STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY
LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

12(a) Pharmacy services

Coverage of drugs is available, limited to the following:

All initial prescriptions shall be limited to a 34-day supply and all refills shall be limited to a 34-day supply or 100 unit doses, whichever is greater, with no more than five refills in a six-month period. Prescription refills shall not be dispensed until 85% of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's original directions for use.

Outpatient prescription drugs, multi-source generic and single-source brand-name drugs, are covered without prior authorization, unless otherwise required by the State's Prospective Drug Utilization Review (PDUR) or the State's Mandatory Generic Drug Substitution Program.

In the State's Mandatory Generic Drug Substitution Program, multi-source brand-name drugs require prior authorization when determined medically necessary. Up to ten (10) days supply of a multi-source brand-name drug may be dispensed without prior authorization. Certain multi-source brand-name drugs including, but not limited to narrow therapeutic index (NTI) drugs and mental health drugs, are excluded from prior authorization, as determined by the Commissioner. Requests for prior authorization are responded to by the State within twenty-four (24) hours.

In the State's PDUR Program, prior authorization is required through a medical exception process (MEP) for prescribed drugs that exceed prospective drug utilization review (PDUR) standards recommended by the New Jersey Drug Utilization Review Board and approved by the Commissioner of the Department of Human Services and the Commissioner of the Department of Health and Senior Services. These standards include, but are not limited to severe drug-drug interactions, maximum daily dosage, therapeutic duplication and durations of drug use. Certain drugs subject to the MEP may require prior authorization when dispensing an initial supply of medication.

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For other drugs, an initial 30-days supply of medication may be dispensed by the pharmacy without prior authorization. During this 30-day period, the prescriber is contacted by the MEP Unit to request written justification for continuing drug therapy exceeding a PDUR standard. No payment shall be made beyond thirty (30) days without prior authorization. In emergencies, up to six (6) days supply of medication may be dispensed without prior approval.

In addition to the Mandatory Generic Drug Substitution and PDUR Programs, prior authorization is also required for anti-obesics or anorexics that may also be used for the treatment of Attention Deficit Hyperactivity Disorders (ADHD); methadone for non-addiction use; and weight gain drugs.

The Medicaid agency does not provide coverage for the following outpatient drugs:

(a) prescriptions not for medically accepted indications as defined in Section 1927(k)(6) of the Social Security Act;
(b) experimental drugs;
(c) drugs used for the treatment of addiction, such as methadone;
(d) Drug Efficacy Study Implementation (DESI) drugs;
(e) Drugs not covered by rebate agreements as defined in Section 4401 of OBRA '90 and Section 1927(a) of the Social Security Act;
(f) drugs for the treatment of erectile dysfunction, as set forth in 42 U.S.C. § 1396r-8(d)(2)(K), on and after January 1, 2006, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration;
(g) any bundled drug service, unless authorized by the Commissioner;

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(h) preventive vaccines, biologicals and therapeutic drugs distributed to hospital clinics and/or community health centers by the New Jersey Department of Health and Senior Services;
(i) any preventive vaccines or biologicals available from the federal Vaccine-for-Children (VFC) program;
(j) Pharmaceuticals or prescription drugs whose use is to promote or enhance fertility;
(k) agents when used for anorexia or weight loss not used for the treatment of attention deficit hyperactivity disorders (ADHD);
(l) agents when used for cosmetic purposes, such as hair or eyelash growth;
(m) legend drugs used for the symptomatic relief of cough and cold for beneficiaries 21 years of age or older, unless associated with antibiotic use or chronic pulmonary diseases;
(n) legend drugs available over-the-counter for beneficiaries 21 years of age or older without prior authorization;
(o) hydrocodone/chlorpheniramine combination products without prior authorization;
(p) lipase inhibitors without prior authorization; and
(q) covered outpatient drugs which the manufacturer seeks to require as a condition of sale associated tests or monitoring services to be purchased exclusively from the manufacturer or its designee, unless authorized by the Commissioner.

Medicaid coverage of non-legend outpatient drugs for all eligible beneficiaries is limited to the following:

(a) spermicidal jellies and foams;
(b) antacids;
(c) oral antihistamines for beneficiaries under 21 years of age;
(d) ophthalmic antihistamine solutions;
(e) proton pump inhibitors; and
(f) smoking cessation products

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Covered outpatient drugs are limited to those drug products manufactured by drug companies that have entered into and comply with the federal Medicaid Drug Rebate Agreement, as provided under Section 1927(a) through (c) of the Act, which are prescribed for a medically accepted diagnostic indication (as provided by Section 1927(d) of the Act. Certain outpatient drugs may be excluded from the drug rebate requirement.

Effective January 1, 2006, the Medicaid agency does not cover any Part D-covered drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides outpatient drug coverage for the following Medicare Part D excluded or otherwise restricted drugs or classes of drugs, or their medical uses, for all full benefit dual eligibles:

(a) prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and high potency minerals including potassium, niacin and related products;
(b) barbiturates; and
(c) benzodiazepines.

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Prior authorization is not required for pharmaceutical services provided to a resident of a licensed nursing facility or certain licensed assisted living settings, including assisted living residences (ALRs), comprehensive personal care homes (CPCHs), and alternative family care (AFC) homes.

Reimbursement is not available for unit-dose packaged drug products dispensed to residents in a boarding home, residential care setting, or other community-type setting. Other community-type settings shall not include certain assisted living settings, including licensed ALRs, CPCHs, and AFC homes. Drug products which are only commercially available in unit-dose packaging are covered when not otherwise marketed as a chemically equivalent product in a non-unit-dose package.

Pharmacies providing unit-dose packaged drugs to beneficiaries residing in long term care and assisted living facilities are required to credit original payments to the State for individual doses of drugs returned to the pharmacy.

Any bundled drug service shall be eligible for reimbursement by Medicaid when determined medically necessary; cost effective; and as authorized by the Commissioner of Human Services. A bundled drug service means a covered outpatient drug for which the manufacturer seeks to require as a condition of sale associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

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STATE OF NEW JERSEY
LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS
(Pregnant Women, Dependent Children, and the Aged, Blind or Disabled)

12(a) Pharmacy services

Coverage of drugs is available, limited to the following:

All initial prescriptions shall be limited to a 34-day supply and all refills shall be limited to a 34-day supply or 100 unit doses, whichever is greater, with no more than five refills in a six-month period. Prescription refills shall not be dispensed until 85% of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's original directions for use.

Outpatient prescription drugs, multi-source generic and single-source brand-name drugs, are covered without prior authorization, unless otherwise required by the State's Prospective Drug Utilization Review (PDUR) or the State's Mandatory Generic Drug Substitution Program.

In the State's Mandatory Generic Drug Substitution Program, multi-source brand-name drugs require prior authorization when determined medically necessary. Up to ten (10) days supply of a multi-source brand-name drug may be dispensed without prior authorization. Certain multi-source brand-name drugs including, but not limited to narrow therapeutic index (NTI) drugs and mental health drugs, are excluded from prior authorization, as determined by the Commissioner. Requests for prior authorization are responded to by the State within twenty-four (24) hours.

In the State's PDUR Program, prior authorization is required through a medical exception process (MEP) for prescribed drugs that exceed prospective drug utilization review (PDUR) standards recommended by the New Jersey Drug Utilization Review Board and approved by the Commissioner of the Department of Human Services and the Commissioner of the Department of Health and Senior Services. These standards include, but are not limited to severe drug-drug interactions, maximum daily dosage, therapeutic duplication and durations of drug use. Certain drugs subject to the MEP may require prior authorization when dispensing an initial supply of medication.

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(Pregnant Women, Dependent Children, and the Aged, Blind or Disabled)

For other drugs, an initial 30-days supply of medication may be dispensed by the pharmacy without prior authorization. During this 30-day period, the prescriber is contacted by the MEP Unit to request written justification for continuing drug therapy exceeding a PDUR standard. No payment shall be made beyond thirty (30) days without prior authorization. In emergencies, up to six (6) days supply of medication may be dispensed without prior approval.

In addition to the Mandatory Generic Drug Substitution and PDUR Programs, prior authorization is also required for anti-obesics or anorexics that may also be used for the treatment of Attention Deficit Hyperactivity Disorders (ADHD); methadone for non-addiction use; and weight gain drugs.

The Medicaid agency does not provide coverage for the following outpatient drugs:

(a) prescriptions not for medically accepted indications as defined in Section 1927(k)(6) of the Social Security Act;
(b) experimental drugs;
(c) drugs used for the treatment of addiction, such as methadone;
(d) Drug Efficacy Study Implementation (DESI) drugs;
(e) Drugs not covered by rebate agreements as defined in Section 4401 of OBRA '90 and Section 1927(a) of the Social Security Act;
(f) drugs for the treatment of erectile dysfunction, as set forth in 42 U.S.C. § 1396r-8(d)(2)(K), on and after January 1, 2006, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration;
(g) any bundled drug service, unless authorized by the Commissioner;

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(Pregnant Women, Dependent Children, and the Aged, Blind or Disabled)

(h) preventive vaccines, biologicals and therapeutic drugs distributed to hospital clinics and/or community health centers by the New Jersey Department of Health and Senior Services;
(i) any preventive vaccines or biologicals available from the federal Vaccine-for-Children (VFC) program;
(j) Pharmaceuticals or prescription drugs whose use is to promote or enhance fertility;
(k) agents when used for anorexia or weight loss not used for the treatment of attention deficit hyperactivity disorders (ADHD);
(l) agents when used for cosmetic purposes, such as hair or eyelash growth;
(m) legend drugs used for the symptomatic relief of cough and cold for beneficiaries 21 years of age or older, unless associated with antibiotic use or chronic pulmonary diseases;
(n) legend drugs available over-the-counter for beneficiaries 21 years of age or older without prior authorization;
(o) hydrocodone/chlorpheniramine combination products without prior authorization;
(p) lipase inhibitors without prior authorization; and
(q) covered outpatient drugs which the manufacturer seeks to require as a condition of sale associated tests or monitoring services to be purchased exclusively from the manufacturer or its designee, unless authorized by the Commissioner.

Medicaid coverage of non-legend outpatient drugs for all eligible beneficiaries is limited to the following:

(a) spermicidal jellies and foams;
(b) antacids;
(c) oral antihistamines for beneficiaries under 21 years of age;
(d) ophthalmic antihistamine solutions;
(e) proton pump inhibitors; and
(f) smoking cessation products

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(Pregnant Women, Dependent Children, and the Aged, Blind or Disabled)

Covered outpatient drugs are limited to those drug products manufactured by drug companies that have entered into and comply with the federal Medicaid Drug Rebate Agreement, as provided under Section 1927(a) through (c) of the Act, which are prescribed for a medically accepted diagnostic indication (as provided by Section 1927(d) of the Act. Certain outpatient drugs may be excluded from the drug rebate requirement.

Effective January 1, 2006, the Medicaid agency does not cover any Part D-covered drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides outpatient drug coverage for the following Medicare Part D excluded or otherwise restricted drugs or classes of drugs, or their medical uses, for all full benefit dual eligibles:

(a) prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and high potency minerals including potassium, niacin and related products;
(b) barbiturates; and
(c) benzodiazepines.

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Prior authorization is not required for pharmaceutical services provided to a resident of a licensed nursing facility or certain licensed assisted living settings, including assisted living residences (ALRs), comprehensive personal care homes (CPCHs), and alternative family care (AFC) homes.

Reimbursement is not available for unit-dose packaged drug products dispensed to residents in a boarding home, residential care setting, or other community-type setting. Other community-type settings shall not include certain assisted living settings, including licensed ALRs, CPCHs, and AFC homes. Drug products which are only commercially available in unit-dose packaging are covered when not otherwise marketed as a chemically equivalent product in a non-unit-dose package.

Pharmacies providing unit-dose packaged drugs to beneficiaries residing in long term care and assisted living facilities are required to credit original payments to the State for individual doses of drugs returned to the pharmacy.

Any bundled drug service shall be eligible for reimbursement by Medicaid when determined medically necessary; cost effective; and as authorized by the Commissioner of Human Services. A bundled drug service means a covered outpatient drug for which the manufacturer seeks to require as a condition of sale associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

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STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

Payment for drugs shall be as follows:

1.16 Maximum Allowable Cost (Ingredient Cost) – legend drugs

(a) The Maximum Allowable Cost for legend drugs shall not exceed the lower of the Estimated Acquisition Cost (EAC); the Federal Upper Limit (FUL), as supplied by the reference drug file contractor, or the pharmacy's usual and customary charge.

1. The FUL or Maximum Allowable Cost (MAC) price for listed multi-source drugs as developed by CMS and supplied by the reference drug file contractor.

2. For legend drugs not included in (a)1 above, the EAC is defined as the average wholesale price (AWP) for the National Drug Code (NDC) of the drug indicated in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file), and their supplements, less a volume discount of 16 percent. The EAC and dispensing fee are both subject to review and approval by CMS through the SPA approval process.

(b) The volume discount shall be automatically deducted, regardless of prescription cost, by the fiscal agent, from the cost of each covered drug during claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

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1.17 Dispensing fee – legend drugs

(a) The dispensing and additional dispensing fees for legend drugs dispensed by providers having retail permits, to beneficiaries other than those in nursing facilities, shall be established by State regulations. Additional dispensing fees (i.e. add-ons) per prescription shall be reimbursed to pharmacy providers who provide the following service or meet the following condition:

1. Twenty-four hour emergency service: The provider shall operate a 24-hour per day, 365 days per year pharmacy operation and shall provide Medicaid beneficiaries opportunities to utilize the service.

2. Impact allowance: The provider shall have a combined State prescription volume equal to or greater than 50 percent of the provider's total prescription volume. State prescription volume only counts if the State is the primary payer.

   i. The nursing facility prescription volume shall be included in the calculation of a provider's total prescription volume when determining eligibility for to the impact allowance.

(b) To be eligible for additional dispensing fees, the provider annually completes the Form FD-70 certifying that the service or condition as defined in (a) above was provided or met.

(c) The maximum dispensing fee is $3.99, consisting of a base dispensing fee of $3.73 and possible additional dispensing fees that total $0.26 ($0.11 for 24-hour emergency services and $0.15 for impact allowance).

1. Payments for any additional dispensing fees are subject to audit and retroactive recovery will appropriate penalties if the Division determines that the provider was not qualified for these fees.

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1.18 Total Charge – legend drugs

The total charge to Medicaid for a legend drug prescription shall not exceed the lower of a drug's EAC, as described in 1.16 above plus a dispensing fee as described in 1.17 above; or a provider's usual and customary charge to the general public.

1.19 Capitation payments for long-term-care pharmacy services

(a) The Division reimburses a capitation fee for providing prescription services in long-term-care facilities. The capitation calculation is based on the total number of Medicaid patient days in a facility under contract with a pharmacy. The capitation fee is established by State regulations.

1. Pharmacies that dispense medications using a 24-hour unit-dose delivery system and deliver medications to a long-term-care facility every 24 hours are reimbursed the Estimated Acquisition Cost for covered drugs plus a capitation fee per Medicaid patient day.

   Exception: Liquid medications that require a measuring device, such as a calibrated medicine dropper.

2. Pharmacies that dispense medications using a 30-day unit-dose delivery system and deliver medications to a long-term-care facility once a month are reimbursed the Estimated Acquisition Cost of covered drugs plus a capitation fee per Medicaid patient day.

3. Pharmacies that dispense medications using a conventional non-unit-dose packaging system and deliver medications to a long-term-care facility once a month are reimbursed the Estimated Acquisition Cost of all covered drugs plus a capitation fee per Medicaid patient day.

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4. Pharmacies that provide ancillary computerized services to a long-term-care facility, such as, but not limited to updated patient profile records, medication/treatment records and physician order sheets are reimbursed an additional incremental capitation fee per Medicaid patient day.

5. Pharmacies that dispense drugs to a long-term-care facility from an on-site institutional pharmacy shall be reimbursed 75 percent of the capitation fees indicated in (a) above.

(b) Pharmacies using more than one drug delivery system in the same long-term-care facility shall receive capitation reimbursement based on the lowest priced distribution system supplied in that long-term-care facility.

1.20 Payments for Ingredient costs – long-term care

(a) The maximum charge to Medicaid for ingredient costs related to pharmaceutical services provided in a nursing facility, shall be equal to the lower of:

1. EAC, as outlined in 1.16; or

2. A provider's usual and customary charge for legend ingredient costs related to long-term care pharmacy services, which is defined as the charge for ingredient costs related to legend drugs provided to non-Medicaid residents in the same facility, based on the contract(s) between the long-term-care facility and the pharmacy provider.

(b) The cost of non-legend drugs is included in the long-term-care facility per diem rate.

(c) Providers of pharmaceutical services in nursing facilities are required, upon a request from the Division or its authorized agent, to provide documentation supporting their usual and customary charges, including any relevant contracts and/or agreements related to similar services provided in the same facility.

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1.21 Compounded Prescriptions

(a) Any prescription containing two or more ingredients that is combined by a pharmacist prior to dispensing is a compounded prescription and shall be charged as follows:

1. total ingredient cost as defined in Section 1.16. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. the dispensing fee as allowed in Section 1.17.

3. The maximum charge for a compounded prescription shall not exceed the Total Charge set forth in Section 1.18.

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1.22 Maximum Allowable Cost (Ingredient Cost) – non-legend drugs

(a) The Maximum Allowable Cost for non-legend drugs shall not exceed the lower of the Estimated Acquisition Cost (EAC), as supplied by the reference drug file contractor, or the pharmacy's usual and customary charge.

1. For non-legend, the EAC is defined as the average wholesale price (AWP) for the National Drug Code (NDC) of the drug indicated in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file), and their supplements, less a volume discount of 16 percent. The EAC shall be established by State regulations.

(b) The volume discount shall be automatically deducted, regardless of prescription cost, by the fiscal agent, from the cost of each covered drug during claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

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1.23 Dispensing fee – non-legend drugs

(a) The dispensing fee for non-legend drugs, dispensed by providers having retail permits, to beneficiaries other than those in nursing facilities, shall be established by State regulation. Additional dispensing fees (i.e. add-ons) per prescription shall be reimbursed to pharmacy providers who provide the following service or meet the following condition:

1. Twenty-four hour emergency service: The provider shall operate a 24-hour per day, 365 days per year pharmacy operation and shall provide Medicaid beneficiaries opportunities to utilize the service.

2. Impact allowance: The provider shall have a combined Medicaid/PAAD/Senior Gold/GA/ADDP/CF prescription volume equal to or greater than 50 percent of the provider's total prescription volume. Medicaid/PAAD/Senior Gold/GA/CF prescription volume counts only if these programs are the primary payers.

    i. The nursing facility prescription volume shall be included in the calculation of a provider's total prescription volume when determining eligibility for the impact allowance.

(b) To be eligible for additional dispensing fees, the provider annually completes the Form FD-70 certifying that the service or condition as defined in (a) above was provided or met.

(c) The maximum dispensing fee is $3.99, consisting of a base dispensing fee of $3.73 and possible additional dispensing fees that could total $0.26 ($0.11 for 24-hour emergency services and $0.15 for impact allowance).

1. Payments for any additional dispensing fees are subject to audit and retroactive recovery with appropriate penalties if the Division determines that the provider was not qualified for these fees.

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1.24 Total Charge – non-legend drugs

The total charge to Medicaid for a non-legend drug prescription shall not exceed the lower of a drug's EAC, as described in 1.22 above plus a dispensing fee as described in 1.23; or a provider's usual and customary charge to the general public.