(b) The usual and customary charge to the Medicaid or NJ KidCare program is defined as the amount a provider charges the general public for a prescription for the same drug product (same NDC number) in the same quantity as the prescription being dispensed to a Medicaid or NJ KidCare beneficiary. "Usual and customary charge" means the actual charge made to the majority (51 percent) of the total patient population served by the individual pharmacy.

1. The provider shall not charge the programs more than would be charged to a cash customer when the general public, including private third party plans, accounts for more than 50 percent of a provider's total prescription volume.

i. In the event Medicaid, NJ KidCare and/or PAAD represent more than 50 percent of a provider's total prescription volume, then, for reimbursement purposes, the provider's usual and customary charge may be considered the amount the programs would reimburse for the same services.

Amended by R.1998 d.488, effective September 21, 1998.
See: 30 N.J.R. 2169(b), 30 N.J.R. 3538(a).
In (b), inserted references to NJ KidCare throughout.

10:51–1.11 Covered pharmaceutical services

(a) All covered pharmaceutical services shall be provided within the scope of the N.J.A.C. 10:49, Administration, and this chapter, and billed to the fiscal agent on the claim form or other approved billing method (see Appendix, Fiscal Agent Billing Supplement).

(b) Covered pharmaceutical services include:

1. Prescribed legend drugs (for their medically accepted indication) as defined in Section 1927(k)(6) of the Social Security Act. "Legend drugs" mean those drugs whose labels include the legend statement "Caution: Federal Law Prohibits Dispensing Without a Prescription."

2. Non-legend drugs, as follows, for which Federal Financial Participation (FFP) is available:

i. Contraceptive devices and contraceptive supplies (such as diaphragms, jellies, foams and condoms);

ii. Over-the-counter, family planning supplies (such as pregnancy test kits);

iii. Pharmaceutical inhalation devices;

iv. Diabetic testing materials;

v. Insulin needles and/or syringes;

vi. Insulin; and

vii. Antacids.

3. In addition, coverage of non-legend drugs for beneficiaries under the age of 21 shall also include:

i. Analgesics, Salicylates;

ii. Analgesics/Antipyretics, Non-salicylate;

iii. Antidiarrheals;

iv. Anti-Emetics;

v. Antiflatulents;

vi. Antihistamines;

vii. Antipruritics;

viii. Antitussives, non-narcotic;

ix. Cathartics;

x. Cough and cold preparations;

xi. Decongestants

xii. Emetics;

xiii. Expectorants;

xiv. Hematinics;

xv. Iron replacement supplements;

xvi. Laxatives;

xvii. Lice treatment products;

xviii. Multiple vitamin preparations;

xix. Oral anti-inflammatory agents;

xx. Pediatric vitamin preparations;

xxi. Vitamins A, B, C, D, E, K, B1, B2, B6, B12 preparations;

xxii. Polymixin and derivatives;

xxiii. Topical preparations, antibacterial;

xxiv. Topical antibiotics; and

xxv. Topical anti-inflammatory preparations.

(c) For beneficiaries in the Medically Needy component of the New Jersey Care ... Special Medicaid programs, pharmaceutical services are available to pregnant women, dependent children and aged, blind or disabled Medically Needy beneficiaries residing in nursing facilities. For information on how to identify a Medicaid beneficiary, see N.J.A.C. 10:49, Administration.

Amended by R.1995 d.358, effective July 3, 1995.
See: 27 N.J.R. 1104(a), 27 N.J.R. 2614(b).
In (b) added 3.
Amended by R.1998 d.488, effective September 21, 1998.
See: 30 N.J.R. 2169(b), 30 N.J.R. 3538(a).
In (b), inserted a new xi, recodified former xi through xv as xii through xvi, inserted a new xvii, recodified former xvi as xviii, inserted a new xix, and recodified former xvii through xxii as xx through xxv; and rewrote (c).

10:51–1.12 Personal contribution to care requirements for NJ KidCare–Plan C and copayments for NJ KidCare–Plan D

(a) General policies regarding the collection of personal contribution to care for NJ KidCare–Plan C and copayments for NJ KidCare–Plan D are set forth at N.J.A.C. 10:49–9.

(b) Personal contribution to care for NJ KidCare–Plan C services are $1.00 per dispensing for generics and $5.00 per dispensing for brand name drugs. Included in drugs are insulin, needles and syringes.

(c) Pharmacies are required to collect the personal contribution to care for the above mentioned NJ KidCare–Plan C services if the NJ KidCare Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ KidCare form which indicates that the beneficiary has reached their cost share limit and no further personal contributions to care is required, until further notice. Personal contribution to care charges cannot be waived.

(d) The copayment for prescription drugs under NJ KidCare–Plan D shall be $5.00 per prescription:

1. If greater than a 34–day supply of a prescription drug is dispensed, a $10.00 copayment shall apply.

(e) Pharmacies shall collect the copayment specified in (d) above. Copayments shall not be waived.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Former N.J.A.C. 10:51–1.12, Noncovered pharmaceutical services, recodified to N.J.A.C. 10:51–1.13.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
In (a), added reference to copayments for NJ KidCare–Plan D; added (d) and (e).

10:51–1.13 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the New Jersey Medicaid or NJ KidCare fee-for-service programs. For beneficiaries in the Medically Needy component of the New Jersey Care ... Special Medicaid programs, pharmaceutical services are not available to the aged, blind nor the disabled who are residing in a long-term care facility (except a nursing facility) or in the community. For information on how to identify a covered person, see N.J.A.C. 10:49, Administration.

1. Prescriptions which are not for medically accepted indications as defined in Section 1927(k)(6) of the Social Security Act;

2. Antiobesics and anorexiants when used in treatment of obesity (see N.J.A.C. 10:51–1.14, Prior authorization);

3. Drug products for which adequate and accurate information is not readily available, such as, but not limited to, product literature, package inserts and price catalogues;

4. Experimental drugs;

i. Exception: Drugs available only for treatment through an Investigational New Drug (IND) application shall be prior authorized;

5. Medication furnished by a prescriber or an employee of a prescriber;

6. Medication prescribed for hospital inpatients;

7. Non-legend drugs other than antacids; contraceptive devices and contraceptive supplies; diabetic testing materials; over-the-counter (OTC) family planning supplies; inhalation devices (pharmaceutical); insulin; and insulin needles and/or syringes;

i. Exception: Non-legend drugs described in N.J.A.C. 10:51–1.11, for beneficiaries under 21 years of age.

8. Prescriptions written and/or dispensed with nonspecific directions;

9. Food supplements, milk modifiers, infant formulas, therapeutic diets, special liquid or powdered diets used in the treatment of obesity;

i. Exception: Enteral nutritional products and electrolyte replacement supplements;

10. Methadone in any form (tablets, capsules, liquid, injectables, or powder) when used for drug detoxification or addiction maintenance (see N.J.A.C. 10:51–1.14, Prior authorization);

11. Drug products for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA);

12. Drugs or drug products not approved by the Food and Drug Administration, when such approval is required by Federal law and/or regulation;

13. Radiopaque contrast materials (for example, Telepaque);

14. Drugs for which Federal Financial Participation (FFP) is not available, including:

i. Drug Efficacy Study Implementation (DESI) drugs and identical, similar and related drugs (see N.J.A.C. 10:51–1.21); and

ii. Drugs not covered by rebate agreements as defined in Section 4401 of OBRA '90 and Section 1927(a) of the Social Security Act (see N.J.A.C. 10:51–1.22);

15. Any bundled drug service (see N.J.A.C. 10:51–1.23);

16. 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.

17. Drugs provided primarily for the treatment of infertility or which may be used to treat other conditions related to infertility, including fertility preparations and gonadotropic (follicle stimulating and luteinizing) hormones.

i. When a drug is provided that is ordinarily considered an infertility drug, but is provided for conditions unrelated to infertility, the claim must be sent with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, PO Box 712, (Mail Code #14), Trenton, New Jersey 08625–0712.

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1. Products whose costs are found to be in excess of defined costs outlined in N.J.A.C. 10:51–1.5, Basis of payment;

2. Drug products in dosage forms whose labeling, prescription or promotional material indicate the primary use is cosmetic in nature; for example, hair restoration;

3. Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting or other community type setting. Other community type setting shall not include certain assisted living settings, including assisted living residences (ALRs), comprehensive personal care homes (CPCHs) and alternative family care (AFC) homes licensed by the Department of Health and Senior Services.

i. Drug products commercially available only as a unit-dose packaged product are covered when not otherwise marketed as a chemically equivalent product. The potency of equivalent products may or may not equal the potency of the unit-dose packaged product;

4. Prescriptions refilled too soon, as described in N.J.A.C. 10:51–1.19(a)5; and

5. Drug products denied payment based on point-of-sale (POS) and prospective drug utilization review (PDUR) standards adopted by the Medicaid or NJ KidCare program. (see N.J.A.C. 10:51–1.26).

(c) Reimbursement shall not be made for any claim submitted by a provider which involves a beneficiary restricted to another pharmacy, except for an emergency situation (see N.J.A.C. 10:49, Administration).

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1995 d.358, effective July 3, 1995.
See: 27 N.J.R. 1104(a), 27 N.J.R. 2614(b).
In (a)7 added ii.
Amended by R.1995 d.359, effective July 3, 1995.
See: 26 N.J.R. 3349(a), 27 N.J.R. 2615(a).
Rewrote (b)3.
Amended by R.1996 d.144, effective March 18, 1996.
See: 27 N.J.R. 3907(a), 28 N.J.R. 1524(a).
Amended by R.1996 d.146, effective March 18, 1996 (operative April 1, 1996).
See: 27 N.J.R. 4566(a), 28 N.J.R. 1526(a).
Recodified from N.J.A.C. 10:51–1.12 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a) and (b), changed N.J.A.C. references throughout. Former N.J.A.C. 10:51–1.13, Services requiring prior authorization, recodified to N.J.A.C. 10:51–1.14.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.1998 d.488, effective September 21, 1998.
See: 30 N.J.R. 2169(b), 30 N.J.R. 3538(a).
Changed N.J.A.C. references throughout; in (a), inserted a reference to NJ KidCare fee-for-service in the first sentence and added "who are residing in a long-term care facility (except a nursing facility) or in the community" at the end of the second sentence in the introductory paragraph, deleted a former i and recodified former ii as i in 7, deleted a former 16, and recodified former 17 and 18 as 16 and 17; and in (b)5, inserted a reference to NJ KidCare.

10:51–1.14 Services requiring prior authorization

(a) The provider shall obtain prior authorization, when required, by telephone or in writing, from the Medicaid District Office (MDO) professional staff or State contractor. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement. Information on the form is transmitted, on-line, from the MDO to the fiscal agent who, in turn, confirms the status of the authorization request by mail and provides the specific prior authorization number.

1. In an administrative emergency (see N.J.A.C. 10:49–6.1(b)3) when the MDO or State contractor is unavailable, the provider may dispense a 72–hour supply of the prescribed drug.

i. If the drug is to be continued beyond 72 hours, and the MDO or State contractor is unavailable or prior authorization is not immediately available from the MDO or State contractor, the provider may dispense a total of six days supply.

ii. If the drug is to be continued beyond a six-day period, the provider shall hold the claim and obtain prior authorization for the balance of the prescription from the MDO or State contractor prior to dispensing.

(b) The following drugs and specific therapeutic drug classes require prior authorization:

1. Enteral nutritional products and special infant formulas may only be authorized when medically necessary and when not available from the Women, Infants and Children (WIC) Nutritional program;

i. Medically necessary enteral nutritional products for treatment of beneficiaries, which may be administered orally, via naso-gastric tube, gastrostomy tube or needle catheter jejunostomy must be prior authorized. Special liquid or powdered diets for treatment of obesity or regular infant formulas are not considered enteral nutritional products;

ii. Electrolyte replacement supplements are not considered enteral nutritional supplements and do not require prior authorization.

2. Methadone (not eligible for reimbursement when used for drug detoxification or for addiction maintenance);

3. Drugs available only for treatment through an Investigational New Drug (IND) application shall be prior authorized;

4. Anorexiants and antiobesics when used for treatment of conditions approved by New Jersey State Board of Medical Examiners at N.J.A.C. 13:35–6.7; and

5. Any prescription claim for the same beneficiary, provided within the same calendar month, that exceeds the monthly prescription volume threshold of seven prescriptions per month. This applies whether the prescriptions were dispensed by one or more pharmacies. The need for prior authorization shall be communicated to providers via the point of sale claims processing system. Prior authorization shall be requested as required by (a) above, except that prior authorization shall not be required in the following circumstances:

i. Pharmaceutical services provided to Medicaid beneficiaries residing in a nursing facility, assisted living residence, comprehensive personal care home, or residential health care facility;

ii. Certain drugs and specific therapeutic drug classes including clozapine, antihemophiliac drugs, immunosuppressants, and HIV/AIDS drugs (limited to protease inhibitor, antiretroviral drugs, nucleoside analogs and reverse transcriptase inhibitors);

iii. Drugs otherwise requiring prior authorization in accordance with this subsection; and

iv. Drugs otherwise requiring prior authorization by the General Assistance program.

Recodified from N.J.A.C. 10:51–1.13 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Former N.J.A.C. 10:51–1.14, Quantity of medication, recodified to N.J.A.C. 10:51–1.15.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1998 d.488, effective September 21, 1998.
See: 30 N.J.R. 2169(b), 30 N.J.R. 3538(a).
In (b), deleted former 5.
Amended by R.1999 d.122, effective April 19, 1999 (operative May 1, 1999).
See: 30 N.J.R. 1014(a), 30 N.J.R. 2185(a), 31 N.J.R. 1064(a).
In (a), inserted a reference to State contractors in the first sentence of the introductory paragraph, and rewrote 1; and in (b), substituted a reference to drug classes for a reference to classes in the introductory paragraph, and added 5.

10:51–1.15 Quantity of medication

(a) For claims with service dates on or after July 15, 1996, but prior to July 1, 1998, the quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or, if required, an amount sufficient to provide medication during intervals between prescriber visits. The amount of medication dispensed shall not exceed a 34–day supply or 100 unit doses, whichever is greater.

(b) For claims with service dates on or after July 1, 1998, but prior to July 1, 1999, the quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or, if required, an amount sufficient to provide medication during intervals between prescriber visits. The amount of medication dispensed shall not exceed a 34–day supply.

(c) For claims with service dates on or after July 1, 1999, the quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or, if required, an amount sufficient to provide medication during intervals between prescriber visits. The amount of medication dispensed shall not exceed a 34–day supply for initial prescriptions and a 34–day supply or 100 unit doses, whichever is greater, for refill prescriptions.

(d) Any medication continuously prescribed regardless of the frequency of administration, for a period of 14 days or more shall be considered a maintenance medication.

(e) The pharmacist shall dispense the full quantity of medication prescribed within the limitations described in (a) above.

(f) Prescriptions shall not be split or reduced in quantity, unless the quantity prescribed exceeds Program limits, in which case the quantity shall be reduced to Program limits described in (a) above.

1. Exception: When the full quantity prescribed (within Program limits) is not available when a prescription is ready to be dispensed, the pharmacist shall retain the claim form or submit an EMC claim after the balance of the medication is dispensed. The pharmacist may dispense the quantity available and shall notify the beneficiary accordingly.

Amended by R.1996 d.146, effective March 18, 1996 (operative April 1, 1996).