MARYLAND MEDICAID PHARMACY PROGRAM

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ADVISORY

*In an effort to give timely notice to the pharmacy community concerning important pharmacy topics, the Department of Health and Mental Hygiene's (DHMH) **Maryland Pharmacy Program** (MPP) has developed the **Maryland Pharmacy Program Advisory**. To expedite information timely to the pharmacy and prescriber communities, an email network has been established which incorporates the email lists of the Maryland Pharmacists Association, EPIC, CARE, Long Term Care Consultants, headquarters of all chain drugstores and prescriber associations and organizations. It is our hope that the information is disseminated to all interested parties. If you have not received this email through any of the previously noted parties or via DHMH, please contact the MPP representative at 410-767-1455.*

Automatic Correction of Underpayments

On Tuesday, May 8, ACS, The Maryland Medicaid Pharmacy Program claims processor, has reversed all incorrectly paid point-of-service claims that were submitted for the three-day period from Friday, March 23, 2007 through Monday, March 26, 2007. The error was due to the wrong pricing information that was transmitted to ACS by First DataBank.

Over-The-Counter Plan B Coverage

Effective immediately, The Maryland Medicaid Pharmacy Program will cover over-the-counter (OTC) Plan B for recipients age 18 and older. Recipients 17 years of age and under will still be required to have a prescription. Claims for OTC Plan B may be submitted in much the same manner as other OTC contraceptives. In place of using a physician's DEA number, fill in the prescriber's DEA

number field with the DEA number of the pharmacy. This is the one exception to the rule that a physician' DEA number must be used for the claim to be acceptable. Legend Plan B will continue to be covered as it has in the past. There is a limit of one Plan B prescription every three months.

Clinical Criteria for Cymbalta®

Although Cymbalta is considered "Preferred," the following clinical criteria will apply:

- No prior authorization will be required if a recipient has a diagnosis of diabetes or a recent history of receiving hypoglycemic agents.
- Recipients currently receiving Cymbalta® for any diagnosis are grandfathered and may continue on Cymbalta.
- Clinical prior authorization is required for the treatment of major depressive disorder unless a recipient has had an 8-week trial of an SSRI (e.g. citalopram, fluoxetine, fluvoxamine paroxetine, Lexapro®, Paxil® CR, Pexeva®, etc.).
- Quantities for all strengths are limited to 68 in a 34-day period.

To ensure patient safety, a 2-week trial of 60mg per day dose is required before a 120mg per day regimen will be authorized. *(According to the labeling, there is no evidence that doses greater than 60 mg/day confer any additional benefits. Also, the increased dosage may pose an increased risk of hepatotoxicity.)*

Coordination of Benefits

Some Medicaid recipients may have prescription drug coverage from one or more third party payer. Medicaid is always the payer of last resort. A provider must submit and secure payment or denial of a claim from all other liable insurance parties before the claim can be submitted to Medicaid. This process is called *Coordination of Benefits*.

A pharmacy may encounter difficulties in submitting a claim when recipients lose eligibility or change coverage with a third party payer and fail to report this information to Medicaid. In such cases, it would be helpful if the pharmacy would advise those recipients to notify Medicaid at 410-767-5075 or 410-767-1773 of the change in coverage.

If after filing a Medicaid claim, a denial message is received that other insurance is available and the recipient denies having other prescription drug coverage, please call the Medicaid claims processor, ACS, at 800-932-3918 for assistance. ACS will be able to help you in the event that the other insurance is no longer active or there is a change in the third party payer. If there does not appear

to be other third party insurance, ACS will grant a one-time override on the submitted claim(s). The reason for the one-time override is to allow sufficient time for the recipient's history file to be updated.

ACS is also available to assist if you experience difficulty handling the co-pay adjustment once a third party had adjudicated a claim and a co-payment is due from Medicaid. The recipient is only responsible for paying the Medicaid co-payment amount, regardless of the reimbursement received from the primary insurance carrier(s). In any case, ACS should be called for assistance in processing Coordination of Benefits.