	Upper Limb Spasticity (ULS) Associated with Spinal Cord Injury without Evidence of Spinal Bone Injury (C5-C7)

* - any number or letter or combination of UP TO FOUR numbers and letters of a valid ICD-10-CM diagnosis code
• - any ONE number or letter of a valid ICD-10-CM diagnosis code

Acceptable Diagnosis Codes for RimabotulinumtoxinB (Myobloc®)

ICD-10-CM Diagnosis Code(s)	Description
K11.7	Chronic sialorrhea

Lidocaine Patches (Lidoderm®)

Pharmacy claims for lidocaine patches (Lidoderm®) have a quantity limit of 30 patches every rolling 30 days.

Select lidocaine patches (Lidoderm®) and lidocaine patch kits may require PA or clinical authorization.

Lofexidine (Lucemyra®)

Pharmacy claims for lofexidine (Lucemyra®) are subject to the following:

1. Age limit;
2. Maximum Daily Dose;
3. Quantity Limit; and
4. Diagnosis Code Requirement.

Pharmacy claims for lofexidine (Lucemyra®) will deny for beneficiaries 17 years or younger.

Lofexidine (Lucemyra®) pharmacy claims are subject to a maximum daily dose of 2.88 mg (16 tablets) per day.

Pharmacy claims for lofexidine (Lucemyra®) tablets are limited to a 14-day supply (224 tablets) per 6-month period (180 days).

Lofexidine (Lucemyra®) pharmacy claims have the following diagnosis code requirement.

Midazolam (Nayzilam®)

Pharmacy claims for midazolam (Nayzilam ®) have a quantity limit.

Generic (Brand Example)	Quantity Limit
Midazolam (Nayzilam®)	5 boxes (10 doses) per 30 days

Naltrexone Tablets

Naltrexone tablets are subject to the following:

1. Age limit;
2. Diagnosis code requirement;
3. Drug-Drug Interaction; and
4. Therapeutic Duplication.

Pharmacy claims for naltrexone tablets will deny for beneficiaries 17 years or younger.

Generic – Brand Example	Diagnosis Description	ICD-10-CM Diagnosis Code(s)
Lofexidine – Lucemyra®	Opioid abuse with withdrawal	F11.13
	Opioid dependence with withdrawal	F11.23
	Opioid use, unspecified with withdrawal	F11.93

Pharmacy claims for naltrexone tablets have the following diagnosis code requirement.

Generic Name	Diagnosis Description	ICD-10-CM Diagnosis Code(s)
Naltrexone Tablets	Opioid dependence	F11.2*
	Alcohol dependence	F10.2*

	* – any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD–10–CM diagnosis code

Pharmacy claims for naltrexone tablets will deny at POS with a drug-drug interaction when there is an active claim on the beneficiary's file for an opioid or buprenorphine-containing product. Pharmacy claims for opioids or buprenorphine-containing products will deny with a drug-drug interaction when there is an active claim on the beneficiary's file for naltrexone tablet.

Incoming pharmacy claims for any naltrexone agent will deny for therapeutic duplication when the beneficiary has an active prescription on file for any other naltrexone agent.

Naltrexone Injection (Vivitrol®)

Pharmacy claims for naltrexone injection (Vivitrol® are subject to the following for reimbursement:

1. Diagnosis code requirement;
2. Age Limit;
3. Quantity Limit; and
4. Drug-Drug Interaction.

Diagnosis Code Requirement

The acceptable diagnosis code(s) for naltrexone injection (Vivitrol®) are listed below:

Medication	Diagnosis Description	ICD-10-CM Diagnosis Code
Naltrexone Injection (Vivitrol®)	Alcohol Dependence	F10.2*
	Opioid Dependence	F11.2*

* any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

Age Limit

Pharmacy claims for naltrexone injection (Vivitrol®) have a minimum age requirement of 18 years old and older.

Quantity Limit

Pharmacy claims for naltrexone injection (Vivitrol®) have a quantity limit of 1 unit (380mg/vial dose kit) per 28 rolling days.

Drug-Drug Interaction

Pharmacy claims for naltrexone injection (Vivitrol®) prescriptions will deny if there is an active claim on the beneficiary's file for an opioid. Pharmacy claims for opioid prescriptions will deny if there is an active claim on the beneficiary's file for naltrexone injection (Vivitrol®).

Opioids

Opioid prescription drugs have the following clinical edits:

1. Diagnosis code requirement for all Schedule II narcotics;
2. 30-day quantity limit for long-acting opioids;
3. 7-day quantity limit for select opioids for opioid naïve beneficiaries;
4. Maximum of 90 Morphine Milligram Equivalent (MME) per day; and
5. Prior drug use required for long-acting opioids.

NOTE: Refer to Section 37.5.5 of this manual chapter to access drug specific forms, criteria, and instructions at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Morphine Milligram Equivalent (MME) Limit

The Morphine Milligram Equivalent (MME) per day for all active opioid prescriptions for a beneficiary will be calculated. For each beneficiary, the cumulative daily MME for all active opioid prescriptions will be limited to a maximum of 90 MME per day.

Opioid pharmacy claims with a total daily Morphine Milligram Equivalent (MME) ≥ 50 MME per day will flag at POS as an educational alert for review by the pharmacist.

Buprenorphine products for the treatment of Substance Use Disorder (SUD) will not be included in the MME limit.

NOTE: The *POS User Guide* can be accessed at: www.lamedicaid.com/Provweb1/Pharmacy/LAPOS_User_Manual_static.pdf or by visiting Section 37.5.1 for detailed billing instructions and override procedures.

Long-Acting Opioid Prior Use Requirement

Pharmacy claims for an incoming prescription for a long-acting opioid will deny if there is not a paid claim for either a short-acting or long-acting opioid medication within the previous 90 days.

Opioid Quantity and MME Limit Exemptions

All Schedule II opioid prescriptions require a valid diagnosis code to process. There are exemptions to the edits for quantity limits and maximum daily MME limits for opioids. Pharmacy claims for opioid products will not be subject to the opioid quantity limits or 90 MME per day limit when the beneficiary has a diagnosis of burn, sickle cell crisis, cancer and/or palliative care. The exemptions to the opioid quantity and MME limit are listed in the chart.

ICD-10-CM Diagnosis Code	Description
T20.2*	Burn of second degree of head, face, and neck
T20.3*	Burn of third degree of head, face, and neck
T20.6*	Corrosion of second degree of head, face, and neck
T20.7*	Corrosion of third degree of head, face, and neck
T21.2*	Burn of second degree trunk
T21.3*	Burn of third degree trunk
T21.6*	Corrosion of second degree of trunk
T21.7*	Corrosion of third degree trunk
T22.2*	Burn of second degree of shoulder and upper limb, except wrist and hand
T22.3*	Burn of third degree of shoulder and upper limb, except wrist and hand

ICD-10-CM Diagnosis Code	Description
T22.6*	Corrosion of second degree of shoulder and upper limb, except wrist and hand
T22.7*	Corrosion of third degree of shoulder and upper limb, except wrist and hand
T23.2*	Burn of second degree of wrist and hand
T23.3*	Burn of third degree of wrist and hand
T23.6*	Corrosion of second degree of wrist and hand
T23.7*	Corrosion of third degree of wrist and hand
T24.2*	Burn of second degree of lower limb, except ankle and foot
T24.3*	Burn of third degree of lower limb, except ankle and foot
T24.6*	Corrosion of second degree of lower limb, except ankle and foot
T24.7*	Corrosion of third degree of lower limb, except ankle and foot
T25.2*	Burn of second degree of ankle and foot
T25.3*	Burn of third degree of ankle and foot
T25.6*	Corrosion of second degree of ankle and foot
T25.7*	Corrosion of third degree of ankle and foot
D57.0	Hb-SS disease with crisis
D57.00	Hb-SS disease with crisis, unspecified
D57.01	Hb-SS disease with acute chest syndrome
D57.02	Hb-SS disease with splenic sequestration
D57.21	Sickle-cell/Hb-C disease with crisis
D57.211	Sickle-cell/Hb-C disease with acute chest syndrome
D57.212	Sickle-cell/Hb-C disease with splenic sequestration
D57.219	Sickle-cell/Hb-C disease with splenic sequestration
D57.41	Sickle-cell thalassemia with crisis
D57.411	Sickle-cell thalassemia with acute chest syndrome
D57.412	Sickle-cell thalassemia with splenic sequestration
D57.419	Sickle-cell thalassemia with crisis, unspecified
D57.81	Other sickle-cell disorders with crisis

ICD-10-CM Diagnosis Code	Description
D57.811	Other sickle-cell disorders with acute chest syndrome
D57.812	Other sickle-cell disorders with splenic sequestration
D57.819	Other sickle-cell disorders with crisis, unspecified
C00.*-C96.*	Cancer
Z51.5	Palliative Care

* - any number or letter or combination of UP TO 4 numbers and letters of an assigned ICD-10-CM diagnosis code.

Opioid (Oral) Liquids

Prescriptions for opioid oral liquids will have a quantity limit of 180 mls or a 7-day supply, whichever is less.

Opioid Dependence Agents

Prescriptions for opioid dependence agents are subject to the following:

1. Age requirement;
2. Concurrent use;
3. Drug-drug interaction;
4. Diagnosis code;
5. Maximum Daily Dose; and
6. Therapeutic Duplication.

Select opioid dependence agents will have the age requirement listed in the chart.

Generic (Brand Example)	Minimum Age
Buprenorphine (Brixadi™, Sublocade®)	18 years
Buprenorphine SL	16 years

Buprenorphine/Naloxone (Suboxone®, Zubsolv®	16 years
Lofexidine (Lucemyra®)	18 years
Nalmefene (Opvee®)	12 years
Naltrexone Extended-Release Injectable Suspension (Vivitrol®)	18 years
Naltrexone Tablet	18 years

Opioid dependence agents are monitored for concurrent use with other agents.

1. Incoming pharmacy claims for an opioid analgesic will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for an opiate dependence agent; and

2. Incoming pharmacy claims for a benzodiazepine will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for an opiate dependence agent.

Pharmacy claims for naltrexone tablets or naltrexone extended-release injectable suspension (Vivitrol®) will deny for drug-drug interaction when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for any opioid (including buprenorphine-containing products) and vice versa

Pharmacy claims for select opioid dependence agents must be submitted with an appropriate diagnosis code.

1. Pharmacy claims for all buprenorphine opiate dependence agents (single-ingredient and combination) must be submitted with a diagnosis code for opioid dependence (F11.2*);

2. Pharmacy claims for lofexidine (Lucemyra®) must be submitted with a diagnosis code for ONE of the following:

    a. Opioid abuse with withdrawal – F11.13;

    b. Opioid dependence with withdrawal – F11.23; and

    c. Opioid use, unspecified with withdrawal – F11.93.

3. Pharmacy claims for naltrexone tablets or naltrexone extended-release injectable suspension (Vivitrol®) must be submitted with either a diagnosis code for opioid dependence (F11.2*) or alcohol dependence (F10.2*).

* *Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code*

Oral buprenorphine agents (single-ingredient and combination) are limited to a maximum daily dose of 24mg per day of buprenorphine or buprenorphine equivalent.

The quantity limits for select opioid dependence agents are listed in the following chart.

Generic Name (Brand Example)	Quantity Limit
Buprenorphine Extended-Release Injection Weekly (Brixadi™) 8mg, 16mg, 24mg or 32mg	4 units/21 days
Buprenorphine Extended-Release Injection Monthly (Brixadi™) 64mg, 96mg or 128mg	1 unit/21 days
Buprenorphine Extended-Release Injection (Sublocade®)	1 unit/26 days
Buprenorphine SL Tablet 2mg	2 units/day
Buprenorphine SL Tablet 8mg	3 units/day
Buprenorphine/Naloxone 2mg/0.5mg SL Tab (Suboxone®)	2 units/day
Buprenorphine/Naloxone 2mg/0.5mg SL Film (Suboxone®)	1 unit/day
Buprenorphine/Naloxone 4mg/1mg SL Film (Suboxone®)	1 unit/day
Buprenorphine/Naloxone 8mg/2mg SL Film/Tab (Suboxone®)	3 units/day
Buprenorphine/Naloxone 12mg/3mg SL Film (Suboxone®)	2 units/day
Buprenorphine/Naloxone SL Tablet 0.7mg/0.18mg (Zubsolv®)	1 unit/day
Buprenorphine/Naloxone SL Tablet 1.4mg/0.36mg (Zubsolv®)	1 unit/day
Buprenorphine/Naloxone SL Tablet 2.9mg/0.71mg (Zubsolv®)	1 unit/day
Buprenorphine/Naloxone SL Tablet 5.7mg/1.4mg (Zubsolv®)	3 units/day
Buprenorphine/Naloxone SL Tablet 8.6mg/2.1mg (Zubsolv®)	2 units/day
Buprenorphine/Naloxone SL Tablet 11.4mg/2.9mg (Zubsolv®)	1 unit/day
Nalmefene (Opvee®)	4 units/30 days
Naloxone Nasal Spray (Narcan®)*	4 units/30 days
Naloxone Nasal Spray (Kloxxado™)*	4 units/30 days
Naloxone Injectable Solution Cartridge/Vial (1ml) 0.4mg/ml*	4 units/30 days
Naloxone Injectable Solution Syringe 1mg/ml*	4 units/30 days
Naloxone Injectable Solution (5ml, 10ml, 20ml) 1mg/ml*	1 unit/30 days

Naloxone Injectable Solution (10ml) 0.4mg/ml*	1 unit/30 days
Naloxone Injectable Solution (Zimhi™)*	4 syringes (2ml)/30 days
Naltrexone Extended-Release Injectable Suspension (Vivitrol®)	1 unit/28 days

Note: Oral buprenorphine agents (single-ingredient and combination) are limited to a maximum daily dose of 24mg per day of buprenorphine or buprenorphine equivalent.

Opiate dependent agents are monitored at the pharmacy POS for duplication of therapy with each other.

1. Incoming prescriptions for buprenorphine or buprenorphine/naloxone agents will deny when the beneficiary has an active prescription (a prescription in which the days' supply has not expired) for any buprenorphine or buprenorphine/naloxone agent; and

2. Incoming prescriptions for any naltrexone agent will deny when the beneficiary has an active prescription for any other naltrexone agent.

Serotonin Agents (Triptans)

Pharmacy claims for quantities of Serotonin agents (Triptans) which are in excess of the quantity limit will deny. Quantity limits are cumulative and are based on a rolling 30 day period. Unless otherwise specified, quantity limits apply to all strengths of an agent.

Quantity limits for Serotonin agents (Triptans) are as follows:

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
Almotriptan Maleate	Tablet	12 units
Eletriptan HBr	Tablet	6 units
Frovatriptan Succinate	Tablet	9 units
Naratriptan HCl	Tablet	9 units
Rizatriptan Benzoate	Tablet, Tablet rapid dissolve	12 units

Generic Name	Dosage Form	Quantity Limit per 30 Rolling Days
Sumatriptan Succinate (Nasal)	Exhaler Powder	1 kit* (package size = 16)
Sumatriptan Succinate/ Naproxen Na	Tablet	9 units
Sumatriptan Succinate	Tablet	9 units
Zolmitriptan	Tablet, Tablet rapid dissolve	6 units

If the prescribing practitioner chooses to exceed the quantity limit, the prescribing practitioner must provide the reason why the quantity limit needs to be exceeded. The pharmacist may override the quantity limit after consulting with the prescriber. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the prescriber's reason why the quantity limit needs to be exceeded. The pharmacist must document on the hardcopy prescription or in the pharmacy's electronic record keeping system the reason for service code, professional service code and result of service code with the POS submission.

Spironolactone

Pharmacy claims for spironolactone require a valid diagnosis code submitted for beneficiaries who are younger than 18 years of age. Pharmacy claims which are submitted with a diagnosis code associated with gender dysphoria or gender reassignment (F64*, Z87.890) will deny.

* – any number or letter or combination of **UP TO 4** numbers and letters of an assigned ICD–10–CM diagnosis code

NOTE: Refer to the Diagnosis Code Policy Chart at:
www.ldh.la.gov/assets/medicaid/PharmPC/9.23.24/Louisiana.Medicaid.ICD-10.Chart.pdf

Quantity Limitations

Prescriptions payable under the Medicaid Program are limited as follows.

Maximum Allowable Quantities

The maximum quantity payable is either a one month's supply or 100 unit doses, whichever is greater.

Maintenance Medication

Pharmacy claims for select maintenance medications will have a 90-day allowance at POS. A 90-day supply is allowed on maintenance drugs after a beneficiary has been on the same drug and strength for 60 days.

Dispensing Fee for Select Maintenance Medications

An educational edit will alert pharmacies when they are submitting pharmacy claims for maintenance medications that are not dispensed in at least a 30 day supply If a Generic/Brand product and strength has been dispensed for at least 60 days, and the current pharmacy claim is for the same Generic/Brand product and strength and is **NOT** dispensed in a 30 day supply, then an educational alert will be sent. The dispensing fee will not be reimbursed. The pharmacy will still be reimbursed for the ingredient cost on each dispensing.

Override procedures are available. Upon consultation with the prescriber to verify the necessity of the short fill (quantity less than 30 days' supply), the pharmacist may override the claim and be reimbursed the dispensing fee.

The quarterly FFS Maintenance Medication List can be found at the following link: https://ldh.la.gov/assets/docs/BayouHealth/Pharmacy/MaintenanceMedications.pdf

Coverage and Limitations for Long-Term Care Beneficiaries

Quantities for Long-Term Care Beneficiaries

Providers shall dispense a one month's supply, unless the prescribing provider specifies a smaller quantity for medical reasons, to beneficiaries in long-term care facilities. Dispensing a smaller quantity should only be done in exceptional cases.

Specific quantity limitations for maintenance medications and prn prescriptions are as follows:

1. "Maintenance" medications are those used to treat chronic conditions or illnesses (see Maintenance Medication section above for quantity limits); and

2. "PRN" prescriptions are those prescriptions that patients utilize on an "as needed" basis. For "prn" prescriptions, thirty units or a 10-day supply shall be supplied, unless otherwise specified by the prescriber.

The beneficiary profile should be periodically reviewed to determine if the "prn" order has become a "maintenance" one. In that event, refer to the "maintenance" drug policy. Otherwise, if every six months, a quantity of the "prn" medication remains unused by the resident, the profile should be reevaluated to determine the necessity of the order as well as the quantity of the prescribed medication. Should the prescriber authorize an additional "prn" medication, then the subsequent dispensed quantity shall be reduced to an amount equal to the utilization of the prior six-month period.

Pharmacies are providing twenty-four hours coverage to the long-term care facilities. Prescription reorders should not be made until a three-day supply remains.

Co-Payment Exemption

Long-term care beneficiaries (residing in a nursing facility or ICF/IID) are exempt from co-payments and monthly prescriptions limits.

NOTE: Refer to Chapters 26: Intermediate Care Facilities for Individuals with Intellectual Disabilities and 34 – Nursing Facilities of the *Medicaid Services Manual* for detailed information regarding beneficiaries in LTC facilities.

Over-the-Counter Drugs

LTC facilities are responsible for providing all OTC drugs to Medicaid beneficiaries. OTC drugs are part of the per diem for LTC beneficiaries.

Over the Counter Drugs for Preventive Care

Select OTC agents for preventive care will be reimbursed when:

1. The prescribing practitioner issues the beneficiary a prescription for the preventive care OTC agent; and

2. The beneficiary meets the criteria to obtain the preventive care OTC agent.

OTC Drug	Medicaid Beneficiary	Preventive Care
Aspirin 81 mg	Women greater than 12 years of age Men greater than 44 years of age	Cardiovascular disease, colorectal cancer, and preeclampsia prevention
Folic Acid 0.4mg and 0.8mg	Women ages 12-54	Pregnancy planning
Vitamin D 400 IU	Women and men greater than 64 years of age	Fall prevention

Age Restriction

Pharmacy claims submitted for beneficiaries outside of the age limits listed above will deny at POS.

Days' Supply

Quantities of 100 units with 100 days' supply will be allowed to process for payment.

Copayment

Pharmacy claims for the select preventive care OTC agents listed above will be exempt from copayment.

Coverage for aspirin 81 mg will be continued for beneficiaries greater than 79 years old; however, these pharmacy claims will be subject to copayment.

Diabetic Supplies

Medicaid will not reimburse pharmacies for claims for diabetic supplies when an individual resides in a long-term care facility.

NOTE: Refer to "Drugs with Special Payment Criteria/Limitations; Diabetic Testing Supplies" in this section for detailed information.

Nebulizer Medications

Medicaid will reimburse pharmacies for the nebulizer medications for those individuals who reside in a long-term care facility who do not have Medicare.

Medicare Skilled Nursing Facilities

When a resident of a skilled nursing facility is in Medicare payment status, payment for prescription medications is the responsibility of the facility, as prescription services are included in the per diem paid by Medicare.

Emergency Kits

All drugs dispensed from an emergency kit shall be billed to the Medicaid Program indicating the date of service that coincides with the date of administration.

Outpatient Drugs Covered by Medicare Part B

Medicare Part B covers oral anticancer drugs, antiemetics, diabetic supplies, glucometers, antihemophilia factor products, oral immunosuppressive drugs, nebulizer medication and some other medications. Providers must be enrolled as Medicare suppliers and must bill Medicare first if the beneficiary receives Medicare benefits. Medicaid will pay any applicable deductibles and coinsurances.

NOTE: Refer to Section 37.5.7 Medicare Prescription Drug Coverage for detailed information on drugs covered by Medicare Part B.

Drug Services for Hospice Beneficiaries

"Hospice" is a concept that extends a process of care to terminally ill patients.

Hospice is a program of palliative (control of pain and symptoms) and supportive services that provides physical, psychological, social and spiritual care for dying persons and their families. Hospice care concentrates on assuring the quality of the terminal patient's remaining life rather than on trying to prolong the length of that life.

For Medicare/Medicaid patients who have elected hospice, services covered in the beneficiary's plan of care should not be billed to Medicaid. These services are covered in the hospice reimbursement.

To ensure the correct billing of drug services, it is imperative that the hospice provider communicate with the pharmacist to verify which drugs are related to the terminal illness (billed to the hospice) and which drugs are not related to the terminal illness (billed to Medicaid). The hospice shall assume that the distinction in billing drugs is understood by enrolled pharmacists who render services to the Medicaid beneficiaries who have elected hospice.

The pharmacy provider shall bill Louisiana Medicaid for out-patient pharmacy claims only for those drugs unrelated to the terminal illness.

Recoupment of drug claims erroneously paid to a pharmacy provider through Medicaid for those Medicaid beneficiaries who have elected hospice will be performed as they are identified. Any provider of services to a hospice beneficiary needs to clear with the hospice provider that the billed service is not included in the beneficiary's plan of care. Erroneous payment will be recouped as identified.

NOTE: Refer to Chapter 24 - Hospice of the *Medicaid Services Manual* for detailed information.

GENERAL PROGRAM INFORMATION

The Pharmacy Program within the LDH, Bureau of Health Services Financing (BHSF) covers all FDA approved legend drugs that meet the Omnibus Budget Reconciliation Act (OBRA) '90 and OBRA '93 criteria with a few exceptions. The Pharmacy Program determines the reimbursement methodology for both the drug ingredient cost and the maximum allowable overhead cost (dispensing fee) for covered drugs.

The Pharmacy Program is responsible for the following components:

1. Policy;

2. Program development and implementation;

3. Network development;

4. Program coverage;

5. PDL development and implementation and PA for certain therapeutic classes;

6. Federal upper limit (FUL) for multiple source drugs;

7. Claims management;

8. Annual provider recertification;

9. Clinical interventions;

10. Prospective and retrospective DUR;

11. Federal and state supplemental pharmaceutical manufacturer rebates;

12. Pharmacy provider desk audits;

13. Beneficiary Lock-In program;

14. Provider help desk;

15. Beneficiary help desk;

16. Provider relations; and

17. Provider education for prescribers and pharmacists.

The Pharmacy Program:

1. Initiates policy development;

2. Implements new policies and clarifies existing pharmacy policies, which include the services associated with outpatient drugs and Medicare/Medicaid pharmacy claims crossovers;

3. Approves all new drugs added to program coverage; and

4. Establishes any limitations on reimbursement or coverage in accordance with the federally approved reimbursement methodology.

The Pharmacy Program directs an extensive network of pharmacy providers and is also responsible for the integrity of several subsystems, including the drug file component of reference subsystem, the DUR subsystem and the drug portion of the Surveillance Utilization Review Subsystem (SURS).

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is a computerized claims processing and information system designed to manage the Medicaid Program's expenditures through effective claims processing and utilization control.

LDH contracts with a FI who operates the federally approved MMIS which is consistent with the Centers for Medicare and Medicaid Services (CMS) and LDH requirements.

The FI is contracted to provide the following pharmacy-related services:

1. Pharmacy claim processing through an on-line, real-time POS system;
2. Coordination of the federally mandated Omnibus Budget Reconciliation Act of 1990 DUR Board activities;
3. Retrospective DUR (LaDUR);
4. Prospective DUR (UniDUR);
5. Educational articles - *Provider Update* newsletter article;
6. Lock-In Program;
7. DUR Board coordination;
8. PDL and PA system;
9. Monthly prescription limit system; and
10. Electronic Data Inquiry/Clinical Drug Inquiry System (e-CDI).