Optum Rx®

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

SYSTEM DOWNTIME

The OptumRx claims processing system will be unavailable due to planned maintenance on Thursday, January 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.

GA Medicaid FFS – Narcan Coverage 12/01/2023

Effective December 1, 2023, brand and generic versions Narcan (NALOXONE HCL NASAL SPRAY 4 MG/0.1ML) will be covered through the outpatient pharmacy program for GA Medicaid Fee-for-Service (FFS) members. Pharmacy providers will be reimbursed up to $45.00 per prescription including any dispensing fee. Per Medicaid policy, all covered OTC products require a prescription.

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 January 01, 2024			
Product Name	**Price**	**Product Name**	**Price**
AMANTADINE HCL CAP 100 MG	0.17032	CLOBETASOL PROPIONATE GEL 0.05%(30ml)	Suspend
AMANTADINE HCL SOLN 50 MG/5ML	0.01918	CLOBETASOL PROPIONATE OINT 0.05%	0.17452
AMANTADINE HCL TAB 100 MG	0.49262	CLOBETASOL PROPIONATE SOLN 0.05%	0.42165
AZELASTINE HCL NASAL SPRAY 0.1% (137 MCG/SPRAY)	0.27812	CLOBETASOL PROPIONATE SOLN 0.05%(25ml)	Suspend
BACLOFEN TAB 5 MG	0.19045	DESOXIMETASONE CREAM 0.05%	1.57230
BENZTROPINE MESYLATE TAB 0.5 MG	0.07516	DEXAMETHASONE ELIXIR 0.5 MG/5ML	0.08236
BENZTROPINE MESYLATE TAB 1 MG	0.06952	DEXAMETHASONE TAB 1.5 MG	0.21046
BENZTROPINE MESYLATE TAB 2 MG	0.10846	DEXAMETHASONE TAB 2 MG	0.44000
Betamethasone Dipropionate Augmented Cream 0.05%	0.19269	DEXAMETHASONE TAB 4 MG	0.48136
Betamethasone Dipropionate Augmented Lotion 0.05%	0.58169	DEXAMETHASONE TAB 6 MG	1.05000
BROMOCRIPTINE MESYLATE CAP 5 MG	3.15230	DEXAMETHASONE TAB THERAPY PACK 0.75 MG	Suspend
BROMOCRIPTINE MESYLATE TAB 2.5 MG	1.11036	DICYCLOMINE HCL CAP 10 MG	0.09526
BUDESONIDE DELAYED RELEASE PARTICLES CAP 3 MG	0.61351	DICYCLOMINE HCL ORAL SOLN 10 MG/5ML	0.18506
CARBIDOPA & LEVODOPA TAB 10-100 MG	0.11045	DICYCLOMINE HCL TAB 20 MG	0.14103
CARBIDOPA & LEVODOPA TAB 25-100 MG	0.08435	DILTIAZEM HCL CAP ER 24HR 180 MG	0.44410
CARBIDOPA & LEVODOPA TAB 25-250 MG	0.11853	DILTIAZEM HCL COATED BEADS CAP ER 24HR 120 MG	0.15856
CARBIDOPA & LEVODOPA TAB ER 25-100 MG	0.13123	DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 120 MG	0.24141
CARBIDOPA & LEVODOPA TAB ER 50-200 MG	0.21029	DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 180 MG	0.27000
CARBIDOPA TAB 25 MG	1.21360	DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 240 MG	0.42690
CARISOPRODOL TAB 250 MG	0.61239	DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 300 MG	0.51945
Chlordiazepoxide HCL-CLIDINIUM BROMIDE CAP 5-2.5 MG	0.34854	DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 360 MG	0.56130
CIMETIDINE TAB 400 MG	0.40415	DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 420 MG	0.93540
CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1%	17.27230	DILTIAZEM HCL TAB 30 MG	0.08316
CLOBETASOL PROPIONATE CREAM 0.05%	0.15926	DILTIAZEM HCL TAB 60 MG	0.15010
CLOBETASOL PROPIONATE EMOLLIENT BASE CREAM 0.05%	0.53263	DILTIAZEM HCL TAB 90 MG	0.20807
CLOBETASOL PROPIONATE FOAM 0.05%	0.44360	DILTIAZEM HCL TAB 120 MG	0.30165
CLOBETASOL PROPIONATE GEL 0.05%	0.96232	DIPHENHYDRAMINE HCL (SLEEP) TAB 25 MG	0.04723
CLOBETASOL PROPIONATE GEL 0.05%(15ml)	Suspend	DOXEPIN HCL (SLEEP) TAB 3 MG	4.57132

Georgia Maximum Allowable Cost (GMAC) Effective January 01, 2024			
Product Name	**Price**	**Product Name**	**Price**
DOXEPIN HCL (SLEEP) TAB 6 MG	5.59512	HYDROCORTISONE CREAM 2.5%	0.08915
DOXYCYCLINE MONOHYDRATE CAP 50 MG	0.17423	HYDROCORTISONE LOTION 2.5%	0.18145
ENTACAPONE TAB 200 MG	0.37481	HYDROCORTISONE OINT 2.5%	0.07258
ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG	0.16470	HYDROCORTISONE PERIANAL CREAM 2.5%	0.26445
ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG	0.16245	HYDROCORTISONE TAB 10 MG	0.23972
ESTRADIOL & NORETHINDRONE ACETATE TAB 1-0.5 MG	0.81692	HYDROCORTISONE TAB 20 MG	0.33269
ESTRADIOL TD PATCH TWICE WEEKLY 0.025 MG/24HR	6.54230	HYDROCORTISONE TAB 5 MG	0.20591
ESTRADIOL TD PATCH TWICE WEEKLY 0.0375 MG/24HR	6.30160	HYDROCORTISONE VALERATE CREAM 0.2%	0.40156
ESTRADIOL TD PATCH TWICE WEEKLY 0.05 MG/24HR	6.74120	HYOSCYAMINE SULFATE SL TAB 0.125 MG	0.11232
ESTRADIOL TD PATCH TWICE WEEKLY 0.075 MG/24HR	6.74823	HYOSCYAMINE SULFATE TAB 0.125 MG	0.13054
ESTRADIOL TD PATCH TWICE WEEKLY 0.1 MG/24HR	6.65165	HYOSCYAMINE SULFATE TAB DISINT 0.125 MG	0.15731
ESTRADIOL TD PATCH WEEKLY 0.0375 MG/24HR	12.87890	IMIQUIMOD CREAM 5%	0.61036
ESTRADIOL TD PATCH WEEKLY 0.06 MG/24HR	13.05130	IPRATROPIUM BROMIDE NASAL SOLN 0.06% (42 MCG/SPRAY)	1.33160
ESZOPICLONE TAB 1 MG	0.16361	ISOSORBIDE DINITRATE TAB 30 MG	0.32126
ESZOPICLONE TAB 2 MG	0.09710	ISOSORBIDE DINITRATE TAB 40 MG	12.16987
ESZOPICLONE TAB 3 MG	0.11000	KETOCONAZOLE TAB 200MG	0.53120
FAMOTIDINE FOR SUSP 40 MG/5ML	0.52169	LACTIC ACID (AMMONIUM LACTATE) CREAM 12%	0.05953
FAMOTIDINE TAB 20 MG	0.02843	LACTIC ACID (AMMONIUM LACTATE) LOTION 12%	0.06513
FAMOTIDINE TAB 40 MG	0.05494	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	0.21032
FLUDROCORTISONE ACETATE TAB 0.1 MG	0.41433	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	0.09813
FLUOCINOLONE ACETONIDE (OTIC) OIL 0.01%	1.49125	Lansoprazole Tab Delayed Release Orally Disintegrating 15 MG	3.57269
FLUTICASONE PROPIONATE CREAM 0.05%	0.29140	Lansoprazole Tab Delayed Release Orally Disintegrating 30 MG	4.25140
FLUTICASONE PROPIONATE NASAL SUSP 50 MCG/ACT	0.29732	LIDOCAINE HCL GEL 2%	Suspend
FLUTICASONE PROPIONATE OINT 0.005%	0.55630	LIDOCAINE HCL URETHRAL/MUCOSAL GEL	0.45120
GLYCOPYRROLATE INJ 1 MG/5ML (0.2 MG/ML)	2.00000	LIDOCAINE OINT 5%	0.15432
GLYCOPYRROLATE INJ 4 MG/20ML (0.2 MG/ML)	1.75000	LIDOCAINE PATCH 5%	1.81230
GLYCOPYRROLATE ORAL SOLN 1 MG/5ML	0.50243	LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%	0.45169
GLYCOPYRROLATE TAB 1 MG	0.10030	METHYLPREDNISOLONE TAB 4 MG	0.15012
GLYCOPYRROLATE TAB 2 MG	0.21771	METHYLPREDNISOLONE TAB THERAPY PACK 4 MG (21)	0.14756
GRISEOFULVIN MICROSIZE TAB 500 MG	7.92361	MISOPROSTOL TAB 100 MCG	0.46126
HALOBETASOL PROPIONATE CREAM 0.05%	0.61136	MISOPROSTOL TAB 200 MCG	0.75330
HALOBETASOL PROPIONATE OINT 0.05%	0.50362	MOMETASONE FUROATE OINT 0.1%	0.24860
Hydrocortisone Butyrate Hydrophilic Lipo Base Cream 0.1%	1.35400	MOMETASONE FUROATE SOLUTION 0.1% (LOTION)	0.43261
HYDROCORTISONE CREAM 1%	0.07762	MOXIFLOXACIN HCL TAB 400 MG	1.98571

Georgia Maximum Allowable Cost (GMAC) Effective January 01, 2024			
Product Name	**Price**	**Product Name**	**Price**
NIFEDIPINE CAP 10 MG	0.34448	PREDNISONE TAB 1 MG	0.05703
NITROGLYCERIN SL TAB 0.3 MG	0.13078	PREDNISONE TAB 2.5 MG	0.07963
NITROGLYCERIN SL TAB 0.4 MG	0.19265	PREDNISONE TAB 5 MG	0.05123
NITROGLYCERIN SL TAB 0.6 MG	0.18326	PREDNISONE TAB 10 MG	0.05661
NYSTATIN CREAM 100000 UNIT/GM	0.17032	PREDNISONE TAB 20 MG	0.09405
NYSTATIN OINT 100000 UNIT/GM	0.24125	PREDNISONE TAB THERAPY PACK 10 MG (21)	0.58263
NYSTATIN TOPICAL POWDER 100000 UNIT/GM	0.20254	PREDNISONE TAB THERAPY PACK 10 MG (48)	0.57269
OFLOXACIN OTIC SOLN 0.3%	1.91560	PREDNISONE TAB THERAPY PACK 5 MG (21)	0.41631
OMEPRAZOLE CAP DELAYED RELEASE 10 MG	0.08123	PREDNISONE TAB THERAPY PACK 5 MG (48)	0.42136
OMEPRAZOLE CAP DELAYED RELEASE 20 MG	0.03324	RABEPRAZOLE SODIUM EC TAB 20 MG	0.21334
OMEPRAZOLE CAP DELAYED RELEASE 40 MG	0.05460	RAMELTEON TAB 8 MG	0.94561
OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	0.98732	ROPINIROLE HYDROCHLORIDE TAB 0.25 MG	0.04321
PALONOSETRON HCL IV SOLN PREF SYR 0.25 MG/5ML	Suspend	ROPINIROLE HYDROCHLORIDE TAB 0.5 MG	0.04000
PANTOPRAZOLE SODIUM EC TAB 20 MG	0.04312	ROPINIROLE HYDROCHLORIDE TAB 1 MG	0.05349
PANTOPRAZOLE SODIUM EC TAB 40 MG	0.05257	ROPINIROLE HYDROCHLORIDE TAB 2 MG	0.05615
PERMETHRIN LOTION 1%	Suspend	ROPINIROLE HYDROCHLORIDE TAB 3 MG	0.08246
PHENOBARBITAL TAB 15 MG	0.08492	ROPINIROLE HYDROCHLORIDE TAB 4 MG	0.08549
PHENOBARBITAL TAB 16.2 MG	0.11000	ROPINIROLE HYDROCHLORIDE TAB 5 MG	0.07865
PHENOBARBITAL TAB 30 MG	0.15932	ROPINIROLE HYDROCHLORIDE TAB ER 24HR 2 MG	0.53642
PHENOBARBITAL TAB 32.4 MG	0.17230	ROPINIROLE HYDROCHLORIDE TAB ER 24HR 4 MG	0.71260
PHENOBARBITAL TAB 60 MG	0.18000	ROPINIROLE HYDROCHLORIDE TAB ER 24HR 12 MG	0.79254
PHENOBARBITAL TAB 64.8 MG	0.20851	SELEGILINE HCL CAP 5 MG	0.80160
PHENOBARBITAL TAB 97.2 MG	0.16210	TETRACYCLINE HCL CAP 250 MG	0.84230
PODOFILOX SOLN 0.5%	Suspend	TETRACYCLINE HCL CAP 500 MG	0.84136
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.088 MG	Suspend	TRETINOIN CREAM 0.025%	1.10000
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.125 MG	0.03574	TRETINOIN CREAM 0.1%	2.14354
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.18 MG	Suspend	TRETINOIN GEL 0.01%	2.55100
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.25 MG	0.04562	TRETINOIN GEL 0.025%	2.21236
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.35 MG	Suspend	TRIAMCINOLONE ACETONIDE CREAM 0.025%	0.11360
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.5 MG	0.05132	TRIAMCINOLONE ACETONIDE CREAM 0.1%	0.10365
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.7 MG	Suspend	TRIAMCINOLONE ACETONIDE LOTION 0.1%	0.28459
PRAMIPEXOLE DIHYDROCHLORIDE TAB 0.75 MG	0.06601	TRIAMCINOLONE ACETONIDE OINT 0.025%	0.12630
PRAMIPEXOLE DIHYDROCHLORIDE TAB 1 MG	0.06015	TRIAMCINOLONE ACETONIDE OINT 0.1%	0.12030
PRAMIPEXOLE DIHYDROCHLORIDE TAB 1.5 MG	0.06751	TRIAMCINOLONE ACETONIDE OINT 0.5%	0.29126

Georgia Maximum Allowable Cost (GMAC) Effective January 01, 2024			
Product Name	**Price**	**Product Name**	**Price**
TRIAZOLAM TAB 0.125 MG	0.78596	VERAPAMIL HCL CAP ER 24HR 180 MG	1.10163
TRIAZOLAM TAB 0.25 MG	0.57269	VERAPAMIL HCL CAP ER 24HR 240 MG	1.29850
TRIHEXYPHENIDYL HCL TAB 2 MG	0.05036	ZALEPLON CAP 10 MG	0.17461
TRIHEXYPHENIDYL HCL TAB 5 MG	0.09483	ZOLPIDEM ER TAB 6.25MG	0.15013
VERAPAMIL HCL CAP ER 24HR 120 MG	1.08430		

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.

GA Medicaid FFS – Oral COVID-19 Antiviral Treatments

The FDA recently announced the emergency use authorization (EUA) of two oral, antiviral medication: Pfizer's PAXLOVID™ (nirmatrelvir/ritonavir) and Merck's molnupiravir, for the treatment of mild-to-moderate coronavirus disease 2019 (COVID-19). At this time, the cost for these oral antiviral medications will be covered by the federal government via funding authorized by the Coronavirus Aid, Relief and Economic Security (CARES) Act.

Effective January 7, 2022, an administrative fee of $10.63 will be paid to pharmacy providers that submit claims for covered COVID-19 oral antiviral medications for GA Medicaid Fee-for-Service (FFS) members within the specified product limits. This $10.63 fee will be paid for each prescription dispensed.

The following is a list of covered oral antiviral medications that are eligible for pharmacy administrative reimbursement:

EAU Approved Product ID	Product Name	Product Limits
00006-5055-06	MOLNUPIRAVIR CAP 200 MG	Covered 18 years of age and older; maximum 8 units/day and 2 courses (80 units)/365 days
00069-1085-06 00069-1085-30	NIRMATRELVIR TAB 20 X 150 MG & RITONAVIR TAB 10 X 100 MG PAK (PAXLOVID™ 300-100 TAB)	Covered 12 years of age and older; maximum 6 units/day and 2 courses (60 units)/365 days
00069-1101-04 00069-1101-20	NIRMATRELVIR TAB 10 X 150 MG & RITONAVIR TAB 10 X 100 MG PAK (PAXLOVID™ 150-100 TAB)	Covered 12 years of age and older; maximum 4 units/day and 2 courses (40 units)/365 days

For pharmacists prescribing Paxlovid: Effective July 6, 2022, 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.

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

Covered Childhood Vaccines (age 3 to 18 years) Eligible for Pharmacy Administration Reimbursement		
Vaccine	**Product Name**	**Quantity Limits**
Meningococcal serogroup B	Bexsero® Trumenba®	Bexsero-1 dose/28days; 2 doses maximum Trumenba-1 dose/180 days; 2 doses maximum
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

Covered Adult Vaccines (19 years and older) Eligible for Pharmacy Administration and Reimbursement		
Vaccine	**Product Name**	**Quantity Limits**
Pneumococcal 23-valent polysaccharide (PPSV23)	Pneumovax® 23	1 dose maximum
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.