



STATE OF NEW JERSEY  
Department of Human Services  
Division of Medical Assistance and Health Services

New Jersey Health Services Program

# NEWSLETTER

Volume BC 261

July 18, 1983

TO: PHARMACY PROVIDERS

SUBJECT: REVISION OF SUBCHAPTER I, APPENDICES B, D, AND E -  
PHARMACEUTICAL SERVICES MANUAL

EFFECTIVE: AUGUST 1, 1983

ACTION: The additions, changes, corrections and deletions to Subchapter I, non-legend drugs (Appendix B), legend devices (Appendix D) and Protein Replacements (Appendix E) become effective August 1, 1983.

For your convenience, the additions, changes and deletions have been attached and listed separately as well as incorporated into the revised replacement pages.

Please replace the attached revised replacement pages in the corresponding numbered order in your Pharmaceutical Services Manual, Subchapter I.

Any questions regarding this Newsletter should be directed to the Bureau of Pharmacy Services, Division of Medical Assistance and Health Services. Telephone (609) 292-3756.

*JML*  
8/25/83

ADDITIONS

Amesec Pulv 100	CAP	0000173-0335-23	Pg 19
Cal-Sup Tabs 100	TAB	0000089-0110-10	Pg 20
Centrum Jr. Tabs 60	TAB	0000005-4234-19	Pg 21
Chlor-Trimeton Tabs 12mg 100	TAB	0000085-0009-02	Pg 21
Drixoral Tabs 100	TAB	0000085-0147-02	Pg 24
Hydrocortisone Cream 0.5%/APC 15gm	EACH	0000084-0523-35	Pg 27
Hydrocortisone Cream 0.5%/Pharmaderm 30gm	EACH	0000462-0014-31	Pg 27
Hydrocortisone Cream 0.5%/Pharmaderm 120gm	EACH	0000462-0014-04	Pg 27
Hydrocortisone Cream 0.5%/URL 30gm	EACH	0000677-0711-37	Pg 27
Hydrocortisone Cream 0.5%/URL 120gm	EACH	0000677-0711-41	Pg 27
Hydrocortisone Cream 0.5%/Bioline 30gm	EACH	0000719-5200-52	Pg 27
Hydrocortisone Cream 0.5%/Clay Pk 30gm	EACH	0045802-0002-03	Pg 27
Hydrocortisone Cream 0.5%/Clay Pk 120gm	EACH	0045802-0002-04	Pg 27
Hydrocortisone Cream 0.5%/APC 30gm	EACH	0000084-0523-21	Pg 27
Hydrocortisone Lot 0.5%/URL 60cc	EACH	0000677-0719-31	Pg 28
Hydrocortisone Lot 0.5%/Bioline 60cc	EACH	0000719-5204-54	Pg 28
Hydrocortisone Lot 0.5%/Bioline 120cc	EACH	0000719-5204-56	Pg 28
Hydrocortisone Lot 0.5%/Clay Pk 120cc	EACH	0045802-0022-06	Pg 28
Hydrocortisone Lot 0.5%/Clay Pk 60cc	EACH	0045802-0022-46	Pg 28
Hydrocortisone Oint. 0.5%/Pharmaderm 30gm	EACH	0000462-0016-31	Pg 28
Hydrocortisone Oint. 0.5%/URL 30gm	EACH	0000677-0721-37	Pg 28
Hydrocortisone Oint. 0.5%/Bioline 30gm	EACH	0000719-5205-02	Pg 28
Hydrocortisone Oint. 0.5%/Clay Pk 120gm	EACH	0045802-0012-04	Pg 28
Hydrocortisone Oint. 0.5%/Clay Pk 30gm	EACH	0045802-0012-03	Pg 28
Hydrocortisone Spray 0.5%/Schein 45gm	EACH	0000364-7303-80	Pg 28
Lytren Nursette 240cc	EACH	0000087-0294-02	Pg 29
Niacinamide Tabs 100mg Generic	TAB	0000999-5052-01	Pg 32
Nico-400 Caps 100	CAP	0000088-1575-47	Pg 32
Nicobid Tempules 125mg 100	CAP	0000053-2835-01	Pg 32
Nicobid Tempules 250mg 100	CAP	0000053-2840-01	Pg 32
Nicobid Tempules 500mg 100	CAP	0000053-2841-01	Pg 32
Nicospan 400mg 100	CAP	0000369-2001-01	Pg 32
Pedialyte R.T.U. 960cc	EACH	0000074-5759-06	Pg 33
Pedialyte Bottles 240cc	EACH	0000074-5769-24	Pg 33
Perdiem Plain Pwd 100gm	EACH	0046213-0695-68	Pg 33
Perdiem Plain Pwd 250gm	EACH	0046213-0695-70	Pg 33
Pro-Cort Cream 30gm	EACH	0000077-0787-21	Pg 34
Sudafed Tabs 60mg 100	TAB	0000081-0868-55	Pg 37
Vit. B Comp Pulv 100	CAP	0000002-0643-02	Pg 40
Vit. B Comp Elixir 480cc	CC	0000002-2604-05	Pg 40
Vit. C Tabs 100mg/Lilly 100	TAB	0000002-2045-02	Pg 40
Vit. C Tabs 250mg/Lilly 100	TAB	0000002-2060-02	Pg 40
Vit. C Tabs 500mg/Lilly 100	TAB	0000002-2067-02	Pg 41
Vitron-C Plus Tabs (Now OTC) 100	TAB	0000585-1125-02	Pg 41

DIABETIC TESTING MATERIAL (PG 44)

Visidex Reagent Strips 25	EACH	0000193-2651-25	
Chemstrip BG Strips 25	EACH	0050924-0501-25	
Chemstrip BG Kits	EACH	0050924-0505-25	

CHANGES  
CHANGES ARE UNDERLINED

Abdec Drops 50cc	EACH	0000071-2323-35	Pg 18
Aquasol-E Drops	EACH	0000075-5800-12	Pg 19
Betalin Complex Pulv	CAP	<u>See Vit B Comp</u>	Pg 20
Betalin Complex Elixir	CC	<u>See Vit B Comp</u>	Pg 20

Calcium Gluc Tabs/PD 1gm 100	TAB	0000071-0764-24	Pg 21
Folbesyn Tabs 50	TAB	0000005-4202-18	Pg 26
Gevrite Tab 60	TAB	0000005-4204-19	Pg 26
Hydrocortisone Cream 0.5% 30gm	EACH	0000157-0460-31	Pg 27
Hydrocortisone Cream 0.5% 15gm	EACH	0000580-0459-22	Pg 27
Hydrocortisone Cream 0.5% 30gm	EACH	0000537-2373-31	Pg 27
Hydrocortisone Cream 0.5% 480gm	EACH	0000781-7017-16	Pg 27
Hydrocortisone Cream 0.5% 30gm	EACH	0000781-7017-24	Pg 27
Hydrocortisone Cream 0.5% 30gm	EACH	0000987-0458-31	Pg 27
Hydrocortisone Cream 0.5% 480gm	EACH	0017236-0018-16	Pg 28
Hydrocortisone Cream 0.5% 30gm	EACH	0017236-0018-30	Pg 28
Hydrocortisone Lot 0.5% 60cc	EACH	0000537-2384-02	Pg 28
Hydrocortisone Lot 0.5% 30cc	EACH	0000781-7070-90	Pg 28
Hydrocortisone Lot 0.5% 120cc	EACH	0000157-0446-04	Pg 28
Hydrocortisone Spray 0.5% 45cc	EACH	0000781-7075-45	Pg 28
Hydrososone Cream 0.5% 30gm	EACH	0000144-5412-30	Pg 28
Hydrososone Lot 0.5% 120cc	EACH	0000144-5402-08	Pg 28
I-Sedrin Sol 30cc	EACH	0000002-2494-67	Pg 28
Mucoplex Tabs 100	TAB	0000038-0420-10	Pg 30
Parcort Cream 0.5% 30gm	EACH	0000349-9023-48	Pg 33
Phenaphen Tabs 100	TAB	0000031-6224-63	Pg 33
Quintess Susp 180cc	CC	0000002-2350-78	Pg 34
Redisol Tabs 25 Mcgm 100	TAB	0000006-0906-68	Pg 34
Sedatussin Liq 480cc	CC	0000002-2337-05	Pg 35
Theron Tabs 100	TAB	0000038-0230-10	Pg 37
Tuamine Sulf Sol 30cc	EACH	0000002-2507-67	Pg 38
Tucks Saf-Tip Enema (135cc)	CC	0000071-1396-18	Pg 38
Vi Aquamin Caps 100	CAP	0000075-4351-00	Pg 39
Vit C Tabs 100mg/Squibb 100	TAB	0000003-0194-50	Pg 40

Insulin Preparations

Insulin Squibb Globin U100 Any Size	CC	0000003-1538-10	Pg 43
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APPENDIX E

Lytren RTU 960cc	EACH	0000087-0789-01	Pg 50
Pedialyte RTU 960cc	EACH	0000074-5759-06	Pg 50



STATE OF NEW JERSEY  
 Department of Human Services  
 Division of Medical Assistance and Health Services

New Jersey Health Services Program **NEWSLETTER**

Volume BC-248

March 1, 1983

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

SUBJECT: I. REALLOCATION OF DELIVERY SERVICE REIMBURSEMENT INCREMENT TO BASIC DISPENSING FEE.  
 II. ANNUAL PHARMACY CERTIFICATION OF PRESCRIPTION VOLUME AND FEE INCREMENTS (FD-70)

ACTION I: Effective April 1, 1983, the New Jersey Medicaid Pharmacy and the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Programs will no longer reimburse pharmacy providers for regular delivery services.

The delivery fee increment of \$.08 will be reallocated to the current basic dispensing fee of \$2.50. Providers with retail permits to dispense legend drugs to patients other than those in long-term care facilities will be reimbursed a basic dispensing fee of \$2.58.

ACTION II: The New Jersey Administrative Code, 10:51-1.16 and 10:51-5.18 requires all participating Medicaid and PAAD pharmacies to annually certify, in writing, to the Division of Medical Assistance and Health Services the total number of prescriptions (new, refill, private, Medicaid, PAAD and all other third party prescriptions) filled.

Also, Pharmacy Providers must annually certify their entitlement to the additional fee increments which are as follows:

<u>SERVICE</u>	<u>INCREMENT</u>
1. 24-hour Emergency Service Availability	\$0.05
2. Patient Consultation	0.08
3. Impact Allowance	0.09

In order to certify the Pharmacy Provider's total prescription volume for the calendar year 1982 and entitlement to the fee increments, the Pharmacy Provider must complete the attached Pharmacy Provider Certification Statement (form FD-70). Please return the completed form in the enclosed envelope or mail to Pharmacy Relations Department, Blue Cross of New Jersey, 33 Washington Street, Newark, New Jersey 07102, no later than March 15, 1983.

Failure to submit the FD-70 will result in the Pharmacy Provider being placed in the maximum discount category (category VI) and being placed in the basic fee category (2.58 or in the case of an institutional pharmacy, 75% of the basic fee).

NOTE: Those pharmacy providers who have been in business for less than one (1) year will have their volume projected over the entire calendar year to determine the appropriate category for next year.

If you have any questions about this Newsletter, please contact Pharmacy Relations Dept., Blue Cross of New Jersey at telephone number 201-456-2188.



STATE OF NEW JERSEY  
 DEPARTMENT OF HUMAN SERVICES  
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PHARMACY PROVIDER CERTIFICATION STATEMENT

Pharmacy Name \_\_\_\_\_ Provider I.D. No. \_\_\_\_\_

Address \_\_\_\_\_

SECTION I. ANNUAL CERTIFICATION OF PRESCRIPTION VOLUME FOR THE YEAR \_\_\_\_\_

Prescriptions Filled: New \_\_\_\_\_ +Refills \_\_\_\_\_ =TOTAL \_\_\_\_\_

SECTION II. FEE INCREMENTS

(1) 24-Hour Emergency Service Availability .....\$0.05

This pharmacy provider certifies it has available a 24-hour per day, 365 days per year prescription service.  Yes  No

If yes, the availability of this service is made known to our customers by:

- Sign in window of store; or
- Sign at prescription counter; or
- Other

Telephone number available to customers for this service is \_\_\_\_\_

(2) Patient consultation .....\$0.08

This pharmacy provider agrees to routinely monitor all Medicaid and PAAD patient profiles for drug interactions, contraindications and adverse reaction and will attempt to discuss, with the patient, the course of therapy, with emphasis on compliance with doctor's orders and alerting the patient to improper utilization of drugs. The pharmacist shall exercise good professional judgment in all encounters.  Yes  No

If the Pharmacy Provider discontinues any of the above services, he/she must notify the New Jersey Medicaid Program, Chief, Provider Enrollment, CN 712, Trenton, New Jersey 08625, in writing within 72 hours of such discontinuance and must immediately cease the practice of adding the increments to the dispensing fee.

(3) Impact Allowance .....\$0.09

This pharmacy provider has a combined Medicaid and PAAD prescription volume equal to or greater than 50% of his/her total prescription volume.  Yes  No

If the conditions warranting the impact allowance change, this pharmacy provider must notify the New Jersey Medicaid Program, Chief, Provider Enrollment, CN 712, Trenton, New Jersey 08625, in writing within 30 days of such change and will immediately cease the practice of adding the nine cents (9¢) to the dispensing fee.

I HAVE THOROUGHLY READ THE PHARMACY PROVIDER CERTIFICATION STATEMENT AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN. I UNDERSTAND THAT THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A MEDICAID OR PAAD PRESCRIPTION FOR A LEGEND DRUG, INCLUDING THE CHARGE OF THE COST OF MEDICATION AND THE DISPENSING FEE, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

- (A) cost plus dispensing fee as outlined in the New Jersey Medicaid Program Pharmacy Manual; or
- (B) usual and customary and/or posted or advertised charge; or
- (C) other third party prescription plan charges or contractual agreements.

L.S. \_\_\_\_\_ Date: \_\_\_\_\_

Name and Title \_\_\_\_\_  
*(Please print — owner, president, other-specify)*

- NOTE:** (1) All of the above statements are subject to audit and review by Division personnel, its contractors, or other state and federal agencies duly authorized.
- (2) Each claimed increment (Section II) is subject to audit. If the New Jersey Medicaid Program determines, upon audit, that the pharmacy provider has an error rate of 5% or more for a claimed increment, the New Jersey Medicaid Program will recover the total reimbursement paid to the pharmacy for that increment, plus interest charges, retroactive to the date of this agreement.

PLEASE RETURN THIS FORM WHEN COMPLETED TO:

Pharmacy Relations Department  
Blue Cross of New Jersey  
33 Washington Street  
Newark, New Jersey 07102



STATE OF NEW JERSEY  
 Department of Human Services  
 Division of Medical Assistance and Health Services

DO NOT CIRCULATE

New Jersey Health Services Program NEWSLETTER

Volume BC-221

December 28, 1981

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

SUBJECT: Revision of Subchapter I, Appendices B and D  
 Pharmaceutical Services Manual

EFFECTIVE: January 4, 1982

The following additions, changes, corrections and deletions to Subchapter I, Appendices B and D become effective January 4, 1982. Please replace the attached revised pages in the corresponding numbered order in your Pharmacy Manual, Subchapter I.

ADDITIONS - APPENDIX B

Hydrocortisone Cream 0.5% Sterimed 30gm	EACH	00188-8267-31
Naldecon - CX Susp. 120cc	CC	00015-5660-40
Trind Syrup (reformulated) 150cc	CC	00087-0750-44
Trind - DM Syrup (reformulated) 150cc	CC	00087-0753-44

ADDITIONS - APPENDIX D

Lacrisert Ophth. Inserts 60	EACH INSERT	00006-3380-60
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CHANGES AND CORRECTIONS (ARE UNDERLINED)

Asthmanefrin Sol. 15cc		<u>00766-5010-11</u>
Asthmanefrin Sol. 30cc		<u>00766-5010-12</u>
Bronkaid Mist Complete		<u>00024-4082-15</u>
Bronkaid Mist Refill		<u>00024-4083-16</u>
Bronkaid Tabs		<u>00024-4081-06</u>
Co-Tylenol Tabs <u>50</u>		<u>00045-0172-50</u>
Effersyllium Inst. Mix Pdr. <u>480gm</u>		
Enzypan Tabs		<u>00752-0003-13</u>
Hydrocortisone Cream 0.5% Fougera 30gm	<u>EACH</u>	
Hydrocortisone Cream 0.5% Fougera 120gm	<u>EACH</u>	
Hydrocortisone Cream 0.5% Fougera <u>480gm</u>	<u>EACH</u>	
I-Sedrin Solution		<u>00002-2494-67</u>
Nupercainal Ointment		<u>00083-5812-86</u>
Nupercainal Suppositories 12		<u>00083-5839-12</u>
Nupercainal Suppositories 24		<u>00083-5839-25</u>
Romilar-CF Syrup		<u>10158-0018-04</u>
Romilar Children's Cough Syr.		<u>10158-0019-02</u>
Syntrogel Tabs		<u>00021-0730-01</u>

*Jan 1/22/82*



STATE OF NEW JERSEY  
Department of Human Services  
Division of Medical Assistance and Health Services

# New Jersey Health Services Program NEWSLETTER

Volume BC-195

May 8, 1981

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

SUBJECT: REVISED APPENDICES B AND D OF SUBCHAPTER 1, "PHARMACEUTICAL SERVICES", OF THE PHARMACEUTICAL SERVICES MANUAL

Enclosed is your copy of the revised Appendix B, "General Non-Legend Drugs", (Rev. 4/81) and Appendix D, "Legend Devices (Debrisan)", (Rev. 4/81) of the Pharmaceutical Services Manual.

Please review the revised appendice pages as they incorporate additions, deletions, NDC changes and changes in the reimbursement method (package sizes) for certain non-legend drugs and legend devices. These changes become effective for all claims received on or after May 15, 1981.

## MANUAL MAINTENANCE

Please discard the outdated Appendix B (Rev. 11/80) pages 18 through 44 and Appendix D (Rev. 11/80) page 48 and replace with the attached Appendix B (Rev. 4/81) pages 18 through 42 and Appendix D (Rev. 4/81) page 46. Also enclosed for your convenience is Appendix C (Rev. 11/80) pages 43 through 45 which has only been renumbered, not revised, so that all pages in Appendices B, C and D will be sequentially numbered.

A handwritten signature in the bottom right corner of the page.



# MEDICAID BULLETIN

April 9, 1979

TO: Providers of Pharmaceutical Services

SUBJECT: Assigned Product Codes for Hypodermic Syringes and Needles

Re: Pharmacy Manual, Chapter II,  
Section 211.1

The following six Hypodermic Syringe and Needle products have been added to Section 211.1 which lists hypodermic syringes and needles which are eligible for reimbursement by the N.J. Medicaid/PAA Programs.

<u>PRODUCT DESCRIPTION</u>	<u>ASSIGNED PRODUCT CODE</u>
<u>SYRINGES AND NEEDLE UNITS, DISPOSABLE</u>	
1. Regular, 2 1/2 cc, w/any size Needle	293-0802-01
2. Regular, 3 cc, w/any size Needle	293-5570-01
3. Insulin, LoDose, 1/2 cc	293-8471-01
4. Insulin, LoDose, 1/2 cc	293-8461-01
5. Insulin, LoDose, 1 cc	293-8412-01
<u>SYRINGES ONLY, DISPOSABLE</u>	
1. Regular, 3 cc	293-5570-01

Please note that assigned product codes must be used when dispensing the described product, regardless of manufacturer. Do not use stock numbers or codes which appear on the product package. These are not NDC's. Use the assigned product code when billing the Medicaid/PAA Program.

All syringes and needles listed in Section 211.1 are reimbursable by the Medicaid Program. Note, however, that only insulin syringes and insulin needles are reimbursable by the PAA Program.

*MS/KAG  
I S/MS  
C/*

Please update your Pharmacy Manual as described below, and refer to the newly revised Section 211.1 when dispensing hypodermic syringes and needles.

DISCARD

REPLACE WITH

Chapter II, Section 211.1  
page 24 (rev. 11/1/78)

Chapter II, Section 211.1  
pages 24 & 24.1 (rev. 3/79)

*mt  
4/27/79*



April 9, 1979

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

SUBJECT: CHANGE OF CLAIMS MAILING ADDRESS -  
PHARMACIES LOCATED IN UNION COUNTY

In order to efficiently service the increased volumes of Medicaid and PAA claims, it has become necessary to redistribute incoming claim volumes between the service centers located in Cherry Hill and Paramus.

Effective immediately, pharmacies located in UNION County will discontinue mailing pharmacy claims to the Blue Cross Paramus address and will begin mailing claims to the following address:

HOSPITAL SERVICE PLAN OF NEW JERSEY  
2 CHERRY HILL EXECUTIVE CAMPUS  
CHERRY HILL, NEW JERSEY 08034

We have enclosed a number of pre-addressed envelopes for use by pharmacies located in UNION County only. Please discard all existing supplies of Paramus (yellow) envelopes.

This change in claims mailing address does not apply to pharmacies which submit claims via service bureaus' tape input, nor does it apply to pharmacies submitting claims via a central billing office.

Attached are the appropriate Pharmacy Manual page revisions. Please note the change as explained above and replace these pages in your Pharmacy Manual, in accordance with the following:

DISCARD

Chapter III, page 8  
(rev. 8/1/78)  
Chapter VI, page 19.  
(rev. 8/1/78)

REPLACE WITH

Chapter III, page 8  
(rev. 3/79)  
Chapter VI, page 19  
(rev. 3/79)

NOTE: PHARMACIES LOCATED IN ALL COUNTIES EXCEPT UNION COUNTY WILL CONTINUE SUBMITTING CLAIMS TO THEIR PRESENTLY ASSIGNED SERVICE CENTER.

*Jue*  
4-27-79



March 12, 1979

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

SUBJECT: Additions to General Non-Legend Drug List;  
Update to Medicaid Pharmacy Manual, Chapter II, Appendix B,  
Section 210.4

Please add the attached four pages to your Medicaid Pharmacy Manual Chapter II, at the end of Appendix B, immediately following page 22LL.

This update includes additional non-legend drugs which are eligible for Medicaid reimbursement. In addition, certain products appearing in the original listing (dated March 8, 1976) have been updated to provide for NDC changes and/or the addition of "created sizes" by the New Jersey Medicaid Program.

Please acquaint yourself with the contents of these new pages. When billing the Medicaid Program for general non-legend drugs, use only the NDC's and package sizes listed in Section 210.4, pages 22a through 22PP, in accordance with the instructions given on Page 19, Section 210.



February 1, 1979

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

SUBJECT: INCENTIVE PAYMENT FOR MAGNETIC TAPE CLAIMS

To encourage pharmacies to submit Medicaid and PAA claims on magnetic tape, the Program will offer an incentive payment of 2¢ per tape claim, effective January 1, 1979. Qualified pharmacy providers will receive a separate incentive payment check in February, 1979, for all tape claims paid during January, 1979.

The incentive payment program is described in detail in the attached page revisions for your Medicaid Manual. Please familiarize yourself with the program and add the page revisions to your manual as follows.

REMOVE AND DISCARD  
Chapter II, page 16  
Rev. 7/1/77

REPLACE WITH  
Chapter II, Pages 16, 16.1  
& 16.2, Rev. 1/1/79

The tape incentive program applies to PAA claims as well as Medicaid claims. Page revisions for your PAA chapter will be issued shortly.

In order to be eligible to submit magnetic tape claims for the Medicaid or PAA Program, a provider must complete Form FD-103 and receive approval from the Division. To obtain copies of the FD-103, contact:

Mr. Steve Gardner, Senior Manager  
Department of Government Operations  
Blue Cross of New Jersey  
33 Washington Street  
Newark, New Jersey 07102  
Telephone 201-456-2727

*Jan*  
*2/28/79*

**Blue Cross**  
of New Jersey



33 Washington Street  
Newark, New Jersey 07102

# ***Just a Reminder***

February, 1979

Re: MEDICAID BULLETIN, JULY 14, 1978

## CLAIMS PRICED OVER \$99.99

On occasion, claims are submitted which exhibit charges greater than \$99.99. In order to avoid delays in processing such claims, we request that you mail all claims for which charges are greater than \$99.99 to the following address:

Blue Cross of New Jersey  
New Jersey Health Services Program  
P.O. Box 549  
Newark, New Jersey 07101

Attention: 100

Your cooperation in this regard will enable us to more rapidly process these claims for complete payment.



January 22, 1979

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

SUBJECT: THIRD PARTY PRESCRIPTION PLAN AGREEMENTS

Effective February 1, 1979, a pharmacy may not charge the Medicaid Program more for a prescription than the least amount acceptable by the pharmacy from any other third party prescription program.

Pharmacies have been allowed a one year period to renegotiate their third party prescription contracts. This one year period expires on February 1, 1979, at which time all pharmacies must extend any lower third party fee to the Medicaid Program as well.

This policy is reflected in the attached manual page revisions. Page revisions for your PAA chapter will be distributed shortly.

REMOVE AND DISCARD

Chapter II, pages 14 & 15  
Rev. 7/1/77

REPLACE WITH

Chapter II, pages 14, 15 & 15.1  
Rev. 2/1/79

*Jed*  
*2/7/79*



November 15, 1978

TO: Providers of Pharmaceutical Services

RE: ENHANCEMENTS TO NDC PRICING SYSTEM:  
CHANGE IN METRIC QUANTITY REPORTING  
FOR LEGEND DRUGS

Since the inception of the New Jersey Medicaid Program, the prescription claims processing system has been operated under a methodology such that certain legend drug costs were paid per tablet, capsule, cc, etc., while other legend drug costs were paid per single bottle, tube, ampoule, vial, etc.

This methodology has created difficulty for providers who have, on occasion, submitted claims for multiple full packages of ointments, creams, injectables, etc., in accordance with prescription orders. Due to the payment mechanism, single unit payments could have been made even when multiple units were indicated on the claim form.

We are pleased to advise you that enhancements to the prescription claims payment system have been implemented such that all eligible legend drugs, with few exceptions, will be paid in a uniform manner. Such payments will be calculated per tablet, capsule, cc, suppository, insert, gram, etc. This change will eliminate problems associated with the proper dispensing of greater than one full package of these legend drugs and will negate the necessity for instituting adjustment requests in order to secure proper payment in cases of multiple package dispensing.

The following guide for proper reporting of metric quantities dispensed has been developed and is effective immediately:

1. Metric quantities dispensed of those injectable products normally reconstituted by physician, nurse, etc., SUBSEQUENT TO DISPENSING, bulk irrigation or I.V. Solutions and prefilled syringes (Ex. Tubex products), should be reported on claim form MC-6 as total number of full ampoules, vials, or bottles dispensed. Enter the NDC from the package label.

EXAMPLES: Report 3 vials of Polycillin-N Injection as 3 in metric quantity field.

Report 6 bottles of Normal Saline Sterile Solution for Irrigation, 1000cc each as 6 in metric quantity field.



December, 1971

TO: Pharmacy Providers

Re: Legibility of Prescription Claims

One of the problems in the processing of prescription claims is involved in the deciphering of the alpha and numeric characters in the claim form. Extra care to assure legibility and the writing of the alpha and numeric characters as exhibited below will assure quicker processing and payment for claims in pharmaceutical services.

The characters as illustrated were created by the American National Standards Institute (ANSI) for standardization and use wherever an alpha-numeric system is used.

We would appreciate your cooperation and care in providing more legible and standardized versions of the alpha and numeric characters in all prescription program claims.

B C D H J P S T

U V X Y

4 5 6 7 0

**Blue Cross**  
of New Jersey



33 Washington Street • Newark • New Jersey 07102

# MEDICAID BULLETIN

September, 1974

TO: All Pharmacy Providers

Re: Medicaid Prescriptions  
Eligible Services Chart

Attached herewith, you will find a chart of eligible pharmaceutical services, revised March 1, 1974. This chart has been prepared for providers as a ready reference and should answer most common questions regarding eligible prescription services. Please display it in a convenient area within your prescription department for reference.

Providers are cautioned that this chart is not a substitute for the New Jersey Health Services Program Pharmacy Manual and in no way does it supercede the Program regulations printed therein. The sole intent of the chart is to provide a convenient adjunct to the official Manual.

MEDICAID PRESCRIPTIONS - ELIGIBLE SERVICES CHART

LEGEND DRUGS

	LEGEND DRUGS	ORAL CONTRACEPTIVES	ANTIOBESICS ANOREXICS	VITAMINS AND OR MINERALS	PREVENTIVE DRUGS
DAYS SUPPLY	Up to 60	Up to a 3-month cycle	Up to 60	Up to 100	Up to 60
REFILLS ALLOWED	2	2	2	2	2
PRIOR AUTHORIZATION NEEDED?	No	No	Yes	No	Yes
ORIGINAL DISPENSING DAYS AND PERIOD FOR REFILLS	6 months	9 months	6 months	Within 1 year-	6 months
ALLOWED FOR PATIENTS IN LONG-TERM CARE FACILITIES?	Yes	Yes	Yes	Yes	Yes

NON-LEGEND DRUGS

	LISTED NON-LEGEND DRUGS	INJECTABLE INSULIN	VITAMINS AND OR MINERALS	UNLISTED NON-LEGEND DRUGS	UNLISTED VITAMINS AND OR MINERALS
DAYS SUPPLY	Up to 60	Up to 60	Up to 100	***	***
REFILLS ALLOWED	2	2	2	***	***
PRIOR AUTHORIZATION NEEDED?	No	No	No	***	***
ORIGINAL DISPENSING DAYS AND PERIOD FOR REFILLS	6 months	6 months	Within 1 year	***	***
ALLOWED FOR PATIENTS IN LONG-TERM CARE FACILITIES?	No - except for Vitamins & Insulin	Yes	Yes	***	***

\*\*\*NO AUTHORIZATION PROCEDURES -- THESE PRODUCTS NOT PAYABLE.



October, 1974

TO: All Pharmacy Providers

Re: Medicaid Pharmacy Missing Claims  
Investigation/Adjustment Request Form

The attached Medicaid Pharmacy Missing Claims Investigation/Adjustment Request Form replaces the Medicaid Adjustment Request Form (5834) previously in use. This new form serves a dual purpose:

1. Missing Claims Investigation
2. Adjustment Request.

### Missing Claims Investigation

To request investigation of apparent missing claims, follow the instructions indicated below:

1. Indicate check mark  in box for "Missing Claims Investigation".
2. Complete the following information:
  - Voucher date, if applicable (use latest date claim appeared)
  - Voucher number
  - Blue Cross locator number
  - Recipient's full name
  - Patient's case and person number (place in column headed, "Recipient's HSP Case Number" on Form FD 84).
  - Claim Number
  - Dispensing Date

### Adjustment Request

To request routine adjustments, follow these instructions:

1. Indicate check mark  in box for "Adjustment Request".
2. Complete the following information:
  - Voucher date
  - Voucher number
  - Blue Cross locator number
  - Recipient's full name

- Patient's case and person number (place in column headed, "Recipient's HSP Case Number" on Form FD 84).
- Claim Number
- Explanation Code
- Dispensing Date
- Reason for Adjustment

The Missing Claims Investigation/Adjustment Request Form consists of three parts. The original and second pages are to be mailed to:

New Jersey Health Services Program  
(New Jersey Blue Cross Plan)  
P.O. Box 549  
Newark, New Jersey 07101

The third copy is to be retained for your records and follow-up. The second copy will be completed by Blue Cross in the "For Blue Cross Use Only" area with information regarding the results of investigation and will be returned to you for your information.

All information supplied in answer to your requests will be according to the following format:

Missing Claims Information

Status of Claim

- #6 - Paid (voucher number and date will be indicated).
- #7 - Declined (voucher number and date will be indicated).
- #8 - Currently pending.
- #9 - Resubmit claim, using established procedures.
- #10 - Other (explanation will be noted).

Adjustment Request

Status of Claim

- #1 - Reverse decision (please check future vouchers).
- #2 - Reprocessed (please check future vouchers).
- #3 - New prescription required.
- #4 - Duplicate of claim number (above) - This will appear in column headed, "Status of Claim".
- #5 - No adjustment.
- #10 - Other (explanation will be noted).



# MEDICAID BULLETIN

JAN 16 1975

TO: Providers of Pharmaceutical Services

SUBJECT: Revisions - Chapter II - Pharmacy Manual

Attached is the revised Manual page 11, which reflects a policy change wherein the New Jersey Medicaid Program will discontinue using non-legend drug reimbursement in computing a providers category. This means that categories will be based on legend drug reimbursements only. Prior to March 1, 1975, you will be notified of your category. The computation will be based on calendar year 1974.

Attached is revised Manual page 2, which reflects a policy change whereby the agreement with the New Jersey Medicaid Program automatically terminates when a sale or other change of ownership of an approved pharmacy occurs.

Please replace pages 2 and 11 with the attached new page revisions. All changes are bracketed accordingly.



# MEDICAID BULLETIN

PROPERTY OF  
NEW JERSEY STATE LIBRARY  
MAY 8 - 1979  
AUGUST 1, 1975

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

RE: REVISION (8/1/75)  
CHAPTER II, PHARMACY MANUAL

Attached to this Bulletin are the revised Manual pages reflecting changes as indicated in Newsletters #56 and #57, dated August 1, 1975. All pages are identified by "Rev. 8/1/75" in the upper right-hand corner and should be inserted in your Manual as follows:

REMOVE

Pages 1 & 2  
4 - 14

INSERT

Pages 1 & 2  
4 - 14  
19 - 22

The following is a summary of the major revisions listed in numerical order:

- (DELETION) 200. Services Covered Under Pharmaceutical Services  
  - Diabetic Testing Materials (Items are no longer eligible under any services.)
  - Allergy Vaccines (Item is now payable under physician's services.)
- (REVISION) 203.1 Quantity of Medication  
  - Exception #2 - Limits exception to Legend vitamin and vitamin/mineral combinations.
- (REVISION) 204.2 Prescription Refill  
  - Exception B - Restricts exception to Legend vitamin and vitamin/mineral
- (DELETION) 205. Services Requiring Prior Authorization  
  - 2. Eliminates protein replacement products. These items are not eligible for payment. There is no authorization procedure (see 206.10).

*NJ/KAB  
IS/MS*



August 15, 1975

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

RE: Dispensing Fee and Copayment  
during the period August 1,  
1975 through August 13, 1975

Effective August 14, 1975, the dispensing fee was temporarily restored to the level that existed prior to August 1, 1975 (\$2.05 and \$2.15). In addition, the recipient copayment of twenty-five cents (25¢) for each prescription was temporarily suspended.

Claims for prescriptions dispensed August 1, 1975 through August 13, 1975, were subject to the reduced dispensing fee (\$1.80 and \$1.90); and, where applicable, a twenty-five cents (25¢) reduction for the copayment collected. Claim payment calculations are based on dispensing dates, and claims for this period have been so calculated.

Adjustment requests for fee adjustment or reimbursement for the 25¢ copayment for claims dispensed August 1, 1975 through August 13, 1975 will not be honored or acknowledged, as calculations were correct.



September 8, 1975

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

The temporary stay of the dispensing fee reduction and recipient copayment requirement was vacated by the State Supreme Court.

Effective September 8, 1975, the dispensing fee for legend drugs and the co-payment requirements will be as indicated in the Pharmacy Manual (rev. 8/1/75).

Claim payments will be calculated as follows:

<u>Claims Dispensed</u>	<u>Disp. Fee</u>	<u>Co-payment</u>
Aug. 1, through Aug. 13, 1975	\$1.80 and \$1.90	25¢
Aug. 14, through Sept. 7, 1975	\$2.05 and \$2.15	0
Sept. 8, 1975 and continuing	\$1.80 and \$1.90	25¢

Claim preparation should reflect the proper fee based on dispensing date. Providers are reminded that the 25¢ recipient co-payment should not appear in their "charge" calculations. The computer will reduce the charge automatically by 25¢ and this will be so indicated in the "amount billed" column on the voucher. Providers servicing recipients in long term care facilities should review Newsletter Volume 57 dated August 1, 1975 for co-payment information.

Blue Cross  
of New Jersey



33 Washington Street • Newark • New Jersey 07102

# BULLETIN

September 17, 1975

TO: ALL PROVIDERS

RE: "UPDATE OF DIRECTORY OF LOCAL  
MEDICAL ASSISTANCE UNITS."

Please be advised that effective Wednesday, September 3, 1975, both Medicaid offices located in Newark (796 Broad Street and 505 South 15th Street) have been moved and consolidated into one office at 155 Washington Street, Newark. The current telephone number will remain intact, i.e. (201) 648-2470 and 648-3700."

"The correct mailing address will be as follows:

State of New Jersey  
Essex County Local Medical Assistance Unit  
155 Washington Street  
Newark, New Jersey 07102



September 18, 1975

TO: Providers of Pharmaceutical Services

Re: Compounded Prescriptions

The following excerpt from the Pharmacy Manual in the New Jersey Health Services (Medicaid) Program has been subject to misinterpretation:

208.2 Compounded Prescriptions

Any prescription containing two or more ingredients, at least one of which is a legend item, in usually accepted therapeutic dosage and mixed by the pharmacist at the time of dispensing is a compounded prescription.

The following interpretations are made for the purpose of reimbursement:

Therapeutic dose is considered acceptable if:

1. such dosage is indicated by manufacturer in product literature.
2. such dosage is indicated in the U.S.P., N.F., U.S.D. or AMA Drug Evaluations.
3. In the case of Homeopathic Physicians, the indicated dosage contained in the official Homeopathic Pharmacopeia.

NOTE: In order to make this determination, it will be necessary for all claims for compounded prescriptions to have the directions for use listed in addition to the ingredients.

Providers are reminded that compounds resulting in mixtures that could be sold "over the counter" will not be considered for reimbursement even though they contain legend items. EXAMPLES: The addition of Codeine to Elixir Terpin Hydrate, resulting in 1 gr. of Codeine per fluid ounce or the addition of Phenol to Calamine Lotion resulting in 1% mixture of Phenol in Calamine Lotion.



September 20, 1976

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

Re: Basis of Payment  
for Legend Drugs

Effective October 1, 1976, Section 208.1 (2) of the Pharmaceutical Services Manual is revised (see attachments) to reflect changes mandated by the Department of Health, Education and Welfare Maximum Allowable Cost/Estimated Acquisition Cost (MAC/EAC) regulations.

All Providers of Pharmaceutical Services will be categorized for the purpose of reimbursement according to total prescription volume (number of prescriptions filled in a calendar year in all categories; i.e., Medicaid, private, other third party). All providers will be surveyed annually to certify as to their prescription volume.

Failure to submit the data on request will result in the provider being placed in the maximum discount category for the period of non-compliance.

Each pharmacy will be notified, in writing, into which category it will be placed.

PHARMACY MANUAL REVISIONS

Remove

Pages 10, 11 & 12

Insert

Pages 10, 11, 11a & 12

Attachment

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MAY 8 - 1979  
TRENTON, N.J.

**Blue Cross**  
of New Jersey



33 Washington Street • Newark • New Jersey 07102

# MEDICAID BULLETIN

October 6, 1975

TO: Providers of Pharmaceutical Services

Re: Change in Mailing Address for  
Claim Submittal; Selected Providers

Effective October 15, 1975, pharmacy providers located in the Counties of:

ATLANTIC, BURLINGTON, CAMDEN, CAPE MAY, CUMBERLAND, GLOUCESTER,  
MERCER, MIDDLESEX, MONMOUTH, OCEAN AND SALEM

SHALL submit Medicaid Pharmacy Claim Forms (MC-6) for processing to:

HOSPITAL SERVICE PLAN OF NEW JERSEY  
2 Cherry Hill Executive Campus  
Suite #104  
Cherry Hill, New Jersey 08034

A supply of mailing envelopes are enclosed for your convenience. When reordering mailing envelopes, please specify "Cherry Hill" address.

Providers located in counties other than those listed above, central billing providers and out-of-state providers will continue to submit claims to the Newark P.O. Box 900.

NOTE: THE MAILING ADDRESS FOR "MEDICAID PHARMACY MISSING CLAIMS INVESTIGATION/ADJUSTMENT REQUEST" FORMS REMAINS P.O. BOX 549, NEWARK, FOR ALL PROVIDERS.



November 1, 1975

TO: Providers of Pharmaceutical Services

- Re: 1. Newsletter, Volume No. 68  
2. Pharmacy Manual Chapter II  
Revisions  
3. New Jersey Medicaid Formulary

NEWSLETTER, VOLUME NO. 68, indicates implementation of Drug Policy changes, effective November 10, 1975.

PHARMACY MANUAL REVISIONS

Remove

Insert

Page 3

Pages 3 & 3a

Page 5

Page 5

NEW JERSEY MEDICAID FORMULARY is required for compliance with the revised Drug Policies. While it is not a physical part of Chapter II, the pages have been three-hole punched to allow insertion of the Formulary after pages referring to Drug Policy.



November 1, 1975

TO: Providers of Pharmaceutical Services

- Re: 1. Newsletter, Volume No. 68  
2. Pharmacy Manual Chapter II  
Revisions  
3. New Jersey Medicaid Formulary

NEWSLETTER, VOLUME NO. 68, indicates implementation of Drug Policy changes, effective November 10, 1975.

#### PHARMACY MANUAL REVISIONS

##### Remove

Page 3  
Page 5

##### Insert

Pages 3 & 3a  
Page 5

NEW JERSEY MEDICAID FORMULARY is required for compliance with the revised Drug Policies. While it is not a physical part of Chapter II, the pages have been three-hole punched to allow insertion of the Formulary after pages referring to Drug Policy.



# MEDICAID BULLETIN

February 1, 1976

TO: Providers of Pharmaceutical Services

Re: (1) Newsletter, Volume #70  
(2) Newsletter, Volume #75 ✓  
(3) Pharmacy Manual Revision,  
Chapter II

NEWSLETTER, VOLUME #70, dated 12/24/75 (issued 12/24/75)

Previously disseminated Newsletter, which indicated expanded coverage of pharmaceutical services to include hypodermic syringes and/or needles as a reimbursable service.

NEWSLETTER, VOLUME #75, dated 2/1/76

Attached Newsletter indicates expanded coverage of pharmaceutical services to include Diabetic Testing Materials, and the inclusion of Protein Replacement Products as reimbursable items when prior authorization accompanies the prescription.

MANUAL REVISIONS

Appendix B is revised to include eligible Diabetic Testing Material. Appendix C is an addition, designating assigned codes for reporting Hypodermic Syringes and/or Needles.

Attached to this Bulletin are the Manual revision pages reflecting the changes as indicated in the above Newsletters. All pages indicate "Rev. 2/1/76" in the upper right-hand corner and should be inserted in your Manual as follows:

REMOVE

Page 1  
4  
8  
9  
14  
19  
22

INSERT

Revision Page 1  
4  
8  
9  
14  
19  
22  
Page 23  
24



April 1, 1976

TO: Providers of Pharmaceutical Services

Re: Tape-to-Tape Claims Processing System

The Tape-to-Tape System is a comparatively new claims processing method which permits pharmacy providers to engage the services of an agent known as a service bureau to submit a magnetic tape for processing instead of individual claim forms or to perform this function themselves without engaging a service bureau.

The magnetic tape, which is created, contains the claims for particular providers for a certain period of time, usually representing one or two weeks of claims volume. The magnetic tape is received by Blue Cross and processed directly through our computer system, bypassing all interim processing steps necessary to prepare the conventional claim form for computer processing. The result is rapid payment of all acceptable claims due to more accurate preparation and complete accountability of payments.

During the first eleven months of 1975, 114 pharmacies were approved for submission of tape Medicaid claims via two approved service bureaus. By year's end, over a half million Medicaid pharmacy claims had been processed through the Tape-to-Tape System, representing approximately 9% of total Medicaid claims volume. Currently, two additional service bureaus have been approved, and Blue Cross of New Jersey is working with eight other service bureaus who intend to enter this new field. Within a short period of time, the Tape-to-Tape Procedure is expected to be operational for claims submission in the New Jersey Blue Cross Prescription Program, in addition to the New Jersey Health Services (Medicaid) Program.

As new service bureaus are approved, they will undoubtedly launch intense marketing campaigns among retail pharmacies. We believe that the competitive offerings to be made by these service bureaus may be of interest to you.

In order to obtain further information regarding the Tape-to-Tape System and its availability, providers may contact:

Mr. Anthony Janeiro  
Senior Manager  
Technical Services Operations  
Blue Cross of New Jersey  
33 Washington Street  
Newark, New Jersey 07102  
(201) 456-2937.



September 20, 1976

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

Re: Basis of Payment  
for Legend Drugs

Effective October 1, 1976, Section 208.1 (2) of the Pharmaceutical Services Manual is revised (see attachments) to reflect changes mandated by the Department of Health, Education and Welfare Maximum Allowable Cost/Estimated Acquisition Cost (MAC/EAC) regulations.

All Providers of Pharmaceutical Services will be categorized for the purpose of reimbursement according to total prescription volume (number of prescriptions filled in a calendar year in all categories; i.e., Medicaid, private, other third party). All providers will be surveyed annually to certify as to their prescription volume.

Failure to submit the data on request will result in the provider being placed in the maximum discount category for the period of non-compliance.

Each pharmacy will be notified, in writing, into which category it will be placed.

PHARMACY MANUAL REVISIONS

Remove

Pages 10, 11 & 12

Insert

Pages 10, 11, 11a & 12

Attachment

*JW*  
11/8/76



# MEDICAID BULLETIN

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NEW JERSEY STATE LIBRARY  
JUL 8 - 1977  
185 W. State Street  
Trenton, N. J.

June 27, 1977

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

Re: Chapter II (Revised)  
Chapter V (New)

Effective July 1, 1977, Sections 200. through 209. of the Pharmaceutical Services Manual are revised (see attached) to reflect information to providers of Pharmaceutical Services to Medicaid Eligibles which are not patients/residents in Long Term Care Facilities.

Chapter V (attached) outlines the requirements for Consultant Pharmaceutical Services in the Medicaid Program and is also effective July 1, 1977.

### PHARMACY MANUAL REVISIONS

Remove

Chapter II,  
Index through Pages 18

Insert

Revised Chapter II,  
Index through Pages 18C

Chapter V

NOTE: Sections 210. through 211.1 (Chapter II) pages 19-24 remain in effect without change.

*NJ/KAS  
-  
C-1*

*JML  
7/15/76*



July 20, 1977

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

Re: Chapter III (Revised)

Effective August 1, 1977, Sections 300. through 310. of the Pharmaceutical Services Manual are revised (see attached) to reflect information regarding Billing Procedures for providers of Pharmaceutical Services.

PHARMACY MANUAL REVISIONS

Remove

Chapter III,  
Index through Pages 5

Insert

Revised Chapter III,  
Index through Pages 18

*Jm 10/18/77*



# MEDICAID BULLETIN

August 1, 1977

TO: PROVIDERS OF PHARMACEUTICAL SERVICES

RE: Corrections to Chapter II (rev. 7/1/77),  
Pharmaceutical Services  
Manual

All providers of Pharmaceutical Services recently received a 7/1/77 revision to New Jersey Health Services (Medicaid) Program Pharmacy Manual, Chapter II. This issue contains one typographical omission and two typographical errors.

Please reference your copy of Chapter II, New Jersey Health Services (Medicaid) Program Manual (rev. 7/1/77) and make the following corrections:

<u>Page Number</u>	<u>Detail</u>	<u>Corrections Required</u>
4 ✓	Second paragraph, sixth line, second word	"FAB" should be corrected to read "FAP".
7 ✓	First paragraph, second line, seventh word	"initiated" should be corrected to read "initialed".
13 ✓	Under <u>Category IV</u> , paragraph omitted	remove page 13 and insert corrected page 13, attached to this Bulletin.

*jm* 10/18/77

Blue Cross  
of New Jersey



33 Washington Street • Newark • New Jersey 07102

# MEDICAID BULLETIN

February 1, 1978

PROPERTY OF  
STATE LIBRARY

FEB 23 1978

100 W. State Street  
Trenton, N. J.

TO: Providers of Pharmaceutical Services

Re: PAA Manual

Enclosed is the Pharmaceutical Assistance to the Aged (PAA) Program Manual, which should be added to your Medicaid Pharmaceutical Services Manual as Chapter VI.

Chapter VI describes the policies and procedures which apply to pharmacies who provide services to individuals eligible under the PAA Program. This new Chapter supplements Newsletter BC-122 which announced the revised PAA Program, which became effective January 1, 1978.

Questions about PAA policies or procedures should be directed to either Blue Cross 201-456-2188 or to the Chief, Pharmacy Services 609-292-3756. Questions about patient eligibility should be directed to the PAA Office at 609-292-9007.

*NJ/KAB*  
*F5/m5*  
*e-l*

*Jm*  
*13/9/77*

PHARMACY MANUAL

HEALTH SERVICES PROGRAM

DEPARTMENT OF INSTITUTIONS AND AGENCIES  
DIVISION OF MEDICAL ASSISTANCE  
AND  
HEALTH SERVICES

STATE OF NEW JERSEY



## FOREWORD

The New Jersey Medical Assistance and Health Services Act (Chapter 413, Laws of 1968) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. This is the New Jersey version of a program commonly known as "Medicaid" or "Title XIX". In identifying persons eligible for such assistance and services this will be known as the New Jersey Health Services Program.

This manual is designed for use by providers billing for services furnished under the Program. It contains informational and procedural material the provider will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. The procedures described in this manual have been devised to achieve the goals of the Program with due consideration to the needs of the covered persons and effective relationships with providers.

A careful effort has been made to insure that the provisions of the law and the regulations are accurately reflected. This issuance should help to assure that the law is uniformly applied without regard to where covered services are furnished.

The manual is designed to accommodate new pages as administrative changes in procedure are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

	SECTION	PAGE
Who is Eligible.....	100.	2
How to Identify a Covered Person.....	101.	3
Plastic Identification Card.....	101.1	3
Validation Form.....	101.2	3
Temporary Identification and Validation Card.....	101.3	4
Authorized Services for Covered Persons.....	102.	5
Eligible Providers.....	103.	6
Free Choice by Covered Persons.....	104.	6
Contractors.....	105.	7
Prior Authorization.....	106.	7
Policy on Out-of-State Medical Care and Services.....	107.	7
General Exclusions.....	108.	8
Confidentiality of Records.....	109.	9
Utilization of Insurance Benefits.....	110.	9
Medical Review and Evaluation.....	111.	10
Provision for Appeals--Fair Hearings.....	112.	10
Fraud.....	113.	10
Civil Rights.....	114.	10
Observance of Religious Belief.....	115.	10
Program Participation.....	116.	10.1

## CHAPTER I

### GENERAL INFORMATION ABOUT THE PROGRAM

#### 100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Assistance to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

GENERAL INFORMATION

101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

This card identifies an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies. It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OR THE STATE OF NEW JERSEY (SEE SECTION 101.2).

<b>NEW JERSEY</b> <b>HEALTH SERVICES PROGRAM</b> CASE NUMBER <b>0123456789</b>	
AUTHORIZED SIGNATURE	<i>John Doe</i> DOE, JOHN

101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: THIS FORM IS THE SOLE INDICATOR OF ELIGIBILITY. THE PLASTIC IDENTIFICATION CARD ALONE IS NOT SUFFICIENT.

The sample shown contains all of the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, H.S.P. Case Number, and Person Number, EXACTLY as it appears on the Validation form on all Requests for Authorization and claim forms.

GENERAL INFORMATION

\_\_\_\_ COUNTY WELFARE BOARD

VALIDATION FOR HEALTH SERVICES PROGRAM

Valid Only for Month of Jan. 1970

BUCKINGHAM                      11 30 051234

01 John                              24 Olive  
 02 Mary                              25 Sarah  
 20 Emma Jones                      26 Adolph  
 21 Lila  
 22 James  
 23 Belinda Smith

101.3 Temporary Identification and Validation Form (Exhibit III)

In certain circumstances, a temporary identification and validation form will be issued. This form will identify the case as eligible for health services for 30 days from the date of issue.

STATE OF NEW JERSEY  
 DEPARTMENT OF INSTITUTIONS AND AGENCIES  
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TEMPORARY IDENTIFICATION AND VALIDATION OF ELIGIBILITY

QUEST. CASE NO.	PL. IDENT. CA.
01 2,3 4,5,6,7,8,9 0,1 0,1 70	

	LAST NAME	FIRST NAME	M.I.	BIRTH DATE		
				MO.	DA.	YR.
1	01	D O E	J O H N	D.	02	05 19
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

**NOTICE TO PROVIDER OF HEALTH SERVICES:**

This form, when signed by or on behalf of the person whose name is first listed, identifies the person(s) listed as eligible for payment for authorized health services under the New Jersey Health Services Program.

This form also serves as a temporary validation of eligibility for a period not exceeding 30 days from the effective date entered above.

The information appearing on this form should be used in completing the claim form to be submitted to the appropriate Contractor for the State of New Jersey.

**NOTICE TO CLIENT:**

This form must be signed on the line below marked "Signature" by or on behalf of the person whose name is first listed. This form must be presented to the provider of health services to prove eligibility for payment. Do not use this form after receiving your plastic identification card and your monthly "Validation for Health Services".

Signature \_\_\_\_\_

Reported By \_\_\_\_\_ Date \_\_\_\_\_  
 Approved By \_\_\_\_\_

MAP-16 (11/69)

## GENERAL INFORMATION

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### 102. AUTHORIZED SERVICES FOR COVERED PERSONS

The items and services provided to covered persons will not normally be limited in duration or amount. Any limitations imposed will be consistent with the medical necessity of the patient's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the Division of Medical Assistance and Health Services. The following items and services, more specifically defined in subsequent sections of the appropriate manual, are authorized under the Program:

- (a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;
- (b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;
- (c) Outpatient hospital services;
- (d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;
- (e) Laboratory and x-ray services;
- (f) Skilled nursing home services;
- (g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;
- (h) Other practitioners' services, limited by State law to podiatrists and optometrists;
- (i) Dental services, including dentures;
- (j) Home health care services;
- (k) Pharmaceutical services [prescribed drugs (legend and non-legend)];
- (l) Prosthetic devices and appliances, medical supplies and equipment; eyeglasses and hearing aids;
- (m) Rehabilitation services; and
- (n) Transportation, i.e., ambulance service to and from a medical facility when the patient's condition precludes the use of other means of transportation.

## GENERAL INFORMATION

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### 103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, institution, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;

Certified Independent Clinical laboratories;

Dentists;

Hearing Aid Dealers;

Home Health Agencies;

Hospitals;

Skilled Nursing Homes;

Opticians;

Optometrists;

Approved Clinics (Independent Outpatient Health Facilities);

Certified Orthotists;

Pharmacies;

Physicians;

Podiatrists;

Certified Prosthetists;

Providers of Medical Transportation.

### 104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the local medical assistance unit may assist in obtaining an appropriate practitioner.

## GENERAL INFORMATION

### 105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical services claims (i.e., legend and non-legend drugs), and claims for out of state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to The Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the program.

### 106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

### 107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.

GENERAL INFORMATION

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2. When it is customary for the inhabitants of the district generally to use medical care resources and facilities outside the State of New Jersey.
3. When out of state care was provided in an emergency.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;
2. Any service or items furnished in connection with elective cosmetic surgery;

Note: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the physician to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;
4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;
5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;
6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy (including any benefits payable under the "New Jersey Automobile Reparation Reform Act", P.L. 1972, c.70), any other private or governmental health benefit system, or through any similar third party liability;
7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage;

## GENERAL INFORMATION

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8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;
9. Any services or items furnished for which the Provider does not normally charge;
10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person's household.

### 109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which covered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

### 110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

#### 1. Title XVIII

The Program, in most instances, shall cover the amount of any deductible or co-insurance liability under Title XVIII of the Social Security Act for all covered persons 65 years of age or older.

#### 2. Workmen's Compensation

No Program payments shall be made for a patient covered by workmen's compensation.

#### 3. Other Health Insurance

When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

## GENERAL INFORMATION

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### 111. MEDICAL REVIEW AND EVALUATION (by Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

### 112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

### 113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

### 114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

### 115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

116. Program Participation

- A. Participation in the Health Services Program of a provider of services is subject to suspension or revocation for good cause shown.

Any of the following shall, inter alia, constitute a good cause for suspension or revocation:

1. Presentment for allowance or payment any false or fraudulent claim for services or merchandise;
2. Submitting false information for the purpose of obtaining greater compensation than that to which he is legally entitled;
3. Submitting false information for the purpose of obtaining authorization requirements;
4. Failure to disclose or make available to the Division or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefore;
5. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of peers;
6. Engaging in a course of conduct or performing an act deemed improper or abusive of the Health Services Program following notification that said conduct should cease;
7. Breach of the terms of agreement of participation entered into with the Division or failure to comply with the terms of providers certification on claim form.
8. Over-utilizing Health Services Program by inducing, furnishing, or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the recipient;

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;
10. Violating any provisions of P.L. 1968, c. 413, (Health Services Act), or any rule or regulations promulgated by the Commissioner of Institutions and Agencies pursuant thereto;
11. Conviction of any crime involving moral turpitude;
12. Violation of applicable State regulations relating to professional conduct or Code of Ethics.

## INTRODUCTION

This Chapter provides information to providers of Pharmaceutical Services to Medicaid eligibles who are not patients/residents in Long Term Care Facilities. Refer to Chapter IV of this Manual for regulations concerning provision of services to Medicaid recipients in Long Term Care Facilities.

PHARMACEUTICAL SERVICES MANUAL  
INDEX  
SUBCHAPTER I

PHARMACEUTICAL SERVICES

N.J.A.C. TITLE 10 - CHAPTER 51

	<u>Subchapter</u>	<u>Page</u>
Scope-----	1.1	1
Covered Pharmaceutical Services-----	1.2	1
Eligible Prescribers-----	1.3	1
Eligible Pharmacies-----	1.4	2
General Policies for Participation-----	1.5	2
Prescription Drug Policies-----	1.6	3-4
Quantity of Medication-----	1.7	4
Dosage and Direction-----	1.8	5
Telephone Ordered Original Prescriptions-----	1.9	5
Changes or Additions to the Original Prescription-----	1.10	6
Non-Proprietary or Generic Dispensing-----	1.11	6
Prescription Refill-----	1.12	6
Services Requiring Prior Authorization-----	1.13	7
Services Not Eligible for Reimbursement-----	1.14	7
Payment Regulations for Prescribed Drugs-----	1.15	8-9
Basis of Payment-----	1.16	9-10
Legend Drug Dispensing Fee-----	1.17	11
Legend Drugs - Total Charge-----	1.18	11
Compounded Prescriptions-----	1.19	12
Non-Legend Drugs-----	1.20	12
Tape-to-Tape Incentive Program-----	1.21	12-13
Appendix A-----		13
Distributing Stations-----		14-16
Appendix B-----		17-44
Appendix C-----		45-47
Appendix D-----		48
Appendix E-----		49-51

---

PHARMACEUTICAL SERVICES

---

200. COVERED PHARMACEUTICAL SERVICES

1. Prescribed drugs, legend and non-legend, as herein defined.
2. Contraceptive devices and contraceptive supplies (i.e., diaphragms, jellies and rubber prophylactics).
3. Diabetic Testing Materials (i.e., Clinitest, Testape).
4. Hypodermic Syringes and/or Needles.

All the above services must be provided within the scope of the Program policies and procedures and billed to the Hospital Service Plan of New Jersey (Blue Cross of New Jersey), on the Prescription Claim Form (MC-6), or other approved billing methods.

NOTE: All other medical or pharmaceutical supplies, durable or non-durable, will be payable through the Prudential Insurance Company of America as services for Medical Supplies and Equipment. Claim forms and information concerning the provisions of these supplies will be furnished to pharmacies by Prudential. Pharmacies not already approved as Medical Suppliers may apply by contacting the Assistant Director, Medical Care Administration, Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, New Jersey 08625 or Prudential Insurance Company, P.O. Box 1900, Millville, New Jersey 08332.

EXCEPTION: Long term care Medicaid eligible recipients do not fall within the scope of this Chapter. In order to service this population, a separate Agreement of Service must be obtained from New Jersey Medicaid Program by writing to Chief, Pharmaceutical Services, Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, New Jersey 08625.

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PHARMACEUTICAL SERVICES

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201. DEFINITIONS

201.1 Eligible Prescribers

All practitioners licensed or authorized by the State of New Jersey to prescribe drugs and medicines (physicians, dentists or podiatrists, within the scope of his license and practice). Out-of-state practitioners may prescribe in this Program as herein outlined if they meet the same requirements in their State.

201.2 Eligible Pharmacies in New Jersey

All pharmacies located in New Jersey and operating under a valid Retail Permit from the Board of Pharmacy of the State of New Jersey, having filed an application and agreement with the State Department of Human Services, Division of Medical Assistance and Health Services, shall be eligible to participate in the New Jersey Medicaid Program upon acceptance of said agreement by the State Department of Human Services.

NOTE: Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. The new owner(s) must apply to the Department of Human Services, Division of Medical Assistance and Health Services and execute a new agreement in order to participate in the New Jersey Medicaid Program.

201.3 Eligible Pharmacies Out of State

Pharmacies licensed in another State may participate providing they abide by all policies and procedures that apply to New Jersey pharmacies.

201.4 Responsibilities of Eligible Pharmacies

Participating pharmacies must provide complete prescription services, in-

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PHARMACEUTICAL SERVICES

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cluding compounding and prescription refill services when allowable. Prescriptions must be dispensed in compliance with all currently existing Federal and State Laws, based on sound professional judgment.

202. GENERAL POLICIES

202.1 Advertising

The pharmacy shall not advertise in any media or solicit covered persons in the Medicaid Program through signs or displays indicating that the pharmacy accepts or dispenses eligible prescriptions except as specifically approved by the Division of Medical Assistance and Health Services.

202.2 Auditing

Properly identified representatives of the Division may inspect the written prescriptions and may audit all records pertaining to prescriptions provided to covered persons and where deemed necessary, for the purpose of complying with Federal regulations to determine a provider's "usual and customary charges to the public", the representatives may inspect private sector prescriptions for the following information only:

- 1) Drug name
- 2) Quantity dispensed
- 3) Price
- 4) Prescription number (for reference purposes only).
- 5) Date dispensed

Information pertaining to patient name and prescriber will remain confidential within the limits of the law.

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PHARMACEUTICAL SERVICES

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203. DRUG POLICIES

The choice of prescription drugs remains at the discretion of the prescriber; but, payment will not be made for certain drugs under specific conditions. (See Section 205. "SERVICES REQUIRING PRIOR AUTHORIZATION" and Section 206. "PHARMACEUTICAL SERVICES NOT ELIGIBLE FOR PAYMENT".)

When prescribing a trade-name multi-source drug product listed in Section I of the New Jersey Medicaid Formulary for which a designated chemically equivalent name in corresponding dosage form and strength is listed in Section II of the Formulary, the prescriber must indicate either "Formulary Alternate Permitted" or "Dispense as Written" (may be abbreviated <sup>"FAP"</sup> ~~"FAB"~~ or "DAW"), on each written or telephoned prescription (See Section 203.3).

When the prescriber indicates "Formulary Alternate Permitted" or "FAP", the pharmacy provider shall dispense an alternate product listed for the designated chemically equivalent name, and will be reimbursed based on the average wholesale price for that product. When the prescriber indicates "Dispense as Written" or "DAW", the pharmacy provider shall follow those instructions and will be reimbursed accordingly.

When the drug product is prescribed by its non-proprietary or generic name, the pharmacy provider shall dispense the least expensive, therapeutically effective product available.

When prescribing a trade name multi-source drug product for which a Maximum Allowable Cost (MAC) limitation has been established by the Pharmaceutical Reimbursement Board, U.S. Department of Health, Education

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PHARMACEUTICAL SERVICES

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and Welfare, "limitation shall not apply in any case where prescriber certifies in his own handwriting that in his medical judgment a specific brand is medically necessary for a particular patient." In this instance the prescriber must write "Brand Necessary" or "Dispense as Written" in his own handwriting, on each written or telephone prescription (See Section 203,3).

203.1 Quantity of Medication

The quantity of medication prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60-day supply. Any drug used continuously (i.e., daily, three times daily, every other day, etc.), for 14 days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the patient for up to 60 days.

EXCEPTIONS:

1. Oral contraceptives may be prescribed up to a supply for three ovulatory cycles.
2. Vitamin and vitamin/mineral combinations may be prescribed and dispensed in quantities up to a 100-day supply.
3. Hypodermic Syringes and/or Needles may be prescribed and dispensed in quantities up to a 100-day supply.

203.2 Dosage and Directions

Dosage and directions for use must be indicated on all original prescriptions. Prescriptions written and dispensed with non-specific directions, such as

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PHARMACEUTICAL SERVICES

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"PRN", "as directed", or "ad lib", etc., are not eligible for payment. Prescriptions written for topical preparations, aerosol inhalers and Nitroglycerin are exceptions to this regulation since the dosage cannot be related to number of days supply of medication. In such situations, the pharmacist must enter the letters "N/A" (not applicable) in the "DAYS SUPPLY" space on the Prescription Claim Form (MC-6). For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, must be entered in the "DAYS SUPPLY" space on the Prescription Claim Form (MC-6)

203.3 Telephone Ordered Original Prescriptions

Telephone orders from the prescriber for original prescriptions, in accordance with all applicable Federal and State laws and regulations, will be permitted.

For drugs listed in the New Jersey Medicaid Formulary, the prescriber must indicate either "Formulary Alternate Permitted" (FAP) or "Dispense as Written" (DAW), for each prescription transmitted and the pharmacist shall transpose this information onto the written prescription.

When a prescriber chooses to certify "Brand Necessary" or "Dispense as Written" on a MAC listed drug product, he must submit a written prescription order to the pharmacist, containing the certification within 7 days of the date of the telephone order. The prescription must be retained by the pharmacist as the original prescription. Failure to comply will result in the claim for that prescription to be reduced to the MAC reimbursement level.

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PHARMACEUTICAL SERVICES

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203.4 Changes or Additions to the Original Prescription

Changes or additions to the original prescription, when approved by the practitioner, must be clearly indicated and ~~initiated~~<sup>initialed</sup> by the dispensing pharmacist. After the prescription claim form is submitted for payment, no changes on the original prescription can be made (i.e., dosage, quantities, number of refills, etc.).

203.5 Non-Proprietary (Generic) Dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacy provider shall dispense the least expensive, therapeutically effective product available.

204. PRESCRIPTION REFILL

The pharmacist must initiate, complete and submit Prescription Claim Form (MC-6) to Blue Cross of New Jersey for payment of an allowable refill. The following instructions apply for allowable refills:

1. Refill instructions must be indicated by the prescriber on the original prescription. Prescriptions without such instructions are not refillable and are not eligible for payment.
2. Prescription refills will be limited to two (2) times within a six-month period if so indicated by the prescriber on the original prescription.

EXCEPTIONS:

- (A) Oral contraceptives originally prescribed for a three ovulatory cycle supply may be refilled two (2) times within a nine-month period.

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PHARMACEUTICAL SERVICES

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(B) Vitamin and vitamin/mineral combinations originally prescribed for a 100-day supply may be refilled two (2) times within one year.

3. Refill instructions indicating "refill prn" or indicating more than two refills will be honored for payment only up to the limits imposed in paragraph 2 above.
4. Payments will not be allowed for telephone authorized refills.
5. Prescription refills shall not be dispensed until a reasonable quantity (approximately 75%) of the medication originally dispensed or refilled could have been consumed in accordance with the practitioner's written directions for use.

EXCEPTION: When medication has been destroyed (e.g., broken container) the pharmacist may refill the prescription; but, a note of explanation for the early refill must be stapled to the Prescription Claim Form (MC-6).

205. SERVICES REQUIRING PRIOR AUTHORIZATION

The following therapeutic classes and dosage forms require Prior Authorization obtained by the prescribing practitioner from the Local Medical Assistance Unit. If the request is approved, an authorization number will be provided and must appear on the prescriber's original or valid transcribed prescription. The pharmacist must check the box in the space provided on the Prescription Claim Form (MC-6), identifying a prior-authorized item, and enter the authorization number in the proper space in this area.

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PHARMACEUTICAL SERVICES

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1. Antiobesics and Anorexics
  2. Preventive drugs listed in Appendix A, Section 209, when not available through listed Distributing Stations (See Section 206,(5).
  3. Injectable drugs as follows:
    - (A) Gammaglobulin when not available from the Department of Health or other agencies.
    - (B) Drugs to be administered to a patient by other than the prescriber or an employee of the prescriber. Written prescription must include the statement, "Medicaid Authorized".
  4. Protein replacement products, such as (but not limited to) Prohana, Portogen, Neo Mullsoy.
  5. Methadone when not prescribed for use in drug detoxification or for addiction maintenance.
206. PHARMACEUTICAL SERVICES NOT ELIGIBLE FOR PAYMENT
- The following classes of prescription drugs will not be honored for payment:
1. Drugs for which adequate literature, i.e., package inserts, etc., and price catalogues are not readily available.
  2. Experimental drugs.
  3. Telephone ordered refills.
  4. Drugs directly furnished by practitioner.
  5. Preventive drugs and biologicals provided without charge through programs of other public or voluntary agencies (i.e., New Jersey

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PHARMACEUTICAL SERVICES

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State Department of Health, New Jersey Heart Association, etc.)

(See Appendix A, Section 209.).

EXCEPTIONS: Instances where preventive drugs are not available at the listed distributing stations and prior authorization to provide these items is obtained from the Local Medical Assistance Unit.

6. Medications prescribed for use by hospital inpatients.
7. Non-legend drugs not listed in Appendix B or C.
8. Prescriptions written and dispensed with non-specific directions.
9. Food supplements, milk modifiers, infant formula and therapeutic diets,

EXCEPTION: Protein replacements, See Section 205.

10. METHADONE or any prescriptions containing Methadone, i.e., tablets, capsules, liquid, injectables or powder, when used for drug detoxification or addiction maintenance. (See Section 205.(5))
11. Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their New Drug Application (NDA).
12. Injectable drugs.

EXCEPTIONS:

- A. Parenteral FDA approved anti-neoplastic drugs
- B. Gammaglobulin when not available from the Department of Health or other agency. Prior authorization must be obtained by the prescriber.
- C. Drugs to be administered to a patient by other than the prescriber or an employee of the prescriber. Prescriber must obtain prior authorization and the written prescription must include the

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PHARMACEUTICAL SERVICES

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statement, "Medicaid Authorized".

D. Insulin

207. PAYMENT REGULATIONS FOR PRESCRIBED DRUGS

- A. Direct (vendor) payment will be made to participating pharmacies by Blue Cross of New Jersey on behalf of the New Jersey Medicaid Program upon receipt of a properly completed Prescription Claim Form (MC-6), as shown in Chapter III of this Manual.
- B. Only one prescription may be submitted on each Prescription Claim Form (MC-6).

208. BASIS OF PAYMENT

208.1 Legend Drugs

- 1. Payment for "legend" drugs (those drugs bearing the legend "Federal Law Prohibits Dispensing Without a Prescription"), and contraceptive diaphragms will be based upon "Maximum Allowable Cost" as herein defined.
- 2. "Maximum Allowable Cost" is defined as:
  - A. The "Maximum Allowable Cost" (MAC) price published by the Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare for listed "multi-source" drugs, or
  - B. The listed Average Wholesale Price (AWP), as so designated for the most frequently purchased package size in the current Drug Topics Red Book (published by Medical Economics Co., Oradell, N.J. 07649), and supplements and price changes listed by the same publisher in Drug Topics Magazine or the designated prices listed

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PHARMACEUTICAL SERVICES

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in Section 203. In the case of unlisted or undesignated AWP "costs" or typographical errors, the known correct price will be used as maximum cost.....whichever is lower.

- (1) Maximum cost for each eligible prescription claim not covered by Section 208.1 (A), shall be subject to the following fiscal conditions based upon six (6) categories determined from the previous year's total prescription volume as determined by the Division, for each participating pharmacy. The categories shall be adjusted annually.
- (2) In order to determine a provider's total prescription volume, which shall include all prescriptions filled, both new and refill, for private, Medicaid and other third party recipients, for the previous calendar year; pharmacies will be required to submit in writing, a report certifying to their prescription volume, annually. Failure to meet this requirement will result in the provider being placed in the maximum discount category (Category VI), for the period of non-compliance.

NOTE: Those pharmacy providers who have been in business for less than one(1) calendar year will have their prescription volume projected over the entire calendar year to determine the appropriate category.

Category I - Pharmacies whose total prescription volume in the previous calendar year was not more than 14,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above.

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PHARMACEUTICAL SERVICES

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Category II - Pharmacies whose total prescription volume in the previous year was in excess of 15,000 prescriptions but did not exceed 19,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above LESS 2% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

Category III - Pharmacies whose total prescription volume in the previous calendar year was 20,000 prescriptions but did not exceed 29,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above LESS 3% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

Category IV - Pharmacies whose total prescription volume in the previous calendar year was 30,000 prescriptions but did not exceed 39,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above LESS 4% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

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PHARMACEUTICAL SERVICES

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Category V - Pharmacies whose total prescription volume for the previous calendar year was 40,000 prescriptions but did not exceed 49,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP), as defined above LESS 5% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

Category VI - Pharmacies whose total prescription volume in the previous calendar year was 50,000 prescriptions or more.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP), as defined above LESS 6% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

\*NOTE: If the published MAC prices as defined in Section 208.1(1) A is higher than the price which would be paid under Section 208.1(2) B, then Section 208.1(2) B will apply.

3. Pharmacies With Retail Permits Not Servicing  
Medicaid Eligible Recipients in Long Term Care Facilities

The dispensing fee for legend drugs provided under the New Jersey Medicaid Program as outlined in this chapter shall be \$2.20.

A. The pharmacy provider may receive additional increments for providing certain services and meeting certain criteria as follows:

1. 24-hour emergency service: \$0.05;
2. Regular delivery service: \$0.08;

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PHARMACEUTICAL SERVICES

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3. Patient consultation: \$0.08;
4. Impact area location: \$0.09.

B. Definitions:

1. "24-hour emergency service" means provider has an available 24-hour, 365-days-per-year prescription service and has made this service known to the public.
2. "Regular delivery service" means provider makes available prescription delivery service on a regular daily basis to all Medicaid recipients.
3. "Patient consultation" means the provider routinely monitors the patient's profile for drug interactions, contraindications, and adverse reactions and attempts to discuss, with the patient, his/her course of therapy, with emphasis on compliance with doctor's orders and alerting the patient to improper utilization of drugs. The pharmacist shall exercise good professional judgment in all encounters.
4. "Impact area location" means the provider has a combined non-long term care facility Medicaid and PAA prescription volume which is in excess of 50% of his total prescription volume.

C. In order to receive any or all of the above increments, the provider must certify to the Division that he or she is providing the service(s) claimed and/or is entitled to the impact increment as defined on form FD-70.

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PHARMACEUTICAL SERVICES

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1. Each claimed increment is subject to audit and recoupment, if not demonstrated to the satisfaction of the Division.
4. The maximum charge to the New Jersey Medicaid Program for a legend drug, including the charge for the cost of medication and the dispensing fee, may not exceed the lowest of the following:
  - A. "Cost plus dispensing fee" as outlined herein; or,
  - B. Usual and customary and/or posted or advertised charges; or,
  - C. Other third-party prescription plan charges.

208.2 Compounded Prescriptions

Any prescription containing two or more ingredients, in usually accepted therapeutic dosage and mixed by the pharmacist at the time of dispensing is a compounded prescription.

1. The ingredient "cost", of a compounded prescription is the sum of the "cost", as defined in Section 208.1(2), of all the ingredients.  
EXCEPTION: The pharmacy may charge up to 25¢ for any ingredient whose "cost" as defined in Section 208.1(2) is less than 25¢.
2. The "dispensing fee" for a compounded prescription shall be as allowed in Section 208.1(3).
3. The maximum charge for a compounded prescription shall not exceed the limits set forth in Section 208.1(4).

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PHARMACEUTICAL SERVICES

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208.3 Non-Legend Drugs

The only non-legend drug products which may be billed to the New Jersey Medicaid Program are:

1. Those items listed in Appendix B and C.
2. Contraceptive materials listed in Appendix B.
3. Diabetic Testing Material listed in Appendix B.
4. General Non-Legend Drugs as listed in Appendix B.
5. Hypodermic syringes and/or needles as listed in Appendix C.

The maximum charge to the New Jersey Medicaid Program for these products may not exceed the lower of the following:

- A. Manufacturer's suggested selling price to the consumer.
- B. The usual retail price charged to other persons in the community.

208.4 Tape-to-Tape Incentive Program

1. An incentive payment will be available to approved pharmacies which submit Medicaid and/or PAA claims on magnetic tape. Incentive payments will be made when the total volume of paid magnetic tape Medicaid/PAA claims, submitted by pharmacy providers as a whole, equals or exceeds 20% of the total volume of paid Medicaid/PAA claims.
2. The amount of the incentive payment will be determined according to the following schedule.

<u>% of Total Medicaid/PAA Paid Claims</u>	<u>Amount of Incentive Payment</u>
If tape claims comprise 20-29%	the incentive payment is 2¢/tape claim
30-39%	" 3¢/tape claim
40-55%	" 4¢/tape claim
over 55%	" 5¢/tape claim

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PHARMACEUTICAL SERVICES

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3. The incentive payment program will begin on January 1, 1979, based upon the percentage of tape claims paid in the previous month. If the volume of paid tape claims is less than 20% of the total, no incentive payments will be made. In that event, incentive payments will begin with the month following the month in which the volume of tape claims reaches 20% of the total paid claims volume. A qualified tape-to-tape provider will receive a separate incentive payment check for all tape claims paid during the preceding month.
4. The original incentive payment amount will apply through the end of the first calendar quarter of 1979. Thereafter, claim volume figures will be reviewed and averaged quarterly. The claim volume totals for the previous quarter will determine the amount of incentive for the subsequent quarter.
5. The incentive payment is an additional fee increment for tape claims only, over and above the dispensing fee allowed by the Program.
6. In order to be eligible to submit magnetic tape claims for the Medicaid or PAA programs, a provider must complete form FD-103 and receive approval by the Division.

209. APPENDIX A

Preventive Drugs and Biologicals

Preventive drugs and biological products listed below, provided by the New Jersey State Department of Health, may be obtained from the listed Biological Distributing Stations without charge by authorized persons for New Jersey residents who need to be spared the cost of the material.

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PHARMACEUTICAL SERVICES

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Preventive Biologicals

Smallpox Vaccine  
Pertussis-Diphtheria-Tetanus (Adsorbed)  
Typhoid Vaccine  
Tetanus & Diphtheria Toxoid (Adult)  
Tetanus & Diphtheria Toxoid (Pediatric)

Preventive Drugs

Isoniazid (INH)  
Para-Amino-Salicylic Acid (PAS),  
Amino Salicylic Acid, or  
Derivatives and combinations  
thereof.

The following biologicals are available to physicians and to local  
boards of health as outlined:

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PHARMACEUTICAL SERVICES

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1. Trivalent Oral Poliomyelitis Vaccine - Measles Vaccine

Available only to child health conferences, pediatric clinics,  
and similar agencies serving groups of needy children.

2. Duck Embryo Rabies Vaccine - Human

This vaccine is available only at the Distributing Stations indicated  
by an asterisk (\*).

3. Anti-Rabies Serum

This serum may be procured upon request from the State Department  
of Health, Area Code 609: 292-5570.

4. Gamma Globulin

German Measles - 20cc for women exposed in the first trimester of  
pregnancy may be procured upon request from the State Department  
of Health, Area Code 609: 292-5570.

Measles - not more than 2cc per individual for modification and  
prevention. This material is supplied by the American Red Cross.

209.1 Distributing Stations

ATLANTIC COUNTY:

Board of Health  
2314 Pacific Avenue  
Atlantic City, New Jersey 08401

District Health Office  
1200 Harding Highway  
Mays Land, New Jersey 08330

BERGEN COUNTY:

Bergen Pines County Hospital  
Paramus, New Jersey 07601

Holy Name Hospital  
718 Teaneck Road  
Teaneck, New Jersey 07666

Hackensack Hospital - Hospital Place  
Hackensack, New Jersey 07601

Board of Health, Health Center  
10 Beaver Avenue  
North Arlington, New Jersey 07032

Englewood Hospital  
Englewood, New Jersey 07631

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PHARMACEUTICAL SERVICES

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BURLINGTON COUNTY:

Burlington Co. Health Dept.  
Raphael Meadow Health Center  
Woodland Road  
Mt. Holly, New Jersey 08060

Board of Health  
254 West Union Street  
Burlington, New Jersey 08016

CAMDEN COUNTY:

East Camden Health Center  
2631 Federal Street  
Camden, New Jersey 08105

District State Health Office  
89 Haddon Avenue  
Haddonfield, New Jersey 08035

CUMBERLAND COUNTY:

Cumberland County Health Dept.  
800 East Commerce Street  
Bridgeton, New Jersey 08302

ESSEX COUNTY:

Board of Health  
94 William Street  
Newark, New Jersey 07102

Board of Health  
Box 310, City Hall  
Bloomfield, New Jersey 07003

Board of Health  
143 New Street  
East Orange, New Jersey 07017

Board of Health, Town Hall  
29 North Day Street  
Orange, New Jersey 07050

Board of Health  
65 Chestnut Street  
Montclair, New Jersey 07042

Board of Health, Town Hall  
Nutley, New Jersey 07110

Dept. of Health and  
Environmental Control  
Municipal Building  
Irvington, New Jersey 07111

Board of Health  
66 Main Street  
West Orange, New Jersey 07052

Board of Health, Town Hall  
Maplewood, New Jersey 07040

Board of Health  
383 Washington Avenue  
Belleville, New Jersey 07109

HUDSON COUNTY:

Dept. of Health  
6028 Broadway  
West New York, New Jersey 07093

Board of Health  
5th Floor, Health Service Building  
Medical Center  
Jersey City, New Jersey 07304

Health Department  
Town of Kearny Health Center  
645 Kearny Avenue  
Kearny, New Jersey 07032

Bayonne Hospital & Dispensary  
Bayonne, New Jersey 07002

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PHARMACEUTICAL SERVICES

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MERCER COUNTY:

Board of Health, City Hall  
Trenton, New Jersey 08608

Board of Health, City Hall  
Princeton, New Jersey 08540

MIDDLESEX COUNTY:

Health Dept., City Hall  
76 Bayard Street  
New Brunswick, New Jersey 08901

Board of Health  
44 Market Street  
Perth Amboy, New Jersey 08861

Board of Health  
800 St. George Avenue  
Woodbridge, New Jersey 07095

MONMOUTH COUNTY:

Board of Health  
913 Sewall Avenue  
Asbury Park, New Jersey 07712

Board of Health, Garfield Court  
Long Branch, New Jersey 07740

Howell Township Health Dept.  
P.O. Box 580  
Howell, New Jersey 07731

Board of Health, Municipal Building  
Red Bank, New Jersey 07701

Middletown Township Board of Health  
78 Kings Highway  
Middletown, New Jersey 07740

MORRIS COUNTY:

Board of Health  
29 Ann Street  
Morristown, New Jersey 07960

Board of Health, Municipal Building  
Dover, New Jersey 07801

Pequanneck Township Health Dept.  
530 Turnpike  
Pompton Plains, New Jersey 07444

Board of Health, Municipal Building  
Morris County  
Madison, New Jersey 07940

Parsippany-Troy Hills Health Dept.  
1001 Parsippany Boulevard  
Parsippany, New Jersey 07054

OCEAN COUNTY:

Board of Health, City Hall  
Lakewood, New Jersey 08701

Ocean County Health Dept.  
C.N. 2191  
Toms River, New Jersey 08753

SOMERSET COUNTY:

Somerset Hospital  
Somerville, New Jersey 08876

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PHARMACEUTICAL SERVICES

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SUSSEX COUNTY:

Sussex County Health Department  
P.O. Box 98  
Newton, New Jersey 07860

UNION COUNTY:

Board of Health, City Hall  
Plainfield, New Jersey

Health Department Laboratory  
City Hall  
Elizabeth, New Jersey 07201

Board of Health, Municipal Building  
Cranford, New Jersey 07016

Board of Health  
71 Summit Avenue  
Summit, New Jersey 07901

Rahway Memorial Hospital  
Rahway, New Jersey 07065

Board of Health  
Municipal Building, Friberger Park  
Union, New Jersey 07083

WARREN COUNTY:

Warren Hospital  
Phillipsburg, New Jersey 08865

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PHARMACEUTICAL SERVICES

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210. Appendix B

Instructions for Use

This revision replaces all previously issued Non-Legend Drug Appendix B, (New Jersey Health Services Program) and should be placed in Chapter II of the New Jersey Health Services (Medicaid) Pharmacy Manual.

The listing is divided into contraceptive materials, which are then listed [in alphabetical order, Insulin, and diabetic testing material.

All diaphragms, because they are "legend" drugs and are priced at cost plus dispensing fee, are listed together in the "D" section. However, all other listed items are to be priced at no higher than usual or customary selling price including sheath contraceptives which are generically listed under "prophylactics" (rubber).

All non-legend preparations are coded according to the NDC and must be priced only in accordance with the sizes listed, without dispensing fee, at the usual and customary selling price. All items, other than Insulin have a reporting unit of "each" (package) and only one such unit is allowable per claim.

Insulin may be dispensed in multiple vials, in accordance with "days' supply" regulations. The appropriate NDC number should be entered, as listed in Appendix B, on the claim. The multiple metric quantity should be listed in the "quantity dispensed" space on the claim form. For example, four vials of a particular Insulin are reported as 40cc in the "quantity dispensed" area and the NDC listed for the given strength is entered.

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

APPENDIX B  
GENERAL NON-LEGEND DRUGS

A.C.N. TABS (FORMERLY RX) 100	TAB	0000096-0014-11
A.S.A. ENSEALS 325MG 100	TAB	0000002-0125-02
A.S.A. ENSEALS 650MG 100	TAB	0000002-0132-02
A.S.A. SUPP/LILLY 325MG 6	SUPP	0000002-1915-16
A.S.A. SUPP/LILLY 650MG 6	SUPP	0000002-1916-16
ABDEC DROPS 50CC	EACH	0000071-2323-35
ABDEC KAPSEALS 100	CAP	0000071-0371-24
ABDOL W/MINERALS CAPSULES 100	CAP	0000071-0240-24
ACCELERASE CAPSULES 60	CAP	0000052-0391-60
ACETAMINOPHEN ELIXIR 120CC	CC	0000999-9090-04
ACETAMINOPHEN SUPP 120MG/UPSHER-SMITH 12	SUPP	0000245-0121-12
ACETAMINOPHEN SUPP 650MG/UPSHER-SMITH 12	SUPP	0000245-0122-12
ACETAMINOPHEN TABS 325MG 100 GENERIC	TAB	0000999-9091-01
ACHROMYCIN TOPICAL OINTMENT 30GM	EACH	0000005-4796-55
ACHROMYCIN TOPICAL OINTMENT 15GM	EACH	0000005-4796-56
ACIDULIN PULV 340MG 100	CAP	0000002-0631-02
ACTOL EXPECTORANT 480CC	CC	0000029-1137-34
ACTOL EXPECTORANT TABS 100	TAB	0000029-1138-30
ADRENALIN CHL SOL/ORAL 1/100 7.5CC	EACH	0000071-3014-09
ADRENALIN CHL SOL/TOP 1/1000 30CC	EACH	0000071-3003-13
AFRIN NASAL SOL (NOSE DROPS) 20CC	EACH	0000085-0756-06
AFRIN NASAL SPRAY 30CC	EACH	0000085-0756-08
AFRIN NASAL SPRAY 15CC	EACH	0000085-0756-05
AFRIN PEDIATRIC NOSE DROPS 20CC	EACH	0000085-0632-04
AFRINOL REPETABS (NOW OTC) 100	TAB	0000085-0258-05
ALCOHOL, ISOPROPYL 91% LILLY 120CC	CC	0000002-2330-58
ALCON-EFRIN-12 DROPS 30CC	CC	0000991-0101-30
ALCON-EFRIN-25 DROPS 30CC	CC	0000991-0102-30
ALCON-EFRIN-25 SPRAY 30CC	CC	0000991-0112-30
ALCON-EFRIN-50 DROPS 30CC	CC	0000991-0103-30
ALLBEE C-800 PLUS IRON TABLETS 60	TAB	0000031-0678-62
ALLBEE C-800 TABLETS 60	TAB	0000031-0677-62
ALLBEE CAPS W/VITAMIN C 100	CAP	0000031-0674-63
ALLBEE-T TABS 100	TAB	0000031-0688-63
ALU-CAP CAPSULES 100	CAP	0000089-0106-10
ALU-TAB TABLETS 250	TAB	0000089-0107-25
ALUDROX SUSPENSION 360CC	CC	0000008-0023-01
ALUDROX TABS 100	TAB	0000008-0022-03

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

AMERICAINE HEMORRHOIDAL OINT 30GM	EACH	0000094-0002-01
AMESEC PULV 100	CAPS	0000173-0335-23
AMMONIUM CHL COMP SYR-NJF 480CC	CC	0000999-7001-16
AMMONIUM CHL ENSEALS 500MG 100	TAB	0000002-0101-02
AMMONIUM CHL ENSEALS 1GM 100	TAB	0000002-0112-02
AMMONIUM CHL TABS 500MG E.C. GENERIC	TAB	0000999-7000-01
AMODRINE TABS 100	TAB	0000025-1291-31
AMOSAN POWDER 40	EACH	0027816-0850-40
AMOSAN POWDER 20	EACH	0027816-0850-20
AMPHOJEL SUSPENSION 360CC	CC	0000008-0010-01
AMPHOJEL TABLETS 300MG 100	TAB	0000008-0119-01
AMPHOJEL TABLETS 600MG 100	TAB	0000008-0013-03
ANUSOL OINTMENT 30GM	EACH	0000071-3075-13
ANUSOL SUPP 12	SUPP	0000071-1088-07
AQUASOL-A DROPS 30CC	EACH	0000075-4200-30
AQUASOL-E CAPS 30 UNITS 100	CAP	0000075-4481-00
AQUASOL-E CAPS 100 UNITS 100	CAP	0000075-4491-00
AQUASOL-E CAPS 400 UNITS 30	CAP	0000075-4470-30
AQUASOL-E DROPS (FORMERLY 15CC) 12CC	EACH	0000075-5800-12
ARTHRALGEN TABS 100	TAB	0000031-1462-63
ARTHROPAN LIQUID 240CC	CC	0000034-5410-80
ASCORBIC ACID SEE: VIT C		
ASCORBICAP CAPS 500MG 50	CAP	0000187-0015-50
ASCRIPITIN TABLETS 100	TAB	0000067-0135-68
ASCRIPITIN-A/D TABLETS 100	TAB	0000067-0137-68
ASPIRIN SUPP 120MG (12) GENERIC	SUPP	0000999-7009-12
ASPIRIN SUPP 325MG (12) GENERIC	SUPP	0000999-7010-12
ASPIRIN SUPP 650MG (12) GENERIC	SUPP	0000999-7011-12
ASTHMANEFRIN SOLUTION 15CC	EACH	0000766-5010-11
ASTHMANEFRIN SOLUTION 30CC	EACH	0000766-5010-12
AUREOMYCIN TOPICAL OINTMENT 30GM	EACH	0000005-4442-55
AUREOMYCIN TOPICAL OINTMENT 15GM	EACH	0000005-4442-56
B-NUTRON TABLETS 100	TAB	0000998-0027-01
BACID CAPS 100	CAP	0000585-0105-01
BACIGUENT OINTMENT 15GM	EACH	0000009-0200-01
BACIGUENT OINTMENT 30GM	EACH	0000009-0200-02
BACIMYCIN OINTMENT 15GM	EACH	0000068-0119-42
BACITRACIN OINTMENT 15GM GENERIC	EACH	0000999-7020-01
BACITRACIN OINTMENT 30GM GENERIC	EACH	0000999-7020-02
BACITRACIN OINTMENT 60GM GENERIC	EACH	0000999-7020-03
BACITRACIN OINTMENT/LILLY 15GM	EACH	0000002-1825-47
BACITRACIN OINTMENT/LILLY 30GM	EACH	0000002-1825-67

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

BACITRACIN NEO-POLYMYX-B 15GM GENERIC	EACH	0000999-7040-15
BACITRACIN NEO-POLYMYX-B 30GM GENERIC	EACH	0000999-7040-30
BALNEOL LOTION 120CC	CC	0000032-1960-74
BASALJEL CAPS 100	CAP	0000008-0472-01
BASALJEL SUSP 360CC	CC	0000008-0131-01
BASALJEL SUSP/EXTRA STRENGTH 360CC	CC	0000008-0474-01
BASALJEL SWALLOW TABLETS 100	TAB	0000008-0473-01
BECOTIN PULVULES 100	CAP	0000777-0662-02
BECOTIN W/VIT C PULV 100	CAP	0000777-0677-02
BECOTIN-T TABLETS 100	TAB	0000777-0322-02
BEMINAL FORTE W/VIT C CAPS 100	CAP	0000046-0817-81
BEMINAL-500 TABLETS 100	TAB	0000046-0832-81
BENOXYL 5 LOTION 30CC	EACH	0000145-3517-05
BENOXYL 5 LOTION 60CC	EACH	0000145-3517-07
BENOXYL 10 LOTION 30CC	EACH	0000145-3514-05
BENOXYL 10 LOTION 60CC	EACH	0000145-3514-07
BENYLIN COUGH SYRUP 120CC	CC	0000071-2195-17
BETALIN COMP PULVULES 100	CAP	See Vit B Comp
BETALIN COMPLEX ELIXIR 480CC	CC	See Vit B Comp
BETALIN-S ELIXIR 480CC	CC	0000002-2442-05
BETALIN-S TABS 10MG	TAB	0000002-2052-02
BETALIN-S TABS 25MG 100	TAB	0000002-2059-02
BETALIN-S TABS 50MG 100	TAB	0000002-2062-02
BETALIN-S TABS 100MG 100	TAB	0000002-2063-02
BEWON ELIXIR 480CC	CC	0000008-0105-01
BILOGEN TABLETS 100	TAB	0000052-0371-91
BILRON PULVULES 150MG 100	CAP	0000002-0661-02
BILRON PULVULES 300MG 100	CAP	0000002-0641-02
BONACAL-PLUS TABS 100	TAB	0000482-0104-01
BONINE TABS 25MG 100	TAB	0000663-2010-66
BRONKAID MIST COMPLETE 10CC	EACH	0000024-4082-10
BRONKAID MIST COMPLETE 15CC	EACH	0000024-4082-15
BRONKAID MIST REFILL 15CC	EACH	0000024-4083-16
BRONKAID TABS 60	TAB	0000024-4081-06
BRONKOLIXIR 480CC	CC	0000057-1004-16
BRONKOTABS 100	TAB	0000057-1006-10
BROWN MIXTURE 120CC GENERIC	CC	0000999-8020-04
BUTESIN PICRATE OINTMENT 30GM	EACH	0000074-4392-01
C.V.P. CAPSULES 100	CAP	0000075-5841-00
CAL-SUP TABS 100	TAB	0000089-0110-10
CALADRYL W/HYDROCORT CREAM .5% 15GM	EACH	0000071-3030-11
CALADRYL W/HYDROCORT LOTION .5% 30CC	EACH	0000071-3002-13
CALCICAPS 100	TAB	0000998-0028-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

CALCIUM GLUC TABS/LILLY 500MG 100	TAB	0000002-2039-02
CALCIUM GLUC TABS/LILLY 1GM 100	TAB	0000002-2036-02
CALCIUM GLUC TABS/UPJOHN 975MG 60	TAB	0000009-0251-01
CALCIUM GLUC W/VIT D PULVULES 100	CAP	0000002-0656-02
CALCIUM GLUC W/VIT D TABS 100	TAB	0000002-2044-02
CALCIUM LACT TABS 325MG GENERIC	TAB	0000999-5008-01
CALCIUM LACT TABS 325MG/LILLY 100	TAB	0000002-2013-02
CALCIUM LACT TABS 325MG/P-D 100	TAB	0000071-0533-24
CALCIUM LACT TABS 650MG GENERIC	TAB	0000999-5009-01
CALCIUM LACT TABS 650MG/LILLY 100	TAB	0000002-2014-02
CALCIUM LACT TABS 650MG/P-D 100	TAB	0000071-0604-24
CALDECORT CREAM 15GM	EACH	0000235-0646-51
CALDECORT CREAM 30GM	EACH	0000235-0646-61
CAMA INLAY-TABS 100	TAB	0000043-0057-51
CAMALOX SUSPENSION 360CC	CC	0000067-0180-71
CAMALOX TABS 50	TAB	0000067-0185-50
CE-VI-SOL DROPS 50CC	EACH	0000087-0400-01
CEBEFORTIS TABLETS 100	TAB	0000009-0109-01
CEBETINIC TABLETS (NEW FORM) 60	TAB	0000009-0756-01
CECON SOLUTION 50CC	EACH	0000074-3492-01
CENTRUM JR TABS 60	TABS	0000005-4234-19
CENTRUM TABLETS 100	TAB	0000005-4239-30
CEROSE-DM LIQUID 120CC	CC	0000082-4128-02
CETRO-CIROSE LIQUID 480CC	CC	0000082-4129-01
CEVALIN TABLETS 100MG 100	TAB	0000002-2045-02
CEVALIN TABLETS 250MG 100	TAB	0000002-2060-02
CEVALIN TABLETS 500MG 100	TAB	0000002-2067-02
CHEL-IRON LIQUID 240CC	CC	0000998-8741-08
CHEL-IRON PEDIATRIC DROPS 60CC	EACH	0000998-8742-60
CHEL-IRON TABLETS 100	TAB	0000998-8743-01
CHERACOL SYRUP 120CC	CC	0000009-0945-02
CHERACOL-D SYRUP BILINGUAL 120CC	CC	0000009-0820-04
CHERACOL-D SYRUP 120CC	CC	0000009-0820-02
CHLOR-TRIMETON EXPECT 480CC	CC	0000085-0841-05
CHLOR-TRIMETON SYRUP 120CC	CC	0000085-0835-03
CHLOR-TRIMETON TABS 4MG 24	TAB	0000085-0080-01
CHLOR-TRIMETON TABS 8MG 100	TAB	0000085-0374-02
CHLOR-TRIMETON TABS 12mg 100	TABS	0000085-0009-02
CHLORPHENIRAMINE CAPS 8MG/PUREPAC 100	CAP	0000228-1234-10
CHLORPHENIRAMINE SYRUP/PUREPAC 480CC	CC	0000228-1232-16
CHLORPHENIRAMINE TABS 4MG/PUREPAC 100	TAB	0000228-1231-10
CHLORPHENIRAMINE TABS 8MG/URL 1000	TAB	0000677-0038-10

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

CLEARAID CREAM 0.5% 15GM	EACH	0000003-1802-15
CLEARAID CREAM 0.5% 30GM	EACH	0000003-1802-30
CLEARAID LOTION 0.5% 30CC	EACH	0000003-1804-10
CLEARAID LOTION 0.5% 60CC	EACH	0000003-1804-20
CLEARAID OINTMENT 0.5% 15GM	EACH	0000003-1803-15
CLEARAID OINTMENT 0.5% 30GM	EACH	0000003-1803-30
CLUSIVOL CAPSULES 100	CAP	0000046-0293-81
CLUSIVOL SYRUP 240CC	CC	0000046-0920-08
CLUSIVOL TABLETS 130	TAB	0000046-0270-81
CO-TYLENOL LIQUID 120CC	CC	0000045-0173-04
CO-TYLENOL TABS 50	TAB	0000045-0172-50
COD LIVER OIL CAPS 100/SCHERING	CAP	0000085-0917-05
COD LIVER OIL LIQUID (360CC) GENERIC	CC	0000999-5020-12
COD LIVER OIL TABS/SCHERING 100	TAB	0000085-0452-02
COD LIVER OIL TABS W/VIT C/SCHERING 100	TAB	0000085-0604-06
COD LIVER OIL/SQUIBB 360CC	CC	0000003-0926-40
COD LIVER OIL/SQUIBB-MINT 360CC	CC	0000003-0927-40
COLACE CAPSULES 50MG 60	CAP	0000087-0713-02
COLACE CAPSULES 100MG 60	CAP	0000087-0714-02
COLACE LIQUID 30CC	EACH	0000087-0717-02
COLACE SYRUP 240CC	CC	0000087-0720-01
COMBEX KAPSEALS 100	CAP	0000071-0363-24
COMBEX KAPSEALS W/VIT C 100	CAP	0000071-0367-24
CONAR EXPECTORANT 480CC	CC	0000029-1747-34
CONAR LIQUID SUSP/SUGARLESS 480CC	CC	0000029-1737-34
CONAR-A SUSP 480CC	CC	0000029-1717-34
CONAR-A TABS 100	TAB	0000029-1725-30
CONSOTUSS LIQUID 180CC	CC	0000068-0259-06
CONVERSPAZ IMP CAPS (FORM RX) 100	CAP	0000225-0351-15
CONVERZYME IMP CAPS (FORM RX) 100	CAP	0000225-0366-15
CORICIDIN COUGH SYRUP 120CC	CC	0000085-0375-02
CORICIDIN DEMILETS 36	TAB	0000085-0540-06
CORICIDIN MEDILETS 36	TAB	0000085-0802-06
CORICIDIN NASAL MIST SPRAY 20CC	EACH	0000085-0230-05
CORICIDIN TABS 100	TAB	0000085-0171-05
CORICIDIN-D TABS 100	TAB	0000085-0871-05
CORTAID CREAM 0.5% 15GM	EACH	0000009-0822-02
CORTAID CREAM 0.5% 30GM	EACH	0000009-0822-03
CORTAID LOTION 0.5% 30CC	EACH	0000009-0932-02
CORTAID LOTION 0.5% 60CC	EACH	0000009-0932-03
CORTAID OINTMENT 0.5% 15GM	EACH	0000009-0629-02
CORTAID OINTMENT 0.5% 30GM	EACH	0000009-0629-03

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

CORTEF FEMININE ITCH CRM 0.5% 15GM	EACH	0000009-3200-01
CORTEF RECTAL ITCH OINT 0.5%	EACH	0000009-3205-01
CORTRIL TOPICAL CREAM 0.5% 15GM	EACH	0000995-3269-40
CORYBAN-D CAPS 24	CAP	0000995-3690-75
CORYBAN-D SYRUP 120CC	CC	0000995-3640-87
COSANYL COUGH SYRUP 120CC	CC	0011010-0001-04
COSANYL-DM COUGH SYRUP 120CC	CC	0011010-0002-04
COTAZYM-B TABLETS 60	TAB	0000052-0385-60
CREAMALIN TABLETS 100	TAB	0000024-0294-04
CYTOFERIN HEMATINIC 100	TAB	0000046-0705-81
D-S-S CAPSULES 100MG/PARKE-DAVIS 100	CAP	0000071-0247-24
DASIN CAPS/NATURAL 100	CAP	0000029-2035-30
DAYALETS FILMTABS 100	TAB	0000074-3925-01
DAYALETS PLUS IRON FILMTABS 100	TAB	0000074-6667-01
DAYALETS-M SEE: DAYALETS PLUS IRON		
DEBROX DROPS 15CC	EACH	0000088-1021-05
DEBROX DROPS 30CC	EACH	0000088-1021-01
DECHOLIN TABLETS 100	TAB	0000026-8121-51
DEGEST-2 DROPS 15CC	EACH	0000077-0655-15
DELACORT LOTION 0.5% - NOW OTC 120CC	EACH	0000394-0839-32
DELACORT LOTION 0.5% - NOW OTC 60CC	EACH	0000394-0839-33
DELCID SUSPENSION 240CC	CC	0000068-0264-08
DEMAMIN REPETABS 100	TAB	0000085-0133-03
DEMAMIN SYRUP 120CC	CC	0000085-0936-01
DERMOLATE ANAL ITCH OINTMENT 30GM	EACH	0000085-0435-05
DERMOLATE ANTI ITCH CREAM 30GM	EACH	0000085-0129-05
DERMOLATE ANTI ITCH SPRAY 45CC	EACH	0000085-0761-06
DERMOLATE SCALP ITCH LOTION 30CC	EACH	0000085-0407-03
DESENEK OINTMENT 25.5GM	EACH	0000235-0955-51
DESENEK OINTMENT 51GM	EACH	0000235-0955-63
DESENEK POWDER 42.5GM	EACH	0000235-0956-53
DESENEK POWDER 85GM	EACH	0000235-0956-65
DESENEK SOLUTION 45CC	EACH	0000235-0800-53
DI-GEL LIQUID 360CC	CC	0000998-1000-02
DI-GEL TABS 100	TAB	0000998-1001-03
DIA-QUEL LIQUID 120CC	CC	0000088-2011-11
DIALOSE CAPSULES 100	CAP	0000038-0470-10
DIALOSE PLUS CAPS 100	CAP	0000038-0475-10
DIALUME CAPSULES 100	CAP	0000053-3250-01
DICAL-D CAPSULES 100	CAP	0000074-3594-04
DICAL-D W/IRON CAPSULES 100	CAP	0000074-3676-03
DICAL-D W/VIT C CAPSULES 100	CAP	0000074-3587-04

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

DICALCIUM PHOS TABS 500MG GENERIC	TAB	0000999-5022-01
DICALCIUM PHOS TABS/LIL 500MG 100	TAB	0000002-2061-02
DICALCIUM PHOS W/COMBO TABS GENERIC	TAB	0000999-5021-01
DICALCIUM PHOS W/VIT D & IRON 100	CAP	0000002-0663-02
DICALCIUM PHOS W/VIT D PULV 100	CAP	0000002-0652-02
DILONE TABLETS 100	TAB	0000056-0024-70
DIMACOL CAPSULES 100	CAP	0000031-1650-63
DIMACOL LIQUID 480CC	CC	0000031-1660-25
DIMETANE DECONGESTANT ELIXIR 120CC	CC	0000031-2127-12
DIMETANE DECONGESTANT TABS 24	TAB	0000031-2117-54
DIMETANE ELIXIR 120CC	CC	0000031-1807-12
DIMETANE TABLETS 24	TAB	0000031-1857-54
DICTYL SOD SULFO SEE: D-S-S		
DICTYL SOD SULFO CAPS 50MG 100	CAP	0000999-9095-01
DICTYL SOD SULFO CAPS 100MG 100	CAP	0000999-9096-01
DIOTHANE OINTMENT 30GM	EACH	0000068-0276-01
DONNAGEL SUSPENSION 120CC	CC	0000031-3016-12
DONNAGEL PG SUSPENSION 180CC	CC	0000031-3083-15
DORBANE TABLETS 100	TAB	0000089-0173-10
DORBANTYL CAPS 30	CAP	0000089-0174-03
DORBANTYL FORTE CAPS 100	CAP	0000089-0178-10
DORCOL SYRUP 120CC	CC	0000043-0527-04
DOXIDAN CAPSULES 100	CAP	0000039-0004-10
DOXINATE CAPS 240MG 100	CAP	0000039-0006-10
DRAMAMINE LIQUID 480CC	CC	0000025-1736-80
DRAMAMINE TABS 100	TAB	0000025-1701-31
DRISDOL DROPS 60CC	EACH	0000024-0391-02
DRIXORAL TABS 100	TABS	0000085-0147-02
DUADACIN CAPS 100	CAP	0000039-0022-10
DULCOLAX SUPPOSITORIES 50	SUPP	0000597-0052-50
DULCOLAX TABLETS 100	TAB	0000597-0012-01
DUO C.V.P. CAPSULES 100	CAP	0000075-5000-00
ECOTRIN TABS 325MG 100	GM	0049692-0901-20
EFFERSYLLIUM INST POWDER (16oz) 480GM	GM	0000038-0440-16
EMETROL LIQUID 90CC	EACH	0000067-0240-58
EMPIRIN ANALGESIC TABS 100	TAB	0000081-0210-55
EN-CEBRIN PULVULES 100	CAP	0000002-0812-02
ENDECON TABS 60	TAB	0000056-0030-60
ENDOTUSSIN-NN SYRUP 120CC	CC	0000056-0222-04
ENDOTUSSIN-NN-PEDIATRIC SYRUP 120CC	CC	0000056-0224-04
ENGRAN-HP TABS (OTC) 100	TAB	0000003-0478-50
ENUCLENE OPH DROPS 15CC	EACH	0000065-0083-15

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

ENZACTIN CREAM 30GM	EACH	0000046-0201-01
ENZYPAN TABLETS 120	TAB	0000752-0003-13
EPHEDRINE SULF CAPS 25MG (100) GENERIC	CAP	0000999-7060-01
EPHEDRINE SULF PULV 25MG 100	CAP	0000002-0624-02
EPHEDRINE SULF SOL-NASAL 3% 30CC	EACH	0000002-2493-67
EPHEDRINE SULF SYR, NOT USP 480CC	CC	0000002-2527-05
EPHEDRINE SULF SYRUP, USP 480CC	CC	0000002-2528-05
EPHEDROL W/CODEINE 480CC	CC	0000002-2327-05
EPROLIN GELSEALS 50MG 100	CAP	0000002-0265-02
EPROLIN GELSEALS 100MG 100	CAP	0000002-0266-02
ESTIVIN OPH DROPS 7.5CC	EACH	0000065-0540-25
ESTOMUL-M LIQUID 360CC	CC	0000089-0921-12
ESTOMUL-M TABLETS 100	TAB	0000089-0193-10
FEDAHIST EXPECTORANT 120CC	CC	0000067-0054-60
FEDAHIST SYRUP 120CC	CC	0000067-0052-60
FEDAHIST TABS 100	TAB	0000067-0050-68
FEDRAZIL TABLETS 100	TAB	0000081-0444-55
FEMININS TABS 100	TAB	0000087-0470-01
FEOSOL ELIXIR 360CC	CC	0049692-0940-52
FEOSOL SPANSULES 30	CAP	0049692-0941-13
FEOSOL TABLETS 100	TAB	0049692-0942-20
FEOSOL PLUS CAPS (NOW OTC) 100	CAP	0049692-0943-20
FER-IN-SOL CAPSULES 100	CAP	0000087-0742-01
FER-IN-SOL DROPS 50cc	EACH	0000087-0740-02
FER-IN-SOL SYRUP 480CC	CC	0000087-0741-01
FERAMEL SEE: IRON W/VIT. C		
FERANCEE TABLETS 100	TAB	0000038-0650-10
FERANCEE-HP TABS 60	TAB	0000038-0863-60
FERGON CAPSULES 30	CAP	0000057-1016-03
FERGON ELIXIR 480CC	CC	0000057-1019-16
FERGON TABLETS 100	TAB	0000057-1015-10
FERMALOX TABLETS 100	TAB	0000067-0260-68
FERO-GRAD-500 FILMTABS 100	TAB	0000074-7238-01
FERO-GRADUMET FILMTABS 100	TAB	0000074-6852-02
FERRO-SEQUELS 100	CAP	0000005-4612-23
FERROUS GLUC PULV 325MG 100	CAP	0000002-0644-02
FERROUS GLUC TABS 325MG GENERIC	TAB	0000999-7070-01
FERROUS SULF ENSEALS/GREEN 100	TAB	0000002-0136-02
FERROUS SULF ENSEALS/RED 100	TAB	0000002-0102-02
FERROUS SULF TABS 325MG GENERIC	TAB	0000999-7071-01
FERROUS SULF TABS/LILLY 325MG 100	TAB	0000002-0313-02
FESTAL TABLETS 100	TAB	0000039-0070-10

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

FILIBON TABLETS 100	TAB	0000005-4294-23
FIOGESIC TABLETS 100	TAB	0000078-0065-05
FLEET BAGENEMA (1500CC) EA ENEMA	EACH	0000132-0901-10
FLEET ENEMA ADULT 135CC	CC	0000132-0201-40
FLEET ENEMA PEDIATRIC 67.5CC	EACH	0000132-0202-20
FLEET MIN. OIL ENEMA 135CC	CC	0000132-0301-40
FLORICAL CAPS 100	CAP	0000394-0102-02
FLUORINSE .05% 240CC	EACH	0027816-0380-06
FLUORINSE .05% 480CC	EACH	0027816-0380-07
FORTESPAN CAPS 100	CAP	0049692-0955-20
FOSTEX 5% GEL (BENZOYL PEROX) 45GM	EACH	0000072-3300-01
FUNGACETIN OINTMENT 30GM	EACH	0000154-3010-01
GANATREX ELIXIR 480CC	CC	0000068-0321-16
GAVISCON FOAMTABS 100	TAB	0000088-1175-47
GAVISCON LIQUID 360CC	CC	0000088-1171-12
GELFOAM PACKS 2GM EACH JAR	EACH	0000009-0364-01
GELFOAM STERILE POWDER IGM	GM	0000009-0433-01
GELUSIL LIQUID (NEW FORM) 360CC	CC	0000071-2036-22
GELUSIL TABS (NEW FORM) 100	TAB	0000071-0034-24
GELUSIL-II LIQUID 360CC	CC	0000071-2042-22
GELUSIL-II TABLETS 80	TAB	0000071-0043-22
GELUSIL-M LIQUID 360CC	CC	0000071-2044-22
GELUSIL-M TABLETS 100	TAB	0000071-0045-24
GEMNISYN TABLETS 100	TAB	0000067-0171-68
GENTIAN VIOLET SOL 1% (30CC) GENERIC	EACH	0000999-7080-30
GENTIAN VIOLET SOL 2% (30CC) GENERIC	EACH	0000999-7081-30
GENTILAX-S TABLETS 60	TAB	0000154-5500-60
GERILETS FILMTABS 100	TAB	0000074-6424-01
GERIPLEX KAPSEALS 100	CAP	0000071-0382-24
GERIPLEX-FS KAPSEALS 100	CAP	0000071-0544-24
GERIPLEX-FS LIQUID 480CC	CC	0000071-2454-23
GERIX ELIXIR 480CC	CC	0000074-6441-01
GEVRABON LIQUID 480CC	CC	0000005-5110-35
GEVRAL TABLETS 100	TAB	0000005-4289-23
GEVRAL-T TABLETS 100	TAB	0000005-4286-23
GLY-OXIDE SOLUTION 15CC	EACH	0000088-1010-05
GLY-OXIDE SOLUTION 60CC	EACH	0000088-1010-02
GLYSENNID TABLETS 100	TAB	0000043-0045-51
GONIOSOL SOL (FORMERLY RX) 15CC	EACH	0000058-0701-15
GUAIFENESIN SYRUP 120CC	CC	0000005-3399-24
GUAIFENESIN SYRUP W/DM 120CC	CC	0000005-3460-24

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

HEXA-BETALIN TABS 10MG 100	TAB	0000002-1056-02
HEXA-BETALIN TABS 25MG 100	TAB	0000002-1045-02
HEXA-BETALIN TABS 50MG 100	TAB	0000002-2072-02
HISTADYL-E.C. SYRUP (NEW FORM) 120CC	CC	0000002-5125-58
HYCORT CREAM 0.5% OTC 15GM	EACH	0000163-0371-35
HYDROCIL FORTIFIED PWDR 480GM	EACH	0000032-1806-68
HYDROCIL INST PWDR (EA 3.7GM) UD 30	EACH	0000032-1808-57
HYDROCIL INST PWDR W/SPOON 250GM	EACH	0000032-1808-66
HYDROCIL PLAIN PWDR 480GM	EACH	0000032-1804-68
HYDROCORTISONE SEE: CORTAID		
HYDROCORTISONE SEE: CORTEF		
HYDROCORTISONE SEE: CORTRIL		
HYDROCORTISONE SEE: HYCORT		
HYDROCORTISONE SEE: HYDROSOSONE		
HYDROCORTISONE SEE: PARCORT		
HYDROCORTISONE SEE: PHARMA-CORT		
HYDROCORTISONE SEE: PREPCORT		
HYDROCORTISONE SEE: RHULICORT		
HYDROCORTISONE SEE: WELLCORTIN		
HYDROCORTISONE CREAM 0.5%/APC 15GM	EACH	0000084-0523-35
HYDROCORTISONE CREAM 0.5%/APC 30GM	EACH	0000084-0523-21
HYDROCORTISONE CREAM 0.5%/BIOCRAFT 15GM	EACH	0000332-5153-44
HYDROCORTISONE CREAM 0.5%/BIOCRAFT 30GM	EACH	0000332-5153-48
HYDROCORTISONE CREAM 0.5%/BIOLINE 30GM	EACH	0000719-5200-52
HYDROCORTISONE CREAM 0.5%/CLAY PK 30GM	EACH	0045802-0002-03
HYDROCORTISONE CREAM 0.5%/CLAY PK 120GM	EACH	0045802-0002-04
HYDROCORTISONE CREAM 0.5%/FOUGERA 120GM	EACH	0000168-0014-04
HYDROCORTISONE CREAM 0.5%/FOUGERA 480GM	EACH	0000168-0014-16
HYDROCORTISONE CREAM 0.5%/FOUGERA 30GM	EACH	0000168-0014-31
HYDROCORTISONE CREAM 0.5%/GENERIX 30GM	EACH	0000182-0951-34
HYDROCORTISONE CREAM 0.5%/GENERIX 480GM	EACH	0000182-0951-45
HYDROCORTISONE CREAM 0.5%/PHARMADERM 30GM	EACH	0000462-0014-31
HYDROCORTISONE CREAM 0.5%/PHARMADERM 120GM	EACH	0000462-0014-04
HYDROCORTISONE CREAM 0.5%/RUGBY 30GM	EACH	0000536-8310-95
HYDROCORTISONE CREAM 0.5%/RUGBY 120GM	EACH	0000536-8310-97
HYDROCORTISONE CREAM 0.5%/SCHEIN 30GM	EACH	0000364-7086-56
HYDROCORTISONE CREAM 0.5%/SCHEIN 120GM	EACH	0000364-7086-77
HYDROCORTISONE CREAM 0.5%/STERIMED 30GM	EACH	0000188-8267-31
HYDROCORTISONE CREAM 0.5%/URL 30GM	EACH	0000677-0711-37
HYDROCORTISONE CREAM 0.5%/URL 120GM	EACH	0000677-0711-41
HYDROCORTISONE CREAM 0.5%/MOORE 30GM	EACH	0000839-5206-49
HYDROCORTISONE CREAM 0.5%/MOORE 120GM	EACH	0000839-5206-53

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

HYDROCORTISONE CREAM 0.5%/MOORE 480GM	EACH	0000839-5206-60
HYDROCORTISONE CREAM 0.5%/THREE-P 30GM	EACH	0046198-0603-11
HYDROCORTISONE LOTION 0.5%/BIOLINE 60CC	EACH	0000719-5204-54
HYDROCORTISONE LOTION 0.5%/BIOLINE 120CC	EACH	0000719-5204-56
HYDROCORTISONE LOTION 0.5%/CLAY PK 60CC	EACH	0045802-0022-46
HYDROCORTISONE LOTION 0.5%/CLAY PK 120CC	EACH	0045802-0022-06
HYDROCORTISONE LOTION .5%/GENERIX 60CC	EACH	0000182-1364-43
HYDROCORTISONE LOTION .5%/RUGBY 60CC	EACH	0000536-8330-96
HYDROCORTISONE LOTION .5%/SCHEIN 30CC	EACH	0000364-7275-56
HYDROCORTISONE LOTION .5%/SCHEIN 120CC	EACH	0000364-7275-77
HYDROCORTISONE LOTION 0.5%/URL 60CC	EACH	0000677-0719-31
HYDROCORTISONE OINT 0.5%/BIOLINE 30GM	EACH	0000719-5205-02
HYDROCORTISONE OINT 0.5%/CLAY PK 30GM	EACH	0045802-0012-03
HYDROCORTISONE OINT 0.5%/CLAY PK 120GM	EACH	0045802-0012-04
HYDROCORTISONE OINT 0.5%/FOUGERA 30GM	EACH	0000168-0016-31
HYDROCORTISONE OINT 0.5%/PHARMADERM 30GM	EACH	0000462-0016-31
HYDROCORTISONE OINT 0.5%/RUGBY 30GM	EACH	0000536-8350-95
HYDROCORTISONE OINT 0.5%/URL 30GM	EACH	0000677-0721-37
HYDROCORTISONE SPRAY 0.5%/RUGBY 45CC	EACH	0000536-8340-76
HYDROCORTISONE SPRAY 0.5%/SCHEIN 45GM	EACH	0000364-7303-80
HYTONE CREAM 0.5% OTC 30GM	EACH	0000066-0082-01
HYTONE OINTMENT 0.5% OTC 30GM	EACH	0000066-0086-01
L.L.X. ELIXIR 360CC	CC	0000482-0105-15
L.L.X. ELIXIR W/B12 360CC	CC	0000482-0106-15
L.L.X. TABLETS W/B12 100	TAB	0000482-0109-01
IBERET FILMTABS 60	TAB	0000074-6863-01
IBERET LIQUID 240CC	CC	0000074-7173-01
IBERET-500 FILMTABS 60	TAB	0000074-7235-01
IBERET-500 LIQUID 240CC	CC	0000074-8422-02
IBEROL FILMTABS 100	TAB	0000074-6829-01
IBEROL-F FILMTABS 100	TAB	0000074-1460-13
INCREMIN SYRUP W/IRON 120CC	EACH	0000005-5604-58
IPECAC SYRUP/NOT LILLY 30CC GENERIC	EACH	0000999-7095-30
IPSATOL SYRUP 120CC	CC	0000369-0234-04
IPSATOL-DM SYRUP 120CC	CC	0000369-0092-04
IRCON TABS 200MG 100	TAB	0000369-0055-01
IRON W/VIT C TABS (FERAMEL) 100	TAB	0000003-0549-50
ISOPTO FRIN (OTC) 15CC	EACH	0000065-0406-15
ISOPTO PLAIN (OTC) 15CC	EACH	0000065-0404-15
ISOPTO TEARS (OTC) 15CC	EACH	0000065-0408-15
KANULASE TABLETS 50	TAB	0000043-0038-50
KAOPECTATE CONC 240CC	CC	0000009-0333-03

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

KAOPECTATE SUSP 360CC	CC	0000009-0400-04
KAOPECTATE SUSP, BILINGUAL 360CC	CC	0000009-0425-03
KASDENOL POWDER 10GM	EACH	0000998-0006-10
KENWOOD THERA LIQ SEE: THERAPEUTIC LIQ		
KERID EAR DROPS 8CC	EACH	0000154-1000-08
KOLANTYL GEL 360CC	CC	0000068-0381-12
KOLANTYL TABS 100	TAB	0000068-0384-61
KOLANTYL WAFERS 96	TAB	0000068-0387-96
KONDREMUL LIQUID 480CC	CC	0000585-0121-00
KONSYL POWDER (6oz) 180GM	EACH	0000247-1801-02
KONSYL POWDER (12oz) 360GM	EACH	0000247-1801-03
L.A. FORMULA (7oz) 210GM	EACH	0000247-1802-01
L.A. FORMULA (14oz) 420GM	EACH	0000247-1802-02
L-GLUTAVITE CAPS 100	CAP	0050419-0270-10
LACRI-LUBE S.O.P. OPH OINT 3.5GM	EACH	0000023-0309-04
LACRIL OPH DROPS 15CC	EACH	0000023-0045-15
LACTINEX GRANULES 12	EACH	0000011-8367-12
LACTINEX TABLETS 50	TAB	0000011-8368-50
LEDERPLEX CAPSULES 100	CAP	0000005-4280-23
LEDERPLEX LIQUID 360CC	CC	0000005-4299-63
LEDERPLEX TABLETS 100	TAB	0000005-4287-23
LIPO-NICIN TABS 100mg (PREV:RX)	TAB	0000248-4904-01
LIPO-NICIN TABS 250MG (PREV:RX)	TAB	0000248-1750-01
LIPOFLAVONOID CAPSULES 100	CAP	0000058-1501-17
LIPOTRIAD CAPSULES 100	CAP	0000058-1500-17
LIPOTRIAD LIQUID 480CC	CC	0000058-2505-30
LIQUIFILM TEARS 15CC	EACH	0011980-0031-15
LIQUIFILM TEARS 30CC	EACH	0011980-0031-30
LIQUIPRIN DROPS 35CC	EACH	0000766-5611-39
LIVITAMIN CAPSULES 100	CAP	0000029-2500-30
LIVITAMIN CHEWABLE TABS 100	TAB	0000029-2540-30
LIVITAMIN LIQUID 480CC	CC	0000029-2530-34
LIVITAMIN PRENATAL (PREV:RX) TAB 100	TAB	0000029-2550-30
LUFA CAPSULES 100	CAP	0000075-4651-00
LYTEERS SOLUTION 15CC	EACH	0000077-0643-15
LYTREN NURSETTE 240CC	*EACH	0000087-0294-02
MAALOX #1 TABLETS 100	TAB	0000067-0335-68
MAALOX #2 TABLETS 100	TAB	0000067-0337-67
MAALOX SUSPENSION 360CC	CC	0000067-0330-73
MAALOX THERAPEUTIC CONCENTRATE 360CC	CC	0000067-0334-73
MAALOX-PLUS SUSP 360CC	CC	0000067-0332-71
MAALOX-PLUS TABLETS 50	TAB	0000067-0339-50

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

MAALOX-PLUS TABLETS (STRIP) -UD-100	TAB	0000067-0339-67
MAG-B-6 TABLETS 100	TAB	0017324-7777-01
MALTSUPEX LIQUID 240CC	EACH	0000037-9001-12
MALTSUPEX POWDER 240GM	EACH	0000037-9101-12
MALTSUPEX TABLETS 100	TAB	0000037-9201-01
MAREZINE TABLETS 12	TAB	0000081-0652-16
MEDACHE TABLETS 100	TAB	0000052-0550-91
MEDICONE SUPPOSITORIES 12	EACH	0000244-0004-12
MEDICONE SUPPOSITORIES 24	EACH	0000244-0004-24
MEDICONE UNGUENT 45GM	EACH	0000244-0005-04
MEDIHALER-EPI W/ADAPTER 15CC	EACH	0000089-0755-21
MEDIHALER-EPI REFILL 15CC	EACH	0000089-0755-11
MERC. OXIDE OPH OINT/YELLOW 1% 3.5GM	EACH	0000002-1855-17
MERC. OXIDE OPH OINT/YELLOW 2% 3.5GM	EACH	0000002-1856-17
MERCODOL W/DECAPRYN SYRUP 480CC	CC	0000068-0396-16
METAMUCIL PACKETS 16	EACH	0000025-2219-17
METAMUCIL PACKETS 30	EACH	0000025-2219-31
METAMUCIL POWDER ANY FLAVOR 200GM	EACH	0000025-2209-08
METAMUCIL POWDER ANY FLAVOR 400GM	EACH	0000025-2209-14
METAMUCIL POWDER ANY FLAVOR 600GM	EACH	0000025-2209-21
METHENAMINE TABS 500MG LILLY 100	TAB	0000002-2020-02
METHISCHOL CAPSULES 100	CAP	0000075-4941-00
MI-CEBRIN TABS 100	TAB	0000777-0319-02
MI-CEBRIN-T TABS 100	TAB	0000777-0320-02
MITROLAN TABLETS 36	TAB	0000031-1535-57
MODANE BULK POWDER 420GM	EACH	0000013-5025-72
MODANE LIQUID 480CC	CC	0000013-5033-51
MODANE TABLETS 100	TAB	0000013-5011-17
MODANE MILD TABLETS 100	TAB	0000013-5021-17
MODANE PLUS TABLETS 100	TAB	0000013-5041-17
MOL-IRON CHRONOSULES 30	CAP	0000085-0966-02
MOL-IRON LIQUID 480CC	CC	0000085-0005-05
MOL-IRON TABLETS 100	TAB	0000085-0666-02
MOL-IRON TABS W/VIT C 100	TAB	0000085-0300-03
MULTICEBRIN TABS 100	TAB	0000002-0371-02
MULTIVIT. CAPS/TABS GENERIC	CAP	0000999-5030-01
MULTIVIT. LIQUID GENERIC	CC	0000999-5034-16
MULTIVIT. LIQUID W/MINERALS GENERIC	CC	0000999-5035-16
MULTIVIT. W/MIN CAPS/TABS GENERIC	CAP	0000999-5032-01
MULTIVIT. THERA CAPS/TABS GENERIC	CAP	0000999-5031-01
MULTIVIT. THERA LIQ GENERIC	CC	0000999-5036-16
MULTIVIT. THERA W/MIN CAP/TABS GENERIC	CAP	0000999-5033-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

MYADEC TABS (NEW FORM) 130	TAB	0000071-0335-26
MYCIGUENT CREAM 15GM	EACH	0000009-0523-01
MYCIGUENT OINTMENT 15GM	EACH	0000009-0666-01
MYCIGUENT OINTMENT 30GM	EACH	0000009-0666-02
MYCITRACIN OINTMENT 15GM	EACH	0000009-0700-01
MYCITRACIN OINTMENT 30GM	EACH	0000009-0700-02
MYLANTA LIQUID 360CC	CC	0000038-0610-12
MYLANTA TABLETS 100	TAB	0000038-0620-10
MYLANTA-II LIQUID 360CC	CC	0000038-0852-12
MYLANTA-II TABS 60	TAB	0000038-0851-60
MYLICON DROPS 30CC	CC	0000038-0630-03
MYLICON TABS 40MG 100	TAB	0000038-0450-10
MYLICON-80 TABLETS 100	TAB	0000038-0858-10
NALDECON-CX SYRUP 120CC	CC	0000015-5660-40
NALDECON-DX SYRUP 120CC	CC	0000015-5666-40
NALDECON-EX DROPS 30CC	EACH	0000015-5662-30
NALDEGESIC TABLETS 100	TAB	0000015-5656-60
NALDETUSS SYRUP 480CC	CC	0000015-5607-60
NATABEC KAPSEALS 100	CAP	0000071-0390-24
NATABEC-F.A. KAPSEALS 100	CAP	0000071-0541-24
NATALINS TABLETS (OTC) 100	TAB	0000087-0700-01
NEO-CALGLUCON SYRUP 480CC	CC	0000043-0516-16
NEO-POLYCIN OINTMENT 15GM	EACH	0000068-2010-93
NEO-POLYCIN OINTMENT 30GM	EACH	0000068-2010-01
NEO-SYNEPHRINE DROPS .125% 30CC	EACH	0000024-1345-02
NEO-SYNEPHRINE DROPS .25% 30CC	EACH	0000024-1347-01
NEO-SYNEPHRINE DROPS .5% 30CC	EACH	0000024-1351-01
NEO-SYNEPHRINE DROPS 1% 30CC	EACH	0000024-1355-01
NEO-SYNEPHRINE NASAL JELLY EACH TUBE	EACH	0000024-1367-01
NEO-SYNEPHRINE SPRAY .25% 15CC	EACH	0000024-1348-03
NEO-SYNEPHRINE SPRAY .5% 15CC	EACH	0000024-1353-01
NEOMYCIN TOP OINT/LILLY 15GM	EACH	0000002-1821-47
NEOMYCIN TOP OINT/LILLY 30GM	EACH	0000002-1821-67
NEOMYCIN TOP OINTMENT GENERIC 15GM	EACH	0000999-9086-01
NEOMYCIN TOP OINTMENT GENERIC 30GM	EACH	0000999-9086-02
NEOSPORIN OINTMENT 30GM	EACH	0000081-0730-87
NEOSPORIN OINTMENT 15GM	EACH	0000081-0730-88
NEOZIN OPHTH SOLUTION 15CC	EACH	0000346-1027-40
NIACIN TABS 20MG/LILLY 100	TAB	0000002-1041-02
NIACIN TABS 25MG GENERIC	TAB	0000999-5040-01
NIACIN TABS 25MG/SQUIBB 100	TAB	0000003-0610-50
NIACIN TABS 50MG GENERIC	TAB	0000999-5041-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

NIACIN TABS 50MG/LILLY 100	TAB	0000002-1043-02
NIACIN TABS 50MG/SQUIBB 100	TAB	0000003-0611-50
NIACIN TABS 100MG GENERIC	TAB	0000999-5042-01
NIACIN TABS 100MG/LILLY 100	TAB	0000002-1042-02
NIACIN TABS 100MG/SQUIBB 100	TAB	0000003-0612-50
NIACIN TABS 500MG/SQUIBB 100	TAB	0000003-0537-50
NIACINAMIDE TABS 25MG GENERIC	TAB	0000999-5050-01
NIACINAMIDE TABS 50MG GENERIC	TAB	0000999-5051-01
NIACINAMIDE TABS 100MG GENERIC	TABS	0000999-5052-01
NIACINAMIDE TABS 50MG/LILLY 100	TAB	0000002-1046-02
NIACINAMIDE TABS 100MG/LILLY 100	TAB	0000002-2053-02
NICO-400 CAPS 100	CAPS	0000088-1575-47
NICOBID TEMPULES 125MG 100	CAP	0000053-2835-01
NICOBID TEMPULES 250MG 100	CAP	0000053-2840-01
NICOBID TEMPULES 500MG 100	CAP	0000053-2841-01
NICOSPAN 400MG 100	CAP	00000369-2001-01
NICOTINAMIDE SEE: NIACINAMIDE		
NICOTINIC ACID SEE: NIACIN		
NORMAL SALINE NASAL DROP 15CC GENERIC	EACH	0000999-0201-01
NORMAL SALINE NASAL DROP 30CC GENERIC	EACH	0000999-0202-01
NORMAL SALINE NASAL DROP 60CC GENERIC	EACH	0000999-0203-01
NORMAL SALINE NASAL DROP 90CC GENERIC	EACH	0000999-0204-01
NORMAL SALINE NASAL DROP 120CC GENERIC	EACH	0000999-0205-01
NORMAL SALINE NASAL DROP 180CC GENERIC	EACH	0000999-0206-01
NORMAL SALINE NASAL DROP 240CC GENERIC	EACH	0000999-0207-01
NORMAL SALINE NASAL DROP 480CC GENERIC	EACH	0000999-0208-01
NOVAFED LIQUID 120CC	CC	0000068-1011-04
NOVAFED A LIQUID 120CC	CC	0000068-1010-04
NOVAFLOX CAPS (OTC) 16	CAP	0000576-0275-16
NOVAHISTINE ELIXIR 120CC	CC	0000068-1021-04
NOVAHISTINE EXPECT 120CC	CC	0000068-1028-04
NOVAHISTINE MELET TABLETS 100	TAB	0000183-0012-02
NOVAHISTINE-DH LIQUID 120CC	CC	0000068-1027-04
NOVAHISTINE-DMX LIQUID 120CC	CC	0000068-1015-04
NOVAHISTINE-FORTIS CAPSULES 100	CAP	0000183-0011-02
NOVAHISTINE-LP TABS (FORM RX) 100	TAB	0000183-0016-02
NTZ NASAL SOLUTION 30CC	EACH	0000024-1375-01
NTZ NASAL SPRAY 22.5CC	EACH	0000024-1377-02
NUPERCAINAL OINTMENT 60GM	EACH	0000083-5812-86
NUPERCAINAL SUPP 12	EACH	0000083-5839-12
NUPERCAINAL SUPP 24	EACH	0000083-5839-25

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

NYLMERATE-II SOLUTION 480CC	EACH	0000027-0700-16
OMINAL TABLETS 100	TAB	0000482-0103-01
OPTILETS-M-500 TABS 100	TAB	0000074-4286-13
OPTILETS-500 FILMTABS 100	TAB	0000074-4287-13
ORABASE EMOLLIENT 5GM	EACH	0000126-0063-45
ORABASE EMOLLIENT 15GM	EACH	0000126-0063-88
ORABASE W/BENZOCAINE 5GM	EACH	0000126-0065-45
ORABASE W/BENZOCAINE 15GM	EACH	0000126-0065-88
ORAZINC 220MG (50MG/ZINC) -OTC- 100	CAP	0000394-0499-02
OREXIN TABLETS 100	TAB	0000038-0280-10
ORNACOL CAPS 20	CAP	0049692-0930-12
ORNADE-2 LIQUID 120CC	CC	0000007-4435-44
ORNEX CAPS 100	CAP	0049692-0925-20
ORTHOXICOL SYRUP 120CC	CC	0000009-0222-03
OS-CAL TABLETS 100	TAB	0000088-1650-47
OS-CAL/FORTE TABLETS 100	TAB	0000088-1653-47
OS-CAL/GESIC TABS 100	TAB	0000088-1656-47
OS-CAL/500 TABS 500MG 60	TAB	0000088-1651-41
OTRIVIN NASAL DROPS-OTC 20CC	EACH	0000028-6114-58
OTRIVIN NASAL SPRAY 0.1% OTC 15CC	EACH	0000028-6118-57
OTRIVIN PED NASAL DROPS .05% 20CC	EACH	0000028-6116-58
OXY-5 LOTION 30CC	EACH	0000766-7101-12
OXY--10 LOTION 30CC	EACH	0000766-7500-12
PABALATE TABLETS 100	TAB	0000031-5816-63
PABIRIN BUFFERED TABS 100	TAB	0000043-0019-51
PALADAC LIQUID 480CC	CC	0000071-2311-23
PALADAC W/MINERALS TABS 100	TAB	0000071-0748-24
PANCREATIN ENSEALS TRIPLE STR 100	TAB	0000002-0104-02
PANCREATIN TABS 325MG 100	TAB	0000002-2026-02
PANTERIC GRANULES 120GM	EACH	0000071-1878-17
PANTERIC FILMSEALS 325MG 100	TAB	0000071-0503-24
PANTHOLIN TABS 10MG (PREV: RX)	TAB	0000002-1053-02
PARELIXIR (OTC) 180CC	CC	0000034-5640-60
PAREPECTOLIN 120CC	CC	0000067-0660-60
PEDIALYTE BOTTLES 240CC	*EACH	0000074-5769-24
PEDIALYTE R.T.U. 960CC	*EACH	0000074-5769-06
PEPTENZYME ELIXIR 480CC	CC	0000021-0206-16
PERCOGESIC TABLETS 100	TAB	0000056-0132-70
PERDIEM PLAIN PWD 100GM	EACH	0046213-0695-68
PERDIEM PLAIN PWD 250 GM	EACH	0046213-0695-70
PERDIEM POWDER 100GM	EACH	0046213-0690-68
PERDIEM POWDER 250GM	EACH	0046213-0690-70
PERI-COLACE CAPSULES 60	CAP	0000087-0715-02

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

PERI-COLACE SYRUP 240CC	CC	0000087-0721-01
PERITINIC TABLETS 60	TAB	0000005-5124-19
PERSISTIN TABS 50	TAB	0000585-0122-00
PHARMA-CORT CREAM 0.5% -OTC- 22.5GM	EACH	0000228-1489-75
PHAZYME TABLETS 100	TAB	0000021-0400-01
PHAZYME-95 TABLETS 100	TAB	0000021-0420-01
PHENAPHEN CAPSULES (OTC) 100	CAP	0000031-6207-63
PHENYLZIN OPH SOL 15CC	EACH	0000058-0702-15
PHOSPHALJEL SUSPENSION 360CC	CC	0000008-0111-01
POLY-VI-SOL DROPS 50CC	EACH	0000087-0402-03
POLY-VI-SOL TABS 100	TAB	0000087-0412-03
POLY-VI-SOL TABS CIRCUS SHAPE 100	TAB	0000087-0414-02
POLY-VI-SOL W/IRON CIRCUS SHAPE 100	TAB	0000087-0456-02
POLY-VI-SOL W/IRON DROPS 50CC	EACH	0000087-0405-01
POLY-VI-SOL W/IRON TABS 100	TAB	0000087-0455-02
POLYMAGMA PLAIN TABLETS 50	TAB	0000008-0443-01
POLYSPORIN OINTMENT 30GM	EACH	0000081-0798-87
POLYSPORIN OINTMENT 15GM	EACH	0000081-0798-88
PRACTIMIN-B W/IRON & LYSINE TABS 100	EACH	0017324-2222-01
PREFRIN OPH SOL 20CC	EACH	0011980-0036-07
PREFRIN-Z OPH SOLUTION 15CC	EACH	0000023-0071-15
PREPARATION-H OINTMENT 30GM	EACH	0000573-2870-10
PREPARATION-H OINTMENT 60GM	EACH	0000573-2870-20
PREPARATION-H SUPP 12	EACH	0000573-2880-10
PREPCORT CREAM 0.5%-OTC- 15GM	EACH	0000573-2851-10
PREPCORT CREAM 0.5% -OTC- 30GM	EACH	0000573-2851-20
PRIMATENE MIST COMPLETE 15CC	EACH	0000573-2910-20
PRIMATENE MIST REFILL 15CC	EACH	0000573-2910-30
PRIMATENE MIST REFILL 22.5CC	EACH	0000573-2910-40
PRIMATENE-M TABS 60	TAB	0000573-2931-20
PRIMATENE-P TABS 60	TAB	0000573-2940-30
PRIVINE NASAL SOLUTION 20CC	EACH	0000083-6511-58
PRIVINE NASAL SPRAY 15CC	EACH	0000083-6534-57
PROBEC-T TABLETS 60	TAB	0000038-0840-60
PRO-CORT CREAM 30GM	EACH	0000077-0787-21
PROCTODON CREAM 30GM	EACH	0000032-1916-61
PROPHYLLIN POWDER PACKETS 12	EACH	0000263-5182-12
PROXIGEL 34GM	EACH	0000021-0150-12
PRUNICODEINE 480CC	CC	0000002-2336-05
PYRIDOXINE SEE: HEXA-BETALIN		
PYRIDOXINE TABS 10MG GENERIC	TAB	0000999-5070-01
PYRIDOXINE TABS 25MG GENERIC	TAB	0000999-5071-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

PYRIDOXINE TABS 50MG GENERIC	TAB	0000999-5072-01
PYRIDOXINE TABS 100MG GENERIC	TAB	0000999-5073-01
PYRROXATE CAPS (REFORMULATED) 24	CAP	0000009-3212-02
QUELIDRINE SYRUP 120CC	CC	0000074-6883-04
QUININE SULF CAPS 325MG 100 GENERIC	CAP	0000999-7030-01
QUININE SULF PULV 130MG 100	CAP	0000002-0626-02
QUININE SULF PULV 200MG 100	CAP	0000002-0627-02
QUININE SULF PULV 325MG 100	CAP	0000002-0629-02
QUININE SULF TABS 325MG 100	TAB	0000002-0336-02
RECOUP TABS 30	TAB	0000005-4591-13
REDISOL TABLETS 50MCGM 100	TAB	0000006-0915-68
RHULICORT CREAM 20GM	EACH	0000005-9098-23
RHULICORT LOTION 60CC	EACH	0000005-9099-41
RIBO-B-C TABS SEE: RNA-BC		
RIBOFLAVIN TABS 5MG 100	TAB	0000002-1047-02
RIBOFLAVIN TABS 5MG GENERIC	TAB	0000999-5080-01
RIBOFLAVIN TABS 10MG GENERIC	TAB	0000999-5081-02
RIBOFLAVIN TABS 10MG 100	TAB	0000002-1063-02
RIBOFLAVIN TABS 25MG GENERIC	TAB	0000999-5082-03
RIBOFLEX TABLETS 100	TAB	0017324-5555-01
RIBOMINS TABLETS 100	TAB	0017324-3333-01
RIOPAN CHEW TABS 100	TAB	0000046-0928-81
RIOPAN SUSPENSION 360CC	CC	0000046-0933-12
RIOPAN SWALLOW TABS 100	TAB	0000046-0927-81
RIOPAN PLUS SUSP 360CC	CC	0000046-0937-12
RNA-BC TAB (PREV: RIBO-B-C) 100	TAB	0017324-4444-01
ROBALATE TABLETS 100	TAB	0000031-7074-63
ROBITUSSIN SYRUP/EXPT 120CC	CC	0000031-8624-12
ROBITUSSIN-AC SYRUP 120CC	CC	0000031-8674-12
ROBITUSSIN-CF SYRUP 120CC	CC	0000031-8676-12
ROBITUSSIN-D.A.C. 480CC	CC	0000031-8680-25
ROBITUSSIN-DM SYRUP 120CC	CC	0000031-8684-12
ROBITUSSIN-PE SYRUP 120CC	CC	0000031-8694-12
ROERIBEC TABLETS 100	TAB	0000995-5080-66
ROMILAR CHILDRENS COUGH SYRUP 90CC	CC	0010158-0019-02
ROMILAR-CF SYRUP 90CC	CC	0010158-0018-04
RYNA LIQUID 120CC	CC	0000037-0638-66
RYNA-C LIQUID 120CC	CC	0000037-0522-66
RYNA-CX LIQUID 120CC	CC	0000037-0801-66
RYNA-TUSSADINE EXPECT LIQUID 480CC	CC	0000037-0725-68
RYNA-TUSSADINE EXPECT TAB 100	TAB	0000037-0721-92
SENOKAP DSS CAPSULES 60	CAP	0000034-1400-60

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

SENOKOT GRANULES 60GM	EACH	0000034-1100-20
SENOKOT GRANULES 180GM	EACH	0000034-1100-60
SENOKOT GRANULES 360GM	EACH	0000034-1100-84
SENOKOT SUPPOSITORIES 6	EACH	0000034-1700-06
SENOKOT SYRUP 240CC	CC	0000034-1800-80
SENOKOT TABLETS 100	TAB	0000034-1200-80
SENOKOT-S TABLETS 60	TAB	0000034-1210-60
SERUTAN GRANULES 200GM	EACH	0022170-0135-31
SERUTAN GRANULES 510GM	EACH	0022170-0135-51
SERUTAN POWDER 200GM	EACH	0022170-0136-31
SERUTAN POWDER 400GM	EACH	0022170-0136-51
SERUTAN POWDER 600GM	EACH	0022170-0136-71
SIGTAB TABLETS (NEW FORMULA) 90	TAB	0000009-0461-02
SILAIN TABLETS 100	TAB	0000031-8831-63
SILAIN GEL LIQUID 360CC	CC	0000031-8858-22
SIMRON CAPSULES 100	CAP	0000068-0620-61
SIMRON PLUS CAPSULES 100	CAP	0000068-0626-61
SINULIN TABLETS 100	TAB	0000086-0250-10
SINUTAB TABLETS 30	TAB	0000047-0110-30
SINUTAB II TABLETS 30	TAB	0000047-0113-30
SK-APAP ELIXIR 120CC	CC	0000007-0175-44
SK-APAP TABLETS 325MG 100	TAB	0000007-0174-20
SOD. CHL. OPH OINT 5% (MURO-128) (FORM: RX) 3.5GM	EACH	0000451-1280-38
SOD. CHL. OPH SOL 5% (MURO-128) (FORM: RX) 15cc	EACH	0000451-0128-85
SOD. CHL. OPH SOL 5% (MURO-128) (FORM: RX) 30cc	EACH	0000451-0128-30
SOD. SALICYLATE ENSEALS 325MG 100	TAB	0000002-0110-02
SOD. SALICYLATE ENSEALS 650MG 100	TAB	0000002-0111-02
SOD. SALICYLATE TABS 325MG-EC GENERIC	TAB	0000999-7050-01
SOD. SALICYLATE TABS 650MG-EC- GENERIC	TAB	0000999-7051-01
SORVITE LIQUID 240CC	CC	0000463-9022-08
SPECTROCIN OINTMENT 15GM	EACH	0000003-0616-30
SPECTROCIN OINTMENT 30GM	EACH	0000003-0616-50
STOKES EXPECTORANT (120CC) GENERIC	CC	0000999-8030-04
STRESSCAPS 100	CAP	0000005-4205-23
STRESSTABS-600 60	TAB	0000005-4124-19
STRESSTABS-600 W/IRON 60	TAB	0000005-4126-19
STRESSTABS-600 W/ZINC 60	TAB	0000005-4125-19
STUART FORMULA TABS 100	TAB	0000038-0866-10
STUART HEMATINIC LIQUID 480CC	CC	0000038-0050-16
STUART PRENATAL TABS (OTC) 100	TAB	0000038-0270-10
STUART THERAPEUTIC VITAMINS 100	TAB	0000038-0060-10
STUARTINIC TABLETS 60	TAB	0000038-0862-60

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

SUDAFED COUGH SYRUP 120CC	CC	0000081-0872-82
SUDAFED S.A. CAPS (PREV: RX) 40	TAB	0000081-0869-40
SUDAFED SYRUP 120CC	CC	0000081-0863-82
SUDAFED TABS 60MG 100	TAB	0000081-0868-55
SUDAFED TABLETS 30MG 100	TAB	0000081-0865-55
SUDAFED PLUS SYRUP 120CC	CC	0000081-0871-82
SUDAFED PLUS TABLETS 24	TAB	0000081-0870-24
SURBEX FILMTABS 100	TAB	0000074-4876-13
SURBEX FILMTABS W/VIT C 100	TAB	0000074-4877-13
SURBEX-T FILMTABS 100	TAB	0000074-4878-13
SURBEX-750 W/IRON 50	TAB	0000074-8029-50
SURBEX-750 W/ZINC 50	TAB	0000074-8152-50
SURFACAINE JELLY 30GM	EACH	0000002-2458-67
SURFAK CAPSULES 50MG 100	CAP	0000039-0002-10
SURFAK CAPSULES 240MG 100	CAP	0000039-0003-10
SYLLAMALT PWDR (10 oz) 300GM	EACH	0000037-9301-13
TAKA-COMBEX KAPSEALS 100	CAP	0000071-0368-24
TAKA-DIASTASE LIQUID 480CC	CC	0000071-2118-23
TEAR-EFRIN OPHTH SOLUTION 15CC	EACH	0000058-0703-15
TEARISOL OPHTH SOLUTION 15CC	EACH	0000058-0725-15
TEDRAL ELIXIR 480CC	CC	0000710-2242-23
TEDRAL SUSPENSION 480CC	CC	0000710-2237-23
TEDRAL TABS 100	TAB	0000710-0230-24
TELDRIN SPANSULES 8MG 50	CAP	0049692-0920-15
TELDRIN SPANSULES 12MG 50	CAP	0049692-0921-15
TEMPRA DROPS 15CC	EACH	0000087-0730-01
TEMPRA SYRUP 120CC	CC	0000087-0733-04
TERPIN HYD ELIXIR (120CC) GENERIC	CC	0000999-8000-04
TERPIN HYD ELIXIR/LILLY 480CC	CC	0000002-2433-05
TERPIN HYD W/COD ELIX (120CC) GENERIC	CC	0000999-8001-04
TERPIN HYD W/COD ELIX/LILLY 480CC	CC	0000002-2434-05
TERPIN HYD W/COD ELIX/P-D 120CC	CC	0000071-2410-17
TERPIN HYD W/DEXTRO ELIX (120CC) GENERIC	CC	0000999-8002-04
TERRAMYCIN TOP OINT 15GM	EACH	0000995-0850-29
TERRAMYCIN TOP OINT 30GM	EACH	0000995-0850-52
THERA-COMBEX H-P KAPSEALS 100	CAP	0000071-0550-24
THERA-COMBEX KAPSEALS 100	CAP	0000071-0374-24
THERAGRAN LIQUID 120CC	EACH	0000003-0826-31
THERAGRAN TABS 100	TAB	0000003-0823-53
THERAGRAN-M TABS 100	TAB	0000003-0825-54
THERAGRAN-Z TABS 60	TAB	0000003-0341-40
THERAMINERALS TABLETS 100	TAB	0000463-6174-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

THERAPEUTIC LIQ/KENWOOD 360CC	CC	0000482-0116-15
THEREMMS TABLETS 100	TAB	0000463-6175-01
THIAMINE ELIXIR (480CC) GENERIC	CC	0000999-6005-16
THIAMINE TABS 10MG GENERIC	TAB	0000999-6000-01
THIAMINE TABS 25MG GENERIC	TAB	0000999-6001-01
THIAMINE TABS 50MG GENERIC	TAB	0000999-6002-01
THIAMINE TABS 100MG GENERIC	TAB	0000999-6003-01
THIAMINE TABS 250MG GENERIC	TAB	0000999-6004-01
TINACTIN CREAM 15GM	EACH	0000085-0715-05
TINACTIN LIQ AEROSOL 120cc	EACH	0000085-0165-02
TINACTIN POWDER 45GM	EACH	0000085-0444-05
TINACTIN POWDER AEROSOL 100GM	EACH	0000085-0254-06
TINACTIN SOLUTION 10CC	EACH	0000085-0333-05
TITRALAC LIQUID 360CC	CC	0000089-0950-12
TITRALAC TABLETS 100	TAB	0000089-0355-10
TOCOPHEREX-H.P. SEE: VIT. E		
TRI-VI-SOL DROPS 50CC	EACH	0000087-0403-03
TRI-VI-SOL TABLETS 100	TAB	0000087-0413-02
TRI-VI-SOL W/IRON DROPS 50CC	EACH	0000087-0453-03
TRIALKA LIQUID 420CC	CC	0010310-0218-07
TRIALKA TABLETS 100	TAB	0010310-0219-31
TRIAMINIC-DM COUGH FORMULA	CC	0000043-0526-04
TRIAMINIC EXPECT (REFORMULATED) 120CC	CC	0000043-0525-04
TRIAMINIC EXPT W/COD 120CC	CC	0000043-0528-04
TRIAMINIC SYRUP (REFORMULATED) 120CC	CC	0000043-0524-04
TRIAMINICIN CHEW TABS 24	TAB	0000043-0059-24
TRIAMINICIN TABS 100	TAB	0000043-0064-51
TRIAMINICOL SYRUP 120CC	CC	0000043-0503-04
TRIMO-SAN JELLY COMP 120gm	EACH	0000396-5030-00
TRIMO-SAN JELLY REFILL 120gm	EACH	0000396-5030-10
TRIND SYRUP (NEW FORMULA) 150CC	CC	0000087-0750-44
TRIND-DM SYRUP (NEW FORMULA) 150CC	CC	0000087-0753-44
TRONOTHANE JELLY 1% 30GM	EACH	0000074-6650-01
TROPH-IRON LIQUID 120CC	CC	0049692-0950-44
TROPHITE LIQUID 120CC	CC	0049692-0945-44
TROPHITE TABLETS 50	TAB	0049692-0946-15
TUCKS CREAM 40GM	EACH	0000071-3022-14
TUCKS OINTMENT 40GM	EACH	0000071-3021-14
TUSSAGESIC SUSP 480CC	CC	0000043-0505-16
TUSSAGESIC TABLETS 100	TAB	0000043-0030-51
TUSSAR-2 SYRUP 480CC	CC	0000053-3636-01
TUSSAR-SF SYRUP 480CC	CC	0000053-3635-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

TUSSCAPINE CHEWABLE TABS 24	TAB	0000585-0316-20
TUSSCAPINE SUSPENSION 120CC	CC	0000585-0317-01
TWO/G LIQUID 120CC	CC	0000068-1035-04
TWO/G-DM LIQUID 120CC	CC	0000068-1036-04
TYLENOL CHEW TABS 80MG 30	TAB	0000045-0485-32
TYLENOL DROPS 15CC	EACH	0000045-0502-21
TYLENOL ELIXIR (CHILDREN'S) 120CC	CC	0000045-0465-04
TYLENOL EX STR CAPS 100	CAP	0000045-0494-60
TYLENOL EX STR TABS 100	TAB	0000045-0499-60
TYLENOL EXTRA STRENGTH LIQUID 140CC	CC	0000045-0500-08
TYLENOL TABS 100	TAB	0000045-0496-60
ULTRA TEARS OPHTH SOL (OTC) 15CC	EACH	0000065-0412-15
UNICAP CAPSULES 90	CAP	0000009-0138-02
UNICAP CHEWABLE TABS 90	TAB	0000009-0198-02
UNICAP SENIOR TABS 90	TAB	0000009-0348-02
UNICAP TABLETS 90	TAB	0000009-0299-03
UNICAP-M TABS 90	TAB	0000009-0284-03
UNICAP-PLUS-IRON TABS 90	TAB	0000009-0285-03
UNICAP-T TABS 90	TAB	0000009-0149-02
URSINUS INLAY TABS 100	TAB	0000043-0037-51
VALADOL LIQUID 120CC	CC	0000003-0351-25
VALADOL TABLETS 100	TAB	0000003-0355-50
VAPONEFRIN SOLUTION 7.5CC	EACH	0000585-0201-03
VAPONEFRIN SOLUTION 15CC	EACH	0000585-0201-04
VAPONEFRIN SOLUTION 30CC	EACH	0000585-0201-05
VERDEFAM CREAM 30GM	EACH	0000299-3990-01
VERDEFAM SOLUTION 60CC	EACH	0000299-3991-02
VEREQUAD SUSPENSION 480CC	CC	0000044-6980-01
VEREQUAD TABLETS 100	TAB	0000044-6920-02
VI-AQUA CAPSULES 100	CAP	0000075-4321-00
VI-AQUA FORTE CAPSULES 100	CAP	0000075-4221-00
VI-AQUA THERA SEE: VI-AQUA FORTE 100	CAP	
VI-AQUAMIN FORTE CAPSULES 100	CAP	0000075-4521-00
VI-AQUAMIN THERA SEE: VI-AQUAMIN FORTE		
VI-DAYLIN ADC DROPS 50CC	EACH	0000074-0105-04
VI-DAYLIN DROPS 50CC	EACH	0000074-0103-04
VI-DAYLIN LIQUID 480CC	CC	0000074-3606-03
VI-DAYLIN PLUS IRON DROPS 50CC	EACH	0000074-0116-01
VI-DAYLIN IRON/ADC DROPS 50CC	EACH	0000074-0117-01
VI-DAYLIN TABS, CHEWABLE 100	TAB	0000074-4519-13
VI-DAYLIN PLUS IRON CHEW TABS 100	TAB	0000074-4520-13
VI-DAYLIN PLUS IRON LIQUID 480CC	CC	0000074-6992-03
VI-PENTA INFANT DROPS 50CC	EACH	0000004-1011-02
VI-PENTA MULTIVIT-DROPS 50CC	EACH	0000004-1013-02
VICON PLUS CAPSULES 60	CAP	0000173-0305-22
VICON-C CAPSULES 60	CAP	0000173-0273-22

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

VIGRAN CHEWABLE TABS 2 X 60	TAB	0000003-0407-61
VIGRAN TABLETS 100	TAB	0000003-0342-51
VIGRAN PLUS IRON TABS 2X90	TAB	0000003-0415-61
VIOFORM CREAM 3% 30GM	EACH	0000083-8462-96
VIOFORM OINTMENT 3% 30GM	EACH	0000083-8467-96
VISINE EYE DROPS 15CC	EACH	0000998-8025-01
VISINE EYE DROPS 22.5CC	EACH	0000998-8025-02
VISINE EYE DROPS 30CC	EACH	0000998-8025-03
VIT. A CAPS 10,000U GENERIC	CAP	0000999-6019-01
VIT. A CAPS 25,000U NATURAL GENERIC	CAP	0000999-6020-01
VIT. A CAPS 25,000U SOLUBLE GENERIC	CAP	0000999-6022-01
VIT. A CAPS 25,000U SYNTHETIC GENERIC	CAP	0000999-6024-01
VIT. A CAPS 25,000U NAT/LEDRLE 100	CAP	0000005-3294-57
VIT. A CAPS 25,000U NAT/TN-PL 100	CAP	0000157-0614-01
VIT. B COMP CAPS GENERIC	CAP	0000999-6026-01
VIT. B COMP CAPS W/VIT C 100 GENERIC	CAP	0000999-9052-01
VIT. B COMP ELIXIR/LILLY 480CC	CC	0000002-2604-05
VIT. B COMP ELIXIR (480CC) GENERIC	CC	0000999-6030-16
VIT. B COMP PULV 100	CAP	0000002-0643-02
VIT. B COMP LIQ W/IRON (120CC) GENERIC	CC	0000999-9053-04
VIT. B COMP TABS/SQUIBB 100	TAB	0000003-0204-50
VIT. B-1 SEE: THIAMINE		
VIT. B-1 TABS 50MG/SQUIBB 100	TAB	0000003-0915-50
VIT. B-1 TABS 100MG/SQUIBB 100	TAB	0000003-0916-50
VIT. B-2 SEE RIBOFLAVIN		
VIT. B-6 SEE PYRIDOXINE		
VIT. B12 CAPS 25MCGM/SQUIBB 100	CAPD	0000003-0788-50
VIT. B12 TABS 5MCGM GENERIC	TAB	0000999-6040-01
VIT. B12 TAB 25MCGM GENERIC	TAB	0000999-6041-01
VIT. B12 TABS 25MCGM SOLUBLE GENERIC	TAB	0000999-6044-01
VIT. B12 TABS 50MCGM GENERIC	TAB	0000999-6042-01
VIT. B12 TABS 50MCGM SOLUBLE GENERIC	TAB	0000999-6045-01
VIT. B12 TABS 100MCGM GENERIC	TAB	0000999-6043-01
VIT. B12 TABS 100MCGM SOLUBLE GENERIC	TAB	0000999-6046-01
VIT. C TABS 25MG GENERIC	TAB	0000999-5002-01
VIT. C TABS 50MG GENERIC	TAB	0000999-5003-01
VIT. C TABS 100MG GENERIC	TAB	0000999-5004-01
VIT. C TABS 250MG GENERIC	TAB	0000999-5005-01
VIT. C TABS 500MG GENERIC	TAB	0000999-5006-01
VIT. C TABS 1000MG GENERIC	TAB	0000999-5007-01
VIT. C TABS 100MG/LILLY 100	TAB	0000002-2045-02
VIT. C TABS 250MG CHEWABLE GENERIC	TAB	0000999-5023-01
VIT. C TABS 250MG/LILLY 100	TAB	0000002-2060-02
VIT. C TABS 250MG/PFIZER 100	TAB	0000995-6210-66
VIT. C TABS 250MG/SQUIBB (CHEW) 100	TAB	0000003-0112-50
VIT. C TABS 250MG/SQUIBB 100	TAB	0000003-0196-50

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

VIT. C TABS 500MG CHEWABLE GENERIC	TAB	0000999-5024-01
VIT. C TABS 500MG/LILLY 100	TAB	0000002-2067-02
VIT. C TABS 500MG/PFIZER 100	TAB	0000995-6240-66
VIT. C TABS 500MG/SQUIBB 100	TAB	0000003-0197-50
VIT. E CAPS 30IU GENERIC	CAP	0000999-6050-01
VIT. E CAPS 50IU GENERIC	CAP	0000999-6051-01
VIT. E CAPS 100IU GENERIC	CAP	0000999-6052-01
VIT. E CAPS 100IU/SQUIBB 100	CAP	0000003-0889-50
VIT. E CAPS 100IU/SQUIBB-NATRL 100	TAB	0000003-0352-50
VIT. E. CAPS 200IU (100) GENERIC	CAP	0000999-6053-01
VIT. E CAPS 200IU/SQUIBB 100	CAP	0000003-0353-50
VIT. E CAPS 400IU (100) GENERIC	CAP	0000999-6054-01
VIT. E CAPS 400IU/SQUIBB 90	CAP	0000003-0354-40
VIT. E CAPS 600IU (100) GENERIC	CAP	0000999-6055-01
VITERRA HI-POT TABS 100	TAB	0000995-6290-66
VITERRA ORIG FORM TABS 100	TAB	0000995-6230-66
VITERRA E CAPS 100MG (VIT. E) 100	CAP	0000995-6250-66
VITERRA E CAPS 200MG (VIT. E) 100	CAP	0000995-6270-66
VITERRA E CAPS 400MG (VIT. E) 100	CAP	0000995-6280-66
VITERRA E CAPS 600MG (VIT. E) 100	CAP	0000995-9910-07
VITRON-C PLUS TABS (NOW OTC) 100	TAB	0000585-1125-02
VITRON-C TABS NDC CHA 100	TAB	0000585-0123-00
WELLCORTIN CREAM 0.5% 15GM	EACH	0000081-0172-88
WELLCORTIN LOTION 0.5% 30GM	EACH	0000081-0173-87
WELLCORTIN OINTMENT 0.5% 15GM	EACH	0000081-0171-88
WINGEL SUSPENSION 360CC	CC	0000024-2247-05
WINGEL TABLETS 100	TAB	0000024-2249-06
WYANOID OINTMENT W/APPLICATOR 30GM	EACH	0000008-0156-01
WYANOIDS SUPPOSITORIES 12	EACH	0000008-0015-01
X-PREP LIQUID 75CC	EACH	0000152-1000-25
XYLOCAINE OINTMENT 2.5%-OTC- 35GM	EACH	0000186-0335-01
Z-BEC TABLETS 60	TAB	0000031-0689-62
ZENTINIC PULVULES 60	CAP	0000002-0719-60
ZENTRON CHEWABLE TABS 50	TAB	0000002-2001-50
ZENTRON LIQUID 240cc	CC	0000002-2466-88
ZEPHIRAN CHL AQUE. SOL 1:750 240CC	CC	0000024-2521-04
ZEPHIRAN CHL CONC SOL 17% 120CC	CC	0008024-2534-01
ZINC SULFIDE COMPD LOT./UPJOHN 120CC	EACH	0000009-0969-01
ZINCFRIN DROPS 15CC	EACH	0000065-0512-15
ZINCONATE TABLETS 100	TAB	0017324-6666-01
ZYMACAP CAPSULES 90	CAP	0000009-0363-02
ZYMALIXIR 360CC	CC	0000009-0944-01
ZYMASYRUP 360CC	CC	0000009-0955-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

CONTRACEPTIVE MATERIALS

BECAUSE CONTRACEPTIVE FOAM 10GM	EACH	0000085-0439-01
CONCEPTROL APPLICATORS 6	EACH	0000062-3252-08
CONCEPTROL APPLICATORS 10	EACH	0000062-3252-10
CONCEPTROL DISP GEL (6PAK)	EACH	0000062-3250-01
CONCEPTROL DISP GEL (10PAK)	EACH	0000062-3250-02
CONCEPTROL STARTER (DELFFEN) 70GM	EACH	0000062-3252-77
CONCEPTROL REFILL (DELFFEN) 70GM	EACH	0000062-3252-00
DELFFEN FOAM W/APP. 20GM	EACH	0000062-3130-11
DELFFEN FOAM REFILL 20GM	EACH	0000062-3130-13
DELFFEN FOAM REFILL 50GM	EACH	0000062-3130-12
EMKO FOAM W/APP. 40GM	EACH	0000085-0050-01
EMKO FOAM REFILL 40GM	EACH	0000085-0050-02
EMKO FOAM REFILL 90GM	EACH	0000085-0050-03
EMKO PRE-FIL FOAM W/APP. 30GM	EACH	0000085-0354-01
EMKO PRE-FIL FOAM REFILL 60GM	EACH	0000085-0354-02
ENCARE OVALS INSERTS 12	EACH	0011926-0221-12
GYNOL-II JELLY W/APPLICATOR 81GM	EACH	0000062-3180-00
GYNOL-II JELLY REFILL 126GM	EACH	0000062-3180-01
KOROMEX FOAM W/APP. 22GM	EACH	0000027-0030-00
KOROMEX FOAM REFILL 22GM	EACH	0000027-0030-22
KOROMEX FOAM REFILL 55GM	EACH	0000027-0030-55
KOROMEX-II CREAM W/APP. 75GM	EACH	0000027-0020-20
KOROMEX-II CREAM REFILL 75GM	EACH	0000027-0020-25
KOROMEX-II CREAM REFILL 128GM	EACH	0000027-0020-22
KOROMEX-II JELLY W/APP. 81GM	EACH	0000027-0010-10
KOROMEX-II JELLY REFILL 81GM	EACH	0000027-0010-15
KOROMEX-II JELLY REFILL 135GM	EACH	0000027-0010-11
KOROMEX-II A JELLY W/APP. 135GM	EACH	0000027-0045-40
KOROMEX-II A JELLY REFILL 135GM	EACH	0000027-0045-45
NORFORMS SUPPOSITORIES 6	EACH	0000149-0101-06
NORFORMS SUPPOSITORIES 12	EACH	0000149-0101-12
NORFORMS SUPPOSITORIES 24	EACH	0000149-0101-24
ORTHO-CREME W/APP. 70GM	EACH	0000062-3190-77
ORTHO-CREME REFILL 70GM	EACH	0000062-3190-00
ORTHO-CREME REFILL 115GM	EACH	0000062-3190-01
ORTHO-GYNOL JELLY W/APP. 81GM	EACH	0000062-3170-77
ORTHO-GYNOL JELLY REFILL 81GM	EACH	0000062-3170-02
ORTHO-GYNOL JELLY REFILL 126GM	EACH	0000062-3170-01
PROPHYLACTICS, RUBBER ONLY, PKG. OF 3	EACH	0000999-9000-03
PROPHYLACTICS, RUBBER ONLY, PKG. OF 12	EACH	0000999-9000-12
PROPHYLACTICS, RUBBER ONLY, PKG. OF 36	EACH	0000999-9000-36
RAMSES JELLY W/APP. 85GM	EACH	0000234-0003-03
RAMSES JELLY REFILL 85GM	EACH	0000234-0003-02
RAMSES JELLY REFILL 142GM	EACH	0000234-0003-05
SEMICID VAGINAL SUPP. 10	EACH	0000573-3301-10

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

INSULIN PREPARATIONS

ACTRAPID INSULIN U100	CC	0011791-0403-01
INSULIN NORDISK MIXTARD U100	CC	0050445-0300-01
INSULIN NORDISK NPH U100	CC	0050445-0200-01
INSULIN NORDISK QUICK U100	CC	0050445-0100-01
INSULIN SQUIBB BEEF LENTE U100 ANY SIZE	CC	0000003-2703-10
INSULIN SQUIBB BEEF NPH U100 ANY SIZE	CC	0000003-2702-10
INSULIN SQUIBB INJ REG 40U ANY SIZE	CC	0000003-3511-15
INSULIN SQUIBB INJ REG U100 ANY SIZE	CC	0000003-3512-15
INSULIN SQUIBB ISO/NPH 40U ANY SIZE	CC	0000003-3521-15
INSULIN SQUIBB ISO/NPH U100 ANY SIZE	CC	0000003-3522-15
INSULIN SQUIBB LENTE 40U ANY SIZE	CC	0000003-3527-15
INSULIN SQUIBB LENTE U100 ANY SIZE	CC	0000003-3528-15
INSULIN SQUIBB PORK REG U100 ANY SIZE	CC	0000003-2701-10
INSULIN SQUIBB PROT ZINC U100 ANY SIZE	CC	0000003-3542-15
INSULIN SQUIBB SEMILENTE U100 ANY SIZE	CC	0000003-3552-15
INSULIN SQUIBB ULTRALENTE U100 ANY SIZE	CC	0000003-3572-15
INSULIN ILETIN REGULAR U40 ANY SIZE	CC	0000002-8240-01
INSULIN ILETIN REGULAR U100 ANY SIZE	CC	0000002-8210-01
INSULIN ILETIN LENTE U40 ANY SIZE	CC	0000002-8440-01
INSULIN ILETIN LENTE U100 ANY SIZE	CC	0000002-8410-01
INSULIN ILETIN NPH U40 ANY SIZE	CC	0000002-8340-01
INSULIN ILETIN NPH U100 ANY SIZE	CC	0000002-8310-01
INSULIN ILETIN PROT ZN U40 ANY SIZE	CC	0000002-8140-01
INSULIN ILETIN PROT ZN U100 ANY SIZE	CC	0000002-8110-01
INSULIN ILETIN SEMILENTE U40 ANY SIZE	CC	0000002-8540-01
INSULIN ILETIN SEMILENTE U100 ANY SIZE	CC	0000002-8510-01
INSULIN ILETIN ULTRALENTE U40 ANY SIZE	CC	0000002-8640-01
INSULIN ILETIN ULTRALENTE U100 ANY SIZE	CC	0000002-8610-01
INSULIN BEEF REGULAR U100 ANY SIZE ILETIN-II	CC	0000002-8212-01
INSULIN BEEF LENTE U100 ANY SIZE	CC	0000002-8412-01
INSULIN BEEF NPH U100 ANY SIZE	CC	0000002-8312-01
INSULIN BEEF PROT ZINC U100 ANY SIZE ILETIN-II	CC	0000002-8112-01
INSULIN PORK REGULAR U100 ANY SIZE	CC	0000002-8211-01
INSULIN PORK LENTE U100 ANY SIZE	CC	0000002-8411-01
INSULIN PORK NPH U100 ANY SIZE	CC	0000002-8311-01
INSULIN PORK PROT ZINC U100 ANY SIZE	CC	0000002-8111-01
LENTARD INSULIN U100	CC	0011791-0433-01
MONOTARD INSULIN U100	CC	0011791-0423-01
SEMITARD INSULIN U100	CC	0011791-0413-01
ULTRATARD INSULIN U100	CC	0011791-0453-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

DIABETIC TESTING MATERIAL

ACETEST REAGENT TABS 100	EACH	0000193-2381-21
ALBUSTIX REAGENT STRIPS 100	EACH	0000193-2870-21
CHEMSTRIP BG STRIPS 25	EACH	0050924-0501-25
CHEMSTRIP BG KITS	EACH	0050924-0505-25
CLINISTIX REAGENT STRIPS 50	EACH	0000193-2844-50
CLINITEST ANALYSIS SET PKG	EACH	0000193-2105-01
CLINITEST REAGENT TABS, FOIL 100	EACH	0000193-2159-21
CLINITEST REAGENT TABS 36	EACH	0000193-2100-36
CLINITEST REAGENT TABS (2-DROP METHOD) 36 TAB	EACH	0000193-2112-36
CLINITEST REAGENT STRIPS 100	EACH	0000193-2100-21
COMBISTIX REAGENT STRIPS 100	EACH	0000193-2867-21
DEXTROSTIX REAGENT STRIPS 10	EACH	0000193-2888-10
DEXTROSTIX REAGENT STRIPS 25	EACH	0000193-2888-25
DIASTIX REAGENT STRIPS 50	EACH	0000193-2802-50
DIASTIX REAGENT STRIPS 100	EACH	0000193-2802-21
GLUCOLA 300CC	EACH	0000193-2607-10
KETO-DIASTIX REAGENT STRIPS 50	EACH	0000193-2882-50
KETO-DIASTIX REAGENT STRIPS 100	EACH	0000193-2882-21
KETOSTIX REAGENT STRIPS 50	EACH	0000193-2880-50
KETOSTIX REAGENT STRIPS 100	EACH	0000193-2880-21
MICROSTIX-NITRITE	EACH	0000193-3007-03
TES-TAPE 1 PKG	EACH	0000002-2344-41
TES-TAPE 2 PKGS	EACH	0000002-2344-02
URISTIX REAGENT STRIPS 100	EACH	0000193-2855-21
VISIDEX REAGENT STRIPS 25	EACH	0000193-2651-25

**PHARMACEUTICAL SERVICES**

**PHARMACEUTICAL SERVICES MANUAL  
APPENDIX C  
HYPODERMIC SYRINGES AND/OR NEEDLES**

This listing provides assigned codes, which will serve as product identification for hypodermic syringes and/or needles, for the purpose of reimbursement. The assigned code must be entered in the drug code area of the prescription claim form (MC-6) when preparing claims for hypodermic syringes and/or needles.

Exception: When a prescribed hypodermic syringe and/or needle is dispensed which is not listed under the "Product Description" section, the product should be described on the reverse side of the claim form (MC-6) and the statement, "Hypodermic Syringe and/or Needle" should be entered in the product name area on the face of the claim form. The description of hypodermic syringe and/or needle is intended to be generic in nature; therefore, it is not limited to specific trade-name products. When reporting "quantity dispensed" on the claim form (MC-6), indicate the number of syringes, needles or syringe/needle units dispensed. Example: If 2 packages of 10 syringe/needle units are prescribed and dispensed, enter "20" in the metric quantity box. Do Not place any additional information in the metric quantity area.

When reusable syringes and/or needles are prescribed and dispensed, enter N/A (Non-applicable) in the "Days Supply" area on the prescription claim form (MC-6).

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

APPENDIX C

HYPODERMIC SYRINGES AND NEEDLES  
ASSIGNED PRODUCT CODES FOR ALL BRANDS\*

<u>PRODUCT DESCRIPTION</u>	<u>REPORTING UNIT</u>	<u>ASSIGNED PRODUCT CODE</u>
<u>NEEDLES, DISPOSABLE</u>		
18G to 20G, ALL LENGTHS	EACH	0000293-5105-01
21G, up to 1½"	EACH	0000293-5107-01
21G, 2"	EACH	0000293-5106-01
22G to 25G, ALL LENGTHS	EACH	0000293-5108-01
26G, ALL LENGTHS	EACH	0000293-5109-01
27G, ALL LENGTHS	EACH	0000293-5110-01
<u>NEEDLES, REUSABLE</u>		
18G to 22G, UP TO 2"	EACH	0000293-1055-01
23G to 27G, ALL LENGTHS	EACH	0000293-1201-01
<u>SYRINGES AND NEEDLE UNITS, DISPOSABLE</u>		
INSULIN, U40-U80, W/26G, ½" NEEDLE	EACH	0000293-5546-01
INSULIN, U40, W/26G, ½" NEEDLE	EACH	0000293-5567-01
INSULIN, U80, W/26G, ½" NEEDLE	EACH	0000293-5568-01
INSULIN, U40, MICRO-FINE, 1cc	EACH	0000293-8413-01
INSULIN, U100, MICRO-FINE, ½cc LODOSE	EACH	0000293-8461-01
INSULIN, U100, MICRO-FINE, 1cc	EACH	0000293-8410-01
REGULAR, 3cc, W/ANY SIZE NEEDLE	EACH	0000293-5570-01
REGULAR, 2½cc W/ANY SIZE NEEDLE	EACH	0000293-5251-01
TUBERCULIN, 1cc, W/ANY SIZE NEEDLE	EACH	0000293-5623-01
INSULIN, LODOSE, ½cc	EACH	0000293-8471-01
INSULIN, LODOSE, 1cc	EACH	0000293-8412-01
<u>SYRINGES ONLY, DISPOSABLE</u>		
TUBERCULIN, 1cc	EACH	0000293-5602-01
REGULAR, 5cc	EACH	0000293-5603-01
<u>SYRINGES ONLY, GLASS REUSABLE WITH DISPOSABLE NEEDLES</u>		
INSULIN, 1cc, U40, W/30 DISP NEEDLES 26G, ½"	EACH	0000293-5008-01
INSULIN, 1cc, U80, W/30 DISP NEEDLES 26G, ½"	EACH	0000293-5009-01
<u>SYRINGES ONLY, GLASS REUSABLE</u>		
INSULIN, SHORT TYPE, GLASS TIP, 1cc FOR U40, U80, U40-U80	EACH	0000293-2022-01
INSULIN, LONG TYPE, GLASS LUER TIP, U100 0.35cc	EACH	0000293-2049-01

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

<u>PRODUCT DESCRIPTION</u>	<u>REPORTING UNIT</u>	<u>ASSIGNED PRODUCT CODE</u>
<u>SYRINGES ONLY, GLASS REUSABLE</u>		
INSULIN, LONG TYPE, GLASS LUER TIP, U100 1cc	EACH	0000293-2029-01
REGULAR, ANY STYLE TIP, 2cc	EACH	0000293-2300-01
REGULAR, ANY STYLE TIP, 3cc	EACH	0000293-2306-01
REGULAR, ANY STYLE TIP, 5cc	EACH	0000293-2301-01
TUBERCULIN, $\frac{1}{4}$ cc	EACH	0000293-2001-01
TUBERCULIN, $\frac{1}{2}$ cc	EACH	0000293-2002-01
TUBERCULIN, 1cc	EACH	0000293-2004-01

\*NOTE: The Product Codes listed have been assigned for all syringes and needles or combination thereof, regardless of manufacturer.

PHARMACEUTICAL SERVICES

**PHARMACEUTICAL SERVICES MANUAL**  
**APPENDIX D**  
**LEGEND DEVICES**

Instructions for use:

1. Diaphragms are reported on the MC-6 claim form as "each" (enter "1" in metric quantity box).
2. Only those legend devices listed in Appendix D are reimbursable under the Jersey Health Services (Medicaid) Program.

APPENDIX D

LEGEND DEVICES

DEBRISAN BEADS 25 GM	EACH	0000016-0024-05
DEBRISAN BEADS 60 GM	EACH	0000016-0024-06
DEBRISAN BEADS 120 GM	EACH	0000016-0024-12
DEBRISAN BEADS 7 UNIT DOSES OF 4 GM	GM	0000016-0024-17
DEBRISAN BEADS 14 UNIT DOSES OF 4 GM	GM	0000016-0024-27
DIAPHRAGM-ALL FLEX KIT ANY SIZE PKG.	EACH	0000062-3301-00
DIAPHRAGM-KORO-FLEX ANY SIZE PKG.	EACH	0000027-0136-60
DIAPHRAGM-KORO-FLEX SET ANY SIZE PKG.	EACH	0000027-0536-70
DIAPHRAGM-KOROMEX ANY SIZE PKG.	EACH	0000027-0131-75
DIAPHRAGM-KOROMEX SET ANY SIZE PKG.	EACH	0000027-0541-80
DIAPHRAGM-ORTHO KIT/COIL ANY SIZE PKG.	EACH	0000062-3341-00
DIAPHRAGM-ORTHO KIT/FLAT ANY SIZE PKG.	EACH	0000062-3381-00
DIAPHRAGM-RAMSES ANY SIZE PKG.	EACH	0000234-0602-01
DIAPHRAGM-RAMSES KIT ANY SIZE PKG.	EACH	0000234-0602-12
HEALON INJ/DISP. SYRINGE	EACH	0000016-0311-12
HEALON INJ/DISP. SYRINGE	EACH	0000016-0311-04
ORTHO UNIVERSAL INTRODUCER	EACH	0000062-3630-00

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

**PHARMACEUTICAL SERVICES MANUAL**  
**APPENDIX E**  
**PROTEIN REPLACEMENTS**

Instructions for use:

The following products have been added to the Medicaid File for claim processing purposes.

Protein replacements are eligible for reimbursement only when prior authorized. Contact the appropriate Local Medical Assistance unit (LMAU) for prior authorization.

When prior authorization has been obtained from the Local Medical Assistance Unit, complete the claim form MC-6. Report the quantity dispensed only as total number of cans, bottles, nursettes, etc., dispensed. DO NOT report grams or cc. Use only the NDCs or product codes listed for each product.

<u>PRODUCT DESCRIPTION</u>	<u>REPORTING UNIT</u>	<u>NDC OR PRODUCT CODE</u>
CASEC POWDER 3.33 OZ	EACH	0000087-0390-02
CHO-FREE CONCENTRATE 14 OZ	EACH	0000033-2391-14
COMPLEAT-B R.T.U.* 8 OZ	EACH	0000212-0200-40
COMPLEAT-B R.T.U.* 13.6 OZ	EACH	0000212-0200-50
DEXTROSE PWDR-BAKER 1 LB	EACH	0010106-1919-01
DEXTROSE PWDR-HUMCO 1 LB	EACH	0000395-0725-01
DEXTROSE PWDR-PUREPAC 1 LB	EACH	0000228-1269-16
ENFAMIL CONCENTR. LIQ. 13 OZ	EACH	0000087-0300-01
ENFAMIL NURSETTE 4 OZ	EACH	0000087-0280-01
ENFAMIL NURSETTE 6 OZ	EACH	0000087-0280-15
ENFAMIL NURSETTE 8 OZ	EACH	0000087-0280-26
ENFAMIL NURSETTE-PLASTIC 8 OZ	EACH	0000087-0284-01
ENFAMIL POWDER 1 LB	EACH	0000087-0330-01
ENFAMIL R.T.U.* 8 OZ	EACH	0000087-0302-24
ENFAMIL R.T.U.* 32 OZ	EACH	0000087-0302-22
ENFAMIL W/IRON CONCENTR. 13 OZ	EACH	0000087-0301-01
ENFAMIL W/IRON NURSETTE 6 OZ	EACH	0000087-0315-01
ENFAMIL W/IRON POWDER 1 LB	EACH	0000087-0331-01
ENFAMIL W/IRON R.T.U.* 8 OZ	EACH	0000087-0305-02
ENFAMIL W/IRON R.T.U.* 32 OZ	EACH	0000087-0305-01
ENSURE LIQUID-CAN 8 OZ ALL FLAVORS	EACH	0000074-4014-08
ENSURE LIQUID-CAN 32 OZ	EACH	0000074-5564-32

\*R.T.U. MEANS READY TO USE

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

ENSURE LIQUID-BOTTLE 8 OZ	EACH	0000074-5562-08
ENSURE POWDER 14 OZ	EACH	0000074-5561-14
ENSURE PLUS LIQUID-BOTTLE 8 OZ	EACH	0000074-3021-08
ENSURE PLUS LIQUID-CAN 8 OZ ALL FLAVORS	EACH	0000074-9780-08
FLEXICAL POWDER 2 OZ	EACH	0000087-0569-41
FLEXICAL POWDER 1 LB	EACH	0000087-0569-42
GEVRAL PROTEIN 0.5 LB	EACH	0000005-4223-61
GEVRAL PROTEIN 5 LB	EACH	0000005-4223-70
ISOCAL LIQUID-CAN 8 OZ	EACH	0000087-0355-01
ISOCAL LIQUID-CAN 12 OZ	EACH	0000087-0355-02
ISOCAL LIQUID-CAN 32 OZ	EACH	0000087-0355-44
ISOCAL LIQUID-BOTTLE 8 OZ	EACH	0000087-0356-01
LOFENALAC POWDER 2.5 LB	EACH	0000087-0340-01
LONALAC POWDER 1 LB	EACH	0000087-0391-01
MEAT BASE FORMULA 15 OZ	EACH	0000999-2504-01
MERITENE POWDER 1 LB ALL FLAVORS	EACH	0000212-1220-02
MERITENE POWDER 4.5 LB ALL FLAVORS	EACH	0000212-1220-03
MEYENBERG GOAT MILK LIQ. 14 OZ	EACH	0000999-0400-01
MEYENBERG GOAT MILK PDR. 14 OZ	EACH	0000999-0400-02
NURSOY CONCENTR. 13 OZ	EACH	0000008-0481-05
NURSOY R.T.U.* 32 OZ	EACH	0000008-0452-05
NUTRAMIGEN POWDER	EACH	0000087-0338-01
NUTRI-1000 10 OZ	EACH	0000161-0560-00
NUTRI-1000 32 OZ	EACH	0000161-0560-11
PORTAGEN POWDER 1 LB	EACH	0000087-0387-01
PREGESTIMIL POWDER 1 LB	EACH	0000087-0367-01
PROBANA POWDER 1 LB	EACH	0000087-0346-01
PROSOBEE CONC. LIQUID 13 OZ	EACH	0000087-0308-01
PROSOBEE R.T.U.* LIQUID 8 OZ	EACH	0000087-0309-42
PROSOBEE R.T.U.* LIQUID 32 OZ	EACH	0000087-0309-01
POLYCOSE LIQUID 4 OZ	EACH	0000074-5554-04
POLYCOSE POWDER 14 OZ	EACH	0000074-5000-14
SIMILAC CONCENTR. - CAN 13 OZ	EACH	0000074-0264-01
SIMILAC R.T.U.* - CAN 8 OZ	EACH	0000074-0177-01
SIMILAC R.T.U.* - CAN 32 OZ	EACH	0000074-0232-01
SIMILAC NURSETTE 4 OZ	EACH	0000074-0480-01
SIMILAC NURSETTE 8 OZ	EACH	0000074-0880-01
SIMILAC POWDER 1 LB	EACH	0000074-0139-01
SIMILAC ADVANCE CONC. 13 OZ	EACH	0000074-3313-01
SIMILAC ADVANCE CONC. 32 OZ	EACH	0000074-3301-01

\*R.T.U. MEANS READY TO USE

NEW JERSEY  
MEDICAID PROGRAM

PHARMACEUTICAL SERVICES

SIMILAC ADVANCE CONC. 32 OZ	EACH	0000074-3301-01
SIMILAC ISOMIL CONC. 13 OZ	EACH	0000074-2110-01
SIMILAC ISOMIL R.T.U.* 8 OZ	EACH	0000074-0173-01
SIMILAC ISOMIL R.T.U.* 32 OZ	EACH	0000074-0230-01
SMA LIQUID CONC. 13 OZ	EACH	0000008-0447-02
SMA POWDER 1 LB	EACH	0000008-0448-02
SMA R.T.U.* 8 OZ	EACH	0000008-0449-11
SMA R.T.U.* 32 OZ	EACH	0000008-0449-02
SOYALAC CONCENTR. 14 OZ	EACH	0041470-0053-60
SOYALAC R.T.U.* 14 OZ	EACH	0041470-0052-50
SOYALAC R.T.U.* 32 OZ	EACH	0041470-0052-70
SOYALAC POWDER 1 LB	EACH	0041470-0053-00
SUSTACAL LIQUID 8 OZ ALL FLAVORS	EACH	0000087-0350-42
SUSTACAL LIQUID 12 OZ ALL FLAVORS	EACH	0000087-0350-01
SUSTACAL LIQUID 32 OZ ALL FLAVORS	EACH	0000087-0350-44
SUSTACAL POWDER 3.8 LB	EACH	0000087-0353-43
SUSTACAL PUDDING 5 OZ ALL FLAVORS	EACH	0000087-0415-41
SUSTACAL PUDDING 6.88 LB ALL FLAVORS	EACH	0000087-0415-42
SUSTAGEN POWDER 1 LB	EACH	0000087-0393-01
SUSTAGEN POWDER 2.5 LB	EACH	0000087-0393-02
SUSTAGEN POWDER 5 LB	EACH	0000087-0393-03
VIVONEX DEL. SYST. 10 SYST.	EACH	0000149-0050-10
VIVONEX HIGH NITROGEN 10X80 GM	EACH	0000149-0051-01
VIVONEX FLAVOR PAK 2.33 GM ALL FLAVORS	EACH	0000149-0058-02
VIVONEX STANDARD DIET 80 GM	EACH	0000149-0052-01

\*R.T.U. MEANS READY TO USE

NEW JERSEY MEDICAID FORMULARY  
NEW JERSEY HEALTH SERVICES (MEDICAID) PHARMACY PROGRAM

SECTION I. Index of Trade-Name Products with their Designated Chemically Equivalent Names.

SECTION II. Acceptable Alternate Product Name and Company for the Designated Chemically Equivalent Name by Dosage Form and Strength.

When prescriber indicates "Formulary Alternate Permitted" (FAP) and the trade name appears in Section I, the provider pharmacy must dispense a listed alternate product when the corresponding dosage form and strength is listed in Section II.

NEW JERSEY HEALTH  
SERVICES PROGRAM

NEW JERSEY MEDICAID FORMULARY  
SECTION I

11/10/75

TRADE NAME AND COMPANY	DESIGNATED CHEMICALLY EQUIVALENT NAME
ACHROMYCIN-V (LEDERLE)	TETRACYCLINE
ALPEN (LEDERLE)	AMPICILLIN
AMCILL (PARKE-DAVIS)	AMPICILLIN
AMNESTROGEN (SQUIBB)	ESTROGENS, ESTERIFIED
BENADRYL (PARKE-DAVIS)	DIPHENHYDRAMINE
BETAPEN VK (BRISTOL)	PENICILLIN-V POT.
BRISTACYCLINE (BRISTOL)	TETRACYCLINE
BRISTAMYCIN (BRISTOL)	ERYTHROMYCIN
CHLOR-PZ (USV)	CHLORPROMAZINE
CHLOR-TRIMETON (SCHERING)	CHLORPHENIRAMINE
COMPOCILLIN-VK (ABBOTT-ROSS)	PENICILLIN-V POT.
CONESTRON (WYETH)	ESTROGENS, CONJUGATED
COSEA (ALCON)	CHLORPHENIRAMINE
CYCLOPAR (PARKE-DAVIS)	TETRACYCLINE
DARVON (LILLY)	PROPOXYPHENE
DARVON COMPOUND-65 (LILLY)	PROPOXYPHENE COMPOUND-65
DOLENE (LEDERLE)	PROPOXYPHENE
DOLENE COMPOUND-65 (LEDERLE)	PROPOXYPHENE COMPOUND-65
DOWMYCIN-E (DOW)	ERYTHROMYCIN
DOXY-II (USV)	DOXYCYCLINE
EQUANIL (WYETH)	MEPROBAMATE
ERYPAR (PARKE-DAVIS)	ERYTHROMYCIN
ERYTHROCIN (ABBOTT)	ERYTHROMYCIN
ESIDRIX (CIBA)	HYDROCHLOROTHIAZIDE
ETHRIL (SQUIBB)	ERYTHROMYCIN
EVEX (SYNTEX)	ESTROGENS, ESTERIFIED
GANTRISIN (ROCHE)	SULFISOXAZOLE
HISTASPAN (USV)	CHLORPHENIRAMINE
HYDRODIURIL (MS&D)	HYDROCHLOROTHIAZINE
ILOSONE (DISTA)	ERYTHROMYCIN
IMAVATE (ROBINS)	IMIPRAMINE
JANIMINE (ABBOTT)	IMIPRAMINE
LEDERCILLIN VK (LEDERLE)	PENICILLIN-V POT.
MENEST (BEECHAM)	ESTROGENS, ESTERIFIED
MILTOWN (WALLACE)	MEPROBAMATE
OMNIPEN (WYETH)	AMPICILLIN
ORETIC (ABBOTT)	HYDROCHLOROTHIAZINE
OXLOPAR (PARKE-DAVIS)	OXYTETRACYCLINE

TRADE NAME AND COMPANY	DESIGNATED CHEMICALLY EQUIVALENT NAME
PANMYCIN (UPJOHN)	TETRACYCLINE
PEN-A (PFIZER)	AMPICILLIN
PENAPAR VK (PARKE-DAVIS)	PENICILLIN-V POT.
PENBRITIN (AYERST)	AMPICILLIN
PENSYN (UPJOHN)	AMPICILLIN
PENTIDS (SQUIBB)	PENICILLIN-G
PEN VEE K (WYETH)	PENICILLIN-V POT.
PFIZER-E (PFIZER)	ERYTHROMYCIN
PFIZERPEN (PFIZER)	PENICILLIN-G
PFIZERPEN VK (PFIZER)	PENICILLIN-V POT.
POLYCILLIN (BRISTOL)	AMPICILLIN
PREMARIN (AYERST)	ESTROGENS, CONJUGATED
PRESAMINE (USV)	IMIPRAMINE
PRINCIPEN (SQUIBB)	AMPICILLIN
PROMAPAR (PARKE-DAVIS)	CHLORPROMAZINE
QIDAMP (MALLINCRODT)	AMPICILLIN
QIDMYCIN (MALLINCRODT)	ERYTHROMYCIN
QIDPEN VK (MALLINCRODT)	PENICILLIN-V POT.
QIDTET (MALLINCRODT)	TETRACYCLINE
ROBICILLIN VK (ROBINS)	PENICILLIN-V POT.
ROBIMYCIN (ROBINS)	ERYTHROMYCIN
ROBITET (ROBINS)	TETRACYCLINE
SK-AMPICILLIN (SKF)	AMPICILLIN
SK-BAMATE (SKF)	MEPROBAMATE
SK-ERYTHROMYCIN (SKF)	ERYTHROMYCIN
SK-ESTROGENS (SKF)	ESTROGENS, ESTERIFIED
SK-PENICILLIN VK (SKF)	PENICILLIN-V POT.
SK-PRAMINE (SKF)	IMIPRAMINE
SK-SOXAZOLE (SKF)	SULFISOXAZOLE
SK-TETRACYCLINE (SKF)	TETRACYCLINE
SK-65 (SKF)	PROPOXYPHENE
SK-65 COMPOUND (SKF)	PROPOXYPHENE COMPOUND-65
SOXOMIDE (UPJOHN)	SULFISOXAZOLE
SULFALAR (PARKE-DAVIS)	SULFISOXAZOLE
SUMYCIN (SQUIBB)	TETRACYCLINE
TELDRIN (SKF)	CHLORPHENIRAMINE
TERRAMYCIN (PFIZER)	OXYTETRACYCLINE
TETRACYN (ROERIG)	TETRACYCLINE
TETREX (BRISTOL)	TETRACYCLINE
TETREX BID (BRISTOL)	TETRACYCLINE
TETREX-S (BRISTOL)	TETRACYCLINE
THIURETIC (PARKE-DAVIS)	HYDROCHLOROTHIAZIDE
THORAZINE (SKF)	CHLORPROMAZINE

<u>TRADE NAME AND COMPANY</u>	<u>DESIGNATED CHEMICALLY EQUIVALENT NAME</u>
<u>TOFRANIL (GEIGY)</u>	<u>IMIPRAMINE</u>
<u>TOTACILLIN (BEECHAM)</u>	<u>AMPICILLIN</u>
<u>UTICILLIN VK (UPJOHN)</u>	<u>PENICILLIN-V POT.</u>
<u>V CILLIN-K (LILLY)</u>	<u>PENICILLIN-V POT.</u>
<u>VEETIDS (SQUIBB)</u>	<u>PENICILLIN-V POT.</u>
<u>VIBRAMYCIN (PFIZER)</u>	<u>DOXYCYCLINE</u>

DESIGNATED CHEMICAL EQUIVALENT DOSAGE FORM AND STRENGTH	ACCEPTED ALTERNATE PRODUCT NAME AND COMPANY
--	--

AMPICILLIN, CAPS 250MG	PEN-A (PFIZER)
AMPICILLIN, CAPS 500MG	PEN-A (PFIZER)
AMPICILLIN, SUSP 125MG 100CC	PEN-A (PFIZER)
AMPICILLIN, SUSP 125MG 200CC	PEN-A (PFIZER)
AMPICILLIN, SUSP 250MG 100CC	PEN-A (PFIZER)
AMPICILLIN, SUSP 250MG 200CC	PEN-A (PFIZER)
CHLORPHENIRAMINE SUST TABS/CAPS 8MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPHENIRAMINE SUST TABS/CAPS 12MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPROMAZINE TABS 10MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE)
CHLORPROMAZINE TABS 25MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 50MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 100MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 200MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
DIPHENHYDRAMINE CAPS 25MG	DIPHENHYDRAMINE (LEDERLE)
DIPHENHYDRAMINE CAPS 50MG	DIPHENHYDRAMINE (LEDERLE)
DOXYCYCLINE CAPS 50MG	DOXY-II (USV)
DOXYCYCLINE CAPS 100MG	DOXY-II (USV)
DOXYCYCLINE ORAL SUSP 25MG/5CC	DOXY-II (USV)
ERYTHROMYCIN TABS/CAPS 250MG	PFIZER-E (PFIZER)
ERYTHROMYCIN TABS/CAPS 500MG	PFIZER-E (PFIZER)
ESTROGENS, CONJ TABS 0.625MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, CONJ TABS 1.25MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, ESTERIFIED TABS 0.625MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 1.25MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 2.5MG	SK-ESTROGENS (SKF)
HYDROCHLOROTHIAZIDE TABS 50MG	ORETIC (ABBOTT) THIURETIC (PARKE-DAVIS)
IMIPRAMINE TABS 10MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 25MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 50MG	IMIPRAMINE (LEDERLE) JANIMINE (ABBOTT) SK-PRAMINE (SKF)
MEPROBAMATE TABS 200MG	SK-BAMATE (SKF)
MEPROBAMATE TABS 400MG	SK-BAMATE (SKF) MEPROBAMATE (LEDERLE)
OXYTETRACYCLINE CAPS 250MG	OXLOPAR (PARKE-DAVIS)

<u>DESIGNATED CHEMICAL EQUIVALENT DOSAGE FORM AND STRENGTH</u>	<u>ACCEPTED ALTERNATE PRODUCT NAME AND COMPANY</u>
PENICILLIN-G TABS 200,000U	PFIZERPEN (PFIZER) PENICILLIN-G (WYETH)
PENICILLIN-G TABS 250,000U	PFIZERPEN (PFIZER) PENICILLIN-G (WYETH)
PENICILLIN-G TABS 400,000U	PFIZERPEN (PFIZER) PENICILLIN-G (WYETH)
PENICILLIN-G LIQ. 250MG 100CC	PFIZERPEN (PFIZER)
PENICILLIN-G LIQ. 250MG 200CC	PFIZERPEN (PFIZER)
PENICILLIN-V POT. TABS 125MG	COMPOCILLIN VK (ABBOTT-ROSS) V CILLIN-K (LILLY)
PENICILLIN-V POT. TABS 250MG	PFIZERPEN VK (PFIZER) QIDPEN K (MALLINCRODT) SK-PENICILLIN VK (SKF)
PENICILLIN-V POT. TABS 500MG	PFIZERPEN VK (PFIZER)
PENICILLIN-V POT. LIQ. 125MG 100CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN-V POT. LIQ. 125MG 200CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN-V POT. LIQ. 250MG 100CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN-V POT. LIQ. 250MG 200CC	PFIZERPEN VK (PFIZER)
PROPOXYPHENE CAPS 65MG	SK-65 (SKF)
PROPOXYPHENE COMPD-65 CAPS	SK-65 COMPOUND (SKF)
SULFISOXAZOLE TABS	SK-SOXAZOLE (SKF) SULFISOXAZOLE (LEDERLE)
TETRACYCLINE CAPS/TABS 250MG	ROBITET (ROBINS) SK-TETRACYCLINE (SKF) TETRACYN (ROERIG) TETRECYCLINE (WYETH)
TETRACYCLINE CAPS/TABS 500MG	ROBITET (ROBINS) SK-TETRACYCLINE (SKF) TETRACYN (ROERIG) TETRACYCLINE (WYETH)
TETRACYCLINE SUSP 125MG/5CC	PANMYCIN (UPJOHN) ROBITET (ROBINS) SK-TETRACYCLINE (SKF)

PHARMACEUTICAL SERVICES MANUAL  
INDEX  
SUBCHAPTER 2

BILLING PROCEDURES

N.J.A.C. TITLE 10 - CHAPTER 51

	<u>Subchapter</u>	<u>Page</u>
General Policy.....	2.1	1
Patient Identification.....	2.2	1
Plastic Pharmacy Card.....	2.3.	1-2
Imprinter.....	2.4	2
Pharmacy Provider Identification Plate.....	2.5	2
Instructions for Completion of Form MC-6.....	2.6	2-9
Abbreviated Drug Codes for the Most Commonly Dispensed Drugs.....	2.6	10
Reporting Quantities Dispensed of Cancer Chemotherapy Injectables.....	2.6	10.1
Medicaid Drug Reference Chart (Legend Drugs).....	2.6	11
Medicaid Drug Reference Chart (Non-legend Drugs).....	2.6	12 /
Payment Voucher.....	2.7	13-18
Claim Return Statement.....	2.8	19-24
Medicaid Pharmacy Adjustment Request Form.....	2.9	25-28
Follow-up Claims Investigation Procedure.....	2.10	28
Ordering Forms, Envelopes, Supplies.....	2.11	29
Tape-to-Tape Claims and Computer Generated Hard Copy Claims.....	2.12	30

**BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL**

**SUBCHAPTER 2. BILLING PROCEDURES**

**10:51-2.1 General policy**

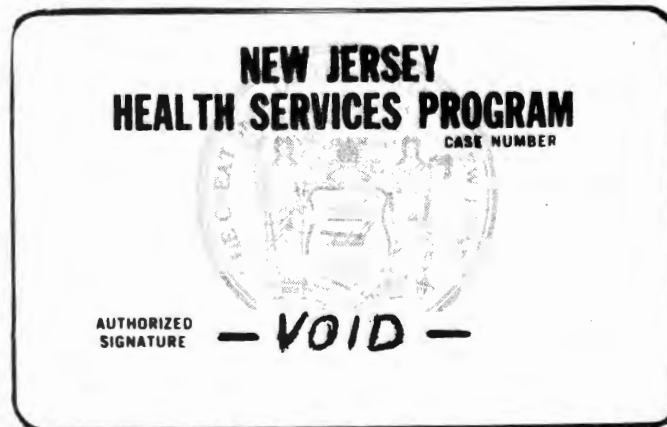
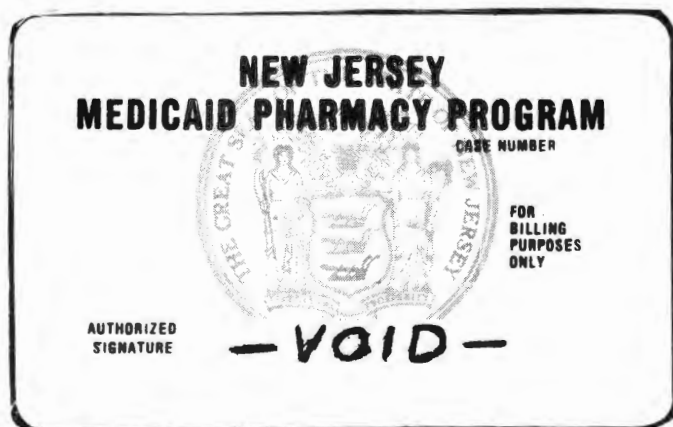
(a) This subchapter contains basic information for the submission of pharmacy claims for Medicaid-eligible patients. (See subchapter 3 of this chapter for specific information on submitting claims for patients in a long-term care facility.) Included is a sample claim form approved for use in submitting bills for covered items or services, and appropriate instructions for the proper completion of the claim form.

(b) Claims should be submitted as frequently as practical, but at least monthly. In all cases, claims must be submitted no later than ninety days after the dispensing of the prescription.

**10:51-2.2 Patient identification**

Verify that the patient is a covered person. This is done by checking the patient's validation form. (See N.J.A.C. 10:49-1.2 "How to identify a covered person.") The patient's plastic pharmacy card is for claims processing purposes only and is not evidence of eligibility.

**10:51-2.3 Plastic pharmacy card**



(a) Pictured above left is the pharmacy program plastic card in use since 1977 and which is intended to replace the old card, pictured above right, which has been in existence since 1970. The replacement process is taking place by attrition; this means that the older cards will still be in existence and can be used. The new card, as well as the old card, is to be utilized exclusively by pharmacy providers with imprinter machines for billing transactions. The current card is provided to the recipient as a service to facilitate billing. You are reminded that the plastic card is not to be used for identification or proof that the recipient is eligible for the Medicaid program.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

(b) For confirmation of individual recipient eligibility, check for the monthly validation stub or the quarterly validation card.

10:51-2.4 Imprinter

Upon request, an imprinter may be purchased at a nominal cost along with operating instructions. Use of the imprinter is not mandatory, but does help eliminate errors and therefore speeds up processing of claims.

10:51-2.5 Pharmacy provider identification plate

(a) This plate was designed for the use with an imprinter and should be placed permanently therein. This information, transposed onto the claim form, will enable Blue Cross of New Jersey to identify all claims submitted by that pharmacy. The Provider Identification Number, name and address may be handwritten in the appropriate area of the claim form (MC-6).

(b) Pharmacy providers servicing long-term care facilities have been issued an additional Provider Identification Number to identify services provided to long-term care facility Medicaid recipients only. Do not use the LTCF Provider Identification Number on any claims for services to other than Medicaid recipients residing in long-term care facilities.

10:51-2.6 Instructions for completion of form MC-6

(a) A properly completed claim form, submitted within 90 days from the dispensing date, as stated in 10:51-2.1 will enable Blue Cross of New Jersey to process your claim quickly. It is recommended that claims be submitted for processing no less than once weekly in order to correspond to the payment cycle.

(b) The tissue copy of the claim form should be detached after completion and retained as your record of claims submitted to Blue Cross of New Jersey. Please keep tissues in claim number order for quick referral.

(c) The Medicaid drug reference chart, at the end of this section, is included to aid in the completion of the claim form.

**BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL**

CLAIM NUMBER <b>75826324</b>	CASE NUMBER				PHARMACY NUMBER				CHARGE	
	1				1				18	
	PATIENT'S FIRST NAME AS ON I.D. STUB		DATE OF BIRTH		PERSON NO.		NAME AND ADDRESS OF PHARMACY		DEFINED COST	\$ 19
	2		3		3				DISPENSING FEE	\$
	CASE NAME				RX NUMBER				TOTAL RX CHARGE	\$
	I ACKNOWLEDGE RECEIPT OF MEDICATION AS STATED IN THIS CLAIM				DATE DISPENSED		DATE WRITTEN		NON-LEGEND DRUG CHARGE	\$ 20
	SIGNATURE OF PATIENT OR REPRESENTATIVE				NATIONAL DRUG CODE				MANUFACTURER	
	IS A PATIENT IN A LONG-TERM CARE FACILITY				12		13		14	
	<small>PROVIDER CERTIFICATION: I certify that the foregoing information is true, accurate and complete, and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such purposes as the State Agency may request, and that the services covered by this claim and the amount charged hereon are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be requested on payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. I understand that payment and collection of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.</small>				CHECK APPROPRIATE BOX		AUTHORIZATION		MEDICAL IDENTIFICATION	
	SIGNATURE OF PHARMACIST				PRESCRIBER'S INDIVIDUAL MEDICAID PRACTITIONER'S NUMBER		AUTHOR. NO.		CHECK IF COMPOUND RX	
DATE				16				17		
PRESCRIBER'S NAME AND DEGREE (PLEASE PRINT)				STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES PRESCRIPTION CLAIM FORM				SUBMIT LIST OF INGREDIENTS AND QUANTITIES ON REVERSE SIDE		

- (d) When completing the claim form enter the following information:
- Item (1); CASE NUMBER is the ten-digit number that identifies the person who is assigned the validation form.
  - Item (2); PATIENT'S FIRST NAME and PERSON NUMBER of the person for whom prescription is being filled, as shown on the validation form. (Nicknames or abbreviations of patient's first name should never be used. Enter only as the name appears on the patient's identification document.) If available, enter patient's date of birth.
  - Item (3); CASE NAME refers to the last name of the "head of the family". Make sure the name is legible.
  - Item (4); Obtain SIGNATURE OF PATIENT OR REPRESENTATIVE. See Chapter 10:49-1.26, "Patient Certification."
  - Item (5); IS A PATIENT IN A LONG-TERM CARE FACILITY. Either "yes" or "no" must be checked. Refer to subchapter 3 of this chapter for further information regarding procedures when patient is in a long-term care facility.
  - Item (6); SIGNATURE OF PHARMACIST.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

- Item (7); PRESCRIBER'S NAME AND DEGREE - Print prescriber's first initial, last name and degree (M.D., O.D., D.D.S., podiatrist, etc.). If prescriber is non-participating, enter his name. If prescriber practices solely in a hospital, enter the name of the hospital.
- Item (8); PHARMACY NUMBER, NAME AND ADDRESS OF PHARMACY - The pharmacy provider's identification number, name and address must be legible on the claim.
- Item (9); DATE DISPENSED - Enter month, day and year drug was dispensed. Providers utilizing old style imprinters which imprint the dates must correct the year digits if a new "date wheel" was not obtained.
- Item (10); RX NUMBER - Enter the prescription number you assigned. If the claim represents a refill, use the original prescription number according to your files.
- Item (11); NATIONAL DRUG CODE of the drug may be obtained from the package label (if available). If the NDC is not available, provide complete drug information in item (14) and leave the NDC area blank.

- i. When entering NDC'S on the claim form, providers should transfer them exactly as they appear on the package label.

- (1) Example: Nalfon Pulvules 300mg. (Dista) 60's. NDC appears on package label as:

NDC 777-0877-60

Enter this NDC on the claim form as such:

NATIONAL DRUG CODE													
			7	7	7	-	0	8	7	7	-	6	0
METRIC QUANTITY   DAYS SUPPLY   NDC CODE   DRUG PRODUCT NAME   DOSE FORM & STRENGTH													

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

- (2) Example: Naprosyn Tablets 250mg.  
(Syntex) 100's. NDC appears  
on package label as:

NDC 18393-272-42

Enter this NDC on the  
claim form as such:

NATIONAL DRUG CODE											
1	8	3	9	3	-	2	7	2	-	4	2
METRIC QUANTITY (HAVE SHIPPER)											

- ii. For the convenience of providers, the most frequently used products have been assigned an abbreviated three digit code which will lessen the possibility of errors for these products in NDC transcription. When entering the abbreviated code, use the last three positions of the NDC field.

- (1) Example: Valium 5mg. Tablets are labelled with NDC 00140-0005-01 and has been assigned the Abbreviated Drug Code of 962.

Enter 962 on the claim form in the last three positions of the NDC field as such:

NATIONAL DRUG CODE												
					-					9	6	2
METRIC QUANTITY (HAVE SHIPPER)												

- (2) The Abbreviated Drug Code is not applicable to tape claims.

Item (12); METRIC QUANTITY - Enter quantity dispensed according to the following:

- i. Metric quantities dispensed of those injectable products normally reconstituted by physician, nurse, etc., SUBSEQUENT TO DISPENSING, bulk irrigation or I.V. solutions and prefilled syringes (ex. Tubex products), should be reported on claim form MC-6 as total number of full ampoules, vials, or

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

bottles dispensed. Enter the NDC from the package label.

- (1) Example: Report 3 vials of Polycillin-N Injection as 3 in metric quantity field.
- (2) Example: Report 6 bottles of Normal Saline sterile solution for Irrigation, 1000cc each as 6 in metric quantity field.

ii. Metric quantities dispensed of all other legend drugs should be reported on claim form MC-6 as total number of cc, grams, tablets, capsules, etc.. Enter the NDC from the product package label.

When reporting metric quantities, providers should interpret metric quantity equivalents as such:

<u>APOTHECARY QUANTITIES OF</u>	<u>WHICH ARE EQUIVALENT TO LABELLED METRIC QUANTITIES OF</u>	<u>SHOULD BE REPORTED AS METRIC QUANTITY OF</u>
1/2 oz.	14.2 gm or cc	15
4 oz.	118.5 gm or cc	120
1 oz.	28.4 gm or cc	30
16 oz.	473 gm or cc	480
8 oz.	237 gm or cc	240
2 oz.	56.8 gm or cc	60
2 x 1/2 oz.	2 tubes, 15 gm each	30
2 x 1 oz.	2 tubes, 28.4 gm each	60
1 1/2 oz.	42.6 gm or cc	45

Use of this reporting procedure will afford proper cost payment for all quantities dispensed, as reimbursement rates have been predicated on this procedure.

In order to give providers a general idea of reporting requirements, several hypothetical cases with instructions are listed below:

- Rx 1. 3 vials of NPH U-100 Insulin, 10 cc each - Report as 30.
- Rx 2. Ampicillin for suspension, 250 mg/5cc, 200 cc - Report as 200.
- Rx 3. Anusol HC Suppositories #12 - Report as 12.
- Rx 4. Garamycin Injection 80 mg/2 cc vial - Report as 2.  
(Report 4 x 2 cc as 8).
- Rx 5. Provera Tablets 10 mg., #20 - Report as 20.
- Rx 6. Cordran Cream 0.025%, 28.4 gm. - Report as 30.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

- Rx 7. Kolyum Packets, 5 gm., #30 - Report as 30.
- Rx 8. Elixophyllin Elixir 473cc - Report as 480.
- Rx 9. NaCl Sterile Irrigant, 2000cc, 8 bottles - Report as 8 and use NDC on 2000cc bottle.
- Rx 10. PhisoHex Emulsion, 1 gallon (3840cc) - Report as 3840.\*
- Rx 11. Polycillin-N Injection 500 mg., 5 vials - Report as 5.
- Rx 12. Ortho Novum (and other dialpaks or packets) - Report as actual number of tablets dispensed.
- Rx 13. Chloromycetin Ophthalmic Drops 25 mg. (Reconstituted to either 5cc, 10cc or 15cc) - Report as 1.

NOTE: THESE REPORTING PROCEDURES ARE APPLICABLE TO LEGEND DRUGS ONLY.  
\*The metric quantity field will now accomodate four numeric characters

CANCER CHEMOTHERAPY INJECTABLE DRUGS

In order to prevent problems which may be associated with the incorrect reporting of expensive drugs such as cancer chemotherapy injectables and ensure proper payment, a list of the most commonly dispensed drugs is provided in Subchapter 2 of this Manual and is identified as page 10.1.

Report the quantities dispensed of these drugs only in accordance with the instructions on that page. Cancer chemotherapy injectables do not require prior authorization.

- Item (13); Calculate DAYS SUPPLY from the prescriber's directions and the quantity dispensed. Enter N/A (not applicable) when it is not possible to calculate days' supply. (See "Dosage and Directions" in subchapter 1.8).
- Item (14); IF NO CODE, GIVE PRODUCT NAME, DOSAGE FORM AND STRENGTH. Complete only if NDC number is not available, or if there is any question of NDC validity. Complete all areas of product identification.
- Item (15); CHECK IF PRIOR AUTHORIZATION, MEDICAL CERTIFICATION OR BOTH REQUIRED AND ENTER AUTHORIZATION NUMBER. Check box, and enter authorization number of medical certification as explained under "Services requiring prior authorization" and "certification" in Subchapter 1.
  - i. Services requiring prior authorization should not be provided until the authorization is received. If the prescriber has not requested prior authorization, it may be obtained from the Local Medical Assistance Unit (See 10:49-1.24, "Directory of Local Medical Assistance Units"). When submitting claims for payment, make certain that the appropriate box on the claim form is checked off and the prior authorization number inserted. Prior authorization is approval to dispense a specific drug and is no guarantee that an individual is eligible for services.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

- ii. The area headed by "Check Appropriate Box" on the MC-6 claim form will be used to indicate prior authorization as well as medical certification as follows:
- (1) If no prior authorization is required, leave box blank;
  - (2) If prior authorization is required and exists, check the "Prior Authorization" box and indicate Prior Authorization number.
  - (3) If medical certification exists, check the "Medical Certification" box.
  - (4) If Prior Authorization and Medical Certification exist, check the box entitled "Both" and indicate the authorization number.

Item (16); PRESCRIBER'S INDIVIDUAL MEDICAID PRACTITIONER'S (IMP) NUMBER. Obtain this number from the IMP Number Directory. If the prescriber is not a Medicaid participating physician, print "non-par" in this area. If the prescriber practices solely in a hospital, fill this field with all 9's. For pharmacy providers calling from New Jersey, the toll free telephone number for assistance in obtaining IMP numbers is 800-582-7052. For pharmacy providers calling from out-of-state, the telephone number for assistance in obtaining IMP numbers is 609-293-2324.

Item (17); CHECK IF COMPOUND RX - check this box only if the prescription was compounded and write the ingredients and their quantities on the reverse side of the claim form. (Fold the tissue and carbon aside before writing on back of claim). Leave NDC area blank. Do not write "compound" in the NDC area. Do not enter multiple NDC's in that field to describe a compound.

Item (18); CHARGE: Enter Usual and Customary charge.

- i. Example - enter charge of \$11.79 as 01179
- ii. Example - enter charge of \$110.65 as 11065.
- iii. Note: The program now accepts up to five digits in the "charge field" (billed amount in the top right hand corner of claim). Providers using old style imprinters which imprint digits representing "date billed", number of refills, and a four digit charge, must leave indicator keys representing "date billed" (red key) and "number of refills" (white key) set at 0. Only when the charge exceeds \$99.99 should the white key be utilized for indicating the charge.

Item (19) and (20); DEFINED COST, DISPENSING FEE, TOTAL CHARGE, AND NON-LEGEND DRUG CHARGE. The use of these fields is not required for the processing of the claim.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

Please Note: When the plastic pharmacy card is available and the imprinter is used, fields identified as (1), (3) and (8) are automatically printed.

(e) Mailing addresses for claims

1. New Jersey pharmacies-claim form MC-6.

- i. All pharmacy providers in the State of New Jersey must submit Medicaid pharmacy prescription claim forms (MC-6) for processing within 90 days from the dispensing date to:

HOSPITAL SERVICE PLAN OF NEW JERSEY  
2 CHERRY HILL EXECUTIVE CAMPUS  
CHERRY HILL, NEW JERSEY 08034

2. Claim Return Statements and claims requiring special handling.

- i. Claim Return Statements should be mailed to P.O. Box 549, Newark, New Jersey 07101, "Attention: Claim Return Statements".
- ii. Claims for amounts billed which exceed \$49.99 should be mailed to P.O. Box 549, Newark, New Jersey 07101, and envelopes should be marked "Attention : 50".
- iii. Claims for compounded drugs and for cancer chemotherapeutic injections should also be mailed to P.O. Box 549, Newark, New Jersey 07101, and envelopes should be marked either "Attention: Compounded Drugs" or "Attention: Special Injection".
- iv. Claims for prior authorized services should be mailed to P.O. Box 549, Newark, New Jersey 07101, and envelopes marked "Attention: Prior Authorization".
- v. Mailing the above claims to P.O. Box 549, Newark, New Jersey 07101, is not mandatory. However, all special claims mailed to that address will receive special handling during processing. Mailing of claim types other than those stated above will delay processing.

3. Out-of-state pharmacy providers

- i. Out-of-state pharmacy providers must submit their claim form (MC-6) for processing within 90 days from the dispensing date to Newark.

New Jersey Health Services Program  
(New Jersey Blue Cross)  
P.O. Box 549  
Newark, N.J. 07101

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

ABBREVIATED DRUG CODES FOR THE MOST COMMONLY DISPENSED DRUGS

<u>PRODUCT NAME AND DESCRIPTION</u>	<u>ABBREVIATED CODE</u>	<u>PRODUCT NAME AND DESCRIPTION</u>	<u>ABBREVIATED CODE</u>
Actifed Syrup-----	012	Lanoxin Tabs 0.125mg-----	512
Actifed-C Expectorant----	024	Lanoxin Tabs 0.25mg-----	524
Actifed Tablets-----	036	Lasix Tabs 40mg-----	536
Aldactazide Tablets-----	048	Lasix Tabs 20mg-----	548
Aldactone 25mg Tablets---	050	Librax Capsules-----	550
Aldomet 250mg Tabs-----	062	Lomotil Tablets-----	562
Aldomet 500mg Tabs-----	074	Mellaril Tabs 25mg-----	574
Aldoril-25 Tabs-----	086	Mellaril Tabs 10mg-----	586
Ambenyl Expectorant-----	098	Mellaril Tabs 50mg-----	598
Amoxil Caps 250mg-----	100	Mellaril Tabs 100mg-----	600
Ativan Tablets 1mg-----	112	Monistat-7 Cream W/App.----	612
Bactrim-DS Tablets-----	124	Motrin Tabs 400mg-----	624
Benylin Cough Syrup-----	136	Naprosyn Tabs 250mg-----	636
Berocca Tablets-----	148	Neosporin Ophth. Sol'n-----	648
Benadryl 25mg Caps-----	150	Naldecon Tablets-----	650
Cefol Tablets-----	162	Naldecon Pediatric Syr.----	662
Clinoril Tabs 150mg-----	174	Ornade Spansules-----	674
Clinoril Tabs 200mg-----	186	Ovral-21 Tablets-----	686
Cogentin Tabs 2mg-----	198	Ovral-28 Tablets-----	698
Dalmane Caps 15mg-----	200	Parafon Forte Tabs-----	700
Dalmane Caps 30mg-----	212	Pavabid Caps 150mg-----	712
Darvocet-N 100mg Tabs----	224	Pen-Vee-K Tabs 250mg-----	724
Diabinese Tabs 250mg-----	236	Percodan Tablets-----	736
Dilantin Kapseals 100mg--	248	Periactin Syrup-----	748
Dimetane Expectorant-----	250	Periactin Tabs 4mg-----	750
Dimetane Expect.-DC-----	262	Persantine Tabs 25mg-----	762
Dimetapp Elixir-----	274	Phenergan Exp. Ped. W/DM----	774
Dimetapp Extentabs-----	286	Phenergan Exp. Plain-----	786
Donnatal Elixir-----	298	Phenergan Exp. W/Cod.-----	798
Donnatal Tablets-----	300	Phenergan VC Ecp. W/Cod.----	800
Drixoral Tablets-----	312	Poly-Vi-Flor Tabs-----	812
Dyazide Capsules-----	324	Poly-Vi-Flor W/Iron Tabs----	824
EES-200 Liquid-----	336	Quibron Liquid-----	836
EES-400 Liquid-----	348	Rondec DM Syrup-----	848
EES-400 Tabs-----	350	Slow-K Tablets-----	850
Elixophyllin Elixir-----	362	Tabron Filmseals-----	862
Empracet W/Codeine #3----	374	Tagamet Tabs 300mg-----	874
E-Mycin Tabs 250mg-----	386	Talwin Tablets 50mg-----	886
Fiorinal Tablets-----	398	Theragran Hematinic Tabs----	898
Fiorinal Capsules-----	400	Tranxene Caps 3.75mg-----	900
Hydrodiuril Tabs 50mg----	412	Tranxene Caps 7.5mg-----	912
Hydergine Oral Tabs 1mg--	424	Tuss Ornade Liquid-----	924
Hygroton Tabs 50mg-----	436	Tuss Ornade Spansules-----	936
Iberet Folic-500 Tabs----	448	Tylenol W/Codeine #3-----	948
Ilosone Liquid-125-----	450	Valium Tabs 2mg-----	950
Inderal Tabs 10mg-----	462	Valium Tabs 5mg-----	962
Inderal Tabs 40mg-----	474	Valium Tabs 10mg-----	974
Indocin Caps 25mg-----	486	Vibramycin Caps 100mg-----	986
Keflex Pulvules 250mg----	498	Zyloprim Tabs 100mg-----	998
Keflex Pulvules 500mg----	501		

BILLING PROCEDURES  
 PHARMACEUTICAL SERVICES MANUAL  
 Reporting Quantities Dispensed of Cancer Chemotherapy Injectables

The following list represents the most commonly dispensed cancer chemotherapy injectable drugs. These products do not require prior authorization.

To ensure complete and proper payment for all eligible quantities of these drugs dispensed, complete the claim form MC-6. Report only the total number of vials dispensed or the total number of cc's dispensed, in accordance with the following guidelines:

DESCRIPTION	REPORT QUANTITIES DISPENSED ONLY AS
Adriamycin Injection 10 mg	Total number of vials
Adriamycin Injection 50 mg	Total number of vials
Adrucil Injection 500 mg	Total number of vials
BICNU Injection	Total number of vials
Blenoxane Injection 15 units	Total number of vials
Cerubidine Injection 20 mg	Total number of vials
Cosmegen Injection 0.5	Total number of cc
Cytosar-U Injection 100 mg	Total number of vials
Cytosar-U Injection 500 mg	Total number of vials
Cytoxan Injection 100 mg	Total number of vials
Cytoxan Injection 200 mg	Total number of vials
Cytoxan Injection 500 mg	Total number of vials
Drolban Injection	Total number of cc
DTIC-Dome Injection 100mg	Total number of vials
DTIC-Dome Injection 200 mg	Total number of vials
Elspar Injection 10,000 Units	Total number of vials
Fluorouracil Injection 500 mg	Total number of cc
FUDR Injection 500 mg	Total number of vials
Methotrexate Inj. 2.5mg/2cc	Total number of cc
Methotrexate Inj. 20 mg/vial	Total number of vials
Methotrexate Inj. 25 mg/2cc	Total number of cc
Methotrexate Inj. 50 mg/vial	Total number of vials
Methotrexate Inj. 50 mg/2cc	Total number of cc
Methotrexate Inj. 100 mg/vial	Total number of vials
Methotrexate Inj. 100 mg/4cc	Total number of cc
Methotrexate Inj. 200 mg/8cc	Total number of cc
Mexate Inj. 20 mg/vial	Total number of vials
Mexate Inj. 50 mg/vial	Total number of vials
Mexate Inj. 100 mg/vial	Total number of vials
Mithracin Inj. 2500 Mcg/vial	Total number of vials
Mustargen Injection	Total number of vials
Mutamycin Inj. 5 mg/vial	Total number of vials
Oncovin Inj. 1 mg/vial	Total number of vials
Oncovin Inj. 5 mg/vial	Total number of vials
Platinol Inj. 10 mg/vial	Total number of vials
Teslac Injection	Total number of cc
Thiotepa Inj. 15 mg/vial	Total number of vials
Velban Inj. 10 mg/vial	Total number of vials

BILLING PROCEDURES

SAMPLE: MEDICAID DRUG REFERENCE CHART

LEGEND DRUGS

	LEGEND DRUGS	ORAL CONTRACEPTIVES	VITAMINS &/OR MINERALS	PREVENTIVE DRUGS	INJECTABLES	HYPODERMIC NEEDLES &/OR SYRINGES
DAYS SUPPLY	Up to 60 or 100 Unit doses, whichever is greater	105	Up to 100	up to 60 or 100 unit doses, whichever is greater	Up to 60 or 100 unit doses, whichever is greater	Up to 100
REFILLS ALLOWED	5*	5* within 6 months or 3* within 1 yr.	5* within 6 months or 2* within 1 yr.	5*	5*	5* within 6 months or 2* within 1 yr.
PRIOR AUTHORIZATION	NO	NO	NO	YES, unless patient is in LTCF	YES, unless patient is in LTCF	NO
ALLOWED FOR LTCF	YES	YES	YES	Yes, no autho. is required	Yes, no autho. is required	NO
PERIOD FOR REFILLS	6 mo.	within 1 year	within 1 year	6 mo.	6 mo.	within 1 yr.

\*Refills are not allowed for patients in LTCF unless receiving Level 4-B type care (See Chapter IV.)

NOTE: THIS CHART IS INTENDED FOR USE AS A READY REFERENCE AND DOES NOT SUPERCEDE THE REGULATION I THIS MANUAL

BILLING PROCEDURES

SAMPLE: MEDICAID DRUG REFERENCE CHART

NON-LEGEND DRUGS

	INSULIN	VITAMINS &/ or minerals	CONTRACEPTIVE MATERIAL	PROTEIN REPLACEMENTS	DIABETIC TESTING MATERIAL
DAYS SUPPLY	Up to 60 or 100 unit doses, whichever is greater	Up to 100	Up to 60 or 100 unit doses, whichever is greater	Up to 60 or 100 unit doses, whichever is greater	Up to 60 or 100 unit doses, whichever is greater
REFILLS ALLOWED	5	5 within 6 months or 2 within 1 yr.	5 within 6 months or 2 within 1 yr.	5	5
PRIOR AUTHORIZATION REQUIRED	NO	NO	NO	YES	NO
ALLOWED FOR LTCF	NO	NO	NO	NO	NO
PERIOD FOR REFILLS	6 mo.	within 1 year	within 1 year	6 mo.	6 mo.

NOTE: THIS CHART IS INTENDED FOR USE AS A READY REFERENCE AND DOES NOT SUPERCEDE THE REGULATIONS IN THIS MANUAL.

BILLING PROCEDURES

SAMPLE: MEDICAID DRUG REFERENCE CHART

LEGEND DRUGS

	LEGEND DRUGS	ORAL CONTRACEPTIVES	VITAMINS &/OR MINERALS	PREVENTIVE DRUGS	INJECTABLES	HYPODERMIC NEEDLES &/OR SYRINGES
DAYS SUPPLY	Up to 60 or 100 Unit doses, whichever is greater	105	Up to 100	up to 60 or 100 unit doses, whichever is greater	Up to 60 or 100 unit doses, whichever is greater	Up to 100
REFILLS ALLOWED	5*	5* within 6 months or 3* within 1 yr.	5* within 6 months or 2* within 1 yr.	5*	5*	5* within 6 months or 2* within 1 yr.
PRIOR AUTHORIZATION	NO	NO	NO	YES, unless patient is in LTCF	YES, unless patient is in LTCF	NO
ALLOWED FOR LTCF	YES	YES	YES	Yes, no autho. is required	Yes, no autho. is required	NO
PERIOD FOR REFILLS	6 mo.	within 1 year	within 1 year	6 mo.	6 mo.	within 1 yr.

\*Refills are not allowed for patients in LTCF unless receiving Level 4-B type care (See Chapter IV.)

NOTE: THIS CHART IS INTENDED FOR USE AS A READY REFERENCE AND DOES NOT SUPERCEDE THE REGULATION IN THIS MANUAL

BILLING PROCEDURES

SAMPLE: MEDICAID DRUG REFERENCE CHART

NON-LEGEND DRUGS

	INSULIN	VITAMINS &/ or minerals	CONTRACEPTIVE MATERIAL	PROTEIN REPLACEMENTS	DIABETIC TESTING MATERIAL
DAYS SUPPLY	Up to 60 or 100 unit doses, whichever is greater	Up to 100	Up to 60 or 100 unit doses, whichever is greater	Up to 60 or 100 unit doses, whichever is greater	Up to 60 or 100 unit doses, whichever is greater
REFILLS ALLOWED	5	5 within 6 months or 2 within 1 yr.	5 within 6 months or 2 within 1 yr.	5	5
PRIOR AUTHORIZATION REQUIRED	NO	NO	NO	YES	NO
ALLOWED FOR LTCF	NO	NO	NO	NO	NO
PERIOD FOR REFILLS	6 mo.	within 1 year	within 1 year	6 mo.	6 mo.

NOTE: THIS CHART IS INTENDED FOR USE AS A READY REFERENCE AND DOES NOT SUPERCEDE THE REGULATIONS IN THIS MANUAL.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

10:51-2.7 Payment Voucher

(a) The payment voucher(s) which will be included with the weekly check, lists all information necessary to identify the disposition of each submitted claim. Claims are reported on the voucher in claim number order. Upon receipt of payment, check relevant tissue copies of claims from your files against the voucher to verify and ascertain each claim's status. Paid claim tissues should be attached to the voucher and filed by date of payment in a permanent paid file.

(b) A facsimile of the voucher appears on the next page.



**Blue Cross**  
of New Jersey

**NEW JERSEY HEALTH SERVICES PROGRAM  
VOUCHER STATEMENT**

PAGE NUMBER	PHARMACY NUMBER	DATE OF PAYMENT
001	28012345	08/21/81

NEW JERSEY PHARMACY  
123 ANY ST  
YOUR CITY NJ 01234

- \*EXPLANATION CODES:**
- 00—Paid as billed less applicable regression
  - 01—Charge exceeds maximum allowable
  - 02—Product requires prior authorization
  - 03—Days supply exceeds program quantity limitation
  - 04—Dispensing date more than two (2) years prior to process date
  - 05—Dispensing date more than ninety (90) days prior to receipt date
  - 21—Product ineligible for Medicaid
  - 22—Product ineligible for patient in a Long Term Care Facility
  - 23—Product is ineligible for PAA
  - 24—Product is ineligible for GAP
  - 41—Maximum allowable number of refills exceeded
  - 42—Refilled beyond Program time limitations
  - 44—Refill too soon
  - 47—Claim pending Blue Cross review
  - 48—Transaction record returned for Provider action
  - 49—Transaction Record Returned to Service Bureau for Action
  - 50—Supplementary payment in full as requested
  - 51—Supplementary payment up to the allowable maximum
  - 52—Supplementary payment declined-Maximum allowable payment previously made
  - 60—Payment for previously declined claim
  - 61—Patient ineligible at time services were rendered
  - 62—An identical prescription was previously paid or declined
  - 65—Recapture of previously paid claim

BLUE CROSS LOCATOR NUMBER	RECIPIENT'S NAME	CASE NUMBER	PER NO	CLAIM NUMBER	METRIC QUANTITY	DAYS SUPPLY	DRUG ENTITY	PRESCRIPTION NO.	AUTH CD	EXPL CD	DISPENSING DATE MO DAY YR	AMOUNT BILLED	AMOUNT PAID
8119000860010	NEWARKCITY GENNAST	523412450	01	00101579	0100	025	0000140-0005-14	636940	0	01	071581	15.50	14.40
8119000860020	MCHENRY MICHAEL	072093764	01	00101580	0120	006	0000031-8407-25	636999	0	00	071581	3.60	3.60
8119000860030	JONES' ROSLYN	612345678	01	00101581	0100	050	*****-*****	637205	0	48	071681		
8119000860040	PAULKIEBSZ JOSEPH	071055588	01	00101582	0030	030	0000228-1428-99	637222	0	21	071681	4.87	
8119000860050	WITSTON CARLA	073099845	20	00101583	0240	012	0000005-3589-60	637304	0	00	071681	8.75	8.75
8119000860060	STEVENSON STACEY	073053776	21	00101584	0100	005	0000071-2301-17	638522	0	00	071781	4.50	4.50
8119000860070	KRONEHEYER CECELIA	073063636	20	00101585	0100	025	0000071-0525-24	612849	2	41	071781	7.60	
8119000860080	DAVISON MARIORI	073092766	320	00101586	0025	012	0000031-4235-63	622346	0	00	071781	4.10	4.10
8119000860090	WEBER ANTOINE	073028976	01	00101587	0480	032	0000005-5107-35	598646	0	3	071781	7.55	
8119000860100	INVENTOJA KATHERI	638744238	01	00101588	0030	060	COMPOUND	637344	0	00	071781	5.60	5.60
8119000860110	TRENT STEVEN	073066683	720	00101589	0030	030	0000007-3519-30	637704	0	5	071881	3.55	
8119000860120	WORTHINGTONALICE	071088473	301	00101590	0100	050	0000002-2103-03	637888	0	00	071881	11.80	11.80
8119000860130	AMATO ANTHONY	614532975	001	00101591	0060	060	0000081-0249-85	637899	0	00	071881	3.15	3.15
8119000860140	MALLON CRAIG	073074625	220	00101592	0100	100	*****-*****	638022	0	48	071881		
8119000860150	DEROGATIS SAMUEL	073054538	02	00101593	0050	050	0000005-3298-23	531048	0	62	052781		
***THE CLAIM LISTED ABOVE WAS PREVIOUSLY PAID OR DECLINED ON PAYMENT DATE													
8119000860160	TOWNSEND RAYMOND	614576993	701	00101594	0020	001	0000002-1108-01	638255	0	00	071981	7.50	7.50
8119000860170	COMERT JAMES	073011174	901	00101595	0040	010	0000368-5005-05	638284	0	48	071981		

**1** CLAIMS EXHIBITING INCORRECT NDCS OR THOSE NOT ON FILE WILL BE SHOWN WITH ASTERISKS (\*) IN THE DRUG ENTITY FIELD AND WILL SHOW EXPLANATION CODE 48, INDICATING THAT A CLAIM RETURN STATEMENT IS INCLUDED FOR NDC CORRECTION OR VERIFICATION. EXPLANATION CODE 48 WILL BE USED FOR PROVIDERS SUBMITTING HARD COPY CLAIMS. EXPLANATION CODE 49 WILL BE USED WHEN PROVIDER SUBMITS CLAIMS VIA TAPE.

**3** THIS CLAIM WAS DECLINED BECAUSE IT WAS REFILLED LATER THAN 6 MONTHS FROM THE ORIGINAL DISPENSING DATE.

**4** CLAIMS FOR COMPOUNDED DRUGS WILL BE IDENTIFIED BY THE WORD 'COMPOUND' IN THE NDC FIELD.

**6** ALL CLAIMS WHICH ARE DECLINED AS DUPLICATE CLAIMS (EXPL CD 62) WILL BE FOLLOWED BY A MESSAGE ON THE NEXT LINE WHICH IDENTIFIES ON WHICH PAYMENT DATE THE ORIGINAL CLAIM FOR THE IDENTICAL PRESCRIPTION FILED ON THE SAME DATE FOR THE SAME PERSON WAS PAID OR DECLINED.

**7** THE BLUE CROSS LOCATOR NUMBER HAS BEEN EXPANDED TO THIRTEEN DIGITS. IT IS IMPORTANT TO USE THIS COMPLETE NUMBER CORRECTLY WHEN REQUESTING ADJUSTMENTS SO THAT PROCESSING OF THE ADJUSTMENT REQUEST CAN BE DONE AS QUICKLY AS POSSIBLE.

**5** THIS CLAIM WAS DECLINED BECAUSE PRIOR AUTHORIZATION WAS NOT INDICATED ON THE CLAIM WHEN SUBMITTED. THE AUTH CD FIELD WILL SHOW EITHER PRIOR AUTH. (1), MEDICAL CERT. (2) OR BOTH (3) WHEN SUCH HAS BEEN INDICATED ON THE CLAIM.

**2** EXPLANATION CODE 41 IS USED FOR MORE THAN 5 REFILLS OF A MEDICAID PRESCRIPTION.

THE NEW VOUCHER STATEMENT WILL BE PRINTED ON ITS WIDE SIDE IN ORDER TO ACCOMMODATE ADDITIONAL INFORMATION WHICH IS PRINTED.

GRAND TOTALS

PAGE BILLINGS	PAGE ADJUSTMENTS	PAGE PAYMENT
88.07	23.67	64.40
TOTAL BILLINGS	TOTAL ADJUSTMENTS	NET PAYMENT
88.07	23.67	64.40

FD-243 (Rev. 4-81)

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

(c) A description and explanation of the columns follows:

- . BLUE CROSS LOCATOR NUMBER - a 13 digit number which allows BLUE CROSS to locate the claim in the files.
- . RECIPIENT NAME - the case last name and first name of the patient.
- . CASE NUMBER - The Health Services Program Eligibility Number
- . PERSON NUMBER - the number assigned to an individual person under the case number.
- . CLAIM NUMBER - an eight digit number identifying the submitted claim.
- . METRIC QUANTITY - the numeric quantity dispensed as indicated on the claim form (maximum of 4 digits).
- . DAYS SUPPLY - the number of days supply indicated on the claim form (maximum of 3 digits).

Note: N/A will appear on the voucher as a "1" day supply.

- . DRUG ENTITY - the numeric drug code that appeared on the claim form.

Exception: Certain eligible products under special conditions will appear as a word of definition or a combination of abbreviated words. These will be as follows:

- a. "UNLIST LEGEND" - certain unlisted legend products which are not included on the computer file even though an NDC has been issued.
- b. "UNLIST OTC" - unlisted OTC products - such products require prior authorization and are not on the computer file.
- c. COMPOUND - compounded prescriptions will give this indication in place of an NDC Number.
- d. UNLIST INJ - certain unlisted injectables which do not have an NDC number on the computer file.
- e. ALLERGY VAC - allergy vaccines which do not have an NDC number contained on the computer file.
- f. IRRIG SOL - irrigation solutions whose NDC number is not contained on the computer file.
- g. BIO INJECT - biological injectables whose NDC number is not contained on the computer file.
- h. PROTEIN REPL - protein replacement products whose NDC Number is not contained on the computer file.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

- i. MULTI CLAIMS - multiple claims - the designation is utilized for those recipients whose claim volume is extremely high where special notice has been sent to pharmacy providers indicating multiple claims will be paid as one claim.
- j. HYPO NEEDLE, HYPO SYRINGE, SYRINGE NEEDLE - these definitions refer to claims where hypodermic needles, hypodermic syringes or combination hypodermic syringes and needles were dispensed and the drug code for these products are not on the computer file.
- k. CHEMO INJ - chemotherapeutic injectables where the drug code is not maintained on the computer file.

NOTE: Invalid NDCs will not be displayed in this column, instead asterisks in an NDC configuration will appear. Claims with an invalid NDC will be returned via a Claim Return Statement.

- . PRESCRIPTION NUMBER - the prescription number that appeared on the claim form (represents the last 6 significant digits of the prescription number).
- . AUTH CD - AUTHORIZATION CODE - the code will reflect the prior authorization and/or medical certification and will be displayed as a single digit:
  - 0 = no authorizations indicated;
  - 1 = prior authorization indicated;
  - 2 = medical certification indicated;
  - 3 = both prior authorization and medical certification indicated.
- . EXPL CD - explanation code - a two digit number identifying the status of claim. The explanation codes are listed at the top right of the voucher to explain the numerical designation in the column. These explanation codes are listed below with some of the definitions expanded.
  - Code 00: The claim has been paid as billed less applicable regressive percentage.
  - Code 01: The amount paid has been reduced to the maximum allowable payment based on the information received.
  - Code 02: Product requires prior authorization. It is necessary to obtain an authorization number from the local Medicaid office prior to dispensing certain products. Review Section 10:51-1.13.
  - Code 03: Days supply exceeds program's limitations. Review section 10:51-1.7.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

- Code 04: Dispensing date more than two (2) years prior to processed date.
- Code 05: Dispensing date more than ninety (90) days prior to receipt date.
- Note: A review for waiver of the ninety (90) day limitation is possible under extenuating circumstances only.
- Code 21: Product ineligible for Medicaid. Review section 10:51-1.2 and 10:51-1.14.
- Code 22: Product ineligible for Medicaid for a patient in a long-term care facility.
- Code 23: Product is ineligible under the Pharmaceutical Assistance to the Aged Program.
- Code 24: Product is ineligible for GAP (General Assistance Program).
- Code 41: Maximum allowable number of refills exceeded. Review section 10:51-1.12.
- Code 42: Refilled beyond program time limitations. Medicaid claims refilled six months or more after original dispensing date are ineligible (Note exceptions for oral contraceptives, vitamins and minerals, hypodermic needles and syringes). PAA claims refilled one year or more after original dispensing date are ineligible.
- Code 44: Refilled to Soon - A sufficient time period must be allowed between filling of the prescription to allow 75% of a prescription to be consumed.
- Code 47: Claim pending Blue Cross review - processing incomplete - claim requires manual adjudication by Blue Cross.
- Code 48: Transaction record returned for provider action. See the next section 10:51-2.8 concerning "Claim Return Statements". It is the provider's responsibility to review all Claim Return Statements and verify that each claim on the voucher with an explanation Code 48 is represented by a Claim Return Statement.
- Code 49: Transaction record returned to service bureau for action - this code will apply only to claims that have been submitted via magnetic tape.
- Code 50: Supplementary payment in full as requested.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

- Code 51: Supplementary payment up to the maximum allowable, - payment has been made based on the information supplied.
- Code 52: Supplementary payment declined - maximum allowable payment previously made. The information supplied for adjustments was reviewed but did not alter payment.
- Code 60: Payment for previously declined claim. This was the result of an adjustment request.
- Code 61: Patient ineligible at the time services were rendered.
- Code 62: An identical prescription was previously paid or declined. When a claim declines as a Code "62" the next line on the voucher will read "CLAIM LISTED ABOVE WAS PREVIOUSLY PAID OR DECLINED ON PAYMENT DATE ---" and the date of the voucher payment will appear under the column headed "dispensing date". Please review vouchers of the indicated date to verify the payment or decline of that claim.

Code 65: Recapture of previously paid claim.

- . DISPENSING DATE - the dispensing date indicated as month/day/year which appeared on the claim form.
- . AMOUNT BILLED - the requested payment as indicated on the claim form.
- . AMOUNT PAID - the determined payment for the claim based on the information supplied.

**BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL**

10:51-2.8 Claim Return Statement (form FD-237)

PLEASE CORRECT AND RETURN:											STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES <b>CLAIM RETURN STATEMENT</b>											DATE				
CLAIM NUMBER			CASE NO.			PHARMACY NUMBER			CHARGE			FIRST INITIAL		PER NO.		DISP. DATE MO. DAY YR.			RX NO.			NATIONAL DRUG CODE			METRIC QUAN.	
01			02			03			06			06		07		08			09			10			11	
DAYS SUPPLY		LTCF	AUTH. CD.	PRIOR AUTHORIZATION NO.		PRESCRIBERS IMP. NO.			FOR PLAN USE ONLY					IF NO CODE, GIVE PRODUCT NAME, DOSAGE FORM, STRENGTH & MANUFACTURER												
									TRAN CODE	ADJ.	DEC. CD.	OVER RIDE	PAYMENT													
12		13	14	15		16			17	18	19	20	21													
PATIENT NAME (LAST, FIRST, MIDDLE INIT.)									ERROR CODES																	
									1	2	3	4	5													

FD-237 (4-81)

(a) This form is an instrument for the provider to correct invalid claim information which is preventing the final payment processing determination of a pending claim. This form is automatically issued on a weekly basis, included with the voucher statement, and is indicated by a Code 48 under the explanation code on the voucher. Duplicate copies of a Claim Return Statement will be available upon request.

(b) A Claim Return Statement will also be utilized for Explanation Code 49; however such forms will be returned to the service bureau which may re-enter the total claim information (with corrections) via tape or return the statement to the provider for further action.

(c) Claim Return Statements should be completed as soon as practical and submitted to Blue Cross of New Jersey; however the time limitation for normal claims submittal (no later than 90 days' from the date of statement return) will apply.

(d) Questions regarding the proper completion of the Claim Return Statement are to be directed to New Jersey Blue Cross, P.O. Box 549, Newark, New Jersey 07101, Attention: Claim Return Statements or call toll free (800) 242-0809 between 8:30 A.M. and 4:15 P.M. (Monday through Friday, except holidays).

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

(e) For each Claim Return Statement issued, the fields in the various boxes will contain information concerning the individual claim in question. In cases where information was missing, the field will be blank or "0" filled. In the case of an invalid National Drug Code, that field will contain an asterisk.

(f) Corrections are made to the Claim Return Statement by entering the correct information in the box immediately below the field in error as follows:

1. In the top left hand corner of each such box to be used for correction there appears a number. In the procedures for correcting various "error codes" these correction fields will be referred to with the corresponding number. In the lower portion of the form an area entitled "error codes" will display the error code(s) in the form of a three digit number which will provide the reason(s) the claim could not be processed.

2. Required action by the pharmacy provider will be indicated by:

i. A blank or zeros will appear in those fields where information is missing or in the case of an erroneous National Drug Code, an asterisk will appear.

ii. Numeric error codes in the error code area of the Statement.

iii. A brief explanation of the error condition at the bottom of the Statement.

iv. To properly correct the claim information refer to the original information used to prepare the claim and institute correction procedures as listed below:

<u>Error Code</u>	<u>Description-Explanation</u>	<u>Instructions</u>
014	Payment determined by computer would be 0.	Review the charge (billing amount), National Drug Code and metric quantity to ascertain that proper information had been submitted. Enter corrections in the appropriate fields.
018	Pharmacy charges are far less than what would be expected based on claim information submitted.	Review charge (billing amount), National Drug Code and metric quantity to ascertain that proper information had been submitted for payment. Enter corrections in appropriate fields if indicated.
020	National Drug Code does not match a product currently contained on the computer file.	Review National Drug Code submitted. If the National Drug Code as submitted on the original

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

<u>Error Code</u>	<u>Description-Explanation</u>	<u>Instructions</u>
020 (Cont'd)		claim was correct insert that code in the NATIONAL DRUG CODE correction field, (#10), and insert an "N" next to the asterisk in the National Drug Code field. In such cases always provide product information in the field below the NDC correction box labeled "IF NO CODE, GIVE PRODUCT NAME, DOSAGE FORM - etc." If the NDC originally submitted was incorrect enter the new NATIONAL DRUG CODE into the NDC correction field (#10).
104	Case Number invalid - missing, illegible or not all numeric.	Enter the valid case number in CASE NO. correction field (#02).
107	Metric quantity invalid - missing or illegible.	Enter quantity dispensed in METRIC QUAN. correction field. (# 11).
108	Charge invalid - illegible or not all numeric.	Enter billed amount in CHARGE correction field (# 05).
109	Patient name invalid - missing, illegible or not all alphabetic.	Enter first initial in FIRST INITIAL correction field (# 06).
110	Person number invalid - missing, illegible, or not equal to a number between 01 and 49.	Enter the correct valid person number in PER. NO. correction field (# 07).
111	Dispensing date invalid - missing, illegible or date exceeds maximum number allowed for the corresponding month.	Enter correct date in DISP. DATE correction field (# 08), as month, day, year. Example: 01/05/81 or 10/15/81.
113	Prescription number invalid - missing or illegible.	Enter valid prescription number in RX NO. correction field (# 09).
114	National Drug Code invalid - missing, illegible or incomplete.	Enter NDC in NATIONAL DRUG CODE correction field (#10), or if no code enter product name, strength, manufacturer in box below the NDC correction field. If the prescription is a compound enter "compound" in the National Drug Code field next to the asterisk.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

<u>Error Code</u>	<u>Description-Explanation</u>	<u>Instructions</u>
114 (Cont'd)		Do not enter the word "compound" into the NDC correction field. List the ingredients and amounts contained in the compound in the area below the NDC correction field. "IF NO CODE GIVE PRODUCT NAME, ETC."
115	Days supply invalid - missing or illegible.	Enter the number of days supply in DAYS SUPPLY correction field (#12). If not applicable enter N/A.
116	LTCF (long-term care facility) indicator is missing.	Enter correct status in LTCF correction field (#13) by indicating a "1" (yes) if patient is in a LTCF or a "2" (No) if patient does not reside in a LTCF. Use the numeric digits 1 or 2 to indicate recipient's status. Do not place the word "yes" or "no" in the LTCF correction field.
118	Prior authorization number missing and prior authorization was indicated on the original claim submitted.	Enter prior authorization number in PRIOR AUTHORIZATION NO. correction field (#15). If prior authorization was not needed or intended - indicate by an entry to the AUTH. CD. correction field (#14). This is accomplished by entering a "0" in the AUTH. CD. correction field. If only medical certification was intended enter "2" in AUTH. CD. correction field (#14).
119	Provider's IMP (Individual Medicaid Practitioner) Number invalid-missing or improper configuration.	Enter correct prescriber's IMP number in PRESCRIBER'S IMP NO. correction field (#16). If prescriber is non-participating print "NON PAR." in correction field.
154	Charge invalid - missing.	Enter amount billed (charge) in CHARGE correction field (#05).

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

<u>Error Code</u>	<u>Description-Explanation</u>	<u>Instructions</u>
197	Provider number (pharmacy number) invalid - provider number utilized was invalid for recipient's program. Most frequent error is that the long-term care provider number was submitted for PAA or General Assistance recipient.	Enter regular Medicaid provider number in PHARMACY NO. correction field (#03), if recipient is under the Medicaid Program and not a LTCF recipient or is a recipient under the PAA Program. Enter the LTCF provider number only if the recipient is under the Medicaid Program and resides in a LTCF.
200	Prescriber IMP number submitted does not match prescriber on file.	Review IMP number as it appears on Claim Return Statement to determine if a transposition error had occurred. If a transposition had occurred please enter the correct number in the PRESCRIBER IMP. NO. correction field (#16). If number shown on Claim Return Statement was correctly transcribed - enter prescriber's last and first name in the prescriber's IMP. NO. correction field. If prescriber is not participating - enter "NON PAR." in correction field.
300	Case number submitted does not appear on eligibility file.	Review submitted eligibility information - if any fields are incorrect make the appropriate entries in the correction fields. If case number, person number and first initial appear correct (on Claim Return Statement) contact the appropriate agency (as listed below) to verify eligibility.
301	Person number submitted is not on file.	
302	Patient first name does not match person number under case number submitted.	
		<ul style="list-style-type: none"> <li>. County Welfare Agency</li> <li>. District Office of Youth and Family Services</li> <li>. local Medicaid office</li> </ul> <p>If the above agency confirms the recipient was eligible when the service was rendered please request that the agency take action necessary to update the Medicaid eligibility file. Please note that claims cannot be paid until the Medicaid eligibility file is</p>

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

<u>Error Code</u>	<u>Description-Explanation</u>	<u>Instructions</u>
300		updated. Such action normally takes approximately three weeks.
301		After that time period, call toll free 800-242-0861 to verify that the correction has been made before re-submitting the Claim Return Statement.
302 (cont'd)		

Note: Medicaid recipient eligibility information may be obtained 8:30 A.M. to 4:15 P.M. Monday through Friday except holidays by calling 800 242-0861. Appropriate staff at Blue Cross of New Jersey will be available to accept no more than three (3) case inquiries per call. This limit is necessary to prevent delays in servicing the large number of calls received.

Due to laws governing the confidentiality of personal information, ONLY the following types of eligibility inquiries will be answered for any given Case Number, Person Number, patient's first and last name and birthdate:

1. Is the person eligible on the date of service?
2. Are the Case Number, Person Number and Name correct as stated?
3. Which governmental agency has control of the eligibility record in the event changes or corrections are necessary?

To assure timely handling of calls, it is suggested that the following format be used in requesting information:

1. Identify yourself:  
Caller's name - type of provider - provider number - county.
2. Identify recipient in question as follows:  
Case number - person number - recipient's first name - recipient's last name - recipient's birthdate.
3. Present Inquiry:  
Is recipient eligible on date of service?  
Are the case number, person number, and name correct as stated?

Inquiries concerning Medicaid Prescription Program matters other than eligibility questions should be directed to 800-242-0809.

(g) Claim Return Statements are to be mailed to:

New Jersey Health Services Program  
(New Jersey Blue Cross)  
P.O. Box 549  
Newark, New Jersey 07101  
Attention: Claim Return Statements

**BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL**

**10:51-2.9 Medicaid Pharmacy Adjustment Request (form FD-238)**

COPY SHADED INFORMATION EXACTLY AS ON VOUCHER										PHARMACY NUMBER																									
DATE OF PAYMENT				PAGE NUMBER				VOUCHER EXPLANATION CODE				NAME AND ADDRESS OF PHARMACY																							
BLUE CROSS LOCATOR NUMBER																																			
CASE NUMBER										PER. NO.																									
ADJUSTMENT NO.	LINE 1	ENTER CORRECTED INFO. ONLY ELIGIBILITY ONLY →		01	CLAIM NO.				02	CASE NUMBER				06	07	PER. NO.	08	DISP DATE		CASE LAST NAME															
	LINE 2	PAYMENT PRICING ONLY →		AMOUNT BILLED				05	AMOUNT PAID				01	CLAIM NO.				05	CHARGE		08	DISP DATE		09	RX NUMBER		10	NATIONAL DRUG CODE		11	QTY		12	UNIT PRICE	
	LINE 3	CHECK APPROPRIATE BOX		14	PRIOR AUTHORIZATION				MEDICAL CERTIFICATION				BOTH		15	AUTHOR. NO.																			
COMMENTS																																			
DATE										PREPARED BY										PROVIDER FILE COPY															
																				STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES <b>ADJUSTMENT REQUEST FORM</b> FD-238 (4-81)															

(a) This form is an instrument for:

1. Requesting adjustment for a contested paid claim.
2. Correcting erroneous information on declined claims to seek a reverse decision.

(b) Time limitation: Adjustment requests for all claims must be received by Blue Cross of New Jersey not later than 180 days after the claim in question appeared on a payment voucher. It should be noted that the 180 day limit does not apply to adjustment requests submitted due to patient eligibility. In this instance the time limitation is two years when the failure to establish timely eligibility on file was the fault of the certifying agency (County or State).

(c) Completion of the Adjustment Request form: Always complete the first three lines of information (shaded areas) in the top portion of the Adjustment Request form. This information should be copied and entered exactly as it appears on the voucher. Do not enter corrections in this area (first three lines of shaded areas.) The following areas will always be completed for every adjustment request:

1. Date of payment;
2. Page number of voucher;
3. Voucher explanation;

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

4. Blue Cross locator number;
5. Case number and person number, and
6. Pharmacy number, name and address. The imprinter may be utilized to insert this information only when using new style imprinter (imprinter without the date wheel). Do not use old style imprinter (imprinter with a date wheel) to fill in this information as the date will fall in the wrong area on this form.

(d) Procedure to request adjustment of an explanation code 61 (patient ineligible at time services were rendered). After completing the adjustment form as indicated in 10:51-2.9(c), claims which were declined as "61s" can have a request for adjustment made by entering new or corrected information in the area designated line 1 - "eligibility only". Enter only the corrected information on this line but in all cases enter the dispensing date of the claim and the Case Last Name.

1. CLAIM NO.: If there is no change in the claim number, do not enter that information. (See 10:51-2.9(f) for exception).

2. CASE NUMBER: If there is a different case number than that which appeared on the voucher, enter the case number. In cases where the County Welfare Agency has indicated that a case number has been reinstated as eligible, enter the case number as it originally appeared on the claim.

3. PER NO.: If the person number displayed on the voucher is incorrect, enter the correct person number.

4. DISP. DATE: Always enter date claim was dispensed.

5. CASE LAST NAME: Always enter recipient CASE name when requesting eligibility adjustment.

(e) Adjustment request due to insufficient payment or outright decline (for other than eligibility). Enter initial information as described in 10:51-2.9(c). In area designated as line 2 "payment pricing only" enter amount billed and amount paid in the shaded areas as it appeared on the voucher. Enter new or corrected information in the areas on lines 2 and 3 only when the information displayed on the voucher was incorrect.

1. CLAIM NO.: Enter claim number only if the original claim number (as shown on the voucher) was in error (See section 10:51-2.9(f) for exception).

2. CHARGE: If the amount charged as it appeared on the voucher (amount billed) was incorrect, enter the corrected amount in this area.

3. DISP. DATE: If the dispensing date as it appeared on the voucher was in error, enter the correction in this field.

4. RX NUMBER: If the prescription number as it appeared on the voucher is in error, enter correction in this field. Please note only the last six significant digits are utilized to describe the prescription number.

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

5. NATIONAL DRUG CODE: Enter a new or corrected code only if different than the code displayed on the voucher. In cases where a numeric code is not indicated and instead a written product description is given enter product or ingredient information in the area at the bottom of the form indicated for comments and place an "N" in the area for the National Drug Code.

6. METRIC QUANTITY: Enter a new or corrected metric quantity only when different than the metric quantity displayed on the voucher.

7. DAYS SUPPLY: Enter a new or corrected days supply only if it is different than the days supply appearing on the voucher.

Notes:

i. N/A will appear as a one day supply on the vouchers.

ii. The area designated as "Line 3" concerns prior authorization or medical certification. In cases where an adjustment is requested due to the lack of prior authorization or medical certification on the original claim, the appropriate box should be checked. In cases where "prior authorization" or "both" have been checked, an authorization number must be entered into the "Author. No." field.

iii. In requesting adjustments for Explanation Codes 04 or 05 (which indicate the dispensing date exceeds time limitations for submittal of claim) the Adjustment Request form should be completed and forwarded along with a detailed letter of explanation as to the reason an adjustment exception should be made.

(f) Interim need for claim number information on Adjustment Request form. Under the revised claim processing system, the new voucher format allows the display of 13 digits for the Blue Cross locator number. This expanded number indicates the specific location of an individual claim, eliminating the need for "claim number" information on the Adjustment Request forms. However, the Blue Cross Locator Number for claims processed under the previous voucher format will contain only eight digits, which alone will not identify the specific claim. Therefore, all requests for claim adjustment where the Blue Cross Locator Number consists of only eight digits requires that the claim number be indicated on the adjustment form in the "CLAIM NO." box ("Line 1" or "Line 2") in order that the adjustment can be processed.

(g) Mailing instructions

1. The Adjustment Request form consists of two parts; the copy indicated as the "Action Copy" is to be mailed to:

New Jersey Health Services Program  
(New Jersey Blue Cross)  
P.O Box 549  
Newark, New Jersey 07101

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

2. The copy indicated as the "Provider File Copy" should be retained by the provider for his/her records and follow-up. The claim will be reprocessed with the new or corrected information and will appear on a future voucher with the resultant disposition.

10:51-2.10 Follow-up claims investigation procedure

(a) This procedure is to be used when:

1. A claim has never appeared on the voucher statement and thirty (30) days has passed since the submittal of that claim.

2. A claim which appeared on a voucher statement with an Explanation Code 47 has after 30 days (from the date of the voucher statement) not appeared again.

3. Only when 10:51-2.10(a)1 or 10:51-2.10(a)2 exists for an individual claim, the following procedure should be used:

i. Review the claim information for completeness and make any necessary corrections;

ii. Obtain a copy of the claim tissue for the claim in question. If a claim tissue is not available transcribe the original claim information onto a new claim form. When utilizing a new claim form for the follow-up claim procedure, enter the word "re-submission" in the patient signature area.

iii. Mail the copy of the tissue or the new claim form to:

New Jersey Health Services Program  
(New Jersey Blue Cross)  
P.O. Box 549  
Newark, New Jersey 07101  
Attention: Follow-Up Claim

iv. Each claim so received will be reprocessed and should appear on a future voucher statement with its proper disposition.

(b) In the case of claims whose Explanation Code was 48 or 49 that have not appeared on a voucher after 30 days since the Claim Return Statement had been submitted to Blue Cross, the provider should request a duplicate copy of the Claim Return Statement which will allow the initiation of action for that claim after corrections have been made and submitted.

(c) Inquiries regarding additional information of a specific claim form or to request a duplicate Claim Return Statement form should be directed to the Medicaid Inquiry Section at (201) 456-2894, 2895, 2896, 2897, or 2898, or call toll free (800) 242-0809. Mail written inquiries to:

New Jersey Health Services Program  
(Blue Cross of New Jersey)  
P.O. Box 549  
Newark, New Jersey 07101

**BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL**

10:51-2.11 Ordering forms, envelopes, supplies - form #5355(4/81)

(a) Use the Medicaid/PAA Order form 5355(4/81) to order claim forms, envelopes and other supplies.

(b) Always order a sufficient quantity of supplies to last approximately three (3) months. Anticipate a four week period for handling and shipping all orders.

<p><b>FROM:</b></p> <p>BLUE CROSS OF NEW JERSEY</p> <p>NEW JERSEY HEALTH SERVICES PROGRAM</p> <p>P.O. BOX 549</p> <p>NEWARK, N.J. 07101</p>	<p><b>TO:</b></p>	<p>_____ NAME OF PHARMACY <span style="float: right;">PROVIDER NUMBER</span></p> <p>_____ STREET ADDRESS</p> <p>_____ CITY <span style="margin-left: 150px;">STATE</span> <span style="float: right;">ZIP CODE</span></p>
---	-------------------	---

**MEDICAID/PAA ORDER FORM**

SUBMIT TOP TWO COPIES - RETAIN THIRD FOR YOUR RECORDS.  
ALLOW FOUR WEEKS FOR HANDLING AND SHIPPING.

DATE \_\_\_\_\_

FOR PLAN USE ONLY

DATE FILLED \_\_\_\_\_

<u>TITLE OR DESCRIPTION OF FORM</u>	<u>FORM NUMBER</u>	<u>INDICATE QUANTITY OF ITEMS REQUIRED</u>
Medicaid/PAA Prescription Claim Form	MC-6	_____
Claim Envelope - Cherry Hill Location	1070	_____
Medicaid/PAA Claim Return & Adjustment Envelope (P.O. Box 549)	523	_____
Medicaid/PAA Adjustment Request Form	FD-238	_____
Medicaid/PAA Order Form	5355	_____

5355(4/81)

BILLING PROCEDURES  
PHARMACEUTICAL SERVICES MANUAL

10:51-2.12 Tape-to-tape claims and computer generated hard copy claims

(a) In addition to the conventional claim form MC-6 which is hand-prepared, the Division of Medical Assistance and Health Services will authorize the submission of claims which may either be created on hard copy by computer or created on magnetic tape.

(b) Providers may contact the following office for complete details and explanation of requirements for such methods of claim submission:

Technical Services Operations  
Blue Cross of New Jersey  
33 Washington Street  
Newark, New Jersey 07102  
(201) 456-3317

(c) Tape-to-tape incentive payment rules are:

1. An incentive payment will be available to approved pharmacies which submit Medicaid and/or PAA claims on magnetic tape. Incentive payment will be made when the total volume of paid magnetic tape Medicaid/PAA claims, submitted by pharmacy providers as a whole, equals or exceeds 20 per cent of the total volume of paid Medicaid/PAA claims.

2. The amount of the incentive payment will be determined according to the following schedule:

<u>% of Total Medicaid/PAA Paid Claims</u>	<u>Amount of Incentive Payment</u>
If tape claims comprise:	The incentive payment is:
20-29%	2 cents/tape claim
30-39%	3 cents/tape claim
40-55%	4 cents/tape claim
Over 55%	5 cents/tape claim

3. The incentive payment program, which began on January 1, 1979, is based upon the percentage of tape claims paid in the previous month. If the volume of paid tape claims is less than 20 per cent of the total, no incentive payments will be made. In that event, incentive payments will begin with the month following the month in which the volume of tape claims reaches 20 per cent of the total paid claims volume. A qualified tape-to-tape provider will receive a separate incentive payment check for all tape claims paid during the preceding month.

4. Claim volume figures will be reviewed and averaged quarterly. The claim volume totals for the previous quarter will determine the amount of incentive for the subsequent quarter.

5. The incentive payment is an additional fee increment for tape claims only, over and above the dispensing fee allowed by the Program.

6. In order to be eligible to submit magnetic tape claims for the Medicaid or PAA programs, a provider must complete form FD-103 and receive approval by the Division.

PHARMACEUTICAL SERVICES MANUAL

INDEX

SUBCHAPTER 3

PHARMACEUTICAL SERVICES PROVIDED TO MEDICAID  
PATIENTS IN LONG-TERM CARE FACILITIES

N.J.A.C. TITLE 10 - CHAPTER 51

	Subchapter	Page
Introduction .....	3.1	1
Covered Pharmaceutical Services .....	3.2	1
Definitions .....	3.3	1-2
General Policies For Participation .....	3.4	2-3
Prescription Drug Policies .....	3.5	3-4
Quantity of Medication.....	3.6	4
Dosage and Directions .....	3.7	4-5
Telephone Ordered Original Prescriptions .....	3.8	5
Changes or Additions to the Original Prescription ...	3.9	5
Non-proprietary or Generic Dispensing .....	3.10	6
Prescription Refill .....	3.11	6
Services Not Eligible For Reimbursement .....	3.12	6-7
Payment Regulations For Prescribed Drugs .....	3.13	7
Basis of Payment .....	3.14	7-9
Capitation of Dispensing Fee For Legend Drugs .....	3.15	9-10
Maximum Charges .....	3.16	10-11
Compounded Prescriptions .....	3.17	11
Instructions For Completing Prescription .....	3.18	11
Claim (form MC-6)		
Capitation Fees .....	3.19	11
Provider Agreement .....	3.20	12
Tape-to-tape Incentive Program .....	3.21	13

## PHARMACEUTICAL SERVICES MANUAL

### SUBCHAPTER 3. PHARMACEUTICAL SERVICES PROVIDED TO MEDICAID PATIENTS IN LONG-TERM CARE FACILITIES

#### 10:51-3.1 Introduction

(a) This subchapter provides information to providers of pharmaceutical services to Medicaid eligibles in long-term care facilities, regarding billing and refills, reimbursement, and so forth, which is substantially different from the information in subchapter 2 of this chapter.

(b) The services defined below are reimbursable under the New Jersey Medicaid Program for eligible patients/residents in Medicaid-approved skilled nursing facilities, intermediate care facilities or infirmary sections of homes for the aged (referred to collectively as long-term care facilities) only.

#### 10:51-3.2 Covered pharmaceutical services

(a) Covered pharmaceutical services are:

1. Prescribed legend drugs;
2. Prescribed legend contraceptive devices;
3. Prescribed devices-debrisan.

(b) All the above services must be provided within the scope of the New Jersey Medicaid Program policies and procedures and billed to the Hospital Service Plan of New Jersey (Blue Cross of New Jersey) on the prescription claim (form MC-6), or other program approved billing methods.

#### 10:51-3.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Conventional distribution system" means, under the New Jersey Medicaid Program, a system in which single or multiple doses of oral medication are dispensed in a reclosable container (that is, capsule, vial, jar, bottle, and so forth).

"Eligible pharmacies in New Jersey" means all pharmacies located in New Jersey and operating under a valid retail permit or a valid institutional permit from the Board of Pharmacy of the State of New Jersey, having an approved Long-Term Care Provider Application and Agreement with the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (herein after called the Division).

## PHARMACEUTICAL SERVICES MANUAL

NOTE: Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. The new owner(s) must apply to the Division of Medical Assistance and Health Services and execute a new agreement in order to participate in the New Jersey Medicaid Program.

"Eligible prescribers" means all practitioners licensed or authorized by the State of New Jersey to prescribe drugs and medicines (physicians, dentists or podiatrists), within the scope of their license and practice.

"Pharmacies out-of-state" are not eligible for participation as providers of services covered by this subchapter.

"Unit dose distribution system" means, under the New Jersey Medicaid Program, a drug distribution system in which each dose of oral medication (solid and liquid) is individually packaged in a sealed, tamper-proof container and carries full disclosure labeling, including, but not limited to, product name and strength, manufacturer or distributor's name, lot number and expiration date, and is delivered in a 24-hour supply.

"Modified unit dose distribution system" means, under the New Jersey Medicaid Program, a drug distribution system in which all oral solid medication is delivered in a unit dose mode, either as a single entity or "bingo" card, and is delivered in a greater than 24-hour supply up to a 30-day supply.

### 10:51-3.4 General policies for participation

(a) Participating pharmacies must provide complete prescription services, including injectables and injectable anti-neoplastic agents, compounding and prescription refill services when allowable in accordance with the drug distribution systems described in this subchapter. Prescriptions must be dispensed in compliance with all currently existing Federal and State laws, based on sound professional judgment.

(b) Participating pharmacies must permit properly identified representatives of the Division of Medical Assistance and Health Services to perform the following:

1. Inspect written prescriptions on file.
2. Audit records pertaining to covered persons.
3. Inspect private sector records, where deemed necessary, to comply with the Federal regulations to determine a pharmacist's "usual and customary charges to the public." Information pertaining to the patient's name, address and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

PHARMACEUTICAL SERVICES MANUAL

- i. Drug name;
- ii. Quantity dispensed;
- iii. Price;
- iv. Prescription number (for reference purposes only);
- v. Date dispensed.

10:51-3.5 Prescription drug policies

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws and as listed herein. However, no payment shall be made for certain drugs under specific conditions. (See exceptions which follow:)

1. Exceptions:

- i. Pharmaceutical services not eligible for payment (see section 10:51-3.12);
- ii. Non-legend drugs.

(b) The New Jersey Drug Utilization Review Council Formulary (hereafter referred to as the Formulary) dated July 9, 1979 and all subsequent revisions, distributed to all prescribers and pharmacists, supersedes the New Jersey Medicaid Formulary dated November 11, 1975.

(c) The Prescription Drug Price and Quality Stabilization Act (N.J.S.A. - 24:6E-1) shall apply to the New Jersey Health Services (Medicaid) Program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute". The prescriber must initial one of the statements in addition to signing the prescription blank.

1. When the prescriber does not initial either statement on a prescription for a drug product listed in the Formulary, the pharmacist shall substitute from the list of interchangeable products, and bill Medicaid accordingly.

2. When the prescriber initials "Substitution Permissible" the pharmacist shall dispense and bill Medicaid for one of the less expensive products listed as interchangeable with the brand name prescribed. The Medicaid client must accept the interchangeable product unless the client is willing to pay the pharmacy's full usual and customary price. If that occurs, the pharmacist shall so note on the prescription blank and no claim shall be submitted to Medicaid.

## PHARMACEUTICAL SERVICES MANUAL

3. When the prescriber initials "Do Not Substitute", the pharmacist shall dispense and bill Medicaid for the prescribed product. Reimbursement shall be the Average Wholesale Price less applicable regressive discount plus applicable capitation fee or the usual and customary charges, whichever is less for that product.

4. When the prescriber orders by generic name, the Formulary does not apply. The pharmacist shall dispense the least expensive, therapeutically effective product available to him/her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.

(d) The Federal Maximum Allowable Cost (MAC) regulations prescribe the upper limit Medicaid may reimburse for certain multi-source drugs. The limit shall apply to all MAC drugs, unless the prescriber indicates in his/her own handwriting on each written or telephoned prescription (see section 10:51-3.8) "Brand Necessary" or "Brand Medically Necessary". The U.S. Department of Health and Human Services requires a handwritten statement and does not permit the use of alternatives, such as a check box, initials, or prescriber's signature next to a preprinted statement "Do Not Substitute". For purposes of reimbursement, the physician's override capability under N.J.S.A. 24:6E-1 does not apply to drugs which have a federal MAC limit.

(e) Blanket authorization denying substitutions will not be permitted. Each prescription for MAC drug must contain the statement, "Brand Necessary" or "Brand Medically Necessary" in the prescriber's own handwriting each time the prescriber chooses not to allow substitution on a MAC drug.

### 10:51-3.6 Quantity of medication

When the quantity of drug or medication is not indicated in writing by the prescriber, the pharmacy provider must dispense an appropriate quantity of medication not to exceed a one month supply (see 10:51-3.11, Prescription Refill).

### 10:51-3.7 Dosage and directions

(a) Dosage and directions for use must be indicated on all prescriptions. Prescriptions written and dispensed with no specific directions, such as "PRN", "as directed" or "ad lib", etc. are not eligible for reimbursement. Specific directions such as "1 tablet 4 times a day PRN" are required.

#### 1. Exceptions:

- i. Topical preparations including ophthalmic and otic drops and ointments;

## PHARMACEUTICAL SERVICES MANUAL

- ii. Aerosal inhalers;
- iii. Nitroglycerin.

(1) Dosage for these medications cannot be related to number of days supply. The pharmacist shall enter the letters "N/A" (not applicable) in the "Days Supply" space on the prescription claim (form MC-6).

2. For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, must be entered in the "Days Supply" space on the prescription claim (form MC-6).

### 10:51-3.8 Telephone ordered original prescriptions

(a) Telephone orders from prescribers for original prescriptions will be permitted in accordance with all applicable Federal and State laws and regulations.

(b) For purposes of reimbursement, telephone authorization to refill an original prescription is considered a new order and requires a new written prescription with a new prescription number. Stamping or writing a new number on the original prescription order does not constitute a new prescription under the Medicaid Program.

(c) When a prescriber chooses not to allow product interchange on a telephone order, the statement "Substitution not permitted by prescriber, telephone Rx", plus the pharmacist's full signature next to or below the statement, must appear on the prescription order. A rubber stamp bearing the statement is acceptable.

(d) When a prescriber chooses to certify "Brand Necessary" or "Brand Medically Necessary" on a telephone prescription for a product included on Federal MAC list, a written signed prescription order containing the certification, must be sent to the pharmacist within 7 days of the date of the telephone order. The written prescription must be retained by the pharmacist as the original prescription. Failure to comply will result in the payment for that prescription being reduced on the MAC reimbursement level.

### 10:51-3.9 Changes or additions to the original prescription

Changes or additions to the original prescription, when approved by the prescriber, must be clearly indicated (including date and time) and signed by the dispensing pharmacist. No changes (i.e. dosage, quantity, number of refills, days supply, etc.) are permitted on the original prescription order after the claim is submitted for payment.

## PHARMACEUTICAL SERVICES MANUAL

### 10:51-3.10 Non-proprietary or generic dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacist shall dispense and bill Medicaid for the least expensive, therapeutically effective equivalent product available, preferably one listed in the Formulary.

### 10:51-3.11 Prescription refill

(a) Refills are not allowed.

(b) For purposes of reimbursement, an order for continuation of medication shall be considered a new prescription requiring a new written prescription and new prescription number.

1. Exception: Patients authorized as "Intermediate Care", non-medical (Level IVB), where the required interval between physicians' visits may be every 60 days rather than every 30 days, the initial one month supply of medication may be refilled 1 TIME ONLY, if authorized on the original medication order (e.g. dispense 60 day supply).

### 10:51-3.12 Services not eligible for reimbursement

(a) The following classes of prescription drugs are not eligible for reimbursement;

1. Antiobesics and anorexiant;
2. Medication for which adequate information (i.e., package inserts, price catalogs etc.) is not readily available;
3. Experimental drugs;
4. Telephone ordered refills;
5. Medication furnished by a prescriber or an employee of a prescriber;
6. Preventive drugs and biologicals provided without charge through other agencies (i.e., New Jersey State Department of Health, New Jersey Heart Association, etc.). See Appendix A.
  - i. Exceptions: Instances where preventive drugs or preventive biologicals are not available at the listed distributing stations.
7. Medication prescribed for hospital inpatients;
8. Prescriptions written and/or dispensed with non-specific directions;

## PHARMACEUTICAL SERVICES MANUAL

9. Food supplements, milk modifiers, infant formulas and therapeutic diets;
10. Methadone in any form, tablets, capsules, liquid, injectables, or powder, when used for drug detoxification or addiction maintenance.
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 Federal Food and Drug Administration, when such approval is required by Federal law and/or regulation;
13. Insulin
14. Radiopaque contrast materials (i.e. Telepaque).

### 10:51-3.13 Payment regulations for prescribed drugs

(a) Payment will be made to participating pharmacies for reimbursable drug products dispensed within Program limits to eligible recipients, by Blue Cross of New Jersey on behalf of the New Jersey Health Services (Medicaid) Program, only under the following conditions:

1. Upon receipt of a properly completed form MC-6, PRESCRIPTION CLAIM FORM, or other approved hard copy, as shown in subchapter 2. The claim form may be completed manually or by computer, but only one prescription may be billed for on each claim form; or
2. Upon receipt of a properly designed and generated computer tape. (See section 10:51-2.12 of subchapter 2.)

### 10:51-3.14 Basis of payment

(a) Payment for legend drugs (those drugs whose labels include the legend "Caution: Federal Law Prohibits Dispensing Without a Prescription"), contraceptive devices and other reimbursable devices shall be based upon "Maximum Allowable Cost".

1. Maximum Allowable Cost is defined as:
  - i. The "Maximum Allowable Cost" (MAC) price published by the Pharmaceutical Reimbursement Board of the U.S. Department of Health and Human Services for listed multi-source drugs or established by the Division of Medical Assistance and Health Services; or

## PHARMACEUTICAL SERVICES MANUAL

- ii. The Average Wholesale Price (AWP) listed for the most frequently purchased package size (as defined by the N.J. Medicaid Program) in the current "Drug Topics Red Book" (published by Medical Economics Co., Oradell, New Jersey 07649), and supplements; price changes listed by the same publisher in "Drug Topics Magazine" or other appropriate sources; or designated prices defined in section 10:51-3.5. In the case of unlisted or undesignated AWP "costs" or of typographical errors, the known correct price will be used as maximum.

(b) Maximum cost for each eligible prescription claim not covered by section 10:51-3.14(a)1 shall be subject to the following fiscal conditions based upon six categories, as determined by the N.J. Medicaid program based on the previous year's total prescription volume for each participating pharmacy. The categories shall be reviewed annually and adjusted as appropriate.

1. To determine a provider's total prescription volume, which shall include all prescriptions filled, both new and refills, for private patients, Medicaid, PAA, and other third party recipients for the previous calendar year, each pharmacy provider shall submit in writing, an annual report certifying its prescription volume. Failure to submit this report annually will result in the provider being placed in the maximum discount category (category VI) for the year of non-compliance, or until the required report is received.

NOTE: Those pharmacy providers who have been in business for less than one calendar year will have their prescription volume projected for the entire year, to determine the appropriate category.

2. Category I: Pharmacies whose total prescription volume in the preceding calendar year was not more than 14,999 prescriptions.

- i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs at average wholesale price (AWP), as defined in section 10:51-3.14a., as the maximum.

3. Category II: Pharmacies whose total prescription volume in the preceding calendar year was at least 15,000 but not greater than 19,999 prescriptions.

- i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs at average wholesale price (AWP), as defined in section 10:51-3.14a, less two per cent, as the maximum.



STATE OF NEW JERSEY  
 Department of Human Services  
 Division of Medical Assistance and Health Services

# New Jersey Health Services Program NEWSLETTER

Volume BC-219

December 7, 1981

TO: Providers of Pharmaceutical Services to Long-Term Care Facilities(LTCF)  
 SUBJECT: Increase in Dispensing Fee of Long-Term Care Facility Legend Drugs  
 EFFECTIVE: January 1, 1982  
 ACTION: The capitation of dispensing fee for legend drugs to long-term care facility pharmacy providers has been increased by approximately 9% per patient day.

These LTCF capitation rates apply to Medicaid recipients only - not to PAA.

The new daily capitation rates for all three levels of service are as follows:

	<u>OLD RATE</u>	<u>NEW RATE</u>
LEVEL A	45¢	49.2¢
LEVEL B	35¢	38.3¢
LEVEL C	30¢	32.8¢

Inquiry concerning this Newsletter should be directed to Pharmacy Relations (201) 456-2727.

Manual Maintenance

Please discard Subchapter 3 10:51-3.15 "Capitation of Dispensing Fee for Legend Drugs" (pgs 9 and 10) and replace with attached updated material.

PHARMACEUTICAL SERVICES MANUAL

4. Category III: pharmacies whose total prescription volume in the previous calendar year was at least 20,000 but not greater than 29,999 prescriptions.

- i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs at average wholesale price (AWP), as defined in section 10:51-3.14a, less three per cent, as the maximum.

5. Category IV: Pharmacies whose total prescription volume in the previous calendar year was at least 30,000 but not greater than 39,999 prescriptions.

- i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs at average wholesale price (AWP), as defined in section 10:51-3.14a, less four per cent, as the maximum.

6. Category V: Pharmacies whose total prescription volume in the preceding year was at least 40,000 but not greater than 49,999 prescriptions.

- i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs at average wholesale price (AWP), as defined in section 10:51-3.14a, less five per cent, as the maximum.

7. Category VI: Pharmacies whose total prescription volume in the preceding calendar year was 50,000 prescriptions or more.

- i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs at average wholesale price (AWP), as defined in section 10:51-3.14, less six per cent, as the maximum.

- NOTES:
- (1) If the published MAC price as defined in section 10:51-3.14(a)1i is higher than the price which would be paid under section 10:51-3.14(a)1ii, then section 10:51-3.14(a)1ii, will apply.
  - (2) The appropriate calculated discount will be automatically deducted (by Blue Cross of New Jersey) from each eligible legend drug claim during the claim processing procedures.
  - (3) For prescription drugs costing more than \$24.99 there will be no discount from the average wholesale price (AWP).

10:51-3.15 Capitation of dispensing fee for legend drugs provided to long-term care patients

- (a) The New Jersey Medicaid Program capitates the dispensing fee for legend

drugs for patients in Medicaid approved long-term care facilities in accordance with the total number of Medicaid patient days in the facility(ies) serviced by the pharmacy.

1. Pharmacies with retail permits dispensing medication in a dispensing system in which a 24-hour supply of unit dose oral medication, both solid (i.e. tablets, capsules) and liquid formulations, is delivered for each patient daily, shall be reimbursed the cost of all reimbursable legend medication plus a fee of \$.492 per patient day.

- i. Exception: Certain liquid medications that are supplied in concentrate form only and are administered by drop dosage cannot be supplied in a 24-hour dose.

2. Pharmacies with a retail permit dispensing medication in a dispensing system in which up to a one month supply of oral unit dose solid medication is delivered for each patient (i.e., unit dose solids, "bingo" card), shall be reimbursed the cost of all reimbursable legend medication plus a fee of \$.383 per patient day.

3. Pharmacies with a retail permit dispensing medication in a dispensing system in which a maximum 1 month supply of medication is delivered for each patient monthly shall be reimbursed the cost of all reimbursable legend medication plus a fee of \$.328 per patient day.

4. Pharmacies which provide ancillary computerized services, such as, but not limited to, continuously updated computerized patient profiles, clinical records (med sheets and physicians' orders on at least a monthly basis), etc., will receive an added increment of \$.05 per patient day, thereby making the total fee \$.542, \$.433 or \$.378, depending upon the dispensing system used.

5. Pharmacies with institutional permits shall be reimbursed as defined in Section 10:51-3.15(a), except that the daily per patient capitation fee shall be 75% of the fee for pharmacies with retail permits.

#### 10:51-3.16 Maximum charges

(a) The maximum charge to the New Jersey Medicaid Program for a legend drug includes the charge for the cost of medication and the capitation fee, and may not exceed the charges made to other medical facilities or agencies through contracts or other agreements.

1. When such contract or other agreements with a medical facility or agency exist, the above (10:51-3.16(a)) shall apply to claims submitted on behalf of Medicaid recipients in said facility or receiving services by said agency.

## PHARMACEUTICAL SERVICES MANUAL

(b) Pharmacies using more than one drug distribution system at a long-term care facility, will receive reimbursement for all legend drugs based upon the lowest priced distribution system supplied to that long-term care facility.

### 10:51-3.17 Compounded prescriptions

(a) Any prescription containing two or more ingredients, one of which is a legend drug, in usually accepted therapeutic dosage and combined by a pharmacist at the time of dispensing is a compounded prescription and shall be charged as follows:

1. Total ingredient costs as defined in section 10:51-3.14(a)1. The provider may charge up to \$0.25 for any ingredient whose "cost" is less than \$0.25.

### 10:51-3.18 Instruction for completing prescription claim (form MC-6)

(a) The prescription claim (form MC-6) is to be completed as in section 10:51-2.6, "Pharmaceutical Services Billing Procedures", except that the provider will submit the AWP cost of the drug(s) only. DO NOT ENTER A DISPENSING FEE.

1. For drug distribution systems as defined in 10:51-3.15(a)1, claims shall be submitted at the end of the billing cycle (i.e., end of the month), only for the actual number of doses consumed or for doses whose package integrity has been legitimately disturbed.

2. For conventional systems as defined in 10:51-3.15(a)2 and 10:51-3.15(a)3, claims may be submitted at time of dispensing.

### 10:51-3.19 Capitation fees

(a) All capitation payments will be processed by Blue Cross of New Jersey who will issue payment directly to pharmacies. The capitation fees are computed as follows:

1. The Division's Bureau of Claims and Accounts will submit monthly to Blue Cross of New Jersey the total number of Medicaid patient days for which each facility was reimbursed.

2. Payment will be made to pharmacy providers for the number of Medicaid patient days, based on previous month's experience, multiplied by the appropriate capitation fee for the applicable drug distribution system, as defined in 10:51-3.15 of this subchapter.

## PHARMACEUTICAL SERVICES MANUAL

### 10:51-3.20 Provider agreement

(a) The pharmacy provider must execute a separate agreement with the New Jersey Medicaid Program in order to be reimbursed for pharmaceutical services provided to Medicaid recipients in long-term care facilities.

1. The separate agreement is in addition to the Provider Application/Agreement which is required to become an approved Medicaid provider of pharmaceutical services.

(b) The Long-Term Care Provider Application/Agreement may be obtained by writing to:

Pharmacy Relations Department  
Blue Cross of New Jersey  
33 Washington Street  
Newark, New Jersey 07102

(c) When the pharmacy provider enters into an agreement to service a long-term care facility, the pharmacy provider must:

1. Notify the N.J. Medicaid Program in writing within 5 days of entering into the agreement; and

2. Notify Pharmacy Relations Department, Blue Cross of New Jersey, 33 Washington Street, Newark, New Jersey 07102 in writing within 5 days of entering into the agreement.

(d) When the pharmacy provider terminates an agreement to service a long-term care facility, the pharmacy provider must:

1. Notify the N.J. Medicaid Program in writing within 5 days of termination of the agreement; and

2. Notify Pharmacy Relations Department, Blue Cross of New Jersey, 33 Washington Street, Newark, New Jersey 07102, in writing, within 5 days of termination of the agreement.

(e) The long-term care facility must notify the N.J. Medicaid Program and Blue Cross of New Jersey in writing within 5 days of any changes in the agreement of service between the long-term care facility and the pharmacy provider.

(f) Upon change of provider of pharmaceutical services to a long-term care facility, capitation payments will be made to the new provider effective the first day of the month following the change. If two pharmacy providers are servicing the same facility during the changeover period, the original pharmacy provider of record will be reimbursed the capitation fee. It is the responsibility of the original pharmacy provider to arrange reimbursement for capitation payments to the new pharmacy provider for that portion of the month that the new pharmacy provider serviced the facility.

PHARMACEUTICAL SERVICES MANUAL

10:51-3.21 Tape-to-tape incentive program

(a) An incentive payment instituted January 1, 1979, is available to approved pharmacies which submit Medicaid and/or PAA claims on magnetic tape. Incentive payments will be made when the total volume of paid magnetic tape Medicaid/PAA claims, submitted by pharmacy providers as a whole, equals or exceeds twenty per cent of the total volume of paid Medicaid/PAA claims.

(b) The reimbursement for incentive payments is based on the following schedule:

% of total Medicaid/PAA Paid Claims	Amount of Incentive Payment
If tape claims comprise:	The incentive payment is:
20 - 29%	2 cents/tape claim
30 - 39%	3 cents/tape claim
40 - 55%	4 cents/tape claim
Over 55%	5 cents/tape claim

(c) The incentive payment is based on the percentage of tape claims paid in the previous month. If the volume of paid tape claims is less than twenty per cent of the total, no incentive payments will be made. A pharmacy provider will be eligible for incentive payments beginning with the month subsequent to the month in which the volume of tape claims reaches twenty per cent of the total paid claims volume. A qualified tape-to-tape pharmacy provider will receive a separate incentive payment check for all tape claims paid during the preceding month.

(d) Claims volume figures will be reviewed and averaged quarterly. The claim volume totals for the previous quarter will determine the amount of incentive for the subsequent quarter.

(e) The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Health Services (Medicaid) Program.

(f) In order to be eligible to submit magnetic tape claims for the Medicaid or PAA programs, a pharmacy provider must complete form FD-103 and receive approval by the Division of Medical Assistance and Health Services.



STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES

HEALTH SERVICES PROGRAM

CONSULTANT PHARMACISTS  
MANUAL

CHAPTER V

CONSULTANT PHARMACIST SERVICES

	<u>SECTION</u>	<u>PAGE</u>
Consultant Pharmacist Services.....	500.	1
Scope of Services.....	A	1
Definition.....	B	1
Qualifications.....	C	1
Responsibilities.....	D	2, 3 & 4
Basis of Payment.....	E	4

CHAPTER V

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CONSULTANT PHARMACIST SERVICES

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500. CONSULTANT PHARMACIST SERVICES

A. Scope of Services

All services required of a Consultant Pharmacist in Long Term Care Medical Facilities, (i.e., SNF, Infirmary Section of Home for the Aged, or Public Medical Institution), as stipulated in Federal and State statutes, rules and regulations, including (but not limited to), those listed herein shall be provided.

B. Definition

The term "Consultant Pharmacist" shall mean a pharmacist licensed by the New Jersey State Board of Pharmacy, and who meets the qualifications in Section C herein.

C. Qualifications

1. Registered Pharmacist holding a current valid license from the New Jersey State Board of Pharmacy.
2. Having at least one year's experience in the practice of institutional pharmacy. This requirement shall become effective one year from the effective date of the other requirements herein.
3. Can, upon request from the Director of the New Jersey Health Services Program or his designee, produce evidence of having annually successfully completed training and/or educational programs pertaining to the practice of institutional pharmacy, acceptable by Council of Pharmaceutical Continuing Education.

CHAPTER V

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CONSULTANT PHARMACIST SERVICES

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D. Responsibilities

In cooperation with the Long Term Care Facility, the Consultant Pharmacist:

1. Shall assure that all drugs are dispensed, and in cooperation with the Director of Nursing, shall assure all drugs are administered in compliance with all State and Federal laws.
2. Shall establish and monitor the implementation of written policies and procedures, through the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), to insure the safe use, storage, integrity, administration, control and accountability of drugs.
3. Shall assure that drug records are in order and an account of all controlled substances is maintained and reconciled.
4. Shall assure that patient's medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physicians' orders and established stop order policies.
5. Shall assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same patient are monitored for potential adverse reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications and that the physician is advised promptly of any recommended changes.

CHAPTER V

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CONSULTANT PHARMACIST SERVICES

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6. Shall review the drug regimen (e.g., dosage form, route of administration, time of administration), of each patient at least monthly, and report any irregularities pertaining to medications to the attending physician, Medical Director or Director of Nursing, as appropriate.  
Irregularities in the administration of medications are also reported promptly to the Director of Nursing.
7. Shall report in writing at least quarterly to the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee) on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a summary of the review of each patient's drug regimen and clinical record and the consultant pharmacist's findings and recommendations.
8. Shall assure there is maintained and available upon request from the Director of the New Jersey Health Services Program or his designee, documented records of the disposition, disposal or destruction of unused or discontinued drugs.
9. Shall serve as an active member of the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee) and Infection Control Committee of the facility.

CHAPTER V

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CONSULTANT PHARMACIST SERVICES

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10. Shall provide, and document, in-service programs for the complete nursing staff. This training shall include, but not be limited to, Registered Nurses, Licensed Practical Nurses, Aides and shall be given at least quarterly,
11. Shall devote a sufficient number of hours to carry out these responsibilities, maintain a written record of activities, findings and recommendations.
12. These are minimum responsibilities and should not be construed as establishing a limit on the services of the consultant pharmacist.

E. Basis of Payment

Reimbursement for consultant pharmacist services shall be the lower of the following:

1. \*Five cents (\$ .05), per patient day, or
2. The fee received by the consultant pharmacist for services provided to non-Medicaid patients in the Long Term Care Facility.

\*NOTE: Each Medicaid approved Long Term Care Facility receives an appropriate amount of money each month to cover this cost and is responsible for reimbursement to the Consultant Pharmacist.

CHAPTER III

CONSULTANT PHARMACIST BILLING PROCEDURES

	Section	Page
Billing Procedures.....	300.	1
General Policy.....	301.	1

CHAPTER III

NEW JERSEY HEALTH  
SERVICES PROGRAM

3/1/76

CONSULTANT PHARMACIST BILLING PROCEDURES

300. Billing Procedures

This Chapter contains basic information on reimbursement for Consultant Pharmacist Services.

301. General Policy

Payments will be processed by Blue Cross of New Jersey. The Division of Medical Assistance and Health Services (Medicaid), through its Bureau of Claims and Accounts, will submit to Blue Cross, each month, the number of Medicaid patient days for which the facility was reimbursed.

A payment for the number of Medicaid patient days multiplied by the fee for Consultant Pharmacist Services, as designated in Section 204. of this Manual, shall be sent to the designated Consultant Pharmacist.





STATE OF NEW JERSEY  
DEPARTMENT OF INSTITUTIONS AND AGENCIES  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NEW JERSEY HEALTH SERVICES PROGRAM  
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT

PROVIDER AGREES:

1. To comply with all applicable State and Federal "Medicaid" laws and policy, and rules and regulations promulgated pursuant thereto;
2. To keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid Program;
3. To furnish the Division of Medical Assistance with such information regarding any payments claimed for providing services under the Medicaid Program as the Division may from time to time request.

The provider may, on thirty days written notice to the Division, terminate this agreement.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Provider or Authorized Agent

\_\_\_\_\_  
Title

CHAPTER VI  
PHARMACEUTICAL SERVICES  
PHARMACEUTICAL ASSISTANCE TO THE  
AGED (PAA) PROGRAM

	<u>SECTION</u>	<u>PAGE</u>
Introduction.....		1
Covered Pharmaceutical Services.....	600.	1
Definitions.....	601.	1
Eligible Prescribers.....	601.1	1
Eligible Pharmacies in New Jersey.....	601.2	1 & 2
Out-of-State Pharmacies.....	601.3	2
Responsibilities of Eligible Pharmacies.....	601.4	2
Eligible Patients.....	601.5	2
General Policies.....	602.	2 & 3
Advertising.....	602.1	3
Auditing.....	602.2	3
Drug Policies.....	603.	3 & 4
Quantity of Medication.....	603.1	4
Dosage and Directions.....	603.2	4
Telephone Ordered Prescriptions.....	603.3	5
Changes or Additions to the Original Prescription.....	603.4	5
Prescription Refill.....	604.	5 & 6
Pharmaceutical Services not Eligible for Payment.....	605.	6
Payment Regulations for Prescribed Drugs.....	606.	6 & 7
Basis of Payment.....	607.	7
Legend Drugs.....	607.1	7, 8, 9 & 10

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PHARMACEUTICAL SERVICES  
PHARMACEUTICAL ASSISTANCE TO THE  
AGED (PAA) PROGRAM

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INTRODUCTION

This chapter provides information to providers of pharmaceutical services to PAA eligibles who are not patients/residents in Long Term Care Facilities, Hospitals or Special Hospitals.

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PHARMACEUTICAL SERVICES

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600. COVERED PHARMACEUTICAL SERVICES

The following services are available to PAA eligibles who are not inpatients in Long Term Care Facilities (SNF or ICF), Hospitals or Special Hospitals.

1. Prescribed Legend Drugs
2. Insulin
3. Insulin Syringes or Insulin Needles.

All the above services must be provided within the scope of the Program policies and procedures and billed to the Hospital Service Plan of New Jersey (Blue Cross of New Jersey), on the Prescription Claim Form (MC-6) or other approved billing methods.

601. DEFINITIONS

601.1 Eligible Prescribers

All practitioners licensed or authorized by the State of New Jersey to prescribe drugs and medicines (physicians, dentists or podiatrists, within the scope of their license and practice). Out-of-state practitioners may prescribe for Program eligibles as herein outlined if they meet the same requirements in their State.

601.2 Eligible Pharmacies in New Jersey

All pharmacies located in New Jersey and operating under a valid Retail Permit from the Board of Pharmacy of the State of New Jersey, having filed an application and agreement to participate in the New Jersey Medicaid Program with the New Jersey Department of Human Services,

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PHARMACEUTICAL SERVICES

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Division of Medical Assistance and Health Services, shall be eligible to participate in the New Jersey PAA Program upon acceptance of said Agreement by the Department of Human Services.

NOTE: Upon sale or other change of ownership of an approved pharmacy, the Agreement is automatically terminated. The new owner(s) must apply to the Department of Human Services, Division of Medical Assistance and Health Services and execute a new agreement in order to participate in the New Jersey Medicaid/PAA Program.

601.3 Out-of-State Pharmacies

Out-of-State pharmacies are not eligible for participation as providers of services covered by this Chapter.

601.4 Responsibilities of Eligible Pharmacies

Participating pharmacies must provide complete prescription services, including compounding and prescription refill services when allowable. Prescriptions must be dispensed in compliance with all currently existing Federal and State Laws, based on sound professional judgment.

601.5 Eligible Patients

An eligible patient is a legal resident of the State of New Jersey, 65 years of age or older with an annual income less than \$9,000. for a single person and less than \$12,000. in combined income for a married couple, who possesses a current, valid eligibility/identification card (See Section 609.).

602. GENERAL POLICIES

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PHARMACEUTICAL SERVICES

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602.1 Advertising

The pharmacy may advertise or solicit covered persons in the PAA Program through signs or displays indicating that the pharmacy accepts or dispenses eligible prescriptions.

602.2 Auditing

Properly identified representatives of the Division may inspect the written prescriptions and may audit all records pertaining to prescriptions provided to covered persons and where deemed necessary, for the purpose of complying with State regulations to determine a provider's "usual and customary charges to the public", the representatives may inspect private sector prescriptions for the following information only:

- 1) Drug name
- 2) Quantity dispensed
- 3) Price
- 4) Prescription number (for reference purposes only)
- 5) Date dispensed

Information pertaining to patient name and prescriber will remain confidential within the limits of the law.

603. DRUG POLICIES

The choice of prescription drugs, insulin, insulin syringes and/or needles, remains at the discretion of the prescriber; but, payment will not be made for certain drugs under specific conditions. (See Section 605. "PHARMACEUTICAL SERVICES NOT ELIGIBLE FOR PAYMENT")

When a trade-name, multi-source drug product for which a designated

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PHARMACEUTICAL SERVICES

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chemically equivalent name in corresponding dosage form and strength is available, the pharmacy provider shall dispense such drug product in accordance with the provisions of the "Prescription Drug Price and Quality Stabilization Act".

603.1 Quantity of Medication

The quantity of medication dispensed may not exceed a 60 day supply.

EXCEPTIONS:

- 1) Legend vitamins and legend vitamin/mineral combinations may be dispensed in quantities up to a 100 day supply.
- 2) Insulin syringes and/or insulin needles may be dispensed in quantities up to a 100 day supply.
- 3) Insulin may be dispensed in quantities of up to four 10cc vials.

603.2 Dosage and Directions

Dosage and directions for use must be indicated on all original prescriptions. Prescriptions written and dispensed with non-specific directions, such as "PRN", "as directed", or "ad lib", etc., are not eligible for payment. Prescriptions written for topical preparations, aerosol inhalers and Nitroglycerin are exceptions to this regulation since the dosage cannot be related to number of days supply of medication. In such situations, the pharmacist must enter the letters "N/A" (not applicable) in the "DAYS SUPPLY" space on the Prescription Claim Form (MC-6).

For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, must be entered in the "DAYS SUPPLY" space on the Prescription Claim Form (MC-6).

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PHARMACEUTICAL SERVICES

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603.3 Telephone Ordered Prescriptions

Telephone orders from the prescriber for prescriptions, in accordance with all applicable Federal and State laws and regulations will be permitted.

603.4 Changes or Additions to the Original Prescription

Changes or additions to the original prescription, when approved by the practitioner, must be clearly indicated and initialed by the dispensing pharmacist. After the claim form is submitted for payment, no changes on the original prescription can be made (i.e., dosage, quantities, number of refills, etc.).

604. PRESCRIPTION REFILL

The pharmacist must initiate, complete and submit Prescription Claim Form (MC-6) to Blue Cross of New Jersey for payment of an allowable refill. The following instructions apply for allowable refills:

- 1) Refill instructions must be indicated by the prescriber on the original prescription. Prescriptions without such instructions are not refillable and are not eligible for payment.
- 2) Prescriptions may be refilled for a maximum of 1 year, subject to prescribing physician instructions and applicable laws and regulations (i.e., drug abuse control act, Federal and State narcotics regulations, etc.).

Refills are acceptable for prescriptions originally filled prior to the recipient being eligible for PAA benefits, when dispensed after the effective date of PAA coverage.

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PHARMACEUTICAL SERVICES

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- 3) Prescription refills shall not be dispensed until a reasonable quantity (approximately 75%) of the medication originally dispensed or refilled could have been consumed in accordance with the practitioner's written directions for use,
- EXCEPTION: When medication has been destroyed (e.g., broken container) the pharmacist may refill the prescription; but, a note of explanation for the early refill must be stapled to the Prescription Claim Form (MC-6).

605. PHARMACEUTICAL SERVICES NOT ELIGIBLE FOR PAYMENT

The following classes of prescription drugs will not be honored for payment:

- 1) Drugs for which adequate literature, i.e., package inserts, etc., and price catalogues are not readily available.
- 2) Experimental drugs.
- 3) Drugs directly furnished by practitioner.
- 4) Medications prescribed for use by hospital inpatients and patients in Long Term Care Facilities.
- 5) Non-legend drugs except insulin.
- 6) Prescriptions written and dispensed with non-specific directions.
- 7) Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their New Drug Application (NDA).

606. PAYMENT REGULATIONS FOR PRESCRIBED DRUGS

- A. Direct (vendor) payment will be made to participating pharmacies

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PHARMACEUTICAL SERVICES

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by Blue Cross of New Jersey on behalf of the New Jersey PAA Program upon receipt of a properly completed Prescription Claim Form (MC-6), as shown in this Chapter of the Manual.

- B. Only one prescription may be submitted on each Prescription Claim Form (MC-6).

607. BASIS OF PAYMENT

607.1 Legend Drugs

- 1) Payment of "legend" drugs (those drugs bearing the legend "Federal Law Prohibits Dispensing Without Prescription"), will be based upon "Maximum Allowable Cost" as herein defined, minus a co-payment of \$1.00 for each prescription (new or refill), which must be paid by or on behalf of the recipient.

- 2) "Maximum Allowable Cost"

The listed Average Wholesale Price (AWP), as so designated for the most frequently purchased package size (as determined by the Division), in the current Drug Topics Red Book (published by Medical Economics Co., Oradell, N.J. 07649), and supplements and price changes listed by the same publisher in Drug Topics Magazine or the designated prices listed in Section 603. In the case of unlisted or undesignated "AWP" costs or typographical errors, the known correct price will be used as maximum cost...whichever is lower.

- (1) Maximum cost for each eligible prescription shall be subject to the following fiscal conditions based upon six (6) categories determined by the Division, for each participating pharmacy.

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PHARMACEUTICAL SERVICES

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The categories shall be adjusted annually.

- (2) In order to determine a provider's total prescription volume which shall include all prescriptions filled, both new and refill, for private, Medicaid, PAA and other third party recipients, for the previous calendar year; pharmacies will be required to submit in writing, a report certifying to their prescription volume annually. Failure to meet this requirement will result in the provider being placed in the maximum discount category (Category VI), for the period of non-compliance.

NOTE: Those pharmacy providers who have been in business for less than one (1) calendar year will have their prescription volume projected over the entire calendar year to determine the appropriate category.

Category I - Pharmacies whose total prescription volume in the previous calendar year was not more than 14,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above.

Category II - Pharmacies whose total prescription volume in the previous calendar year was in excess of 15,000 prescriptions but did not exceed 19,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above LESS 2% of such cost.

The calculated amount will be automatically deducted from

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PHARMACEUTICAL SERVICES

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each prescription claim in the reimbursement processing procedure.

Category III - Pharmacies whose total prescription volume in the previous calendar year was 20,000 prescriptions but did not exceed 29,999 prescriptions.

Pharmacies placed in this category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above LESS 3% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

Category IV - Pharmacies whose total prescription volume in the previous calendar year was 30,000 prescriptions but did not exceed 39,999 prescriptions.

Pharmacies placed in this Category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP) as defined above LESS 4% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

Category V - Pharmacies whose total prescription volume for the previous calendar year was 40,000 prescriptions but did not exceed 49,999 prescriptions.

Pharmacies placed in this Category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP), as defined above LESS 5% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

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PHARMACEUTICAL SERVICES

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Category VI - Pharmacies whose total prescription volume in the previous calendar year was 50,000 prescriptions or more.

Pharmacies placed in this Category will receive maximum cost reimbursement for Legend Prescription Claims at Average Wholesale Price (AWP), as defined above LESS 6% of such cost.

The calculated amount will be automatically deducted from each prescription claim in the reimbursement processing procedure.

3. Dispensing Fee: Pharmacies With Retail Permits

The "dispensing fee" for legend drugs provided under the New Jersey PAA Program as outlined in this Manual shall be the prevailing New Jersey Medicaid rate as outlined in Chapter II of this Manual (See Section 208.1(3)(A)).

4. The maximum payment by the New Jersey PAA Program for a legend drug, including the charge for the cost of medication and the dispensing fee will not exceed the lowest of the following, minus a co-payment of \$1.00 for each prescription (See Section 607.1(1)).

- (A) "Cost plus dispensing fee" as outlined herein; or,
- (B) Usual and customary and/or posted or advertised charges; or,
- (C) Other third party prescription plan charges, when contracts or agreements to participate have been entered into subsequent to the adoption of this regulation.

NOTE: Collection of the co-pay is mandatory.

Failure to collect the co-pay will result in retroactive reduction of payment by an amount equivalent to the co-payment or portion thereof, whichever is applicable.

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PHARMACEUTICAL SERVICES

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607.2 Compounded Prescriptions

Any prescription containing two or more ingredients, one of which must be a legend drug, in usually accepted therapeutic dosage and mixed by the pharmacist at the time of dispensing is a compounded prescription.

- 1) The ingredient "cost" of a compounded prescription is the sum of the "cost", as defined in Section 607.1(2), of all the ingredients.

EXCEPTION: The pharmacy may charge up to 25¢ for any ingredient whose "cost", as defined in Section 607.1(2) is less than 25¢.

- 2) The "dispensing fee" for a compounded prescription shall be as allowed in Section 607.1(3).
- 3) The maximum charge for a compounded prescription shall not exceed the limits set forth in Section 607.1(4).

607.3 Non-Legend Drugs

The only non-legend products which may be billed to the New Jersey PAA Program are:

- 1) Insulin (maximum 4 vials per claim).
- 2) Insulin syringes and/or insulin needles as listed in Appendix C of Chapter II of this Manual.

The maximum payment by the New Jersey PAA Program for these products will not exceed the lower of the following, minus a \$1.00 co-payment per prescription (See Section 607.1(1) and NOTE Section of 607.1(4)):

- 1) Manufacturers suggested selling price to the consumer.
- 2) The usual retail price charged to others in the community.

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PHARMACEUTICAL SERVICES

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608. BILLING PROCEDURES

This section contains basic information for the submission of pharmacy claims for PAA eligible patients. Included is a facsimile claim form approved for use in submitting bills for covered items or services and appropriate instructions for proper completion of the claim form.

609. PAA PATIENT IDENTIFICATION

Pharmacies should verify that the patient is a PAA covered person. This is done by checking the patient's plastic PAA identification card or the Temporary Eligibility Card. (See example on next page) The Division will issue to all PAA eligibles a Temporary Eligibility Card which will be followed up by the Plastic PAA Identification Card. Both documents will contain the patient's name, PAA Identification Number, effective date and an expiration date. The patient is eligible only for the period of time indicated on these documents. The plastic identification card has been designed to fit into the standard imprinter machine that many pharmacies have.

PHARMACEUTICAL SERVICES

STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES  
PHARMACEUTICAL ASSISTANCE TO THE AGED

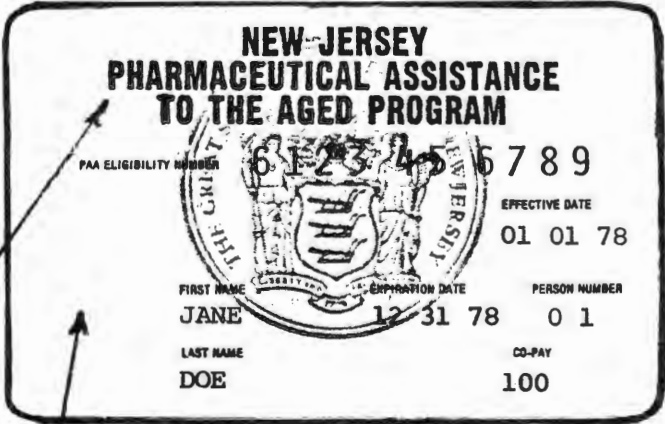
AP-8

\*\*\*\*\*  
\* TEMPORARY ELIGIBILITY CARD \*  
\*\*\*\*\*

USE THIS CARD UNTIL YOU RECEIVE YOUR PLASTIC ID CARD.

JOHN W DOE  
408 OLIVER ST  
ANY TOWN N J 01234

CO-PAY - \$1.00  
\*\* EFFECTIVE DATE \*\*  
JANUARY 1, 1978  
\*\* EXPIRATION DATE \*\*  
JUNE 30, 1978  
PAA ID #6000000005



Blue lettering on gold background.

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PHARMACEUTICAL SERVICES

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610. IMPRINTER

Upon request an imprinter may be purchased at a nominal cost along with operating instructions. Use of the imprinter is not mandatory, but does help eliminate errors and therefore speeds up processing of claims.

611. PHARMACY PROVIDER IDENTIFICATION PLATE

This plate was designed for use with an imprinter and should be placed permanently therein. The Provider Identification number, name and address may be handwritten in the appropriate area of the claim form. This information, transcribed onto the claim form, will enable us to identify all claims submitted by your pharmacy.

612. INSTRUCTIONS FOR COMPLETION OF CLAIM FORM MC-6

A properly completed claim form, must be submitted within 90-days from the dispensing date.

The tissue copy of the claim form should be detached after completion and retained as your record of claims submitted to Blue Cross of New Jersey. Please keep tissues in claim number order for quick referral.

PHARMACEUTICAL SERVICES

CASE NUMBER				PHARMACY NUMBER				CHARGE	
1				10				21	
PATIENT'S FIRST NAME AS ON ID. STUB		DATE OF BIRTH MO. DAY YR.		PERSON NO.		NAME AND ADDRESS OF PHARMACY		DEFINED COST \$	22
2		3		4		11		DISPENSING FEE \$	
CASE NAME				RX NUMBER				TOTAL RX CHARGE \$	
5				12				NON-LEGEND DRUG CHARGE \$	23
I ACKNOWLEDGE RECEIPT OF MEDICATION AS STATED IN THIS CLAIM				MO. DATE LICENSED		YR.			
6				13		14			
SIGNATURE OF PATIENT OR REPRESENTATIVE				NATIONAL DRUG CODE		MANUFACTURER			
IS A PATIENT IN A LONG-TERM CARE FACILITY				YES <input type="checkbox"/>		NO <input type="checkbox"/>			
7				15		16		17	
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE; AND I AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED; AND TO FURNISH INFORMATION FOR SUCH SERVICES AS THE STATE AGENCY MAY REQUEST; AND THAT THE SERVICES COVERED BY THIS CLAIM AND THE AMOUNT CHARGED THEREFOR ARE IN ACCORDANCE WITH THE REGULATIONS OF THE NEW JERSEY HEALTH SERVICES PROGRAM; AND THAT NO PART OF THE NET AMOUNT PAYABLE UNDER THIS CLAIM HAS BEEN PAID; AND THAT PAYMENT OF SUCH AMOUNT WILL BE ACCEPTED AS PAYMENT IN FULL WITHOUT ADDITIONAL CHARGE TO THE PATIENT OR TO OTHERS, ON HIS BEHALF. I ALSO CERTIFY THAT THE SERVICES HAVE BEEN FURNISHED IN FULL COMPLIANCE WITH THE NON-DISCRIMINATION REQUIREMENTS OF TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT. I UNDERSTAND THAT FRAUD OR CONCEALMENT WILL BE PUNISHABLE UNDER APPLICABLE FEDERAL OR STATE LAW, OR BOTH.				METRIC QUANTITY (DAYS SUPPLY)		IF NO CODE, GIVE PRODUCT NAME, DOSAGE FORM & STRENGTH			
8				18		19		20	
SIGNATURE OF PHARMACIST				IF PRIOR AUTHORIZED SERVICE		AUTHOR. NO.		CHECK IF COMPOUND RX <input type="checkbox"/>	
9				DATE		PRESCRIBER'S S. S. A. NO.		SUBMIT LIST OF INGREDIENTS AND THEIR QUANTITIES ON REVERSE SIDE	
PRESCRIBER'S NAME AND DEGREE (PLEASE PRINT)				STATE OF NEW JERSEY DEPARTMENT OF INSTITUTIONS AND AGENCIES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES PRESCRIPTION CLAIM FORM REC-4 (2-78)					

When completing the claim form for PAA patients, enter the following information:

- (1) CASE NUMBER is the 10 digit identification number for the person who is eligible for PAA benefits.
- (2) PATIENT'S FIRST NAME - Enter patient's first name as shown on the plastic Identification Card or Temporary Eligibility Card.
- (3) DATE OF BIRTH - This field will be used to indicate the expiration date of the benefit period for PAA eligibles only. Enter expiration date as shown on Plastic Identification Card or Temporary Eligibility Card. DO NOT USE PATIENT'S BIRTHDATE.
- (4) PERSON NUMBER - Enter 01 on all PAA claims.
- (5) CASE NAME - Enter patient's last name as indicated on Plastic Identification Card or Temporary Eligibility Card.
- (6) Obtain SIGNATURE OF PATIENT OR REPRESENTATIVE. Under ordinary circumstances, the patient must sign the claim form when services

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PHARMACEUTICAL SERVICES

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have been received. The claim form to be signed should indicate services rendered, and the patient must not sign a blank claim form prior to receiving services or as a condition for receiving services. However, when the patient's signature is unobtainable, the following procedures may be used:

- (A) Illiterate Patient: The patient may sign by mark (X), and the signature must be witnessed by another person including the provider of service who signs his name and address on the same line.
- (B) Other: If a patient is physically or mentally incapable of signing, or for other reasons the patient's signature is not obtainable through reasonable effort, the form may be signed on his behalf by:
1. A relative, or
  2. A friend, or
  3. An individual provider, or
  4. A representative of a governmental agency providing assistance.

Attached to the claim form or written directly on the reverse side of the form, should be a brief explanation of the reason the patient was not personally able to sign and the relationship of the signee to the patient/recipient.

- (7) IS A PATIENT IN A LONG TERM CARE FACILITY - When patient is an in-patient in a Long Term Care Facility (SNF or ICF) or a hospital, PAA benefits are not payable,

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PHARMACEUTICAL SERVICES  
\_\_\_\_\_

- (8) SIGNATURE OF PHARMACIST
- (9) PRESCRIBER'S NAME AND DEGREE - Print prescriber's first initial, last name, and degree (M.D., O.D., D.D.S., Podiatrist, etc.).
- (10) & (11) PHARMACY NUMBER, NAME AND ADDRESS OF PHARMACY - The pharmacy provider's identification number, name and address must be entered legibly on the claim.
- (12) DATE DISPENSED - Enter month, day and year drug was dispensed.
- (13) Enter a valid RX NUMBER to identify the prescription. If claim is a refill, use the original Rx number according to your files.
- (14) NATIONAL DRUG CODE of the drug should be obtained only from the package label. If the NDC is not available, provide complete drug information in item 16.

When entering NDC's on the claim form, providers should transfer them exactly as they appear on the package label.

EXAMPLE: Nalfon Pulvules 300mg. (Dista) 60's  
NDC appears on the package label as:  
NDC 777-0877-60

Enter this NDC on the claim form as such:

EXAMPLE: Naprosyn Tablets 250mg. (Syntex) 100's  
NDC appears on package label as:  
NDC 18393-272-42

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PHARMACEUTICAL SERVICES

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- (15) METRIC QUANTITY - Enter quantity dispensed in metric system only.
- (16) Calculate DAYS SUPPLY from the prescriber's directions and the quantity dispensed. Enter N/A (not applicable), when it is not possible to calculate days supply (See "Dosage and Directions" in Section 603.2 of this Chapter).
- (17) IF NO CODE, GIVE PRODUCT NAME, DOSAGE FORM AND STRENGTH Complete only if NDC number is not available, or if there is any question of NDC validity. Complete all areas of product identification.
- (18) CHECK IF PRIOR AUTHORIZED SERVICE, AUTHORIZATION NUMBER Prior authorization is not required for the PAA Program.
- (19) PRESCRIBER'S S.S.A. NUMBER Not required for the PAA Program. Enter NON-PAR in this field.
- (20) CHECK IF COMPOUND RX Check this box only if the prescription was compounded and write the ingredients and their quantities on the reverse side of the claim form. (Fold the tissue and carbon before writing on the back of claim.)
- (21) CHARGE Enter Usual and Customary Charge as four digits.  
EXAMPLE: \$5.25 should be entered as 0525.  
NOTE: The \$1.00 co-payment will automatically be deducted from each prescription claim in the reimbursement processing procedure.
- (22) Leave BLANK.
- (23) Leave BLANK.

PLEASE NOTE: When the plastic pharmacy card is available and the imprinter is used, fields identified as (1), (2), (3), (4), and (5) will automatically be printed. ]

NEW JERSEY PHARMACEUTICAL  
ASSISTANCE TO THE AGED  
PROGRAM (PAA)

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PHARMACEUTICAL SERVICES

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MAILING ADDRESSES FOR CLAIMS

1. Pharmacy Providers Submitting Claim Form MC-6

All Pharmacy Providers in the State of New Jersey must submit PAA Claim Forms (MC-6) for processing within 90 days from the dispensing date to:

HOSPITAL SERVICE PLAN OF NEW JERSEY  
2 CHERRY HILL EXECUTIVE CAMPUS  
CHERRY HILL, NEW JERSEY 08034

When reordering mailing envelopes, please specify "Cherry Hill" address.

2. Pharmacy Providers Submitting Tape Claims

All Pharmacy Providers submitting PAA claims by tape must submit their claims for processing within 90 days from the dispensing date to the original Newark address.

All claims must be submitted no later than 90 days from the dispensing date in order to be considered for payment.

NOTE: THE MAILING ADDRESS FOR MEDICAID/PAA PHARMACY MISSING CLAIMS INVESTIGATION/ADJUSTMENT REQUEST FORMS REMAINS P.O. BOX 549, NEWARK, FOR ALL PROVIDERS. THESE REQUESTS MUST BE SUBMITTED WITHIN 180 DAYS FROM VOUCHER DATE.

PHARMACY PROVIDERS SHOULD ALSO USE THE ADDRESS ABOVE (P.O. BOX 549, NEWARK) FOR MAILING CLAIMS FOR AMOUNTS BILLED EXCEEDING \$99.99 AND CLAIMS FOR COMPOUNDED DRUGS.

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PHARMACEUTICAL SERVICES

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NOTE: THE PAA PROGRAM WILL UTILIZE THE MEDICAID MISSING CLAIMS INVESTIGATION/ADJUSTMENT REQUEST FORM FD84, WHICH SHOULD BE SUBMITTED TO P.O. BOX 549, NEWARK. FOR ALL PROVIDERS, THESE REQUESTS MUST BE SUBMITTED WITHIN 180 DAYS FROM VOUCHER DATE.

613. PAYMENT VOUCHER

The Payment Voucher, which you will receive with each check, lists all information necessary to identify the disposition of each submitted claim. Upon receipt of payment, check relevant tissues of claims from your files against the voucher (statement) to identify and to ascertain each claim's status. Paid claims should be attached to the voucher and filed by Date of Payment in a permanent paid file.

PAA claim payments will appear on your Medicaid Payment Voucher and each paid PAA claim will be uniquely identified by an ampersand (&), appearing to the left of the amount billed. In addition, all PAA identification numbers begin with the digit "6".

PHARMACEUTICAL SERVICES

PHARMACY NAME				VOUCHER NUMBER		PHARMACY NUMBER		DATE OF PAYMENT	
NEW JERSEY PHARMACY				768134		28012345		03/14/78	
BLUE CROSS LOCATOR NUMBER	RECIPIENT'S NAME	PATIENT IDENTIFICATION NO	CLAIM NUMBER	EXPL CODE	DISPENSING DATE MO DAY YR	AMOUNT BILLED		AMOUNT PAID	
7291097	WILSON TERRENC	0730005873	01 45966335	0 00	022278	6.67		6.67	
7291097	DRYLEWSKI FREDERI	0730026744	20 45966336	0 01	022278	11.47		11.39	
7291097	ZAMBETTA BERNICE	0730000588	01 45966337	0 00	022278	9.44		9.44	
7291097	KOENIG MARIA	6146329750	01 45966338	0 00	022278 &	5.38		5.38	
7291097	HARRINGTON MICHAEL	0930004478	22 45966339	0 00	022278	10.66		10.66	
7291097	WEAVER ALICE	0730044822	01 45966340	0 47	022278				
7331444	TOLLEY THERESA	0710566435	01 45966341	0 01	022378	7.66		7.53	
7331444	GOMEZ ELOISE	6145318648	01 45966342	0 00	022378 &	12.43		12.43	
7331444	BARRETT RICHARD	0730004871	22 45966343	0 00	022378	3.28		3.28	
7331444	BUCHANAN MYRTLE	0930047332	01 45966344	0 00	022378	5.88		5.88	
7331444	UPDYKE ALICE	0730059724	20 45966345	0 47	022378				
7331444	LORENZO CARLOS	0730006833	21 45966346	0 00	022378	12.84		12.84	
7331444	PREDNEFSKY MARVIN	6141332564	01 45966347	0 01	022378 &	4.85		4.78	
7356478	WINDER MARGARE	0730005874	01 45966348	0 00	022478	2.99		2.99	
7356478	HAYES JOSEPH	0730002445	20 45966349	0 00	022478	7.37		7.37	
7356478	MALONE AIDA	0930066287	01 45966350	0 00	022478	1.99		1.99	
7356478	INTROCASSO CHARLES	6145336625	01 45966351	0 00	022478 &	10.21		10.21	

All Patient Identification Numbers for P.A.A. eligible persons will exhibit 6 as the first digit.

All Person Numbers for P.A.A. eligible persons will be 01, as each eligible person has his/her own I.D. card.

An ampersand (&) indicates that the actual total charge has been reduced by the \$1.00 co-payment.

* EXPLANATION CODES				TOTAL BILLINGS	TOTAL ADJUSTMENTS	NET PAYMENT
01 - CHARGE EXCEEDS MAXIMUM ALLOWABLE	21 - PRODUCT NOT ELIGIBLE FOR MEDICARE	31 - SUPPLEMENTARY PAYMENT UP TO THE ALLOWABLE MAXIMUM		113.12	1.28	112.84
02 - PRODUCT BELONGS TO ANOTHER PERSON	22 - NON-LEADS USE - PRODUCT NOT ELIGIBLE FOR PATIENT IN LONG TERM CARE FACILITY	32 - SUPPLEMENTARY PAYMENT EXCEEDED - MAXIMUM ALLOWABLE				
03 - DAYS SUPPLY EXCEEDED - HOSPITAL QUANTITY LIMITATION	23 - EXCEEDS MAXIMUM ALLOWABLE NO. OF REFILLS	33 - PAYMENT PREVIOUSLY MADE				
04 - EXPIRES DATE MORE THAN TWO (2) YEARS PRIOR TO PRESCRIPTION DATE	24 - REFILLED AT 6 MONTHS INTERVAL	34 - PAID FOR PREVIOUSLY DECLINED CLAIM				
05 - EXPIRES DATE MORE THAN NINETY (90) DAYS PRIOR TO RECEIPT DATE	25 - BEST LOCATION	35 - RECAPTURE OF PREVIOUSLY PAID CLAIM				
	26 - PRESCRIPTION INCOMPLETE - CLAIM UNDER REVIEW	36 - PREVIOUSLY PAID CLAIM				
	27 - SUPPLEMENTARY PAYMENT IN FULL AS REQUESTED	37 - PRESCRIBER CANNOT BE IDENTIFIED				

5080 (6-76)

768134

HOSPITAL SERVICE PLAN OF NEW JERSEY  
(NEW JERSEY BLUE CROSS PLAN)  
NEWARK, NEW JERSEY 07101

55-9  
212

- INSTRUCTIONS
1. Detach Voucher and retain for your records.
  2. Cash Check within 60 days of date of payment.
  3. Detach this Stub before cashing check.

03 14 78 28012345  
DATE OF PAYMENT CODE

FIDELITY UNION TRUST COMPANY  
NEWARK, NEW JERSEY 07101

NON-NEGOTIABLE

VOID 6 MONTHS  
AFTER ISSUE DATE

112.84  
DOLLARS CENTS

NEW JERSEY HEALTH SERVICES PROGRAM

TO THE ORDER OF  
NEW JERSEY PHARMACY  
123 ANY ST  
YOUR TOWN N J 01234

VOID

⑈768134⑈ ⑆0212⑈0009⑆ 0⑈00814 4⑈

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PHARMACEUTICAL SERVICES

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613.1 Explanation Code

The column on the voucher labeled "EXPL CODE" identifies and explains reductions in the amount billed, supplementary payments, pending claims and declined claims. The EXPLANATION CODES listed in the bottom portion of the voucher explain the numerical designations in the column. For better understanding, the codes are explained below.

- 00 - (defined only - not listed in "Explanation Codes") Original claim paid as billed, less applicable regressive percentage. When identified with an ampersand (&), reflects a \$1.00 reduction for co-payment, from the eligible billed amount.
- 01 - The amount paid has been reduced to the "maximum allowable".
- 02 - Does not apply to PAA Program.
- 03 - The "days supply" has exceeded the program limitation of 60 days and/or the exception of vitamins or vitamin/mineral combinations and insulin needles and insulin syringes (100 days).
- 04 - Does not apply to PAA Program.
- 05 - Dispensing date over 90 days old. Exception review for waiver of 90 day limitation possible in extenuating circumstances only.
- 21 - Product ineligible. Mainly applied to non-legend drugs.
- 22 - Does not apply to PAA Program.
- 41 - Does not apply to PAA Program.
- 42 - Does not apply to PAA Program.
- 44 - Refilled too soon. Approximately 75% of Rx should be consumed before refilling.

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PHARMACEUTICAL SERVICES

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- 47 - Processing incomplete. Claims under review; generally, for the following reasons: a. Questionable eligibility, b. NDC not on file, c. incomplete or incorrect information.
- 50 - Supplementary payment in full as requested.
- 51 - Supplementary payment has been made up to the allowable maximum.
- 52 - Supplementary payment declined - maximum allowable payment previously made.
- 60 - Indicates payment for previously declined claims as a result of an adjustment request.
- 61 - Claims declined for ineligible patients.
- 62 - Duplicate claims are created through erroneous information on the claim or through the unauthorized submission of claims.
- 65 - Recapture of previously paid claim.
- 67 - Prescriber cannot be identified.
614. MEDICAID PHARMACY MISSING CLAIMS INVESTIGATION/ADJUSTMENT REQUEST FORM (FD-84)
- This form is an instrument for:
- A. Requesting adjustments for contested paid claims.
  - B. Correcting information on declined claims to seek a reversed decision (i.e., new or corrected eligibility information.)
  - C. Verifying the status of claims under review (code 47),
  - D. Instituting an investigation for claims that appear to be missing.
- IMPORTANT NOTE: IN THE CASES OF LETTERS C OR D ABOVE, IT IS HELPFUL AND NECESSARY FOR THE PHARMACIST TO CHECK ALL VOUCHERS SUBSEQUENT TO THE LAST VOUCHER UPON WHICH THE CLAIM WAS LISTED TO MAKE SURE THE CLAIM WAS NOT "PAID" OR "DECLINED" IN A LATER ACTION.

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PHARMACEUTICAL SERVICES

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MAILING INSTRUCTIONS: The Missing Claims Investigation/Adjustment Request Form consists of three parts. The original and second pages are to be mailed to  
NEWARK:

New Jersey Health Services Program  
(New Jersey Blue Cross Plan)  
P.O. Box 549  
Newark, New Jersey 07101

A third copy is to be retained for your records and follow-ups. A copy will be completed by Blue Cross in the "for Blue Cross Use Only" area with information regarding the results of investigation and will be returned to you for your information.

614.1 Completion of Missing Claims Investigation/Adjustment Request Form (FD-84)

ADJUSTMENTS

Adjustment Requests should be submitted separately from missing claims.

A. Time Limitation

Adjustment Requests for all claims must be received by Blue Cross of New Jersey not later than 180 days after the claim in question appeared on a payment voucher. It should be noted that the 180-day limit does not apply to Adjustment Requests submitted due to patient eligibility.

B. Adjustment Request - Procedure for Ineligible Recipients (Code 61)

Declined claims, because of patient ineligibility (code 61), must be verified for eligibility with the PAA Eligibility Unit in Trenton; CN038, Trenton, New Jersey 08625, Telephone (609) 292-9007.



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PHARMACEUTICAL SERVICES

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If authoritative eligibility verification is received, the information must be properly listed on a separate Adjustment Request Form to confirm and clear the claim.

C. Adjustment Request

To request routine adjustments, follow these instructions:

1. Indicate check mark ( ✓ ) in box for "Adjustment Request".
2. Complete the following information:

.Voucher date	.Recipient's HSP Case Number (patient's
.Voucher number	PAA identification number)
.Blue Cross locator number	.Claim number
.Recipient's full name	.Explanation Code
.Person number	.Dispensing date
	.Reason for Adjustment

614.2 Missing Claims Investigation/Adjustment Request Form (FD-84)

MISSING CLAIMS

Missing Claims investigation requests should be submitted separately from Adjustment Requests.

A. Time Limitation

Missing Claim Investigations for all claims must be received by Blue Cross of New Jersey not later than 180 days after the last date of service (dispensing date) as noted on the claim(s) in question.

B. Waiting Time

From the date of the last appearance of the claim on a voucher, a reasonable period of "waiting time" before instituting a Missing Claim Investigation is 45 days. PLEASE NOTE: 180 days is the maximum "waiting time".

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PHARMACEUTICAL SERVICES

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C. Missing Claims Investigation

To request investigation of apparent MISSING CLAIMS, follow these instructions:

1. Indicate check mark ( ✓ ) in box for "Missing Claims Investigation".
2. Complete the following information:
  - . Voucher date, if applicable (use latest date claim appeared)
  - . Voucher number, if applicable
  - . Blue Cross locator number, if applicable
  - . Recipient's full name
  - . Recipient's HSP Case Number (PAA patient's identification number)
  - . Person number (PAA person number is always 01)
  - . Claim number
  - . Explanation code (if applicable)
  - . Dispensing date

615. RESUBMISSION OF CLAIMS

Claims are to be resubmitted only when the pharmacist is requested to do so. Unauthorized resubmission of claims will create a "duplicate claim" situation (Code 62) and a further delay in clearance.

615.1 Procedure for Resubmission of Claims

When the pharmacist receives approval to resubmit a claim, the following procedure should be instituted:

- A. Copy the information that appeared on the original claim form (including original dispensing date) onto the new claim form.
- B. Note on the front of the new claim the word "resubmitted" in the "Signature of Patient or Representative" area of the claim form (MC-6).
- C. Enter the old claim number and the word "resubmitted" on the back of the claim form.

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PHARMACEUTICAL SERVICES

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D. Submit this claim(s) in a separate envelope marked, ATTENTION:

Medicaid Prescription Inquiry Unit.

Inquiries regarding additional information, a specific claim or a request for additional forms should be directed to the Medicaid Prescription Inquiry Unit at (201) 456-2894, 456-2895, 456-2896, 456-2897, 456-2898, or:

Blue Cross of New Jersey  
P.O. Box 549  
Newark, New Jersey 07101

616. TAPE-TO-TAPE CLAIMS AND COMPUTER GENERATED HARD COPY CLAIMS

In addition to the conventional claim form MC-6 which is hand-prepared, The Division of Medical Assistance and Health Services will authorize the submission of claims which may either be created on a hard copy by computer or created on magnetic tape.

Providers may contact the following office for complete details and explanation of requirements for such methods of claim submission:

Technical Services Operations  
Blue Cross of New Jersey  
33 Washington Street  
Newark, New Jersey 07102

(201) 456-2937