cfri Center for Financing Reform and Innovation

Medicaid Coverage of Medications to Reverse Opioid Overdose and Treat Alcohol and Opioid Use Disorders

SAMHSA
Substance Abuse and Mental Health Services Administration

Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Financing Reform and Innovation (CFRI) under contract number HHSS283201700031I/75S 20322F42003 with SAMHSA, U.S. Department of Health and Human Services (HHS). Nadine Benton served as contracting officer representative.

Disclaimer

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. Nothing in this document constitutes a direct or indirect endorsement by SAMHSA or HHS of any non-Federal entity's products, services, or policies, and any reference to non-Federal entity's products, services, or policies should not be construed as such.

Electronic Access

This publication may be downloaded from http://store.samhsa.gov.

Recommended Citation

Substance Abuse and Mental Health Services Administration: Medicaid Coverage of Medications to Reverse Opioid Overdose and Treat Alcohol and Opioid Use Disorders. Publication No. PEP22-06-01-009. Rockville, MD: Center for Substance Abuse Treatment. Substance Abuse and Mental Health Services Administration, 2024.

Originating Office

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, HHS Publication No. PEP22-06-01-009. Released 2024.

Nondiscrimination Notice

SAMHSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). SAMHSA does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

Publication No. PEP22-06-01-009
Released 2024

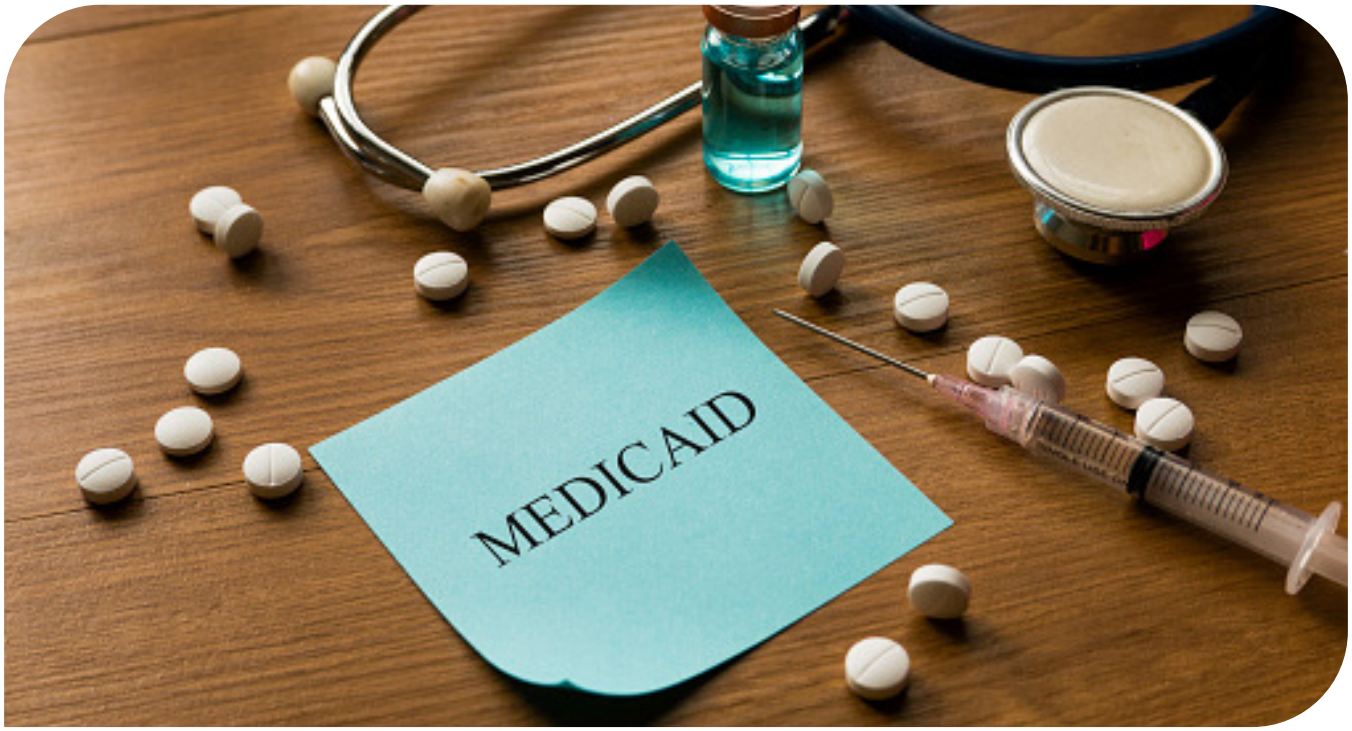
Table of Contents

Executive Summary

Medication is an essential component in the evidence-based treatment of substance use disorders (SUDs). The U.S. Food and Drug Administration (FDA) has approved several medications for the treatment of alcohol use disorder (AUD), opioid use disorder (OUD), and reversal of opioid overdose, all of which are covered by Medicaid. However, there remains a significant gap between Medicaid beneficiaries who need SUD treatment and those who receive it. It is critical that states and jurisdictions have comprehensive coverage of these medications and approaches to make them accessible to individuals who need them.

This report presents information on the availability of, and access to, medications for treating ongoing AUD and OUD and reversing an opioid overdose within state Medicaid plans. This work builds on two prior Substance Abuse and Mental Health Services Administration (SAMHSA) reports. The current report provides an update on the present state of coverage and availability of these treatments to Medicaid beneficiaries. It also includes examples of innovative efforts to increase access to medications for the treatment of SUDs.

Since 2018 there has been growth in the number of states covering nearly every drug for the treatment of SUDs. Furthermore, many states have reduced limitations associated with prescribing medications for treating OUD. A number of policies and regulations impact and support access to and coverage of these medications. For example, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (the SUPPORT Act), which became law on October 24, 2018, requires that state Medicaid programs cover all FDA-approved medications for treating OUD. States have made progress in expanding access to medication treatment through regulatory vehicles that encourage innovation and coverage, such as Section 1115 Demonstration Waivers. A review of publicly available sources such as Medicaid and managed care websites found that large proportions of state fee-for-service (FFS) Medicaid programs and Medicaid managed care organizations (MMCO) cover medications to treat AUD and OUD.



This report is divided into four chapters:

- Chapter 1 provides background on SUDs and medications used to treat AUD, OUD, and reverse opioid overdose. It also highlights Medicaid's role in providing access to these medications.
- Chapter 2 reviews policies and regulations that affect coverage of and access to medications for AUD, OUD, and opioid overdose.
- Chapter 3 describes Medicaid coverage of these medications in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.
- Chapter 4 provides examples of the ways that states are using innovative financing and delivery models to increase access to OUD medications for Medicaid beneficiaries. Each of the five innovative models highlighted in this report aims to extend medication access to underserved Medicaid populations, such as those residing in rural areas, American Indian/Alaska Native communities, and individuals recently released from incarceration. While the models featured in this report are designed to address OUD, the innovations have the potential to also increase treatment coverage for people with all types of SUDs by improving access to services.

This updated report highlights promising improvement in Medicaid coverage of vital medications, but it also shows the need for additional efforts to increase access to these medications to combat the SUD crisis nationwide.

CHAPTER 1

Introduction

Substance use disorders (SUDs) are characterized by the recurrent use of alcohol and other drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[1]

Alcohol use disorder (AUD) is a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences.[1]

Opioid use disorder (OUD) is characterized by a problematic pattern of opioid use that causes significant impairment and distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, and use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria.[4]

Substance use disorders (SUDs) are complex and chronic conditions that are associated with a wide range of negative health impacts and social consequences. Long-term treatment and care is necessary to support individuals seeking to recover from SUD.[5] The increasing prevalence and severity of SUDs in the United States has taken an enormous toll on the public health system, and the COVID-19 pandemic has exacerbated the problem even further.[6,7] Overdose deaths rose by over 30 percent between 2019 (more than 70,000 deaths) and 2020 (nearly 94,000 deaths) and 15 percent between 2020 and 2021 (nearly 107,000 deaths).[8] In addition, every year more than 140,000 individuals die in the United States due to conditions associated with alcohol misuse and alcohol use disorder (AUD).[9]

The economic costs associated with SUDs in the United States are also staggering. Estimates of the annual costs related to opioid use disorder (OUD) and overdose deaths have steadily increased from $504 billion in 2015[10] to $1.02 trillion in 2017[11] and $1.5 trillion in 2020.[7] The annual costs associated with AUD are estimated to be $249 billion.[12]

This report presents information on the availability of and access to medications for treating AUD and OUD and reversing opioid overdose in Medicaid.

This work builds on two prior SAMHSA-funded reports[2,3] to provide an update on the current state of coverage and availability of these treatments to Medicaid beneficiaries and to highlight innovations that increase access to medications for SUD.

Medication is a key component in the comprehensive approach to treatment of OUD and AUD.[13,14] A number of medications are approved by the FDA to treat these disorders as well as opioid overdose, and a strong evidence base supports their effectiveness. Those who receive medications for OUD are more likely to engage in other services[15] and are less likely to experience subsequent overdose or use of acute health care[16] than those who participate in other types of treatment. Use of medications for treatment of AUD is also associated with reduced recurrence and improved treatment outcomes.[17] Access to naloxone, a medication that reverses opioid overdose, is an effective means to combat mortality related to OUD.[18]

Medicaid is the single largest payer of behavioral health services in the United States. As of April 2023, more than 87 million Americans were enrolled in Medicaid.[19] Approximately 20.6 percent of Medicaid beneficiaries age 12 and older have a SUD compared to 14.8 percent of privately insured individuals.[20] Given the impact of SUDs and the high rates of SUDs among Medicaid beneficiaries, it is imperative to understand Medicaid coverage for treating AUD, OUD, and reversing opioid overdose with medication. It is also important to examine state Medicaid policies and other policies and practices related to these medications.

The FDA has approved several medications for the treatment of AUD, OUD, and reversal of opioid overdose (see Table 1).

Medications to Treat Alcohol Use Disorder

Medicaid covers three approved medications to treat AUD: acamprosate; disulfiram; and naltrexone.[21] These medications have been shown to help individuals maintain abstinence, reduce the risk of relapse, and decrease alcohol consumption.

Although there are also medications for life-threatening AUD intoxication or withdrawal, the review in this report does not include a focus on these medications because they are not used to treat the underlying AUD.

Medications to Treat Opioid Use Disorder

Approved medications that are covered by Medicaid for the treatment of opioid use disorder (MOUD) include: methadone; buprenorphine; and naltrexone. Methadone and buprenorphine are both opioid agonists, while naltrexone is an opioid antagonist.[22]

Table 1. Medications Used to Treat Alcohol and Opioid Use Disorders

Use	Generic Name	Brand name(s)
AUD	disulfiram	Antabuse™ (oral)
	acamprosate	Campra™l (oral)
	naltrexone	Revia™ (oral) Vivitrol™ (extended-release injection)
OUD	buprenorphine	Sublocade™ (extended-release injection)
	buprenorphine-naloxone naltrexone	Suboxone™ (sublingual film) Zubsolv™ (sublingual tab) Vivitrol™ (extended-release injection)
	methadone	
Opioid-related overdose	naloxone nalmefene	Narcan™, Kloxxado™ (nasal spray), Opvee™ (nalmefene)

Medications to Reverse Opioid-Related Overdose

The FDA has approved naloxone, a medication that rapidly reverses opioid overdose. Naloxone effectively reverses and blocks the effects of opioids by binding to opioid receptors. Its effects begin within minutes of administration and last for 30 to 90 minutes.

In March 2023, the FDA approved Narcan 4 mg nasal spray for over-the-counter purchase and have since approved another non-prescription formulation of naloxone.[23] Medicaid continues to cover naloxone obtained with a prescription at low or no cost.[23] In May 2023, the FDA also approved the first nalmefene hydrochloride nasal spray. Nalmefene is an opioid receptor antagonist used to reverse opioid overdose and is available by prescription.[24]

Substance Use Disorder Among Medicaid Beneficiaries

Medicaid covers some of the most vulnerable populations in the United States. Underserved populations, such as racial and ethnic minorities, people with disabilities and chronic illness, and those in rural areas, are overrepresented on Medicaid beneficiary rolls.[25-27] The 2021 National Survey on Drug Use and Health found that 20.6 percent of Medicaid beneficiaries aged 12 years and older meet diagnostic criteria for a SUD.[20] However, only 2.8 percent of Medicaid beneficiaries aged 12 years and older received treatment for alcohol or illicit drugs at a specialty facility in the past year.[20] The disparity between these figures suggests that many Medicaid beneficiaries with SUDs may not be receiving needed treatment.

There are various barriers that may limit access to SUD treatment for Medicaid recipients. Many Medicaid beneficiaries face difficulties accessing available SUD treatment due to limited transportation resources and lack of accessible providers.[28,29] Other factors include cultural barriers and lack of trust in health care institutions.[30] Stigma also poses a significant barrier to seeking and completing treatment for SUD.[20,31] Negative attitudes and stereotypes about SUDs held by family members, friends, neighbors, colleagues, and health care providers can further stigmatize individuals and act as barriers to obtaining treatment.[32]

Research Questions

1. What policies and regulations affect access to medications for AUD, OUD, and opioid overdose?
2. What are Medicaid coverage policies for medications used to treat AUD and OUD or reverse opioid overdose in the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands?
3. What are some innovative approaches currently being taken to increase access to medication to treat SUD and reverse opioid overdose for Medicaid beneficiaries?

CHAPTER 2

Policies and Regulations Affecting Access to Medications for Alcohol Use Disorder, Opioid Use Disorder, and Opioid Overdose

A number of national policies and regulations impact the prescription and provision of medications for AUD, OUD, and opioid overdose among Medicaid beneficiaries. This chapter reviews policies that improve access to medication for AUD and OUD, policies that address barriers to accessing these medications, policies that pose challenges for SUD treatment and medication access, and facility licensing and regulation policies relevant to the provision of medications for AUD and OUD.

Policies Improving Access to Medication for AUD and OUD

SUPPORT Act and Medicaid Drug Rebate Program

The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requires that state Medicaid programs cover all FDA-approved medications for treating OUD.[33] It also requires state Medicaid programs to cover OUD counseling services and other behavioral therapy. States are only exempt from these rules when they can demonstrate provider shortages. These requirements are in effect through September 2025, after which they will lapse if not renewed by Congress.

In addition, under the Medicaid Drug Rebate Program, pharmaceutical manufacturers enter negotiated agreements with Medicaid in which manufacturers rebate a portion of Medicaid payments for covered medications back to states, which then share a portion of those rebates with the federal government. This amounts to a discount intended to reduce barriers to treatment among Medicaid beneficiaries and other vulnerable populations. The combination of the SUPPORT Act and the Medicaid Drug Rebate Program leaves states with considerable flexibility in determining how to cover medications for AUD and OUD[34] in accordance with appropriate medical standards, some of which are established in the Code of Federal Regulations (CFR).[35] States and providers either individually or simultaneously negotiate a supplemental layer of rebates with manufacturers to further lower the prices of certain medications. Selective labeling of drugs as preferred and requiring prior authorization (PA) can be used to influence prescribers to use specific medications.

Variation in supplemental rebate agreements can result in state-level differences in whether generic or preferred brands of a specific medication are prescribed.[34,36] State Medicaid agencies have drug utilization review programs to establish standards for the safe and appropriate use of prescribed medications.[34,36] These standards can include quantity limitations that reduce the risk of misuse and guidelines for prescription. While the SUPPORT Act leaves states with less discretion to determine coverage for MOUD than previously, these considerations support evidence-based practice in the treatment of OUD.

Affordable Care Act and Medicaid Expansion

The Patient Protection and Affordable Care Act of 2010 (ACA) contains a provision for expanding Medicaid eligibility. Designed to encourage coverage of lower-income Americans, Medicaid eligibility was extended to adults under 65 with incomes up to 138 percent of the federal poverty level. Medicaid expansion is associated with an increase in the use of medication to treat those referred to SUD treatment facilities through the criminal justice system,[37] rapid increases in buprenorphine-waivered providers from 2014 to 2017,[38] and increased breadth of buprenorphine-prescriber networks in MMCOs.[39] Not all states have adopted expansion and the additional funding accompanying it. During the COVID-19 public health emergency, additional reimbursement for states and flexibility regarding continuous enrollment in Medicaid increased Medicaid enrollment. However, with the end of the public health emergency on May 11, 2023, states now must redetermine Medicaid eligibility for enrollees, with this 'unwinding' likely to decrease enrollment of Medicaid patients, including those with SUDs.[40,41]

Medicaid 1115 SUD Waivers

Waivers granted under Section 1115 of the Social Security Act allow states additional flexibility when designing pilot or experimental demonstration changes to their Medicaid programs. The Centers for Medicare & Medicaid Services (CMS) created an opportunity under the authority of Section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the continuum of care for beneficiaries with SUDs. CMS requires 1115 SUD Demonstrations to meet American Society of Addiction Medicine (ASAM) criteria or other nationally recognized, evidence-based SUD program standards.[42] According to the Medicaid and CHIP Payment and Access Commission, as of March 2023, 33 states and the District of Columbia have approved 1115 SUD Waivers and three states have waiver applications pending CMS approval.[42]

Policies Addressing Barriers to Accessing Medication for AUD, OUD, and Opioid Overdose

Limitations and regulations on prescribing medications for AUD, OUD, and opioid overdose can act as barriers to accessing them. In recent years, federal and state policymakers have taken a variety of steps to provide exemptions to or relax policies and regulations around prescribing these medications, supporting broader access.

Exemptions and Waivers for Prescribing Buprenorphine

Buprenorphine is a Drug Enforcement Administration (DEA) Schedule III medication with a broader safety profile than those medications in Schedule II. On December 29, 2022, President Biden signed the Consolidated Appropriations Act, 2023 into law, which included the immediate repeal of the Drug Addiction Treatment Act (DATA 2000) Waiver requirement. The Consolidated Appropriations Act, 2023 removed previous federal requirements for practitioners to apply for a special waiver to the Controlled Substances Act in order to prescribe buprenorphine for the treatment of OUD.[43,44] It also removed other federal requirements associated with the waiver such as discipline restrictions, limits on the number of patients a practitioner can treat, and certification related to the provision of counseling. Practitioners who wish to prescribe buprenorphine for the treatment of OUD no longer have to submit a Notice of Intent, and all prescribers whose current DEA registration includes Schedule III authority can prescribe this medication, subject to applicable state laws. Effective June 27, 2023, the same legislation mandates that new or renewing DEA registrants complete at least 8 hours of training on SUD upon submission of their application or renewal.[45] It is important to note that because this change is relatively recent in relation to this report, it is unclear how it will impact coverage of or access to MOUD medications.

Exemptions and Waivers for Prescribing Methadone

Methadone is a DEA Schedule II medication used to treat both pain and OUD. For the treatment of OUD, methadone can only be ordered by a practitioner working in an opioid treatment program (OTP) certified by SAMHSA and registered as a narcotics treatment program with DEA. In March 2020, SAMHSA issued an exemption that permitted state regulatory authorities to request blanket exceptions to allow patients to take home more doses of methadone;[46] 43 states and the District of Columbia did so. With this flexibility, SAMHSA allowed OTPs to dispense up to 28 days of take-home methadone doses to "stable" patients for the treatment of OUD, and up to 14 doses of take-home methadone for "less stable" patients who the OTP believes can safely handle this level of take-home medication. In 2021, SAMHSA extended the methadone take-home guidance. This guidance was reissued in 2023 for the period of 1 year past the end of COVID-19 public health emergency (May 11, 2024) or until such time that the Department of Health and Human Services (HHS) publishes the 42 CFR Part 8 final rule, whichever occurs sooner.[46,47]

Naloxone Access Laws and Policies

States have passed laws and taken other administrative actions to remove barriers and increase access to naloxone. As of January 2023, all 50 states, the District of Columbia, and Puerto Rico have at least one type of law designed to increase naloxone access.[48] Thirty-three states have a statewide standing order (meaning medication can be dispensed without an individual prescription) for naloxone, and 14 states have policies allowing a pharmacist and prescriber to enter into a standing order agreement.[48] Twenty states have requirements to co-prescribe naloxone with an opioid to persons at high risk for overdose or based on opioid prescription dose. Forty-eight states, the District of Columbia, and Puerto Rico provide immunity from civil and/or criminal liability to laypeople administering naloxone to people experiencing an overdose.[48] The majority of states (47 states, the District of Columbia, and Puerto Rico) provide some level of immunity to naloxone prescribers and dispensers (46 states and the District of Columbia).[48] As of March 2023, naloxone is available over the counter. Although this means that this vital life-saving medication is now accessible to anyone without the need for a prescription, naloxone may also become less affordable for Medicaid beneficiaries, as not all state Medicaid programs cover over-the-counter medications.[49]

Expanded Access to SUD Medications in Telehealth

Telehealth is a powerful tool by which electronic information and telecommunication support remote clinical health care, patient and professional health-related education, health administration, and public health. From 2016 to 2019, the proportion of SUD treatment facilities offering telehealth services increased from 13.5 percent to 17.4 percent, and adoption was higher in rural areas.[50] Despite this growth, telehealth was still used in less than 1 percent of mental health and SUD-related visits.[51] The COVID-19 pandemic caused an unprecedented increase in telehealth use, as health care providers responded to social distancing guidance.[52] By October 2020, 41 percent of SUD-related visits were conducted using telehealth.[53] Practitioners could, for the first time, prescribe buprenorphine via telehealth visits. Nearly every state expanded access to telehealth for mental health and treatment of SUD during this period.[54] Data shows that the expansion of telehealth reduced treatment dropout and increased MOUD treatment engagement.[55] Despite the COVID-19 public health emergency expiring on May 11, 2023,[52] work is underway to retain some of the flexibilities implemented during the COVID-19 pandemic.[56]

Policy Challenges to Accessing Medication for AUD and OUD

Billing Requirements

Most state Medicaid agencies have been increasing reimbursement rates for treatment related to SUD,[57] and the SUPPORT Act contains provisions to extend Medicare Part B coverage to hospital-provided outpatient OTP services and add revised codes for these and related services.[58] However, challenges remain. For example, federal Medicaid law enables separate same-day reimbursement of medical and behavioral health services and makes federal matching funds available for states that allow two billings. Despite this, reimbursement for both a primary care and a behavioral health visit on the same day is not allowed in some states.[59] Other states may limit reimbursement based on the provider setting.[59] Licensure requirements for SUD counselors can also restrict the ability to provide and bill for SUD-related services because they often link individuals to clinicians who can prescribe medications to treat AUD and OUD.[60] Federal regulations have been revised to reduce the role of billing procedures in restricting access and create billing procedures that reflect and reinforce the goal of integrated care, but challenges based on varying state laws still remain.

Data Exchange Regulations

Title 42, Part 2 of the CFR prohibits certain types of treatment programs from disclosing that patients have SUD without patient consent or court order. These regulations and the Health Insurance Portability and Accountability Act (HIPAA) are designed to protect the privacy of those with SUD. However, they can also limit the ability for providers to share essential treatment information and may act as a barrier to SUD treatment. The HHS has proposed changes in 42 CFR 2 to better align Part 2 with HIPAA as required by Section 3221 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).[61,62] A final Part 2 rule was in process at the time this report was completed (October 2023). Changes introduced by this rule may ease data sharing and promote integrated care and care coordination for SUD treatment services.

Professional Licensure and Certification

State health care providers are highly regulated and must meet a wide variety of licensure and certification requirements. Research from the HHS, Office of the Assistant Secretary for Planning and Evaluation (ASPE), identified multiple barriers to entry into the field of SUD treatment.[60,63,64] Barriers included: **1)** absence of defined career ladders and low reciprocity of certification/licensure requirements across states, **2)** lack of common educational requirements for all SUD practitioners, **3)** uneven availability or convoluted licensure in many states, **4)** dearth of pathways to independent practice, **5)** insufficient insurance coverage, and **6)** low reimbursement rates.[60,63,64] This research suggests that the adoption of uniform minimum SUD education requirements as a condition of providing SUD treatment counseling for independent practitioners, coupled with a mechanism for independent billing, may help address the workforce shortage that is one of the largest barriers to SUD services. Since the ASPE reports were published in 2019, some of these barriers have been addressed. For example, as of June 27, 2023, all practitioners registered with the DEA will be required to meet an 8-hour training requirement for SUD identification and treatment.[65] Practitioner training is associated with an increased likelihood of prescribing medications for AUD and OUD.[66] The most important recent development relates to removing the DATA 2000 Waiver requirement, which could significantly expand the number of providers eligible to prescribe buprenorphine.

Facility Licensing and Certification Policies Regarding the Use of Medication for AUD and OUD

Efforts are ongoing to improve the integration of treatment for SUDs with other components of the health care system, including both physical and mental health, by providing pathways for certification and licensure for Certified Community Behavioral Health Clinics (CCBHCs) and Federally Qualified Health Centers (FQHCs) and expanding the reach of OTPs by encouraging the integration of medication units in other settings. Certification requirements for CCBHCs include care coordination with other providers, staffing, and scope of services,[67] and FQHCs provide a range of services at single locations. However, OTPs are the only outpatient settings in which methadone can be legally provided to patients needing treatment for OUD.

Certified Community Behavioral Health Clinics

There are over 500 CCBHCs, 82 percent of which provide at least one form of MOUD.[68] CCBHCs provide a comprehensive array of mental health and substance use services, ensuring delivery of coordinated health care through case managers who guide clients within CCBHCs and other community service providers known as designated collaborating organizations.[69] CCBHCs are required to serve anyone who requests care for mental health or substance use without restriction based on ability to pay, insurance status, or place of residence. All CCBHCs can provide assessment and justification for prescription medication, and certification requirements include the addition of MOUD to the continuum of care that CCBHCs offer. Thus, CCBHCs may prescribe all medications used to treat SUDs, including methadone, if the CCBHC is also a licensed OTP.

Federally Qualified Health Centers

More than 1,400 FQHCs are funded by the Health Resources and Services Administration (HRSA), an agency of HHS. Located in medically underserved urban and rural areas, they provide access to integrated behavioral health care for individuals who might have difficulty accessing appropriate services due to limited public transportation services, provider shortages, and lack of health insurance. Under federal law, state Medicaid programs are required to reimburse services provided by FQHCs. In 2021, more than 30 million people relied on a HRSA-funded health center for affordable and accessible primary health care.[70] Approximately 93 percent of health centers were able to provide on-site mental health treatment services to those in need through care delivery systems that integrate primary and behavioral health care.[71]

Physicians, nurse practitioners, psychologists, and social workers at FQHCs also may treat Medicaid beneficiaries with SUDs. FQHCs identified over 1 million individuals with SUD, and approximately 95,000 of these individuals received MOUD. SUD services were available at 67 percent of health centers.[71] Collaborative approaches to health care, in which the relevant specialists address a range of health concerns in a coordinated manner, have demonstrated success in retaining individuals receiving medications for SUDs compared to other approaches.[72] Integrated buprenorphine treatment programs in FQHCs resulted in improved treatment retention compared to other established settings.[73] FQHCs also make innovative use of telehealth options. The relaxation of face-to-face provider prescribing requirements for controlled substances during the COVID-19 public health emergency facilitated this shift, making integrated services, such as MOUD, more accessible. With the end of the public health emergency, many state Medicaid programs will continue offering remote visits for behavioral health care.[74]

Opioid Treatment Programs

Treatment of OUD with methadone may only occur in a certified OTP, with certain limited exceptions. OTPs may also dispense buprenorphine and naltrexone while providing psychosocial and case management services. The ongoing expansion of access to OTPs is crucial to ensure access to treatment. OTPs are regulated by the DEA, SAMHSA, and relevant state agencies.[75] Access to OTPs is inconsistent due to a number of factors such as differing population needs, geographic distribution, state regulations, and funding. Federal and state requirements for establishing new OTPs protect patient confidentiality and include security procedures for medication management.

Medicaid is mandated to cover methadone, buprenorphine, and naltrexone for OUD,[76] but as recently as 2020, 17 percent of OTPs did not accept Medicaid as a form of payment for SUD treatment.[1] It has been hypothesized that gaps in Medicaid coverage for OTP services, and challenges meeting Medicaid reimbursement standards, may explain this coverage gap.[75] Medicaid acceptance at SUD treatment providers has also been linked to the generosity of state Medicaid benefits.[28] It is necessary to update inconsistencies in payment structures for MOUD through OTPs to increase Medicaid payment. This will help maximize the impact of new rules recently proposed by SAMHSA to increase access to and retention in MOUD.[47]

There are two primary means of improving access to MOUD through OTPs

- **Establishment of new OTPs.** In 2018, 80 percent of U.S. counties did not have OTPs available,[77] a mismatch of OTP access with high rates of OUD that is especially acute in the Southeast.[28] Many states have regulatory requirements that pose barriers to the establishment of new OTPs. These include zoning restrictions and requiring pharmacy registration/licensure, applying general pharmacy regulations, or hiring a pharmacist.[77] Also, OTPs, like many treatment facilities, may experience substantial difficulties finding qualified staff.[1] Perhaps most significantly, ongoing community resistance to the presence of SUD treatment facilities constitutes a pervasive barrier to the establishment of OTPs.[78,79]
- **Integration with other health care providers.** ACA included a provision for Medicaid to reimburse providers for coordinated health care for Medicaid enrollees in behavioral health care settings.[80] This development helps address the fragmented delivery of health care that occurs when OTPs are not integrated with other health care providers. Medicaid now reimburses OTP-based health homes that provide patients with coordinated care. This tool has been used in innovative ways to offer integrated care to beneficiaries with OUD. Maryland, Rhode Island, and Vermont have each implemented a coordinated care approach based on the health home option.[7]

CHAPTER 3

Review of Medicaid Coverage and Availability of Medications for Alcohol Use Disorder, Opioid Use Disorder, and Opioid Overdose

This chapter summarizes Medicaid coverage policies for medications used to treat AUD and OUD or reverse opioid overdose in the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Publicly available sources were assessed to determine state and territory Medicaid coverage and limitations for both FFS and MMCO plans. A secondary aim was to determine how easily beneficiaries and providers could access this crucial information.

In this chapter, bar graphs depict counts of states in which medications are covered, preferred, and subject to prior authorization or quantity limitations for the following medications:

- Acamprosate and disulfiram
- Naltrexone (oral and extended-release injection)
- Buprenorphine (oral monoproduct and extended-release injection)
- Buprenorphine-Naloxone
- Methadone
- Naloxone

Methodology

To assess whether a medication used to treat AUD or OUD, or reverse opioid overdose is covered within a state or territory by Medicaid, the following resources were reviewed: state-level Medicaid Drug Utilization Data; state Medicaid FFS and MMCO formularies; state preferred drug lists (PDLs); the national master Medicaid rebate agreement; and additional sources such as state-level regulatory announcements and state plan amendments. A complete list of Medicaid documents and webpages used to identify medication coverage is provided in Appendix A.

For this report, if any of the source documents indicated that a given state or territory's Medicaid agency covered a medication or that a payment for that medication had been made,[81] then that medication was counted as being "covered."[82] Covered medications are typically listed in the National Medicaid Drug Rebate Program, subject to ongoing changes.[83]

Once manufacturers have a rebate agreement in effect, state Medicaid agencies are required to provide coverage of generally all medications that meet the definition of a covered outpatient drug ((1927(k)(2)) with the exception of permitted restrictions or exclusions as found in section 1927(d) of the Social Security Act.84 Not all states maintained formularies distinct from their PDL. Additionally, states may cover medications not listed in the PDL. If a medication is listed in neither the formulary nor the Medicaid Drug Utilization Data, it was counted as not covered in this report.

Sources of Data on Medicaid Coverage of AUD/OUD Medications

- **Medicaid Drug Utilization Data:** For each state, Medicaid publishes annual lists of medications and the amounts that Medicaid has paid to cover those medications for its members. This data is stratified by FFS and MMCO claims. Medications are listed according to the National Drug Code (NDC).
- **State Formularies:** Lists of all medications covered by each state Medicaid agency and any MMCOs delivering Medicaid services. (Formulary - Glossary | HealthCare.gov).
- **State PDLs:** Lists of medications with preferred drug status within each state. Each PDL only includes medications in the relevant formulary. This list serves as a means for negotiating higher supplemental rebates. Higher costs and additional limitations may be required for medications not included in the PDL (https://www.kff.org/other/state-indicator/medicaid-preferred-drug-lists/).
- **Master rebate agreement:** The national agreement between Medicaid and pharmaceutical companies determines the rates Medicaid pays for medications. The agreement is negotiated on an ongoing basis and changes annually.
- **Other sources:** Other sources of data include documentation related to specialized treatment.

To confirm coverage of a medication, each state's drug utilization data was downloaded from CMS. These data were combined with a list of NDC codes for relevant medications and NDC codes in the state data that were accompanied by an indication of payment.

Special steps were taken to identify whether a state or territory covers methadone for MOUD, which is also listed in state PDLs in its use for pain. First, state Medicaid documents were examined. Kaiser Family Foundation data describing Medicaid FFS coverage of methadone in 2022,[85] state Medicaid 1115 waiver documentation, and Medicaid state plan amendments were then consulted. If any of these sources provided evidence of methadone coverage for MOUD, then it was assumed that methadone was covered in that state.

Coverage and Availability Categories

Among covered drugs, several categories of coverage and availability were considered. These categories included whether the drug was preferred or non-preferred, whether PA was required to prescribe the drug, and whether the drug was subject to quantity limits or maximum daily doses. Research did not identify instances of limitations on drug availability related to requirements for psychosocial treatment or counseling, step therapy, or lifetime limits.

Categories of Drug Coverage and Availability

- **Drug preferred or non-preferred:** Preferred drugs are prescribed over other versions of that drug, whether generic or branded, usually due to the preferred drugs' presence in the rebate agreements between state Medicaid programs and drug manufacturers. A drug can only be preferred if it is covered. Documentation from each state's most recent FFS and MMCO PDL determined preferred drug status.
- **Prior authorization required:** The requirement for prior authorization (PA) is assumed when the drug is covered but non-preferred. Otherwise, PDLs or formularies typically contain this information for FFS and MMCOs. There are a range of types of prior authorization requirements. This means that some form of prior authorization, usually provided by the prescriber, is necessary for Medicaid to pay for the drug in question. PA is typically required for covered non-preferred drugs, and occasionally for preferred drugs.
- **Quantity limits or maximum daily doses:** Some medications are subject to limits on how much of the drug can be prescribed within a specific time window or maximum daily doses. This is particularly relevant for and can impact clients' ability to maintain their treatment for AUD or OUD and is usually related to safety concerns.

Challenges and Limitations

There are challenges and limitations associated with this methodology. As with SAMHSA's 2018 report on Medicaid coverage of drugs for AUD and OUD, the reliance on publicly available data sources places the burden of accuracy on those sources themselves.[3] As a result, delays or shortcomings in state-level document preparation or updating publicly available information and changing web links can result in inaccuracies. While some states offer easily accessible formularies or comprehensive PDLs, the quality of data and ease of access in other states pose obstacles to the availability of specific drugs. In addition, publicly available information reflects a constantly shifting Medicaid environment, making generalizations challenging. It also is important to note the impact of factors such as policy and legal changes, COVID-19, increased use of telehealth and other factors between 2018 and this report that may impact Medicaid AUD and OUD drug coverage and availability. These considerations should be borne in mind when comparing findings among the 2014, 2018, and 2023 reports.

Challenges associated with this report's reliance on publicly available data include:

- Data describe coverage and limitations at the points at which the referenced PDLs and other documents were effective or the data were directly accessed. Coverage and limitations documented here may be outdated at this report's publication.
- When only lists of preferred drugs are available online, it can be difficult to assess whether non-preferred drugs, which may better address a patient's needs, are available.
- Some PDLs omit medications, including those used for AUD and OUD.
- While the contents of MMCO PDLs are usually similar to FFS PDLs, there are sometimes differences, and it may not always be clear which PDL is relevant for a particular patient. It is also not uncommon for availability of AUD and OUD medications to differ among MMCOs even within a single state.
- CMS state drug utilization data sometimes contradicts state PDLs and formularies. State PDLs and formularies often list as available drugs for which CMS has no record of reimbursement by Medicaid. The question of why those drugs listed in state formularies or on PDLs are not, according to CMS use data, actually being prescribed by Medicaid providers is beyond the scope of this report.
- Reimbursement for methadone and buprenorphine varies among states because they are used for pain treatment as well as MOUD.

Findings

The graphs in the remainder of this chapter present data on all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. The bar graphs describing availability of individual drugs depict counts of states in which drugs are covered, preferred, and subject to PA or quantity limitations. Only states that either cover the drugs or for which coverage data was not found are included in counts of the remaining availability parameters. If a drug is not covered, then its preferred status and availability limitations do not apply.

Overview of Medicaid Coverage

- MMCO coverage is more consistent across the different medications than FFS coverage (see Fig. 1a and 1b). Medicaid FFS state coverage rates are high for at least one formulation of each medication to treat OUD.
- Buprenorphine and oral naltrexone are each more widely covered than their injectable versions, the gap between buprenorphine and extended-release injectable buprenorphine being more substantial than that between versions of naltrexone. Methadone coverage appears complete.
- Acamprosate and disulfiram have the lowest observed coverage rates for FFS and MMCO beneficiaries. These medications are often not listed in PDLs or formularies. When these drugs do not appear in the drug utilization data, we counted them as being not covered, but their absence from the databases may also be due to not being prescribed.
- The observed rates of coverage are largely similar to or higher than those observed in 2018. However, 2023 FFS coverage rates of acamprosate and disulfiram appear lower than those observed in 2018. This may be due to the prior report's combination of FFS and MMCO formularies. In addition, other drugs, including naltrexone, may replace acamprosate and disulfiram in the treatment of AUD.

Figure 1a. Medicaid Coverage of Medications for Alcohol and Opioid Use Disorders (FFS), 2023

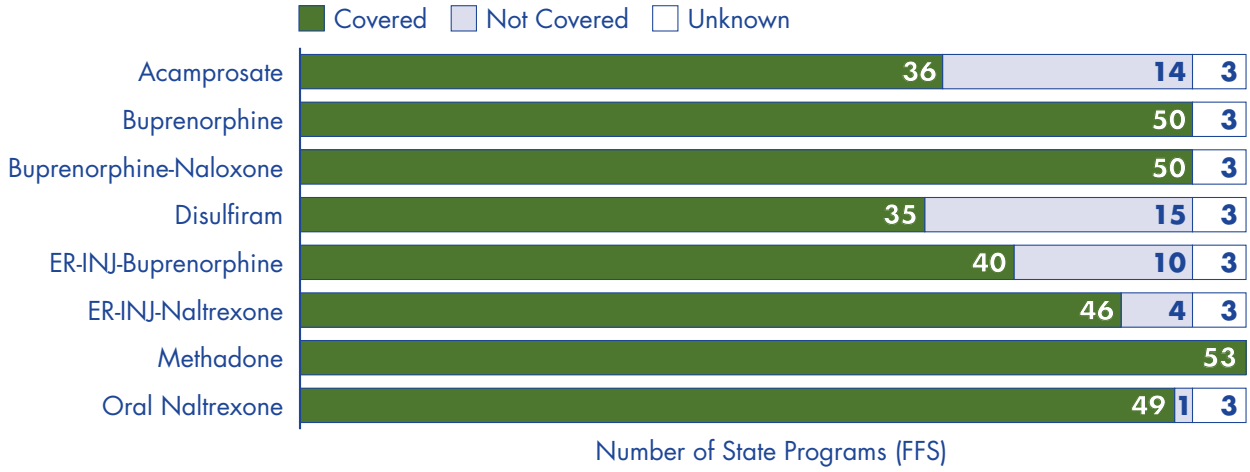
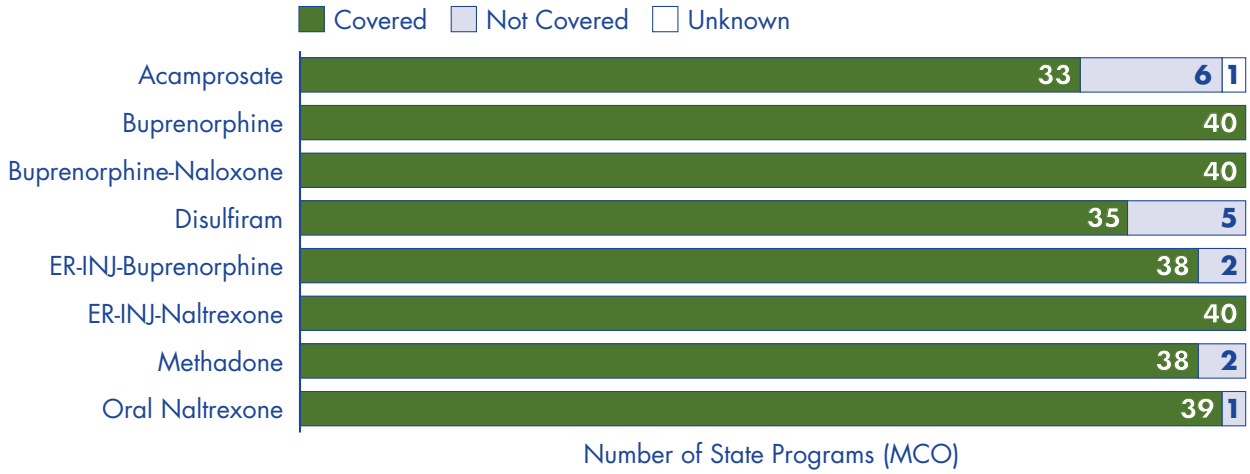


Figure 1b. Medicaid Coverage of Medications for Alcohol and Opioid Use Disorders (MCO), 2023



Acamprosate and Disulfiram

- Acamprosate (see Fig. 2a and 2b) and disulfiram (see Fig. 3a and 3b) have relatively low rates of coverage and preferred status, but they are unlikely to require PA or have quantity limitations.
- The medications were often difficult to find in state formularies and PDLs. Consequently, CMS drug utilization data was frequently the sole determinant of coverage.

Figure 2a. Acamprosate (FFS), 2023

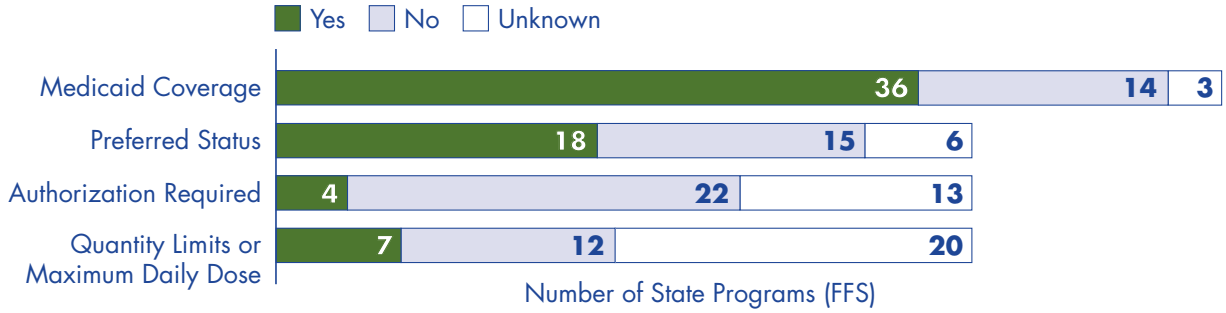


Figure 2b. Acamprosate (MCO), 2023

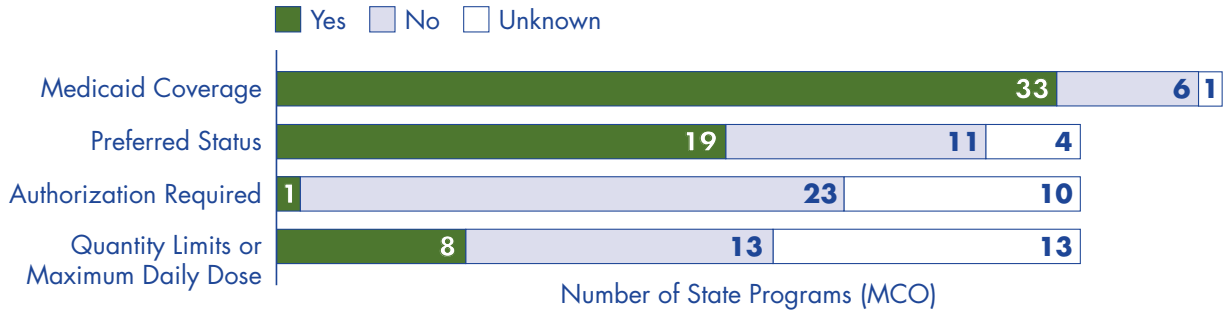


Figure 3a. Disulfiram (FFS), 2023

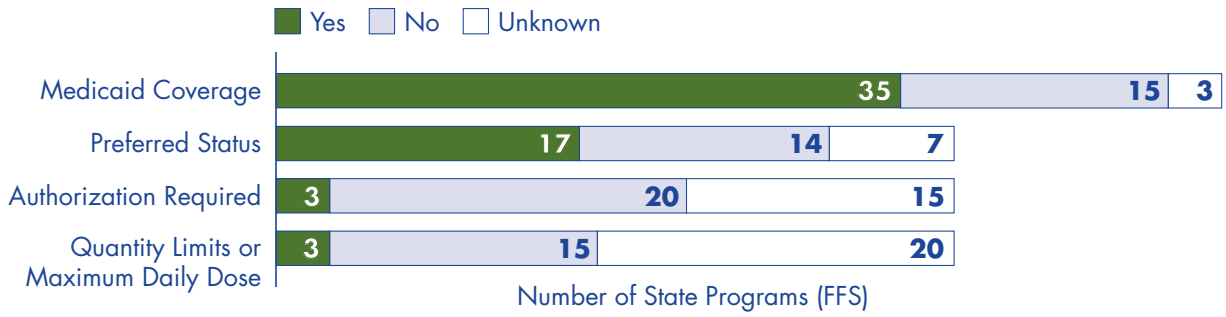
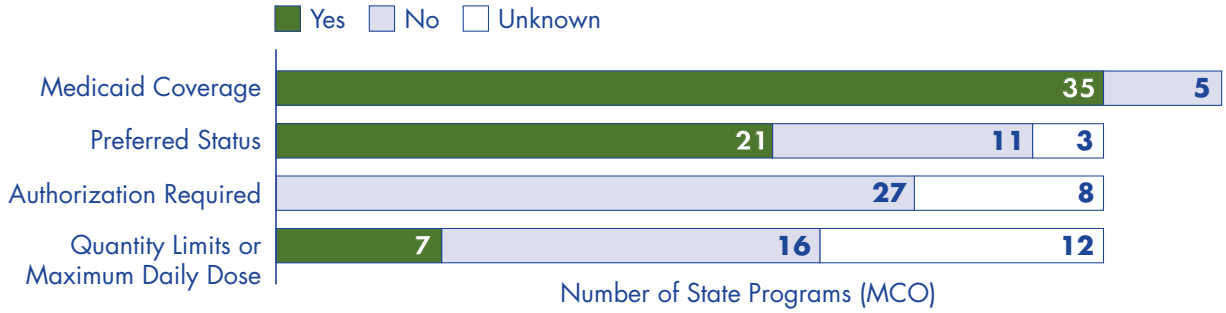


Figure 3b. Disulfiram (MCO), 2023



Naltrexone (Oral and Extended-Release Injection)

- Both forms of naltrexone are widely covered and unlikely to require PA or be subject to quantity limits (see Fig. 4a and 4b and 5a and 5b). Vivitrol was the most covered form of injectable naltrexone.
- Availability has not changed dramatically since 2018, although there have been slight reductions in states requiring PA or having quantity limits.

Figure 4a. Naltrexone (FFS), 2023

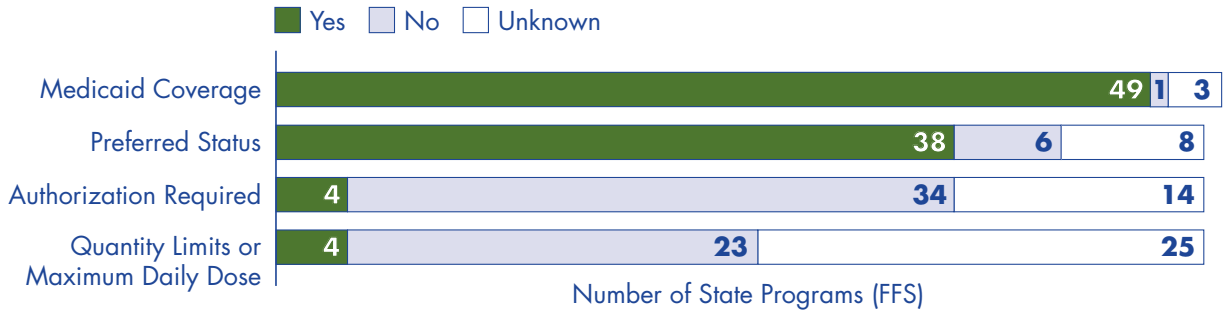


Figure 4b. Naltrexone (MCO), 2023

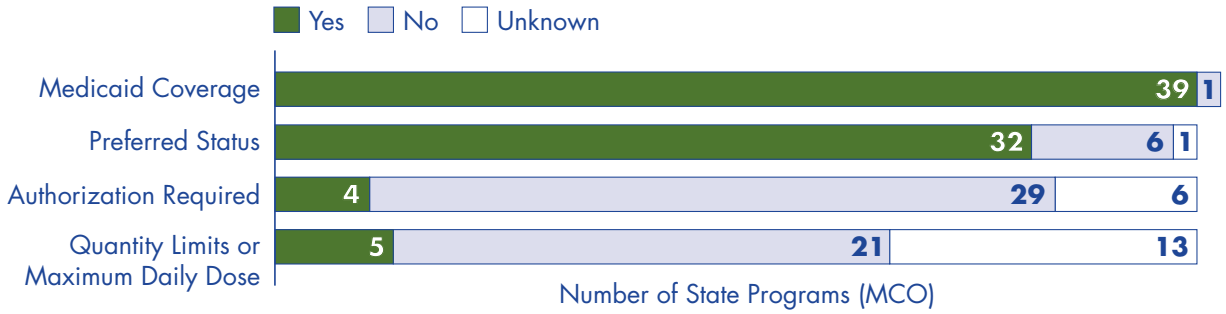


Figure 5a. ER INJ Naltrexone (FFS), 2023

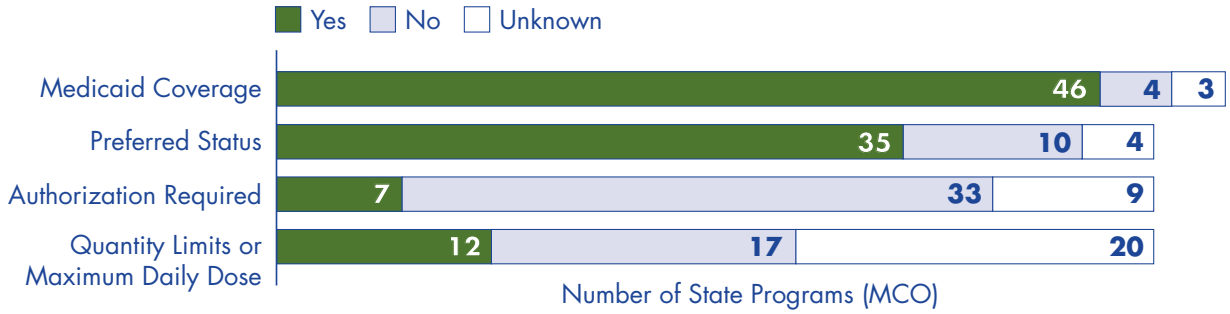
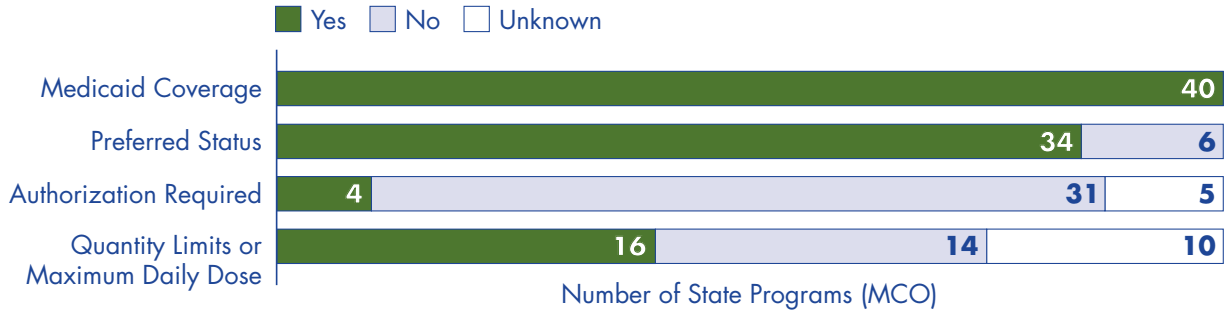


Figure 5b. ER INJ Naltrexone (MCO), 2023



Buprenorphine (Monoproduct and Extended-Release Injection)

- Buprenorphine monoproduct (buprenorphine alone) is very widely covered (see Fig. 6a and 6b). Injectable buprenorphine is covered in fewer states, and the rates of preferred status among those states with coverage is similar (see Fig. 7a and 7b). However, buprenorphine monoproduct is more likely to require PA and have quantity limits. This medication is almost exclusively used for people who are pregnant or have significant intolerance to naloxone, as the absence of naloxone makes buprenorphine more readily misused.[86]
- Compared with 2018, access has improved for both monoproduct and extended-release injection forms. The drugs are preferred in more states, and fewer states have PA requirements or quantity limits. This expansion of access aligns with recent research describing utilization restrictions on buprenorphine across Medicaid, Medicare, and commercial insurance providers.[84] This research also found higher rates of restriction on extended-release buprenorphine.[84]

Figure 6a. Buprenorphine (FFS), 2023

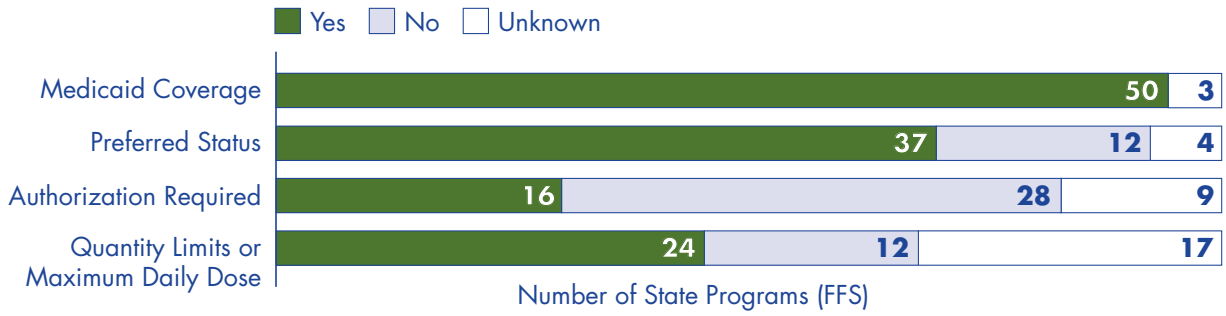


Figure 6b. Buprenorphine (MCO), 2023

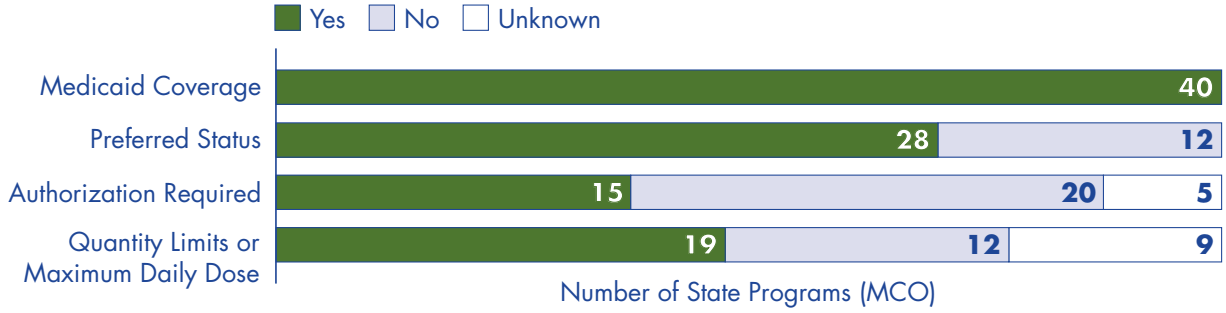


Figure 7a. ER INJ Buprenorphine (FFS), 2023

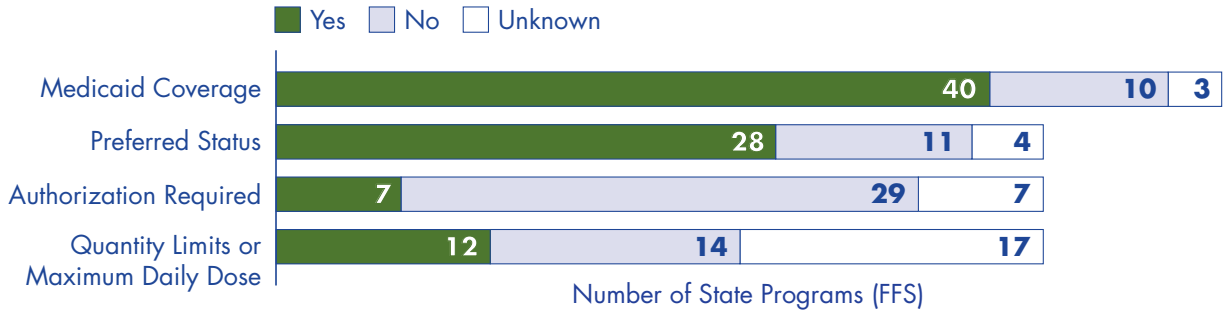
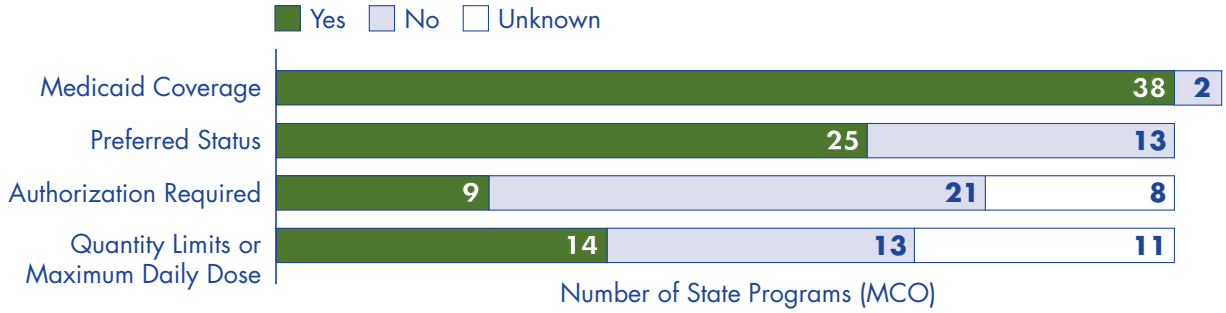


Figure 7b. ER INJ Buprenorphine (MCO), 2023



Buprenorphine-Naloxone

- Buprenorphine-Naloxone coverage is nearly complete, and it has preferred drug status in a large proportion of states (see Fig. 8a and 8b).
- In 2018, coverage was also nearly complete. Fewer states now require PA or have quantity limits.

Figure 8a. Buprenorphine-Naloxone (FFS), 2023

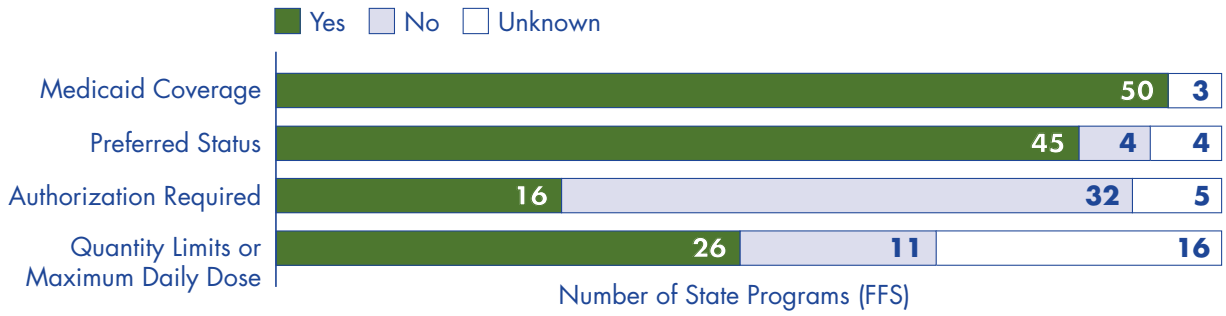
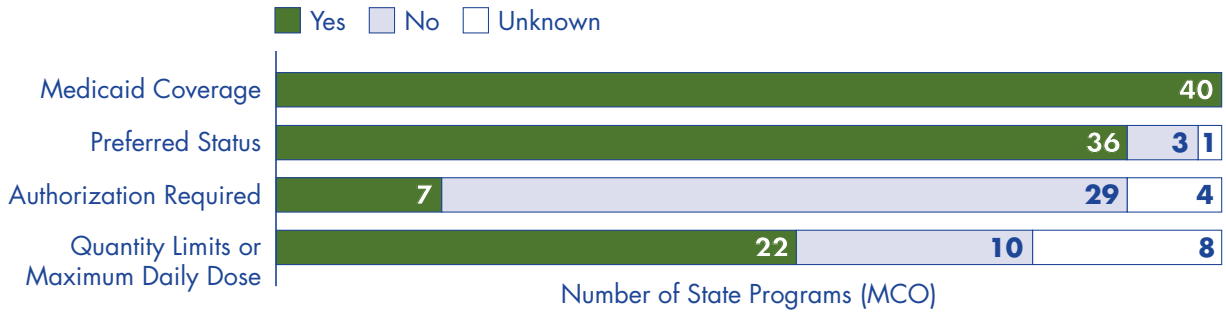


Figure 8b. Buprenorphine-Naloxone (MCO), 2023



Methadone

- Coverage of methadone is consistent across FFS and MMCO plans and is nearly complete (see Fig. 9a and 9b). Rates of PA and quantity limitations are relatively high. The availability of methadone to Medicaid beneficiaries can be difficult to assess using the methods employed to investigate the other medications in this report. Methadone is often not listed in state Medicaid formularies and PDLs, and it is often necessary to seek out other sources of information. For example, websites of OTPs often specify that methadone treatment is available to Medicaid beneficiaries. However, detailed parameters on availability are often not available.
- Compared with 2018, information regarding methadone is more widely available and coverage rates have improved.

Figure 9a. Methadone as MOUD (FFS), 2023

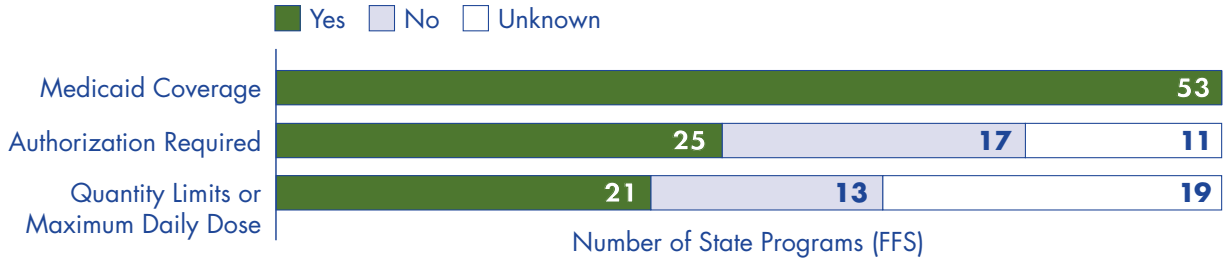
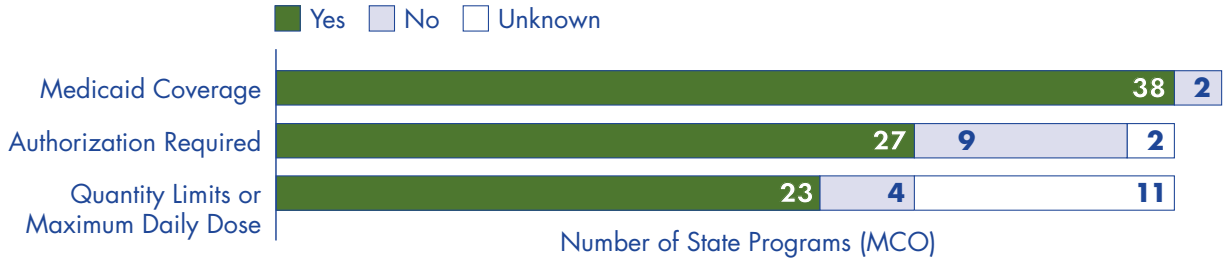


Figure 9b. Methadone as MOUD (MCO), 2023



Naloxone

- Generic naloxone (see Fig. 10a and 10b), in either inhaled or injectable form, and Narcan (see Fig. 11a and 11b) are widely covered and usually have preferred status. PA and quantity limitations are similar for each. The March 2023 approval of naloxone nasal spray for over-the-counter sale will likely impact state-level regulations governing naloxone's sale and its availability to Medicaid beneficiaries. Nalmefene hydrochloride, another opioid receptor antagonist used to reverse opioid overdose, was also very recently approved for availability by prescription.[24]

Figure 10a. Naloxone (FFS), 2023

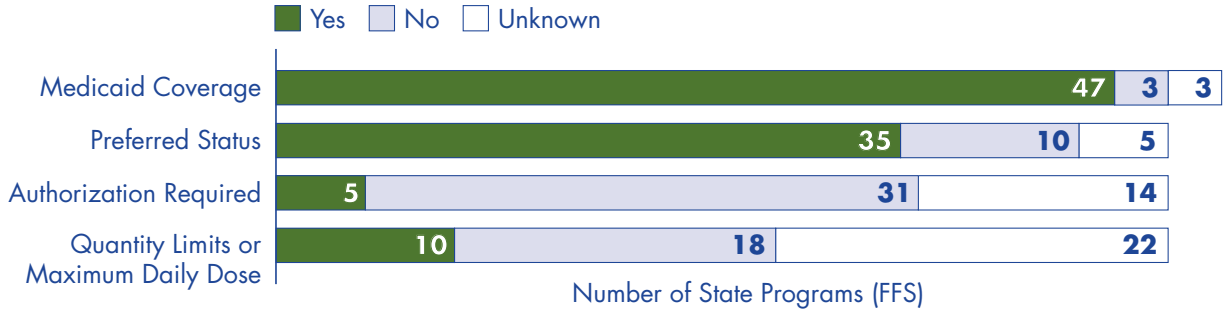


Figure 10b. Naloxone (MCO), 2023

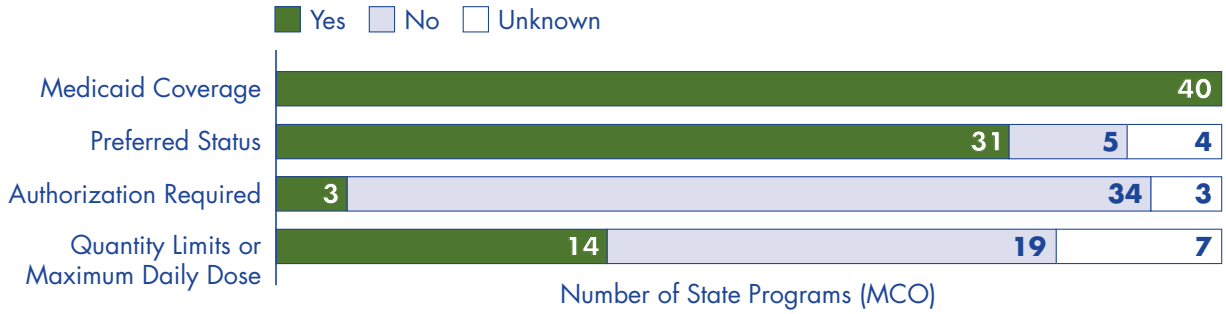


Figure 11a. Narcan (FFS), 2023

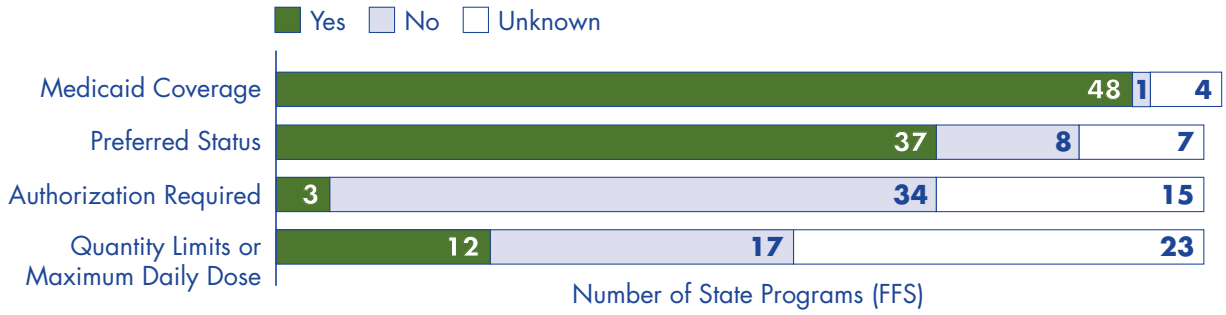
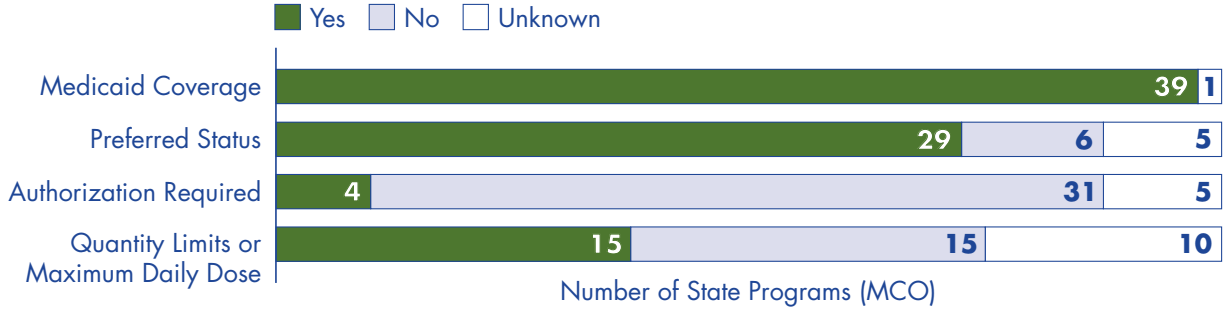


Figure 11b. Narcan (MCO), 2023



CHAPTER 4

Innovative Models Expanding Access to Medications for the Treatment of Substance Use Disorders

This section describes five innovative models that improve the availability of medications for the treatment of SUD for Medicaid beneficiaries. Models were selected through discussions with subject matter experts at the National Association of State Alcohol and Drug Abuse Directors and SAMHSA. Subject matter experts chose models that are replicable and reflect systemic factors shared by many states as opposed to those emerging from states with unique conditions or historic circumstances. Selected models are also primarily focused on Medicaid beneficiaries, Medicaid certified services or providers, or Medicaid reimbursement. Innovations represented in the highlighted models could encompass expanding access for underserved Medicaid populations (for example, those in the criminal justice system, individuals lacking permanent housing, young adults, or rural populations), improving service delivery at the practice or system level, and expanding services through innovative use of Medicaid funding. Models previously described in the 2018 report were omitted from the selection process. It is important to note that none of the innovative models solely focus on the treatment of AUD as subject matter experts could not identify any.

Model Innovation Key

Service expansion
Models focused on expanding service provision to an underserved Medicaid population.

Evaluation
Models that have been evaluated for effectiveness in some manner.

Practice-based
Models that either expand the role of existing settings or expand the number and types of settings providing services to Medicaid beneficiaries.

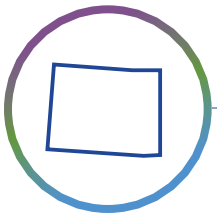
System-based
Models that improve identification and treatment by facilitating communication and cooperation between providers.

California – The CA Bridge Program

In 2018 the California Department of Health Care Services launched the California (CA) Bridge Program to increase access to medication treatment for SUDs in emergency departments (EDs).[87] Funded through state, federal, and philanthropic organizations, this initiative has grown rapidly from 8 hospitals in 2018 to 226 hospitals as of January 2023, comprising approximately 85 percent of the state's EDs. CA Bridge provides technical assistance and evidence-based resources and guidance for initiating SUD treatment in EDs at participating hospitals. The program first focused on initiating buprenorphine treatment in the ED, but it has since expanded to include individuals with any SUD and co-occurring mental health conditions.[87] After initiating treatment in the ED, patients are also connected to a substance use navigator (SUN). The focus of CA Bridge is on providing evidence-based and patient-centered care that meets patients where they are and removing unnecessary barriers to treatment such as diagnostic tests or specialist consultations.[88] The CA Bridge program's core elements include rapid access to low barrier treatment, connection to care and community, and a culture of harm reduction.[87]

The CA Bridge program includes guidelines specific to treating patients with AUD in the ED to help support medication initiation and reduce use of acute care. The guidelines are: **1)** treat acute withdrawal using hospital protocols; **2)** prescribe medication for extended withdrawal (Gabapentin 600 mg-900 TID) and medication to reduce relapse (Naltrexone 50 mg); **3)** contact the SUN to help the patient engage in follow up care and support; and **4)** at follow up, offer 30-day Naltrexone injection.[89]

The University of California, Los Angeles, recently published findings from the CA Bridge Patient Outcomes Study, which found that the CA Bridge program provides SUD support and treatment to more than 7,500 people per month in California EDs.[87] The study also found that the program serves the most vulnerable populations in the state. More than 75 percent of patients who accessed buprenorphine treatment through CA Bridge were covered by Medicaid.[87] A CA Bridge implementation study compared outcomes between adult patients discharged from EDs with cocaine, alcohol, and opioid use-related diagnoses who received care from a SUN to those who did not. The study found that patients who had the SUN intervention were three times more likely to engage in treatment within 30 days of discharge compared to those who did not.[90] CA Bridge is working with hospitals and payers to create sustainable financing streams to support the program after state and federal funding ends.[87]

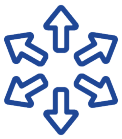


Colorado – Mobile Unit Project

To combat the opioid crisis in rural and frontier communities, the Colorado Department of Human Services Office of Behavioral Health (COBH), with support from a SAMHSA State Opioid Response Grant (SOR),[91] funded mobile health units to deliver MOUD in underserved and rural regions. The majority of the 22 OTPs available in Colorado were in urban areas. However, individuals in rural areas have the highest level of opioid overdose and lacked access to providers that treat OUD.[92]

COBH used $6.7 million of the $30.1 million SOR federal grant to fund six mobile health units, one for each of six rural regions.[93] The COBH partnered with an MMCO that contracted with three behavioral health providers to operate the mobile health units, which were staffed with a licensed nurse or certified SUD counselor and a peer support specialist and run out of retrofitted recreational vehicles. Available services included induction and maintenance services for buprenorphine, such as counseling, telehealth sessions, drug testing, referrals to wraparound services, syringe disposal, and naloxone distribution. Before the mobile health units were operational, the staff conducted outreach to the local communities to announce the mobile health units' services. These connections made possible client referral to other community resources, such as food banks and outpatient counseling. The program also operated pop-up clinics, which offered the same services as the mobile health units but for limited hours and in borrowed space in clinics with private rooms and bathrooms. These were beneficial during the construction of the mobile units because in most areas no alternative treatments for OUD existed.[93]

Under a contract with COBH, the Evaluation Center at the University of Colorado evaluated the mobile health unit program during its second year (2019 to 2020). The evaluation examined program reach, client satisfaction, and implementation, and found that mobile health units successfully targeted clients in need across all service areas. The majority of clients served were unemployed, aged 25 to 54, and reported 8th to 12th grade as their highest education level, and 39 percent identified as Hispanic.[93] Overall, nearly all clients reported that their treatment needs were being met and reported high levels of satisfaction with access to services. Clients stated that the combination of counseling and medication helped keep them in recovery.[93] When the grant ended in 2022, the three clinics operating the program kept the mobile health units and continue to utilize them and fund the services by billing Medicaid and private insurance.[94]



North Carolina – Enhanced Tribal MOUD and Other Treatments

The Eastern Band of Cherokee Indians (EBCI) is the only federally recognized Tribe in North Carolina and has a population of approximately 16,000. In 2021, the drug overdose death rate in the state of North Carolina was the highest among American Indian/Indigenous people (94.1 per 100,000) and more than two times higher than non-Hispanic white people (42 per 100,000). In addition, in 2018 EBCI was among the 10 areas in the United States with the highest concentration of drug trafficking.[95] To help combat the opioid crisis, the EBCI received $1.9 million of a $35 million SOR grant funded by SAMHSA.

The EBCI and Cherokee Indian Hospital Authority & Public HHS used the SOR funds to implement Beauty for Ashes (BFA), a culturally appropriate trauma-informed care program, and to develop an integrated pain management program for those with OUD.[96] As of 2021, 41 individuals participated in BFA and 21 individuals received the Advanced Leader Education Training for BFA. The funds were also used to purchase naloxone and create safe syringe disposal sites.[91]

New Jersey – Intensive Recovery Treatment Support Program

Research suggests that more than 65 percent of those incarcerated in the United States have an active SUD.[97] Many studies have shown high rates of overdose deaths among those recently incarcerated, with the highest risk of a fatal drug overdose in the 2 weeks after release.[98] To help support this at-risk population, New Jersey's Intensive Recovery Treatment Support (IRTS) Program was developed collaboratively by the New Jersey Department of Corrections, the New Jersey Department of Mental Health and Addiction Services, and Rutgers University Behavioral Health Care and was launched in 2018.[99] This team-based program provides recovery-focused assessment, linkage to treatment, and comprehensive reentry support for individuals with OUD.[99] IRTS addresses the many obstacles individuals with SUDs may encounter after leaving prison, including finding housing and employment, securing Medicaid, and maintaining recovery. The IRTS support team includes case managers, nurses, and peer health navigators (PHNs). The IRTS PHNs are individuals that have been incarcerated, have at least 5 years without criminal activity, and are also recovering from SUDs.[99] These shared experiences help build connections and trust between the PHNs and their clients.[100,101] Utilizing peer workers is a SAMHSA recommended, evidence-based practice.[102]

Six months before release, inmates are assigned a PHN and form relationships with them to work together to create plans for sober reentry into society. For 12 months after release, IRTS provides participants with services such as MOUD linkage, distribution of naloxone to families and significant others, cell phones, housing and employment assistance, food resources and other social services. Rutgers University conducted a mixed-methods evaluation of IRTS and found that the majority of participants had a positive experience and felt that having PHNs was the most beneficial component of the progam.[101] On average from 2019 to 2020, 65 percent IRTS participants adhered to MOUD, 80 percent obtained stable housing, and 46 percent were gainfully employed.[100]

West Virginia – Comprehensive Opioid Addiction Treatment

The West Virginia University (WVU) Comprehensive Opioid Addiction Treatment (COAT) program began in 2005 and uses an outpatient, group treatment-based model to provide comprehensive, evidence-based care to OUD clients.[103] Interdisciplinary treatment teams are composed of one office-based MOUD prescriber, a case manager, a licensed therapist, and a medical assistant.

The COAT program uses treatment in phases based on the length of time a patient has abstained from using alcohol, illicit or licit substances not prescribed, treatment adherence, and readiness to move to the next phase. Treatment stages include beginner (1-90 days abstinent), intermediate (91-365 days abstinent), and advanced (365+ days abstinent). Requirements for group and individual therapy sessions vary with stage. Each stage includes a 30-minute medication management group, in which clients discuss treatment planning and assess individual progress, challenges, and needs, followed by group therapy. Buprenorphine prescriptions are given after participation in therapy sessions.[104]

The COAT program has consistently overcome challenges associated with OUD in its rural regions. COAT's multi-specialty treatment teams use a chronic disease management approach supporting all stages of a patient's recovery. To facilitate long-term retention of patients in a rural setting where poverty and distance present formidable barriers, the COAT program has integrated into WVU's health care network, benefiting from existing networks and connecting service providers in rural areas with SUD specialists.[105]

The outcomes of the COAT program are promising. Nearly three-quarters of clients in the program utilized public insurance, such as Medicaid or Medicare, followed by private insurance (25%), and self-pay (1%). More than one-third (38%) of clients were retained in the program for up to a year, and about 15 percent were retained for 10 or more years.[104]

Conclusion

The need for access to SUD treatment is critical. In 2021, nearly a quarter of a million people in the United States died due to either drug overdose or causes associated with AUD.[9,106] The effectiveness of medications for treating AUD and OUD and the life-saving benefits of naloxone are well established. The severity of the SUD epidemic highlights the importance of making these treatments available.

This report provides a detailed overview of the availability of and access to these medications for Medicaid beneficiaries. It paints a complex picture in which medication availability—measured by coverage and limitations to prescribing—has expanded. State health care and substance use treatment agencies are using newly available means of improving access to medication treatment of OUD.

The SUPPORT Act mandates that state Medicaid agencies cover available medications for treatment of OUD. States have made progress in expanding access to medications through regulatory vehicles that encourage innovation and coverage (1115 Waivers), improving access to more types of providers (CCBHCs, FQHCs, and OTPs), and using novel means of service delivery (telehealth). In addition, the recent removal of the DATA 2000 Waiver requirement creates new opportunities to expand availability of MOUD to Medicaid beneficiaries. States generally appear to reimburse for these medications, but the documentation available to the public is often incomplete. Coverage by MMCOs is more consistent across the different medications than FFS coverage. Limitations have diminished since 2018 as requirements for psychosocial or step therapy and lifetime quantity limits were not widely found. In addition, most medications saw increases in rates of preferred status and decreases in the number of states with quantity limits or requirements for PA, with patterns similar across FFS and MMCO plans. Unlike OUD, Medicaid coverage of medications for AUD has not changed significantly. In fact, rates of coverage of acamprosate and disulfiram appear lower than those observed in 2018. This may be due in part to the increased use of naltrexone for AUD treatment.

The innovative models described in this report focus primarily on expanding OUD medication access for underserved populations, such as American Indians/Alaska Natives, recently incarcerated people, and those in rural areas, and making more effective use of existing systems. It is important to note that despite the high number of alcohol related deaths, there is less innovative programming to address AUDs. Additional efforts are needed to support treatment of this chronic condition.

Medicaid coverage of medications for treatment of SUDs is essential to support the long-term recovery of individuals. The findings in the report show promising growth in availability of these medications. However, continued efforts to improve access to medication to treat AUD, OUD, and reverse opioid overdose are necessary.

References

1. Substance Abuse and Mental Health Services Administration (SAMHSA). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2020. Data on Substance Abuse Treatment Facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Published 2018. Accessed April 10, 2023. https://www.samhsa.gov/data/sites/default/files/reports/rpt35313/2020_NSSATS_FINAL.pdf
2. Substance Abuse and Mental Health Services Administration (SAMHSA). *Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders*. No. HHS Publication No. SMA-14-4854. Rockville, MD: Substance Abuse and Mental Health Services Administration. Published before 2014. Accessed May 15, 2023. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4854.pdf
3. Substance Abuse and Mental Health Services Administration (SAMHSA). *Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose*. HHS Publication No. SMA-18-5093. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2018. Accessed April 10, 2023. https://store.samhsa.gov/sites/default/files/d7/priv/medicaidfinancingmatreport_0.pdf
4. Substance Abuse and Mental Health Services Administration (SAMHSA). *Medications for Opioid Use Disorder: For Health Care and Addiction Professionals, Policymakers, Patients, and Families*. Treatment Improvement Protocol (TIP) Series 63. Samhsa.gov. Updated 2021. Accessed September 5, 2023. https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
5. Office of the Surgeon General, U.S. Department of Health and Human Services (HHS). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC; 2016.
6. Spencer MR, Miniño AM, Warner M. *Drug Overdose Deaths in the United States, 2001–2021*. NCHS Data Brief. 2022;457:1-8.
7. JEC. *The Economic Toll of the Opioid Crisis Reached Nearly $1.5 Trillion in 2020*. Joint Economic Committee Democrats; 2022.
8. National Institute on Drug Abuse. *Trends and Statistics: Drug Overdose Death Rates*. Nida.nih.gov; 2023. Accessed September 5, 2023. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
9. Alcohol and Public Health: Excessive Alcohol Deaths. Centers for Disease Control and Prevention; 2023. Accessed September 1, 2023. https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html

10. The Council of Economic Advisors: The White House: Executive Office of the President. *The Council of Economic... of the Opioid Crisis*. Published 2017. Accessed September 5, 2023. https://trumpwhitehouse.archives.gov/briefings-statements/cea-report-underestimated-cost-opioid-crisis/
11. Florence C, Luo F, Rice K. The Economic Burden of Opioid Use Disorder and Fatal Opioid Overdose in the United States, 2017. *Drug Alcohol Depend*. 2021;218:108350.
12. Centers for Disease Control and Prevention. *Alcohol and Public Health: Excessive Drinking is Draining the U.S. Economy*. Accessed September 5, 2023. https://www.cdc.gov/alcohol/features/excessive-drinking.html
13. Carley JA, Oesterle T. Therapeutic Approaches to Opioid Use Disorder: What is the Current Standard of Care? *Int J Gen Med*. 2021;14:2305-2311.
14. Patel AK, Balasanova AA. Treatment of Alcohol Use Disorder. *JAMA*. 2021;325(6):596.
15. Stahler GJ, Mennis J. The Effect of Medications for Opioid Use Disorder (MOUD) on Residential Treatment Completion and Retention in the US. *Drug Alcohol Depend*. 2020;212:108067.
16. Wakeman SE, Larochelle MR, Ameli O, Chaisson CE, McPheeters JT, Crown WH, Azocar F, Sanghavi DM. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open*. 2020;3(2):e1920622.
17. Akbar M, Egli M, Cho YE, Song BJ, Noronha A. Medications for Alcohol Use Disorders: An Overview. *Pharmacol Ther*. 2018;185:64-85.
18. Razaghizad A, Windle SB, Filion KB, Gore G, Kudrina I, Paraskevopoulous E, Kimmelman J, Martel MO, Eisenberg MJ. The Effect of Overdose Education and Naloxone Distribution: An Umbrella Review of Systematic Reviews. *Am J Public Health*. 2021;111(8):e1-e12.
19. Medicaid. *April 2023 Medicaid & CHIP Enrollment Data Highlights*. Medicaid.gov. Published 2023. Accessed August 3, 2023. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html
20. Substance Abuse and Mental Health Services Administration (SAMHSA). *National Survey on Drug Use and Health. 2021 NSDUH Detailed Tables*. Samhsa.gov; 2023. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health
21. Soyka M, Müller CA. Pharmacotherapy of Alcoholism - an Update on Approved and Off-Label Medications. *Expert Opin Pharmacother*. 2017;18(12):1187-1199.
22. Racha S, Buresh M, Fingerhood MI. Pharmacotherapy of Opioid Use Disorder—Update and Current Challenges. *Psychiatr Clin North Am*. 2022;45(3):335-346.
23. U.S. Food and Drug Administration. *FDA Approves First Over-the-Counter Naloxone Nasal Spray: Agency Continues to Take Critical Steps to Reduce Drug Overdose Deaths Being Driven Primarily by Illicit Opioids*. News Release: U.S. Food and Drug Administration; 2023.

24. *Information about Naloxone and Nalmefene*. U.S. Food and Drug Administration; 2023. Accessed June 30, 2023. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-naloxone-and-nalmefene
25. U.S. Census Bureau. *Who Is Receiving Social Safety Net Benefits?* U.S. Census Bureau. Accessed May 22, 2023. https://www.census.gov/library/visualizations/interactive/social-safety-net-benefits.html
26. Guth M, Haldar S, Rudowitz R, Artiga S. *Medicaid and Racial Health Equity*. Kaiser Family Foundation. Published 2022. Accessed May 26, 2023. https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/
27. Foutz J, Artiga S, Garfield R. *The Role of Medicaid in Rural America*. Kaiser Family Foundation. Published 2017. Accessed May 26, 2023. https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/
28. Abraham AJ, Andrews CM, Yingling ME, Shannon J. Geographic Disparities in Availability of Opioid Use Disorder Treatment for Medicaid Enrollees. *Health Serv Res*. 2018;53(1):389-404.
29. Joudrey PJ, Edelman EJ, Wang EA. Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States. *JAMA*. 2019;322(13):1310-1312.
30. Garpenhag L, Dahlman D. Perceived Healthcare Stigma Among Patients in Opioid Substitution Treatment: A Qualitative Study. *Subst Abuse Treat Prev Policy*. 2021;16(1):81.
31. Hammarlund R, Crapanzano KA, Luce L, Mulligan L, Ward KM. Review of the Effects of Self-Stigma and Perceived Social Stigma on the Treatment-Seeking Decisions of Individuals with Drug- and Alcohol-Use Disorders. *Subst Abuse Rehabil*. 2018;9:115-136.
32. Taylor BG, Lamuda PA, Flanagan E, Watts E, Pollack H, Schneider J. Social Stigma Toward Persons with Opioid Use Disorder: Results from a Nationally Representative Survey of U.S. Adults. *Subst Use Misuse*. 2021;56(12):1752-1764.
33. Costello AM. *Dear State Health Official*. Medicaid.gov. Published 2020. https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf
34. Dolan R. *Understanding the Medicaid Prescription Drug Rebate Program*. Kaiser Family Foundation. Published Nov 12, 2019.
35. National Archives. *Medication Assisted Treatment for Opioid Use Disorders*. 42 CFR §8 (2023).
36. Dolan R, Tian M. *Management and Delivery of the Medicaid Pharmacy Benefit*. Kaiser Family Foundation. Published Dec 6, 2019.
37. Sledge D, Thomas HF, Hoang BL, Mohler G. Impact of Medicaid, Race/Ethnicity, and Criminal Justice Referral on Opioid Use Disorder Treatment. *J Am Acad Psychiatry Law*. 2022;50(4):545-551.
38. Sanmartin MX, Ali MM, Dwyer DS. Trends in Buprenorphine-Waivered Providers in Medicaid Expansion and Non-Expansion States by Their Public Listing Status. *Subst Abus*. 2022;43(1):1072-1074.

39. Meiselbach MK, Drake C, Zhu JM, Manibusan B, Nagy D, Sorbero MJ, Saloner B, Stein BD, Polsky D. State Policy and the Breadth of Buprenorphine-Prescriber Networks in Medicaid Managed Care. *Med Care Res Rev*. 2023;80(4):423-432:10775587231167514.
40. Tolbert J, Ammula M. *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision*. The Kaiser Family Foundation. Published Jun 9, 2023.
41. Centers for Medicare & Medicaid Services. *Unwinding and Returning to Regular Operations After COVID-19*. Published 2023. Accessed July 18, 2023. https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html
42. Medicaid and CHIP Payment and Access Commission. *Section 1115 Waivers for Substance Use Disorder Treatment*. Macpac.gov. Published 2023. Accessed May 26, 2023. https://www.macpac.gov/subtopic/section-1115-waivers-for-substance-use-disorder-treatment/
43. Substance Abuse and Mental Health Services Administration (SAMHSA). *Waiver Elimination (MAT Act)*. Revise to read: Samhsa.gov. Published 2023. Accessed May 26, 2023. https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement
44. Park E, Dwyer A, Brooks T, Clark M, Alker J. *Consolidated Appropriations Act, 2023: Medicaid and CHIP Provisions Explained*. Georgetown University Health Policy Institute Center for Children and Families; 2023.
45. Milgram A. Informational Documents. Deadiversion.usdoj.gov. Updated 2023. Accessed May 26, 2023. https://www.deadiversion.usdoj.gov/pubs/docs/dear_registrant_AM_01122023.html
46. Substance Abuse and Mental Health Services Administration (SAMHSA). *Opioid Treatment Program (OTP) Guidance 2020*. Substance Abuse and Mental Health Services Administration; 2020.
47. Substance Abuse and Mental Health Services Administration (SAMHSA). Methadone Take-Home Flexibilities Extension Guidance. Samhsa.gov. Published 2023. Accessed May 26, 2023. https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance
48. Legislative Analysis and Public Policy Association. *Naloxone Access: Summary of State Laws*. Published January 2023. Accessed September 5, 2023. https://legislativeanalysis.org/wp-content/uploads/2023/02/Naloxone-Access-Summary-of-State-Laws.pdf
49. Saunders H, Rudowitz R. *Will Availability of Over-the-Counter Narcan Increase Access?* Kaiser Family Foundation. Published September 19, 2023. Accessed October 4, 2023. https://www.kff.org/policy-watch/will-availability-of-over-the-counter-narcan-increase-access/

50. Uscher-Pines L, Cantor J, Huskamp HA, Mehrotra A, Busch A, Barnett M. Adoption of Telemedicine Services by Substance Abuse Treatment Facilities in the U.S. *J Subst Abuse Treat*. 2020;117:108060.
51. Huskamp HA, Busch AB, Souza J, Uscher-Pines L, Rose S, Wilcock A, Landon BE, Mehrotra A. How Is Telemedicine Being Used In Opioid And Other Substance Use Disorder Treatment? *Health Aff (Millwood)*. 2018;37(12):1940-1947.
52. Centers for Medicare & Medicaid Services. *CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency*. Fact Sheet. Cms.gov. Published 2023. Accessed May 26, 2023. https://www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency
53. Mehrotra A, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider EC. *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients*. Commonwealth Fund; 2020. Accessed May 26, 2023. https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels
54. Guth M. *Telehealth Delivery of Behavioral Health Care in Medicaid: Findings from a Survey of State Medicaid Programs*. Kaiser Family Foundation. Published January 10, 2023. Accessed May 26, 2023. https://www.kff.org/medicaid/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/
55. Gainer DM, Wong C, Embree JA, Sardesh N, Amin A, Lester N. Effects of Telehealth on Dropout and Retention in Care among Treatment-Seeking Individuals with Substance Use Disorder: A Retrospective Cohort Study. *Subst Use Misuse*. 2023;58(4):481-490.
56. Melchionna M. *DEA Proposes Limits on Telehealth Prescriptions of Controlled Substances*. mhealthintelligence.com; 2023. Accessed May 26, 2023. https://mhealthintelligence.com/news/dea-proposes-limits-on-telehealth-prescriptions-of-controlled-substances?utm_source=nl&utm_medium=email&utm_campaign=newsletter
57. U.S. Government Accountability Office. *Medicaid: States' Changes to Payment Rates for Substance Use Disorder Services*. No. GAO-20-260. U.S. Government Accountability Office; 2020.
58. Centers for Medicare & Medicaid Services. Opioid Treatment Programs: Enrollment. Cms.gov; 2023. Accessed May 22, 2023. https://www.cms.gov/medicare/medicare-fee-for-service-payment/opioid-treatment-program/enrollment
59. American Society of Addiction Medicine. *Reimbursement for Medications for Addiction Treatment Toolkit*. American Society of Addiction Medicine; 2020. Accessed May 25, 2023. https://pcssnow.org/wp-content/uploads/2021/07/Reimbursement-Toolkit.pdf

60. U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE). *State Licensure for Substance Use Disorder Counseling: Implications for Billing Eligibility*. ASPE Issue Brief 2019. Published November 30, 2019.

61. U.S. Department of Health and Human Services. Confidentiality of Substance Use Disorder (SUD) Patient Records: A Proposed Rule. *Fed Regist*; 2022;87(231):74216-74287. Accessed May 25, 2023. https://www.federalregister.gov/documents/2022/12/02/2022-25784/confidentiality-of-substance-use-disorder-sud-patient-records

62. U.S. Department of Health and Human Services Press Office. *HHS Proposes New Protections to Increase Care Coordination and Confidentiality for Patients With Substance Use Challenges*. hhs.gov; 2022. Published November 28, 2022.

63. Isvan N, Gerber R, Hughes D, Battis K, Anderson E, O'Brien J. *Credentialing, Licensing, and Reimbursement of the SUD Workforce: A Review of Policies and Practices Across the Nation*. Human Services Research Institute, Assistant Secretary for Planning and Evaluation (ASPE). Published November 2019.

64. U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE). *Credentialing Substance Use Disorder Counselors: The Need for Uniform Standards*. ASPE Issue Brief 2019. Published November 30, 2019.

65. Prevoznik T. U.S. Department of Justice Drug Enforcement Agency. *DEA Registered-Practitioners*. Springfield, VA. Published 2023. https://www.deadiversion.usdoj.gov/pubs/docs/MATE_Training_Letter_Final.pdf

66. Komaromy M, Duhigg D, Metcalf A, Carlson C, Kalishman S, Hayes L, Burke T, Thornton K, Arora S. Project ECHO (Extension for Community Healthcare Outcomes): A New Model for Educating Primary Care Providers about Treatment of Substance Use Disorders. *Subst abus*. 2016;37(1):20-24.

67. Substance Abuse and Mental Health Services Administration (SAMHSA). *Certified Community Behavioral Health Center (CCBHC) Certification Criteria*. Updated March 2023. Accessed September 5, 2023. https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

68. Opioid & Health Indicators Database: Facilities Providing at Least Two Different Forms of Medication Assisted Treatment. amfAR; 2022. Accessed May 22, 2023. https://opioid.amfar.org/indicator/TMAT_fac

69. Substance Abuse and Mental Health Services Administration (SAMHSA). *Certified Community Behavioral Health Clinics (CCBHCs)*. Updated March 24, 2023. Accessed May 26, 2023. https://www.samhsa.gov/certified-community-behavioral-health-clinics

70. Health Resources & Services Administration. *Health Center Program: Impact and Growth*. HRSA; 2022. Accessed May 26, 2023. https://bphc.hrsa.gov/about-health-centers/health-center-program-impact-growth

71. Health Resources & Services Administration. *HRSA Behavioral Health*. HRSA; 2021. Accessed September 1, 2023. https://www.hrsa.gov/behavioral-health
72. Weinstein LC, Iqbal Q, Cunningham A, Debates R, Landistratis G, Doggett P, Silverio A. Retention of Patients With Multiple Vulnerabilities in a Federally Qualified Health Center Buprenorphine Program: Pennsylvania, 2017-2018. *Am J Public Health*. 2020;110(4):580-586.
73. Haddad MS, Zelenev A, Altice FL. Integrating Buprenorphine Maintenance Therapy into Federally Qualified Health Centers: Real-World Substance Abuse Treatment Outcomes. *Drug Alcohol Depend*. 2013;131(1-2):127-135.
74. Lombardi BM, de Saxe Zerden L, Greeno C. Federally Qualified Health Centers Use of Telehealth to Deliver Integrated Behavioral Health Care During COVID-19. *Community Ment Health J*. 2022:1-9.
75. The Pew Charitable Trusts. *Opioid Treatment Programs: A Key Treatment System Component*. Pew Issue Brief. Published July 16, 2021.
76. SUPPORT for Patients and Communities Act. PL 115-271.
77. The Pew Charitable Trusts. *Overview of Opioid Treatment Program Regulations by State 2022*. Pew Issue Brief. Published September 19, 2022.
78. Bernstein SE, Bennett D. Zoned Out: "NIMBYism", Addiction Services and Municipal Governance in British Columbia. *Int J Drug Policy*. 2013;24(6):e61-65.
79. Lofaro RJ, Miller HT. Narrative Politics in Policy Discourse: The Debate Over Safe Injection Sites in Philadelphia, Pennsylvania. *Contemp Drug Probl*. 2021;48(1):75-95.
80. Mann C. *Health Homes for Enrollees with Chronic Conditions*. HHS, Centers for Medicare & Medicaid. Published November 16, 2010. Accessed May 26, 2023. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf
81. State Drug Utilization Data. Medicaid.gov; 2022. Accessed April 10, 2023. https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html
82. Drug Utilization Review (DUR). Medicaid.gov; 2021. Updated November 8, 2021. Accessed September 8, 2023. https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/index.html
83. Medicaid Drug Rebate Program Data. Medicaid.gov; 2023. Updated 12, 2023. Accessed June 17, 2023. https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/medicaid-drug-rebate-program-data/index.html
84. Medicaid Drug Rebate Program (MDRP). Medicaid.gov; 2022. Updated August 11, 2022. Accessed June 17, 2023. https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html

85. Medicaid Behavioral Health Services: Methadone for Medication Assisted Treatment (MAT). Kaiser Family Foundation; 2022. Accessed May 26, 2023. https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-methadone-for-medication-assisted-treatment-mat/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

86. Lofwall MR, Walsh SL. A Review of Buprenorphine Diversion and Misuse: the Current Evidence Base and Experiences from Around the World. *J Addict Med*. 2014;8(5):315-326.

87. *CA Bridge Impact Update January 2023*. Cabridge.org; 2023. Accessed September 7, 2023. https://bridgetotreatment.org/wp-content/uploads/CA-Bridge-Impact-Update-January-2023-1.pdf

88. Snyder H, Kalmin MM, Moulin A, Campbell A, Goodman-Meza D, Padwa H, Clayton S, Speener M, Shoptaw S, Herring AA. Rapid Adoption of Low-Threshold Buprenorphine Treatment at California Emergency Departments Participating in the CA Bridge Program. *Ann Emerg Med*. 2021;78(6):759-772.

89. *GUIDE: Acute Care Treatment of Alcohol Use Disorder*. bridgetotreatment, November 2020. Accessed September 7, 2023. https://bridgetotreatment.org/resource/acute-care-treatment-of-alcohol-use-disorder/

90. Anderson ES, Rusoja E, Luftig J, Ullal M, Shardha R, Schwimmer H, Friedman A, Hailozian C, Herring AA. Effectiveness of Substance Use Navigation for Emergency Department Patients With Substance Use Disorders: An Implementation Study. *Ann Emerg Med*. 2023;81(3):297-308.

91. Substance Abuse and Mental Health Services Administration (SAMHSA). *2021 Report to Congress on the State Opioid Response Grants (SOR)*. Samhsa.gov; 2021. Accessed May 25, 2023. https://www.samhsa.gov/sites/default/files/2021-state-opioid-response-grants-report.pdf

92. Colorado Health Institute. *Needs Assessment for the SAMHSA State Targeted Response to the Opioid Crisis Grant*. Office of Behavioral Health, Colorado Department of Human Services; 2017. Accessed May 25, 2023. https://drive.google.com/file/d/0B_Qu7DlYJwx7d0FuVzdwVFp0bVU/view?resourcekey=0-DfHMB60BNyGpsMEqdZezUQ

93. The Evaluation Center at University of Colorado Denver. *State Opioid Response Grant: Mobile Health Units Delivering MAT Treatment Year Two Evaluation Report*. Colorado Department of Human Services, Office of Behavioral Health; 2020. Accessed May 25, 2023. https://drive.google.com/file/d/18ATZ3FSoRrMNJfiuh8qfc_Gbg-EhX1hy/view

94. Rural Health Information Hub. *Mobile Health Units for Opioid Disorder Treatment*. RHIhub; 2021. Accessed May 26, 2023. https://www.ruralhealthinfo.org/project-examples/1089

95. The White House: Executive Office of the President. *High Intensity Drug Trafficking Area Annual Report 2021*. Accessed July 10, 2023. https://www.whitehouse.gov/wp-content/uploads/2021/08/2021-HIDTA-Annual-Congressional-Report-FINAL-FOR-TRANSMISSION.pdf

96. *North Carolina State Opioid Response Grant Application*. NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services: Department of Health and Human Services; 2018. Accessed May 25, 2023. https://www.ncdhhs.gov/documents/files/nc-state-opioid-response-application-posted/download

97. National Institute on Drug Abuse. *Criminal Justice DrugFacts*. National Institutes of Health; 2020.

98. Mital S, Wolff J, Carroll JJ. The relationship between incarceration history and overdose in North America: A scoping review of the evidence. *Drug Alcohol Depend*. 2020;213:108088.

99. Legislative Analysis and Public Policy Association. *The Intensive Recovery Treatment Support (IRTS) Program*. October 2019. Accessed May 26, 2023. https://legislativeanalysis.org/intensive-recovery-treatment-support/#:~:text=The%20IRTS%20program%20maintains%20a,and%20most%20importantly%2C%20peer%20navigators

100. Hillis M, Kuebler C, Treitler P. *Providing Team-Based, Recovery Focused Support for People with Substance Use Disorders Leaving State Prisons*. Camden Coalition Webinar; 2022. Accessed August 31, 2023. https://camdenhealth.org/resources/after-incarceration-providing-team-based-recovery-focused-support-for-people-with-substance-use-disorders-leaving-state-prisons/

101. Enich M, Treitler P, Swarbrick M, Belsky L, Hillis M, Crystal S. Peer Health Navigation Experiences Before and After Prison Release Among People With Opioid Use Disorder. *Psychiatr Serv*. 2023;74(7):737-745.

102. Substance Abuse and Mental Health Services Administration (SAMHSA). *Incorporating Peer Support Into Substance Use Disorder Treatment Services*. Treatment Improvement Protocol (TIP) Series 64. 2023. Accessed May 26, 2023. https://store.samhsa.gov/sites/default/files/pep23-02-01-001.pdf

103. West Virginia University Health System. *WVCTSI Expands Access to Substance Abuse Treatment in West Virginia*. WVUMedicine.org; 2017. Accessed May 26, 2023. https://wvumedicine.org/news/article/wvctsi-expands-access-to-substance-abuse-treatment-in-west-virginia/

104. Lander LR, Zheng W, Hustead JD, Mahoney III JJ, Berry JH, Marshalek P, Winstanley EL. Long-Term Treatment Retention in West Virginia's Comprehensive Opioid Addiction Treatment (COAT) Program. *J Neurol Sci*. 2020;411:116712.

105. West Virginia University School of Medicine. Comprehensive Opioid Addiction Treatment (COAT). Date unknown. Accessed May 26, 2023. https://medicine.hsc.wvu.edu/bmed/addiction-services/comprehensive-opioid-addiction-treatment-coat/

106. National Institute on Drug Abuse. Drug Overdose Death Rates. National Institutes of Health; 2023. Accessed May 5, 2023. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

APPENDIX A

Coverage of Medications for Alcohol and Opioid Use Disorders by State as of June 2023

Table A-1. State Medicaid Documents and Web Pages Used to Identify Medication Coverage for Alcohol and Opioid Use Disorders or to Reverse Opioid Overdose

State	Effective/ Access Date	Document Name/ Page Description	FFS/ MMCO
Alabama	12/22/22	AL Medicaid Drug Lookup	FFS
Alaska	4/20/23	AK PDL	FFS
	4/20/23	Max Units List	FFS
	4/20/23	AK Medicaid PA Medication List	FFS
	4/20/23	AK Medicaid PA: Main Page	FFS
Arizona	4/20/23	Arizona Health Care Cost Containment System Pharmacy Main Page	FFS
	4/20/23	AZ PA Guidelines	FFS
	4/20/23	AZ PDL	FFS
	12/13/22	AZ Health Care Cost Containment System is the AZ Medicaid Program	MMCO
Arkansas	12/18/22	AR PDL	FFS
	12/18/22	AR Prescription Drug Program PA Criteria (magellanrx.com)	FFS
	12/18/22	AR formulary	FFS
	12/19/22	AR PASSE serves Medicaid beneficiaries with complex behavioral health, developmental, or intellectual disabilities. PASSE complies with the AR Medicaid PDL	MMCO
	12/19/22	AR PASSE service guide	MMCO

State	Effective/ Access Date	Document Name/ Page Description	FFS/ MMCO
California	5/30/23	Medi-Cal Links Page	FFS
	5/30/23	Beneficiaries Links Page	FFS
	5/1/23	Prescription Contract Drugs List	FFS
	12/28/22	Medi-Cal links	MMCO
	12/28/22	County Organized Health Systems (COHS) plans	MMCO
	12/28/22	Regional Model Benefits	MMCO
	12/28/22	CA Health & Wellness (regional plan) PDL	MMCO
	12/28/22	Senior Care Action Network (SCAN) formulary documents	MMCO
	12/28/22	Positive Healthcare/Los Angeles, specialty plan	MMCO
	12/28/22	Family Mosaic Program/San Francisco, specialty plan	MMCO
Colorado	4/1/23	CO PDL links; PA policy links	FFS
	12/20/22	CO Medicaid MMCOs	MMCO
	12/20/22	Rocky Mountain Health Plans	MMCO
	12/20/22	Description of SUD benefits	MMCO
	12/20/22	Denver Health formulary	MMCO
Connecticut	4/13/23	CT PDL	FFS
	4/13/23	CT PDL	FFS
	1/2/23	CT Behavioral Health Partnership	FFS
Delaware	1/15/23	DE Drug Lookup	FFS
	1/15/23	DE Pharmacy Page (PDL, PA, etc.)	FFS
	1/15/23	Amerihealth Caritas Member Handbook	MMCO
	1/15/23	Amerihealth Caritas Searchable Formulary	MMCO
	1/15/23	Highmark Health Options pharmacy page	MMCO
	1/15/23	Highmark Health Options formulary	MMCO
	1/15/23	Delaware First Health pharmacy page	MMCO
	1/15/23	Delaware First Health handbook and forms links	MMCO
District of Columbia	3/17/23	DC PDL	FFS
	5/30/23	DC PDL links	FFS
	3/17/23	DC MMCOs	MMCO
	3/17/23	Amerihealth Caritas searchable formulary	MMCO
	9/1/22	Carefirst PDL	MMCO
	3/17/23	Amerigroup DC Medicaid pharmacy page	MMCO

State	Effective/ Access Date	Document Name/ Page Description	FFS/ MMCO
Florida	1/4/23	FL PDL	FFS
	1/4/23	FL Pharmacy Policy	FFS
	1/4/23	Statewide Medicaid Managed Care home	MMCO
Georgia	5/1/23	GA PDL	FFS
	5/1/23	GA MMCOs	MMCO
	5/1/23	Peach State Health Plan pharmacy page	MMCO
	5/1/23	Caresource PDL & related documents	MMCO
Hawaii	1/9/23	HI pharmacy Home	FFS
	1/9/23	HI FFS overview	FFS
	1/9/23	HI MMCO plans	MMCO
	1/9/23	Alohacare formulary	MMCO
	1/9/23	Alohacare drug lookup	MMCO
	1/9/23	HMSA Quest formulary	MMCO
	1/9/23	HMSA Quest member handbook	MMCO
	1/9/23	KP Quest benefits & formulary	MMCO
	1/9/23	Ohana Health Plan pharmacy page	MMCO
	1/9/23	Wellcare pharmacy page	MMCO
	1/9/23	Ohana drug lookup	MMCO
Idaho	1/1/23	ID FFS Pharmacy links	FFS
	1/1/23	ID PDL	FFS
	1/1/23	ID PA form	FFS
Illinois	1/1/23	IL PDL	FFS
	1/16/23	IL Drug Search	FFS
	1/16/23	HealthChoice Illinois	MMCO
Indiana	5/17/23	Indiana Medicaid Preferred Drug List	FFS
	5/22/23	Healthy Indiana Plan PDL	MMCO
	5/22/23	Indiana Managed Health Services	MMCO
Iowa	6/1/23	Iowa PDLs	FFS & MMCO
	1/1/23	Iowa Medicaid Drug PA Criteria	FFS & MMCO
Kansas	5/17/23	Kansas NDC Code Search	FFS
	3/15/23	CRITERIA FOR PA Buprenorphine	
Kentucky	5/4/23	Kentucky Medicaid Pharmacy Program Single PDL	FFS & MMCO
	5/4/23	Kentucky Medicaid Single PDL PA Criteria	FFS & MMCO

State	Effective/ Access Date	Document Name/ Page Description	FFS/ MMCO
Louisiana	5/17/23	Louisiana Medicaid PDL/Non-Preferred Drug List (NPDL)	FFS & MMCO
	5/17/23	Louisiana Methadone Point of Sale Safety Limits	
Maine	5/5/23	Maine PDL	FFS
	5/22/23	MaineCare PA - Buprenorphine	
Maryland	3/17/23	Maryland Office of Pharmacy Services Medicaid Pharmacy Program Preferred Drug List	FFS
	5/23/23	Maryland Medicaid Pharmacy Program FFS covered medication list on Formulary Navigator™	FFS
	5/23/23	OPIOID PA FORM	FFS & MMCO
	5/1/23	Aetna Better Health of Maryland Formulary Guide	MMCO
	3/1/23	MedStar Family Choice – Maryland HealthChoice Prescribing Guide	MMCO
	1/1/15	Maryland Clinical Criteria for SUD	FFS
Massachusetts	5/17/23	MassHealth Drug List	FFS & MMCO
	5/17/23	PA Form for Opioids	FFS & MMCO
Michigan	5/17/23	Michigan PDL/Single PDL	FFS & MMCO
	5/17/23	Michigan Department of Health & Human Services Quantity Limitations	
Minnesota	5/17/23	Minnesota FFS and Managed Care Medicaid Uniform PDL effective: March 1, 2023	FFS & MMCO
Mississippi	4/1/23	MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST	FFS & MMCO
	2/3/20	SUBLOCADE™ (buprenorphine) extended-release injection PA Criteria	FFS & MMCO
	2/2/20	Vivitrol® (naltrexone) PA Criteria	FFS & MMCO
Missouri	5/1/23	MO HealthNet PDL	FFS
	5/18/23	Opioid Policy Update	FFS
Montana	7/20/22	Montana Medicaid Preferred Drug List (PDL)	FFS
	6/1/17	Montana Healthcare Programs Buprenorphine-containing products (transmucosal) for Opioid SUD (updated 2/2021)	FFS
	4/20/21	Montana Healthcare Programs PA Request Form for Use of Vivitrol (naltrexone extended-release injectable suspension)	
Nebraska	5/1/23	Medicaid-Approved PDL	FFS
	4/1/23	Heritage Health PDL	MMCO

State	Effective/ Access Date	Document Name/ Page Description	FFS/ MMCO
Nevada	5/1/23	Medicaid-Approved PDL	FFS & MMCO
New Hampshire	4/11/23	Medicaid-Approved PDL	FFS
	5/1/23	NH Healthy Families PDL	MMCO
New Jersey	5/1/23	Medicaid-Approved PDL	FFS
	4/1/23	United Healthcare PDL	MMCO
	5/1/23	Amerigroup PDL	MMCO
New Mexico	5/1/23	Western Sky Community PDL	FFS
	1/1/23	Blue Cross Community Centennial DL	MMCO
New York	4/27/23	New York Medicaid Pharmacy Program PDL	FFS
	3/1/23	Medicaid-Approved PDL	FFS
	4/1/23	Empire Formulary for HARP	MMCO
North Carolina	10/1/22	Medicaid-Approved PDL	FFS
North Dakota	1/1/23	Pharmacy Drug Coverage Policy Manual	FFS & MMCO
Ohio	1/1/23	Unified PDL	FFS & MMCO
Oklahoma	2/20/23	OHCA Substance Use Stewardship	FFS
	5/24/23	SoonerSelect Web Page	FFS
	9/12/22	OHCA Policies and Rules	FFS
Oregon	10/1/22	FFS Enforceable Physical Health PDL	FFS & MMCO
Pennsylvania	1/9/23	PDHS Statewide PDL	FFS & MMCO
Puerto Rico	6/11/21	State Plan Amendment 21-0002	FFS
	5/31/22	Vita Health Plan Covered PDL	MMCO
	9/1/21	Managed Care in Puerto Rico	MMCO
Rhode Island	7/18/22	Executive Office of HHS Rhode Island FFS Medicaid Preferred Drug List (PDL)	FFS
	4/1/23	Neighborhood Health Plan of Rhode Island 23 Medicaid Drug formulary	MMCO
South Carolina	1/1/23	South Carolina Department of HHS PDL	FFS & MMCO
South Dakota	10/1/22	South Dakota Medicaid Drugs and Biologicals Fee Schedule	FFS
Tennessee	5/1/23	TennCare PDL	FFS & MMCO

State	Effective/ Access Date	Document Name/ Page Description	FFS/ MMCO
Texas	1/1/23	Texas Preferred Drug List	FFS
	5/1/23	TEXAS STAR COMPLETE FORMULARY	MMCO
	5/2/23	Texas HHS Vendor Drug Program	MMCO
	1/1/23	Texas Preferred Drug List	MMCO
U.S. Virgin Islands	5/2/23	Medicaid & CHIP in United States Virgin Islands	FFS
Utah	5/1/23	Utah Medicaid PDL	FFS & MMCO
Vermont	4/21/23	Department of Vermont Health Access Pharmacy Benefit Management Program Vermont PDL and Drugs Requiring Prior Authorization	FFS
Virginia	1/1/22	Virginia PDL/Common Core Formulary QuickList	FFS
	5/2/23	State Drug Utilization Data 22	FFS
	1/1/22	Virginia PDL / Common Core Formulary QuickList	MMCO
	5/2/23	State Drug Utilization Data 22	MMCO
Washington	4/1/23	PDL Washington – Apple Health	FFS
	5/2/23	Client Formulary Navigator	MMCO
West Virginia	4/1/23	Bureau for Medical Services West Virginia Medical Services PDL with PA Criteria	FFS & MMCO
Wisconsin	5/11/23	Forward Health Wisconsin Pharmacy	FFS & MMCO
Wyoming	5/5/23	WYOMING MEDICAID PDL	FFS

Table A-2a. Fee-For-Service Medicaid Coverage of Acamprosate, by State, 2022-2023

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	Yes	No	No
Alaska	Yes	No	Yes	No
Arizona	No	No	No	No
Arkansas	No	No	No	No
California	Yes	Yes	No	No
Colorado	Yes	Yes	No	Yes
Connecticut	Yes	No	Yes	-
Delaware	Yes	-	-	-
District of Columbia	No	No	-	-
Florida	Yes	Yes	No	No
Georgia	Yes	Yes	No	Yes
Hawaii	-	-	-	-
Idaho	Yes	No	Yes	-
Illinois	Yes	Yes	No	-
Indiana	Yes	Yes	No	-
Iowa	Yes	Yes	No	No
Kansas	-	-	-	-
Kentucky	Yes	No	No	No
Louisiana	No	-	-	-
Maine	Yes	No	Yes	-
Maryland	Yes	No	No	Yes
Massachusetts	Yes	No	No	No
Michigan	Yes	No	No	No
Minnesota	Yes	No	-	-
Mississippi	No	-	-	-
Missouri	Yes	No	-	-
Montana	Yes	No	-	-
Nebraska	Yes	Yes	No	No
Nevada	Yes	Yes	No	Yes
New Hampshire	No	No	-	-
New Jersey	Yes	Yes	No	Yes

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	Yes	No	No
New York	Yes	Yes	No	Yes
North Carolina	Yes	No	-	-
North Dakota	Yes	No	-	-
Ohio	Yes	No	-	-
Oklahoma	Yes	No	-	-
Oregon	Yes	Yes	No	No
Pennsylvania	Yes	Yes	No	Yes
Puerto Rico	No	No	-	-
Rhode Island	No	-	-	-
South Carolina	No	-	-	-
South Dakota	No	-	-	-
Tennessee	Yes	Yes	No	-
Texas	No	-	-	-
U.S. Virgin Islands	-	-	-	-
Utah	No	-	-	-
Vermont	Yes	Yes	No	-
Virginia	No	-	-	-
Washington	Yes	Yes	No	No
West Virginia	Yes	-	-	-
Wisconsin	Yes	-	-	-
Wyoming	No	-	-	-

Arkansas: No units paid for in 2022 Medicaid Drug Utilization data.

California: State carve-out (billed directly to FFS).

Connecticut: Acamprosate is non-formulary.

Georgia: QLL: quantity or therapy limits apply. The QLL listing and therapy limitation description are in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Maine: Maine has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Montana: Montana has one PDL for all Medicaid health plans.

Virginia: PDL preferred drugs do not require Service Authorizations (SA) unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Table A-2b. Managed Care Organization Medicaid Coverage of Acamprosate, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	No	No	No	No
Arkansas	Provider-Led Arkansas Shared Savings Entity (PASSE) Program	No	No	-	-
	Connect Care	Yes	No	-	-
California	County Organized Health Systems (COHS) Model	Yes	Yes	No	No
	Regional Model	Yes	Yes	No	No
	Geographic Managed Care (GMC) Model	Yes	Yes	No	No
	SCAN	Yes	Yes	No	No
	Two-Plan Model	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	Yes	No	Yes
	Denver Health Medicaid Choice	Yes	Yes	No	No
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	-	-	-
	Highmark Health Options	Yes	No	-	-
	Delaware First Health	Yes	-	-	-
District of Columbia	Amerihealth Caritas	Yes	Yes	No	Yes
	Amerigroup	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Florida	Managed Medical Assistance Program	Yes	Yes	No	No
Georgia	Georgia Families: Caresource	-	-	-	-
	Georgia Families: Peachtree	-	-	-	-
Hawaii	AlohaCare	Yes	Yes	No	Yes
	HMSA	Yes	Yes	No	No
	Kaiser Permanente	Yes	No	Yes	-
	Ohana	Yes	Yes	No	Yes
	United HealthCare	Yes	Yes	No	Yes
	Community Care Services	Yes	Yes	No	Yes
Illinois	HealthChoice Illinois	Yes	Yes	No	No
Indiana	Healthy Indiana	Yes	Yes	No	No
	HoosierCare	Yes	Yes	No	No
	HoosierHealthWise	Yes	No	No	No
Iowa	IA Healthlink	Yes	Yes	No	-
Kansas	KanCare	Yes	-	-	-
Kentucky	Kentucky Managed Care	Yes	No	-	-
Louisiana	Healthy Louisiana	No	-	-	-
	Healthy Louisiana	Yes	No	-	-
Maryland	HealthChoice	Yes	No	No	-
Massachusetts	MassHealth Managed Care	Yes	No	-	-
Michigan	Comprehensive Health Care Program	Yes	No	No	No
	Healthy Michigan Plan	Yes	No	No	No
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	No	No	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	No	-	-	-
Missouri	MO HealthNet Managed Care/1915b	Yes	No	No	No
Nebraska	Heritage Health	Yes	Yes	No	Yes
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	Yes	No	Yes
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	No	No
New Jersey	NJFamilyCare	Yes	Yes	No	Yes
	FIDE SNP	Yes	Yes	No	Yes
New Mexico	Centennial Care	Yes	Yes	No	No
New York	Medicaid Advantage Plus	Yes	Yes	No	No
	Medicaid Advantage	Yes	Yes	No	No
	Medicaid Managed Care	Yes	Yes	No	Yes
	Health and Recovery Plans	Yes	Yes	No	No
North Dakota	North Dakota Medicaid Expansion	No	No	-	-
Ohio	Ohio Medicaid Managed Care Program	Yes	No	-	-
Oregon	OHP - Oregon Health Plan	Yes	Yes	No	No
Pennsylvania	Health & Wellness	Yes	Yes	No	Yes
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	No	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
South Carolina	South Carolina Managed Care Organizations	No	-	-	-
	South Carolina Medical Homes Network	No	-	-	-
Tennessee	TennCare II	No	-	-	-
Texas	STAR	Yes	No	No	-
	STAR+PLUS	Yes	No	No	-
	STAR HEALTH	Yes	No	No	-
	STAR KIDS	Yes	-	-	-
Utah	Utah Medicaid Integrated Care	No	-	-	-
	UNI HOME	No	-	-	-
	Choice of Health Care Delivery	No	-	-	-
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	No	No
	Medallion 4.0	Yes	Yes	No	No
West Virginia	Mountain Health Promise	Yes	-	-	-
	Mountain Health Trust	Yes	-	-	-
Washington	Apple Health/ Healthy Options Health Home Program	Yes	Yes	No	No
	Fully Integrated Managed Care (FIMC)	Yes	Yes	No	No
Wisconsin	SSI Managed Care	Yes	-	-	-
	BadgerCare Plus	Yes	-	-	-
	Family Care Partnership	Yes	-	-	-

Florida: Acamprosate's presence on the MMCO's PDLs is inconsistent.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Texas: We used Texas PDL to answer "preferred status" but used the Formulary for Medicaid-covered drugs.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require Service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Table A-3a. Fee-For-Service Medicaid Coverage of Disulfiram, by State, 2022-2023

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	Yes	No	No
Alaska	Yes	No	Yes	No
Arizona	No	No	No	No
Arkansas	Yes	No	No	No
California	Yes	Yes	No	No
Colorado	Yes	Yes	No	Yes
Connecticut	Yes	No	Yes	-
Delaware	Yes	-	-	-
District of Columbia	No	No	-	-
Florida	Yes	Yes	No	No
Georgia	Yes	Yes	No	Yes
Hawaii	-	-	-	-
Idaho	Yes	No	Yes	-
Illinois	Yes	Yes	No	-
Indiana	Yes	Yes	No	No
Iowa	Yes	Yes	No	No
Kansas	-	-	-	-
Kentucky	No	-	-	-
Louisiana	No	-	-	-
Maine	Yes	Yes	No	No
Maryland	Yes	No	-	-
Massachusetts	Yes	No	No	No
Michigan	Yes	No	No	No
Minnesota	Yes	No	-	-
Mississippi	No	No	-	-
Missouri	Yes	No	-	-
Montana	Yes	No	-	-
Nebraska	Yes	Yes	No	No
Nevada	Yes	Yes	No	No
New Hampshire	No	No	-	-
New Jersey	Yes	Yes	No	No

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	Yes	No	No
New York	Yes	Yes	No	No
North Carolina	Yes	No	-	-
North Dakota	Yes	No	-	-
Ohio	No	No	-	-
Oklahoma	Yes	No	-	-
Oregon	Yes	No	-	-
Pennsylvania	Yes	Yes	No	Yes
Puerto Rico	No	No	-	-
Rhode Island	No	-	-	-
South Carolina	No	-	-	-
South Dakota	Yes	-	-	-
Tennessee	No	-	-	-
Texas	No	-	-	-
U.S. Virgin Islands	-	-	-	-
Utah	No	-	-	-
Vermont	Yes	Yes	No	-
Virginia	No	-	-	-
Washington	Yes	Yes	No	-
West Virginia	Yes	-	-	-
Wisconsin	Yes	-	-	-
Wyoming	No	-	-	-

California: State carve-out (billed directly to FFS).

Delaware: Disulfiram is in the "supplemental formulary."

Georgia: QLL: quantity or therapy limits apply. The QLL listing and therapy limitation description are in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Maine: Maine has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Montana: Montana has one PDL for all Medicaid health plans.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Table A-3b. Managed Care Organization Medicaid Coverage of Disulfiram, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Yes	No	No	No
Arkansas	PASSE Program	Yes	No	-	-
	Connect Care	Yes	No	-	-
California	County Organized Health Systems (COHS) Model	Yes	Yes	No	No
	Regional Model	Yes	Yes	No	No
	GMC Model	Yes	Yes	No	No
	SCAN	Yes	Yes	No	No
	Two-Plan Model	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	Yes	No	Yes
	Denver Health Medicaid Choice	Yes	Yes	No	No
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	-	No	-
	Highmark Health Options	Yes	-	-	-
	Delaware First Health	Yes	Yes	No	-
District of Columbia	Amerihealth Caritas	Yes	Yes	No	No
	Amerigroup	Yes	Yes	No	No
Florida	Managed Medical Assistance Program	Yes	Yes	No	No
Georgia	Georgia Families: Caresource	Yes	Yes	No	No
	Georgia Families: Peachtree	Yes	Yes	No	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Hawaii	AlohaCare	Yes	Yes	No	No
	HMSA	Yes	Yes	No	No
	Kaiser Permanente	Yes	Yes	-	-
	Ohana	Yes	Yes	No	No
	United HealthCare	Yes	Yes	No	Yes
	Community Care Services	Yes	Yes	No	No
Illinois	HealthChoice Illinois	Yes	Yes	No	No
Indiana	Healthy Indiana Plan	Yes	Yes	No	Yes
	Hoosier Care Connect	Yes	Yes	No	Yes
	Hoosier Healthwise	Yes	Yes	No	Yes
Iowa	IA Healthlink	Yes	Yes	No	No
Kansas	KanCare	Yes	No	-	-
Kentucky	Kentucky Managed Care	Yes	No	-	-
Louisiana	Healthy Louisiana	Yes	-	-	-
Maryland	HealthChoice	Yes	Yes	No	-
Massachusetts	MassHealth Managed Care	Yes	No	No	No
Michigan	Comprehensive Health Care Program	Yes	No	No	No
	Healthy Michigan Plan	Yes	No	No	No
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	No	No	No
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	No	-	-	-
Missouri	MO HealthNet Managed Care/1915b	Yes	No	No	No
Nebraska	Heritage Health	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	Yes	No	No
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	No	No
New Jersey	NJFamilyCare	Yes	Yes	No	Yes
	FIDE SNP	Yes	Yes	No	No
New Mexico	Centennial Care	Yes	Yes	No	No
New York	Medicaid Advantage Plus	Yes	Yes	No	No
	Medicaid Advantage	Yes	Yes	No	No
	Medicaid Managed Care	Yes	Yes	No	Yes
	Health and Recovery Plans	Yes	Yes	No	No
North Dakota	North Dakota Medicaid Expansion	No	No	-	-
Ohio	Ohio Medicaid Managed Care Program	Yes	No	-	-
Oregon	OHP - Oregon Health Plan	Yes	No	-	-
Pennsylvania	Health & Wellness	Yes	Yes	No	Yes
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	No	No
South Carolina	South Carolina Managed Care Organizations	No	-	-	-
	South Carolina Medical Homes Network	No	-	-	-
Tennessee	TennCare II	No	-	-	-
Texas	STAR	Yes	No	No	-
	STAR+PLUS	Yes	No	No	-
	STAR HEALTH	Yes	No	No	-
	STAR KIDS	Yes	-	-	-
Utah	Utah Medicaid Integrated Care	No	-	-	-
	UNI HOME	No	-	-	-
	Choice of Health Care Delivery	No	-	-	-

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	No	No
	Medallion 4.0	Yes	Yes	No	No
Washington	Apple Health/Healthy Options Health Home Program	Yes	Yes	No	-
	Fully Integrated Managed Care (FIMC)	Yes	Yes	No	-
West Virginia	Mountain Health Promise	Yes	-	-	-
	Mountain Health Trust	Yes	-	-	-
Wisconsin	SSI Managed Care	Yes	-	-	-
	BadgerCare Plus	Yes	-	-	-
	Family Care Partnership	Yes	-	-	-

California: For COHS, PA: "All services rendered to COHS recipients (except for emergency, sensitive, minor consent, and SERVICES NOT CAPITATED under the COHS contract) must have prior approval from the recipient's primary care provider or the COHS medical director."

Colorado: For Accountable Care Collaborative: Rocky Mountain Health Plans Prime, QLL for 250 mg tab not 500 mg tab.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require Service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Table A-4a. Fee-For-Service Medicaid Coverage of Naltrexone, by State, 2022-2023

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	Yes	No	No
Alaska	Yes	Yes	No	No
Arizona	Yes	Yes	No	No
Arkansas	Yes	No	No	No
California	Yes	Yes	No	No
Colorado	Yes	Yes	No	No
Connecticut	Yes	Yes	No	-
Delaware	Yes	Yes	No	No
District of Columbia	Yes	Yes	No	-
Florida	Yes	Yes	No	Yes
Georgia	Yes	Yes	No	No
Hawaii	-	-	-	-
Idaho	Yes	Yes	Yes	No
Illinois	Yes	Yes	No	-
Indiana	Yes	-	-	-
Iowa	Yes	Yes	No	No
Kansas	-	-	-	-
Kentucky	Yes	Yes	No	-
Louisiana	Yes	Yes	-	-
Maine	Yes	Yes	Yes	No
Maryland	Yes		No	Yes
Massachusetts	Yes	No	Yes	Yes
Michigan	Yes	No	No	Yes
Minnesota	Yes	No	-	-
Mississippi	Yes	Yes	No	No
Missouri	Yes	-	-	-
Montana	Yes	Yes	-	-
Nebraska	Yes	Yes	No	No
Nevada	Yes	Yes	No	No
New Hampshire	No	No	-	-
New Jersey	Yes	Yes	No	No

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	Yes	No	No
New York	Yes	Yes	No	No
North Carolina	Yes	Yes	No	No
North Dakota	Yes	Yes	No	No
Ohio	Yes	No	-	-
Oklahoma	Yes	No	-	-
Oregon	Yes	Yes	No	No
Pennsylvania	Yes	Yes	No	No
Puerto Rico	Yes	Yes	No	No
Rhode Island	Yes	Yes	No	-
South Carolina	Yes	-	-	-
South Dakota	Yes	-	-	-
Tennessee	Yes	Yes	No	-
Texas	Yes	Yes	-	-
U.S. Virgin Islands	-	-	-	-
Utah	Yes	Yes	No	No
Vermont	Yes	Yes	No	-
Virginia	Yes	Yes	No	-
Washington	Yes	Yes	No	-
West Virginia	Yes	No	-	-
Wisconsin	Yes	Yes	No	-
Wyoming	Yes	Yes	Yes	-

California: State carve-out (billed directly to FFS).

Florida: 2 capsules/day (excluding patients with cancer or sickle cell).

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Maine: Maine has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Montana: Montana has one PDL for all Medicaid health plans.

Nebraska: Age limit restrictions.

New Mexico: Considered a specialty drug.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

West Virginia: We used the generic LUCEMYRA.

Wyoming: Client must have a diagnosis of alcohol or opioid dependance. PA will be required before any narcotic, carisoprodol, or benzodiazepine prescription will be allowed between fills. PA will be required before a short-acting stimulant prescription from any doctor other than the prescriber of naltrexone or Vivitrol will be allowed between fills.

Table A-4b. Managed Care Organization Medicaid Coverage of Naltrexone, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Yes	Yes	No	No
Arkansas	PASSE Program	Yes	No	-	-
California	County Organized Health Systems (COHS) Model	Yes	Yes	No	No
	Regional Model	Yes	Yes	No	No
	GMC Model	Yes	Yes	No	No
	SCAN	Yes	Yes	No	No
	Two-Plan Model	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	Yes	No	No
	Denver Health Medicaid Choice	Yes	Yes	No	No
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	Yes	No	-
	Highmark Health Options	Yes	Yes	No	No
	Delaware First Health	Yes	Yes	No	No
District of Columbia	Amerihealth Caritas	Yes	Yes	No	Yes
	Amerigroup	Yes	Yes	No	No
Florida	Managed Medical Assistance Program	Yes	Yes	No	Yes
Georgia	Georgia Families: Caresource	Yes	Yes	No	No
	Georgia Families: Peachtree	Yes	Yes	No	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Hawaii	AlohaCare	Yes	Yes	No	No
	HMSA	Yes	Yes	No	No
	Kaiser Permanente	Yes	Yes	-	-
	Ohana	Yes	Yes	No	No
	United HealthCare	Yes	Yes	No	No
	Community Care Services	Yes	No	-	-
Illinois	HealthChoice Illinois	Yes	Yes	No	No
Indiana	Healthy Indiana	Yes	Yes	No	Yes
	HoosierCare	Yes	Yes	No	Yes
	HoosierHealthWise	Yes	No	No	Yes
Iowa	IA Healthlink	Yes	Yes	No	No
Kansas	KanCare	Yes	No	-	-
Kentucky	Kentucky Managed Care	Yes	Yes	Yes	No
Louisiana	Healthy Louisiana	Yes	Yes	Yes	-
Maryland	HealthChoice	No	Yes	No	Yes
Massachusetts	MassHealth Managed Care	Yes	No	Yes	-
Michigan	Comprehensive Health Care Program	Yes	No	No	Yes
	Healthy Michigan Plan	Yes	No	No	Yes
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	No	No	-
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	Yes	Yes	-	No
Missouri	MO HealthNet Managed Care/1915b	Yes	Yes	No	No
Nebraska	Heritage Health	Yes	Yes	No	No
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	Yes	No	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	Yes	No
New Jersey	NJFamilyCare	Yes	Yes	No	No
	FIDE SNP	Yes	Yes	No	No
New Mexico	Centennial Care	Yes	Yes	No	No
New York	Medicaid Advantage Plus	Yes	Yes	No	No
	Medicaid Advantage	Yes	Yes	No	No
	Medicaid Managed Care	Yes	Yes	No	Yes
	Health and Recovery Plans	Yes	Yes	No	No
North Dakota	North Dakota Medicaid Expansion	Yes	Yes	No	No
Ohio	Ohio Medicaid Managed Care Program	Yes	No	-	-
	MyCare Ohio Opt-Out Program	-	-	-	-
Oregon	OHP - Oregon Health Plan	Yes	Yes	No	No
Pennsylvania	Health & Wellness	Yes	Yes	No	No
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	No	No
South Carolina	South Carolina Managed Care Organizations	Yes	-	-	-
	South Carolina Medical Homes Network	Yes	-	-	-
Tennessee	TennCare II	Yes	Yes	No	-
Texas	STAR	Yes	Yes	No	-
	STAR+PLUS	Yes	Yes	No	-
	STAR HEALTH	Yes	Yes	No	-
	STAR KIDS	Yes	Yes	No	-
Utah	Utah Medicaid Integrated Care	Yes	Yes	No	No
	UNI HOME	Yes	Yes	No	No
	Choice of Health Care Delivery	Yes	Yes	No	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	No	-
	Medallion 4.0	Yes	Yes	No	-
Washington	Apple Health/Healthy Options Health Home Program	Yes	Yes	No	-
	Fully Integrated Managed Care (FIMC)	Yes	Yes	No	-
West Virginia	Mountain Health Promise	Yes	No	-	-
	Mountain Health Trust	Yes	no	-	-
Wisconsin	SSI Managed Care	Yes	Yes	No	-
	BadgerCare Plus	Yes	Yes	No	-
	Family Care Partnership	Yes	Yes	No	-

California: For COHS, PA: "All services rendered to COHS recipients (except for emergency, sensitive, minor consent, and SERVICES NOT CAPITATED under the COHS contract) must have prior approval from the recipient's primary care provider or the COHS medical director."

Delaware: For Highmark Health, age restriction.

Florida: 2 capsules/day (excluding patients with cancer or sickle cell).

Georgia: Oral naltrexone does not appear on the Georgia Medicaid/PeachCare PDL of preferred and non-preferred drugs, but it does appear on the CareSource Georgia Medicaid.

Hawaii: Diagnosis required for Ohana and United.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Nebraska: Age limitations.

New Hampshire: Considered a specialty drug.

Rhode Island: PDL list does not provide info or dosages. The length of PA is 1 year.

Texas: Used Texas PDL to answer "preferred status" but used the Formulary for Medicaid-covered drugs.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require a Service Authorization.

Washington: Limited to members of a certain age. The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

West Virginia: Used LUCEMYRA, generic version of Naltrexone.

Table A-5a. Fee-For-Service Medicaid Coverage of Extended-Release Injectable Naltrexone, by State, 2022-2023

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	Yes	No	No
Alaska	Yes	Yes	No	No
Arizona	Yes	Yes	No	No
Arkansas	Yes	Yes	Yes	Yes
California	Yes	Yes	No	No
Colorado	Yes	No	Yes	-
Connecticut	Yes	No	Yes	-
Delaware	Yes	Yes	No	No
District of Columbia	Yes	Yes	No	-
Florida	Yes	Yes	No	Yes
Georgia	Yes	Yes	No	Yes
Hawaii	-	-	-	-
Idaho	Yes	Yes	Yes	No
Illinois	Yes	Yes	No	-
Indiana	Yes	-	-	-
Iowa	No	-	-	-
Kansas	-	-	-	-
Kentucky	Yes	Yes	No	No
Louisiana	Yes	No	No	-
Maine	Yes	Yes	No	Yes
Maryland	Yes	Yes	No	Yes
Massachusetts	Yes	No	No	No
Michigan	Yes	No	No	Yes
Minnesota	Yes	No	-	-
Mississippi	Yes	No	Yes	-
Missouri	Yes	Yes	No	No
Montana	Yes	No	-	-
Nebraska	No	No	-	-
Nevada	Yes	No	-	-
New Hampshire	No	No	-	-
New Jersey	Yes	No	-	-

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	Yes	No	No
New York	Yes	Yes	No	Yes
North Carolina	Yes	Yes	No	No
North Dakota	Yes	Yes	No	No
Ohio	Yes	Yes	No	No
Oklahoma	Yes	Yes	No	No
Oregon	Yes	Yes	No	No
Pennsylvania	Yes	Yes	No	Yes
Puerto Rico	Yes	Yes	No	No
Rhode Island	Yes	Yes	Yes	-
South Carolina	Yes	Yes	No	-
South Dakota	No	-	-	-
Tennessee	Yes	Yes	No	Yes
Texas	Yes	Yes	-	-
U.S. Virgin Islands	-	-	-	-
Utah	Yes	Yes	No	Yes
Vermont	Yes	Yes	No	Yes
Virginia	Yes	Yes	No	-
Washington	Yes	Yes	No	Yes
West Virginia	Yes	Yes	No	No
Wisconsin	Yes	Yes	No	-
Wyoming	Yes	Yes	Yes	-

Arkansas: PA: "Prescribers are required to fill out the appropriate Statement of Medical Necessity for Non-Preferred Agents and Injectable Agents."

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission." Limit 1 injection/28 days.

Georgia: QLL: quantity or therapy limits apply. The QLL listing and therapy limitation description are in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

Kentucky: Kentucky has one PDL for all Medicaid health plans. Kentucky has age limits on the quantity of extended-release naltrexone.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Maine: Maine has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Montana: Montana has one PDL for all Medicaid health plans.

New Mexico: Considered a specialty drug.

New York: Considered a specialty drug.

Utah: Minimum Age: 18 years old, 1 unit /28 days.

Vermont: 1 injection (380 mg) per 28 days.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The United Healthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The United Healthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Table A-5b. Managed Care Organization Medicaid Coverage of Extended-Release Injectable Naltrexone, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Yes	Yes	No	No
Arkansas	PASSE Program	No	Yes	-	-
	Connect Care	Yes	Yes	-	-
California	County Organized Health Systems (COHS) Model	Yes	Yes	No	No
	Regional Model	Yes	Yes	No	No
	GMC Model	Yes	Yes	No	No
	SCAN	Yes	Yes	No	No
	Two-Plan Model	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	No	Yes	-
	Denver Health Medicaid Choice	Yes	Yes	No	Yes
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	Yes	No	-
	Highmark Health Options	Yes	Yes	No	No
	Delaware First Health	Yes	Yes	No	No
District of Columbia	Amerihealth Caritas	Yes	Yes	No	Yes
	Amerigroup	Yes	No	-	-
Florida	Managed Medical Assistance Program	Yes	Yes	No	Yes
Georgia	Georgia Families: Caresource	Yes	Yes	No	No
	Georgia Families: Peachtree	Yes	Yes	No	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Hawaii	MedQUEST	-	-	-	-
	AlohaCare	Yes	No	-	-
	HMSA	Yes	No	-	-
	Kaiser Permanente	Yes	No	Yes	-
	Ohana	Yes	No	Yes	-
	United HealthCare	Yes	Yes	No	Yes
	Community Care Services	Yes	No	-	-
Illinois	HealthChoice Illinois	Yes	Yes	No	Yes
Indiana	Healthy Indiana	Yes	Yes	No	Yes
	HoosierCare	Yes	Yes	No	Yes
	HoosierHealthWise	Yes	Yes	No	Yes
Iowa	IA Healthlink	Yes	Yes	No	Yes
Kansas	KanCare	Yes	No	-	-
Kentucky	Kentucky Managed Care	Yes	Yes	No	No
Louisiana	Healthy Louisiana	Yes	No	Yes	Yes
Maryland	HealthChoice	Yes	Yes	No	Yes
Massachusetts	MassHealth Managed Care	Yes	Yes	No	No
Michigan	Comprehensive Health Care Program	Yes	No	No	No
	Healthy Michigan Plan	Yes	No	No	No
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	Yes	No	-
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	Yes	No	Yes	No
Missouri	MO HealthNet Managed Care/1915b	Yes	Yes	No	No
Nebraska	Heritage Health	Yes	No	-	-
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	No	No
New Jersey	NJFamilyCare	Yes	Yes	No	Yes
	FIDE SNP	Yes	No	-	-
New Mexico	Centennial Care	Yes	No	-	-
New York	Medicaid Advantage Plus	Yes	Yes	No	Yes
	Medicaid Advantage	Yes	Yes	No	No
	Medicaid Managed Care	Yes	Yes	No	Yes
	Health and Recovery Plans	Yes	Yes	No	Yes
North Dakota	North Dakota Medicaid Expansion	Yes	Yes	No	No
Ohio	Ohio Medicaid Managed Care Program	Yes	Yes	No	No
	MyCare Ohio Opt-Out Program	-	-	-	-
Oregon	OHP - Oregon Health Plan	Yes	Yes	No	No
Pennsylvania	Health & Wellness	Yes	Yes	No	Yes
	Community HealthChoices	-	-	-	-
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	No	No
South Carolina	South Carolina Managed Care Organizations	Yes	Yes	No	-
	South Carolina Medical Homes Network	Yes	Yes	No	-
Tennessee	TennCare II	Yes	Yes	No	Yes
Texas	STAR	Yes	Yes	No	-
	STAR+PLUS	Yes	Yes	No	-
	STAR HEALTH	Yes	Yes	No	-
	STAR KIDS	Yes	Yes	No	-
Utah	Utah Medicaid Integrated Care	Yes	Yes	No	Yes
	UNI HOME	Yes	Yes	No	Yes
	Choice of Health Care Delivery	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	No	-
	Medallion 4.0	Yes	Yes	No	-
Washington	Apple Health/Healthy Options Health Home Program	Yes	Yes	No	Yes
	Fully Integrated Managed Care (FIMC)	Yes	Yes	No	Yes
West Virginia	Mountain Health Promise	Yes	Yes	No	No
	Mountain Health Trust	Yes	Yes	No	No
Wisconsin	SSI Managed Care	Yes	Yes	No	-
	BadgerCare Plus	Yes	Yes	No	-
	Family Care Partnership	Yes	Yes	No	-

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission." Limit 1 injection/28 days.

Georgia: Caresource's PDL lists a QL, but PeachTree's does not.

Hawaii: Does not appear in Alohacare or HMSA PDL. Diagnosis required for United Healthcare.

Illinois: NDS = Non-Extended Days' Supply: you will be limited to how many days' supply you can receive.

Kentucky: Kentucky has one PDL for all Medicaid health plans. Kentucky has age limits on extended-release naltrexone.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

New Hampshire: Considered a specialty drug.

New York: Considered a specialty drug.

Rhode Island: The PDL list does not provide information on preferred status, psychosocial treatment, qty limits or dosages. The length of PA is 1 year.

Texas: Used Texas PDL to answer "preferred status" but used the Formulary for Medicaid-covered drugs.

Utah: Minimum Age: 18 years old. 1 unit/28 days.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require a Service Authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Table A-6a. Fee-For-Service Medicaid Coverage of Buprenorphine, by State, 2022-2023

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	No	Yes	Yes
Alaska	Yes	No	Yes	Yes
Arizona	Yes	No	Yes	No
Arkansas	Yes	Yes	Yes	Yes
California	Yes	Yes	No	No
Colorado	Yes	Yes	No	Yes
Connecticut	Yes	Yes	No	-
Delaware	Yes	Yes	No	Yes
District of Columbia	Yes	Yes	No	-
Florida	Yes	Yes	No	Yes
Georgia	Yes	Yes	No	Yes
Hawaii	-	-	-	-
Idaho	Yes	Yes	Yes	Yes
Illinois	Yes	Yes	No	-
Indiana	Yes	Yes	No	Yes
Iowa	Yes	Yes	Yes	No
Kansas	-	-	-	-
Kentucky	Yes	Yes	No	Yes
Louisiana	Yes	Yes	-	-
Maine	Yes	No	Yes	Yes
Maryland	Yes	Yes	No	Yes
Massachusetts	Yes	No	Yes	Yes
Michigan	Yes	Yes	No	-
Minnesota	Yes	No	No	No
Mississippi	Yes	No	Yes	-
Missouri	Yes	Yes	No	No
Montana	Yes	No		-
Nebraska	Yes	Yes	No	Yes
Nevada	Yes	Yes	No	Yes
New Hampshire	Yes	Yes	Yes	No
New Jersey	Yes	Yes	No	Yes

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	Yes	No	Yes
New York	Yes	Yes	No	Yes
North Carolina	Yes	Yes	No	No
North Dakota	Yes	Yes	No	No
Ohio	Yes	No	No	No
Oklahoma	Yes	Yes	Yes	Yes
Oregon	Yes	No	-	-
Pennsylvania	Yes	Yes	Yes	Yes
Puerto Rico	Yes	Yes	No	No
Rhode Island	Yes	Yes	Yes	-
South Carolina	Yes	Yes	No	No
South Dakota	Yes	-	-	-
Tennessee	Yes	No	Yes	Yes
Texas	Yes	Yes	-	-
U.S. Virgin Islands	-	-	-	-
Utah	Yes	Yes	-	Yes
Vermont	Yes	No	Yes	Yes
Virginia	Yes	Yes	No	-
Washington	Yes	Yes	No	Yes
West Virginia	Yes	Yes	No	No
Wisconsin	Yes	Yes	No	-
Wyoming	Yes	Yes	Yes	-

Alaska: Patch & tablet.

Arizona: Patch & tablet.

Arkansas: PA: "Prescribers are required to fill out the appropriate Statement of Medical Necessity for Non-Preferred Agents and Injectable Agents."

California: State carve-out (billed directly to FFS).

District of Columbia: Tablet.

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission."

Georgia: QLL: quantity or therapy limits apply. The QLL listing and therapy limitation description are in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

Idaho: Film & tablet.

Kentucky: Kentucky has one PDL for all Medicaid health plans. Kentucky has age limits on the quantity of buprenorphine.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Maine: Maine has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Montana: Montana has one PDL for all Medicaid health plans.

Nebraska: Age limit restrictions.

Vermont: QTY Limit: 4 patches/28 days (Maximum 28-day Fill).

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Wisconsin: There is a diagnosis restriction.

Wyoming: Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain PA will be required before any narcotic, benzodiazepine, or carisoprodol prescription will be allowed between fills. PA will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills. Oral buprenorphine will be approved for clients with a documented allergy to naloxone. Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org. Dosage limits apply. PA will be required for doses >16 mg.

Table A-6b. Managed Care Organization Medicaid Coverage of Buprenorphine, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Yes	No	Yes	No
Arkansas	PASSE Program	Yes	Yes	-	-
	Connect Care	Yes	Yes	-	-
California	County Organized Health Systems (COHS) Model	Yes	Yes	No	No
	Regional Model	Yes	Yes	No	No
	GMC Model	Yes	Yes	No	No
	SCAN	Yes	Yes	No	No
	Two-Plan Model	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	Yes	No	Yes
	Denver Health Medicaid Choice	Yes	Yes	No	Yes
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	Yes	No	-
	Highmark Health Options	Yes	Yes	No	Yes
	Delaware First Health	Yes	Yes	No	No
District of Columbia	Amerihealth Caritas	Yes	Yes	No	Yes
	Amerigroup	Yes	Yes	No	Yes
Florida	Managed Medical Assistance Program	Yes	Yes	No	Yes
Georgia	Georgia Families: Caresource	Yes	Yes	No	Yes
	Georgia Families: Peachtree	Yes	Yes	Yes	No

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Hawaii	AlohaCare	Yes	Yes	No	Yes
	HMSA	Yes	Yes	No	No
	Kaiser Permanente	Yes	Yes	-	-
	Ohana	Yes	Yes	No	No
	United HealthCare	Yes	Yes	No	Yes
	Community Care Services	Yes	Yes	No	No
Illinois	HealthChoice Illinois	Yes	Yes	No	No
Indiana	Healthy Indiana	Yes	Yes	No	Yes
	HoosierCare	Yes	Yes	No	Yes
	HoosierHealthWise	Yes	Yes	No	Yes
Iowa	IA Healthlink	Yes	Yes	-	-
Kansas	KanCare	Yes	No	Yes	-
Kentucky	Kentucky Managed Care	Yes	Yes	Yes	Yes
Louisiana	Healthy Louisiana	Yes	Yes	-	-
Maryland	HealthChoice	Yes	Yes	Yes	No
Massachusetts	MassHealth Managed Care	Yes	No	Yes	No
Michigan	Comprehensive Health Care Program	Yes	No	No	No
	Healthy Michigan Plan	Yes	No	No	No
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	No	Yes	Yes
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	Yes	No	Yes	No
Missouri	MO HealthNet Managed Care/1915b	Yes	Yes	No	No
Nebraska	Heritage Health	Yes	Yes	No	Yes
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	Yes	No
New Jersey	NJFamilyCare	Yes	Yes	Yes	Yes
	FIDE SNP	Yes	Yes	No	Yes
New Mexico	Centennial Care	Yes	Yes	No	Yes
New York	Medicaid Advantage Plus	Yes	Yes	No	Yes
	Medicaid Advantage	Yes	Yes	No	Yes
	Medicaid Managed Care	Yes	Yes	No	Yes
	Health and Recovery Plans	Yes	Yes	No	Yes
North Dakota	North Dakota Medicaid Expansion	Yes	No	Yes	No
Ohio	Ohio Medicaid Managed Care Program	Yes	No	No	No
Oregon	OHP - Oregon Health Plan	Yes	No	-	-
Pennsylvania	Health & Wellness	Yes	Yes	Yes	Yes
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	No	Yes
South Carolina	South Carolina Managed Care Organizations	Yes	Yes	No	-
	South Carolina Medical Homes Network	Yes	Yes	No	-
Tennessee	TennCare II	Yes	No	Yes	Yes
Texas	STAR	Yes	No	Yes	-
	STAR+PLUS	Yes	No	Yes	-
	STAR HEALTH	Yes	No	Yes	-
	STAR KIDS	Yes	No	Yes	-
Utah	Utah Medicaid Integrated Care	Yes	No	Yes	Yes
	UNI HOME	Yes	No	Yes	Yes
	Choice of Health Care Delivery	Yes	No	Yes	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	No	-
	Medallion 4.0	Yes	Yes	No	-
Washington	Apple Health/Healthy Options Health Home Program	Yes	Yes	No	Yes
	Fully Integrated Managed Care (FIMC)	Yes	Yes	No	Yes
West Virginia	Mountain Health Promise	Yes	Yes	No	No
	Mountain Health Trust	Yes	Yes	No	No
Wisconsin	SSI Managed Care	Yes	Yes	No	-
	BadgerCare Plus	Yes	Yes	No	-
	Family Care Partnership	Yes	Yes	No	-

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission."

Georgia: Inconsistent between Caresource & Peachtree. Caresource had QL but no PA; Peachtree has PA but no QL.

Hawaii: Ohana requires diagnoses for some doses. United requires a diagnosis.

Kentucky: Kentucky has one PDL for all Medicaid health plans. Kentucky has age limits on quantities of buprenorphine.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Nebraska: Age limitations.

New Jersey: Generic version is preferred. Butrans is non-preferred and requires PA.

Rhode Island: 2 mg, 12 tabs every 1 day; 8 mg, 3 tabs every 1 day.

Utah: Not Required if within Limits. Buprenorphine/Naloxone: Minimum Age - 16 years old, 24 mg & 3 tablets/day.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require Service Authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Wisconsin: Diagnosis restriction.

Table A-7a. Fee-For-Service Medicaid Coverage of Extended-Release Injectable Buprenorphine, by State, 2022-2023

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	Yes	Yes	Yes
Alaska	Yes	Yes	Yes	No
Arizona	No	Yes	Yes	No
Arkansas	No	No	Yes	Yes
California	Yes	Yes	No	No
Colorado	Yes	No	Yes	-
Connecticut	Yes	No	Yes	-
Delaware	Yes	Yes	No	-
District of Columbia	Yes	Yes	No	-
Florida	Yes	Yes	No	Yes
Georgia	No	No	-	-
Hawaii	-	-	-	-
Idaho	No	No	Yes	Yes
Illinois	Yes	Yes	No	-
Indiana	Yes	No	No	Yes
Iowa	No	No	-	-
Kansas	-	-	-	-
Kentucky	Yes	Yes	No	Yes
Louisiana	Yes	No	-	-
Maine	Yes	No	No	No
Maryland	Yes	Yes	No	Yes
Massachusetts	Yes	Yes	No	No
Michigan	Yes	No	No	No
Minnesota	Yes	No	No	-
Mississippi	Yes	No	Yes	No
Missouri	Yes	Yes	No	No
Montana	Yes	No	-	-
Nebraska	No	No	-	-
Nevada	Yes	No	-	-
New Hampshire	Yes	Yes	No	No
New Jersey	No	No	-	-

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	Yes	No	No
New York	Yes	Yes	No	Yes
North Carolina	Yes	Yes	No	No
North Dakota	Yes	Yes	No	No
Ohio	Yes	Yes	No	Yes
Oklahoma	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	No	No
Pennsylvania	Yes	Yes	No	Yes
Puerto Rico	Yes	Yes	No	No
Rhode Island	Yes	Yes	Yes	-
South Carolina	Yes	Yes	No	-
South Dakota	Yes	-	-	-
Tennessee	No	-	-	-
Texas	No	-	-	-
U.S. Virgin Islands	-	-	-	-
Utah	Yes	Yes	No	Yes
Vermont	Yes	No	No	Yes
Virginia	Yes	Yes	No	-
Washington	Yes	Yes	No	Yes
West Virginia	Yes	Yes	No	No
Wisconsin	Yes	Yes	No	-
Wyoming	No	-	-	-

Arkansas: PA: "Prescribers are required to fill out the appropriate Statement of Medical Necessity for Non-Preferred Agents and Injectable Agents."

California: State carve-out (billed directly to FFS).

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission." Limit 1 injection/28 days.

Idaho: SUBLOCADE (buprenorphine) injection will be approved for patients who are stable on sublingual buprenorphine at doses between 8-24 mg daily for at least 30 days with the following documentation: 1) Evidence that the patient has had their cravings and withdrawal symptoms clinically controlled while on sublingual buprenorphine. 2) Clinically valid evidence-based reason to switch from sublingual buprenorphine to injectable SUBLOCADE.

Indiana: Indiana has age limits on quantities of extended-release injectable buprenorphine.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Maine: Maine has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Montana: Montana has one PDL for all Medicaid health plans.

New Mexico: Considered a specialty drug.

New York: Considered a specialty drug.

Vermont: QTY Limit: Maximum 30-day supply.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Wisconsin: There is a diagnosis restriction.

Table A-7b. Managed Care Organization Medicaid Coverage of Extended-Release Injectable Buprenorphine, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Yes	Yes	Yes	No
Arkansas	PASSE Program	No	No	-	-
	Connect Care	Yes	No	-	-
California	COHS Model	Yes	Yes	No	No
	Regional Model	Yes	Yes	No	No
	GMC Model	Yes	Yes	No	No
	SCAN	Yes	Yes	No	No
	Two-Plan Model	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	No	Yes	-
	Denver Health Medicaid Choice	Yes	Yes	No	Yes
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	Yes	-	-
	Highmark Health Options	Yes	Yes	No	No
	Delaware First Health	Yes	Yes	No	No
District of Columbia	Amerihealth Caritas	Yes	Yes	No	Yes
	Amerigroup	-	-	-	-
Florida	Managed Medical Assistance Program	Yes	Yes	No	Yes
Georgia	Georgia Families: Caresource	Yes	-	-	-
	Georgia Families: Peachtree	Yes	Yes	Yes	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Hawaii	MedQUEST	-	-	-	-
	AlohaCare	Yes	No	-	-
	HMSA	Yes	No	-	-
	Kaiser Permanente	Yes	No	Yes	-
	Ohana	Yes	No	Yes	-
	United HealthCare	Yes	No	Yes	-
	Community Care Services	Yes	No	-	-
Illinois	HealthChoice Illinois	Yes	Yes	No	Yes
Indiana	Healthy Indiana	Yes	No	-	-
	HoosierCare	Yes	No	-	-
	HoosierHealthWise	Yes	No	-	-
Iowa	IA Healthlink	Yes	No	-	-
Kansas	KanCare	Yes	No	-	-
Kentucky	Kentucky Managed Care	Yes	Yes	Yes	Yes
Louisiana	Healthy Louisiana	Yes	No	No	Yes
Maryland	HealthChoice	Yes	Yes	No	Yes
Massachusetts	MassHealth Managed Care	Yes	Yes	No	No
Michigan	Comprehensive Health Care Program	Yes	No	No	No
	Healthy Michigan Plan	Yes	No	No	No
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	No	Yes	No
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	Yes	No	Yes	No
Missouri	MO HealthNet Managed Care/1915b	Yes	Yes	No	No
Nebraska	Heritage Health	Yes	No	-	-
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	No	-	-

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	Yes	Yes
New Jersey	NJFamilyCare	Yes	No	-	-
	FIDE SNP	Yes	No	No	No
New Mexico	Centennial Care	Yes	No	-	-
New York	Medicaid Advantage Plus	Yes	Yes	No	No
	Medicaid Advantage	Yes	Yes	No	Yes
	Medicaid Managed Care	Yes	Yes	No	No
	Health and Recovery Plans	Yes	Yes	No	No
North Dakota	North Dakota Medicaid Expansion	Yes	Yes	No	No
Ohio	Ohio Medicaid Managed Care Program	Yes	Yes	No	Yes
	MyCare Ohio Opt-Out Program	-	-	-	-
Oregon	OHP - Oregon Health Plan	Yes	Yes	No	No
Pennsylvania	Health & Wellness	Yes	Yes	No	Yes
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	Yes	No
South Carolina	South Carolina Managed Care Organizations	Yes	Yes	No	-
	South Carolina Medical Homes Network	Yes	Yes	No	-
Tennessee	TennCare II	No	-	-	-
Texas	STAR	No	-	-	-
	STAR+PLUS	No	-	-	-
	STAR HEALTH	No	-	-	-
	STAR KIDS	No	-	-	-

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Utah	Utah Medicaid Integrated Care	Yes	Yes	No	Yes
	UNI HOME	Yes	Yes	No	Yes
	Choice of Health Care Delivery	Yes	Yes	No	Yes
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	No	-
	Medallion 4.0	Yes	Yes	No	-
Washington	Apple Health/Healthy Options Health Home Program	Yes	Yes	No	Yes
	Fully Integrated Managed Care (FIMC)	Yes	Yes	No	Yes
West Virginia	Mountain Health Promise	Yes	Yes	No	No
	Mountain Health Trust	Yes	Yes	No	No
Wisconsin	SSI Managed Care	Yes	Yes	No	-
	BadgerCare Plus	Yes	Yes	No	-
	Family Care Partnership	Yes	Yes	No	-

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission." Limit 1 injection/28 days.

Georgia: Inconsistent between Caresource & Peachtree. Caresource has no listing; Peachtree has it (sublocade) as preferred and with PA.

Hawaii: Does not appear in AlohaCare, Ohana, or HMSA PDLs.

Illinois: Limited to 0.5 mL per 30 days.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

New Hampshire: Considered a specialty drug.

New York: Considered a specialty drug.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require Service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Wisconsin: There is a diagnosis restriction.

Table A-8a. Fee-For-Service Medicaid Coverage of Buprenorphine-Naloxone, by State, 2022-2023

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	No	Yes	Yes
Alaska	Yes	Yes	Yes	Yes
Arizona	Yes	Yes	Yes	No
Arkansas	Yes	Yes	Yes	Yes
California	Yes	Yes	No	No
Colorado	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	No	-
Delaware	Yes	Yes	No	Yes
District of Columbia	Yes	Yes	No	-
Florida	Yes	Yes	No	Yes
Georgia	Yes	Yes	No	Yes
Hawaii	-	-	-	-
Idaho	Yes	Yes	Yes	Yes
Illinois	Yes	Yes	No	-
Indiana	Yes	Yes	No	Yes
Iowa	Yes	Yes	Yes	No
Kansas	-	-	-	-
Kentucky	Yes	Yes	Yes	Yes
Louisiana	Yes	Yes	-	-
Maine	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	No	Yes
Massachusetts	Yes	Yes	Yes	-
Michigan	Yes	Yes	No	No
Minnesota	Yes	Yes	No	No
Mississippi	Yes	Yes	Yes	-
Missouri	Yes	Yes	No	-
Montana	Yes	Yes	No	-
Nebraska	Yes	Yes	No	Yes
Nevada	Yes	Yes	No	Yes
New Hampshire	Yes	Yes	No	No
New Jersey	Yes	Yes	No	Yes

State	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	No	No	Yes
New York	Yes	Yes	No	Yes
North Carolina	Yes	Yes	No	No
North Dakota	Yes	No	Yes	No
Ohio	Yes	Yes	No	No
Oklahoma	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	No	Yes
Pennsylvania	Yes	No	No	Yes
Puerto Rico	Yes	Yes	No	No
Rhode Island	Yes	Yes	No	-
South Carolina	Yes	Yes	No	Yes
South Dakota	Yes	-	-	-
Tennessee	Yes	Yes	Yes	Yes
Texas	Yes	Yes	No	-
U.S. Virgin Islands	-	-	-	-
Utah	Yes	Yes	No	Yes
Vermont	Yes	Yes	Yes	Yes
Virginia	Yes	Yes	No	Yes
Washington	Yes	Yes	No	Yes
West Virginia	Yes	Yes	No	No
Wisconsin	Yes	Yes	No	-
Wyoming	Yes	Yes	Yes	-

Alaska: Tablet & film.

Arizona: Buprenorphine HCL-Naloxone HCL dihydrate film; Suboxone brand only.

Arkansas: PA: "Prescribers are required to fill out the appropriate Statement of Medical Necessity for Non-Preferred Agents and Injectable Agents."

District of Columbia: Film and tablet.

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission." Maximum of 3 sublingual film/tabs per day.

Georgia: QLL: quantity or therapy limits apply. The QLL listing and therapy limitation description are in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

Kentucky: Kentucky has one PDL for all Medicaid health plans. Kentucky has age limits on buprenorphine-naloxone.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Maine: Maine has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Montana: Montana has one PDL for all Medicaid health plans.

Oklahoma: PA required on Zubsolv only.

Utah: 24 mg & 3 films/day.

Vermont: QTY LIMIT: 8 mg = 2 films per day, 4 and 12 mg = 1 film per day, 2 mg N/A. (Maximum daily dose = 16 mg/day, PA required for over 16 mg.)

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Wisconsin: There is a diagnosis restriction.

Wyoming: Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain PA will be required before any narcotic, benzodiazepine, or carisoprodol prescription will be allowed between fills. PA will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills. Oral buprenorphine will be approved for clients with a documented allergy to naloxone.

Table A-8b. Managed Care Organization Medicaid Coverage of Buprenorphine-Naloxone, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Yes	Yes	Yes	No
Arkansas	PASSE Program	Yes	Yes	-	-
	Connect Care	Yes	Yes	-	-
California	COHS Model	Yes	Yes	No	No
	Regional Model	Yes	Yes	No	No
	GMC Model	Yes	Yes	No	No
	SCAN	Yes	Yes	No	No
	Two-Plan Model	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	Yes	No	Yes
	Denver Health Medicaid Choice	Yes	Yes	No	Yes
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	Yes	No	
	Highmark Health Options	Yes	Yes	No	Yes
	Delaware First Health	Yes	Yes	No	No
District of Columbia	Amerihealth Caritas	Yes	Yes	No	Yes
	Amerigroup	Yes	Yes	No	Yes
Florida	Managed Medical Assistance Program	Yes	Yes	No	Yes
Georgia	Georgia Families: Caresource	Yes	Yes	No	Yes
	Georgia Families: Peachtree	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Hawaii	AlohaCare	Yes	Yes	No	Yes
	HMSA	Yes	Yes	No	No
	Kaiser Permanente	Yes	Yes	-	-
	Ohana	Yes	Yes	No	No
	United HealthCare	Yes	Yes	No	Yes
	Community Care Services	Yes	No	-	-
Illinois	HealthChoice Illinois	Yes	Yes	No	No
Indiana	Healthy Indiana	Yes	Yes	No	Yes
	HoosierCare	Yes	Yes	No	Yes
	HoosierHealthWise	Yes	Yes	No	Yes
Iowa	IA Healthlink	Yes	Yes	-	-
Kansas	KanCare	Yes	No	-	-
Kentucky	Kentucky Managed Care	Yes	Yes	Yes	Yes
Louisiana	Healthy Louisiana	Yes	Yes	No	No
Maryland	HealthChoice	Yes	-	-	-
Massachusetts	MassHealth Managed Care	Yes	Yes	Yes	-
Michigan	Comprehensive Health Care Program	Yes	No	No	No
	Healthy Michigan Plan	Yes	No	No	No
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	Yes	No	Yes
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	Yes	Yes	No	No
Missouri	MO HealthNet Managed Care/1915b	Yes	Yes	No	No
Nebraska	Heritage Health	Yes	Yes	No	Yes
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	Yes	Yes
New Jersey	NJFamilyCare	Yes	Yes	No	Yes
	FIDE SNP	Yes	Yes	No	Yes
New Mexico	Centennial Care	Yes	Yes	No	Yes
New York	Medicaid Advantage Plus	Yes	Yes	No	Yes
	Medicaid Advantage	Yes	Yes	No	Yes
	Medicaid Managed Care	Yes	Yes	No	Yes
	Health and Recovery Plans	Yes	Yes	No	Yes
North Dakota	North Dakota Medicaid Expansion	Yes	No	Yes	No
Ohio	Ohio Medicaid Managed Care Program	Yes	Yes	No	No
	MyCare Ohio Opt-Out Program	-	-	-	-
Oregon	OHP - Oregon Health Plan	Yes	Yes	No	Yes
Pennsylvania	Health & Wellness	Yes	Yes	No	Yes
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	No	Yes
South Carolina	South Carolina Managed Care Organizations	Yes	Yes	No	-
	South Carolina Medical Homes Network	Yes	Yes	No	-
Tennessee	TennCare II	Yes	Yes	Yes	Yes
Texas	STAR	Yes	Yes	Yes	-
	STAR+PLUS	Yes	Yes	Yes	-
	STAR HEALTH	Yes	Yes	Yes	-
	STAR KIDS	Yes	Yes	Yes	-
Utah	Utah Medicaid Integrated Care	Yes	Yes	No	Yes
	UNI HOME	Yes	Yes	No	Yes
	Choice of Health Care Delivery	Yes	Yes	No	Yes

State	MMCO	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	No	Yes
	Medallion 4.0	Yes	Yes	No	Yes
Washington	Apple Health/Healthy Options Health Home Program	Yes	Yes	No	Yes
	Fully Integrated Managed Care (FIMC)	Yes	Yes	No	Yes
West Virginia	Mountain Health Promise	Yes	Yes	No	No
	Mountain Health Trust	Yes	Yes	No	No
Wisconsin	SSI Managed Care	Yes	Yes	No	-
	BadgerCare Plus	Yes	Yes	No	-
	Family Care Partnership	Yes	Yes	No	-

Arizona: Suboxone brand only.

Florida: "Auto PA - System automated criteria check for specific requirements (e.g., diagnosis, age, previous therapies, etc.). If all requirements are found, the claims will pay at the pharmacy counter without need of manual PA submission." Maximum of 3 sublingual film/tabs per day.

Georgia: Inconsistent between Caresource & Peachtree. Caresource has no PA for sublingual tab (its only b-n listing); Peachtree has PA for highest dose of film (3 mg) but not 1 mg and 2 mg or sublingual tab.

Hawaii: Ohana: diagnosis required; tablet. United Healthcare: diagnosis required; tablet and film. Does not appear in Ohana CCS PDL.

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Nebraska: Age limitations. Suboxone is preferred.

New Jersey: Generic version is preferred. Suboxone requires PA.

Rhode Island: 3 films/day.

Texas: Used Texas PDL to answer: "preferred status."

Utah: 24 mg & 3 films /day.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require Service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Wisconsin: There is a diagnosis restriction.

Table A-9a. Fee-For-Service Medicaid Coverage of Methadone as MOUD, by State, 2022-2023

State	Does Medicaid cover this drug?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Yes	Yes	Yes
Alaska	Yes	Yes	Yes
Arizona	Yes	Yes	No
Arkansas	Yes	Yes	Yes
California	Yes	Yes	Yes
Colorado	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes
Delaware	Yes	-	-
District of Columbia	Yes	Yes	Yes
Florida	Yes	Yes	Yes
Georgia	Yes	Yes	Yes
Hawaii	Yes	-	-
Idaho	Yes	No	Yes
Illinois	Yes	-	-
Indiana	Yes	Yes	No
Iowa	Yes	Yes	No
Kansas	Yes	-	-
Kentucky	Yes	No	-
Louisiana	Yes	No	Yes
Maine	Yes	-	No
Maryland	Yes	No	Yes
Massachusetts	Yes	Yes	No
Michigan	Yes	No	No
Minnesota	Yes	No	No
Mississippi	Yes	No	No
Missouri	Yes	No	Yes
Montana	Yes	No	-
Nebraska	Yes	-	-
Nevada	Yes	Yes	Yes
New Hampshire	Yes	-	-
New Jersey	Yes	Yes	Yes

State	Does Medicaid cover this drug?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Mexico	Yes	No	No
New York	Yes	Yes	Yes
North Carolina	Yes	No	No
North Dakota	Yes	Yes	No
Ohio	Yes	No	Yes
Oklahoma	Yes	-	-
Oregon	Yes	No	No
Pennsylvania	Yes	No	Yes
Puerto Rico	Yes	No	No
Rhode Island	Yes	Yes	-
South Carolina	Yes	-	-
South Dakota	Yes	-	-
Tennessee	Yes	Yes	Yes
Texas	Yes	Yes	-
U.S. Virgin Islands	Yes	-	-
Utah	Yes	Yes	-
Vermont	Yes	No	-
Virginia	Yes	Yes	-
Washington	Yes	Yes	Yes
West Virginia	Yes	Yes	-
Wisconsin	Yes	No	-
Wyoming	Yes	Yes	Yes

Colorado: This link is a guide to SUD services and stipulates that one unit/day is allowed for FFS clients. https://hcpf.colorado.gov/behavioral-health-ffs-manual#methClinic

Connecticut: Member_Handbook-English.pdf (pcdn.co)

Florida: Microsoft Word - 59G-4.029 BH_Med.Mangmt_NOC_Policy (myflorida.com)

Idaho: 3 days at a time.

Illinois: No appearance in CMS drug utilization data.

Rhode Island: Methadone tab is no PA required, solution or concentration is PA required; used solution/concentrate.

South Dakota: Drug List states: Injection, Methadone HCL, up to 10 mg.

Utah: For treatment of chronic pain only.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization. Methadone requires the completion of the Clinical SA form (Methadone SA Form) unless prescribed for neonatal abstinence syndrome for an infant under the age of one.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

West Virginia: Methadone will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.

Wyoming: Limited to 3 tablets per day.

Table A-9b. Managed Care Organization Medicaid Coverage of Methadone as MOUD, by State, 2022-2023

State	MMCO	Does Medicaid cover this drug?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Yes	Yes	No
Arkansas	PASSE Program	Yes	-	-
California	COHS Model	Yes	Yes	Yes
	Regional Model	Yes	Yes	Yes
	GMC Model	Yes	Yes	Yes
	SCAN	Yes	Yes	Yes
	Two-Plan Model	Yes	Yes	Yes
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Yes	Yes	Yes
	Denver Health Medicaid Choice	Yes	Yes	-
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Yes	-	-
	Highmark Health Options	Yes	No	-
	Delaware First Health	Yes	No	-
District of Columbia	Amerihealth Caritas	Yes	No	Yes
	Amerigroup	Yes	Yes	No
Florida	Managed Medical Assistance Program	Yes	Yes	Yes
Georgia	Georgia Families: Caresource	Yes	Yes	Yes
	Georgia Families: Peachtree	Yes	Yes	Yes

State	MMCO	Does Medicaid cover this drug?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Hawaii	AlohaCare	Yes	Yes	Yes
	HMSA	Yes	No	Yes
	Kaiser Permanente	Yes	Yes	-
	Ohana	Yes	Yes	Yes
	United HealthCare	Yes	No	Yes
	Community Care Services	Yes	Yes	Yes
Illinois	HealthChoice Illinois	Yes	Yes	Yes
Indiana	Healthy Indiana	Yes	No	No
	HoosierCare	Yes	No	No
	HoosierHealthWise	Yes	No	No
Iowa	IA Healthlink	Yes	No	-
Kansas	KanCare	Yes	Yes	-
Kentucky	Kentucky Managed Care	Yes	No	Yes
Louisiana	Healthy Louisiana	Yes	No	Yes
Maryland	HealthChoice	Yes	Yes	No
Massachusetts	MassHealth Managed Care	Yes	Yes	-
Michigan	Comprehensive Health Care Program	Yes	Yes	Yes
	Healthy Michigan Plan	Yes	Yes	Yes
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+) Minnesota Cares	Yes	Yes	Yes
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	Yes	Yes	Yes
Missouri	MO HealthNet Managed Care/1915b	No	-	-
Nebraska	Heritage Health	Yes	Yes	Yes
Nevada	Mandatory Health Maintenance Program (MMCO)	Yes	Yes	Yes

State	MMCO	Does Medicaid cover this drug?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Hampshire	New Hampshire Medicaid Care Management	Yes	Yes	Yes
New Jersey	NJFamilyCare	Yes	No	Yes
	FIDE SNP	Yes	Yes	Yes
New Mexico	Centennial Care	Yes	No	Yes
New York	Medicaid Advantage Plus	Yes	Yes	Yes
	Medicaid Advantage	Yes	No	No
	Medicaid Managed Care	Yes	Yes	Yes
	Health and Recovery Plans	Yes	Yes	Yes
North Dakota	North Dakota Medicaid Expansion	Yes	Yes	No
Ohio	Ohio Medicaid Managed Care Program	Yes	No	Yes
	MyCare Ohio Opt-Out Program	No	-	-
Oregon	OHP - Oregon Health Plan	No	-	-
Pennsylvania	Health & Wellness	Yes	No	Yes
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Yes	Yes	Yes
South Carolina	South Carolina Managed Care Organizations	Yes	-	-
	South Carolina Medical Homes Network	Yes	-	-
Tennessee	TennCare II	Yes	Yes	Yes
Texas	STAR	Yes	Yes	-
	STAR+PLUS	Yes	Yes	-
	STAR HEALTH	Yes	Yes	-
	STAR KIDS	Yes	Yes	-
Utah	Utah Medicaid Integrated Care	Yes	Yes	-
	UNI HOME	Yes	Yes	-
	Choice of Health Care Delivery	Yes	Yes	-

State	MMCO	Does Medicaid cover this drug?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Virginia	Commonwealth Coordinated Care Plus	Yes	Yes	-
	Medallion 4.0	Yes	Yes	-
Washington	Apple Health/Healthy Options Health Home Program	Yes	Yes	Yes
	Fully Integrated Managed Care (FIMC)	Yes	Yes	Yes
West Virginia	Mountain Health Promise	Yes	Yes	-
	Mountain Health Trust	Yes	Yes	-
Wisconsin	SSI Managed Care	Yes	No	-
	BadgerCare Plus	Yes	No	-
	Family Care Partnership	Yes	No	-

Florida: Microsoft Word - 59G-4.029 BH_Med.Mangmt_NOC_Policy (myflorida.com)

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

New York: Step therapy is used as a treatment option.

Texas: Used Texas PDL to answer: "preferred status."

Utah: Treatment of chronic pain only.

Virginia: Methadone requires the completion of the Clinical SA form (Methadone SA Form) unless prescribed for neonatal abstinence syndrome for an infant under the age of one. PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

West Virginia: Methadone will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.

Table A-10a. Fee-For-Service Medicaid Coverage of Naloxone, by State, 2022-2023

State	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Alabama	Naloxone	Yes	No	Yes	Yes
	Narcan	Yes	No	Yes	Yes
Alaska	Naloxone	Yes	No	Yes	No
	Narcan	Yes	Yes	No	No
Arizona	Naloxone	No	Yes	No	No
	Narcan	Yes	Yes	No	No
Arkansas	Naloxone	Yes	No	Yes	Yes
	Narcan	Yes	No	Yes	Yes
California	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Colorado	Naloxone	Yes	Yes	No	Yes
	Narcan	Yes	No	No	Yes
Connecticut	Naloxone	Yes	No	Yes	-
	Narcan	Yes	Yes	No	-
Delaware	Naloxone	Yes	No	No	-
	Narcan	Yes	No	No	No
District of Columbia	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	Yes
Florida	Naloxone	Yes	Yes	No	Yes
	Narcan	Yes	Yes	No	Yes
Georgia	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Hawaii	Naloxone	-	-	-	-
	Narcan	-	-	-	-
Idaho	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Illinois	Naloxone	Yes	Yes	No	-
	Narcan	Yes	Yes	No	-

State	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Indiana	Naloxone	Yes	Yes	-	-
	Narcan	Yes	Yes	-	-
Iowa	Naloxone	Yes	No	Yes	-
	Narcan	Yes	Yes	Yes	-
Kansas	Naloxone	-	-	-	No
	Narcan	Yes	-	No	No
Kentucky	Naloxone	Yes	No	-	-
	Narcan			-	-
Louisiana	Naloxone	Yes	Yes	-	-
	Narcan	-	-	-	-
Maine	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	Yes
Maryland	Naloxone	Yes	Yes	No	-
	Narcan	Yes	Yes	No	-
Massachusetts	Naloxone	Yes	Yes	-	-
	Narcan	Yes	Yes	-	-
Michigan	Naloxone	Yes	No	-	-
	Narcan	Yes	No	-	-
Minnesota	Naloxone	Yes	Yes	-	-
	Narcan	Yes	Yes	-	-
Mississippi	Naloxone	Yes	Yes	-	-
	Narcan	Yes	Yes	-	-
Missouri	Naloxone	Yes	Yes	-	-
	Narcan	Yes	Yes	-	-
Montana	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Nebraska	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Nevada	Naloxone	Yes	Yes	No	Yes
	Narcan	Yes	Yes	No	Yes

State	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Hampshire	Naloxone	No	No	-	-
	Narcan	Yes	Yes	-	-
New Jersey	Naloxone	Yes	Yes	No	Yes
	Narcan	Yes	Yes	No	Yes
New Mexico	Naloxone	Yes	Yes	No	No
	Narcan	Yes	No	No	No
New York	Naloxone	Yes	Yes	No	Yes
	Narcan	Yes	Yes	No	Yes
North Carolina	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
North Dakota	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Ohio	Naloxone	Yes	No	-	-
	Narcan	Yes	No	-	-
Oklahoma	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Oregon	Naloxone	Yes	Yes	No	No
	Narcan	Yes	No	-	-
Pennsylvania	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Puerto Rico	Naloxone	No	No	-	-
	Narcan	No	No	-	-
Rhode Island	Naloxone	Yes	Yes	No	-
	Narcan	Yes	Yes	No	-
South Carolina	Naloxone	Yes	Yes	No	-
	Narcan	Yes	Yes	No	-
South Dakota	Naloxone	Yes	-	-	-
	Narcan	Yes	-	-	-
Tennessee	Naloxone	Yes	Yes	No	Yes
	Narcan	Yes	Yes	No	Yes

State	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
U.S. Virgin Islands	-	-	-	-	-
Texas	Naloxone	Yes	Yes	No	-
	Narcan	Yes	Yes	No	-
Utah	Naloxone	Yes	-	-	-
	Narcan	Yes	-	-	-
Vermont	Naloxone	Yes	No	No	Yes
	Narcan	Yes	Yes	No	Yes
Virginia	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Washington	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
West Virginia	Naloxone	Yes	Yes	No	No
	Narcan	Yes	Yes	No	No
Wisconsin	Naloxone	Yes	Yes	No	-
	Narcan	Yes	Yes	No	-
Wyoming	Naloxone	Yes	Yes	No	Yes
	Narcan	Yes	Yes	No	Yes

Alabama: Naloxone: syringe & nasal spray.

Alaska: Naloxone: syringe & nasal spray. Kloxxado same as Narcan.

Arizona: Naloxone: nasal spray.

Arkansas: Naloxone: nasal spray. Kloxxado same as Narcan.

California: Syringe & nasal spray; state carve-out (billed directly to FFS); claim must reflect indicated labeler code for claim to pay.

Colorado: Naloxone: injection & nasal spray.

Connecticut: Naloxone: syringe & nasal spray. Kloxxado same as Narcan.

Delaware: Naloxone: syringe & nasal spray. Kloxxado same as Narcan.

District of Columbia: Naloxone: nasal spray.

Florida: Naloxone: syringe & nasal spray. Kloxxado same as Narcan.

Georgia: Naloxone: syringe & nasal spray. Kloxxado same as Narcan.

Idaho: Naloxone: syringe & nasal spray. Narcan, not Kloxxado.

Illinois: Naloxone: nasal spray. Kloxxado same as Narcan.

Rhode Island: Length of PA is 1 year. Naloxone syringe and vial are no PA required, naloxone nasal is PA required.

South Dakota: Drug list states: Injection, Naloxone Hci, Per 1 mg (Narcan).

Vermont: KloxxadoTM (naloxone HCl) 8 mg Nasal Spray QTY Limit: 4 single-use sprays/28 days. Narcan is 4 single-use sprays/28 days.

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization. Methadone requires the completion of the Clinical SA form (Methadone SA Form) unless prescribed for neonatal abstinence syndrome for an infant under the age of one.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Table A-10b. Managed Care Organization Medicaid Coverage of Naloxone, by State, 2022-2023

State	MMCO	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Arizona	Arizona Health Care Cost Containment System	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Arkansas	PASSE Program	Naloxone	Yes	No	Yes	No
		Narcan	Yes	No	Yes	Yes
California	COHS Model	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	Regional Model	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	GMC Model	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	SCAN	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	Two-Plan Model	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Colorado	Accountable Care Collaborative: Rocky Mountain Health Plans Prime	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
	Denver Health Medicaid Choice	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Delaware	Diamond State Health Plan & Diamond State Health Plan Plus	Naloxone	Yes	Yes	No	-
		Narcan	Yes	Yes	No	-
	Highmark Health Options	Naloxone	Yes	-	-	-
		Narcan	Yes	-	-	-
	Delaware First Health	Naloxone	Yes	-	-	-
		Narcan	Yes	-	-	-

State	MMCO	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
District of Columbia	Amerihealth Caritas	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
	Amerigroup	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Florida	Managed Medical Assistance Program	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Georgia	Georgia Families 360	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Hawaii	AlohaCare	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
	HMSA	Naloxone	Yes	Yes	No	Yes
		Narcan	No	No	-	-
	Kaiser Permanente	Naloxone	Yes	Yes	-	-
		Narcan	No	No	-	-
	Ohana	Naloxone	Yes	Yes	No	No
		Narcan	No	Yes	No	No
	United HealthCare	Naloxone	Yes	Yes	No	Yes
		Narcan	No	No	Yes	Yes
Illinois	HealthChoice Illinois	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Indiana	Healthy Indiana	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
	HoosierCare	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
	HoosierHealthWise	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Iowa	IA Healthlink	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	-
Kansas	KanCare	Naloxone	Yes	-	-	-
		Narcan	-	-	-	-

State	MMCO	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Kentucky	Kentucky Managed Care	Naloxone	Yes	No	Yes	Yes
		Narcan	Yes	No	Yes	Yes
Louisiana	Healthy Louisiana	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Maryland	HealthChoice	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Massachusetts	MassHealth Managed Care	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Michigan	Comprehensive Health Care Program	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
	Healthy Michigan Plan	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Minnesota	Prepaid Medical Assistance Plan Plus (PMAP+)	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	Minnesota Senior Health Option (MSHO)	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	Special Needs Basic Care (SNBC)	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Mississippi	Mississippi Coordinated Access Network (MississippiCAN)	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Missouri	MO HealthNet Managed Care/1915b	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Nebraska	Heritage Health	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Nevada	Mandatory Health Maintenance Program (MMCO)	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	Yes
New Hampshire	New Hampshire Medicaid Care Management	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	No	-	-

State	MMCO	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
New Jersey	NJFamilyCare	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	No	Yes	Yes
	FIDE SNP	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
New Mexico	Centennial Care	Naloxone	Yes	-	No	No
		Narcan	Yes	-	No	No
New York	Medicaid Advantage Plus	Naloxone	Yes	-	No	Yes
		Narcan	Yes	-	No	Yes
	Medicaid Advantage	Naloxone	Yes	-	No	No
		Narcan	Yes	-	No	No
	Medicaid Managed Care	Naloxone	Yes	-	No	Yes
		Narcan	Yes	-	No	Yes
	Health and Recovery Plans	Naloxone	Yes	-	No	Yes
		Narcan	Yes	-	No	Yes
North Dakota	North Dakota Medicaid Expansion	Naloxone	Yes	No	Yes	No
		Narcan	Yes	Yes	No	No
Ohio	Ohio Medicaid Managed Care Program	Naloxone	Yes	No	-	-
		Narcan	Yes	No	-	-
Oregon	OHP - Oregon Health Plan	Naloxone	Yes	Yes	No	No
		Narcan	Yes	No	-	-
Pennsylvania	Health & Wellness	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Rhode Island	Rite Care, Rhody Health Partners and Medicaid Expansion	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
South Carolina	South Carolina Managed Care Organizations	Naloxone	Yes	Yes	No	-
		Narcan	Yes	Yes	No	-
	South Carolina Medical Homes Network	Naloxone	Yes	Yes	No	-
		Narcan	Yes	Yes	No	-

State	MMCO	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Tennessee	TennCare II	Naloxone	Yes	Yes	No	Yes
		Narcan	Yes	Yes	No	Yes
Texas	STAR	Naloxone	Yes	No	No	-
		Narcan	Yes	No	No	-
	STAR+PLUS	Naloxone	Yes	No	No	-
		Narcan	Yes	No	No	-
	STAR HEALTH	Naloxone	Yes	No	No	-
		Narcan	Yes	No	No	-
	STAR KIDS	Naloxone	Yes	No	No	-
		Narcan	Yes	No	No	-
Utah	Utah Medicaid Integrated Care	Naloxone	Yes	-	-	-
		Narcan	Yes	-	-	-
	UNI HOME	Naloxone	Yes	-	-	-
		Narcan	Yes	-	-	-
	Choice of Health Care Delivery	Naloxone	Yes	-	-	-
		Narcan	Yes	-	-	-
Virginia	Commonwealth Coordinated Care Plus	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	Medallion 4.0	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
West Virginia	Mountain Health Promise	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	Mountain Health Trust	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No

State	MMCO	Formulation	Does Medicaid cover this drug?	Does this drug have preferred status?	Is prior authorization required?	Are there quantity limits or maximum daily doses?
Washington	Apple Health/ Healthy Options Health Home Program	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
	Fully Integrated Managed Care (FIMC)	Naloxone	Yes	Yes	No	No
		Narcan	Yes	Yes	No	No
Wisconsin	SSI Managed Care	Naloxone	Yes	Yes	No	-
		Narcan	Yes	Yes	No	-
	BadgerCare Plus	Naloxone	Yes	Yes	No	-
		Narcan	Yes	Yes	No	-
	Family Care Partnership	Naloxone	Yes	Yes	No	-
		Narcan	Yes	Yes	No	-

Kentucky: Kentucky has one PDL for all Medicaid health plans.

Louisiana: Louisiana has one PDL for all Medicaid health plans.

Minnesota: Minnesota has one PDL for all Medicaid health plans.

Mississippi: Mississippi has one PDL for all Medicaid health plans.

Nebraska: Naloxone has age restrictions.

Rhode Island: Naloxone is one kit for every fill.

Texas: Used Texas PDL to answer: "preferred status."

Virginia: PDL preferred drugs do not require SA unless subject to additional clinical criteria (e.g., long-acting opioids, hepatitis C therapies, growth hormone). Non-preferred drugs require service authorization.

Washington: The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on most products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a PA. The UnitedHealthcare Community Plan PDL PA list does not include branded items where a generic equivalent is covered.

Contributors

This publication was developed through significant contributions from the following individuals:

SAMHSA Project Leads

Robert Baillieu
Substance Abuse and Mental Health Services Administration

Nadine Benton
Substance Abuse and Mental Health Services Administration

Mitchell Berger
Substance Abuse and Mental Health Services Administration

Leslie Chae
Substance Abuse and Mental Health Services Administration

Trina Dutta
Substance Abuse and Mental Health Services Administration

Judith Ellis
Substance Abuse and Mental Health Services Administration

Arlin Hatch
Substance Abuse and Mental Health Services Administration

Patti Juliana
Substance Abuse and Mental Health Services Administration

Margaret O'Brien
Substance Abuse and Mental Health Services Administration

Yngvild Olsen
Substance Abuse and Mental Health Services Administration

Amy Smith
Substance Abuse and Mental Health Services Administration

Asha Stanly
Substance Abuse and Mental Health Services Administration

Udeme Umo
Substance Abuse and Mental Health Services Administration

Other Contributors

Jennifer Caputo
Westat

Steven Dettwyler
National Association of State Mental Health Program Directors Research Institute, Inc.

John Easterday
Independent Consultant

Douglas Fuller
National Association of State Alcohol and Drug Abuse Directors

Shoma Ghose
Westat

Howard Goldman
University of Maryland

Cindy Gruman
Westat

Brenda Jackson
Brenda Jackson Consulting, LLC

Mustafa Karakus
Westat

Nathan Lowe
Westat

Justin Metcalfe
Westat

Joshua Noda
Westat

Beth Rabinovich
Westat

Elian Rosenfeld
Westat

David Shern
National Association of State Mental Health Program Directors

Melanie Whitter
National Association of State Alcohol and Drug Abuse Directors

Greg Williams
Third Horizons Strategies

Melissa Wilson
Westat

Center for Financing
Reform and Innovation

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

1-877-SAMHSA-7 (1-877-726-4727) | 1-800-487-4889 (TDD) | www.samhsa.gov

Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

PEP22-06-01-009 | Released 2024

SAMHSA
Substance Abuse and Mental Health Services Administration