AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
CATEGORICALLY NEEDY

12a. **Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

Prescription Drugs

~~**Payment:**~~
~~Payment is made from Title XIX funds to pharmacies with whom the Agency has a contract on behalf of categorically needy recipients up to a maximum of six (6) prescriptions (new or refill) with a limit of two (2) brand name per month per eligible recipient. A brand limit override is available for one additional brand prescription based on medical necessity and established criteria. The policy regarding the monthly two (2) brand name limitation and the one (1) brand limit override is effective January 1, 2012~~

Payment:
Payment is made from Title XIX funds to pharmacies with whom the Agency has a contract on behalf of categorically needy recipients up to a maximum of six (6) prescriptions (new or refill) with a limit of one (1) brand name per month per eligible recipient. The policy regarding the monthly one (1) brand name limitation is effective October 1, 2017. A brand limit override may be authorized based on medical necessity and established criteria.

Exceptions:

(1) For persons served by a 1915(c) home and community based services waiver, payment is made from Title XIX funds for up to a maximum of six (6) prescriptions (new or refill) with a limit of three (3) brand name per month per eligible recipient.

(2) Prescription drugs under EPSDT, birth control drugs, antineoplastics, antiretroviral agents for persons diagnosed with acquired immune deficiency syndrome (AIDS), certain prescriptions which require frequent laboratory monitoring, and hemophilia drugs are not limited to either the six (6) prescriptions per month or the two (2) brand name drugs per month limit.

(3) Brand name prescription drugs which are preferred over their generic equivalents due to a lower net cost are exempt from the brand limit but are included in the monthly limit

Limitations:

(1) Prescription quantities are limited to a 34 day supply unless (1) the medication is included in the Maintenance Drug List, in which case, 100 dosage units may be dispensed or (2) the drug has a recommended dispensing quantity less than either of those limits. Drug classes listed on the Maintenance Drug List include anticoagulation, asthma, diabetic, hormone, cardiovascular, thyroid, and seizure. A complete list of the selected drugs included on the Maintenance Drug List can be viewed on the agency's website at www.okhca.org.

(2) Some prescription drugs may require prior authorization as determined by the Drug Utilization Review Board (DUR).

(3) Only prescription drugs whose manufacturers have a rebate agreement with CMS are covered.

(4) Investigational drugs are not covered, including FDA approved drugs being used in post-marketing studies.

Prior Authorization

The prior authorization process provides for a response by telephone or other telecommunications device within 24 hours of receipt of a completed prior authorization request. In emergency situations, providers may be reimbursed for a 72 hour supply of medication.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
CATEGORICALLY NEEDY

12.a. Prescription drugs (continued)

An Open Formulary is administered, maintained, and subject to the provisions of Title 42, United State Code (U.S.C.), Section 1396r-8. All covered drugs may be excluded or coverage limited if the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. §1396r-8 or the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

~~**The following legend drugs are excluded from coverage:**~~

~~Anorexia or Weight Gain Medications: Medications used for anorexia or weight gain will not be a covered drug benefit. Exceptions: Methylphenidate and Dextroamphetamine shall be covered drug benefits for Medicaid covered children when prescribed for hyperactivity and narcolepsy. A prior authorization is required for adults. Methamphetamine and Methamphetamine/Dextroamphetamine require prior authorization for both children and adults.~~

The following legend drugs are excluded from coverage:

Anorexia or Weight Gain Medications: Medications used for anorexia or weight gain are not a covered drug benefit.

Fertility Medications: Medications used to promote fertility will not be a covered drug benefit.

Cosmetic or Hair Growth Medications: Medications used to promote hair growth for cosmetic purposes will not be a covered drug benefit.

Cough and Cold Medications: Medications used for the symptomatic relief of coughs and colds will not be a covered drug benefit.

Prescription Vitamins and Minerals Products: Legend vitamin medications will not be a covered drug benefit. Exception: Vitamin medications containing fluoride for children, prenatal vitamins, prescription iron supplements for pregnant women, prescription vitamins to treat end stage renal disease, prescription vitamins covered for specific diagnosis when the FDA has approved use for a specific indication, and medically necessary prescription vitamin preparations for children under 21 when pursuant to EPSDT protocol, shall be a covered drug benefit.

Obesity Medications: Medications with primary usage for the treatment of obesity, such as appetite suppressants, will not be a covered drug benefit.

Less-than-effective Medications: Medications determined by the FDA to be less-than-effective are not covered.

Experimental Medications: Medications that are experimental or investigational are not covered.

Legend Medications Requiring Associated Tests: Legend medications requiring associated tests and/or monitoring will be a covered drug benefit only after obtaining prior authorization. A prior authorization process will also be used to authorize coverage of selected non-covered medications for individuals with specific diseases.

~~Non-Legend Medications: Non-legend medications will not be a covered drug benefit. Exception: Insulin preparations, OTC drugs that are both cost effective and clinically appropriate, and over the counter contraceptive drugs shall be a covered drug benefit. The State maintains a complete listing of covered nonprescription (over-the-counter or OTC) drug categories on its public website, found at http://www.okhca.org/rx~~

Non-Legend Medications: Non-legend medications are not a covered drug benefit. Exceptions: Non-prescription insulin, family planning products, and smoking cessation products are covered for children and adults. Non-prescription drugs that are both cost-effective and clinically appropriate may be covered for children. The State maintains a complete listing of covered non-prescription (over-the-cover or OTC) drug categories on its public website, found at http://www.okhca.org/rx

Sexual or erectile dysfunction: Medications when used for the treatment of sexual or erectile dysfunction will not be covered.

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