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

If medical necessity is established, limitations in this section do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

a. Prescribed Drugs

(1) Coverage is provided for drugs included in the Medicaid drug lists that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs added to the Preferred Drug List (PDL) are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Commissioner of the Kentucky Department for Medicaid Services for approval. Drugs requiring prior authorization must follow the process listed below. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. Effective January 1, 2021, the Managed Care Organizations contracted with the Kentucky Department for Medicaid Services (DMS) will follow the preferred drug list established by DMS.

(2) Kentucky will provide reimbursement for covered outpatient drugs when prescribed by an enrolled licensed provider within the scope of their license and practice as allowed by State law and in accordance with Section 1927 of the Social Security Act. This will apply to drugs of any manufacturer that has entered into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72- hour supply of drugs in emergency circumstances. The preferred drug list meets the formulary requirements that are specified in Section 1 927(d)(4) of the Social Security Act.

(3) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Medicaid drug lists or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:

(a) A drug for which the FDA has issued a “less than effective (LTE)” rating or a drug “identical, related, or similar (IRS)” to an LTE drug;
(b) A drug that has reached the termination date established by the drug manufacturer;
(c) A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug. Note: Because federal financial participation is not generally available for a non-rebated drug, state funds will be used to cover such drugs if necessary to protect the health of a Medicaid recipient and no other appropriate options exist;

(d) A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program;

(e) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:

1. A drug if used for anorexia, weight loss, or weight gain;
2. A drug if used to promote fertility;
3. A drug if used for cosmetic purposes or hair growth;
4. A drug if used for the symptomatic relief of cough and colds;
5. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;
6. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;
7. A drug 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; or
8. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;

(f) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service. However, a legend drug may be provided through prior authorization to a recipient admitted to an inpatient facility that does not bill patients, Medicaid, or other third-party payers for health care services.

(g) A drug for which the department requires prior authorization if prior authorization has not been approved; and

(4) Except for emergencies, a recipient "locked-in" to one pharmacy due to over-utilization may receive prescriptions:

(a) Only from his/her designated lock-in pharmacy and prescribed by his/her lock-in provider; or

(b) For specified controlled substances prescribed by his/her designated controlled substance lock-in prescriber.

(5) If authorized by the prescriber, a prescription for a controlled substance in Schedule III-V may be refilled up to five times within a six month period from the date the prescription was written or ordered; a non-controlled substance may be refilled up to 11 times within a 12 month period from the date the prescription was written or ordered. In addition, a prescription fill for a maintenance drug may be dispensed in a 92-day supply if a recipient has demonstrated stability on the maintenance drug. However, a 92-day supply of a maintenance drug shall not be dispensed if a prescribing provider specifies that the quantity should be less. Also, individuals receiving supports for community living services, long term care, and personal care shall not be subject to the 92-day supply requirement.

(6) A refill of a prescription shall not be covered unless at least 90 percent of the prescription time period has elapsed. However, a refill may be covered before 90 percent of the prescription time period has elapsed if the prescribing provider or dispensing pharmacy submits a prior authorization request by phone, fax, or web submission. Medicaid recipients residing in a long-term care facility or personal care home will be exempt from the 90 percent requirement and remain at the current 80 percent.

(7) Supplemental Rebate Program:

The state is in compliance with Section 1927 of the Social Security Act. The state has the following policies for the Supplemental Rebate Program for the Medicaid population:

(a) CMS has authorized the Commonwealth of Kentucky to enter into supplemental agreements with drug manufacturers for drugs provided to fee-for-service and managed care Medicaid beneficiaries, which are covered by a unified preferred drug list (PDL). The Supplemental Rebate Agreement (SRA), titled "Commonwealth of Kentucky Supplemental Rebate Agreement", has been submitted to the Centers for Medicare & Medicaid Services (CMS) on April 25, 2023 and has been authorized to cover supplemental rebates. The Commonwealth of Kentucky will begin using the SRA on January 1, 2024. The pharmaceutical manufacturer agreements and renewals for supplemental rebates may be negotiated by the Sovereign States Drug Consortium (SSDC) multi-state purchasing pool or individually by the Commonwealth of Kentucky.

(b) CMS has authorized Kentucky to enter into value-based contracts with manufacturers on a voluntary basis. These contracts will be executed on the model agreement entitled "Value-Based Supplemental Rebate Agreement" authorized for use beginning July 1st, 2025.

(c) CMS has authorized Kentucky's collection of supplemental rebates through the SSDC or through state-negotiated contracts.

(d) 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 drug rebate agreement.

(e) All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provision of the national drug rebate agreement.

(f) Any contracts not authorized by CMS will be submitted for CMS approval in the future.

(g) As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.

(6) A refill of a prescription shall not be covered unless at least 90 percent of the prescription time period has elapsed. However, a refill may be covered before 90 percent of the prescription time period has elapsed if the prescribing provider or dispensing pharmacy submits a prior authorization request by phone, fax, or web submission. Medicaid recipients residing in a long-term care facility or personal care home will be exempt from the 90 percent requirement and remain at the current 80 percent.

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Commonwealth Global Choices

B. Dentures

Dentures are covered for adults. Dentures may be covered for children through the Early, Periodic. Screening. Diagnosis and Treatment Program (EPSDT)..

C. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-A, page 13.

D. Eyeglasses and contact lenses are covered for adults and children. Recipients may choose either glasses or contacts lens per year, not both

(1) Eyeglasses are provided 1 per year per member.
   a. An additional 1 pair of glasses is covered for lost, stolen, or broken glasses with prior authorization.
   b. Bifocal, multifocal, and progressive lens is covered.
   c. Scratch resistant, UV and anti-reflective coating is covered.
(2) Contact lenses are provided to children and adults. 2 contact lens (1 per eye) per year.
(3) Telephone contacts are not covered.
(4) If medically necessary, prisms shall be added within the cost of the lenses.

If medical necessity is established, additional services apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

Dentures, eyeglass and contact lenses expanded to adult population January 1, 2023
Limits may be exceeded based upon emergencies and medical necessity with prior authorization and DMS review

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