

## 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 **a schedule of allowable charges based on the Average Wholesale Price (AWP)**.

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 **a schedule of allowable charges based on the AWP**, 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

LEGEND DRUGS AND INSULIN

E. The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), National Level II Medicare “J” codes are to be priced using the following.

1. Drugs (except for home infusion drugs) administered other than oral method, including chemotherapy drugs, are to be priced from the “J” code pricing file.

2. Drugs that do not appear on the “J” code pricing file will be priced at the lesser of billed charges or 95% of the AWP.

3. Home infusion drugs provided prior to January 30, 2012: Home infusion drugs will be paid the lesser of the billed amount or 95% 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 or other person with an interest in the claim. Home infusion drugs will be billed using the appropriate “J” code or any other appropriate HCPCS coding for home infusion drugs not appearing on the “J” code pricing file along with a specific National Drug Code (NDC). The unique HCPCS code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug’s AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding (e.g., “J”, “Q”, and “S” codes) for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA)-approved and have specific NDCs for pricing.

4. Home infusion drugs provided on or after January 30, 2012: Home infusion drugs must be provided in accordance with the TRICARE Policy Manual (TPM), Chapter 8, Section 20.1. Home infusion drugs will be paid the lesser of the billed amount or 95% of the AWP only in cases where the home infusion drug is not available through the TRICARE Pharmacy (TPharm), or the beneficiary is not required by the TPM, Chapter 8, Section 20.1 to obtain the drug from the TPharm. Home infusion drugs not provided through the TPharm will be billed using the appropriate “J” code or any other appropriate HCPCS coding for home infusion drugs not appearing on the “J” code pricing file along with a specific NDC. The unique HCPCS code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug’s AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding (e.g., “J”, “Q”, and “S” codes) for reporting purposes as long as the drugs are FDA-approved and have specific NDCs for pricing.

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

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