

LEGEND DRUGS AND INSULIN

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I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are legend drugs and insulin to be reimbursed?

III. POLICY

A. Pricing of legend drugs (those drugs that require a prescription by law) and insulin will depend on the claimant: beneficiary (consolidated drug claim) or provider (vendor pharmacy or physician).

B. For beneficiary submitted claims, reimbursement is to be based on the billed charge. For vendor pharmacy (participating provider) submitted claims, the allowable charge for outpatient prescription drugs paid to a vendor pharmacy will be the acquisition cost (taking into account the strength, quantity, and generic/nongeneric status) plus a flat amount determined by the contractor for each prescription. This fixed fee does not apply to insulin. The acquisition cost should include the sales tax.

C. The acquisition cost of drugs for participating providers, i.e., vendor pharmacies, physicians, etc., is to be determined from the Drug Topics Blue Book, which lists the wholesale price. In all cases the contractor is to use the latest annual edition of the Blue Book as well as the monthly updates.

D. Allergy preparations are custom made in a laboratory and are not considered prescription drugs. Since the cost of these allergy preparations are not found in the Drug Topics Blue Book, reimbursement will be based on the allowable charge methodology. The prevailing will include both the cost of the drug and the administrative fee. An allowance of a separate additional charge for an "office visit" would not be warranted where the services rendered did not really constitute a regular office visit.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 1, SECTION 15

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E. The Centers for Medicare and Medicaid Services Common Procedure Coding System, National Level II Medicare "J" codes are to be priced using the following. Drugs administered other than oral method, including chemotherapy drugs, are to be priced from the "J" code pricing file except for home infusion drugs furnished through a covered item of durable medical equipment which will be paid the lesser of the billed amount or 95 percent of the AWP retroactive back to April 1, 2005. However, this retroactive coverage will not require the contractors to research their claims history and adjust previously submitted home infusion drug claims unless brought to their attention by a provider. Home infusion drugs will be billed using the appropriate J-code along with a specific National Drug Code (NDC) for pricing. The unique HCPCS "J" code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. Drugs that do not appear on the Medicare "J" code pricing file will also be priced using 95% of the AWP.

F. A separate payment shall be made for the **pharmacy compounding and dispensing services under HCPCS S9430**.

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