Connecticut interChange MMIS

Provider Manual

Chapter 7 - Pharmacy

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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Pharmacy Services Regulation/Policy
Chapter 7

Medical Services Policy 7.1

This section of the Provider Manual contains the Medical Services Policy and Regulations of Connecticut State Agencies pertaining to pharmacy services.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Pharmacy Services

Requirements for Payment of Pharmacy Services

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(Medical Services Policy)

Requirements for Payment Under the Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE)

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174 Drugs

The drug program provides Medicaid reimbursement for accepted methods of drug treatment for Title XIX patients.

A. Definitions

I. "Average Wholesale Price" (A.W.P.) means the published wholesale price as determined by the Department from the price listed by one or more national publications recognized by the Department.

II. "Brand Name/Trade Name" means the name assigned to a drug by the pharmaceutical innovator, i.e., manufacturer and/or distributor for the purpose of distribution to wholesalers or retailer, whether or not this name is registered in the United States Patent Office.

III. A "Compounded Prescription" means two or more drugs mixed together and at least one ingredient must be a legend drug. A compounded prescription must include name, strength, and amount of each prescribed ingredient.

IV. "Connecticut Over-the-Counter Formulary" means the formulary of O.T.C. (nonlegend) drugs which are reimbursable by the Department.

V. "Department" means the Connecticut Department of Social Services.

VI. "Dispensing Fee" means an amount of money paid to a pharmacist for rendering a professional service involving the preparation and dispensing of a prescribed drug ordered by a licensed authorized practitioner.

VII. "Documented in Writing" means that the prescription has been handwritten, typed or computer printed. Computerized systems must meet all of the requirements of the Commission of Pharmacy Regulations Chapter 382 Sections 20-164B-1 through 20-164b-11 for non-controlled drugs and Sections 21a-244-1 through 21a-244-6 for controlled drugs and as they may be amended from time to time. (Note: Record retention for all Medicaid claims extends to a five (5) year period per Section G.II.).

VIII. "Drug Efficacy Study Implementation (DESI) Program" means the program through which the Food and Drug Administration has identified certain products which lack sufficient evidence of their effectiveness for the approved indication(s).

IX. "Estimated Acquisition Cost" (E.A.C.) means the Department's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

X. "Federal Acquisition Cost/Federal Upper Limit" (F.A.C.) means the upper limit allowable cost established and published by HCFA for those multiple source drugs which appear on HCFA's list of multiple source drugs for which upper limits have been established as revised from time to time.

XI. "HCFA" means the Health Care Financing Administration of the United States Department of Health and Human Services.

XII. "Legend Drugs" means any article, substance, preparation or device which bears the legend: "Caution - Federal Law prohibits dispensing without a prescription".

XIII. "Licensed Authorized Practitioner" means any physician or other licensed practitioner who is authorized to prescribe drugs within the scope of his or her professional practice as defined and limited by Federal and State law.

XIV. "Multiple-Source Drug" means a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names, or both under a proprietary name and without such a name.

XV. "Nutritional Supplements" means commercially prepared products, the primary purpose of which is to treat a diagnosed deficiency or potential deficiency in the patient's diet or nutrition.

XVI. "Over-the-Counter/Nonlegend Drugs" (O.T.C.) means drugs which do not require a prescription by Federal or State law (O.T.C. items are available for purchase by the general public with or without a prescription) and generally are used by persons residing in the community and are usually administered or used by the patient on the basis of self-diagnosis.

XVII. "Pharmacy" means a facility licensed by the Commission of Pharmacy in the Department of Consumer Protection under Section 20-168 of the Connecticut General Statutes or by the appropriate regulatory body of the state in which it is located.

XVIII. "Prescribed Drug" means a single drug or compound or mixture of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that is

a. Prescribed by a licensed authorized practitioner within the scope of his or her professional practice as defined and limited by Federal and State law; and

b. Dispensed by the licensed pharmacist on a written or oral prescription issued in accordance with the State Medical Practice Act and that is recorded and maintained in the pharmacist's records.

XIX. "Prescription" means an order issued by a licensed authorized practitioner and documented in writing by either the practitioner or pharmacist. In nursing homes the signed order of a licensed authorized practitioner will be accepted in lieu of a written or oral prescription. The written prescription includes

a. the name and address of the patient; and

b. whether the patient is an adult or a child, or the patient's specific age; and

c. the compound or preparation ordered; and

d. its strength when applicable and the specific amount thereof, to be dispensed at one time; and

e. directions for the use of the medication and any cautionary statements required; and

f. the number of times that the prescription may be refilled, if applicable; and

g. date of issuance; and

h. name and address of the prescribing practitioner and his/her Drug Enforcement Act number when appropriate.

XX. "Prior Authorization" (P.A.) means approval for a service from the Department before the provider actually provides the services. In order to receive approval from the Department a provider must comply with all prior authorization requirements found in policy. P.A. does not, however, guarantee payment unless all other eligibility requirements are met.

XXI. "Usual and Customary Charge to the General Public" means a charge which will be made for the particular prescription by the provider to the patient group accounting for the largest number of non-Medicaid prescriptions. In determining such charge, all charges made to third party payers and special discounts offered to an individual such as a senior citizen will be excluded.

B. Provider Participation

In order to participate in the Medicaid program and receive payment directly from the Department, all pharmaceutical providers must:

I. be licensed by the appropriate regulatory body of the state in which it is located to operate a pharmacy and provide the Department with a copy of the license; and

II. meet and maintain all applicable license requirements of Federal and State statutes and regulations; and

III. meet and maintain all applicable Departmental enrollment requirements; and

IV. have a valid provider agreement on file which is signed by the provider and the Department upon application for enrollment into the Medicaid program and periodically thereafter as required by the Department and which is in effect for the period as stated in the agreement. The provider agreement specifies conditions and terms (Federal and State statutes, regulations and standards) which govern the program and to which the provider is mandated to adhere in order to participate in the program.

C. Eligibility

Payment for Pharmaceutical Services is available for all Medicaid eligible recipients subject to the conditions and limitation which apply to these services.

D. Services Covered and Limitations

I. Services Covered

Except for the limitations and exclusions listed below, the Department will pay for drugs which are prescribed by a licensed authorized practitioner as a result of accepted methods of diagnosis and treatment.

II. Service Limitations

a. Maximum Allowable Supply

The Department will not reimburse for an original prescription or refill that exceeds the supply requirement for a period of thirty (30) days not to exceed two hundred and forty (240) units except in the following instances:

1. 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.

2. For prescriptions for oral contraceptives, a supply sufficient for a maximum period of three (3) months may be dispensed at any time.

b. Refills

Payment will be made for refills of a prescription as authorized by the licensed authorized practitioner for an acute, or chronic illness, or condition as follows:

1. 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. 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 is 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.

2. 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.

c. The Department will not pay for any nonlegend drugs for nursing home patient when these items are used in usual and customary amount of routine care and treatment; the cost of such items is included in the nursing home's daily rate as set by the Department.

d. The Department will not pay for 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.

e. A licensed authorized practitioner may telephone prescription orders to a pharmacist. These orders must be documented in writing and countersigned or initialed by the pharmacist and must include the date of the telephone call.

III. Services Not Covered

The Department will not pay for

a. Any vaccines and/or biologicals which can be obtained free of charge from the Connecticut State Department of Health Services. The Department will notify pharmacists of such vaccines and biologicals.

b. Any drugs used in the treatment of obesity.

c. Drugs included in the DESI program. The Department will notify providers of such drugs.

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. Alcoholic liquors.

g. O.T.C.'s except those on the State of Connecticut's "O.T.C. Formulary" or as otherwise provided in this policy.

h. Anything of an unproven, experimental or research nature.

i. Items used for personal care and hygiene or for cosmetic purposes.

j. Drugs not directly related to the patient's diagnosis, when diagnosis is required by the Department to be written on the prescription.

k. Drugs solely used to promote fertility.

l. Drugs used to promote smoking cessation.

E. Need for Service and Authorization Process

I. Need for Service

A patient's need for pharmaceutical service is indicated when a licensed authorized practitioner prescribes a legend or nonlegend drug for treatment of or prevention of an illness or condition as documented in the patient's medical record.

II. Prior Authorization

a. The Department will not require P.A. for certain prescribed drugs which otherwise would require P.A. when prescribed by a licensed authorized practitioner for certain specific diagnoses. The diagnoses must be written on the prescription either by the authorized practitioner, or the pharmacist, after verification with the prescriber. The Department will notify providers of such medications with the corresponding diagnosis and diagnosis indicator.

b. The following drugs require prior authorization for all patients:

1. Any prescribed nonlegend (O.T.C.) medication or its equivalent used in the treatment of specific conditions and which does not appear on the Connecticut's "O.T.C. Formulary", or on the NDC/Diagnosis cross reference list with an appropriate diagnosis indicator (see E.II.a.).

2. All vitamins, except pediatric vitamins for children prior to the child's seventh birthday, vitamins with fluoride and Legend Hematinic alone or in combination with vitamins, or any product so specified by the manufacturer as hematinic.

3. Nutritional supplements (not covered under E.II.a.).

4. Amphetamines, amphetamine-like drugs (not covered under E.II.A.).

III. Authorization Procedures

a. Prior authorization for prescribed drugs is obtained by submitting the Department's P.A. form, "Authorization Request and Bill for Prescription Drugs" to

Department of Social Services
Utilization Review Unit
25 Sigourney St.
Hartford, Connecticut 06106-5033

b. Prior authorization will be approved covering a maximum of a three (3) month period. The effective starting date will be the date service is initially rendered and approved. If the need for service exceeds the authorization period, a request for an extension must be submitted on a form provided by the Department and approved prior to the onset of the period of extension. The request is sent to the Department with documentation by the physician that the medication continues to be medically necessary.

c. A pharmacist receiving a prescription for medication requiring prior authorization must complete the pharmacy section of the P.A. form. The licensed authorized practitioner (prescriber) must complete all relevant portions of the P.A. form. The pharmacist will then submit the request to the Department for consideration.

d. In emergency situations, the pharmacist may telephone the Department to obtain verbal authorization. The written request for authorization must be submitted to the Department within fifteen (15) working days following verbal authorization.

e. In emergency situations which occur after normal working hours, the pharmacist must call the Department for verbal approval on the following work day. The written request for authorization must be submitted to the Department within fifteen (15) working days following the date the medication was dispensed.

F. Other

I. Information Required on Prescriptions

All prescriptions must be processed in accordance with the regulations of the Commission of Pharmacy.

II. Retention of Prescriptions

All claims for covered drugs must be substantiated by a prescription from a licensed authorized practitioner on file in the pharmacy supplying the service, in accordance with Section 20-184c of the Connecticut General Statutes. In addition, documentation of prescriptions and/or medication orders must be retained by the pharmacy for a period of five (5) years or if any dispute arises concerning a prescription, until such dispute has been finally resolved.

III. Patient Profile

A patient profile record listing prescriptions must be maintained by the pharmacy for Title XIX patients.

IV. Oral Prescriptions

An oral prescription which is telephoned by a licensed authorized practitioner to a pharmacist must be documented in writing by the pharmacist for his records. These orders must be countersigned or initialed by the pharmacist and must meet the requirements as contained in Section 20-184b of the General Statutes and as it may be amended from time to time.

G. Billing

Bills for covered drugs from pharmacy providers are submitted on the Pharmacy Claim Form or electronically transmitted to the Department's billing fiscal agent and must include all information required by the Department to process the claim for payment.

H. Payment

I. Payment for Legend Drugs

Except for vaccine(s) utilized in mass inoculation, payment for legend drugs shall be based on the quantities set forth in A.W.P. for one hundred units, a pint if liquid or pound if powder, or as determined by the Department. Reimbursement will be made under E.A.C. or F.A.C., whichever is applicable to the particular drug dispensed plus the dispensing fee, or the usual and customary charge to the general public, or amount billed whichever is lower.

The Department will pay for mass inoculation of Influenza, Pneumovax or Hepatitis-B vaccine(s) provided they are prescribed by a licensed authorized practitioner and documented in the patient's medical record. The reimbursable amount and reimbursement procedures will be determined by the Department and supplied to providers via a fee schedule.

a. Estimated Acquisition Cost

The Department of Social Services must determine an E.A.C. for all legend drugs not covered by the F.A.C.

1. The Department's E.A.C. will be the Department's best estimate of the price generally and currently paid by providers for a drug marketed and sold by a particular manufacturer or labeler in the package size of drugs most frequently purchased by providers. E.A.C. will be set at a percentage of A.W.P.

   The Department will notify providers in the event that the Department's best estimate of the appropriate percentage changes.

2. The Department shall reimburse providers at the lower of the following:

   (a). The Department's E.A.C. plus the applicable dispensing fee; or

   (b). The provider's usual and customary charge to the general public; or

   (c). The amount billed by the provider.

b. Multiple-Source Drugs

For each multiple-source drug for which HCFA has identified and designated an F.A.C., reimbursement shall be the lower of the following:

1. The F.A.C. as established by HCFA plus the applicable dispensing fee; or

2. The provider's usual and customary charge to the general public; or

3. The amount billed by the provider.

c. Certification of Brand Name Drugs

Reimbursement for multiple-source drugs for which HCFA has designated a F.A.C. is not limited to the F.A.C. if a licensed authorized practitioner determines that a specific brand is medically necessary for a particular patient, provided the following requirements are met:

1. A licensed authorized practitioner may certify in writing that there shall be no substitution for a specified brand name drug product prescribed for a particular patient, by writing the phrase "Brand Medically Necessary" on the prescription form. The phrase shall be in the practitioner's handwriting and shall not be preprinted, stamped, initialed, or checked off in a box on such form.

2. If the licensed authorized practitioner specifies by telephone that there shall be no substitution, handwritten certification bearing the phrase "Brand Medically Necessary" must be mailed to the pharmacy within ten days. The written certification must be kept by the pharmacist as part of his or her permanent records.

d. Compounded Prescriptions

The Department will pay for compounded prescriptions at the lower of

1. The E.A.C. or F.A.C., whichever is applicable to the given drug, for each ingredient plus an applicable dispensing fee; or

2. The provider's usual and customary charge to the general public; or

3. The amount billed by the provider.

e. Unit Dose Packaging

The Department will not pay providers for unit dose packaging or any other specially packaged drugs when standard packages are available and/or where the special packaging is strictly for convenience and does not contribute to the therapeutic benefit of the drug.

II. Payment for Nonlegend Drugs

a. The Department of Social Services will pay for all O.T.C. drugs listed on the Connecticut O.T.C. Formulary, provided they are prescribed for a specific illness and/or condition by a licensed authorized practitioner.

1. The reimbursable amount shall be established by the Commissioner. The Department will publish the reimbursable amounts via a fee schedule.

III. Substitution of Generically Equivalent Drugs

a. The Department will pay a pharmacist a professional dispensing fee of fifty cents ($.50) per prescription in accordance with Section 17-134q of the Connecticut General Statutes in addition to any other dispensing fee, for substituting a generically equivalent drug product, in accordance with Section 20-185b of the Connecticut General Statutes, for the drug prescribed by the licensed authorized practitioner for a Medicaid recipient, except in the following instances:

1. When a drug product is dispensed for which HCFA has designated a F.A.C.; or

2. When a compounded prescription is being dispensed; or

3. When a nonlegend drug is dispensed; or

4. When the substitution is required by Federal law or regulation.

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The ConnPACE program has been terminated as of 12/31/2013 as a result of changes made in Legislation in 2013.

REGULATIONS OF CONNECTICUT STATE AGENCIES
DEPARTMENT OF SOCIAL SERVICES

Concerning
Requirements for Payment Under the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE)

Section 17b-262-684. Scope

Sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment for pharmacy services provided to enrollees determined eligible under provisions of sections 17b-490 to 17b-498, inclusive, of the Connecticut General Statutes, the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE) Program.

Section 17b-262-685. Definitions

As used in sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Administrative lock-in" means the restriction by the department of an enrollee to a provider of the enrollee's choice pursuant to section 17b-275 of the Connecticut General Statutes;

(2) "Average wholesale price" or "AWP" means the published wholesale price as listed by one or more national drug databases which obtain their pricing information either directly from the manufacturer or by surveying drug wholesalers;

(3) "Brand name" means "brand name" as defined in section 20-619 of the Connecticut General Statutes;

(4) "Commissioner" means the Commissioner of the Department of Social Services or his or her agent;

(5) "ConnPACE" means the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program as described in section 17b-491 of the Connecticut General Statutes;

(6) "Copayment" means the dollar amount which is required under section 17b-491 of the Connecticut General Statutes to be paid to providers by enrollees for each prescription;

(7) "Department" means the Department of Social Services or its agent;

(8) "Dispensing fee" means an amount of money paid to a pharmacy for rendering a professional service involving the preparation and dispensing of a prescribed drug ordered by a prescribing practitioner;

(9) "Drug efficacy study implementation" or "DESI" means the review through which the United States Food and Drug Administration has identified certain products which lack sufficient evidence of their effectiveness for the approved indication(s);

(10) "Drug utilization review program" or "DUR" means the prospective and retrospective utilization review as mandated by the Omnibus Budget Reconciliation Act (OBRA) of l990 (P.L. 101-508);

(11) "Enrollee" means a person who meets the relevant requirements specified in the department's Uniform Policy Manual, section 8075 and whose application for enrollment in the ConnPACE program has been approved by the department;

(12) "Estimated acquisition cost" or "EAC" means the department's best estimate of the price as related to the average wholesale price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler, as identified by the national drug code (NDC);

(13) "Experimental drug" means a drug currently being administered under an investigational new drug application as required by the United States Food and Drug Administration under 21 CFR 312;

(14) "Federal upper limit" or "FUL" means the listing of multiple source drugs and pricing according to criteria set forth in 42 CFR 447.332;

(15) "Generic name" means "generic name" as defined in section 20-619 of the Connecticut General Statutes;

(16) "Generically equivalent drug" means a therapeutically equivalent generic drug product which may be substituted for a brand name drug under section 20-619(b) of the Connecticut General Statutes;

(17) "Legend drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;

(18) "Manufacturer rebate program" means the program as described in section 17b-491(d) of the Connecticut General Statutes;

(19) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(20) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(21) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring;

(22) "National drug code" or "NDC" means the numeric characters identifying a drug product by labeler code, product name and package size;

(23) "Pharmaceutical manufacturer" means any entity holding legal title to or possession of a national drug code issued by the United States Food and Drug Administration;

(24) "Pharmacy" means "pharmacy" as defined in section 20-571 of the Connecticut General Statutes;

(25) "Prescribing practitioner" means "prescribing practitioner" as defined in section 20-571 of the Connecticut General Statutes;

(26) "Prescription" means "prescription" as defined in section 20-571 of the Connecticut General Statutes;

(27) "Prescription drugs" means "prescription drugs" as defined in section 17b-490 of the Connecticut General Statutes;

(28) "Provider" means a pharmacy that is enrolled with the department as a ConnPACE provider;

(29) "Unit" means the lowest identifiable amount of a drug, for example: tablet or capsule for solid dosage forms, milliliter for liquid forms, gram for ointments or creams; and

(30) "Usual and customary charge" means an enrolled provider's charge to the general public for a prescription drug, in a specific strength and quantity on the day the prescription is dispensed**.** In determining such charges all charges made to third party payers shall be excluded.

Section 17b-262-686. Provider Participation

In order to receive payment from the department under the ConnPACE program, a pharmacy shall meet the following requirements:

(a) meet and maintain all departmental enrollment requirements for a pharmacy participating in Medicaid as described in sections 17b-262-522 to 17b-262-533, inclusive, with the exception of section 17b-262-526(12) of the Regulations of Connecticut State Agencies. A ConnPACE provider does not need to be enrolled as a provider under Medicaid; and

(b) be located in the State of Connecticut.

Section 17b-262-687. Eligibility

In order to be eligible for ConnPACE a person must meet all relevant requirements specified in the department's Uniform Policy Manual, section 8075.

Section 17b-262-688. Services Covered and Limitations

(a) The department shall pay for prescription drugs dispensed under the ConnPACE program:

(1) that are medically necessary and appropriate and listed in section 17b-490(b) of the Connecticut General Statutes; and

(2) that do not exceed the recommended dosage level and duration as approved by the United States Food and Drug Administration and presented in the manufacturer's literature, and as monitored and operationalized in the department's drug utilization review program.

(b) The department shall pay for any number of authorized refills by the prescribing practitioner for a maximum period of six (6) months. The exception is controlled substances that are regulated by 21 USC 829(b) and section 21a-249(h) of the Connecticut General Statutes.

(c) A provider shall substitute a therapeutically equivalent generic drug product for a prescribed drug product unless the prescribing practitioner has written on the prescription "brand medically necessary" in accordance with sections 17b-274 and 17b-493 of the Connecticut General Statutes.

(d) The department shall pay at the estimated acquisition cost for the generic drug only when available but not yet on the federal upper limit list.

REGULATIONS OF CONNECTICUT STATE AGENCIES
DEPARTMENT OF SOCIAL SERVICES

Section 17b-262-689. Services Not Covered

The department shall not pay providers for:

(1) the replacement of lost or destroyed prescription drugs;

(2) any prescription drug of a manufacturer that does not participate in the manufacturer rebate program, unless the department determines the prescription drug is medically necessary and medically appropriate for the program enrollees;

(3) any drugs excluded pursuant to section 17b-490(b). The department shall pay for amphetamines and amphetamine-like drugs for specific diagnoses as specified in the billing instructions;

(4) over the counter preparations;

(5) DESI drugs;

(6) prescriptions dispensed but not received by the enrollee;

(7) drugs for an administrative lock-in enrollee who is not locked in to the billing pharmacy;

(8) anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary and medically appropriate by the department to meet the enrollee's condition or for services not directly related to the enrollee's diagnosis, symptoms or medical history;

(9) claims of quantities which exceed 120 oral dosage units or a 30 day supply, whichever is greater; and

(10) claims for services which are covered by other insurance.

Section 17b-262-690. Payment Rate

(a) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the estimated acquisition cost (EAC) plus the dispensing fee minus the copayment;

(2) the federal upper limit (FUL) plus the dispensing fee minus the copayment;

(3) the billed amount to the department, i.e. ingredient cost plus the dispensing fee, minus the copayment;

(4) the usual and customary charge of the provider minus the copayment.

(b) The commissioner shall determine the dispensing fee for each prescription.

(c) The provider shall collect the full copayment as described in section 17b-491 of the Connecticut General Statutes.

(d) The department shall pay at the federal upper limit price for brand name drugs that appear on the federal upper limit list when the prescribing practitioner has indicated "brand medically necessary" in accordance with section 17b-493 of the Connecticut General Statutes.

(e) If an enrollee requests the brand name product and the prescribing practitioner has not specified "brand medically necessary" in accordance with section 17b-493 of the Connecticut General Statutes, then the enrollee is responsible for paying for the full amount of the prescription and the claim may not be billed to ConnPACE.

(f) Providers are prohibited from seeking reimbursement for covered drugs from enrollees with the exception of the co-payment.

Section 17b-262-691. Documentation

(a) The pharmacy shall maintain the original prescription which shall conform to the documentation requirements described in section 20-614(c) of the Connecticut General Statutes.

(b) The pharmacy shall maintain patient profiles as required in section 17b-494(5) of the Connecticut General Statutes.

(c) In addition, prescriptions transmitted by facsimile machine shall meet all requirements of sections 20-164-1 to 20-164-5, inclusive, of the Regulations of Connecticut State Agencies.

(d) For any prescription for a brand name drug for which a generically equivalent drug exists, there shall be a prescription on file on which, in the prescribing practitioner's handwriting, the phrase "brand medically necessary" is written and signed by the prescribing practitioner in accordance with section 17b-493 of the Connecticut General Statutes.

(e) Prescriptions for controlled substances shall also meet the requirements of sections 21a-244-1 to 21a-244-6, inclusive, of the Regulations of Connecticut State Agencies.

(f) The provider shall maintain all required documentation for at least five years, or longer in accordance with statute or regulation, in the provider's file subject to review by the department. In the event of a dispute concerning a service or item provided, documentation shall be maintained until the end of the dispute, five years, or the length of time required by statute or regulation, whichever is longest.

(g) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider.

Section 17b-262-692. Manufacturer Rebate Program

Pharmaceutical manufacturers must apply to participate in a rebate program with the department in order to have their prescription drugs covered by the ConnPACE program. All prescription drugs allowed by the program of a pharmaceutical manufacturer that participates in the manufacturer rebate program shall be immediately available. The cost of such drugs shall be reimbursed in accordance with sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies

Other Administrative Provisions

Section 17a-345-111. Forms, handbooks, and other materials

The Department may supplement or clarify this chapter by developing and issuing forms, handbooks, or other materials necessary to the effective administration of the program.
(Effective April 22, 1992)