

APPENDIX B: VENDOR DRUG PROGRAM

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 1

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APPENDIX B: VENDOR DRUG PROGRAM

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B.1 Vendor Drug Program Information

B.1.1 Pharmacy Benefit

The Texas Vendor Drug Program (VDP) provides statewide access to prescription drugs as authorized by a prescribing provider for clients enrolled in:

- Medicaid (fee-for-service and managed care).
- Children’s Health Insurance Program (CHIP).
- Children with Special Health Care Needs (CSHCN) Services Program.
- Healthy Texas Women (HTW) Program.
- Kidney Health Care (KHC) Program.

VDP manages the Medicaid and CHIP drug formularies and Medicaid Preferred Drug List (PDL).

Note: *Pharmacy services for clients in Medicaid managed care are administered by a client’s managed care organization (MCO).*

Referto: The *Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks)* for additional information about managed care prescription drug and pharmacy benefits.

B.1.2 Pharmacy Enrollment

VDP enrolls any eligible, in-state pharmacy licensed as Class A or C by the Texas State Board of Pharmacy.

Any out-of-state pharmacies or pharmacies that hold any other class of pharmacy license are considered for inclusion in the program on a case-by-case basis. Consideration is relative to the benefits made available to the client eligible for pharmacy benefits. Enrollment is not granted unless additional benefits are established.

Pharmacy providers must be enrolled with VDP prior to providing outpatient prescription services and prior to participating in any Medicaid managed care network. To participate in the Medicaid or CHIP managed care networks the pharmacy must contact the health plan.

Pharmacy providers that have enrolled with VDP should refer to the VDP Pharmacy Provider Procedure Manual for policies and procedures pertaining to fee-for-service outpatient pharmacy claims, including drug benefit guidance, pharmacy prior authorization, coordination of benefits, drug pricing, and reimbursement.

Referto: The [VDP Pharmacy Provider Procedure Manual](#) on the VDP website.

B.1.3 Program Contact Information

Vendor Drug Program	Telephone Number
Pharmacy Benefits Access: for questions about outpatient drug and billing (the 800 number is for pharmacy use only and can be used to reach any area within VDP).	1-800-435-4165
Pharmacy Enrollment	1-512-462-6317
Program Management	1-512-707-6108
Program Policy	1-512-707-6108
Drug formulary (Texas listing of national drug codes)	1-512-462-6390
Texas Pharmacy Prior Authorization Center Hotline	1-877-728-3927

Vendor Drug Program	Telephone Number
Texas Pharmacy Third Party Call Center	1-866-389-5594

B.2 Drug Information

The Texas Drug Code Index, or formulary (or list of available drugs), includes non-legend (over-the-counter) drugs. Additionally, certain supplies and select vitamin and mineral products are also available as a pharmacy benefit. Some drugs are subject to one or both types of prior authorization, clinical and non-preferred. VDP does not reimburse claims for nutritional products (enteral or parenteral), medical supplies, or equipment other than a limited set of home health supplies.

The PDL is arranged by drug therapeutic class, and contains a subset of many, but not all, drugs that are on the Medicaid formulary. Most drugs are identified as preferred or non-preferred. Drugs listed on the PDL as preferred or not listed at all are available without prior authorization unless there is a clinical prior authorization associated with that drug. For more information about prior authorization, refer to Subsection B.5, “Pharmacy Prior Authorization” in this handbook.

B.2.1 Formulary Search

The VDP Formulary Search is an online tool available to health-care providers to help clients get access to medications.

Users can search by either brand or generic name of the drug or product, the 11-digit national drug code (NDC), the PDL drug class, or type of home health supply.

Detailed filters allow searches for:

- Diabetic supplies
- Drugs that require clinical or non-preferred prior authorization
- Products used for family planning
- Products that require 90% utilization prior to refilling

Users can also search program-specific formularies for CHIP, the CSHCN Services Program, HTW Program, or KHC Program (e.g., CHIP, CSHCN, HTW, and KHC).

Referto: The [Formulary Search](#) on the VDP website for more information.

Providers are also eligible to register for Epocrates (epocrates.com), which is a free drug information service that can be downloaded to a mobile device. In addition to listing a drug’s preferred status, Epocrates includes drug monographs, dosing information, and warnings.

B.2.2 Vitamin and Mineral Products

Pharmacies enrolled with VDP can dispense vitamin and mineral products to clients who are 20 years of age and younger and enrolled in traditional Medicaid. These products are also available to clients enrolled in Medicaid managed care, if the dispensing pharmacy is contracted with the client's health plan.

To expedite pharmacy claim processing for vitamin and mineral products, prescribing providers are encouraged to include the diagnosis on the prescription.

The list of products that can be dispensed at a pharmacy and information about the provision of these products to clients enrolled in fee-for-service can be found in the VDP [Pharmacy Provider Procedure Manual](#) on the VDP website.

For clients enrolled in Medicaid managed care or CHIP, claims are submitted to the clients’ health plans. Pharmacy staff must work with the health plan’s pharmacy benefit manager to determine the billing requirements, reimbursement rates, and coverage limitations for these products.

B.2.3 Home Health Supplies

Pharmacies enrolled with VDP can dispense a limited set of home health supplies that are commonly found in a pharmacy to clients enrolled in traditional Medicaid. These supplies are also available to clients enrolled in Medicaid managed care, provided the dispensing pharmacy is contracted by the client's health plan.

The list of supplies that can be dispensed at a pharmacy and information about the provisions of these supplies for clients enrolled in traditional Medicaid can be found in the VDP [Pharmacy Provider Procedure Manual](#) on the VDP website.

Providers should contact the appropriate health plan or pharmacy benefit manager for more information about providing these supplies to clients enrolled in managed care.

B.2.4 Long-Acting Reversible Contraception Products

Long-acting reversible contraception (LARC) products are available to clients through either a Medicaid pharmacy or medical benefit.

Referto: The [list of long-acting reversible contraception products](#) on the VDP website.

B.2.4.1 Pharmacy Benefit

Providers can refer to Subsection B.2.1, "Formulary Search" in this handbook for program specific formularies and prescribe LARC products for women enrolled in Medicaid or HTW.

Providers can obtain LARC products with no upfront cost by submitting a completed and signed prescription request form to certain specialty pharmacies. The specialty pharmacy will dispense the LARC product by shipping it to the practice address in care of the client and bill Medicaid or HTW for the product. Providers can only bill for product administration at the time of service. LARC products obtained by providers from specialty pharmacies are eligible to be returned if unused and unopened.

B.2.4.2 Medical Benefit

Providers may obtain LARC products through the existing buy and bill process, which requires providers to purchase LARCs from wholesalers or other sources before obtaining reimbursement upon insertion of the device, and opting to receive reimbursement for LARC products as a clinician-administered drug.

B.2.4.3 Product Returns and Abandoned Units

Manufacturers offer abandoned unit return programs that allow a provider to return an abandoned LARC product. An "abandoned unit" is an unused and unopened product that was shipped by a participating specialty pharmacy with a prescription label that includes the name of the patient. In order to be returnable, the LARC product should be in its original packaging.

B.2.5 Makena

B.2.5.1 Pharmacy Benefit

Makena (hydroxyprogesterone caproate injection) requires clinical prior authorization for clients enrolled in traditional Medicaid. Providers should complete the Makena Prior Authorization Request (HHS Form 1345) and submit to the Texas Prior Authorization Call Center.

Health Plans may require prior authorization for Makena. Providers should refer to the appropriate health plan for specific requirements and forms.

B.2.5.2 Medical Benefit

Makena and the compounded version of 17P are available as a Medicaid medical benefit. For additional information about the medical benefit, providers can visit the TMHP website at www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126.

B.3 Prescribing Information

The federal Patient Protection and Affordable Care Act and the Code of Federal Regulations Title 42 §455.410(b) require all physicians or other professionals who order, refer, or prescribe drugs, supplies and services for a recipient of traditional Medicaid, CHIP, CSHCN, and HTW Program to be enrolled as participating Medicaid providers.

Referto: “Section 1: Provider Enrollment and Responsibilities” (*Vol. 1, General Information*) for more information.

B.3.1 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the VDP were written on a compliant tamper resistant pad.

The Centers for Medicare & Medicaid Services (CMS) has stated that special copy-resistant paper is not a requirement for electronic medical records (EMRs) or e-prescribing-generated prescriptions and prescriptions that are faxed directly to the pharmacy. These prescriptions may be printed on plain paper and will be fully compliant if they contain at least one feature from each of the following three categories:

- Prevents unauthorized copying of completed or blank prescription forms
- Prevents erasure or modification of information written on the prescription form
- Prevents the use of counterfeit prescription forms

Two features that can be incorporated into computer-generated prescriptions printed on plain paper to prevent passing a copied prescription as an original prescription are as follows:

- Use a very small font that is readable when viewed at 5x magnification or greater and illegible when copied.
- Use a “void” pantograph accompanied by a reverse “Rx,” which causes a word such as “Void” to appear when the prescription is photocopied.

Referto: The [VDP Pharmacy Provider Procedure Manual](#) on the VDP website.

B.3.2 Prescription Refills and Expirations

Medicaid prescriptions for non-controlled substances are valid for one year from the date written and up to 11 refills if authorized by prescriber.

Medicaid prescriptions for controlled substances in Schedules III, IV, and V are valid for six months from the date written and up to five refills if authorized by prescriber provider. Controlled substance prescriptions written by advanced practice registered nurses and physicians assistants are valid for 90 days.

Medicaid prescriptions for Schedule II drugs cannot be refilled and must be dispensed within 21 days of the date on which the prescription was written.

Prescriptions for Schedule II drugs may be written as multiples of three for a total of a 90 day supply subject to federal and state law.

Referto: The [VDP Pharmacy Provider Procedure Manual](#) on the VDP website.

[Pharmacy Laws & Rules](#) page of the Texas State Board of Pharmacy (TSBP) website for rules about issuance of identical sets of Schedule II prescriptions.

B.3.3 Prescription Monitoring of Controlled Substances

The Texas Prescription Monitoring Program (PMP) collects and monitors prescription data for all Schedule II, III, IV and V controlled substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. The PMP also provides a venue for monitoring patient prescription history for practitioners and the ordering of Schedule II Texas Official Prescription Forms.

Pharmacies that dispense Schedule II, III, IV, and V drugs are required to report the information directly to the Texas State Board of Pharmacy's contracted vendor. Prescription data is reported by the prescriber's federal Drug Enforcement Administration (DEA) number. Prescribers and pharmacies are required by statute to have a valid, active DEA numbers in order to possess, administer, prescribe or dispense controlled substances.

Referto: The [Texas Prescription Monitoring Program](#) page of TSBP website.

B.3.4 Requirements for Early Refills

A refill is considered too soon, or early, if the client has not used at least 75 percent of the previous fill of the medication.

For clients enrolled in traditional Medicaid or the CSHCN Services Program, a refill for certain controlled substances is considered too soon if the client has not used at least 90 percent of the previous fill of the medication.

Note: *Some drugs, such as attention deficit hyperactivity disorder drugs and certain seizure medications, are excluded from this change.*

To identify drugs that require 90 percent utilization, refer to the VDP Formulary Search and select the "90% Utilization" filter. The returned results will include only those drugs that meet this requirement.

Referto: The [Formulary Search](#) on the VDP website for more information.

Justifications for early refills include, but are not limited to, the following:

- A verifiable dosage increase
- An anticipated prolonged absence from the state

If a client requests an early refill of a drug, the pharmacy must contact VDP to request an override of the early refill restriction. Prescribing providers may be asked to verify the reason for the early refill by the dispensing pharmacy or VDP staff.

Note: *Providers who are members of Medicaid managed care plans should contact the appropriate health plan or pharmacy benefits manager for specific requirements and processes related to dispensing early refills.*

B.3.5 Clinician-Administered Drugs

All Texas Medicaid providers must submit a rebate-eligible NDC for professional or outpatient claims submitted to TMHP with a clinician-administered drug procedure code.

The NDC is an 11-digit number on the package or container from which the medication is administered. Providers must enter identifier N4 before the NDC code. The NDC unit and the NDC unit of measure must be entered on all professional or outpatient claims that are submitted to TMHP and Medicaid managed care plans.

A list of drugs that require an NDC for Texas Medicaid reimbursement is available on the TMHP website at www.tmhp.com under the Topics section. Clinician-administered drugs that do not have a rebate-eligible NDC will not be reimbursed by Texas Medicaid.

Referto: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for additional information on claim filing using NDC.

B.3.5.1 Pharmacy Delivery Method for Clinician-Administered Drugs

Providers administering clinician-administered drugs in an outpatient setting for clients enrolled in Medicaid (both traditional and managed care) can send a prescription to a pharmacy and wait for the drug to be shipped or mailed to their office. This delivery method is called “white-bagging.”

Providers should use the following steps for this delivery method:

- 1) The treating provider identifies that the client is enrolled in Medicaid.
- 2) The treating provider or treating provider’s agent sends a prescription to a Texas Medicaid-enrolled pharmacy and obtains any necessary prior authorizations.
- 3) If any prior authorization is approved, the dispensing pharmacy fills the prescription and overnight ships an individual dose of the medication, in the client’s name, directly to the treating provider.
- 4) The treating provider administers the medication in the office setting. The provider bills for an administration fee and any medically necessary service provided at time of administration. The provider should not bill Medicaid for the drug.

The pharmacy contacts the provider each month, prior to dispensing any refills, to ensure that the client received all previously dispensed medication. Auto-refills are not allowed.

These medications cannot be used on any other client and cannot be returned to the pharmacy for credit.

Exception: *Unused long-acting reversible contraceptives may be returned in certain circumstances.*

Note: *Physicians who use this delivery method will not have to buy the clinician-administered drug, therefore, the physician is allowed to administer the drug and should only bill for the administration of the drug.*

B.4 Patient Information

B.4.1 Medication Synchronization

B.4.1.1 Overview

Medication Synchronization establishes processes for early refills in order to align the filling or refilling of multiple medications for a client with chronic illnesses.

The *Texas Insurance Code §1369(j)* allows a client enrolled in Medicaid, their prescribing physician, or the dispensing pharmacist to initiate the medication synchronization request. This process allows for clients to pick up all their medication on a single day each month versus requiring clients to make multiple pharmacy visits to obtain different prescription medications with different refill dates.

B.4.1.2 Eligible Medications

A drug is eligible for medication synchronization if it meets the following conditions:

- It is listed on the Medicaid, CHIP, KHC or CSHCN formulary.
- It is used for treatment and management of chronic illnesses.
- It is a formulation or dosage form that can be effectively dispensed in a medication synchronization protocol.
- It must meet all prior authorization criteria applicable to the medication on the date the synchronization request is made. This includes clinical prior authorizations, non-preferred prior authorizations, and drug utilization review edits.
- The original prescription must have refills.

Exception: *The prescription could be new but the drug is categorized with the same Generic Code Number (GCN) class, and if the pharmacy uses the override code, the claim will pay. Having available refills is not required.*

A claim cannot be synchronized if it is a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

B.4.1.3 Chronic Illness

Medications eligible for synchronization must be used to treat chronic illnesses. A chronic illness is defined as an illness or physical condition that is:

- Reasonably expected to continue for an uninterrupted period of at least three months, and
- Controlled, but not cured by medical treatment. This includes drugs used to treat mental health conditions and substance use.

B.4.1.4 Traditional Medicaid Claims Processing

A synchronized claim will count as one of the three prescriptions Medicaid will pay if a client is limited.

B.4.1.5 Medicaid Managed Care and CHIP Claims Processing

Each health plan has an HHSC-approved process for medication synchronization for clients eligible for Medicaid or CHIP. In CHIP, cost sharing or co-payment amounts will be prorated. Dispensing fees will not be prorated.

Pharmacy staff should contact the client's health plan for medication synchronization requirements using the contact information on the [Pharmacy MCO Assistance Chart](#).

B.4.2 Medicaid Drug Benefits

Clients enrolled in traditional Medicaid are limited to three prescriptions per month with the following exceptions:

- Clients enrolled in waiver programs such as Community Living Assistance (CLASS) and Community-Based Alternatives (CBA)
- Texas Health Steps (THSteps)-eligible clients (clients who are 20 years of age and younger)
- Clients in skilled nursing facilities

The following categories of drugs do not count against the three prescription per month limit:

- Family planning drugs and supplies
- Smoking cessation drugs
- Insulin syringes

***Note:** Prescriptions for family planning drugs and limited home health supplies are not subject to the three-prescription limit.*

Though TMHP reimburses family planning agencies and physicians for family planning drugs and supplies, the following family planning drugs and supplies are also available through the VDP and are not subject to the three-prescription limit:

- Oral contraceptives
- Long-acting injectable contraceptives
- Vaginal ring
- Hormone patch
- Certain drugs used to treat sexually transmitted diseases (STDs)

B.4.3 Cost Avoidance Coordination of Benefits

Cost avoidance coordination of benefits for pharmacy claims ensures compliance with CMS regulations. Under federal rules, Medicaid agencies must be the payer of last resort. The cost avoidance model checks for other known insurance at point of sale, preventing Medicaid from paying a claim until the pharmacy attempts to obtain payment from the client's primary third party insurance.

Referto: The [VDP Pharmacy Provider Procedure Manual](#) on the VDP website.

B.4.4 Medicaid Children's Services Comprehensive Care Program

Medically-necessary drugs and supplies that are not covered by the VDP may be available to children and adolescents (birth through 20 years of age) through the Medicaid Comprehensive Care Program (CCP). Drugs and supplies not covered could include, as examples, some over-the-counter drugs, nutritional products, diapers, and disposable or expendable medical supplies.

The Prior Authorization fax number is 1-512-514-4212.

Referto: Subsection 2.7.1.1, "Pharmacies (CCP)" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information about pharmacy enrollment in CCP.

B.4.5 Pharmacy Lock-In

Clients enrolled in traditional Medicaid can be "locked-in" to a specific primary care pharmacy. Those clients will have "Lock-in" identified on the face of their Your Texas Benefits Medicaid card. Clients who are not "locked-in" to a specific pharmacy may obtain their drugs or supplies from any enrolled Medicaid pharmacy.

Referto: Subsection 4.3.2, "Client Lock-in Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information about lock-in limitations.

Family planning services are excluded from lock-in limitation.

B.4.6 Free Delivery of Medicaid Prescriptions

Many Medicaid pharmacies offer free delivery of prescriptions to clients enrolled in Medicaid.

To find out which pharmacies offer delivery services:

- Refer clients enrolled in traditional Medicaid to the VDP Pharmacy Search. Click the "Delivers" indicator on the search. The returned results will include only those pharmacies that provide a delivery service. These VDP-enrolled pharmacies have certified their delivery services meet the minimum conditions for the payment of the delivery fee. These certified delivery pharmacies are reimbursed a delivery fee that is included in the medication dispensing formula.
- Refer clients enrolled in Medicaid managed care to their respective health plan. Each health plan develops its own participating pharmacy network for the delivery service.

Deliveries are made to client's home and not institutions, such as nursing homes. Delivery service is not applicable for mail-order prescriptions and not available for over-the-counter drugs.

B.5 Pharmacy Prior Authorization

Some Medicaid drugs are subject to one or both types of prior authorization, clinical and non-preferred.

B.5.1 Clinical Prior Authorization

Clinical prior authorizations utilize evidence-based clinical criteria and nationally recognized peer-reviewed information. These prior authorizations may apply to an individual drug or a drug class on the formulary, including some preferred and non-preferred drugs. There are certain clinical prior authorizations that all health plans are required to perform. Usage of all other clinical prior authorizations will vary between health plans and at the discretion of each health plan.

Referto: The [Clinical Prior Authorization Assistance Chart](#) on the VDP website. It identifies the prior authorization each health plans uses and how those authorizations relate to the authorizations used for traditional Medicaid claim processing. The chart is updated quarterly.

Subsection B.5.5, “Palivizumab (Synagis)” in this section for information about Synagis prior authorizations.

B.5.2 Non-preferred Prior Authorization

The PDL is arranged by drug therapeutic class and contains a subset of many, but not all, drugs that are on the Medicaid formulary. Drugs are identified as preferred or non-preferred on the PDL. Drugs listed on the PDL as preferred, or those not listed at all, are available without PDL prior authorization. Drugs identified as non-preferred on the PDL require a PDL prior authorization.

Referto: Medicaid health plans are required to adhere to the Texas Medicaid Preferred Drug List.

Note: *CHIP does not have a PDL.*

Referto: The [PDL Prior Authorization Criteria Guide](#) that explains the criteria that are used to evaluate the PDL prior authorization requests.

B.5.3 Obtaining Prior Authorization

Prior authorization for clients enrolled in traditional Medicaid is requested through the Texas Prior Authorization Call Center.

The Texas Prior Authorization Call Center accepts prior authorization requests by phone at 1-877-PA-TEXAS (1-877-728-3927) (Monday through Friday, between 7:30 a.m. and 6:30 p.m., central) or online through PAXpress. Online submissions are only available for non-preferred prior authorization requests.

Referto: The [Account Registration Instructions](#) on the PAXpress website.

The [VDP Prior Authorization Program Quick Reference Guide for Prescribers](#) on the PAXpress website.

Note: *Pharmacists cannot obtain prior authorization for medications. If the client arrives at the pharmacy without prior authorization for a non-preferred drug and/or a drug requiring clinical prior authorization, the pharmacist will alert the provider’s office and ask the provider to get prior authorization.*

B.5.4 72-Hour Emergency Supply

Federal and Texas law allows for a 72-hour emergency supply of a prescribed drug to be provided when a medication is needed without delay and prior authorization is not available. This rule applies to non-preferred drugs on the PDL and any drug that is affected by a clinical prior authorization.

Drugs not on the PDL may also be subject to clinical prior authorization.

Referto: The [Texas Pharmacy Provider Procedure Manual](#) on the VDP website.

B.5.5 Palivizumab (Synagis)

Palivizumab is available to physicians for administration to clients in Medicaid and the CSHCN Services Program through VDP. The enables physicians to have palivizumab shipped directly to their office from a network pharmacy, and not purchase the drug.

Physicians who obtain palivizumab through VDP may not submit claims to TMHP for the drug. The administering provider may submit a claim to TMHP for an injection administration fee and any medically necessary office-based evaluation and management service provided at time of injection.

B.5.5.1 Schedule and Forms

Referto: The [Synagis](#) page on the VDP website for more information about the current season, including forms and schedule.

Prior authorization request forms are reviewed annually. Providers must use the most current version of the Medicaid Synagis Prior Authorization Request (HHS Form 1033) to submit prior authorization requests. Forms received outside the RSV season schedule will not be processed.

Note: *Edited: Palivizumab is also available for clients enrolled in the Children with Special Health Care Needs (CSHCN) Services Program. Providers can refer to the [CSHCN Services Program Provider Manual](#) for details.*