

# Clinical Policy: Fill Limits

Reference Number: WA.PHAR.141

Effective Date: 08/2024

Last Review Date:

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## Description

Outline criteria for when a medication may be dispensed more than allowable fill limit per month as defined by the Washington State Health Care Authority (HCA).

## Policy/Criteria

- I. Coordinated Care of Washington, Inc. will allow medication to be dispensed more than allowable fill limit per month under the following circumstances:
  - a) The prescription is written for short days-supply because the prescriber is monitoring the member's supply.
  - b) A member needs a take-home supply of medication for school, camp, or skilled nursing facility.
  - c) For Lost, Stolen, Spilled or Broken Medication Requests, please refer to Coordinated Care's CC.PHAR.05 Lost, Stolen, Spilled or Broken Medication Addendum
  - d) For Vacation Overrides, please refer to Coordinated Care's CC.PHAR.19 Vacation Overrides Addendum
  - e) For any other circumstance, provider must acknowledge monitoring and provide justification that it is medically necessary for needing more than the allowable fill limit per month.

II. If **a** or **b** is met, pharmacy may enter PA Override type 8 with PAMC code 28011004444 to override fill limit rejection at Point of Sale.

**Approval Duration:** 12 months or duration of request, whichever is less.

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy Created	07/29/2024	08/20/2024

## References

1. [Prescription Drug Program Billing Guide \(wa.gov\)](#)

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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