

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A

#12.a.

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Prescribed Drugs Limitations (continued)

- (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
- (d) select agents when used for the symptomatic relief cough and colds
- (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
- (f) select nonprescription drugs: Analgesics; Antiemetic/Antivertigo Agents; Antihistamines; Antipyretics; Ear Wax Removers; Insulins; Fat Absorption Decreasing Agents; Miotics/Other Intraocular Pressure Reducers; NSAIDs/Cox Inhibitors; Topical Antibiotics; Topical Antifungals; Topical Anti-inflammatory Steriodals; Topical Antiparasitics; Urinary pH Modifiers; Vaginal Antifungals; Antidiarrheals; Laxatives; Compound Medication Vehicles; Topical Protectants; Hyperglycemics; Eye Antihistamines; and Urinary Tract Analgesics.
- (g) covered outpatient drugs which the manufacture seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- (h) select barbiturates
- (i) select benzodiazepines
- (j) smoking cessation for non-dual eligibles as Part D will cover: For non-dual eligible, non-pregnant beneficiaries: nicotine patches, bupropion SR (Zyban®), and varenicline (Chantix®); for pregnant women: the Medicaid agency will provide coverage of prescription and over-the-counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence – 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

 No excluded drugs are covered.

These drugs and drug categories are covered for dual eligible individuals to the same extent and with the same restrictions and limitations as they are covered for Medicaid-only individuals.

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Prescribed Drugs Limitations

The maximum quantity of medication that will be reimbursed for any prescription is a 31 day supply.

Pharmacy services for parenteral administration of total nutritional replacements and intravenous medications in the consumer's home are not covered through the pharmacy program and must be billed through the Home Health Services/Durable Medical Equipment program.

Pharmacy services related solely to non-covered transplant procedures are non-covered.

There will be a limit of four (4) brand name prescription claims allowed per beneficiary per month. The exclusions to this policy are: KBH beneficiaries, antiretroviral drugs, anti-rejection drugs used by transplant patients, chemotherapy drugs, antiemetics, interferon, immune globulins, antipsychotics, antidepressants, stimulants, antihemophilic drugs and all contraceptives, drugs on the preferred drug list and any product in the supplemental rebate program. Pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid recipients if the physician requests additional brand name drugs due to a medical necessity. Children from birth to age 21 will continue to receive an unlimited number of Medicaid-covered prescriptions per month.