

Pharmacy Services

Revised: [November 4, 2024](#)

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Overview

Information in this section applies to all of [Minnesota's Health Care Programs \(MHCP\)](#). Providers must contact the appropriate health plan for pharmacy information related to members in [managed care organizations \(MCO\)](#).

Beginning Nov. 4, 2024, outpatient pharmacy claims processing and related pharmacy benefit functions will transition to Prime Therapeutics (formerly known as Magellan Health). This change is only for the fee-for-service outpatient pharmacy benefit. The Managed Care Organizations (MCOs) will continue to provide outpatient pharmacy benefits for members enrolled in their plans. Prime Therapeutics posted a [Provider Manual](#) on the Minnesota Medical Assistance Portal to assist providers in submitting claims and understanding system edits in their pharmacy module.

Key Points

Federal Anti-Fraud Statutes

Pharmacies cannot use pharmaceutical manufacturers' coupons, discounts or similar promotions to attract prescription business from Medical Assistance (MA) members. Federal anti-fraud and abuse provisions prohibit certain types of business transactions or arrangements, per Section 231(h) of HIPAA and the Office of Inspector General Special Fraud Alert, 59 Fed. Reg. 242; 1994. Refer to [Provider Requirements](#) for details.

How to Determine Drug Coverage

Use the [National Drug Code \(NDC\)](#) search site to determine MHCP coverage of individual drug products.

Labeler Codes

The U.S. Food & Drug Administration (FDA) assigns each listed drug product a unique 11-digit, 3-segment number, known as the National Drug Code (NDC). The first segment (5-digits) identifies the manufacturer or labeler of the drug, the second segment (4-digits) identifies the drug and the third segment (2-digits) refers to the package size. MHCP requires the 11-digit 5-4-2- format for billing or reporting an NDC.

If a manufacturer is not listed as a participant in the federal [Medicaid Drug Rebate Program](#), the MHCP program will not cover products from that manufacturer.

Payment for Prescribed Drugs

Refer to the Provider Reimbursement chapters of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

Tamper-Resistant Prescription Blanks

The [Appropriations Act of 2007-H. R. 2206–76 \(PDF\)](#) states that Medical Assistance (MA) will not pay for prescriptions in non-electronic form for MA-covered outpatient drugs unless the prescription was executed on a tamper resistant prescription blank. This law does not affect prescriptions electronic-prescribed, faxed or phoned in to the pharmacy by the prescriber.

Hand-written prescriptions must be executed on a tamper-resistant prescription blank with at least one characteristic from all three categories as outlined in the July 2008 NCPDP letter to Medicaid.

Eligible Providers

Dispensing Providers

To dispense prescription drugs, an enrolled provider must meet at least one of the following criteria:

- A [pharmacy](#) that is licensed by the [Minnesota Board of Pharmacy](#)
- An out-of-state pharmacy licensed by a state board of pharmacy

- A physician located in a local trade area where there is no MHCP enrolled pharmacy. To be eligible for payment, the physician must personally dispense the [prescribed drug](#) according to applicable Minnesota statutes, and must adhere to the labeling requirements of the Minnesota Board of Pharmacy
- A physician or nurse practitioner employed by or under contract with a community health board for communicable disease control

Prescribing Providers

To be eligible for coverage, an enrolled prescriber must write prescriptions. MHCP fee-for-service (FFS) will not cover prescriptions written by non-enrolled providers.

The following enrolled providers may prescribe drugs within the scope of their profession:

- Dentists
- Certified nurse practitioners
- Mental health certified clinical nurse specialists
- Optometrists
- Osteopaths
- Physician Assistants
- Physicians
- Podiatrists
- Other health care professionals licensed to prescribe drugs under Minnesota statutes

Pharmacists may [prescribe over-the-counter \(OTC\)](#) medications to FFS or managed care

Prescribers are required to comply with section 5042 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act when prescribing controlled substances to MHCP members. Section 5042 of the SUPPORT for Patients and Communities Act requires prescribers to check the prescription drug monitoring program (PDMP), hosted by the Minnesota Board of Pharmacy, before prescribing controlled substances to an MHCP member. If a prescriber is unable to check the PDMP prior to prescribing a controlled substance, then the prescriber must document the good faith effort, including the reason why they were unable to check the PDMP. Prescribers may be required to submit the documentation of the failure to check the PDMP prior to prescribing a controlled substance to an MHCP member to DHS upon request.

Eligible Members

[MHCP](#) members are eligible for a certain level of pharmacy and [medical supply](#) benefits. Use [MN-ITS Eligibility Request \(270\)](#) to verify member eligibility and [other insurance coverage](#).

Programs with limited prescription drug coverage include the following:

- Emergency Medical Assistance (EMA): Refer to [EMA Service Limitations](#) for services not available
- Program HH [ADAP Drug Formulary](#)

Members eligible for both MHCP and Medicare Part D ([dual eligibility](#)) must select a Medicare Part D plan and receive most of their medications through their selected Medicare Part D plan. MHCP will only cover drugs excluded by law from Medicare Part D coverage that are otherwise covered in the Medical Assistance program.

When a member elects [hospice coverage](#), bill outpatient drugs and medical supplies directly related to the terminal illness to the hospice provider. If members need prescription drugs or medical supplies

to treat a preexisting condition outside the scope or purpose of treating the terminal illness, follow the standard billing guidelines to bill for MHCP members.

Covered Services

Covered Drugs

Most decisions regarding MHCP drug coverage are made at the federal level in accordance with federal Omnibus Budget Reconciliation Act (OBRA) Laws of 1990. Those areas left to Minnesota's discretion are described in this chapter in the [Pharmacy Service Limitations](#) section. Consult the following documents for more information on drug coverage:

- [Drug Categories with Limited Coverage](#)
- [Prior Authorization Criteria Sheets](#)
- [Preferred Drug List \(PDL\) \(PDF\)](#)

Responsibilities of the [Drug Formulary Committee](#) and [Drug Utilization Review Board](#) are on the designated webpages

Minnesota Family Planning Program (MFPP)

The Minnesota Family Planning Program (MFPP) provides family planning services and supplies for people ages 15 to 50. Refer to [Pharmacy Services](#), in the [Minnesota Family Planning Program](#) section of the MHCP Provider Manual.

Pharmacist Administered Immunizations and Vaccines

MHCP covers vaccines administered by a pharmacist within the scope of their license. MHCP does not pay for immunizations or vaccines that are available through the Minnesota Vaccines for Children (MNVFC) program. The affiliated pharmacy is responsible for [billing](#) MHCP for the pharmacist-administered vaccine and administration fee using the correct CPT codes.

Physician Administered Drugs

Bill drugs that are administered to a patient as part of a clinic or other outpatient visit to MHCP using the appropriate health care common procedural coding system (HCPCS) code(s). Refer to the [Physician and Professional Services](#) section in the MHCP Provider Manual. Do not bill drugs administered during an outpatient visit through the pharmacy point-of-sale (POS) system. MHCP does not cover drugs dispensed by a pharmacy to a member, or shipped to a clinic, for administration in a clinic or other outpatient facility. Pharmacies, including mail order pharmacies, who are providing the drugs for a clinic visit, may not bill MHCP for the drugs dispensed. MHCP may make an exception only if a member has third-party liability and the third-party payer requires that the drugs be billed through the pharmacy benefit.

Pharmacist Prescribing – OTC Medications

The following policies apply to pharmacists prescribing OTC medications:

- OTC medication must be medically necessary and the member must not need a referral to another health care professional.
- The pharmacist must review the member's drug therapy for potential adverse interactions.
- The pharmacist must provide drug counseling consistent with [Minnesota Rules, 6800.0910](#).
- The pharmacy must keep a prescription on file as defined in [Minnesota Statutes, 151.01](#), subdivision 16 for five years. For the purposes of providing OTC drugs to members, the pharmacist is the prescriber who must sign the prescription. Prescriptions may be refilled for up to 12 months as specified in [Minnesota Rules, 6800.3510](#).
- The OTC medication must be dispensed in accordance with all relevant sections of [Minnesota Statutes, 151](#) and [Minnesota Rules, 6800](#).

- Pharmacists must submit claims using the MHCP pharmacy's national provider identifier (NPI) number as the prescriber number.
- For the original fill, the pharmacist must document on the prescription information regarding medical necessity, drug therapy reviews and drug counseling. For refills, the pharmacist must document in the patient's profile any updated information regarding medical necessity, drug therapy reviews and drug counseling.
- The pharmacy must dispense the lesser of the amount of OTC medication needed by the member for a 34-day supply or the entire package of the OTC medication.

To verify if MHCP covers an over-the-counter (OTC) product, use the Magellan [NDC Search](#).

Pharmacy Service Limitations

Refer to the Program Specifications chapter of the Prime Therapeutics [Prime Therapeutics Provider Manual \(PDF\)](#) for more information.

Specialty Pharmaceutical Reimbursement

State law defines specialty pharmaceuticals as those used by a small number of members with complex and chronic diseases that require expensive and challenging drug regimens. The Minnesota Legislature has granted the Minnesota Department of Human Services (DHS) the authority to establish specialty pharmacy reimbursement rates lower than the estimated actual acquisition cost. Refer to the [Specialty Drug List](#) for current specialty pharmacy reimbursement rates (SMAC pricing).

Noncovered Services

Drugs and Costs

Refer to the Drug Information and Edits chapter of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

Automatic Refills

MHCP does not allow automatic refills. Prescription refills are not eligible for payment without an explicit request from a member or authorized caregiver for each refill based on continued medical necessity. The pharmacy provider may not contact the member in an effort to initiate a refill, unless it is part of medication therapy management services authorized under [Minnesota Statutes, 256B.0625](#), subdivision 13h.

A nurse or other authorized agent of the facility may initiate a request for refill for a member residing in a skilled nursing facility, group home or assisted living arrangement.

Authorization and Limitation Requirements

Do not submit [prior authorization](#) (PA) requests for the previously listed MHCP noncovered drugs. We cannot grant authorization for noncovered drugs.

Pharmacies and prescribing providers must submit all drug PA requests for outpatient prescription drugs and physician-administered drugs that require authorization to the MHCP prescription drug PA review agent, Prime Therapeutics. Refer to the Prime Services Support Centers and Prior Authorization chapters of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

Dispense as Written (DAW) - Brand Necessary

MHCP may prefer a brand name drug over the generic version if the brand name drug has a lower net cost to the State of Minnesota. When DHS prefers the brand to the generic, the prescriber is not required to write "DAW-brand medically necessary" on the prescription or enter "Brand Medically

Necessary” in the “Prescriber note to Pharmacy” field if it is electronically prescribed. If MHCP does not prefer the brand name version over the generic, a prescriber must obtain prior authorization before MHCP will cover a claim for a brand name drug that has a generic formulation available.

Refer to the Program Specifications chapter of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

Maximum Allowable Cost (MAC) price and the National Average Drug Acquisition Cost for the generic formulation limitations do not apply if the prescriber has certified that a particular brand is medically necessary and has obtained the prior authorization or if MHCP prefers the brand formulation over the generic.

Early-Refill Override and Authorization Requests

Refer to the Prospective Drug Utilization Review and Prior Authorization chapters of the [Prime Therapeutics Provider Manual](#) for additional information.

The MHCP Provider Resource Center cannot issue a prior authorization or early refill overrides.

Billing

Pharmacies must use their National Council for Prescription Drug Programs (NCPDP) D.0 POS (point of sale) to bill for prescription drugs. Pharmacies should not bill for drugs administered in a clinic. Refer to the [Minnesota Medicaid Version D.0 NCPDP Payer Sheet \(PDF\)](#) for specific billing instructions.

Providers are responsible to [coordinate services](#). Refer to the [Billing Policy Overview](#) section of Provider Basics for general billing information.

Bill [primary](#) health insurance plans and receive payment to the fullest extent possible before billing MHCP. Private health care coverage is primary to MHCP and must be used first and according to the rules of the specific plan. You are responsible for the following:

- Obtain prior authorization for services as required by the primary plan if applicable.
- Follow rules and protocols of the primary health plan.

Refer to the Program Setup and Coordination of Benefits chapters of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

Accepting Cash Payments

Do not accept cash payment from a member, or from someone paying on behalf of the member, for any MHCP-covered prescription drug.

A pharmacy may accept cash payment for a [noncovered](#) prescription drug if **all** of the following apply:

- The member is not enrolled in the [Minnesota Restricted Recipient Program](#)
- The pharmacist has reviewed all available covered alternatives with the member
- The pharmacy obtains an [Advance Member Notice of Noncovered Prescription \(DHS-3641\) \(PDF\)](#)
- The prescription is not for a controlled substance
- The prescription is not for gabapentin

A pharmacy may accept cash payment for a controlled substance or gabapentin only if the pharmacy has received an [Advance Member Notice of Noncovered Prescription \(DHS-3641\) \(PDF\)](#) signed by the prescriber and all criteria has been met for a member who is not enrolled in the restricted member program. MHCP will not authorize a pharmacy to accept cash if the medication requires prior

authorization or is subject to a quantity limit and the prescriber has not attempted to obtain the prior authorization or authorization to exceed the quantity limit. MHCP will authorize cash payment if the pharmacy and member complete their sections of the DHS-3641 and the prescriber also confirms the following:

- Covered alternatives are not viable options for the member
- The prescriber is aware that he or she is seeking authorization for the pharmacy to charge the member for the medication
- The prescriber is aware of the last time the medication was filled for the member, if applicable
- The prescriber attests that allowing the member to purchase the medication is medically necessary

The prescriber must sign the DHS-3641, send the completed form to the pharmacy and retain a copy of the completed form in the member's medical record. The pharmacy must also retain a copy of the completed form as documentation of approval from MHCP to accept cash payment on the date of service. The completed DHS-3641 is authorization from MHCP to accept cash payment on the date of service; you do not need to submit a copy to MHCP, unless requested. The prescriber or pharmacy does not need to call MHCP for additional authorization.

If a member's MHCP [eligibility](#) status is in question and the member offers cash payment for prescriptions, the pharmacy must verify eligibility through MN-ITS or the Eligibility Verification System (EVS). If the person does not have coverage through MHCP, you may charge that person and accept cash as payment. If the member is covered by MHCP, do not accept cash payment from the member for the prescription if he or she is enrolled in the restricted member program.

Online Claims Screening (ProDUR)

Federal law requires providers to conduct prospective drug utilization review for medications dispensed to MHCP members. Refer to the Prospective Drug Utilization Review chapter of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

MN-ITS

[MN-ITS](#) is a no-cost online DHS web-based HIPAA-compliant billing, inquiry and communication tool. Computer and internet access are required. For more information about using MN-ITS, refer to the following:

- Refer to this [MN-ITS User Guide](#) to bill individual claims for [Equipment and Supplies](#) and services requiring the use of a HCPCS code.
- Refer to [Basic Instructions](#) to submit professional (837P) claims.

Clozapine Case Management Services

Use HCPCS code G9012 for case management service for the specialized care management service required to ensure the safety of the members receiving clozapine. Submit claims using MN-ITS Professional (837P). Clozapine management services consist of the following:

- Ensuring the required white blood cell (WBC) and absolute neutrophil count (ANC) testing for clozapine occurs at a frequency in accordance with the rules set forth in the "black box" warning of the manufacturer's package insert. (Food and Drug Administration labeling requirements)
- Providing and documenting coordination of care with the member's provider(s) for the purposes of:
 - Obtaining blood test results in a timely fashion
 - Ensuring the member receives medications as scheduled or stops therapy when required (and is subsequently and appropriately monitored)
 - Helping transition and coordinate the use of the clozapine formulations and clozapine management services between different care locations

- Meeting the requirements of the drug manufacturers' clozapine registries as well as additional record keeping requirements that include maintaining:
 - Copies of the physician's prescription for clozapine and clozapine management
 - Copies of laboratory results of WBC counts and ANC
 - Signed and dated notes documenting all clozapine management services

Billing for Clozapine Case Management

Refer to the following when billing for clozapine case management:

- Submit claims for clozapine management only as often as a member's WBC count and ANC are tested, even if clozapine is more frequently dispensed. The prescriber determines frequency of WBC and ANC tests.
- MHCP allows a single fee for clozapine management services per one date of service (DOS).
- For members who have weekly WC count and ANC tests, submit claims for one DOS per calendar week.
- For members who have biweekly or monthly WBC and ANC tests, submit claims for one DOS per two weeks or one DOS per month.

Note: The blood test is separately reimbursable for a Medicaid-certified laboratory.

Billing for Administering Injectable Antipsychotics and Vivitrol

Pharmacies can bill for the administration of injectable antipsychotics and for administering the medication Vivitrol for fee-for-service members as medical claims, not pharmacy claims. Pharmacies must bill for the drug component and the administration on an 837P claim form.

Medical Supplies and Equipment

Pharmacies that dispense medically necessary medical supplies and equipment, such as enteral nutritional products, incontinence products, gauze pads or walkers, must submit the claim to MHCP using the HCPCS code set and, in some cases, a modifier. A modifier further defines the product or service by indicating for example: if the item is new, a rental or being repaired, if the product or service warrants additional pricing, etc.

For diabetic supplies, please refer to the Drug Information and Edits chapter of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

Contact your software vendor or billing intermediary for their specific billing instructions for medical supplies and equipment.

Use [MN-ITS](#) 837P to bill for medical supplies and equipment. Refer to the [MN-ITS User Guide](#) for Durable Medical Equipment (DME), Medical Supplies, Prosthetic and Orthotic Service for billing instructions.

Submit authorization requests with the required documentation to the [authorization](#) medical review agent. Submit authorization requests through [MN-ITS](#), fax or U.S. Postal Service.

Refer to [Equipment and Supplies](#) in the MHCP Provider Manual for coverage criteria and billing instructions.

National Drug Codes (NDC)

All pharmacy claims submitted to DHS must identify the 11-digit NDC printed on the stock container in which the drug was purchased.

A pharmacy may not dispense a repackaged drug and then bill DHS using the original manufacturer's NDC.

Prescribing Provider NPI Numbers

All pharmacy claims must include the National Provider Identifier (NPI) of the prescribing provider, or in certain rare situations, an alternate NPI as follows:

- Use the NPI of an MHCP-enrolled supervising physician if the NPI of the prescribing provider is not available because they are an intern or resident.
- Use the NPI of the dispensing pharmacy as the prescribing provider when the pharmacist has prescribed OTC medications.

Refer to the Drug Information and Edits chapter of the [Prime Therapeutics Provider Manual \(PDF\)](#) for additional information.

Drug Formulary Committee

The Drug Formulary Committee (DFC) reviews and recommends which drugs require authorization. The DFC also reviews over the counter (OTC) drugs for which coverage is optional under federal and state law (for possible inclusion in the Medicaid fee-for-service formulary).

Additional information about the Drug Formulary Committee is available on the [committee's webpage](#).

Drug Utilization Review Board

The Drug Utilization Review (DUR) Board selects specific drug entities or therapeutic classes to target for provider and member educational interventions, and provides guidelines for their use.

Additional information about the Drug Utilization Review Board is available on the [board's webpage](#).

Definitions

Actual Acquisition Cost: The commissioner estimates the Actual Acquisition Cost as the National Average Drug Acquisition Cost. For multisource drugs, the Actual Acquisition Cost is the National Average Drug Acquisition Cost of the generic drug.

Compounded Prescription: A prescription prepared in accordance with [Minnesota Rules, 6800.3100](#).

Drug Efficacy Study Implementation (DESI) Drugs: Federal Food and Drug Administration (FDA) designations related to "substantial evidence" of effectiveness. Drug manufacturers introduced DESI drugs to the market between 1937 and 1962, during which time manufacturers did not have to show that their products were effective. Federal Medicaid statutes prohibit state Medicaid agencies from paying for these drugs.

Dual Eligibility: Individuals entitled to Medicare Part A/Part B and eligible for some form of Medicaid benefit.

Federal Drug Rebate Program: Established by the federal statute referred to as OBRA 90, requires manufacturers to sign a rebate agreement with the federal Centers for Medicare and Medicaid Services (CMS) in order to have their products covered for Medicaid members. State Medicaid agencies administer the program and collect rebates from the manufacturers.

Generically Equivalent Drug: A drug product that, in the pharmacist's professional judgment, is safely interchangeable with the prescribed drug.

Legend drug: A drug that is required by federal law to bear one of the following statements: "Caution: Federal law prohibits dispensing without prescription" or "Rx only."

Maintenance Drug: A prescribed drug that a member uses for a period greater than two consecutive months.

Maximum Allowable Cost (MAC): The highest drug ingredient reimbursement that DHS allows for drugs designated by the Centers for Medicare and Medicaid Services (CMS) or by DHS as multisource.

National Average Drug Acquisition Cost (NADAC): Prices are determined based on CMS's monthly surveys of retail pharmacies to determine average acquisition cost to covered outpatient drugs.

Pharmacist: An individual with a currently valid license issued by a state board of pharmacy to practice pharmacy.

Pharmacy: An established place of business, licensed by a state board of pharmacy, in which prescriptions, drugs, medicines, chemicals and poisons are prepared, compounded, dispensed, vended or sold to or for the use of patients and from which related clinical pharmacy services are delivered.

Pharmacy Service: The dispensing of drugs, counseling, drug utilization and regimen review and other activities as described in [Minnesota Statutes, 151.01](#), subdivision 27, or as performed by a dispensing physician.

Point of Sale (POS): Software used to submit a pharmacy claim

Prescribed Drug: A drug as defined in [Minnesota Statutes, 151.01](#), subdivision 5. Ordered by a practitioner who is licensed to prescribe.

Usual and Customary: The Usual and Customary price means the lowest price charged to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or the pharmacy chain.

Legal References

[Minnesota Statutes, 151](#) (Pharmacy)

[Minnesota Statutes, 151.01](#), subdivisions 5, 27 and 49 (Definitions)

[Minnesota Statutes, 256B.0625](#), subdivision 55 (Payment for noncovered services.)

[Minnesota Rules, 6800](#) (Pharmacies and Pharmacists)

[Minnesota Rules, 6800.2700](#) (Return of Drugs and Devices)

[Minnesota Rules, 6800.3100](#) (Compounding and Dispensing)

[Minnesota Rules, 9505.0175](#), subpart 49 (Usual and customary)

[Minnesota Rules, 9505.0340](#) (Pharmacy Services)

[Minnesota Rules, 9505.5000 to 9505.5105](#) (Prior Authorization Applicability)

[Code of Federal Regulations, title 42, section 440.120\(a\)](#) (Prescribed drugs, dentures, prosthetic devices, and eyeglasses)

[Title XIX, Section 1927](#) of the Social Security Act (Payment for Covered Outpatient Drugs)