

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State CONNECTICUT  
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO THE  
CATEGORICALLY NEEDY GROUP (S): ALL**

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12. Prescribed Drugs, Dentures, Orthotic and Prosthetic Devices, Eyeglasses

a. Drugs

- (1) Payment will be made for refills of a prescription as prescribed/authorized by the licensed authorized practitioner for an acute or chronic illness or condition as follows:
  - (a) Payment will be made for the original prescription and as many refills as ordered by the licensed authorized practitioner covering a maximum period of six (6) months in accordance with paragraphs 12.a (5)(a) thru (c), below. This does not apply to those items which fall within the “Controlled Substance Act” that being five (5) refills or six (6) months whichever comes first as governed by 21 U.S.C. Section 829(b) and Section 21a-249(h) of the Connecticut General Statutes and as they may be amended from time to time.
  - (b) Payment shall be made for a refill of a prescription for oral contraceptives which may cover a maximum period of twelve (12) months, including the original filling.
- (2) The Department will not reimburse for an original prescription(s) or refill that exceeds the drug requirements for a period of thirty (30) days or that exceed two hundred forty (240) units except in the following instances:
  - (a) Prescriptions for chronic conditions or maintenance drugs shall be for at least a thirty (30) day supply not to exceed two hundred and forty (240) units unless a lesser amount is prescribed.
  - (b) For prescriptions for oral contraceptives, a supply sufficient for a maximum period of three (3) months may be dispensed at any one time.
- (3) The Department will not pay for the following:
  - (a) Any non-legend drugs for nursing home patients when these items are used in usual and customary amount for the routine care and treatment; the cost of such items is included in the nursing home’s daily rate as set by the Department.
  - (b) Any nutritional supplements for nursing home patients; the cost of such items is included in the nursing home’s daily rate as set by the Department.
  - (c) Any vaccines and/or biologicals which can be obtained free of charge from the Dept. of Public Health. The Department will notify pharmacists of such vaccines and biologicals.
  - (d) Controlled Substances dispensed to Medicaid Recipients which are in excess of the product manufacturer’s recommendation for safe and effective use for which there is no documentation of medical justification in the pharmacy’s file.
  - (e) Drugs for a Lock-In recipient who is not locked into the billing pharmacy.
  - (f) Drugs not directly related to patient’s diagnoses, when diagnosis is required by the Department to be written on the prescription

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

The following drugs or classes of drugs are excluded from coverage by the Medicaid agency, except the drugs checked, for which the Medicaid agency provides coverage, as described below, to ALL Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D:

- Agents when used for anorexia, weight loss, weight gain  
(Weight gain medications, anabolic steroids, growth hormones only)
  - Agents when used to promote fertility
  - Agents when used for cosmetic purposes or hair growth
  - Agents when used for the symptomatic relief of cough and colds
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride
  - Nonprescription drugs  
(OTC formulary includes: Antacids, H2 antacids, birth control products, calcium and magnesium preparations, diabetic related products, electrolytic replacement products, hematinics, nutritional supplements, vitamins, cough, cold and allergy, nasal mast stabilizer, laxatives, antihistamines, decongestants, topical Antifungals, vaginal Antifungals, artificial tear products)
  - Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
  - Barbiturates
  - Benzodiazepines
  - Smoking cessation (except dual eligibles as Part D will cover)
- (5) Certification of Brand Name Drugs  
Reimbursement for multiple-source drugs for which CMS has designated a FUL is not limited to the FUL if a licensed authorized practitioner determines that a specific brand is medically necessary for a particular patient provided the requirements noted in section 5(a) are met.
- (6) Prior Authorization Requirements:  
PA shall be available in accordance with 1927(d)(5) of the Social Security Act. The state shall provide a response within two (2) hours upon a request for prior authorization. An automatic fourteen (14) day supply of medication shall be made available if no prior authorization has been requested and granted. In addition, a one-time five (5) day emergency supply shall be made available when the department representative has been contacted and no prior authorization has been requested and granted.

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Providers will be required to seek prior authorization when prescribing a brand medication when a generic equivalent exists; when a client requests an early refill of any prescription; for drugs not included on the preferred drug list and for drugs determined by the Department to be of high cost.

- (a) A licensed authorized practitioner must obtain prior authorization from the Department or the Department's representative to allow for the dispensing of a brand name drug by providing adequate medical justification for dispensing the brand name drug and by writing the phrase "Brand Medically Necessary" and the medical justification on the prescription form. The phrase "Brand Medically Necessary" and the medical justification shall be in the practitioner's handwriting and shall not be preprinted, initialed, or checked off in a box on such form.
- (b) Early refill is a request to provide a refill of an original prescription in accordance with paragraph 12.a.(1)(a), above, before at least 85% of the days supply of the original prescription or latest authorized refill has expired. Payment for an early refill will occur only with prior authorization from the Department or the Department's representative to allow for the early refill of prescription drugs
  - (1) Upon request of the recipient, the pharmacy provider (for non-controlled prescriptions) and the prescribing provider (for controlled prescriptions) shall obtain prior authorization from the Department or the Department's representative to allow early refill of the prescription drug product due to unusual or unforeseen circumstances such as loss or theft, fire, or flood. The Department or the Department's representative may require supporting evidence of the circumstance leading to the necessity of the early refill of controlled substances, such as a report from a police or emergency services organization documenting such loss or theft, fire, or flood.
  - (2) Nothing in this section shall preclude a licensed authorized practitioner from modifying the dose or drug regimen of a patient. A licensed authorized practitioner may modify the dose of a prescribed drug product, or change the prescribed drug product within a Hierarchical Ingredient Code (GC4), without the pharmacy provider having to obtain prior authorization to obtain reimbursement for early refill.
- (c) Pharmacy providers will be required to obtain prior authorization from the Department or the Department's representative for any drugs not included on the preferred drug list in accordance with paragraphs 12.a (7).
- (d) Pharmacy providers will be required to obtain prior authorization for certain high cost drugs as determined by the Department

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(7) Drug Rebate Agreements

The State is in compliance with §1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

A rebate agreement between the state and a participating drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on September 24, 2004 and entitled, "State of Connecticut Department of Social Services Supplemental Rebate Agreement," has been authorized by CMS. Any additional versions of such rebate agreements negotiated between the State and manufacturer(s) after September 24, 2004 will be submitted to CMS for authorization.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

Once the State authorizes the inclusion of a drug on the PDL based on the P&T Committee vote, the manufacturer has an obligation to pay the state supplemental rebates. Manufacturers shall have no obligation to pay supplemental rebate amounts for a drug product in the event that the drug product is not included on the PDL or removed from the PDL.

An independent third party will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

(8) Preferred Drug List with Prior Authorization

(a) Pursuant to 42 U.S.C. §1396r-8 and Section 17b-274d of the Connecticut General Statutes, as amended by Section 83 of Public Act 03-3 (June Special Session) and, effective August 1, 2004, as amended by Section 8 of Public Act 04-258, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list as set forth in paragraph 12.a(6) above.

(b) Prior authorization may be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

(c) The State will appoint a Pharmaceutical and Therapeutics Committee in accordance with federal and state law.

b. Dentures

(1) No more than (1) set of dentures in any five (5) year period (with exceptions).

TN# 09-022  
Supersedes  
TN# 05-009

Approval Date \_\_\_\_\_

Effective Date 10/01/09

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE CONNECTICUTMethods and Standards for Establishing Payment Rates - Other Types of Care

- (a) Prescribed Drugs
1. With the exception of (a)2 and (a)3 below the cost of drugs is determined by the drug product allowance established by the HCFA Upper Payment Limits plus a reasonable professional Dispensing Fee; The State's estimated acquisition cost (E.A.C.) which is AWP -14% plus a reasonable professional Dispensing Fee; or the usual and customary charge to the general public, whichever is lower.
  2. The maximum allowable cost paid for selected multi-source brand and generic drugs meeting the following criteria shall be the Average Wholesale Price (AWP) minus 45% plus a reasonable professional Dispensing Fee:
    - at least two suppliers of the generic product are available,
    - drug is not on the Federal Upper Limit (FUL) list or the Department of Justice (DOJ) list, and
    - all dosage forms (including tablets, capsules, eye drops, inhalers, topicals and liquids).
  3. The maximum allowable cost paid for Factor VIII (Factorate, Antihemophilic Factor, AHF) pharmaceuticals shall be the Actual Acquisition Cost (AAC) plus eight per cent.
- (b) Prosthetic devices - Negotiated fixed fee schedule.
- (c) Eyeglasses -- Negotiated fixed fee schedule when provided by the optician or the actual wholesale cost when provided by the optometrist.
- (d) Hearing aid -The price allowed shall be the cost of the hearing aid to the provider, not to exceed \$ 160.00.
- (13)** Other diagnostic, screening, preventive and rehabilitative services.
- (a) Durable Medical Equipment - Fixed negotiated fee schedules.
- (b) Rehabilitation Services
- (1) School Based Child Health Services -- Bundled Rate. Rates for rehabilitation services provided in accordance with an Individual Education Program (IEP) through the State Department of Education by or on behalf of Local Educational Agencies (LEAs) will be based upon annual audited cost and audited utilization filings made by LEAs. School Based Child Health (e.g. Special Education), rates for evaluation (including triennial reevaluations) will be on a cost per child per year basis by type of placement (in-district and out-of-district). Rates