DATE: August 25, 2017

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Adopted Rule: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual (MBM), Ch. II, Sec. 80, Pharmacy Services

This letter gives notice of an adopted rule: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual (MBM), Ch. II, Sec 80, Pharmacy Services

This rulemaking adopts the following changes:

1. Definitions of “Acute Pain,” “Buprenorphine,” “Chronic Pain,” “Opioid Medication,” and “Prescription Monitoring Program” have been added to Section 80.01, Definitions.

2. In Section 80.07-6, Policies and Procedures, Dispensing Practices, language has been added requiring that generic drugs must be dispensed as a ninety (90) day supply for drugs identified as maintenance drugs after the initial thirty (30) day supply, with additional language excluding opioid medications from the requirement.

3. The addition of a new section, Section 80.07-12, Prescribing Opioids for Pain Management, which aligns MaineCare with Maine statutes and the Department’s Office of Substance Abuse and Mental Health Services rules governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications. The section incorporates current best practices guidelines and includes subsections on prescribing requirements for treating chronic pain; limitations and exemptions; rules regarding prior authorization for both acute and chronic pain prescriptions; and medical record documentation requirements.

4. The addition of a new section, Section 80.07-13, Buprenorphine and Buprenorphine Combination Products for Substance Use Disorder (SUD) which provides best practice guidelines for Medication-Assisted Treatment (MAT) using buprenorphine and derivatives for individuals who have been diagnosed with SUD. This sections includes subsections associated with prescriber requirements; detailed protocols; limitations on members qualified to receive the drug; and rules regarding prior authorizations. The section also outlines requirements for medical records which follow the model established by the Drug Addiction Treatment Act of 2000 (DATA).

5. Section 80.09, the reimbursement sections for retail and specialty pharmacy providers, has been amended to align MaineCare policy with the CMS Covered Outpatient Drug final rule. The change to this section also includes changing the pharmacy dispensing fee from $3.35 to $11.89 following the New England States Consortium Systems Organization (NESCISO) pharmacy cost of dispensing survey.

Finally, as a result of public comments and further review by the Department and the Office of the Attorney General, there were additional technical changes, formatting updates, and changes to language for clarity. The Summary of Public Comments and Department Responses document identifies changes that were made to the final rule.

Rules and related rulemaking documents may be reviewed at, or printed from, the Office of MaineCare Services website at [http://www.maine.gov/dhhs/oms/rules/index.shtml](http://www.maine.gov/dhhs/oms/rules/index.shtml) or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or call Maine Relay at 711.
A concise summary of the adopted rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process.
Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Section 80, Pharmacy, Chapter II

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This rulemaking adopts the following changes:

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EFFECTIVE DATE: September 1, 2017

AGENCY CONTACT PERSON: Thomas M Leet, Comprehensive Health Planner

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## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.01 DEFINITIONS .................................................................</td>
</tr>
<tr>
<td>80.01-1 Authorized Representative .................................................</td>
</tr>
<tr>
<td>80.01-2 Acute Pain ..........................................................................</td>
</tr>
<tr>
<td>80.01-3 Brand-Name Drug ..................................................................</td>
</tr>
<tr>
<td>80.01-4 Buprenorphine ....................................................................</td>
</tr>
<tr>
<td>80.01-5 Caloric Supplements/Substitutes ...........................................</td>
</tr>
<tr>
<td>80.01-6 Chronic Pain ........................................................................</td>
</tr>
<tr>
<td>80.01-7 Compound Prescription ..........................................................</td>
</tr>
<tr>
<td>80.01-8 Controlled Substances ............................................................</td>
</tr>
<tr>
<td>80.01-9 Covered Drugs .....................................................................</td>
</tr>
<tr>
<td>80.01-10 Creditable Coverage ............................................................</td>
</tr>
<tr>
<td>80.01-11 DESI ..................................................................................</td>
</tr>
<tr>
<td>80.01-12 Dispensing Practitioner ..........................................................</td>
</tr>
<tr>
<td>80.01-13 Drug Utilization Review (DUR) ................................................</td>
</tr>
<tr>
<td>80.01-14 Drug Utilization Review Committee (DUR Committee) .................</td>
</tr>
<tr>
<td>80.01-15 Food and Drug Administration Orange Book ..................................</td>
</tr>
<tr>
<td>80.01-16 Formulary ..........................................................................</td>
</tr>
<tr>
<td>80.01-17 Generic Drugs ....................................................................</td>
</tr>
<tr>
<td>80.01-18 Legend Drug .......................................................................</td>
</tr>
<tr>
<td>80.01-19 Lock-In ............................................................................</td>
</tr>
<tr>
<td>80.01-20 Mail Order Pharmacy ...............................................................</td>
</tr>
<tr>
<td>80.01-21 Maine Drugs for the Elderly Program (DEL) .................................</td>
</tr>
<tr>
<td>80.01-22 Maine Maximum Allowable Cost (MMAC) ....................................</td>
</tr>
<tr>
<td>80.01-23 Maintenance Drugs ................................................................</td>
</tr>
<tr>
<td>80.01-24 Maximum Allowable Cost (MAC) .................................................</td>
</tr>
<tr>
<td>80.01-25 Medical Food ......................................................................</td>
</tr>
<tr>
<td>80.01-26 Medicare Part D ...................................................................</td>
</tr>
<tr>
<td>80.01-27 Medicare Part D Excluded Drug ...............................................</td>
</tr>
<tr>
<td>80.01-28 Medi-Span .........................................................................</td>
</tr>
<tr>
<td>80.01-29 Metropolitan Statistical Area (MSA) ..........................................</td>
</tr>
<tr>
<td>80.01-30 National Drug Code (NDC) ......................................................</td>
</tr>
<tr>
<td>80.01-31 New Drugs .........................................................................</td>
</tr>
<tr>
<td>80.01-32 Non-Preferred Drugs ..............................................................</td>
</tr>
<tr>
<td>80.01-33 OBRA 90 ...........................................................................</td>
</tr>
<tr>
<td>80.01-34 Opioid Medication .................................................................</td>
</tr>
<tr>
<td>80.01-35 Over-ride ..........................................................................</td>
</tr>
<tr>
<td>80.01-36 Over-The-Counter Drug (OTC) ..................................................</td>
</tr>
<tr>
<td>80.01-37 Pharmacy Provider ................................................................</td>
</tr>
<tr>
<td>80.01-38 Preferred Drugs ...................................................................</td>
</tr>
<tr>
<td>80.01-39 Preferred Drug List ...............................................................</td>
</tr>
<tr>
<td>80.01-40 Prescription Monitoring Program .............................................</td>
</tr>
<tr>
<td>80.01-41 Retail Pharmacy ...................................................................</td>
</tr>
<tr>
<td>80.01-42 Specialty Drug ...................................................................</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.01-43</td>
<td>Specialty Drug List</td>
<td>5</td>
</tr>
<tr>
<td>80.01-44</td>
<td>Specialty Pharmacy Provider</td>
<td>5</td>
</tr>
<tr>
<td>80.01-45</td>
<td>State Drug File</td>
<td>5</td>
</tr>
<tr>
<td>80.01-46</td>
<td>Telepharmacy</td>
<td>5</td>
</tr>
<tr>
<td>80.01-47</td>
<td>Therapeutic Category</td>
<td>5</td>
</tr>
<tr>
<td>80.01-48</td>
<td>Usual and Customary Charge</td>
<td>5</td>
</tr>
<tr>
<td>80.02</td>
<td>ELIGIBILITY FOR CARE</td>
<td>5</td>
</tr>
<tr>
<td>80.03</td>
<td>DURATION OF CARE</td>
<td>6</td>
</tr>
<tr>
<td>80.04</td>
<td>PHARMACY COMMITTEES</td>
<td>6</td>
</tr>
<tr>
<td>80.04-1</td>
<td>Drug Utilization Review (DUR) Committee</td>
<td>6</td>
</tr>
<tr>
<td>80.04-2</td>
<td>Formulary Committee</td>
<td>12</td>
</tr>
<tr>
<td>80.04-3</td>
<td>Academic Detailing Committee</td>
<td>16</td>
</tr>
<tr>
<td>80.05</td>
<td>COVERED SERVICES</td>
<td>17</td>
</tr>
<tr>
<td>80.05-1</td>
<td>Drug Benefits</td>
<td>17</td>
</tr>
<tr>
<td>80.05-2</td>
<td>Compound Prescriptions</td>
<td>18</td>
</tr>
<tr>
<td>80.05-3</td>
<td>Drugs Covered for Certain Conditions/Procedures Only</td>
<td>18</td>
</tr>
<tr>
<td>80.05-4</td>
<td>Drugs Obtained Through The Department’s Mail Order Pharmacies</td>
<td>18</td>
</tr>
<tr>
<td>80.06</td>
<td>NON-COVERED SERVICES</td>
<td>18</td>
</tr>
<tr>
<td>80.07</td>
<td>POLICIES AND PROCEDURES</td>
<td>20</td>
</tr>
<tr>
<td>80.07-1</td>
<td>Regulation of Pricing</td>
<td>20</td>
</tr>
<tr>
<td>80.07-2</td>
<td>Standards of Participation for Retail Pharmacies</td>
<td>20</td>
</tr>
<tr>
<td>80.07-3</td>
<td>Standards for Mail Order Pharmacies</td>
<td>21</td>
</tr>
<tr>
<td>80.07-4</td>
<td>Prior Authorization (PA)</td>
<td>22</td>
</tr>
<tr>
<td>80.07-5</td>
<td>Preferred Drug List (PDL)</td>
<td>26</td>
</tr>
<tr>
<td>80.07-6</td>
<td>Dispensing Practices</td>
<td>29</td>
</tr>
<tr>
<td>80.07-7</td>
<td>Refills</td>
<td>31</td>
</tr>
<tr>
<td>80.07-8</td>
<td>Pharmacist's Responsibility</td>
<td>32</td>
</tr>
<tr>
<td>80.07-9</td>
<td>Restriction and Narcotic Prescriber Plans</td>
<td>32</td>
</tr>
<tr>
<td>80.07-10</td>
<td>Program Integrity</td>
<td>32</td>
</tr>
<tr>
<td>80.07-11</td>
<td>Over-Rides</td>
<td>32</td>
</tr>
<tr>
<td>80.07-12</td>
<td>Prescribing Opioids for Pain Management</td>
<td>33</td>
</tr>
<tr>
<td>80.07-13</td>
<td>Buprenorphine and Buprenorphine Combination Products for Substance Use Disorder (SUD)</td>
<td>37</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

80.08 CO-PAYMENT .................................................................................................................... 41
  80.08-1 Pharmacy Benefits Provided By Retail and Specialty Pharmacy Providers ............. 41
  80.08-2 Pharmacy Benefits Provided By Mail Order Pharmacy Providers.......................... 42
  80.08-3 Benefit for People Living With HIV/AIDS................................................................. 42
  80.08-4 Tobacco Cessation Products With No Co-Payment Requirements......................... 42

80.09 REIMBURSEMENT ............................................................................................................ 42
  80.09-1 Reimbursement Rates............................................................................................... 42

80.10 BILLING INSTRUCTIONS .............................................................................................. 48
80.01 DEFINITIONS

80.01-1 **Authorized Representative** refers to the Department’s authority per 22 M.R.S.A. §§ 3174-II and LD 1325 to enroll and reenroll MaineCare members into a Medicare Part D plan, apply for Medicare Part D benefits and subsidies on their behalf, and at the Department’s discretion, file exceptions and appeals on their behalf. The Department may also identify a designee for this function.

80.01-2 **Acute pain** is pain, whether related to disease, injury, or recent surgery, that is the normal, predicted physiological response and is time-limited, usually diminishing with soft tissue healing.

80.01-3 **Brand-Name Drug** is defined as a single-source drug, a cross-licensed drug, or an innovator drug.

80.01-4 **Buprenorphine** is used in Medication-Assisted Treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine. Buprenorphine and all products containing buprenorphine are controlled in Schedule III of the Controlled Substances Act.

80.01-5 **Caloric Supplements/Substitutes** are over-the-counter products that contain fats, and/or proteins, and/or carbohydrates and are prescribed by a licensed provider for the express purpose of enhancing caloric intake to address an illness or condition.

80.01-6 **Chronic Pain** is pain that persists beyond the usual course of an acute disease or healing of an injury that causes continuous or intermittent pain over months or years and involves neurological, emotional, and behavioral features that often impact a patient’s quality of life and function.

80.01-7 **Compound Prescription** is any product for which two (2) or more ingredients are extemporaneously mixed in usually accepted therapeutic doses. This requires the pharmacist’s skill in weighing, measuring, levigating, etc., at the time of dispensing. The allowable compounding fee applies to the preparation of an individual prescription. It does not apply to prescriptions dispensed from a previously prepared stock supply (i.e., premixing a special lotion or ointment in gallons or pounds).

80.01-8 **Controlled Substances** are drugs that come within the scope of the Controlled Substances Act and are divided into five schedules- I, II, III, IV and V.

80.01-9 **Covered Drugs** are drugs that are reimbursable pursuant to Section 80.05.

80.01-10 **Creditable Coverage** is when the actual value of coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines.
80.01 DEFINITIONS (cont.)

80.01-11 DESI means the Drug Efficacy Study Implementation Program of the Food and Drug Administration (FDA).

80.01-12 Dispensing Practitioner is a licensed practitioner who, within the scope of his or her license, prepares and dispenses medication, instructs patients to self-administer medication on a regular basis, and is located no less than fifteen (15) miles from a licensed pharmacy.

80.01-13 Drug Utilization Review (DUR) means a process designed to ensure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical results.

80.01-14 Drug Utilization Review Committee (DUR Committee) means an advisory committee to the Department of Health and Human Services for the MaineCare program and other State prescription benefits administered by the Office of MaineCare Services (OMS), comprised of physicians and pharmacists who are licensed to prescribe or dispense drugs in Maine. The DUR Committee conducts drug utilization review for the Department.

80.01-15 Food and Drug Administration (FDA) Orange Book, referred to as the “Orange Book” in this Section, is the FDA Approved Drug Products with Therapeutic Equivalence Evaluations, which rates the therapeutic equivalence of generic drugs.

80.01-16 Formulary is a list of medicines that includes all Legend (prescription) Drugs, to comply with OBRA 90 as amended, except those excluded by these regulations and those over-the-counter drugs listed in Section 80.05-1.

80.01-17 Generic drugs are drugs other than those defined as brand-name drugs.

80.01-18 Legend Drug is a drug bearing the statement "CAUTION: Federal Law Prohibits Dispensing Without a Prescription" or “Rx Only,” as allowed by the Food and Drug Administration.

80.01-19 Lock-in, for the purpose of this Section, is when members are restricted to obtaining all or specific prescriptions from only one provider and/or pharmacy.

80.01-20 Mail Order Pharmacy Provider is a pharmacy provider that dispenses prescription medications by U.S. mail or private carrier. Mail order pharmacy providers must have a NABP (National Association of Boards of Pharmacy) provider number uniquely identifying the provider as a mail order pharmacy for purposes of billing. Mail order pharmacy providers must be licensed by the Maine Board of Pharmacy, enrolled as Medicare and MaineCare providers, and be operating under contract with the Department. Mail order pharmacy providers must dispense prescription medications from within the United States. Mail order pharmacy providers must
80.01 DEFINITIONS (cont.)

process claims through the State’s electronic claims processing system to the standards required by the Department.

80.01-21 Maine Drugs for the Elderly Benefit (DEL) provides low-cost prescription and limited over-the-counter drugs and medical supplies to certain elderly and disabled members pursuant to 22 M.R.S.A. §254-D. The DEL Benefit, which is not a MaineCare benefit, is further described in Chapter 104, Section 2.

80.01-22 Maine Maximum Allowable Cost (MMAC) is the maximum cost allowed by the Maine Department of Health and Human Services for some multiple source drugs and other non-drug covered products provided through the pharmacy point of service system (POS).

80.01-23 Maintenance Drugs are drugs that are used to treat conditions that are usually chronic or long-term. Maintenance drugs include caloric supplements/substitutes, medical foods, and specialty drugs.

80.01-24 Maximum Allowable Cost (MAC) is the Federal Upper Limit (FUL) established by the federal government for certain prescription drugs. The MaineCare program reimbursement to a pharmacy may not exceed the MAC for any such drugs.

80.01-25 Medical Food is a product prescribed by a licensed provider for a member with special nutrient needs, in order to manage a disease or health condition, when the member is under the provider’s on-going care. The label must clearly state that the product is intended to manage a specific medical disorder or condition. An example of a medical food is a food for use by persons with phenylketonuria, i.e., foods formulated to be free of the amino acid phenylalanine. Medical foods are limited to formula only.

80.01-26 Medicare Part D means the prescription drug benefit provided under the Medicare Prescription Drug Improvement and Modernization Act of 2003, Public Law 108-173.

80.01-27 Medicare Part D Excluded Drugs are those drugs not covered by Medicare Part D pursuant to Title XIX, Section 1927, which the Department will continue to reimburse if otherwise covered under this Section.

80.01-28 Medi-Span is a nationally recognized published drug database. The Department uses the designations in this database to create its State drug file to determine which drugs are brand-name (single-source, cross-licensed or innovator) and which drugs are generic (multiple-source) drugs for the purposes of calculating reimbursement.

80.01-29 Metropolitan Statistical Area (MSA) is a federal standardized designation using postal zip codes to define rural areas. The Department will define rural by applying MSA/Non-MSA designation to the zip code of the member’s residence.
80.01 DEFINITIONS (cont.)

80.01-30 National Drug Code (NDC) is a universal drug coding system for human drugs established by the Federal Food and Drug Administration (FDA). The FDA assigns each drug a unique identifier specifying the labeler/vendor, product, and package.

80.01-31 New Drugs are drugs that receive a New Drug Application (NDA) from the Food and Drug Administration after November 1, 1990.

80.01-32 Non-Preferred Drugs are covered drugs that are not preferred drugs.

80.01-33 OBRA 90 is the Omnibus Budget Reconciliation Act of 1990 as amended.

80.01-34 Opioid Medication is a controlled substance containing an opioid and included in 21 United States Code, Section 812 or 21 Code of Federal Regulations, Part 1308.

80.01-35 Over-ride is a situation where unusual circumstances warrant the Department to authorize a pharmacy to waive a standard condition or requirement for dispensing a medication in order to process a claim.

80.01-36 Over-The-Counter Drug (OTC) is a drug that can be purchased without a prescription.

80.01-37 Pharmacy Provider is, for the purposes of determining the proper reimbursement charge, a corporation, association, partnership, or individual that either provides pharmacy services pursuant to a provider agreement or is related by ownership or control to an entity that provides MaineCare pharmacy services, and also accepts Medicare assignment. This definition of provider applies only to Section 80, Pharmacy Services, in the MaineCare Benefits Manual.

80.01-38 Preferred Drugs are covered drugs that have a lower net cost and/or advantages in clinical efficacy within a therapeutic category as determined by the Department after reviewing the recommendation of the Drug Utilization Review Committee.

80.01-39 Preferred Drug List (PDL) is a listing of covered drugs setting forth such information as their status as preferred or non-preferred, whether prior authorization is required, step order, and any other information as determined by the Department to be helpful to members, pharmacists, prescribers and other interested parties.

80.01-40 Prescription Monitoring Program (PMP) the Controlled Substances Prescription Monitoring Program, established under 22 M.R.S.A. § 7248, is a database of transactions for controlled substances dispensed in the State of Maine.

80.01-41 Retail Pharmacy Provider is a pharmacy that possesses a valid outpatient pharmacy license issued by the Board of Pharmacy, accepts Medicare assignment, and which serves MaineCare members. Out-of-state domestic retail pharmacy providers within fifteen (15) miles of the Maine/New Hampshire border are treated the same as Maine
SECTION 80  PHARMACY SERVICES  ESTABLISHED 4/1/79  LAST UPDATED 9/1/17

80.01  DEFINITIONS (cont.)

retail pharmacy providers, as provided in MaineCare Benefits Manual, Chapter I, Section 1.03.

80.01-42  Specialty Drugs are covered drugs that, due to their high cost, short shelf life, special handling requirements and instruction, or other factors, are obtained from Specialty Pharmacy Providers. Specialty drugs are prescribed for a limited number of usually chronic conditions that generally affect a relatively small portion of the population.

80.01-43  Specialty Drug List is a list established by the Department of covered drugs consisting of certain specialty drugs that the Department has determined may be obtained through Department-approved Specialty Pharmacy Providers. The Department will post and update the Specialty Drug List on the designated website.

80.01-44  Specialty Pharmacy Providers are those pharmacies approved by the Department to dispense specialty drugs. Specialty pharmacy providers must have a separate MaineCare provider number uniquely identifying the provider as a specialty pharmacy for purposes of billing. Specialty pharmacy providers must be approved by the Department, unless the pharmacy provider already has an approved written agreement with the Department as of April 1, 2005 to dispense growth hormones or synagis only.

80.01-45  State Drug File is the drug file database used by the Department for the purpose of managing the pharmacy benefit.

80.01-46  Telepharmacy is a method of delivering prescriptions dispensed by a pharmacist to a remote site. Pharmacies using telepharmacy delivery of prescriptions must follow all applicable State and Federal regulations and Maine State Board of Pharmacy rules, including using staff qualified to deliver prescriptions through telepharmacy.

80.01-47  Therapeutic Category is a grouping of drugs by comparable therapeutic effect, as determined by the Department.

80.01-48  Usual & Customary Charge is the reimbursement amount the general public is requested to pay for the goods or services provided.

80.02  ELIGIBILITY FOR CARE

Individuals must meet the eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify eligibility and benefit level. The following members are eligible for some or all of the covered services set forth in this Section:

MaineCare members who receive full MaineCare benefits and certain members who receive special benefits are eligible to receive pharmacy benefits as described in this Section.
80.02 ELIGIBILITY FOR CARE (cont.)

Members who are eligible for Medicare Part D are not eligible for MaineCare coverage of drugs covered by Medicare Part D. The Department may automatically enroll such eligible MaineCare members without creditable coverage into Medicare Part D and act as an authorized agent on their behalf. The Department will reimburse Medicare Part D Excluded Drugs for members dually eligible for Medicare Part D when those drugs are otherwise covered by MaineCare for members not eligible for Medicare Part D.

80.03 DURATION OF CARE

Each MaineCare member is eligible for as many covered services as are medically necessary within the limits of this Section. The Department reserves the right to request additional information to evaluate medical necessity.

80.04 PHARMACY COMMITTEES

80.04-1 Drug Utilization Review (DUR) Committee

A. Purpose

The purpose of the Drug Utilization Review (DUR) Committee is to provide advice to the OMS on prescription drug utilization with the goal of assuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse results. The DUR Committee is created in compliance with OBRA 90 as amended (Title XIX, Section 1927).

B. Membership

The Director of the OMS will appoint DUR Committee members. The Committee shall consist of at least the following members, to be composed as follows:

1. A minimum of four members shall be allopathic physicians currently licensed and actively practicing medicine in Maine.
2. One member shall be an osteopathic physician currently licensed and actively practicing medicine in Maine.
3. Three members shall be pharmacists currently licensed and actively practicing pharmacy in Maine.
4. One member shall be a designated pharmacy physician consultant.
5. One member shall be either a hospital pharmacist who is currently licensed and actively practicing pharmacy in Maine or a pharmacist with
pharmacy benefit management experience. The OMS Director may also require a hospital pharmacy background.

6. One pharmacist shall have been nominated by the DUR.

7. The Department shall be represented by at least one person employed by the Department and may include the MaineCare Medical Director or MaineCare Pharmacy Director. Department representatives will be available to provide information on policy and legislative changes, and assist the Board as needed.

The Department representative will support the DUR in assuring that DUR initiated policy, programmatic and system configuration changes are implemented. Department representatives are not considered voting members.

C. Method of Selection

The Director of the OMS shall choose appointed members of the DUR Committee from lists of nominees presented by the following groups. The Director may elect not to appoint from a list if no nominee on the list is acceptable to the Director. (These lists shall contain sufficient numbers of nominees in order to allow the OMS Director flexibility in selecting a Committee with diverse membership):

1. The physicians may be nominated by the Maine Medical Association, the DUR Committee, and other state medical societies including the Nursing Home Medical Director Association.

2. The osteopathic member may be nominated by the Maine Osteopathic Association, other medical societies, or the DUR Committee.

3. The pharmacists shall be nominated by the Maine Pharmacy Association or the DUR Committee.

4. The hospital pharmacist or pharmacist with pharmacy benefit management (PBM) experience shall be nominated by the Maine Society of Hospital Pharmacists or the DUR Committee.

5. The Committee may nominate candidates for ad-hoc specialty committees to offer advice on an as needed basis.

D. Terms of Appointment

Members of the DUR Committee shall be appointed to terms as follows:
80.04 PHARMACY COMMITTEES (cont.)

1. All physician and pharmacist members are appointed for three-year terms.

2. All vacancies shall be filled by the appointment of a person to fill the remainder of the term. Such person shall be from the same category as the person replaced.

3. No appointed person may serve more than three terms, except that appointees with initial terms of less than three years may be reappointed for three subsequent full three-year terms.

4. Except as otherwise noted, all subsequent appointments shall be for three-year terms.

5. In order to ensure the successful, uninterrupted operation of the DUR Committee, if no qualified and willing candidates are found, Committee members with expired appointments may have their term extended at the discretion of the OMS Director until such time as a suitable replacement is obtained.

E. Operation of the DUR Committee

The DUR Committee shall develop and adopt formal policies and procedures for its use. These policies shall include but not be limited to:

1. Selection of a chairperson;

2. Setting a schedule for regular meetings, (at least quarterly);

3. Setting quorum requirements;

4. Publishing notices of meetings;

5. Ensuring that all DUR activities will be consistent with confidentiality requirements of the DHHS, including 42 C.F.R. 431, sub part F;

6. Establishing, as needed, regional DUR committees to assist the DUR Committee in its evaluations;

7. Establishing procedures for appeal of its decisions;

8. Preparing and disseminating its minutes;

9. Agreeing to use a consensus process to resolve differences between source materials; and
10. Providing direction for the preparation and approval of its annual report.

F. Functions and Responsibilities

The DUR Committee shall be responsible for the following duties and functions:

1. In compliance with Federal and State requirements, the DUR Committee shall determine policy, procedures, and standards for the implementation of MaineCare DUR process, the primary focus of which shall be the utilization of drugs and education of providers and members to maximize the quality of care provided. The DUR may also review drug utilization from other pharmacy benefits. The DUR will make recommendations to the Department as to which drugs require prior authorization and the prior authorization criteria for those drugs. The DUR Committee will also review new drugs for Preferred Drug List (PDL) status.

2. The DUR shall develop and maintain a working agreement with related Boards, agencies or societies, including, but not limited to: the Board of Commissioners of the Profession of Pharmacy, the Maine Board of Osteopathic Medicine, the Board of Registration in Medicine, Program Integrity staff, the Maine Medical Association, the Maine Osteopathic Association, and the staff of the Office of MaineCare Services, in order to clarify the areas of responsibility for each.

3. The DUR Committee shall develop a drug utilization review process in accordance with the following:

   a. The DUR Committee shall develop parameters in accordance with Federal guidelines to perform on-going periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and MaineCare members.

   b. The DUR Committee shall establish standards of review based upon compendia that shall consist of at least the following:

      i. American Society of Hospital Pharmacists Formulary Service;

      ii. United States Pharmacopoeia Drug Information;

      iii. American Medical Association Drug Evaluations; and

      iv. Current peer-reviewed literature.
80.04 PHARMACY COMMITTEES (cont.)

c. The DUR Committee shall resolve, by consensus, any discrepancies in the compendia.

4. The DUR Committee shall:

   a. Submit recommendations to the OMS for policy changes for more efficient management of services,

   b. Provide for on-going intervention for members, physicians, and pharmacists targeted toward therapy problems, including individuals identified in the course of drug reviews performed under this section. Such interventions shall include in the appropriate instances the following:

      i. Information to physicians and pharmacists concerning the DUR Committee’s duties and the profile for its standards;

      ii. Written, oral, or electronic reminders concerning patient-specific or drug-specific (or both) information with suggested changes in prescribing or dispensing practices, communicated in a manner designated to ensure the privacy of member related information.

   c. Use face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions;

   d. Provide intensified review or monitoring of selected members, prescribers or dispensers; and

   e. Reevaluate interventions after an appropriate time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and to recommend modifications as necessary.

5. The DUR Committee shall:

   a. Review new drugs for Preferred Drug List (PDL) status and make determinations no later than six (6) months after their entry onto the market.
80.04 PHARMACY COMMITTEES (cont.)

b. In making a determination of PDL status, the DUR Committee shall consider whether a new drug is:

i. therapeutically equivalent or superior to existing preferred or non-preferred choices; and

ii. as safe or safer than existing preferred or non-preferred choices; and

iii. whether the net cost, adjusted for all rebates, is less expensive than all existing PDL choices.

c. The Department will designate new drug entities as follows:

i. If the FDA classifies a new medication as a priority drug, the Department may indicate that such a drug is preferred until the DUR Committee reviews the drug; or

ii. The Department may also decide to designate a new drug as "draft preferred" and provide immediate temporary access and increased therapeutic choice to physicians until the drug is reviewed; or

iii. The Department will designate new drug entities as non-preferred by default until the DUR Committee has completed the PDL review.

6. The DUR Committee shall prepare and submit a report to the OMS Director not less frequently than annually that shall include a description of the Committee’s activities, including the nature and scope of the prospective and retrospective drug utilization review along with the DUR Committee’s recommendations, a summary of the interventions on quality of care, and an estimate of the savings generated as result.

7. Other reports and data shall be provided by the DUR Committee to the State at such time and in such format as the United States Secretary of Health and Human Services shall require from the State.

G. Confidentiality

The DUR Committee shall perform its duties in compliance with the confidentiality policies and rules of the OMS, including 42 C.F.R.b 431, sub part F and of other Maine boards of registration.
H. **Independence of the DUR Committee**

The DUR Committee’s relationship to the OMS’s Program Integrity Unit and to physician and pharmacist regulatory boards shall be as follows:

1. The DUR Committee shall not directly participate in any Program Integrity Unit fraud or abuse operation or activities except to the extent that educational materials prepared by the DUR Committee are provided to the OMS, as they are provided, members, and to the public.

2. The DUR Committee shall not involve itself as an entity in any individual cases relating to professional conduct or practice standards that may be before physicians’ (MD or DO), or pharmacists’ regulatory or oversight boards.

3. The DUR Committee may, however, following educational interventions and other educational assessments it may perform, refer individual matters to the OMS or to the appropriate regulatory board if in its judgment such referral is appropriate.

80.04-2 **Formulary Committee**

A. **Purpose**

The purpose of the Formulary Committee, if initiated, will be to establish a formulary for the MaineCare program to identify which prescription and over-the-counter drugs are subject to coverage under the MaineCare program in compliance with OBRA 90 as amended (Title XIX, Section 1927). The statutory authority to establish a Formulary Committee is found at 22 M.R.S.A. §3174-M.

B. **Membership**

The Director of OMS will appoint the Formulary Committee. The Committee shall consist of nine members, including three actively practicing pharmacists and three actively practicing physicians.

At least one pharmacist shall be a clinical hospital pharmacist. At least one physician shall be a doctor who specializes in infectious diseases, one in primary care, and one in surgery. The pharmacists and physicians shall be MaineCare providers and shall serve for staggered three-year periods of time at the pleasure of the Director of the OMS.
PHARMACY SERVICES

SECTION 80

PHARMACY COMMITTEES (cont.)

In addition to the members outlined above, the Director of the OMS or the
Director's designee, as well as the Pharmacy Unit Manager employed by the
OMS, and the Director of the Maine HHS Public Health or the Director's
designee shall serve on the Committee. In addition to the nine voting members
outlined above, the Formulary Committee will have at least two non-voting
consumer members appointed by the MaineCare Advisory Committee, who
shall not be included when determining a two-thirds majority. The committee
shall choose a chairperson from among the voting members. The Director of
the OMS will appoint a secretary.

C. Meetings

Meetings of the Drug Formulary Committee will be held at the discretion of
the Director of the OMS or the Committee chairperson upon written petition of
one-third of the Committee members.

D. Approval of New Drugs

Drugs will be added to the formulary, and will be deleted from the formulary,
only upon a vote of two-thirds of the Formulary Committee members present,
the procedure for which is described in Section 80.04-2(E). When a new drug
does not meet the two-thirds vote for approval to be added to the formulary,
requests for such drugs shall be reviewed on a prior authorization (PA) basis as
outlined in Section 80.07-4.

E. Formulary Policy and Procedures

1. Drugs will be considered for addition to the formulary in one of four ways:

a. By the Formulary Committee, on the basis of evidence of
   sufficient requests for the drug through the PA process outlined
   in Section 80.07-4 to justify consideration for addition to the
   formulary.

   The OMS may also request consideration of drugs based on the
   volume of inquiries received.

b. The Committee may initiate consideration of over-the-counter
   drugs, since such drugs are not generally approved through the
   PA process.

c. The Committee may also, through an on-going review of the
   formulary by therapeutic class, identify areas that are deficient or
   areas of possible deletion or restriction.
d. The drug manufacturer may initiate consideration of drugs for which there will be no fiscal impact as defined herein.

2. The steps to be followed for consideration by the Committee for the addition of drugs to the formulary are as follows:

   a. The Department will prepare material for distribution to Committee members commenting on efficacy, therapeutic benefits, and current peer reviewed literature.

   The Committee will arrange for specialty providers, as appropriate, to comment on this written material. The Department shall classify the drug(s) under consideration into one of three categories, described below, which shall trigger a predetermined procedure. The Committee shall review that determination and after review of the available material, may change the determination by a two-thirds majority vote of those members present.

   **Category A:**

   Therapeutic benefit and no projected fiscal impact or no therapeutic benefit and no projected fiscal impact.

   Approval for drugs with no fiscal impact as defined herein shall be submitted to the next meeting of the Formulary Committee and shall be automatically recommended for addition to the formulary. No projected fiscal impact is defined as follows:

   Reimbursement for the drug at the lowest adult daily dose for the primary indication will be compared to the average of the costs of the lowest adult daily dose for drugs within the same class, weighted by utilization for each drug within that class for the prior quarter. No consideration should be given to recommended course of therapy, improved compliance, etc., for drugs in this category.

   For combination drugs, the billed amount should be less than the combined prices of its components to have no fiscal impact.

   **Category B:**

   Therapeutic benefit and a projected fiscal impact.

   Therapeutic benefit is defined as a clinically (not pharmacologically) more effective drug and/or a less toxic drug than alternative therapies currently on the formulary.
A drug for which the sole advantage is convenience or compliance is not considered to have a therapeutic benefit.

Therapeutic benefit will be addressed by the clinician assigned the particular drug through his or her review with a final determination made by the Committee.

Drugs with an estimated fiscal impact shall normally be added to the formulary only in one of two ways:

i. a specific appropriation of funds from the Legislature with approval of the Governor; or

ii. a deletion of other drugs from the formulary to maintain budget neutrality.

The therapeutic benefit of the drug being considered should be weighed against the therapeutic benefit of drugs already on the formulary. If the value of the drug under consideration is not thought to be great enough to justify an offsetting deletion and if no funds are appropriated for the addition, the drug shall be put on a pending list of drugs to be added to the formulary once funds become available.

Category C:

No therapeutic benefit and a projected fiscal impact.

a. Drugs determined to be of no therapeutic benefit that have a projected fiscal impact shall not be added to the formulary. Such drugs would be available only through the PA process to the extent necessary for a specific individual.

b. At the conclusion of discussion of all drugs being considered at a meeting, the Committee members shall record their vote for each drug on a form to be supplied at each meeting. The Chairperson will tally the votes and announce the Committee's preliminary determination. Written documentation of the vote will be kept on file at the OMS.

c. The Department shall promulgate as a rule any additions or deletions to the formulary. After any hearing or comment period has expired, the Committee shall review any comments and take a final vote on the addition or deletion of any drugs.
80.04 PHARMACY COMMITTEES (cont.)

Any preliminary or final determination by the Committee requires a two-thirds majority vote of the members present. Inclusion of a drug on the formulary will automatically include all conventional dosage forms of that drug, with the exception of transdermal systems, sustained release and injectable dosage forms, unless specifically approved by the Formulary Committee.

d. All drugs added to the formulary will be referred to the Drug Utilization Review Committee for monitoring.

80.04-3 Academic Detailing Committee

A. Purpose

The purpose of the Academic Detailing Committee is to provide evidence based education to providers to enhance the health of residents of the State, to improve the quality of decisions regarding drug prescribing, to encourage better communication between the department and health care practitioners participating in publicly funded health programs and to reduce the health complications and unnecessary costs associated with inappropriate drug prescribing.

B. Membership

Committee

The Director of Health Care Management will appoint the Academic Detailing Committee. The Committee shall consist of at least one prescriber, pharmacist and one private insurance agency representative. Others may be asked to join based on specialty. The Committee will meet quarterly to review the status of the work group projects. The term of an appointment shall be up to four (4) years.

Work Group

The workgroup will consist of the detailers, the Department and its contractors.

C. Meetings

Meetings of the Academic Detailing Committee will be held no less than quarterly.

The work group will meet monthly. Each quarter the group will report to the Committee on the work performed, results of detailing and next steps.
80.04 PHARMACY COMMITTEES (cont.)

D. Funding

Funding for this program will be made available through the collection of fees under Maine statute, 22 M.R.S.A. §2700-A, governing clinical drug trials.

E. Outreach

The work group with the Committee’s guidance, will create an outreach and prescription drugs as issued in peer reviewed, scientific, medical and academic research publications. Results and recommendations will be made available to prescribers and dispensers of drugs in the State through written information and through personal visits from staff. Program components, to the extent possible, must include information regarding clinical trials, pharmaceutical efficiency, adverse effects of drugs, evidence based treatment options and drug marketing approaches that are intended to circumvent competition from generic and therapeutically equivalent drugs. All components of the program will be reviewed and agreed upon by the Committee. The Committee shall ensure that the program adheres to standards of conduct required by 22 MRSA 2685 (3).

80.05 COVERED SERVICES

80.05-1 Drug Benefits

Reimbursement is available for the following drugs when medically necessary.

A. Legend drugs. All legend drugs found on the MaineCare program State drug file, except those drugs set forth in Section 80.05-3, which must meet the requirements of prior authorization, and those drugs set forth in Section 80.05-4, which are covered for certain diagnoses only as set forth in that Section. In addition, those legend drugs described as a non-covered service in Section 80.06 are not reimbursable.

B. Over-the-Counter drugs. Some over-the-counter drugs and supplies are covered when filled pursuant to a prescription. Over-the-counter drugs will be eligible for reimbursement, by prescription only, if such coverage is efficacious, safe, has a lower net cost, the drug has an NDC, and coverage is recommended by the Drug Utilization Review Committee and approved by the Department. A list of covered over-the-counter drugs will be posted and updated on the Department’s designated website.

C. Medicare Part D Excluded Drugs

The Department will post a complete list on its designated website of Medicare Part D Excluded Drugs that are covered drugs under this Section to the extent that they are covered for MaineCare non-dual eligible members.
80.05 COVERED SERVICES (cont.)

80.05-2 Compound Prescriptions

Reimbursement may be made for a compound prescription when the Department determines that the compound prescription contains at least one ingredient that is a legend drug, present in a therapeutic quantity, and obtainable in effective strength only by prescription.

A compound prescription, which contains a laxative, stool softener, vitamin, antacid or cough and cold preparation and is prescribed solely to circumvent these MaineCare reimbursement limitations, is not covered. Reimbursement for compound drugs must not include the cost of DESI (less than effective) drugs. The primary ingredient contained in a compound prescription must be covered under a rebate agreement with the MaineCare program and have a valid NDC in the State’s drug file.

80.05-3 Drugs and Products Covered for Certain Conditions/Procedures Only

Reimbursement for Methamphetamine, methylphenidate, dexamphetamine, and dextroamphetamine for attention deficit disorders or narcolepsy will be made only for the conditions described and only when the prescriber has written the diagnosis on the prescription.

Reimbursement for formula as a medical food product will be available for a member with special nutrient needs when the prescription includes a written diagnosis.

For a member living in a nursing facility or an ICF-IID the diagnosis must be noted in the member’s chart.

80.05-4 Drugs Obtained Through the Department’s Mail Order Pharmacy Providers

Members are not required to obtain drugs through mail order. Members may voluntarily choose to obtain drugs through mail order. All prior authorization requirements apply to drugs obtained through mail order pharmacy providers. There is no member co-payment for drugs obtained through a mail order pharmacy provider. When refilling a prescription through a mail order pharmacy provider, refills may be provided only by a member’s request; mail order pharmacy providers may not automatically refill prescriptions for members.

Providers of mail order pharmacy services must be enrolled as a Mail Order Pharmacy Provider. The Department or mail order pharmacy providers will provide members and providers with instructions for submitting a prescription by mail order.

80.06 NON-COVERED SERVICES

MaineCare does not reimburse for the following drugs or products as drugs:

A. Anorexic, or certain weight loss drugs.
80.06 NON-COVERED SERVICES (cont.)

B. Vitamins, vitamin combinations, and herbal products other than those listed on the PDL, except vitamins covered for dialysis and members with quadriplegia and paraplegia or when the criteria in Section 80.05-3 are met, and prenatal vitamins.

C. Hexachlorophene scrubs for nursing facility patients.

D. Products listed as part of the per diem rate of reimbursement in Chapter II, Section 67, Nursing Facility Services, or as defined in Section 50, ICF-IID Services, or as defined in Section 60, Medical Supplies and Durable Medical Equipment, of the MaineCare Benefits Manual or as defined in Attachment A or B of the Agreement between the Department and an assisted living facility.

E. Drugs discontinued or recalled by the manufacturers.

F. Less than Effective Drugs (DESI) as defined by the Food and Drug Administration.

G. Drugs prescribed for TB (these are normally available free of charge from the Maine HHS Public Health's Tuberculosis program). MaineCare coverage is only available after referral from the Maine HHS Public Health and MaineCare prior authorization.

H. Over-the-counter drugs except drugs listed on the Department’s designated website.

I. Any drug that is for experimental use or prescribed for indications (other than those approved under OBRA 90 guidelines) or have no Food and Drug Administration (FDA) sanctioned or approved indications; unless there is evidence of two published peer-reviewed placebo-controlled randomized trials and all cost-effective choices for the specific condition have failed.

J. Drugs not covered under OBRA 90 as amended.

K. Drugs prescribed primarily for cosmetic purposes, e.g., Retin-A when used for wrinkles, Rogaine for hair growth.

L. Drugs of manufacturers not participating in the federal Medicaid Rebate program pursuant to 42 U.S.C. §1396r-8, except certain over-the-counter drugs, enteral and parenteral products and instances where no clinically equivalent drug is available.

M. Fertility drugs.

N. Drugs, Medical Food or nutritional support products prescribed for managing body weight or enhancing nutritional intake when the member is able to eat conventional foods.

O. Agents when used for the symptomatic treatment of cough and cold unless on the Preferred Drug List.

P. Early refills, as detailed in Section 80.07-7.
80.06 **NON-COVERED SERVICES** (cont.)

Q. Drugs used to treat sexual or erectile dysfunction are not covered, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration.

R. Medicare Part D covered drugs for Medicare Part D eligible members.

S. Effective October 1, 2007, prescriptions in written and non-electronic form that are not executed on a tamper-resistant pad, as required by section 1903(i)(23) of the Social Security Act (42 USC §1396b(i)(23)). Providers must comply with all of the provisions of this Act in order to be appropriately reimbursed.

80.07 **POLICIES AND PROCEDURES**

80.07-1 **Regulation of Pricing**

A. Drugs added and deleted and price changes with regard to drugs that fall within the parameters of the Federal Upper Limits will be updated upon notification from the United States Government Centers for Medicare and Medicaid Services (CMS).

B. Price changes with regard to drugs that fall within the MMAC guidelines and all other MaineCare drugs will be updated according to periodic review by the Department of fluctuations in the average wholesale price list maintained by the Department of Health and Human Services, OMS under the guidelines of OBRA 90, as amended. The Department is under no obligation to apply these changes retroactively.

C. Designation of an effective date for all MMAC changes will be determined together with allowance for mailing requirements in order to afford a minimum five (5) day notice to the provider.

80.07-2 **Standards of Participation for Retail Pharmacy Providers**

A. A pharmacy provider must be duly licensed or certified by the appropriate regulatory body in the state in which it is located, and must also be approved and accepting Medicare assignment.

B. The Department may issue a request for proposals from labelers or manufacturers and issue a contract for the provision of generic drugs.

Participant providers may be required by the Department to obtain a generic drug from labelers or manufacturers with which the Department contracts. The Department will notify providers and give instructions for compliance with this provision.
80.07 Policies and Procedures (cont.)

C. An out-of-state provider may participate and receive payment for dispensed drugs only if the member has been injured or suffers a disease or illness while temporarily absent from Maine. MaineCare will only reimburse drugs dispensed by out-of-state providers on an emergency basis. Coverage of chronic or maintenance drugs is not considered an emergency. Exceptions to this requirement are 1) domestic border providers within fifteen (15) miles of the Maine/New Hampshire border, as defined in Section 80.01-31, that provide regular services to Maine members; or 2) those pharmacies that provide drugs for foster care children or other members who permanently reside in other states and are wards of the State of Maine.

D. A pharmacy provider will receive reimbursement only for drugs supplied by manufacturers who comply with the rebate requirements of the CMS in accordance with the Omnibus Budget Reconciliation Act of 1990. If a pharmacy provider does not have a drug available that is provided by a manufacturer/labeler who complies with the rebate requirement of CMS in conformance with OBRA 90, the pharmacist must directly and individually inform the individual of other pharmacies that may carry the drug.

Additionally, drugs that are otherwise covered by MaineCare but are provided from manufacturers/labelers not covered under the rebate agreement may be subject to prior authorization requirements upon thirty days written notice from the OMS. (See 80.07-4 for prior authorization policy.)

E. Any pharmacist or dispensing practitioner, whether in state or out-of-state, who wishes to submit claims for payment must be an approved MaineCare provider. Providers must submit an application (MaineCare Provider Agreement) for approval by the OMS, Provider Enrollment Unit. The OMS will review the application and notify the submitting provider whether or not he or she is accepted as a provider and if accepted, the effective date. An application may be denied, terminated or not renewed for any of the grounds set forth in the MaineCare Benefits Manual, Chapter I. A signed agreement must be on file before any reimbursement for any item or service will be made.

80.07-3 Standards for Mail Order Pharmacy Providers

Mail order pharmacy providers must be appropriately licensed by the Maine Board of Pharmacy and by the appropriate licensing authority in the state in which they are located. Mail order pharmacy providers must satisfy all MaineCare provider enrollment requirements including, but not limited to, meeting standards for quality of care and prior authorization requirements as established by the Department, accepting Medicare assignment, and operating under contract with the Department. Mail order pharmacy providers must dispense MaineCare prescription medications from within the United States.
80.07 POLICIES AND PROCEDURES (cont.)

80.07-4 Prior Authorization (PA)

A. Determining Which Drugs May Be Subject to Prior Authorization

The Department may require prior authorization for certain drugs as set forth in this Section. In all instances, MaineCare members will be assured access to all medically necessary outpatient drugs.

In determining when prior authorization will be required, the Department will consider the recommendations of the DUR Committee. The Department will provide notice of DUR meetings in newspapers, through legislative notice procedures, to the MaineCare Advisory Committee, the Maine Medical Association, and the Maine Osteopathic Association.

Those portions of the meetings that do not involve confidential or protected information, including, to the extent possible, the process of decision making, shall be open to the public.

The determination to impose prior authorization will be based on the efficacy, safety, and net cost of any given drug and of the other drugs within the therapeutic category. The Department’s determination of a drug’s efficacy and safety shall be consistent with the standards set forth in (1) the peer-reviewed literature, and (2) the following compendia: the American Hospital Formulary Service Drug Information, the United States Pharmacopeia-Drug Information, the DRUGDEX Information System, and American Medical Association Drug Evaluations. The Department’s determination of a drug’s net cost shall consider the pharmacy reimbursement amount as set forth at Section 80.09, as adjusted by any manufacturer rebates and/or supplemental rebates to be paid to the Department for that drug. The Department may not consider net cost when imposing prior authorization unless it determines that the drug to be subject to prior authorization has no significant clinical or safety advantages over one or more alternative drugs, when used for a given purpose.

The Department will provide prescribers with the list of drugs subject to prior authorization by posting and updating it on the designated website.

The Department will review previous Prior Authorization requests when reviewing a prior authorization for opioids/narcotics. Previous PA requests and medical records, as well as Lock-in or Intensive Benefits Management (IBM) records, may be considered in making decisions for current prior authorization requests.

The Department may require prior authorization of any generic drug that has a net cost that is greater than the net cost of its brand-name version.
80.07 POLICIES AND PROCEDURES (cont.)

B. Exemptions From Prior Authorization

The Department has the discretion to exempt providers and/or members from prior authorization requirements. The Department may discontinue these PA compliance exemptions any time with written notice. Exemptions are as described in this Section:

1. Provider Exemptions from Prior Authorization

   a. Three (3) Month PA Compliance Exemptions

      Providers may receive a three (3) month exemption from prior authorization requirements for certain categories of drugs when they demonstrate high compliance with the Department’s PDL. The Department runs quarterly reports to identify providers who prescribe ninety-five percent (95%) or more of their prescriptions, within certain categories of drugs, in compliance with the PDL.

      When providers are thus identified, they may receive a three (3) month exemption from PA requirements when prescribing drugs for members within the identified drug categories. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption.

   b. Twelve (12) Month PA Compliance Exemptions

      When providers have met all requirements for the three (3) month compliance exemption described above, and have received that exemption for three (3) out of four (4) quarters of a year, the Department may grant a one (1) year exemption for prior authorization requirements when prescribing drugs for members within certain categories of drugs. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption.

   c. Exemptions for Specialty Providers

      The Department, in consultation with the DUR Committee, and consistent with standards set forth in 80.07-4(A), may waive the prior authorization requirements for specific provider specialists on a drug-by-drug basis.
2. **Member Exemptions from Prior Approval**
   
a. **Primary Insurance Exemptions from Prior Authorization**

   The Department may waive the prior authorization requirements for members receiving non-preferred drugs when MaineCare is the secondary payer.

b. **Other Special Exemptions from Prior Authorization for Members**

   The Department, in consultation with the DUR Committee, and consistent with standards set forth in 80.07-4(A), may waive the prior authorization requirement for specific drugs or medical conditions, on a drug-by-drug basis for members who have been established for at least one (1) year on a drug that otherwise might be subject to prior authorization.

c. **Open-Ended Member Prior Approval**

   The Department may grant members open-ended PAs for some specified drugs listed on the Department’s designated website after having been established on a non-preferred drug and meeting all other prior authorization requirements for at least one (1) year, with the exception of any controlled substance drugs. These open-ended PAs do not need to be renewed on an annual basis. These PAs may be issued after the Department determines that the member’s condition is stable, and will remain unchanged if continued on the specific drug. The Department reserves the right to review and reconsider the PA status should a new and more efficacious alternative become available.

C. **Process for Seeking Prior Authorization**

   When the Department requires prior authorization, the member’s prescriber must complete a form in writing and submit it and any required attachments, documenting the medical necessity of the prescribed drug. The Department may seek information, such as documentation of other measures that have been attempted to correct the risk/condition, the timeframe in which those other measures were attempted, and the reason for failure. The prescriber is also required to submit documentation that other drugs in the same therapeutic category are contraindicated.
The Department will notify prescribers of the drugs that are subject to prior authorization and will provide them with forms for requesting authorization setting forth the information needed to approve a request. The forms will also be available on a website designated by the Department.

The requesting prescriber must complete the form applicable to the drug for which prior authorization is sought. The prescriber must send the completed form to the Department or its designee, as instructed by the Department, by mail, fax or by hand delivery, in compliance with the Health Insurance Portability and Accountability Act (HIPAA) standards.

During regular business days, the Department or its designee will respond to a completed request for prior authorization by fax, telephone or other telecommunications device within twenty-four (24) hours of receipt.

During weekends, holidays, or any other time that the Department or its designee is not able to respond to a completed prior authorization request within twenty-four (24) hours of receipt, the pharmacy provider is authorized to provide a one-time ninety-six (96)-hour supply of any prescribed drug that is a covered drug. The Department or its designee shall respond to a completed request under this subpart on the next regular business day. The provision of a ninety-six (96)-hour supply under this subpart does not relieve the prescriber of the obligation to complete and submit the prior authorization request form.

In the event that a prescriber fails to submit a completed form for a drug requiring prior authorization, the Department or its designee may authorize the pharmacy provider to dispense a one-time four (4)-day supply of the prescribed drug. The authorization of a one-time supply under this provision does not relieve the prescriber of the obligation to complete and submit the prior authorization request form. If the prescriber has still failed to submit a completed prior authorization request by the end of the additional four (4)-day period, the Department will consider any refills of that prescription on a case-by-case basis.

Prior authorization is effective for up to twelve (12) months unless otherwise specified by the Department. In instances where coverage is continued pending an approval, the period of PA is calculated from the latter of either the end date of the previous approval or the date of the request for a hearing, unless otherwise specified by the Department.

D. Temporary Prior Authorization Requirements:

Drugs that have not been reviewed by the DUR Committee may be subject to temporary prior authorization by the Department under the following circumstances:
80.07 POLICIES AND PROCEDURES (cont.)

1. The Department may impose temporary prior authorization requirements on drugs that have been added to the State drug file since the last meeting of the DUR Committee if the Department determines that those drugs present substantial concerns regarding efficacy, safety or cost; and

2. The Department may impose temporary prior authorization requirements on drugs that are already covered by MaineCare if, since the last meeting of the DUR Committee, the Department has received new or additional information raising a substantial concern regarding efficacy, safety or cost.

Temporary prior authorization requirements imposed pursuant to this subsection shall conform to current DUR Committee prior authorization guidelines described above, and shall be effective immediately. Drugs subject to temporary prior authorization shall be reviewed at the next meeting of the DUR Committee.

80.07-5 Preferred Drug List

A. General

In order to facilitate appropriate utilization, the Department will establish a list of covered drugs, ordered by therapeutic category. This listing will be known as the Preferred Drug List or PDL. Within each therapeutic category, the Department may designate some or all drugs as preferred on the basis of efficacy, safety, and net cost. The Department’s determination of a drug’s efficacy and safety shall be consistent with the standards set forth in (1) the peer-reviewed literature, and (2) the following compendia: the American Hospital Formulary Service Drug Information, the United States Pharmacopeia-Drug Information, and the DRUGDEX Information System. The Department’s determination of a drug’s net cost shall consider the pharmacy reimbursement amount as set forth at Section 80.09, as adjusted by any manufacturer rebates and/or supplemental rebates to be paid to the Department for that drug. The Department may not consider net cost unless it determines that the drug has no significant clinical or safety advantages over one or more alternative drugs, when used for a given purpose.

In addition to the preferred/non-preferred designation, the PDL may include information such as generic name, strength/unit, National Drug Code identification number, and brand name.

All covered drugs, whether preferred or non-preferred, are available to any eligible member for whom those drugs are medically necessary.
Some drugs must have their medical necessity confirmed for a given member through the prior authorization process before the Department will provide reimbursement. When medically necessary covered brand-name drugs have an FDA approved A-rated generic equivalent available, the most cost-effective medically necessary version will be approved and reimbursed by MaineCare, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. If an A-rated generic version fails due either to reported inefficacy or side effects, the member should proceed to a chemically different therapy. The Department does not make determinations as to a generic drug’s equivalence or clinical efficacy compared to the brand-name version, since this is the role of the FDA.

B. Step Order

In addition to the preferred/non-preferred designations, the Department may assign some drugs on the PDL a further designation of preference within a therapeutic category. This further designation will be known as step order.

The step order is a means of reducing the need to obtain prior authorization. When a member has been prescribed all drugs at a higher step(s) within a therapeutic category, the drug at the next lower step will automatically be reimbursed for that member without requiring prior authorization. Only drugs prescribed to the member since enrollment and reflected in the Department’s automated pharmacy management information Point of Purchase System will be considered in applying the step order.

Once the Department has determined that a member has undertaken a satisfactory trial of a preferred or lower-step drug, the member will not be required to repeat that drug trial in the future unless there is evidence of a change in the member’s condition or new or newly acquired research that would warrant a new trial, or newly acquired evidence suggesting that the previous drug trial was inadequate.

The minimum trial periods for each preferred and step-order drug is two weeks unless otherwise stated on the Department’s Preferred Drug List, or unless an acceptable clinical explanation is submitted by the attending physician. Trials with less than a two-week duration will be reviewed on a case-by-case basis. A trial will not be considered valid if non-preferred products were readily available (paid by override, individual purchase, cash, or samples, etc.), and certain drug trials may require evidence that the preferred drugs were actually tried (e.g., to confirm trials of preferred narcotics with urine drug screens). Furthermore, adequate trials require documentation of attempts to titrate dose(s) of preferred agents toward the desired clinical response.
C. **Mandatory Generic Substitution**

The Department shall require substitution for a brand-name drug of a generic and therapeutically equivalent drug as required by Maine Revised Statues, Title 32, Section 13781, absent Prior Authorization from the Department. Prior Authorization requires that the prescriber has indicated that the brand-name drug must be dispensed and that the brand name drug is medically necessary.

The following shall be exempt from the requirements stated above:

1. Brand-name drugs for children under the age of eighteen (18);
2. Brand-name drugs for pregnant women;
3. Brand-name drugs required by federal law;
4. Brand-name drugs for the treatment of cancer;
5. Brand-name drugs for the treatment of HIV or AIDS;
6. Brand-name antipsychotic drugs; and,
7. Brand-name drugs that have been determined by the Department to be more cost-effective to the Department than a generic and therapeutically equivalent drug.

D. **Other Limitations**

1. **Drug Benefit Management**

   The Department may provide drug benefit management to certain high-cost and/or high utilizing members of the MaineCare pharmacy benefit. The Department may identify these members by reviewing any or all of the following factors: drug costs within the top ten percent (10%) of the aggregate prescription drugs costs, utilization within the top ten percent (10%) of specific drug categories, or high costs or utilization within specific drug categories where more cost-effective drug therapies could be utilized while maintaining or improving health outcomes.

   The Department may provide drug benefit management intervention for these members and/or prescribers by providing education and case management.

2. **Intensive Benefits Management**

   The Department may provide intensive benefits management for members for whom drug benefit management does not result in the implementation of targeted recommendations.
As part of the ongoing drug utilization review process, members whose drug profiles are of sufficient complexity, or who receive prescriptions from multiple prescribers, or whose prescribers have demonstrated frequent disregard for Departmental policies, may be identified for participation in intensive benefits management. Intensive benefits management may require long-term case management for members, enhanced coordination of care among providers, address inappropriate prescribing behavior, and promote cost-effective pharmaceutical care.

Intervention also may require prescriber and/or pharmacy lock-in, prior authorization of all drugs, assignment of prescribers to peer review, and enrollment of members in disease management services or intensive medical management. The Department also may require member participation in the Restriction and Narcotic Prescriber Plans, as described in Chapter IV, Section 1 of the MaineCare Benefits Manual.

E. Notification

The Department will post the PDL and any changes on the Department's designated website. The Department will also provide quarterly notification of the drugs selected for placement on the PDL, and any other changes in the PDL.

80.07-6 Dispensing Practices

Compliance with the following dispensing policies is required:

A. Dispensing practices must be in accordance with the best medical, pharmaceutical and economical practice.

B. Generic drugs as rated A in the current edition of the FDA Orange Book must be dispensed, in accordance with State law, if available at a lower cost than the brand name product.

C. Single source, brand multisource or co-licensed drugs must be dispensed in quantities not to exceed a thirty-four (34)-day supply, unless dispensed by a mail order pharmacy, which allows up to a ninety (90) day supply. FDA A-rated generic drugs must be dispensed in quantities sufficient to effect optimum economy, up to ninety (90) days. Drugs that are identified by the Department as characterized by combinations of higher than average expense, side effects and discontinuation rates, maybe subject to an initial fill limitation of a maximum fifteen days’ supply (trial prescription). Pharmacists will not be reimbursed for split prescriptions unless necessary to meet MaineCare policy, including but not limited to dispensing a thirty-four (34)-day supply.
Also see Section 80.09. Where unit of use packaging prevents the pharmacist from measuring a thirty-four (34)-day supply (e.g., ointments, eye drops, insulin and inhalers) prescriptions shall be dispensed in a size consistent with a thirty-four (34)-day supply.

D. Payment for medications dispensed in quantities in lesser or greater amounts than therapeutically reasonable may be withheld pending contact with the prescriber to determine justification for the amount.

E. All prenatal vitamins must be dispensed in quantities for up to a one hundred (100)-day supply with no more than three (3) refills.

F. Upon dispensing the prescription in person, the pharmacy provider must obtain a signature verifying receipt from the member or person picking up the prescription.

G. Providers may dispense prescriptions via telepharmacy when obtaining approval from the Department. Providers must assure that member counseling is available at the remote site from the dispensing provider or the provider delivering the prescription, and that only qualified staff, as defined by the Maine State Board of Pharmacy, deliver prescriptions. The Department may terminate this approval at any time by written notice.

H. Generic drugs must be dispensed as a ninety (90) day supply for drugs identified by the Department as a maintenance drug after an initial thirty (30) day supply. Opioid drugs are excluded from this requirement and must follow the days’ supply restrictions as outlined in 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications.

A pharmacy affiliated through common ownership or control with a hospital, boarding home, ICF-IID, private non-medical institution, assisted living facility and/or nursing home is allowed to dispense covered MaineCare prescription drugs to MaineCare members in that facility. Providers must report these affiliations to the OMS Provider Enrollment Unit and the Pharmacy Director. A registered pharmacist must dispense the drugs according to dispensing regulations. Drugs are to be billed in a manner consistent with the Department's billing guidelines and drug claim processing system (see Section 80.09) without a professional dispensing fee.

Practitioners who have been authorized to dispense drugs for MaineCare members shall not receive a dispensing fee, but will be allowed to charge a three dollar ($3.00) co-payment amount, except for tobacco cessation products (see Section 80.08-4), in addition to the acquisition cost of drugs dispensed. Records of all such dispensing must be available for review and audit.
80.07 POLICIES AND PROCEDURES (cont.)

A pharmacy provider must maintain the original or electronic copy of all prescriptions for which payment from the MaineCare program is requested. The original prescription shall be either a hard copy generated by a computer, written by the prescriber, or reduced to writing when received by the pharmacist by telephone.

Information required by the Maine State Board of Pharmacy shall be recorded on each prescription and must include name of member, name of drug, quantity ordered, directions, name of prescriber, date written and initials of pharmacist filling prescription. A record of each refill must be kept on the prescription or on the profile or be available on a computer.

80.07-7 Refills

Except as set forth below, reimbursement for refills will be made only if the following conditions are met:

A. The prescription authorizes refills.

B. No more than one (1) year has passed since the date of the original issue. Reimbursement for a drug later than one (1) year from the date of original issue requires a new prescription, subject to the limitations described in subsection 80.07-6, Dispensing Practices.

C. Reimbursement will be made for refills dispensed in no less than a thirty (30)-day supply for conditions except when the prescriber specifically directs otherwise. Mail order pharmacies may only dispense up to ninety (90) -day supplies.

D. Single source, brand multisource or co-licensed drugs must be dispensed in quantities not to exceed a thirty-four (34)-day supply, except for mail order pharmacies, which may only dispense up to ninety (90) -day supplies. If a member will suffer undue hardship from the requirement that prescriptions must be refilled every thirty-four (34) days, the provider may submit a miscellaneous prior authorization form requesting authorization to dispense a ninety (90)-day supply. FDA A-rated generic drugs must be dispensed in quantities sufficient to effect optimum economy, not to exceed ninety (90) days. Pharmacy providers will not be reimbursed for split prescriptions. See Section 80.07-6(C).

E. Early refills in excess of an eighty-five percent (85%) threshold must be authorized on a case-by-case basis through the Department or its designee, or on a basis set forth by Section 80.07-11.

F. Early refills in mail order prescription in excess of a ninety percent (90%) threshold must be authorized on a case-by-case basis through the Department or its designee, or on a basis set forth by Section 80.07-11.
80.07  POLICIES AND PROCEDURES (cont.)

G. Refills shall be mailed to the member upon request, where such mailing is the policy of the pharmacy provider with respect to the general public.

H. MaineCare may not pay for early refills because the member will be out of town for an extended period of time.

I. MaineCare may not pay for early refills for lost, stolen, or destroyed medications.

J. MaineCare may not pay for early refills for controlled substances, including Oxycontin.

K. When refilling a prescription through mail order, refills may be provided only by a member’s request; mail order pharmacies may not automatically refill prescriptions for members.

80.07-8  Pharmacist’s Responsibility

The Department supports generally accepted professional judgments made by pharmacists, including the right to refuse to dispense any prescription that appears to be improperly executed or unsafe, based on the pharmacist's professional judgment. The Department expects that any pharmacist who suspects that a member may be inappropriately using a drug will report the member to the Pharmacy Unit or Program Integrity Unit, OMS, 11 State House Station, Augusta, Maine 04333-0011.

80.07-9  Restriction and Narcotic Prescriber Plans

Some members may be enrolled in the Restriction and Narcotic Prescriber Plans. See Chapter IV, Section 1, of MaineCare Benefits Manual for more details.

80.07-10  Program Integrity

Program Integrity (formerly Surveillance and Utilization) review requirements are delineated in Chapter I of the MaineCare Benefits Manual.

80.07-11  Over-Rides

The Department or its designee may authorize over-rides in certain situations to allow a pharmacy to waive standard conditions or requirements for dispensing a medication. All over-rides enabling a pharmacy to dispense a four (4) day supply or less do not constitute continued benefits under MaineCare. The following is a list of situations where the Department or its designee may authorize an over-ride to dispense medications:
80.07 POLICIES AND PROCEDURES (cont.)

A. Dosage Change

The prescriber has determined that a change in the therapy is required that results in dosage change, i.e., increased dosage or continued treatment after a starter dose.

B. Co-Payment Information Not Current

The co-payment information in the automated eligibility system is not current. This over-ride may be used only when members should be exempt from co-payment, but for whom there is a co-payment indicated, as outlined in Chapter I.

C. Ninety-Six (96) Hour Over-Ride

To enable a pharmacy to dispense up to a ninety-six (96) hour supply for situations as defined in Section 80.07-4(C). One-time over-rides enabling a pharmacy to dispense a ninety-six (96)-hour supply or less do not constitute continued benefits under MaineCare, as detailed in Chapter I.

D. Special Exceptions

When none of the conditions above apply, yet medical necessity is demonstrated. Providers must call the PA help desk to request these special exceptions, and the Department or its authorized representative will determine approval on a case-by-case basis.

80.07-12 Prescribing Opioids for Pain Management

The goal of this section is to offer a balanced approach to pain management that includes recommendations for using opioids when appropriate, such as with acute injuries and flare ups, for postoperative pain management, and during painful procedures; and recommending alternative therapies in general for all chronic pain patients. The section aligns with Maine statutes and the Department of Health and Human Services’ Office of Substance Abuse and Mental Health Services Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications. (See 14-118, C.M.R. Chapter 11). This section does not address the use of opioids as part of medication-assisted treatment (MAT) for opioid use disorder. MAT is addressed elsewhere in this policy under Section 80.07-13.

A. Covered Services

Refer to Section 80.05, Covered Services, of this policy for pharmacologic coverage. For nonpharmacological treatment coverage, refer to the corresponding policy chapters of the MaineCare Benefits Manual (MBM) that address the specific treatment or therapy.
80.07 POLICIES AND PROCEDURES (cont.)

B. Prescriber Requirements for Treating Chronic Pain

Once a member has reached the opioid prescription cumulative maximum of twenty-eight (28) days, the member is considered to have transitioned from treatment of acute pain to treatment of chronic pain for MaineCare purposes of these requirements.

1. Prescribers must perform a thorough history and physical examination, including an opioid therapy risk assessment, at the initial visit for pain management.

2. Prescribers must review the Prescription Monitoring Program database as medically indicated and required by 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications, to verify that no concomitant narcotic use by the member is occurring, and the reviews must be evidenced in the medical documentation.

3. Before starting opioid therapy for pain, prescribers must establish a treatment plan that addresses realistic treatment goals for pain and function; includes nonpharmacologic therapy and non-opioid pharmacologic therapy, as appropriate; includes plan strategies to mitigate risk; and includes a plan of how therapy will be discontinued if benefits do not outweigh risks. The treatment plan must be reviewed and updated at a minimum of every ninety (90) days.

4. Prescribers must counsel the member about the potential side effects, risks and benefits of opioid use at the initial visit, annual visit, and any time there is a dosage change. Evidence of the discussions must be documented in the member’s medical record.

5. When prescribing opioids for chronic pain, a urine drug test (UDT) or other medically appropriate toxicology test must be completed before the start of opioid therapy and considered at least quarterly, as medically indicated, on a random basis to assess prescribed medication, as well as any non-prescribed or illicit drug use. Results of drug testing are to be documented in the client record with evidence that the results of drug tests have been reviewed with the member and considered as part of the treatment planning process. Testing must follow federal and state guidelines including Chapter II, Section 55, Laboratory Services, of the MaineCare Benefits Manual.

7. Prescribers must evaluate benefits and harms of continued opioid therapy with members who have continued therapy beyond three (3) months at least once every six (6) months face-to-face or more frequently thereafter.

8. If opioid therapy is continued beyond three (3) months, prescribers must, if medically indicated, consider offering naloxone if the member has a risk factor such as a mental health disorder; a substance use disorder; a medical condition that increases sensitivity; or current use of benzodiazepines.

9. If clinically indicated, the prescriber must consider the use of a written agreement between the physician and member outlining the member’s responsibilities, including but not limited to, urine screening when requested, the consequences of unexplained loss or shortage of medications; the consequences of obtaining similar prescription medications from other prescribers; and an agreement to use only one pharmacy.

C. Limitations and Exemptions

Prescribers are required to follow Maine statutes and the prescribing guidelines, limitations, and exemptions as outlined in 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioids.

D. Prior Authorizations

Prescribers are required to follow the following prior authorization guidelines when prescribing opioid medications for pain management:

1. Treatment for Acute Pain
   a. A face-to-face visit between the member and the prescriber must occur at the time of the initial prescription of an opioid drug for the treatment of acute pain. Each authorization will allow for up to seven (7) days of coverage.
   b. Prior authorization is required after a total of seven (7) days of opioids have been prescribed for the treatment of acute pain within a calendar year.

2. Transitioning to Treatment of Chronic Pain
   a. In order to maintain continuity of care for transition to longer-term treatment of chronic pain, a pain management care plan consisting of an alternative treatment option must be developed.
80.07  POLICIES AND PROCEDURES (cont.)

3. Treatment of Chronic Pain

   a. Reimbursement of opioid medication beyond the 28-day limit for acute pain is allowed by prior authorization if the request documents that the MaineCare member:

      i. Has been referred to two (2) or more alternative treatment options;

      ii. Is actively waiting for the alternative treatment provider to begin treatment; or actively participating in the alternative treatment options;

      iii. Medical record documents alternative treatment progress notes; and

      iv. Has not shown clinically meaningful improvement in function or pain within the last prescription dose period.

   Alternative treatment options include nonpharmacologic treatments, such as physical therapy, occupational therapy, osteopathic manipulation, chiropractic treatment, outpatient counseling, psychological therapies, Eye Movement Desensitization and Reprocessing (EMDR), and nonopioid pharmacologic treatments, such as acetaminophen, NSAIDS, gabapentin, and selected antidepressants. Benzodiazepines will not be considered an alternative treatment option.

   Each prescription may be for no more than thirty (30) days. Approved prior authorization will not exceed six (6) months.

   The Department may grant prior authorization for an opioid drug when participation in all appropriate alternative treatments is not feasible and opioid treatment is medically necessary.

E. Medical Records

The prescribing physician shall keep accurate and complete records to include:
A. The medical history and physician examination;
B. Diagnostic, therapeutic and laboratory results;
C. Documentation of urine drug tests and review of results with member;
D. Evaluations and consultations;
E. Prescription Monitoring Program reviews;
F. Treatment of objectives;
G. Discussion of risks and benefits;
H. Informed consent;
I. Treatments;
80.07 POLICIES AND PROCEDURES (cont.)

J. Medications (including date, type, dosage, and quantity prescribed and/or dispensed to each patient);
K. Instructions and agreements;
L. Treatment planning updated every ninety (90) days inclusive of nonpharmacologic therapy and non-opioid pharmacologic therapy, as appropriate; includes plan strategies to mitigate risk; and includes a plan of how therapy will be discontinued if benefits do not outweigh risks; and

Records shall remain current and be maintained in an accessible manner and readily available for review.

80.07-13 Buprenorphine and Buprenorphine Combination Products for Substance Use Disorder (SUD)

MaineCare’s coverage of buprenorphine, a Schedule III narcotic, is subject to strict limitations on members qualified to receive the drug, rules regarding prior authorization, and clearly defined maximum daily dosages. MaineCare covers multiple formulations of the drug buprenorphine only for a member who has a diagnosis of Substance Use Disorder (SUD).

All prescriptions for buprenorphine, buprenorphine derivatives, and naltrexone must be reported to the Maine Prescription Monitoring Program (PMP) pursuant to the rules established at 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications.

A. Covered Services

MaineCare covers buprenorphine for a member who has a diagnosis of SUD. The medication must be prescribed by a practitioner who has obtained an XDEA identification number (which denotes buprenorphine prescriber status) from the U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control and meets all requirements as set forth in Maine statutes and Maine’s Office of Substance Abuse and Mental Health Services, Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications (http://www.maine.gov/sos/cec/rules/10/chaps10.htm#118). Reimbursement for FDA-approved buprenorphine products for opioid use disorder treatment as listed on the MaineCare Preferred Drug Lists will be made if approved through the prior authorization process. (See Section 80, Pharmacy Services, §80.07-4, Prior Authorization).

B. Prescriber Requirements

1. Prescribers must acquire an XDEA identifying number from the U.S. Department of Justice, Drug Enforcement Administration, Office of
80.07 POLICIES AND PROCEDURES (cont.)

Diversion Control. (Refer to 14-118, Maine’s Office of Substance Abuse and Mental Health Services, Chapter 11, § 4.)

2. Prescribers must clearly indicate their XDEA number on every prescription for a controlled substance written by the prescriber.

3. If U.S. Military affiliated prescribers with a service identification number do not have a valid XDEA number, the prescriber’s service identification number may be used. These providers must clearly indicate their service identification number on every prescription for a controlled substance written by the prescriber.

4. Prescribers must conduct a comprehensive screening and assessment of the member including a complete history; physical examination; mental status examination; relevant laboratory testing; and a formal psychiatric assessment (if indicated). The initial assessment must address the following elements in the preparation and development of treatment planning goals: Educational needs; Vocational rehabilitation needs; Employment needs; Medical support services; Psychosocial support services; Economic support services; Legal support services; Other special needs and/or services.

5. Prescribers must counsel members, at the initial visit, annual visits, and any time there is a dosage change, about the potential side effects, risks and benefits of buprenorphine treatment including all available alternative options. Evidence of these discussions must be documented in the member’s medical record.

6. Prescribers must review the Prescription Monitoring Program database as medically indicated and required by 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications to verify that no concomitant narcotic use by the member is occurring. Reviews of the PMP must be evidenced in the medical documentation.

7. During SUD treatment with buprenorphine a urine drug test or medically appropriate toxicology test for all relevant illicit drugs must be administered as clinically indicated, initially and randomly thereafter. Prescribers must determine the frequency of toxicology testing by evaluating the appropriateness in relation to the member’s stage of treatment. All maintenance members must receive a minimum of eight (8) toxicology tests per year. Results of toxicology testing is to be documented in the client record with evidence that the results of the tests have been reviewed with the member and considered as part of the treatment planning process. Testing must follow federal and state guidelines including Chapter II, Section 55, Laboratory Services, of the MaineCare Benefits Manual.
80.07 POLICIES AND PROCEDURES (cont.)

8. Prescribers must develop a treatment plan that includes planned dosing for the induction and maintenance phases of treatment, projected frequency of office visits, proposed psychosocial counseling and referral, treatment goals, and the conditions under which treatment is to be discontinued. The treatment plan must be reviewed and updated at least every ninety (90) days.

9. Prescribers must coordinate and refer members to psychosocial counseling and document member’s record with progress notes as to member’s adherence with counseling treatment.

10. The prescriber must, if clinically indicated, employ the use of a written agreement between prescriber and member addressing such issues as alternative treatment options; regular toxicology testing for drugs of abuse and therapeutic drug levels; aberrant test results; number and frequency of all prescription refills; and reasons for which drug therapy may be discontinued.

11. If prescriber should determine involuntary termination of treatment is necessary, prescriber must make appropriate referrals to other treatment providers or must manage the appropriate withdrawal of buprenorphine as to minimize withdrawal discomfort if member will not be receiving treatment in another setting.


13. Prescribers are required to follow prescribing guidelines as outlined in 21 C.F.R., Part 1300 to end (DEA Regulations for Controlled Substances), 32 M.R.S. § 2210(1) (Nurses and Nursing), 32 M.R.S. § 2600-C(1) (Osteopathic Physicians), 32 M.R.S. § 3300-F(1) (Board of Licensure in Medicine), 32 M.R.S. § 18308(1) (Dental Professionals), 32 M.R.S. § 3657(1) (Podiatrists), and 32 M.R.S. § 4878(1) (Veterinarians).

C. Providers must document that the member has agreed to the following:

1. Member must agree to return to the prescriber’s office as instructed by prescriber during the induction period of treatment if required;

2. Members must agree to random screenings;

3. Members must actively participate in Substance Use Disorder (SUD) counseling;

4. Members must appear within 24 hours of receiving a random screening call;

5. Members must bring medications to all prescriber appointments to be counted;
80.07 POLICIES AND PROCEDURES (cont.)

6. Members must avoid all illegal or inappropriate substances of abuse;

7. Members must be prepared to provide a random urine sample, and if testing is positive, member must agree to meet with the monitoring physician.

8. Buprenorphine kept at home must be locked in a safe place to prevent accidental use by others, especially children.

D. Limitations
For limitation guidelines for prescribing buprenorphine products, please refer to MaineCare’s Preferred Drug List at www.mainecarepdl.org for the most current and accurate prescribing criteria.

E. Prior Authorization Requirements


4. Prescriptions issued by a prescriber other than the prescribing practitioner who signed the prior authorization require a new prior authorization and documentation that the previous prescribing practitioner has communicated transfer of care.

5. Every prior authorization must contain a prescribing practitioner’s original signature.

6. Preferred drugs must first be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exist.

7. Prior authorization requests will be reviewed for dose titration downward; whether the patient is engaged in recovery-oriented support services; providing periodic urine drug screens; random drug counts; factors that threaten stability of recovery; and evidence of improvement in social, physical, and occupational areas.

8. Members that stop treatment after twenty-four (24) months and need to restart will require a prior authorization. This prior authorization will assess the patient risk of relapsing or evidence that the patient has relapsed.
80.07 POLICIES AND PROCEDURES (cont.)

F. Medical Records

The prescriber physician shall keep accurate and complete records to include:

1. The medical history and physician examination;
2. Diagnostic, therapeutic and laboratory results;
3. Documentation of urine drug tests and review of results with member;
4. Evaluations and consultations;
5. Prescription Monitoring Program reviews;
6. Treatment of objectives;
7. Discussion of risks and benefits;
8. Informed consent;
9. Treatments;
10. Medications (including date, type, dosage, and quantity prescribed and/or dispensed to each patient);
11. Instructions and agreements;
12. Treatment planning updated every ninety (90) days inclusive of planned dosing for the induction and maintenance phases of treatment, projected frequency of office visits, proposed psychosocial counseling and referral, treatment goals, and the conditions under which treatment is to be discontinued; and

Records shall remain current and be maintained in an accessible manner and readily available for review.

80.08 CO-PAYMENT

A co-payment is to be charged by the pharmacy to each MaineCare member for each prescription filled or refilled, with the exception of prescriptions filled by the Department’s mail order pharmacy providers and tobacco cessation products. Members shall not pay a co-payment for drugs obtained from the Department’s mail order pharmacy providers and tobacco cessation products. Co-payment dispute resolution procedures are described in Chapter I of the MaineCare Benefits Manual. No pharmacy may discount the co-payment for promotional purposes.

80.08-1 Pharmacy Benefits Provided By Retail and Specialty Pharmacy Providers

A. The amount of the co-payment shall be three dollars ($3.00) per prescription, except for tobacco cessation products (see Section 80.08-4), not to exceed thirty dollars ($30.00) per member per month, except as otherwise described below. The co-payment is the same for Medicare Part D Excluded Drugs.

B. The pharmacy shall not deny pharmacy services to a MaineCare member on account of the member’s inability to pay a co-payment. Providers must rely upon the member’s representation that he or she does not have the cash
80.08  **CO-PAYMENT** (cont.)

available to pay the co-payment. However, the individual's inability to pay does not eliminate his or her liability for the co-payment.

C. If a member is dispensed a drug in a quantity specifically intended by the prescriber or pharmacist to last less than one month for the member’s health and welfare, only one co-payment for that drug that month is required.

D. Co-payment exemptions are described in Chapter I of the *MaineCare Benefits Manual*.

80.08-2  **Pharmacy Benefits Provided By Department-approved Mail Order Pharmacy Providers**

Members shall have no co-payment for drugs dispensed through Department-approved mail order pharmacy providers, except as otherwise described below.

80.08-3  **Benefit for People Living With HIV/AIDS**

Co-payment policies for members receiving the Benefit for People Living with HIV/AIDS can be found in the *MaineCare Benefits Manual*, Chapter X, Section 1.

80.08-4  **Pharmacy Benefits Provided by Department-Approved Smoking Cessation Products With No Co-Payment Requirements**

Effective August 1, 2014, no co-payments or other out-of-pocket cost sharing, including deductibles, shall be imposed on a MaineCare member eighteen (18) years of age or older or who is pregnant who has been prescribed a smoking cessation product. No annual or lifetime dollar limit or lifetime limit on attempts to quit may be imposed on the member. The member cannot be required to participate in counseling as a condition for receiving medication. Smoking cessation products must be approved by the Federal Food and Drug Administration and be listed on the Preferred Drug List. Please see the following link: [www.mainecarepdl.org](http://www.mainecarepdl.org).

80.09  **REIMBURSEMENT**

80.09-1  **Reimbursement Rates**

MaineCare reimbursement for drugs covered under this Section will only be made for drugs of any manufacturer that has entered into and complies with a rebate agreement, except as noted in Section 80.09, and specific reporting requirements as defined by Title XIX of the Social Security Act Section 1927 described in OBRA 90 as amended.

A.  **Reimbursement for Retail Pharmacy Providers**
1. **Generic Drugs**

The reimbursement rate for covered generic drugs shall be the lowest of the following:

a. The usual and customary charge; or

b. The Average Wholesale Price minus sixteen point six seven percent (16.67%) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee except as otherwise noted below; or

c. The Federal Upper Limit (FUL) unless the Department meets the FUL in aggregate; or

d. The Maine maximum allowable cost plus eleven dollars and eighty-nine cents ($11.89) dispensing fee except as otherwise noted below; or

e. The Wholesale Acquisition Cost (WAC) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee; or

f. The Submitted Ingredient Cost plus eleven dollars and eighty-nine cents ($11.89) dispensing fee; or

g. Gross Amount Due (GAD); or

h. National Average Drug Acquisition Cost (NADAC) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee.

2. **Brand-name Drugs**

The reimbursement rate for covered brand-name drugs shall be the lowest of the following:

a. The usual and customary charge; or

b. The Average Wholesale Price minus sixteen percent (16%) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee except as otherwise noted below; or
80.09 REIMBURSEMENT (cont.)

c. The Maine maximum allowable cost plus eleven dollars and eighty-nine cents ($11.89) dispensing fee except as otherwise noted below; or

d. The Wholesale Acquisition Cost (WAC) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee; or

e. The Submitted Ingredient Cost plus eleven dollars and eighty-nine cents ($11.89) dispensing fee; or

f. Gross Amount Due (GAD); or

g. National Average Drug Acquisition Cost (NADAC) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee.

3. Rural Dispensing Fee Adjustment

The Department will pay a supplemental dispensing fee for prescriptions provided to members residing in rural areas in an attempt to assure continuing access to prescription services for these members. The rural dispensing fee will range from 55¢ to 65¢ per prescription dispensed to rural members, and will change on a quarterly basis to reflect the prior quarter’s number of prescriptions filled. The Department will distribute the rural dispensing fee adjustment retrospectively on a quarterly basis. The Department will calculate the quarterly adjustment for each pharmacy by taking that quarter’s total allotment ($500,000 per quarter) and dividing the total allotment for the quarter by the number of prescriptions filled for rural members in the quarter.

The Department will then group these by pharmacy and distribute in the quarter following. Pharmacies will be notified on a quarterly basis on the Department’s designated website the amount of the adjustment for the quarter.

Rural members will be defined using a standard and federally recognized definition of rural using Metropolitan Statistical Area (MSA) designations. The Department will determine MSA/Non-MSA designation based on the zip code of the member’s residence.

B. Reimbursement for Specialty Pharmacy Providers

The reimbursement rate for Specialty Pharmacy Providers shall be the lowest of the following:
1. The usual and customary charge; or

2. The Average Wholesale Price minus sixteen point six seven (16.67%) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee except as otherwise noted below; or

3. The Federal Upper Limit (FUL) unless the Department meets the FUL in aggregate or the Maine maximum allowable cost plus eleven dollars and eighty-nine cents ($11.89) dispensing fee except as otherwise noted below.

4. The Maine maximum allowable cost plus eleven dollars and eighty-nine cents ($11.89) dispensing fee except as otherwise noted below; or

5. The Wholesale Acquisition Cost (WAC) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee; or

6. The Submitted Ingredient Cost plus eleven dollars and eighty-nine cents ($11.89) dispensing fee; or

7. Gross Amount Due (GAD); or

8. National Average Drug Acquisition Cost (NADAC) plus eleven dollars and eighty-nine cents ($11.89) dispensing fee.

C. Reimbursement for Mail Order Pharmacy Providers

1. Generic Drugs

The reimbursement rate for covered generic drugs obtained through mail order pharmacy providers shall be the lowest of the following:

a. The usual and customary charge; or

b. The Average Wholesale Price minus sixty percent (60%) plus a two-dollar and fifty cent ($2.50) dispensing fee except as otherwise noted below; or

c. The Federal Upper Limit (FUL) unless the Department meets the FUL in aggregate or the Maine maximum allowable cost plus a two-dollar and fifty cent ($2.50) dispensing fee except as otherwise noted below.
80.09 REIMBURSEMENT (cont.)

2. **Brand Name Drugs**

   The reimbursement rate for covered brand name drugs obtained through mail order pharmacy providers shall be the lowest of the following:

   a. The usual and customary charge; or

   b. The Average Wholesale Price minus twenty percent (20%) plus a two-dollar and fifty cent ($2.50) dispensing fee except as otherwise noted below; or

D. **Reimbursement for 340B Drugs**

   Providers or entities who purchase drugs under the 340B policy, must sign a memorandum of understanding (MOU) with the state. When the state and the entity reach an agreement on the billing process, reporting process, specific covered drugs, and pricing standards this MOU must be individualized to include the term of these components.

   For entities and providers that are eligible to enroll in the 340B program, see the listing on [http://www.hrsa.gov/opa/introduction.htm](http://www.hrsa.gov/opa/introduction.htm). All providers and entities must comply with federal and HRSA 340B rules and regulations.

E. **Effective October 1, 2009** the reimbursement rate for the Seasonal Flu Vaccine and/or Allowable Immunizations as allowed by 32 MRSA §13831, shall be the Federal Upper Limit or the Maine maximum allowable cost plus five dollars ($5.00) dispensing fee except as otherwise noted.

F. The Department’s reimbursement rate will be reduced by any applicable member co-payment.

G. In accordance with Chapter I, of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from every other source. It is the responsibility of the provider to verify a member’s eligibility for MaineCare prior to providing services by requesting the individual to present his or her MaineCare ID card on each occasion that a service is provided and verifying this information as described in Chapter I of the MBM.

H If the provider is aware that a member’s eligibility is due to expire within one (1) month of the date of service, reimbursement will only be made for up to a one (1) month's supply.

I. **Maine Maximum Allowable Cost (MMAC)**. The establishment of a MMAC is subject, but not limited, to the following considerations:
1. Multiple active rebatable manufacturers;
2. Multiple covered non-drug products available through the pharmacy POS
3. Broad wholesale acquisition, average manufacturer price, actual acquisition cost and wholesaler price spans;
4. Availability of drugs to retailers, specialty stores and mail order providers at the selected cost;
5. High volume of MaineCare member utilization; and
6. Bioequivalence or interchangeability.

The Department will periodically notify pharmacies of updates to the list of drugs affected by FUL or MMAC pricing. This information will also be available on the OMS website.

G. Reimbursement for Drugs More Expensive Than MAC or MMAC Allowances

A prescriber who requests a drug more expensive than an equivalent MAC or MMAC limited generic drug must get prior authorization for the requested product before reimbursement will be permitted. Prescribers and providers will be notified of the drugs requiring prior authorization and this list, and any updates, will be posted on the Department’s designated website.

H. Reimbursement for Compounded Drugs for Retail Pharmacy Providers

Reimbursement for compounded drugs is determined by subtracting the co-payment described in Section 80.08, from the sum of the dispensing fee and the ingredient cost. The ingredient cost is the sum of the cost of the defined ingredients contained in the compounded drug. The provider must list the NDC for each active and inactive ingredient and the corresponding quantity used for each ingredient. Ingredients that are identified as DESI (less than effective) may not be included in the reimbursement for the compounded drug. Only electronic claims will be accepted.

1. Dispensing fees for compound drugs are as follows:
   a. Eleven dollars and eighty-nine cents ($11.89) except for filling insulin syringes as provided under 1(b).
   b. Twelve dollars and fifty cents ($12.50) for filling insulin syringes per fourteen (14) day supply.
80.10 BILLING INSTRUCTIONS

A. Billing using paper claims must be accomplished in accordance with the Department’s billing requirements, "Billing Instructions for Pharmacy Services."

B. Electronic billing must be accomplished in accordance with the Department’s billing requirements as described in the Electronic Media Claims rider to the Provider Agreement.

C. Mail order pharmacy providers must comply with the Department’s billing requirements and submit claims through the Department’s claims system.