

# Frequently Asked Questions (FAQs): Pharmacy Benefit Carve-Out

## Provider FAQs

1. Does a physician have to be enrolled in the Medicaid Fee-For-Service (FFS) program to prescribe for a Medicaid member?

Pharmacies and practitioners must be enrolled in the NYS Medicaid Fee-For-Service (FFS), to prescribe for Medicaid members. Exceptions exist for Interns, Resident and Student Healthcare Providers.

2. How can a provider enroll with the Medicaid Fee-For-Service (FFS) program?

Providers can contact ePACES/NYS Fee-For-Service Provider Enrollment at (800) 343-9000 (Option 2).

Providers can also email [providerenrollment@health.ny.gov](mailto:providerenrollment@health.ny.gov) or use this webportal <https://www.emedny.org/info/ProviderEnrollment> for enrollment.

3. How does the transition of the pharmacy benefit from Medicaid Managed Care (MMC) to the Medicaid NYRx Pharmacy Program affect providers?

Practitioners that are prescribing outpatient drugs (or other products covered under the outpatient pharmacy benefit), for Medicaid Managed Care (MMC) members, will access the NYRx formulary and the Preferred Drug List to determine coverage parameters.

Pharmacies that are billing for outpatient drugs for MMC members will submit claims to the eMedNY system instead of billing the Managed Care Plans.

4. How can a provider find resources including the medication preferred drug list, DME list, diabetic supply list and submit a prior authorization online?

Providers can access the NYRx resource site at the below webpage.

<https://newyork.fhsc.com/#>

## 5. How can a provider submit a prior authorization request for a medication?

Providers can contact the Magellan Clinical Call Center at (877) 309-9493.

Providers can also fax the request to Magellan at (800) 268-2990 or submit online via PAXpress portal at <https://paxpress.nypa.hidinc.com/apex/f?p=109:1:>

## 6. How can a provider submit a prior authorization request for DME?

Providers should contact The Bureau of Medical and Dental Review Call Center at (800) 342-3005.

Providers can also email DME requests to [ohipmedpa@health.ny.gov](mailto:ohipmedpa@health.ny.gov).

## 7. How can a provider submit a prior authorization request for enteral therapy?

Providers should contact the NYS Enteral Division, specifically eMedNY Enteral Therapy Authorization Line at their Interactive Voice Response System (IVR) line at (866) 211-1736 or submit via webportal: <https://medicaidentalportal.health.ny.gov/portal/>

## 8. For members who receive oral enteral products, such as Ensure, with existing an prior authorization (PA) from Managed Care Plans (MCPs), will prescribers need to obtain a new PA for these products?

Providers will need to obtain a new prior authorization for oral enteral products. Providers can contact eMedNY Enteral Therapy Authorization Line at their Interactive Voice Response System (IVR) line at (866) 211-1736 or submit via webportal: <https://medicaidentalportal.health.ny.gov/portal/>

## 9. How will the transition impact Prior Authorization volume for providers?

NYS DOH has taken the below steps to prevent an increase in Prior Authorization volume. These include:

- Utilizing a fully automated system, operated by Kepro, where claims that meet clinical criteria will adjudicate and automatic approvals are generated 50% of the time. By leveraging this process members may be allowed to continue receiving non-formulary/non-preferred medications if members were previously using these medications.
- Implementing a member transition period that allows members to receive a one-time fill of a non-formulary/non-preferred product. This allows additional time for prescribers

to either seek prior authorization or change to a preferred drug, which does not require prior authorization.

- Honoring prior authorizations issued by Medicaid Managed Care (MMC) prior to April 1, 2023 will allow for previously approved drugs to continue to be approved. This includes clinical PAs that also require authorization under the Medicaid NYRx Pharmacy program.

10. What will be the duration of the transition period/fill and what is the criteria for the transition logic to apply at Point of Service (POS)? Will NYS DOH outreach prescribers before the transition period ends to prevent Point of Service (POS) rejects?

Prior to the transition period, NYS DOH will be outreaching high volume prescribers of non-formulary/non-preferred products to educate them on the NYRx preferred drug program and clinical criteria. Additionally, during the transition period, from April 1, 2023, to June 30, 2023 (90 days), NYS DOH will be conducting outreach to prescribers to inform them of the members receiving non-preferred products in order to familiarize them with Preferred Drug Program.

11. What is the supply quantity for the one-time fill during the transition period?

During the transition period from April 1, 2023 through June 30, 2023, members will be provided with a one-time, temporary fill for up to a 30 day supply of a drug that would normally require prior authorization or is non-preferred under the NYRx Preferred Drug Program (PDP). This allows additional time for prescribers to either seek prior authorization or change to a preferred drug, which does not require prior authorization.

12. How will the transition impact physician administered drugs (J-codes)?

There is no impact. Providers can continue to send physician administered claims directly to MetroPlus Health Plan.

Claims can be submitted to MetroPlus Health Plan electronically using Emdeon Payer ID# 13265. Paper claims must be submitted on HCFA 1500 or UB-04 forms.

Send paper claims for MetroPlus Medicaid Plan, MetroPlus Enhanced (HARP) Plan, or MetroPlus Partnership in Care (PIC) Medicaid Plan members to:

MetroPlus Health Plan  
P.O. Box 830480  
Birmingham, AL 35283-0480

13. How can pharmacies process restricted receipt pharmacy claim, specifically, if the member urgently needs to use a pharmacy that is different from their restricted pharmacy or urgently needs to fill a prescription written by provider that is different from my restricted provider.

If the member's restricted primary provider referred the member to another provider, the pharmacy processing the prescriptions must enter the prescribing provider's NPI in the ordering/prescribing provider field and the member's primary provider's NPI must be entered in the primary care provider field.

In an emergency, a 72-hour supply can be provided when the prescribing provider is not the member's restricted provider or if the member is using a pharmacy other than the member's restricted pharmacy. Providers or Pharmacies should contact the Magellan Clinical Call Center at (877) 309-9493 to request the emergency fill.