Optum Rx®

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

MEDICAID-PEACHCARE NOTIFICATION 04/01/2024
OUTPATIENT FEE-FOR-SERVICE PHARMACY PROGRAM
IMPORTANT INFORMATION

SYSTEM DOWNTIME

The OptumRx claims processing system will be unavailable due to planned maintenance on Thursday, April 04, 2024, between 2:30 a.m. – 5:30 a.m. Eastern Standard Time. Claims requiring submission during this period should be held until the maintenance is completed.

GMAC CHANGES

Please be aware of the following changes to the Georgia Maximum Allowable Cost (GMAC) list. A summary of these changes is listed in the tables below, but for a complete list of GMAC prices please refer online under www.mmis.georgia.gov → Pharmacy → Pricing List → GMAC List.

Georgia Maximum Allowable Cost (GMAC) Effective April 01, 2024			
Product Name	**Price**	**Product Name**	**Price**
ABACAVIR SULFATE TAB 300 MG	0.60132	AMLODIPINE BESYLATE-BENAZEPRIL HCL CAP 10-40 MG	0.11500
ACETYLCYSTEINE INHAL SOLN 10%	0.43566	AMLODIPINE BESYLATE-BENAZEPRIL HCL CAP 5-20 MG	0.10980
ACETYLCYSTEINE INHAL SOLN 20%	1.14360	AMOXICILLIN & K CLAVULANATE FOR SUSP 200-28.5 MG/5ML	0.05840
ACYCLOVIR CAP 200 MG	0.08983	AMOXICILLIN & K CLAVULANATE FOR SUSP 250-62.5 MG/5ML	0.41922
ACYCLOVIR SUSP 200 MG/5ML	0.09484	AMOXICILLIN & K CLAVULANATE FOR SUSP 400-57 MG/5ML	0.05984
ACYCLOVIR TAB 400 MG	0.08351	AMOXICILLIN & K CLAVULANATE FOR SUSP 600-42.9 MG/5ML	0.05915
ACYCLOVIR TAB 800 MG	0.17001	AMOXICILLIN & K CLAVULANATE TAB 250-125 MG	1.75000
ALBENDAZOLE TAB 200 MG	9.85360	AMOXICILLIN & K CLAVULANATE TAB 500-125 MG	0.26160
ALBUTEROL SULFATE SOLN NEBU 0.083% (2.5 MG/3ML)	0.05067	AMOXICILLIN & K CLAVULANATE TAB 875-125 MG	0.27000
ALBUTEROL SULFATE SOLN NEBU 0.5% (5 MG/ML)	Suspend	AMOXICILLIN (TRIHYDRATE) CAP 250 MG	0.05400
ALBUTEROL SULFATE SOLN NEBU 0.63 MG/3ML	0.18332	AMOXICILLIN (TRIHYDRATE) CAP 500 MG	0.07535
ALBUTEROL SULFATE SOLN NEBU 1.25 MG/3ML	0.19571	AMOXICILLIN (TRIHYDRATE) FOR SUSP 125 MG/5ML	0.01773
ALBUTEROL SULFATE SYRUP 2 MG/5ML	0.03957	AMOXICILLIN (TRIHYDRATE) FOR SUSP 200 MG/5ML	0.02510
ALBUTEROL SULFATE TAB 2 MG	0.56470	AMOXICILLIN (TRIHYDRATE) FOR SUSP 250 MG/5ML	0.02347
ALBUTEROL SULFATE TAB 4 MG	0.42770	AMOXICILLIN (TRIHYDRATE) FOR SUSP 400 MG/5ML	0.02730
AMBRISENTAN TAB 10 MG	9.56910	AMOXICILLIN (TRIHYDRATE) TAB 500 MG	0.12745
AMBRISENTAN TAB 5 MG	8.45980	AMOXICILLIN (TRIHYDRATE) TAB 875 MG	0.11400
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-10 MG	0.83167	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG	0.54923
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-20 MG	1.95162	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG	0.56010
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-40 MG	1.31561	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 25 MG	0.57234
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-80 MG	3.20460	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	0.54013
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 2.5-10 MG	Suspend	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 5 MG	0.53156
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 2.5-20 MG	Suspend	AMPHETAMINE-DEXTROAMPHETAMINE TAB 10 MG	0.20000
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 2.5-40 MG	Suspend	AMPHETAMINE-DEXTROAMPHETAMINE TAB 12.5 MG	0.38520
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-10 MG	0.81967	AMPHETAMINE-DEXTROAMPHETAMINE TAB 30 MG	0.28290
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-20 MG	1.82123	AMPHETAMINE-DEXTROAMPHETAMINE TAB 5 MG	0.24165
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-40 MG	1.68364	AMPICILLIN & SULBACTAM SODIUM FOR INJ 1.5 (1-0.5) GM	1.30000
AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-80 MG	3.49870	AMPICILLIN & SULBACTAM SODIUM FOR INJ 3 (2-1) GM	2.75130

Georgia Maximum Allowable Cost (GMAC) Effective April 01, 2024			
Product Name	**Price**	**Product Name**	**Price**
AMPICILLIN SODIUM FOR IV SOLN 10 GM	32.85000	DICLOFENAC SODIUM OPHTH SOLN 0.1%	2.01000
APRACLONIDINE HCL OPHTH SOLN 0.5%	Suspend	DIPHENHYDRAMINE HCL CAP 25 MG	Suspend
ASPIRIN CHEW TAB 81 MG	Suspend	DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML	0.00815
ATOVAQUONE-PROGUANIL HCL TAB 250-100 MG	2.15040	DIPHENHYDRAMINE HCL TAB 25 MG	0.01949
BACITRACIN-POLYMYXIN B OPHTH OINT	2.54130	DISOPYRAMIDE PHOSPHATE CAP 150 MG	0.89430
BENAZEPRIL & HYDROCHLOROTHIAZIDE TAB 10-12.5 MG	0.23210	DORZOLAMIDE HCL OPHTH SOLN 2%	1.31600
BENAZEPRIL & HYDROCHLOROTHIAZIDE TAB 20-12.5 MG	0.36021	DORZOLAMIDE HCL-TIMOLOL MALEATE OPHTH SOLN 2-0.5%	1.01650
BENAZEPRIL & HYDROCHLOROTHIAZIDE TAB 20-25 MG	0.32870	DOXAZOSIN MESYLATE TAB 1 MG	0.05930
BENZONATATE CAP 100 MG	0.07013	DOXAZOSIN MESYLATE TAB 2 MG	0.06313
BENZONATATE CAP 200 MG	0.10959	DOXAZOSIN MESYLATE TAB 4 MG	0.08503
BENZPHETAMINE HCL TAB 50 MG	Suspend	DOXAZOSIN MESYLATE TAB 8 MG	0.09481
BETAXOLOL HCL OPHTH SOLN 0.5%	Suspend	ENALAPRIL MALEATE TAB 2.5 MG	0.07713
BRIMONIDINE TARTRATE OPHTH SOLN 0.2%	0.65214	ENALAPRIL MALEATE TAB 5 MG	0.07514
CAFFEINE CITRATE ORAL SOLN 60 MG/3ML (10 MG/ML)	4.73433	ERYTHROMYCIN OPHTH OINT 5 MG/GM	2.58610
CANDESARTAN CILEXETIL TAB 32 MG	0.84821	FAMCICLOVIR TAB 125 MG	0.26713
CAPTOPRIL TAB 100 MG	0.85613	FAMCICLOVIR TAB 250 MG	0.35000
CAPTOPRIL TAB 12.5 MG	0.49124	FAMCICLOVIR TAB 500 MG	0.74263
CAPTOPRIL TAB 25 MG	0.38147	FENOFIBRATE MICRONIZED CAP 200 MG	0.15723
CAPTOPRIL TAB 50 MG	0.22000	FOSINOPRIL SODIUM & HYDROCHLOROTHIAZIDE TAB 10-12.5 MG	0.31569
CETIRIZINE HCL TAB 10 MG	0.05970	FOSINOPRIL SODIUM & HYDROCHLOROTHIAZIDE TAB 20-12.5 MG	0.53126
CETIRIZINE HCL TAB 5 MG	0.03450	FOSINOPRIL SODIUM TAB 10 MG	0.13569
CETIRIZINE-PSEUDOEPHEDRINE TAB ER 12HR 5-120 MG	Suspend	FOSINOPRIL SODIUM TAB 20 MG	0.13120
CHLORPHENIRAMINE MALEATE TAB 4 MG	Suspend	FOSINOPRIL SODIUM TAB 40 MG	0.19469
CHOLINE FENOFIBRATE CAP DR 135 MG (FENOFIBRIC ACID EQUIV)	0.32910	GENTAMICIN SULFATE OPHTH SOLN 0.3%	0.68521
COLESTIPOL HCL TAB 1 GM	0.67136	HYDRALAZINE HCL TAB 10 MG	0.03033
CROMOLYN SODIUM OPHTH SOLN 4%	Suspend	HYDRALAZINE HCL TAB 100 MG	0.08131
CROMOLYN SODIUM SOLN NEBU 20 MG/2ML	1.24042	HYDRALAZINE HCL TAB 25 MG	0.03371
CYCLOSPORINE MODIFIED CAP 100 MG	1.57950	HYDROXYCHLOROQUINE SULFATE TAB 200 MG	0.16545
CYCLOSPORINE MODIFIED CAP 25 MG	0.41230	IPRATROPIUM BROMIDE INHAL SOLN 0.02%	0.06600
CYPROHEPTADINE HCL TAB 4 MG	0.08032	IPRATROPIUM-ALBUTEROL NEBU SOLN 0.5-2.5(3) MG/3ML	0.06556
DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	0.87136	IRBESARTAN TAB 150 MG	0.12610
DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	1.20390	IRBESARTAN TAB 300 MG	0.17832
DEXMETHYLPHENIDATE HCL TAB 10 MG	0.27017	IRBESARTAN TAB 75 MG	0.14023
DEXTROAMPHETAMINE SULFATE TAB 10 MG	0.36810	KETOROLAC TROMETHAMINE OPHTH SOLN 0.5%	1.39261

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Product Name	**Price**	**Product Name**	**Price**
LAMIVUDINE TAB 100 MG (HBV)	1.50236	PENICILLIN V POTASSIUM TAB 250 MG	0.05590
LAMIVUDINE TAB 150 MG	0.78361	PENICILLIN V POTASSIUM TAB 500 MG	0.08626
LAMIVUDINE TAB 300 MG	1.21360	PERINDOPRIL ERBUMINE TAB 2 MG	Suspend
LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG	0.62170	PERINDOPRIL ERBUMINE TAB 4 MG	Suspend
LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML	0.24360	PHENTERMINE HCL CAP 30 MG	0.09813
LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML	0.27463	PHENTERMINE HCL TAB 37.5 MG	0.08643
LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML	0.25012	PILOCARPINE HCL OPHTH SOLN 1%	3.49512
LISINOPRIL & HYDROCHLOROTHIAZIDE TAB 20-25 MG	0.03802	PILOCARPINE HCL OPHTH SOLN 4%	3.43231
LORATADINE & PSEUDOEPHEDRINE TAB ER 24HR 10-240 MG	0.45160	PIPERACILLIN SOD-TAZOBACTAM SOD FOR INJ 4.5 GM (4-0.5 GM)	5.94680
LORATADINE ORAL SOLN 5 MG/5ML	0.03875	PIPERACILLIN SOD-TAZOBACTAM SOD FOR INJ 40.5 GM (36-4.5 GM)	34.15000
LORATADINE TAB 10 MG	0.04422	POLYMYXIN B-TRIMETHOPRIM OPHTH SOLN 10000 UNIT/ML-0.1%	0.40270
LOSARTAN POTASSIUM & HYDROCHLOROTHIAZIDE TAB 100-12.5 MG	0.09522	PRAVASTATIN SODIUM TAB 20 MG	0.04169
LOSARTAN POTASSIUM & HYDROCHLOROTHIAZIDE TAB 50-12.5 MG	0.08340	PRAVASTATIN SODIUM TAB 40 MG	0.07816
LOVASTATIN TAB 20 MG	0.04826	PRAZOSIN HCL CAP 1 MG	0.13891
LOVASTATIN TAB 40 MG	0.04910	PRAZOSIN HCL CAP 2 MG	0.14036
MEFLOQUINE HCL TAB 250 MG	Suspend	PRAZOSIN HCL CAP 5 MG	0.28171
METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	1.49000	PROMETHAZINE HCL INJ 25 MG/ML	1.46000
METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	2.09130	PROMETHAZINE HCL INJ 50 MG/ML	2.11230
METHYLPHENIDATE HCL TAB 10 MG	0.13486	PROMETHAZINE HCL SUPPOS 12.5 MG	3.41620
METHYLPHENIDATE HCL TAB 20 MG	0.18532	PROMETHAZINE HCL SUPPOS 25 MG	2.05660
METHYLPHENIDATE HCL TAB 5 MG	0.10912	PROMETHAZINE HCL SYRUP 6.25 MG/5ML	0.02845
METHYLPHENIDATE HCL TAB ER 10 MG	0.35740	PROMETHAZINE HCL TAB 12.5 MG	0.04101
METOPROLOL & HYDROCHLOROTHIAZIDE TAB 100-25 MG	1.44536	PROMETHAZINE HCL TAB 25 MG	0.04875
METOPROLOL & HYDROCHLOROTHIAZIDE TAB 50-25 MG	0.90220	PROMETHAZINE HCL TAB 50 MG	0.08946
MYCOPHENOLATE SODIUM TAB DR 360 MG (Mycophenolic Acid Equiv)	0.26883	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	0.03634
Neomycin-Bacitrac ZN-Polymyx 5(3.5)MG-400UNT-10000UNT OP OIN	6.27420	PROPARACAINE HCL OPHTH SOLN 0.5%	1.21650
NEVIRAPINE TAB 200 MG	0.12514	PSEUDOEPHED-BROMPHEN-DM SYRUP 30-2-10 MG/5ML	0.05863
NEVIRAPINE TAB ER 24HR 400 MG	3.62160	PYRANTEL PAMOATE SUSP 144 MG/ML (50 MG/ML)	0.18171
OFLOXACIN OPHTH SOLN 0.3%	1.48600	PYRAZINAMIDE TAB 500 MG	3.15000
Olmesartan-Amlodipine-Hydrochlorothiazide TAB 40-10-12.5 MG	1.35140	QUININE SULFATE CAP 324 MG	0.58331
Olmesartan-Amlodipine-Hydrochlorothiazide TAB 40-10-25 MG	1.35641	RAMIPRIL CAP 1.25 MG	0.07356
Olmesartan-Amlodipine-Hydrochlorothiazide TAB 40-5-12.5 MG	1.03691	RAMIPRIL CAP 5 MG	0.04851
OLOPATADINE HCL OPHTH SOLN 0.1%	Suspend	RIFAMPIN CAP 300 MG	0.61020
OSELTAMIVIR PHOSPHATE FOR SUSP 6 MG/ML	0.24000	SALSALATE TAB 500 MG	Suspend

Georgia Maximum Allowable Cost (GMAC) Effective April 01, 2024			
Product Name	**Price**	**Product Name**	**Price**
SALSALATE TAB 750 MG	Suspend	TERBUTALINE SULFATE TAB 5 MG	1.34591
SILDENAFIL CITRATE TAB 100 MG	0.19081	THEOPHYLLINE TAB ER 24HR 400 MG	0.61260
SILDENAFIL CITRATE TAB 20 MG	0.07193	THEOPHYLLINE TAB ER 24HR 600 MG	Suspend
SILDENAFIL CITRATE TAB 25 MG	0.14819	TIMOLOL MALEATE OPHTH GEL FORMING SOLN 0.25%	7.66430
SILDENAFIL CITRATE TAB 50 MG	0.16714	TIMOLOL MALEATE OPHTH GEL FORMING SOLN 0.5%	16.15780
SIMVASTATIN TAB 10 MG	0.02833	TIMOLOL MALEATE OPHTH SOLN 0.25%	0.62145
SIMVASTATIN TAB 20 MG	0.02549	TIMOLOL MALEATE OPHTH SOLN 0.5%	0.93123
SIMVASTATIN TAB 40 MG	0.04407	TIMOLOL MALEATE PRESERVATIVE FREE OPHTH SOLN 0.5%	2.15745
SIMVASTATIN TAB 5 MG	0.02944	TOBRAMYCIN OPHTH SOLN 0.3%	1.03624
SIMVASTATIN TAB 80 MG	0.07781	TOBRAMYCIN-DEXAMETHASONE OPHTH SUSP 0.3-0.1%	3.98230
SIROLIMUS TAB 0.5 MG	2.01569	TRANDOLAPRIL TAB 1 MG	0.12102
SIROLIMUS TAB 2 MG	4.64810	TRANDOLAPRIL TAB 2 MG	0.12016
SODIUM POLYSTYRENE SULFONATE POWDER	0.08327	TROPICAMIDE OPHTH SOLN 0.5%	Suspend
TADALAFIL TAB 20 MG	0.25169	TROPICAMIDE OPHTH SOLN 1%	0.46130
TADALAFIL TAB 20 MG (PAH)	0.34978	VALACYCLOVIR HCL TAB 1 GM	0.44944
TELMISARTAN-HYDROCHLOROTHIAZIDE TAB 40-12.5 MG	0.53670	VALACYCLOVIR HCL TAB 500 MG	0.25120
TERBUTALINE SULFATE TAB 2.5 MG	1.30260		

GA Medicaid FFS – OTC COVID-19 Test Kits

Effective January 15, 2022, over the counter (OTC) COVID-19 tests will be covered through the outpatient pharmacy program for GA Medicaid Fee-for-Service (FFS) members within the specified product limits. Pharmacy providers will be reimbursed up to $12.00 per test and co-payments will not apply.

The following is a list of FDA approved OTC COVID-19 tests that are eligible for reimbursement:

Product ID	Product Name	# of Tests in Kit	Billing Unit	GMAC Unit Rate	Product Limits
08290256094	BD VERITOR AT-HOME COVID-19 TEST	2	2	$12.00/test; $24.00/kit	4 tests per month; maximum qty of 2 per claim; minimum day supply of 7
11877001140	BINAXNOW COVID-19 AG CARD HOME TEST	2	2	$12.00/test; $24.00/kit	
50010022431	CARESTART COVID-19 ANTIGEN HOME TEST	2	2	$12.00/test; $24.00/kit	
69978000004	CLEARDETECT COVID-19 ANTIGEN HOME TEST	2	2	$12.00/test; $24.00/kit	
00111070752	COVID-19 AT-HOME TEST KIT	1	1	$12.00/test; $12.00/kit	
50021086001	ELLUME COVID-19 HOME TEST	1	1	$12.00/test; $12.00/kit	
56964000000	ELLUME COVID-19 HOME TEST	1	1	$12.00/test; $12.00/kit	
82607066026	FLOWFLEX COVID-19 AG HOME TEST	1	1	$12.00/test; $12.00/kit	
82607066027	FLOWFLEX COVID-19 ANTIGEN HOME TEST	2	2	$12.00/test; $24.00/kit	
56362000589	IHEALTH COVID-19 ANTIGEN RAPID TEST	2	2	$12.00/test; $24.00/kit	
08337000158	INTELISWAB COVID-19 RAPID TEST	2	2	$12.00/test; $24.00/kit	
60006019166	ON/GO COVID-19 ANTIGEN SELF-TEST	2	2	$12.00/test; $24.00/kit	
14613033972	QUICKVUE AT-HOME COVID-19 TEST	2	2	$12.00/test; $24.00/kit	
56362000589	IHEALTH COVID-19 ANTIGEN RAPID TEST	2	2	$12.00/test; $24.00/kit	
16490002597	CLINITEST RAPID COVID-19 ANTIGEN SELF-TEST	2	2	$12.00/test; $24.00/kit	
60008040780	INDICAID COVID-19 RAPID ANTIGEN AT-HOME TEST	2	2	$12.00/test; $24.00/kit	
96852025431	GENABIO COVID-19 RAPID SELF TEST KIT	1	1	$12.00/test; $12.00/kit	
96852095300	GENABIO COVID-19 RAPID SELF TEST KIT	2	2	$12.00/test; $24.00/kit	

Per Medicaid policy, all covered OTC products require a prescription. Pharmacies may utilize a Submission Clarification Code (SCC) of 42 in NCPDP Field: 420-DK in response to a rejection regarding prescriber NPI when the prescribing NPI is the pharmacist of record and is compliant with state and federal guidance.

All prescription claims paid for OTC COVID-19 tests are subject to audit including signature log verification.

The Georgia Department of Community Health will not reimburse GA Medicaid FFS members directly for OTC COVID-19 tests.

PHARMACIST ADMINISTERED VACCINES FOR CHILDREN

The U.S. Department of Health and Human Services (HHS) issued a third amendment to the Declaration under the Public Readiness and Emergency Preparedness Act (PREP Act) to increase access to childhood vaccines.

The amendment authorizes State-licensed pharmacists (and pharmacy interns acting under their supervision to administer vaccines, if the pharmacy intern is licensed or registered by his or her State Board of Pharmacy) to order and administer vaccines to individuals ages three through 18 years.

Effective October 15, 2020, the Department of Community Health (DCH) will begin reimbursing pharmacy providers for the administration of select childhood vaccines for GA Medicaid Fee-for-Service (FFS) members 3 – 18 years of age.

The vaccines are provided free of charge by the Vaccine for Children (VFC) program through the GA Department of Public Health.

Listed below are Vaccine for Children (VFC) program resources:
Website = https://dph.georgia.gov/immunization-section/vaccines-children-program
Phone = 1-800-848-3868
Email = DPH-gavfc@dph.ga.gov

The following is a list of covered childhood vaccines that are eligible for pharmacy administration reimbursement:

Covered Childhood Vaccines (age 3 to 18 years) Eligible for Pharmacy Administration Reimbursement		
Vaccine	**Product Name**	**Quantity Limits**
Diphtheria, tetanus, acellular pertussis (DTaP)	Daptacel® Infanrix®	1 dose/28 days; 5 doses maximum
Diphtheria, tetanus vaccine (DT)	No trade name	1 dose/28 days; 5 doses maximum
Haemophilus influenzae type b (Hib)	ActHIB® Hiberix® PedvaxHIB®	1 dose/28 days; 4 doses maximum
Hepatitis A (HepA)	Havrix® Vaqta®	1 dose/180 days; 2 doses maximum
Hepatitis B (HepB)	Engerix-B® Recombivax HB®	1 dose/28 days; 3 doses maximum
Human papillomavirus (HPV)	Gardasil 9®	1 dose/28 days; 3 doses maximum
Influenza vaccine (inactivated) (IIV)	Multiple	1 dose/season
Influenza vaccine (live, attenuated) (LAIV)	FluMist® Quadrivalent	1 dose/season
Measles, mumps, rubella (MMR)	M-M-R® II Priorix	1 dose/28 days; 2 doses maximum
Meningococcal serogroups A, C, W, Y	Menactra® Menveo® MenQuadfi®	1 dose/56 days; 2 doses maximum
Meningococcal serogroup B	Bexsero® Trumenba®	Bexsero-1 dose/28days; 2 doses maximum Trumenba-1 dose/180 days; 2 doses maximum

Covered Childhood Vaccines (age 3 to 18 years) Eligible for Pharmacy Administration Reimbursement		
Vaccine	**Product Name**	**Quantity Limits**
Pneumococcal 13-valent conjugate (PCV13)	Prevnar 13®	1 dose/28 days; 4 doses maximum
Pneumococcal 15-valent conjugate vaccine (PCV15)	Vaxneuvance™	1 dose maximum
Pneumococcal 20-valent conjugate vaccine (PCV20)	Prevnar 20™	1 dose maximum
Pneumococcal 23-valent polysaccharide (PPSV23)	Pneumovax® 23	1 dose maximum
Poliovirus (inactivated) (IPV)	IPOL®	1 dose/28 days; 4 doses maximum
Respiratory Syncytial Virus vaccine (RSV)	Abrysvo™	1 dose maximum
Tetanus, diphtheria, acellular pertussis (Tdap)	Adacel® Boostrix®	1 dose maximum
Tetanus and diphtheria vaccine	Tenivac® Tdvax™	1 dose maximum
Varicella (VAR)	Varivax®	1 dose/28 days; 2 doses maximum
DTaP, hepatitis B, and inactivated poliovirus (DTaP-HepB-IPV)	Pediarix®	1 dose/56 days; 3 doses maximum
DTaP, inactivated poliovirus, and Haemophilus influenzae type b (DTaP-IPV/Hib)	Pentacel®	1 dose/28 days; 4 doses maximum
DTaP and inactivated poliovirus (DTaP-IPV)	Kinrix® Quadracel®	1 dose maximum
DTaP, inactivated poliovirus, Haemophilus influenzae type b, and hepatitis B (DTaP-IPV-HibHepB)	Vaxelis®	1 dose/28 days; 3 doses maximum
Measles, mumps, rubella, and varicella (MMRV)	ProQuad®	1 dose/28 days; 2 doses maximum

Billing and Reimbursement

- All claims should be submitted through the Pharmacy Point of Sale System using the product ID of the vaccine that’s being administered by the pharmacy
- An administration fee of $10.00 will be paid to pharmacy providers that submit claims for covered childhood vaccines for GA Medicaid Fee-for-Service (FFS) members 3 – 18 years of age
- Pharmacy providers will not be reimbursed an ingredient cost for VFC Program Vaccination, and will receive an administration fee only

PHARMACIST ADMINISTERED ADULT VACCINES

Effective November 1, 2020, the Department of Community Health (DCH) will begin reimbursing pharmacy providers through the Pharmacy Point of Sale System on select vaccines for GA Medicaid Fee-for-Service (FFS) members 19 years of age and older.

As a reminder, pharmacists must enter the patient's vaccination information in the Georgia Registry of Immunization Transactions and Services ("GRITS").

The following is a list of covered adult vaccines that are eligible for pharmacy administration and reimbursement:

Covered Adult Vaccines (19 years and older) Eligible for Pharmacy Administration and Reimbursement		
Vaccine	**Product Name**	**Quantity Limits**
Haemophilus influenzae type b (Hib)	ActHIB® Hiberix® PedvaxHIB®	1 dose/28 days; 3 doses maximum
Hepatitis A (HepA)	Havrix® Vaqta®	1 dose/180 days; 2 doses maximum
Hepatitis A and hepatitis B vaccine (HepA-HepB)	Twinrix®	1 dose/7 days; 4 doses maximum
Hepatitis B (HepB)	Engerix-B® Heplisav-B® PreHevbrio® Recombivax HB®	1 dose/28 days; 4 doses maximum
Human papillomavirus (HPV)	Gardasil 9®	1 dose/28 days; 3 doses maximum
Influenza vaccine (inactivated) (IIV)	Many Brands	1 dose/season
Influenza vaccine (live, attenuated) (LAIV)	FluMist® Quadrivalent	1 dose/season
Influenza vaccine (recombinant) (RIV)	Flublok® Quadrivalent	1 dose/season
Measles, mumps, rubella (MMR)	M-M-R® II Priorix	1 dose/28 days; 2 doses maximum
Meningococcal serogroups A, C, W, Y (MenACWY)	Menactra® Menveo® MenQuadfi®	1 dose/56 days; 2 doses maximum
Meningococcal serogroup B (MenB-4C, MenB-FHbp)	Bexsero® Trumenba®	Bexsero-1 dose/28days; 2 doses maximum Trumenba-1 dose/180 days; 2 doses maximum
Pneumococcal 15-valent conjugate vaccine (PCV15)	Vaxneuvance™	1 dose maximum
Pneumococcal 20-valent conjugate vaccine (PCV20)	Prevnar 20™	1 dose maximum
Pneumococcal 23-valent polysaccharide (PPSV23)	Pneumovax® 23	1 dose maximum

Covered Adult Vaccines (19 years and older) Eligible for Pharmacy Administration and Reimbursement		
Vaccine	**Product Name**	**Quantity Limits**
Poliovirus (inactivated) (IPV)	IPOL®	1 dose/28 days; 3 doses maximum
Respiratory Syncytial Virus vaccine (RSV)	Arexvy® Abrysvo™	1 dose maximum
Tetanus, diphtheria, acellular pertussis (Tdap)	Adacel® Boostrix®	1 dose/28 days; 9 doses maximum
Tetanus and diphtheria vaccine	Tenivac® Tdvax™	1 dose/28 days; 9 doses maximum
Varicella (VAR)	Varivax®	1 dose/28 days; 2 doses maximum
Zoster vaccine, recombinant (RZV)	Shingrix®	1 dose/28 days; 2 doses maximum

Billing and Reimbursement

- All claims should be submitted through the Pharmacy Point of Sale System using the product ID of the vaccine that is being administered by the pharmacy
- In lieu of a dispensing fee, an administration fee of $10.00 will be paid to pharmacy providers that submit claims for covered vaccines for GA Medicaid Fee-for-Service (FFS) members 19 years of age and older.
- Ingredient cost will be reimbursed in accordance with the existing Medicaid reimbursement methodology.

**Please note that effective November 1, 2020, pharmacist administered vaccines will no longer be reimbursed when processed by Gainwell Technologies (f.k.a. DXC Technology) through the Georgia Medicaid Management Information System (GAMMIS) for category of service (COS) 300. **

WEBSITE UPDATE – PHARMACY DOCUMENTS

Website	Web Location	Information
www.mmis.georgia.gov	Pharmacy → Pharmacy Notices	**Banner Messages:** Pharmacy provider banners updated weekly.
	Pharmacy → Pricing List	**Full GMAC List:** Full Georgia Maximum Allowable Cost List (GMAC) updated quarterly.
		GMAC Additions: Intra-quarter additions to the Georgia Maximum Allowable Cost List (GMAC)
		GMAC Increases: Intra-quarter increases to the Georgia Maximum Allowable Cost List (GMAC)
		GMAC Decreases: Intra-quarter decreases to the Georgia Maximum Allowable Cost List (GMAC)
		GMAC Suspensions: Intra-quarter suspensions to the Georgia Maximum Allowable Cost List (GMAC)
		Georgia Estimated Acquisition Cost (GEAC) and Specialty Pharmacy Rates (SSPR): Specialty Pharmacy Drug List with current rates.
	Pharmacy → Other Documents	**PDL:** Monthly preferred drug lists (PDL) displayed by Drug Name and Therapeutic Category.
		Cough & Cold PDL: Preferred drug list (PDL) specific to Cough and Cold products. Coverage for these products applies to member's less than 21 years of age.
		QLL: Georgia Medicaid Quantity Level Limits (QLL)
		Vaccine Coverage List: Covered Pharmacist Administered Vaccines for Children and Adults
www.dch.georgia.gov/pharmacy	Preferred Drug Lists	**PDL:** Medicaid Fee for Service Outpatient Pharmacy Program represents the preferred and non-preferred drug products as well as drugs requiring prior approval, quantity level limits, and therapy limits.
	Drug Utilization Review Board	**DURB:** The Georgia Drug Utilization Review Board (DURB) was established under the authority of Section 1903(3) A of the Omnibus Budget Reconciliation Act of 1990 (OBRA). The Board reviews drug therapy, drug studies and utilization information, thus enabling the Department to identify the most cost-effective policies for its members.
	Prior Authorization Process and Criteria	**PA Process and Criteria:** The Georgia Department of Community Health establishes the guidelines for drugs requiring a Prior Authorization (PA) in the Georgia Medicaid Fee-for-Service/PeachCare for Kids® Outpatient Pharmacy Program.
	Pharmacy Links	**Pharmacy Links:** This section contains links to various resources specific to the Georgia Medicaid Fee-for-Service (FFS) Pharmacy Program.
https://ga-providerportal.optum.com	OptumRx GA Provider Portal	**OptumRx GA Provider Portal:** Requires registration with Optum Rx. This site contains valuable resources for enrolled GA Medicaid providers that include weekly pharmacy banners, PA process guide, member information (including Rx history), PDLs, provider resources, and access to remittance summaries online.