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## **Phase Two Implementation: Off Label Antipsychotic Monitoring in Children through Age 17**

**Phase Two Implementation: Children 13 through 17 Years of Age – Start Date August 24, 2011.** Effective April 12, 2011, DMA implemented a policy titled *Off Label Antipsychotic Monitoring in Children through Age 17*. Phase one was the 0 – 12 age group. Implementation of the second phase for ages 13 – 17 was August 24, 2011. The policy requests the prescriber of any antipsychotic medication to a Medicaid recipient in these age groups to document monitoring parameters done that support safe use of the antipsychotic agent. Antipsychotic choices are not limited by the policy.

The policy creates an opportunity to gather information about antipsychotic prescribing trends within the child and adolescent Medicaid population of North Carolina. In accordance with the policy, DMA, in partnership with Community Care of North Carolina (CCNC) is maintaining a registry for providers to document the use of antipsychotic therapy. The registry called **A+KIDS** (Antipsychotics-Keeping It Documented for Safety) is supported by an advisory panel consisting of child psychiatrists from North Carolina's four medical universities. The registry encourages the use of appropriate baseline and follow up monitoring parameters to facilitate the safe and effective use of antipsychotics in this population.

Objectives of the **A+KIDS** registry include improvement in the use of evidence-based safety monitoring for antipsychotics; reduction of antipsychotic polypharmacy; and reduction of cases with the prescribed dose differing from the FDA approved dosage for an indication. Data elements collected within the registry reflect a generally accepted monitoring profile for the safety and efficacy follow-up of the prescribed antipsychotic pharmacotherapy. The requirement of safety monitoring documentation in the registry by the prescriber occurs when:

- The antipsychotic is prescribed for an indication that is not approved by the FDA.
- The antipsychotic is prescribed at a different dosage than approved for a specific indication by the FDA.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents.

### **About the A+KIDS Registry:**

Prescribers are directed to the **A+KIDS** website <http://www.documentforsafety.org> to register as an **A+KIDS** provider to enable access to the online registry or to learn more about this initiative. Pharmacy providers are encouraged to visit the website to understand how the policy may impact pharmacy claims processing for antipsychotic medications.

The registry process captures demographics and brief clinical information. The information can be submitted electronically through the **A+KIDS** website <http://www.documentforsafety.org> or by completing a form to submit by fax to ACS at 866-246-8507. The form is available on the DMA Outpatient Pharmacy web page <http://www.ncdhs.gov/dma/pharmacy/> and the **A+KIDS** website <http://www.documentforsafety.org>. Using the fax method to provide information will result always in a 3-month approval period. Faxed forms missing essential information cannot be processed and will be returned to the prescriber. When information is provided electronically through the registry, approval periods from 6 to 12 months are possible depending on case-specific clinical variables. Providers can complete registry information in advance for patients.

### **Pharmacy Override Protocol – Unlimited use extended**

Point of sale (POS) overrides are available for occurrences where the prescriber has not provided registry documentation either electronically or by fax for the recipient. Each override will apply to all claims for antipsychotic medication(s) on the same date of service. The message "Safety documentation requested. Prescriber go to [www.documentforsaftey.org](http://www.documentforsaftey.org) or call ACS 866-246-8505" will return to the pharmacy for antipsychotic claims for a recipient without registry documentation. The claim will not process successfully. A POS override should be utilized for rejected claims if timely A+KIDS registration by the prescriber does not occur. **A "1" in the PA field (461-EU) or a "2" in the submission clarification field (420-DK) will override the PA edit.** Patients should not be denied their antipsychotic medication(s) in response to the safety documentation requested message. The prescriber of the antipsychotic medication should be alerted when an override is used, and the language returned in the original POS message regarding the safety documentation request should be shared with him/her.

Use of an override to successfully process a claim for an antipsychotic medication remains unrestricted. **Override limits did not go into effect on July 13, 2011 as previously communicated. The unlimited override period remains in effect.** Pharmacists are encouraged to ensure all pharmacy staff are informed about the override option. It is important to follow all antipsychotic claims until a paid status results. Denial codes or DUR alerts subsequent to use of an override should be responded to in a timely manner according to professional judgment. Such diligence will support the purpose of unrestricted overrides which is to ensure recipients don't go without needed antipsychotic medication.

Many resources are available to assist providers with understanding the policy and registry. Technical support is available to assist providers with registration and questions and can be accessed by calling the toll free number, 855-272-6576, found on the website. Community Care of North Carolina network psychiatrists and pharmacists are available to educate about the registry. Additionally, help may be obtained by calling the ACS helpline at 866.246.8505. DMA assistance with understanding the policy and registry is available by contacting the outpatient pharmacy program at 919.855.4300.

### **Procedures for PA Request for Synagis for RSV Season 2011/2012**

The clinical criteria utilized by N.C. Medicaid for the 2011/2012 RSV season are consistent with published guidelines in the *Red Book: 2009 Report of the Committee on Infectious Diseases, 28<sup>th</sup> Edition*. **Prior approval (PA) is required** for Medicaid coverage of Synagis during the upcoming RSV season. The coverage season is November 1, 2011, through March 31, 2012. An Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical necessity review will be performed for all Synagis requests.

Requesting PA for Synagis for the upcoming season will be an electronic process. The electronic PA system is designed to capture data succinctly. Prompts, alerts, dropdown choices, attachment capability as well as free text opportunities will allow the provider to submit a request with all information essential to justify medical necessity. When the system offers an opportunity to upload supporting documents, a note documenting the patient's pulmonary or cardiac status should always be submitted as an attachment when available. The electronic system can automatically approve based on criteria submitted and allows the provider to monitor the status of a pending request. The auto approval feature will improve the overall timeliness of reviews especially at the beginning of the season when the volume of requests is the highest.

The electronic PA method will approve up to five monthly doses of Synagis, but each dose will be individually authorized on a monthly basis. After the initial approval, providers will submit very limited information such as the most recent weight of the child and date the prior dose was administered for authorization of subsequent doses. The number of doses requested for authorization by the provider should be adjusted if an infant received the first dose prior to a hospital discharge.

It is important for a pharmacy to have a Synagis authorization notification on hand prior to billing a claim to Medicaid. These notifications must be submitted to the pharmacy by the provider and will include the number of vials approved for the patient. A claim transmitted at POS will be denied if a prior approval request was not submitted by the provider or if the request was not approved. It is the responsibility of the provider to ensure that the pharmacy has a prescription for Synagis.

### **Maximum of Five Doses**

Up to five doses during the season can be authorized for chronic lung disease (CLD) and hemodynamically significant congenital heart disease (HSCHD) for infants and children less than 24 months of age.

#### **CLD**

The diagnosis causing the long-term respiratory problems must be specific. Treatment, such as supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy, in the six months before the start of the season is required.

#### **HSCHD**

Infants not at increased risk from RSV who generally should **not** receive immunoprophylaxis include those with hemodynamically insignificant heart disease, such as secundum atrial septal defect, small ventricular septal defect (VSD), pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus (PDA), lesions adequately corrected by surgery unless the infant continues on medication for CHF, or mild cardiomyopathy not requiring medication.

In addition to the two conditions listed above, a premature infant (prematurity must be counted to the exact day) may qualify for five doses as follows:

- Born at an EGA of  $\leq 28$  weeks 6 days and DOB is on or after November 2, 2010;
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 2, 2011; or
- Born at an EGA of  $\leq 34$  weeks 6 days and DOB is on or after November 2, 2010, and also has severe neuromuscular disease that compromises handling of respiratory secretions; **or** congenital abnormalities of the airways that compromises handling of respiratory secretions.

The diagnosis to justify severe neuromuscular disease or congenital airway abnormalities must be specific.

### **Five Dose Authorization Exceptions**

Coverage of Synagis for CLD and HSCHD will terminate when the recipient exceeds 24 months of age AND has received a minimum of three doses during the season. Coverage of Synagis for

congenital abnormalities of the airways and severe neuromuscular disease that compromises handling of respiratory secretions will terminate when the recipient exceeds 12 months of age AND has received a minimum of three doses during the season. For these occurrences, coverage will continue always to ensure a medication supply for three doses.

**Maximum of Three Doses; Last Dose Administered at Three Months of Age (90 Days of Life)**

Infants meeting clinical criteria as follows may be approved for up to three doses of Synagis during the season:

- Born at an EGA of 32 weeks 0 days to 34 weeks 6 days, and DOB is on or after August 2, 2011, and has at least one of the two following defined risk factors:
  - ◆ Attends child care [defined as a home or facility where care is provided for any number of infants or young toddlers (toddler age is up to the third birthday)]. The name of the day care facility must be submitted with the request.
  - ◆ Has a sibling younger than five years of age in the home. A twin sibling does not meet this requirement.

Generally, the following diagnoses do not singularly justify medical necessity for Synagis prophylaxis:

- a positive RSV episode during the current season
- repeated pneumonia
- sickle cell
- multiple birth with approved sibling
- apnea or respiratory failure of newborn

**Submitting a Request to Exceed Policy**

For doses exceeding policy or for Synagis administration outside the defined coverage period, the provider should use the **Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age** to request Synagis. The form is available on DMA's website at <http://www.ncdhhs.gov/dma/epsdt/>. A medical necessity review will be done under EPSDT (see <http://www.ncdhhs.gov/dma/epsdt/index.htm>); if the information provided justifies medical need, the request will be approved.

**Pharmacy Distributor Information**

Medicaid will allow Synagis claims processing to begin on October 26, 2011, to allow sufficient time for pharmacies to provide Synagis by November 1, 2011. Payment of Synagis claims prior to October 26, 2011, and after March 31, 2012, will not be allowed. POS claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by DMA Program Integrity. Physicians and pharmacy providers are subject to audits of patient records by DMA Program Integrity.

Providers will fax the approval notification to the pharmacy distributor of choice. Single dose vial specific authorizations will be done by DMA up to the maximum number of doses approved for the patient. Please ensure that an authorization notification is received before billing Synagis a

claim to Medicaid. The authorizations should be maintained in accordance with required record keeping time frames.

### **Provider Information**

Please refer to the follow up article coming in the October 2011 Medicaid Bulletin for specific details about the electronic PA process. The PA website, fax numbers and help numbers will be provided in the article. Provider registration for the electronic PA process will start in mid to late September. Providers without internet access should contact Charlene Sampson at (919)855-4300 to facilitate submission of a PA request for Synagis.

### **NCPDP Version D.0 Implementation Schedule**

In accordance with 45 CFR Part 162 – Health Insurance Reform; Modifications to the [Health Insurance Portability and Accountability Act \(HIPAA\)](#); Final Rule, HIPAA-covered entities, which include state Medicaid agencies, must adopt modifications to the HIPAA required standard transactions by January 1, 2012. The modifications are to the HIPAA named transactions to adopt and implement ASC X12 version 5010 and NCPDP Telecommunication version D.0.

North Carolina Medicaid has published a companion guide for NCPDP D.0. to assist providers and trading partners in their effort to become HIPAA compliant. This companion guide is specific to N.C. Medicaid and is intended to be used in conjunction with NCPDP Standards for Retail Pharmacy Services for complete implementation information. Consult the NCPDP website at <http://www.ncpdp.org> for the NCPDP Transaction Standards for Retail Pharmacy Services. N.C. Medicaid companion guides are now available at <http://www.ncdhhs.gov/dma/hipaa/compguides.htm>

Medicaid will implement NCPDP Version D.0 on November 22, 2011 and will continue to support NCPDP 5.1 until December 31, 2011.

### **Basic Medicaid Seminars**

Basic Medicaid seminars are scheduled for the month of October 2011. Seminars are intended to educate providers on the basics of Medicaid billing as well as to provide an overview of Medicaid updates and resources. The seminar sites and dates will be announced in the September 2011 Medicaid Bulletin. The October 2011 Basic Medicaid Billing Guide will be used as the training document for the seminars and will be available prior to the seminars on DMA's Basic Medicaid Billing Guide web page at <http://www.ncdhhs.gov/dma/basicmed/index.htm>.

Pre-registration will be required. Due to limited seating, registration will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

### **Recipient Notices**

During the month of July, the Division of Medical Assistance (DMA) mailed notices to all eligible Medicaid recipients to inform them of the important changes in the Medicaid and Health Choice programs. Some of the changes were due to recent legislation passed through the

North Carolina General Assembly. The changes for Medicaid and Health Choice for Children Recipients were:

**CARE-LINE Service Change**

Effective July 1, 2011, CARE-LINE services will be discontinued. For questions or concerns after July 1, 2011, you can use the current CARE-LINE number (1-800-662-7030; TTY: 1-877-452-2514) to reach the DHHS Customer Service Center. The DHHS Customer Service Center is available Monday – Friday 8 am to 5 pm.

**Changes for North Carolina Health Choice for Children Recipients were:**

New NC Health Choice (NCHC) ID cards will be mailed beginning September 15, 2011. The new cards are effective October 1, 2011. These new cards are gray in color with the NCHC logo at the top.

**Requirements of Medicaid and Health Choice Providers**

In accordance with Senate Bill 496 which was signed into law on July 25, 2011, the Division of Medical Assistance (DMA) will make changes to the requirements for Medicaid and Health Choice providers. DMA is required by law to:

- Assess providers and assign them to a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described, the highest level of screening is applicable.
- Conduct criminal history record checks for certain providers.
- Suspend payments to providers and audits utilizing extrapolation.
- Establish a registry of billing agents, clearinghouses, and/or alternate payees that submit claims on behalf of providers.
- Require a provider to undergo prepayment claims review.
- Not pursue recovery of Medicaid or Health Choice overpayments owed to the State for any total amount less than one hundred fifty dollars (\$150.00).
- Require all applicants who submit an initial application for enrollment in North Carolina Medicaid or North Carolina Health Choice to submit an attestation and complete trainings prior to being enrolled.

For a complete listing of the bill, see

<http://www.ncga.state.nc.us/Sessions/2011/Bills/Senate/PDF/S496v5.pdf>

**Health Choice Transition**

Effective with date of service on and after October 1, 2011, NC Health Choice (NCHC) claims will be processed by DMA's fiscal agent, HP Enterprise Services. For questions regarding claims processing, providers may contact the HP Provider Services Department at 1-800-688-6696, menu option 3. For dates of service prior to the transition date of October 1, 2011, providers will continue to submit pharmacy claims to Medco.

Active N.C. Medicaid providers that want to participate in NCHC will not need to take any action for NCHC enrollment. Any provider that is not currently enrolled in the N.C. Medicaid program that wants to provide care to NCHC members will need to complete the enrollment application on [www.nctracks.nc.gov](http://www.nctracks.nc.gov). CSC, DMA's contractor for enrollment, verification and credentialing (EVC), is available to assist providers who want to participate in NCHC. CSC contact information is provided below.

Additional information will be provided to providers in the general N.C. Medicaid bulletin and on the NCHC webpage found on DMA's website.

<b>Enrollment, Verification, and Credentialing Call Center Toll-Free Number</b>	866-844-1113
<b>EVC Call Center Fax Number</b>	866-844-1382
<b>EVC Call Center E-Mail Address</b>	<a href="mailto:NCMedicaid@csc.com">NCMedicaid@csc.com</a>
<b>CSC Mailing Address</b>	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
<b>CSC Site Address</b>	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073
<b>CSC Website Address</b>	<a href="http://www.nctracks.nc.gov">http://www.nctracks.nc.gov</a>

### NC Health Choice - Legislative Update

Session Law 2011-145 became law on June 16th. It mandates that "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Medicaid Program except for the following:

- 1) No services for long-term care;
- 2) No non-emergency medical transportation;
- 3) No EPSDT; and
- 4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

The new law also repealed N.C. GEN. STAT. § 108A-70.23, which addressed services for children with special health care needs under the Health Choice Program. Prior to the passage of the new law, Health Choice children with special health care needs were screened for service eligibility and then received the same level of services available under the Medicaid State Plan. Health Choice recipients will no longer be screened for special needs, because the Health Choice Program will already be benchmarked to the Medicaid State Plan. The North Carolina Commission on Children with Special Health Care Needs will continue to monitor and evaluate the availability and provision of health services for special needs children in the State overall and under the North Carolina Health Choice Program.

To help ensure that each Health Choice Program recipient has a medical home, Session Law 2011-145 requires the provision of services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC). Effective October 1, 2011, NC Health Choice (NCHC) enrollees will be mandated to select a CCNC primary care provider (PCP) practice to serve as their medical home for sick and well-child visits. CCNC PCP practices are required to provide direct care and care coordination including authorizing and documenting medically necessary referrals to specialty care for its NCHC panel members. In addition to fee-for-service reimbursement, CCNC PCP practices will be paid a per member, per month fee for coordinating the care of their NCHC panel members. New NCHC ID cards will have the CCNC PCP practice's name, address and telephone number printed on the front of the card. For primary care providers who are interested in enrolling in CCNC, please visit the following web address: <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm>.

In addition to the benefit changes in Health Choice, Session Law 2011-145 amended the procedures for changing medical policy and expanded DMA's rule making authority for the program. The law became effective as of July 1, 2011, but DMA has from October 1, 2011 to March 12, 2012 to fully implement the transition to a Medicaid look-alike program.

In addition to the four benefits exceptions outlined in the new law, several prior approval exceptions and service limitations will distinguish NC Health Choice clinical coverage policies from Medicaid clinical coverage policies. For example:

- Under EPSDT, children enrolled in Medicaid may get replacement eyeglass frames every 12 months. In Health Choice, eyeglass frame replacement will be covered every 24 months.
- Health Choice will also retain some unique prior approval requirements that have been recommended by the Physician Advisory Group.

Such exceptions and service limitations stem from the fact that Health Choice is not an entitlement program, and the State has enrollment and service limitations within the Health Choice budget. The NC Health Choice Program is undergoing a transition both administratively and programmatically, the following projects are underway:

1. Revision of the NC Health Choice recipient Handbook and ID cards;
2. Development of an NC Health Choice Billing Guide chapter to be incorporated into the Medicaid Billing Guide;
3. Promulgation of new or amendment of existing NC Health Choice Clinical Coverage Policies;
4. Development of Rules for the NC Administrative Code in collaboration with the NC Attorney General's Office;
5. Signing of new contractor agreements with medical and pharmacy claims processing fiscal agents; and
6. Submission of a revised State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS).

NCHC families are receiving notices informing them of these upcoming changes. You can read more detail about some of these projects below.

### **NEW HEALTH CHOICE HANDBOOK COMING SOON**

The NCHC Handbook is currently undergoing revisions to reflect the program benefit changes required by Session Law 2011-145. The revised version will soon be published as a combined Handbook with information for both the NC Health Choice Program *and* the Medicaid Program for Families and Children (Health Check). The Division of Medical Assistance has targeted mailings of the new handbooks to all current and new NCHC and Medicaid Health Check

recipients in September 2011. An electronic copy of the revised Handbook will also be posted on the Division of Medical Assistance Web site. Both the paper and electronic versions will be available in English and Spanish.

### **NEW HEALTH CHOICE ID CARDS COMING SOON**

Beginning October 1, 2011, there will be a new NCHC Identification card. The card will be gray with the NCHC logo, but it will resemble the Medicaid ID card. The card will list the NCHC recipient and his or her identification number and the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) medical home/Primary Care Provider (PCP) information. As a function of CCNC/CA, all NCHC recipients **must** be referred by their PCP for all services not performed at their medical home. Contact the PCP located on the card if there is any doubt of the referral. The Division of Medical Assistance will mail the new ID card to all current NCHC recipients during the month of September for use with services from October 1, 2011, and after. NCHC recipients approved after October 1, 2011 will also receive the new card. If someone is approved after October 1 for a time period prior to October 1, he or she will receive the old Blue Cross/Blue Shield NCHC card which should be used for billing for all services received prior to October 1, 2011.

**The NCHC card is not proof of eligibility.** The provider must verify eligibility by using one of the following:

- Recipient Eligibility Verification Web Tool
- Real Time Eligibility Verification (270/271 Transaction)
- Batch Eligibility Verification (270/271 Transaction)
- Automated Voice Response (AVR) System – 1-800-723-4337, Option 6

You can find additional information about the verification process in Appendix F of the Medicaid Billing Guide.

### **NEW HEALTH CHOICE BILLING GUIDE COMING SOON**

The NCHC Billing Guide is currently undergoing revisions to reflect the program benefit changes required by Session Law 2011-145. The fall 2011 Medicaid Billing Guide update will include a new chapter insert specific to the Health Choice Program.

### **CLINICAL COVERAGE POLICY UPDATE**

For a complete list of N.C. Health Choice clinical coverage policies, please refer to the N.C. Health Choice Policies web page at <http://www.ncdhhs.gov/dma/hcmp/>.

### **Update on NC Tracks**

The Centers for Medicare and Medicaid Services (CMS) and the NC Department of Health and Human Services (DHHS) have approved an extension of the schedule to design, develop and implement NCTracks, the Replacement MMIS that will be operated by CSC. The amended schedule moves the NCTracks operational start date to 2013 and includes a four-month period for providers to participate in Provider Operational Preparedness (POP) activities beginning on the Operational Readiness Date, March 1, 2013. More information and a schedule of activities to be included in the POP period will be provided at a later date.

The NCTracks Operational Start Date for claim adjudication is July 1, 2013. DHHS has the option to initiate operations earlier than July 1, 2013, based on feedback from the POP activities and with 30 days notice to CSC.

### **Termination of Inactive Medicaid Provider Notices**

An announcement was made in the July general bulletin regarding the termination of inactive Medicaid providers. The article stated, effective July 1, 2011, once a provider is terminated due to billing inactivity within the previous 12 months, a new application and agreement to re-enroll must be submitted. A letter dated July 1, 2011, was mailed to providers notifying them of the August 1, 2011 termination date. Providers should disregard this letter because providers will not be terminated on August 1st and do not need to re-enroll in the Medicaid Program.

### **Changes in Drug Rebate Manufacturers**

The following changes have been made in manufacturers with Drug Rebate Agreements. It is listed by manufacturer's code, which are the first five digits of the NDC.

#### **Addition**

The following labelers have entered into a Drug Rebate Agreement and have joined the rebate program effective on the date indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
43066	Baxter Healthcare Corporation	08/12/2011
52343	Gensource RX	08/18/2011
52427	Almatica, Inc	08/09/2011

#### **Terminated Labelers**

The following labelers will be terminated from the Medicaid Drug Rebate Program effective January 1, 2012:

Tiber Laboratories	(Labeler 23589)
River's Edge Pharmaceuticals	(Labeler 68032)

#### **Voluntarily Terminated Labelers**

The following labeler will be terminated from the Medicaid Drug Rebate Program effective October 1, 2011:

QOL Medical, LLC	(Labeler 67871)
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The following labeler will be terminated from the Medicaid Drug Rebate Program effective January 1, 2012:

Pamlab LCC	(Labeler 00525)
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**Checkwrite Schedule**

August 02, 2011	September 13, 2011	October 12, 2011
August 09, 2011	September 22, 2011	October 18, 2011
August 16, 2011	October 04, 2011	October 27, 2011
August 25, 2011	October 12, 2011	November 01, 2011

**Electronic Cut-Off Schedule**

July 28, 2011	September 01, 2011	October 06, 2011
August 04, 2011	September 08, 2011	October 13, 2011
August 11, 2011	September 15, 2011	October 20, 2011
August 18, 2011	September 29, 2011	October 27, 2011

*Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS Claims must be transmitted and completed by 12:00 midnight on the day of the electronic cut-off date to be included in the next checkwrite.*

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