TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are experimental or whose side effects make usage controversial.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(2) The drug categories listed in (A) through (E) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to age 50;

(ii) fluoride preparations are covered for persons under 16 years of age or pregnant; ~~and~~

(iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered~~.~~;

(iv) iron supplements may be covered for pregnant women if determined to be medically necessary; and

(v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol.

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

(D) Coverage of non-prescription or over the counter drugs is limited to:

(i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions~~,~~;

(ii) certain smoking cessation products~~,~~;

(iii) family planning products~~, and~~;

(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate~~.~~; and

(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(E) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. ' 1396r-8; or

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-77. Brand necessary certification

(a) When a product is available in both a brand and generic form, a prior authorization is required before the branded product may be dispensed. The prescribing provider must certify the brand name drug product is medically necessary for the well being of the patient, otherwise a generic must be substituted for the name brand product.

(1) The certification must be written in the physician's or other prescribing provider's handwriting.

(2) Certification must be written directly on the prescription blank or on a separate sheet which is attached to the original prescription.
(3) A standard phrase indicating the need for a specific brand is required. The OHCA recommends use of the phrase "Brand Necessary".
(4) It is unacceptable to use a printed box on the prescription blank that could be checked by the physician to indicate brand necessary, or to use a hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription blank.
(5) If a physician phones a prescription to the pharmacy and indicates the need for a specific brand, the physician should be informed of the need for a handwritten certification. The pharmacy can either request that the certification document be given to the patient who then delivers it to the pharmacy upon receipt of the prescription, or request the physician send the certification through the mail.

(b) The Brand Necessary Certification applies to CMS Federal Upper Limit and State Maximum Allowable Cost (SMAC) products.

(c) For certain narrow therapeutic index drugs, a prior authorization will not be required. The DUR Board will select and maintain the list of narrow therapeutic index drugs.

(d) Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) facilities are exempt from prior authorization requirements for brand name drugs.

317:30-5-78. Reimbursement

(a) **Reimbursement**. Reimbursement for pharmacy claims is based on the sum of an estimate of the ingredient cost, plus a dispensing fee.

(b) **Ingredient Cost.** Ingredient cost is estimated by one of the following methods:

(1) **Maximum Allowable Cost.**

(A) The State Maximum Allowable Cost ~~(MAC)~~ (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The ~~State MAC~~ SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific ~~product's MAC~~ product's SMAC price by providing invoices that reflect a net cost higher than the calculated ~~State MAC~~ SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.

(B) The Federal Upper Limit (FUL) is established by CMS in accordance with applicable federal laws and regulations.

(C) Injectable drugs which are dispensed by a retail pharmacy through the Vendor Drug Program shall be priced based on a formula equivalent to the Medicare allowed charge whether they are furnished through the pharmacy program or through the medical program.

(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage. The current benchmark price is the Average Wholesale Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%.

(c) **Maximum allowable dispensing fee.** The maximum allowable dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the ~~Rates and Standards Committee~~ State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) ~~**Payment**~~ **Reimbursement for prescription claims.** ~~Payment for prescription claims will be:~~ Prescription claims will be reimbursed using the lower of the following calculation methods:

(1) the lower of estimated acquisition cost, Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) plus a dispensing fee, or

(2) usual and customary charge to the general public~~, whichever is lower~~. The pharmacy is responsible to determine its usual and customary charge to the general public. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations

unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

(1) have an existing provider agreement with OHCA,

(2) submit the claim in a format acceptable to OHCA,

(3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

(4) have a proper brand name certification for the drug, if necessary, and

(5) include the usual and customary charges to the general public as well as the estimated acquisition cost and dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

317:30-5-78.1. Special billing procedures

(a) **Antihemophiliac Factor (AHF) Products.** AHF products are sold by the amount of drug (International Units of AHF) in the container. For their products, regardless of the container size, the package size is always "1". Therefore, pricing assumes that the "package size" actually dispensed is the actual number of units dispensed. Examples: If 250 AHF units are dispensed and multiplied by a unit cost of $.25, the allowable cost would be $62.50. Metric Quantity is shown as 250; if 500 AHF units are dispensed and multiplied by a unit cost of $.25, the allowable would be $125.00. Metric Quantity is shown as 500.

(b) **Compound and intravenous drugs.** Prescriptions claims for compound and Intravenous (IV) drugs are billed and reimbursed

using the NDC number and quantity for each compensable ingredient in the compound or IV, up to 25 ingredients. Ingredients without an NDC number are not compensable. A dispensing fee as described in OAC 317:30-5-78(c) is added to the total ingredient cost.

(c) **Co-Payment.** Pharmacies must pursue all third party resources before filing a claim with OHCA as set out in 42 CFR 433.139.

(d) **Over-the-counter drugs.** Payment for covered over-the-counter medication is made according to the reimbursement methodology in OAC 317:30-5-78(d).

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services. The appropriate Durable Medical Equipment Regional Carrier (DMERC) must be billed prior to billing OHCA for all Medicare compensable drugs. Part B crossover claims cannot be submitted through the pharmacy point of sale system and must be submitted using the CMS 1500 form or electronic equivalent.

(f) **Claims for prescriptions which are not picked up.** A prescription for a member which has been submitted to and approved for payment by OHCA which has not been received by the member within 15 days of the date of service must be reversed. An electronic reversal will cause a refund to be generated to the agency. Claims may also be reversed using a manual process if electronic reversal is not possible. For the purpose of this Section, the date of service means the date the prescription was filled.

(g) **Non-prescription products.** The coverage of non-prescription products that are determined to be medically necessary must be billed through the pharmacy point of sale system.