## Rules of Department of Social Services

**Division 70—Division of Medical Services**

**Chapter 20—Pharmacy Program**

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 CSR 70-20.010 Participating Drug Vendors</td>
<td>3</td>
</tr>
<tr>
<td>13 CSR 70-20.030 Drugs Covered by Medicaid</td>
<td>3</td>
</tr>
<tr>
<td>13 CSR 70-20.031 List of Excludable Drugs for Which Prior Authorization is Required</td>
<td>4</td>
</tr>
<tr>
<td>13 CSR 70-20.032 List of Drugs Excluded From Coverage Under the Missouri Medicaid Program</td>
<td>4</td>
</tr>
<tr>
<td>13 CSR 70-20.033 Medicaid Program Coverage of Investigational Drugs Used in the Treatment of Acquired Immunodeficiency Syndrome (AIDS)</td>
<td>4</td>
</tr>
<tr>
<td>13 CSR 70-20.034 List of Non-Excludable Drugs for Which Prior Authorization Is Required</td>
<td>5</td>
</tr>
<tr>
<td>13 CSR 70-20.040 Five Prescription Limit Per Month Per Recipient</td>
<td>5</td>
</tr>
<tr>
<td>13 CSR 70-20.045 Thirty-One Day Supply Maximum Restriction on Pharmacy Services Reimbursed by the Division of Medical Services</td>
<td>6</td>
</tr>
<tr>
<td>13 CSR 70-20.050 Return of Drugs</td>
<td>7</td>
</tr>
<tr>
<td>13 CSR 70-20.060 Professional Dispensing Fee</td>
<td>7</td>
</tr>
<tr>
<td>13 CSR 70-20.070 Computer-Generated Drug Pricing Tape and Drug Reimbursement Methodology</td>
<td>9</td>
</tr>
<tr>
<td>13 CSR 70-20.071 Multiple Source Drugs for Which There Exists a Federal Upper Limit on Reimbursement</td>
<td>9</td>
</tr>
<tr>
<td>13 CSR 70-20.080 Labeling of Medicaid Prescriptions (Rescinded December 9, 1993)</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-20.100 Missouri Nonsteroidal Anti-Inflammatory Drug List (Rescinded September 30, 1991)</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-20.110 Medicaid Program Coverage of Approved Drugs for Treatment of Acquired Immunodeficiency Syndrome (AIDS) (Rescinded September 30, 1991)</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-20.120 Medicaid Program Coverage of Anti-Ulcer Preparations (Rescinded June 29, 1989)</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-20.200 Drug Prior Authorization Process</td>
<td>11</td>
</tr>
</tbody>
</table>
13 CSR 70-20.250  Prior Authorization of New Drug Entities or New Drug Dosage Form ........12
13 CSR 70-20.300  Retrospective Drug Use Review Process ........................................12
13 CSR 70-20.310  Prospective Drug Use Review Process and Patient Counseling .................13
13 CSR 70-20.320  Pharmacy Reimbursement Allowance ........................................14
Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

13 CSR 70-20.010 Participating Drug Vendors

PURPOSE: This rule limits the dispensers of drugs to licensed pharmacists, except in those localities where there are no pharmacies and where it is necessary for a licensed medical practitioner to dispense drugs in order to provide adequate pharmacy service in that community.

(1) Participation in the Missouri drug vendor program shall be limited to duly licensed pharmacies; provided, that licensed authorized medical practitioners may be eligible to participate in the Missouri drug vendor program in the event the Division of Family Services (DFS), in its discretion, determines that participation by practitioners is necessary to insure delivery of pharmacy services to the community. In the localities where there are no pharmacies and the DFS has drug dispensing agreements or would accept these agreements from licensed medical practitioners, the division shall not limit participation to any one (1) licensed medical practitioner if other licensed medical practitioners wish to participate as dispensers of prescription drugs. Those licensed medical practitioners with whom the DFS had a dispensing physician agreement by February 11, 1979, the effective date of this rule, will be exempt from this rule.

AUTHORITY: section 207.020, RSMo 1986.*
This rule was previously filed as 13 CSR 40-81.01. Original rule filed Nov. 13, 1978, effective Feb. 11, 1979.


13 CSR 70-20.030 Drugs Covered by Medicaid

PURPOSE: This rule implements recent changes in drug coverage as mandated by federal Health Care Financing Administration.

(1) Limiting Definition—As defined in the Social Security Act, section 1927(k)(3), the term covered outpatient drug does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

“(A) Inpatient hospital services.
“(B) Hospice services.
“(C) Dental services, except that drugs for which the state plan authorized direct reimbursement to the dispensing dentist are covered outpatient drugs.
“(D) Physicians’ services.
“(E) Outpatient hospital services.
“(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.
“(G) Other laboratory and x-ray services.
“(H) Renal dialysis.

“Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological used for a medical indication which is not a medically accepted indication."

(2) Participating Manufacturers—The Missouri Division of Medical Services identifies those manufacturers whose products are reimbursable along with effective dates of coverage, based on date of service, corresponding to effective dates of their participation under the national rebate contract. All products marketed by participating manufacturers are reimbursable, with the following exceptions: those products identified as Drug Efficacy Study Implementation (DESI) drugs by the federal Food and Drug Administration (FDA); products considered by the federal FDA to be similar, identical or related to a DESI product; products identified in 13 CSR 70-20.031 and 13 CSR 70-20.032; and products not meeting the definition of drug in sections 505, 506 and 507 of the federal Food, Drug and Cosmetic Act.

(3) According to the federal Social Security Act, section 1927(a)(1) in order for federal financial participation to be available for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement with the secretary of the federal Department of Health and Human Services. States are periodically notified by the federal Health Care Financing Administration of manufacturers that have entered into as well as terminated rebate agreements with the secretary of the federal Department of Health and Human Services. The Missouri Medicaid Pharmacy Manual and updating bulletins shall provide the detailed listing of manufacturers that have in effect a rebate agreement with the federal Department of Health and Human Services.

13 CSR 70-20.031 List of Excludable Drugs for Which Prior Authorization is Required

PURPOSE: This rule establishes a listing of excludable drugs and categories of drugs for which prior authorization is required in order for them to be reimbursable under the Missouri Medicaid Pharmacy Program.

(1) Permissible Exclusions—As specified in the Social Security Act, Section 1927(d)(1)(B), states may exclude or otherwise restrict coverage of certain covered outpatient drugs. Section 1927(d)(2) of the Social Security Act provides a listing of the categories of drugs that are permissible for exclusion. Drugs included on this list may be excluded from coverage entirely or restricted by diagnosis as determined by the state.

(2) As specified in Section 1927(d)(1) of the Social Security Act, states may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of Section 1927(d)(5) of the Social Security Act.

(3) List of drugs or categories of excludable drugs which are restricted to require prior authorization for certain specified indications shall be made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual.


(2) Reimbursement for the drug product approved for coverage under the provisions of this rule.

(A) Providers shall be reimbursed for the drug in accordance with the pricing methodology established in 13 CSR 70-20.070.

(B) The drug dispensed shall be subject to the recipient cost-sharing requirements as established in 13 CSR 70-4.051.


---

13 CSR 70-20.040 Five Prescription Limit Per Month Per Recipient

**PURPOSE:** This rule imposes a limitation on the number of prescriptions which may be covered services within a specified time period for each recipient.

(1) The number of prescriptions which may be filled or refilled will be limited to five (5) per recipient during any one (1) period of eligibility which does not exceed the normal monthly eligibility span for the recipient’s assistance category involved.

(A) The only allowable exception to the five (5)-prescription limitation will be for certain specified drugs which are commonly prescribed for long-term chronic medical conditions and for prior authorized drugs.

(B) These listed drugs shall be considered to be used for the treatment of long-term chronic medical conditions and shall therefore be exempted from the prescription limitation.

**Acetuxolol HCl**

**Acetazolamide**

**Acetohexamide**

**Acetohexamidide**

**Albuterol**

**Albuterol Sustained Release Tablets**

**Amanatadine HCI**

**Amiloride HCl and Hydrochlorothiazide Tablets**

**Amiloride HCl Tablets**

**Aminophylline**

**Anhydrous Calcium Iodide and Isoproterenal Sulfate Syrup**

**Atenolol and Chlorthalidone Tablets**

**Atenolol Tablets**

**Beclomethasone Dinipionate**

**Bendroflumethiazide**

**Bendroflumethiazide and Nadolol Tablets**

**Benztropine Mesylate**

**Betaxolol HCl Ophthalmic Solution**

**Bethanechol Chloride**

**Biperiden Tablets**

**Bitolterol Mesylate**

**Bumeinate Tablets**

**Claptopril and Hydrochlorothiazide Tablets**

**Claptopril Tablets**

**Carbachol Ophthalmic Solution**

**Carbamazepine**

**Carbidopa and Levodopa**

**Chlorothiazide**

**Chloropropamide Tablets**

**Chlorthalidone and Clonidine HCI Tablets**

**Chlorthalidone Tablets**

**Cholestyramine**

**Clofibrate**

**Clonazepam**

**Clonidine HCI**

---

13 CSR 70-20.034 List of Non-Excludable Drugs for Which Prior Authorization Is Required

**PURPOSE:** This rule establishes a listing of non-excludable drugs and categories of drugs for which prior authorization is required in order for them to be reimbursable under the Missouri Medicaid Pharmacy Program.

(1) As specified in section 1927(d)(1) of the Social Security Act, states may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of section 1927(d)(5) of the Social Security Act.

(2) List of drugs or categories of drugs which are restricted to require prior authorization for certain specified indications shall be made available through the Department of Social Services, Division of Medical Services web site at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual.


Hydralazine
Hydralazine and Hydrochlorothiazide
Hydralazine, Hydrochlorothiazide and Reserpine
Hydrochlorothiazide and Lisinopril
Hydrochlorothiazide and Methylpapine Tablets
Hydrochlorothiazide and Metoprolol Tartrate
Hydrochlorothiazide and Spironolactone Tablets
Hydrochlorothiazide and Timolol
Hydrochlorothiazide and Triamterene
Hydrochlorothiazide Tablets
Hydrochlorothiazide with Labetalol
Hydrofumethiazide and Reserpine
Indapamide Tablets
Indomethacin Suppositories
Insulin
Intravenous Fluids
Dextrose 25%, Sodium Chloride 0.45%
Dextrose 5%
Dextrose 5%, Lactated Ringer’s
Dextrose 5%, Sodium Chloride 0.225%
Dextrose 5%, Sodium Chloride 0.3%
Dextrose 5%, Sodium Chloride 0.45%
Lactated Ringer’s
Sodium Chloride 0.45%
Sodium Chloride 0.9%
Ipatropium Bromide
Isoorhine HCI
Isoflurophate Ophthalmic
Isoperterenol
Isoperterenol and Phenylephrine
Bitartrate Oral Inhaler
Isosorbide Dinitrate
Labetalol
Levobunolol HCI Ophthalmic Solution
Levodopa
Levophylline Sodium
Lisinopril
Lovastatin
Mecamylamine HCI
Metaproterenol Sulfate
Methazolamide Tablets
Methyldopa
Methylothiazide
Methylpapine
Metazolone
Metoprolol Tartrate
Meténysine
Mexiletine HCI
Nadolol Tablets
Niacin Tablets
Nicardipine HCl
Nifedipine Capsules
Nifedipine Controlled Release Tablets
Nitroglycerin Spray
Nitroglycerin Sublingual Tablets
Nitroglycerin Sustained Release Capsules
Nitroglycerin Topical Ointment
Nitroglycerin Transdermal Systems
Oxtriphylline
Papaverine HCI Sustained Release 150 mg.
Penoxifylline
Phenobarbital
Phenytoin
Pilocarpine HCI Ophthalmic Solution
Pindolol
Pirbuterol Acetate
Polychlazide
Potassium Chloride Capsules
Potassium Chloride 10% Liquid
Potassium Chloride 20% Liquid
Potassium Chloride Oral Tablets
Potassium Chloride Sustained Release Capsules
Potassium Chloride Sustained Release Tablets
Prazosin HCI
Primidone
Probuloc
Procainamide HCI Capsules
Procyclidine
Propanolol HCI Sustained Release Capsules
Propylthiouracil
Quinidine Sulfate Tablets
Rauwolfia Serpentina Tablets
Reserpine and Trichlormethiazide
Reserpine Tablets
Spironolactone
Synges, Disposable, Insulin
Terazosin HCI
Terbutaline Sulfate
Theophylline
Theophylline Sustained Release Capsules
Theophylline Sustained Release Tablets
Thyroid Tablets
Timolol Maleate
Toacinate
Tolazamide Tablets
Tolbutamide
Triacineonone Acetone Oral Inhaler
Trichlormethiazide
Trihexyphenyld
Valproic Acid
Valproic Acid, E.C.
Verapamil HCl
Verapamil HCI Sustained Release Tablets
Warfarin Sodium Tablets


13 CSR 70-20.045 Thirty-One Day Supply Maximum Restriction on Pharmacy Services Reimbursed by the Division of Medical Services

PURPOSE: The purpose of this is to establish a thirty-one day supply maximum restriction per dispensing on pharmacy services reimbursed by the Division of Medical Services on behalf of patients eligible for any of the fee-for-service programs.

(1) The maximum days supply of medication which may be provided per dispensing on behalf of a patient eligible for any of the fee-for-service programs is thirty-one (31) day supply, except for those drugs and/or categories under the provisions of this rule. Medication may be dispensed in quantities...
less than a thirty-one (31) day supply, if so ordered by the prescriber, except as specified elsewhere in this rule.

(2) Drugs and/or categories of medications which are exempt from the thirty-one (31) day supply limitation and therefore may be dispensed in quantities exceeding a thirty-one (31) day supply are as follows:

<table>
<thead>
<tr>
<th>Drug or Category</th>
<th>Maximum Limitation If Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral Agents</td>
<td></td>
</tr>
<tr>
<td>Contraceptives, Oral</td>
<td>One year</td>
</tr>
<tr>
<td>Drug products limited by packaging requirements</td>
<td></td>
</tr>
<tr>
<td>Vitamins, Children’s</td>
<td>100 days</td>
</tr>
<tr>
<td>Vitamins, Prenatal</td>
<td>100 days</td>
</tr>
</tbody>
</table>

(3) All spend down recipients are exempt from the Missouri Medicaid thirty-one (31) day supply maximum restriction on pharmacy services.

(4) Exemptions from the thirty-one (31) day supply limitation may be given with prior authorization by the Division of Medical Services to prevent a higher level of care.


13 CSR 70-20.050 Return of Drugs

PURPOSE: The Division of Medical Services establishes that when a pharmacy dispenses drugs in a controlled-dose delivery system, the pharmacy must give the Division of Medical Services credit for any unused portion of the drug that is reusable in accordance with applicable federal or state law.

(1) Definitions.

(A) Controlled-dose delivery system. A controlled-dose delivery system is defined as a system of dispensing of medications on behalf of a resident in a long-term care facility in manufacturer’s unit dose packaging or pharmacist packager’s unit dose, unit-of-use, or strip packaging with each tablet or capsule individually wrapped, or in blister cards, all of which must be dispensed according to applicable state and federal laws or regulations.

(B) Dispense medication in a drug distribution system(s) which meets minimum standards of packaging (at least class B as defined in United States Pharmacopeia XXI);

(C) Indicate, as prescribed by the Division of Medical Services, on each claim that the prescription was provided in packaging qualifying for the dispensing fee add-on to a recipient in a long-term care facility.


MISSOURI MEDICAID
LONG TERM CARE PHARMACY DISPENSING FEE
PROVIDER SPECIALTY APPLICATION

PROVIDER INFORMATION

Complete or affix provider label below:
Missouri Medicaid Provider Number ____________________________
Provider Name _____________________________________________
Provider Address ____________________________________________

Business telephone _______________________________

APPLICATION

1. Facilities For Whom You Dispense in Unit-Dose or Controlled-Dose Drug Distribution System
   Drug Distribution System

   Name ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________

2. Type of Unit-Dose or Controlled-Dose Drug Distribution System Dispensed in Each Facility

   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________
   ________________________________________________

By my signature, I hereby certify that I provide the required distribution system as stated above, and that I provide emergency services and 24 hour a day, seven (7) day a week availability to the long term care facility. In addition, I am able and willing to assist the facility and its residents in accessing medications through the Medicaid exception process.

Provider Signature ___________________________ Date ____________

Return to: Provider Enrollment Unit
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500
Telephone No: (314)751-2617
13 CSR 70-20.070 Computer-Generated Drug Pricing Tape and Drug Reimbursement Methodology

PURPOSE: This rule establishes the basis and the method for pricing all drug claims in Missouri under the Title XIX Medicaid program. The purchase of a computer-generated tape, with weekly updates, will make it possible to utilize the computer for review purposes, which greatly increases the speed with which claims can be paid.

PUBLISHER’S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) The Division of Medical Services will obtain, by contract with a reputable medical publishing company, a weekly computer-generated tape which will provide the information needed to price all fee-for-service Medicaid drug claims. The tape will contain National Drug Code (NDC), drug name, drug strength, dosage form, package size, the Average Wholesale Price (AWP), the prices set by direct-selling manufacturers (direct prices), Wholesale Acquisition Cost (WAC), and federal Health and Human Services upper limits for specified multiple source drugs. A multiple source drug is defined as a drug marketed or sold by two (2) or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two (2) or more different proprietary names or both under a proprietary name and without that name.

(2) The Division of Medical Services will add the Missouri Maximum Allowable Cost (MMAC) limits, for multiple source drugs as defined, to the data shown on the tape described in section (1) of this rule.

(3) Reimbursement for covered drugs will be made at the lower of the—

(A) Usual and customary charge as billed by the provider; or

(B) Price(s) included on the Drug Pricing File which is derived from one (1) or more of the following:

   1. The AWP as furnished by the state’s contracted agent, less ten and forty-three hundredths percent (10.43%);  

   2. The MMAC as determined by the state agency for selected multiple source drugs;  

   3. Applicable federal upper limits as found at www.dss.state.mo.us/dms; or  

   4. The WAC as furnished by the state’s contracted agent, plus ten percent (10%).


13 CSR 70-20.071 Multiple Source Drugs for Which There Exists a Federal Upper Limit on Reimbursement

PURPOSE: This rule establishes, via regulation, the Department of Social Services, Division of Medical Services’ upper limits on reimbursement for selected multiple source drugs, in response to the implementation of new federal guidelines.

(1) The federal Health Care Financing Administration has established policy that federal matching funds will be provided for certain multiple source drugs, at the appropriate match rate, of an amount not to exceed specified upper limits of reimbursement. The specific upper limits of reimbursement are communicated to state Medicaid agencies periodically, with effective dates designated.

(2) As specified in 13 CSR 70-20.070, reimbursement for multiple source drugs shall be made in an amount not to exceed the federal upper limit, unless prior authorization is obtained by the prescribing physician. Prior authorization must be obtained by telephone or by mailing a completed Drug Prior Authorization Form to the Division of Medical Services to allow reimbursement at the trade name price. The Medicaid Pharmacy Manual and updating bulletins shall provide the detailed listing of the specific drug products that shall not be reimbursed in an amount that exceeds the federal upper limit.


### PLEASE PRINT OR TYPE. ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL NOT BE PROCESSED.

<table>
<thead>
<tr>
<th>INITIAL REQUEST</th>
<th>RENEWAL REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICARE NUMBER</td>
<td>DATE OF BIRTH</td>
</tr>
</tbody>
</table>

### DIAGNOSIS (TYPE AND SEVERITY, BE VERY SPECIFIC)

<table>
<thead>
<tr>
<th>DATE OF ONSET</th>
<th>REQUESTED DRUG NAME, DOSAGE FORM, AND STRENGTH</th>
</tr>
</thead>
</table>

If the patient has tried or currently takes the requested drug, has it been effective?  
☐ Yes  ☐ No

### DURATION OF NEED:
Current medications and dosages for this diagnosis, including date started (attach additional sheet if necessary)

If diagnosis is drug-induced, can the source of the condition be eliminated by changing or discontinuing current drug(s)?  
☐ Yes  ☐ No

All alternative treatments and medications tried, including dates used (attach additional sheet if necessary)

Reason(s) alternative(s) is/are contraindicated

For request for reimbursement for brand name drug: Was generic of requested drug tried?  
☐ Yes  ☐ No

**ATTACH ANOTHER SHEET IF ADDITIONAL DOCUMENTATION IS REQUIRED. FOR DRUG-SPECIFIC REQUIREMENTS YOU MAY CALL 1-800-392-8030**

**REQUESTING PHYSICIAN NAME**

**TELEPHONE NUMBER**

**ADDRESS**

**PHYSICIAN'S SIGNATURE**

**PROVIDER NUMBER**

MO 668-3003 (3-93)
13 CSR 70-20.080 Labeling of Medicaid Prescriptions
(Rescinded December 9, 1993)


13 CSR 70-20.100 Missouri Nonsteroidal Anti-Inflammatory Drug List
(Rescinded September 30, 1991)


13 CSR 70-20.110 Medicaid Program Coverage of Approved Drugs for Treatment of Acquired Immunodeficiency Syndrome (AIDS)
(Rescinded September 30, 1991)


13 CSR 70-20.120 Medicaid Program Coverage of Anti-Ulcer Preparations
(Rescinded June 29, 1989)


13 CSR 70-20.200 Drug Prior Authorization Process

PURPOSE: This rule establishes the division process by which drugs may be restricted under Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990) and are determined to be appropriate for inclusion as a regular benefit of the Missouri Medicaid program or through prior authorization.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency which filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

1. This rule establishes a Medicaid drug prior authorization committee in the Department of Social Services, Division of Medical Services. The committee shall be composed of three (3) practicing physicians licensed pursuant to Chapter 334, RSMo; three (3) practicing pharmacists licensed pursuant to Chapter 338, RSMo, one (1) of whom shall hold a doctoral degree in pharmacy (Pharm. D.); and one (1) registered professional nurse, as defined in Chapter 335, RSMo, practicing in a long-term care setting. All members shall be appointed by the director of the Department of Social Services. The members shall serve for a term of four (4) years, except that of the members first appointed, two (2) shall be appointed for one (1) year, two (2) shall be appointed for two (2) years and three (3) shall be appointed for three (3) years. Members of the committee shall receive no compensation for their services, but shall be reimbursed for their actual and necessary expenses incurred, as approved by the Division of Medical Services out of appropriations made for that purpose.

2. All persons eligible for medical assistance benefits shall have access to all pharmaceutical products for which there is federal financial participation except those drugs which may be restricted under Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990). The Medicaid drug prior authorization committee shall review those drugs which may be restricted and recommend those appropriate for inclusion as a regular benefit of the Missouri Medicaid program or through prior authorization.

3. The department or the division may require prior authorization of pharmaceutical products. Any such restriction shall be based on medical and clinical criteria, and Missouri-specific data. The committee shall develop this medical and clinical criteria based on predetermined standards consistent with the following:

(A) The American Hospital Formulary Service Drug Information;
(B) The United States Pharmacopeia Drug Information;
(C) The American Medical Association Drug Evaluations; and
(D) Peer-reviewed medical literature.

4. If the division finds that the data enumerated in section (3) of this rule has been documented, the Medicaid drug prior authorization committee shall hold a public hearing in order to make recommendations to the department prior to any final decision by the division to require prior authorization for that pharmaceutical product, class or category.

5. If, after the hearing required pursuant to section (4) of this rule, prior authorization of the pharmaceutical product is required, this prior authorization requirement shall be reviewed at least once every twelve (12) months by the Medicaid drug prior authorization committee.

6. The division shall not otherwise restrict the prescribing and dispensing of covered outpatient prescription drugs (other than Drug Efficacy Implementation Study (DESI) drugs as designated by federal law) pursuant to this rule without consulting the drug prior authorization committee. The division may limit the number of prescriptions allowed for each medical assistance recipient.

7. As used in the rule, DESI drugs are drugs described in section 107(c)(3) of the Drug Amendments of 1962 and identical, similar or related drugs (within the meaning of section 310.6(b)(1) of Title 21 of the Code of Federal Regulations).

8. When implementing the provisions of section (3), Missouri-specific data shall include the consideration of use and cost data, pharmacoeconomic information and prudent utilization of state funds, and shall include medical and clinical criteria.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000.* Original rule filed Feb. 3,
13 CSR 70-20.250 Prior Authorization of New Drug Entities or New Drug Dosage Form

PURPOSE: This rule outlines the process by which new drugs or new drug dosage forms of existing drugs may be subject to prior authorization prior to payment by the Missouri Medical Assistance Program.

(1) New drug entities, and new drug product dosage forms of existing drug entities, that have been approved by the Food and Drug Administration and are available on the market, shall comply with prior authorization requirements imposed by the division, in compliance with federal law.

(2) Prior authorization restrictions shall continue on new drug entities and new drug product dosage forms of existing drugs until reviewed by the division and the division eliminates the restriction or makes a final determination to require restriction. The division shall consider known cost and use data, medical and clinical criteria, and prudent utilization of state funds in the review. Interested parties may present clinical data to the division’s Pharmacy Program Director.

(3) The review referenced in section (2) shall occur within thirty (30) business days after the division receives notice through pricing updates of the availability of the drug entity on the market. Upon completion of the review, the division shall make the drug available for use without prior authorization at that time by all Medicaid recipients or refer the new drug or new drug dosage form to the Medicaid Drug Prior Authorization Committee (MDPAC) with a recommendation for continued prior authorization. During the subsequent review by the MDPAC and Drug Use Review (DUR) Board, the drug shall continue to be available only through prior authorization. Staff recommendations regarding continued prior authorization of a new drug or new drug dosage form shall be made in writing to the MDPAC outlining the criteria used to develop such recommendations. A copy shall be available to the public prior to the MDPAC meeting in which the continued prior authorization is to be discussed.

(4) The MDPAC shall consider any recommendations related to continued prior authorization of a new drug or new drug dosage form at the next scheduled MDPAC meeting. The division and the MDPAC may actively seek comments about the proposed restrictions. The MDPAC shall include a minimum of fifteen (15) minutes for any interested parties who have notified the division in advance of the scheduled meeting to comment about such proposed restrictions.

(5) If the MDPAC finds that use and cost data, pharmacoeconomic information, along with medical and clinical implications of restriction, are documented and restriction is warranted, the MDPAC shall hold a public hearing regarding the continued restriction and make a recommendation to the division. Such recommendation shall be provided to the division, in writing, prior to the division making a final determination. The division shall provide notice of the final determination through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual.

(6) If, after the hearing referenced in section (5) above, prior authorization of the new drug or new drug dosage form is required, the prior authorization requirement shall be reviewed at least once every twelve (12) months by the MDPAC.


13 CSR 70-20.300 Retrospective Drug Use Review Process

PURPOSE: This rule establishes the division process by which the Drug Use Review Board will be established as required by Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990) and by section 208.175, RSMo.

(1) Drug Use Review (DUR) Board. This rule establishes a Medicaid DUR board in the Department of Social Services, Division of Medical Services. The board shall be composed as specified in section 208.175, RSMo.

(2) Members of the DUR board must have the following minimum qualifications:

(A) Must be licensed by Missouri, with that license in active status and in good standing; and

(B) Must have recognized knowledge and expertise in one (1) or more of the following:

1. The clinically appropriate prescribing of covered outpatient drugs;

2. The clinically appropriate dispensing and monitoring of covered outpatient drugs;

3. Drug use review, evaluation and intervention; or

4. Medical quality assurance.

(3) A chairperson shall be elected by the board members.

(4) The board shall meet at least once every ninety (90) days. A quorum of two-thirds (2/3) of the total members, including no fewer than two (2) physicians or two (2) pharmacists, is required for the board to act in its official capacity.

(5) Members shall serve four (4)-year terms, except the terms of the original members, two (2) shall be appointed for a term of two (2) years, three (3) shall be appointed for a term of three (3) years, and three (3) shall be appointed for a term of four (4) years. Members may be reappointed, provided that minimum qualifications for membership continue to be met. Nominations shall be referred for final appointment by the governor subject to advice and consent of the Senate. As vacancies occur, the DUR board shall solicit and select a slate of nominees.

(6) The members of the board shall receive no compensation for their services other than reasonable expenses actually incurred in the performance of their official duties.

(7) The DUR board shall provide, either directly or through contracts between the Division of Medical Services and accredited health care schools, state medical societies or state pharmacist associations or societies or other appropriate organizations, provide for educational outreach programs as required by P.L. 101-508, Section 4401, to educate practitioners on common drug therapy problems with the aim of improving, prescribing and dispensing practices. This outreach shall include an educational newsletter to Missouri Medicaid providers including appropriate drug use guidelines and Medicaid utilization statistics.

(8) As specified by P.L. 101-508, Section 4401, the DUR board shall monitor drug use,
and prescribing and dispensing practices in the Medicaid program. This monitoring shall include reviewing and refining therapeutic criteria modules used in both retrospective and prospective DUR, as well as overseeing retrospective DUR intervention methods used.

(9) The DUR board shall advise the Department of Social Services regarding all activities associated with the DUR process, including identifying types of intervention methods to be initiated by the review committees, ranging from letters to physicians and pharmacists, face-to-face education and educational symposiums for targeted providers. The board shall provide educational support and guidance as needed by the review committees. The review committees, in turn, shall report intervention results and make recommendations based on these results to the board.

(10) The DUR board shall review and research recommendations from the Prior Authorization Committee, as established by 13 CSR 70-20.200, regarding the advisability of implementing or removing prior authorization requirements for a drug or class of drugs, and make a recommendation to the Department of Social Services.

(11) Specialized DUR Committees. Subject to appropriation, up to six (6) regional review committees may be appointed by the director of the Department of Social Services for the areas surrounding St. Louis, Kansas City, Springfield, Cape Girardeau, Kirksville and Columbia. Other specialized review committees may be formed at the discretion of the Department of Social Services. Members of the review committees shall be physicians and pharmacists appointed by the DUR board, totaling no fewer than five (5) and no more than ten (10) members per committee. A quorum of fifty-one percent (51%) of the total members must be present to conduct business. Regional committee members shall have the same minimum qualifications as required for the DUR board members. Regional committee meetings shall be held every other month. The members of each committee shall elect a chairperson, who shall serve as an ex officio member of the DUR board. Committee members shall receive no compensation other than reasonable expenses actually incurred in the performance of their official duties.

(12) The regional review committees shall conduct patient profile reviews, including opening and closing of cases at the committee meetings. Interventions shall be initiated and follow-up reviews performed by the regional committees. Patterns of inappropriate or aberrant prescribing or dispensing shall be identified and referred to the board in order for targeted education to be formulated.

(13) Agency Responsibility Regarding Confidentiality of Information. All information concerning applicants and recipients of medical services shall be confidential and any disclosure of this information shall be restricted to purposes directly related to the administration of the medical assistance program. Purposes directly related to administration of the medical assistance program include:

(A) Establishing eligibility;
(B) Determining the amount of medical assistance;
(C) Providing services for recipients; and
(D) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program.

(14) Provider Responsibility Regarding Confidentiality of Information. All information concerning applicants and recipients of medical services shall be confidential. Any disclosure of this information shall be restricted to purposes directly related to the treatment of the patient and promotion of improved quality of care. The confidential information includes:

(A) Names and addresses;
(B) Social Security number;
(C) Medical services provided;
(D) Social and economic conditions or circumstances;
(E) Medical data, including diagnosis and past history of disease or disability;
(F) Any information received for verifying income eligibility; and
(G) Any information received in connection with the identification of legally liable third-party resources.


(1) Prospective Drug Use Review (DUR). This rule establishes a Medicaid prospective drug use review process within the Department of Social Services, Division of Medical Services, as specified in section 208.176, RSMo.

(2) Electronic Point-of-Sale Review. The Division of Medical Services shall provide for electronic point-of-sale review of drug therapy using predetermined standards before each prescription is dispensed to the non-nursing home Medicaid recipient or Medicaid recipient’s caregiver for the current date of service. The process will provide screening for potential drug therapy problems using clinical modules which have been reviewed and approved for use by the Missouri Drug Use Review Board.

(3) Federal Prospective DUR screening requirements for Medicaid beneficiaries. 42 CFR part 456.705(b) requires that the state plan must provide for a point of distribution review of drug therapy using predetermined standards before each prescription is filled or delivered to the recipient or the recipient’s caregiver. The review, performed with or without online access to the Pharmacy Point of Service system, must include screening to identify potential drug therapy problems of the following types:

(A) Incorrect drug dosage, that is, the dosage lies outside the daily dosage range specified in predetermined standards as necessary to achieve therapeutic benefit. Dosage range is the strength multiplied by the quantity dispensed divided by days supply;
(B) Adverse drug-drug interaction, that is, the potential for, or occurrence of, an adverse medical effect as a result of the recipient using two (2) or more drugs together;
(C) Drug-disease contraindication, that is the potential for, or occurrence of—

1. An undesirable alteration of the therapeutic effect of a given prescription because of the presence, in the patient for whom it is prescribed, of a disease condition; or

(D) Therapeutic duplication, that is, the prescribing and dispensing of two (2) or more drugs from the same therapeutic class so that the combined daily dose puts the recipient at risk of an adverse medical result or incurs additional program costs without additional therapeutic benefit.
(E) Incorrect duration of drug treatment, that is, the number of days of prescribed therapy exceeds or falls short of the recommendations contained in the predetermined standards;

(F) Drug-allergy interactions, that is, the significant potential for, or the occurrence of, an allergic reaction as a result of drug therapy; and

(G) Clinical abuse/misuse, that is, the occurrence of situations referred to in the definitions of abuse, gross overuse, overutilization and underutilization, as defined in 42 CFR 456.702, and incorrect dosage and incorrect duration, as defined in subsections (3)(A) and (E) of this rule.

(4) Screens Available for Medicaid Beneficiaries. The following screens will be provided by the Pharmacy Point of Service system:

(A) Drug Disease Contraindications.
   1. Drug (actual) disease precaution.
   2. Inferred Drug Disease precaution;

(B) Drug to Drug Interactions;

(C) Side Effects.
   1. Additive toxicity side effects.
   2. Medical condition/additive side effect.
   3. Side effect.
   4. Drug indicated for side effect of previously prescribed drug;

(D) Dose Range Checking.
   1. High dose alert.
   2. Low dose alert;

(E) Minimum/Maximum Daily Dose.
   1. High dose alert.
   2. Low dose alert;

(F) Duplicate Therapy Checking.
   1. Therapeutic duplication.
   2. Ingredient duplication; and

(G) Duration of Therapy (H2).
   1. Excessive duration alert.

(5) Medicaid Patient Counseling. As part of the prospective DUR program, participating pharmacies shall perform Medicaid patient counseling according to the standards established by the Board of Pharmacy under 4 CSR 220-2.190.

(6) Medicaid Patient Profiles. The term, reasonable effort means that each time a Medicaid patient or caregiver presents a prescription, the pharmacist or pharmacist’s designee should request profile information verbally or in writing. For example, if the patient presents the prescription in person, the request should be made verbally, and if the prescription is received by mail, the request should be made in writing. This does not imply that the service should be denied solely on the basis of the patient’s refusal to supply this information. Pharmacies must make a reasonable effort to obtain records and maintain patient profiles containing, at a minimum:

(A) The name, address, telephone number, date of birth (or age) and gender of the patient;

(B) Individual medical history, if significant, including disease states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices; and

(C) Pharmacist’s comments relevant to the individual’s drug therapy.

(7) Documentation of Offer to Counsel. The pharmacist shall document for each Medicaid patient’s prescription in a uniform fashion, whether the offer to counsel was accepted or refused by the patient or the patient’s agent.

(8) Agency Responsibility Regarding Confidentiality of Information. All information concerning applicants and recipients of medical services shall be kept confidential by the Division of Medical Services, and any disclosure of this information shall be restricted to purposes directly related to the administration of the Medicaid assistance program. Purposes directly related to administration of the Medicaid assistance program include:

(A) Establishing eligibility;

(B) Determining the amount of medical assistance;

(C) Providing services for recipients; and

(D) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program.

(9) Provider Responsibility Regarding Confidentiality of Medicaid Beneficiary Information. All information concerning applicants and recipients of medical services shall be confidential. Any disclosure of this information by the pharmacy shall be restricted to purposes directly related to the treatment of the patient and promotion of improved quality of care, or conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program. The confidential information includes:

(A) Names and addresses;

(B) Social Security number;

(C) Medical services provided;

(D) Social and economic conditions or circumstances;

(E) Medical data, including diagnosis and past history of disease or disability;

(F) Any information received for verifying income eligibility; and

(G) Any information received in connection with the identification of legally liable third party resources.


13 CSR 70-20.320 Pharmacy Reimbursement Allowance

PURPOSE: This rule establishes a Pharmacy Federal Reimbursement Allowance and the methodologies to determine the formula for the amount of allowance each pharmacy is required to pay for the privilege of providing outpatient prescription drugs.

(1) Pharmacy Reimbursement Allowance (PRA). PRA shall be assessed as described in this section.

(A) Definitions.

1. Department—Department of Social Services.

2. Director—Director of Department of Social Services.

3. Division—Division of Medical Services.

4. Monthly gross retail prescription receipts—For ease of administration for the department as well as the industry, this shall be an annual amount. The basis of tax in any fiscal year will be the gross prescription sales of the last calendar year prior to the previous fiscal year.

(B) Each pharmacy engaging in the business of providing outpatient prescription drugs in Missouri to the general public shall pay a PRA.

1. The PRA owed for existing pharmacies shall be calculated by multiplying the pharmacy’s total gross retail prescription receipts by the tax rate determined by the department. Subject to the limitations established in section 538.520, RSMo, the range of such said tax rate shall be uniformly distributed in bands determined by a ratio of total Medicaid prescriptions divided by total sales and shall not exceed six percent (6%).

2. The PRA shall be divided by and collected over the number of months for which the PRA is effective.

3. The initial PRA owed by a newly licensed pharmacy shall be calculated by estimating the total prescription sales and multiplying the estimate by the rate determined by the department.
4. If a pharmacy ceases to provide outpatient prescription drugs to the general public, the pharmacy is not required to pay the PRA during the time it did not provide outpatient prescription drugs.

5. If the pharmacy reopens, it shall resume paying the PRA. It shall owe the same PRA as it did prior to closing, if the PRA has not changed per paragraph (1)(B)1.

(C) Each pharmacy shall submit an affidavit to the department with the following information:

1. Pharmacy name;
2. Contact;
3. Telephone number;
4. Address;
5. Federal tax ID number;
6. Medicaid pharmacy number (if applicable);
7. Pharmacy sales (total);
8. Medicaid pharmacy sales;
9. Number of paid Medicaid prescription; and
10. Gross receipts attributable to prescription drugs that are delivered directly to the patient via common carrier, by mail, or a courier service.

(D) The department shall prepare a confirmation schedule of the information provided by each pharmacy and the amount of PRA that is due from the pharmacy.

(E) Each pharmacy shall review the information prepared by the department and the amount of PRA calculated by the department to verify that the information is correct.

1. If the information supplied by the department is incorrect, the facility, within thirty (30) calendar days of receiving the confirmation schedule must notify the division and explain the correction.
2. If the division does not receive corrected information within thirty (30) calendar days, it will be assumed to be correct, unless the pharmacy files a protest in accordance with subsection (2)(D) of this regulation.

(2) Payment of the PRA.

(A) Offset.

1. Each pharmacy may request that its PRA offset against any Missouri Medicaid payment due to that pharmacy.

   A. A statement authorizing the offset must be on file with the division before any offset may be made relative to the PRA by the pharmacy.

   B. Assessments shall be allocated and deducted over the applicable service period.

   C. Any balance due after the offset shall be remitted to the Director of the Department of Revenue and be deposited in the state treasury to the credit of the Pharmacy Reimbursement Allowance Fund.

D. If the remittance is not received before the next Medicaid payment cycle, the division shall offset the balance due from that check.

(B) Check.

1. If no offset has been authorized by the pharmacy, the division will begin collecting the pharmacy reimbursement allowance on the first day of each month for the preceding months.

2. The PRA shall be remitted by the pharmacy to the department. The remittance shall be made payable to the Director of the Department of Revenue and be deposited in the state treasury to the credit of the Pharmacy Reimbursement Allowance Fund.

(C) Failure to comply with this request for information or failure to pay the PRA.

1. If a pharmacy fails to comply with a request for information from the Division of Medical Services or fails to pay its PRA within thirty (30) days of notice, the PRA shall be delinquent.

2. For any delinquent PRA, the department may:

   A. Proceed to enforce the state’s lien of the property of the pharmacy;

   B. Cancel or refuse to issue, extend or reinstate the Medicaid provider agreement; or

   C. Seek denial, suspension or revocation of license granted under Chapter 338, RSMo.

3. The new owner, as a result of a change in ownership, shall have his/her PRA paid by the same method the previous owner elected.

(D) Each pharmacy, upon receiving written notice of the final determination of its PRA, may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the pharmacy so requested, grant the pharmacy a hearing to be held within forty-five (45) days after the protest was filed, unless extended by agreement between the pharmacy and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a pharmacy’s appeal of the director’s final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156, RSMo 2000 and 621.055, RSMo Supp. 2001.

(E) PRA Rates.

1. The PRA tax rates will be done in bands and will be determined by the ratio of paid Medicaid claims to total prescription sales.