wisconsin Medicaid update and BadgerCare

June 2005 ● No. 2005-32

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Dentists

Federally Qualified Health Centers

Nurse Practitioners

Nursing Homes

Pharmacies

Physician Assistants

Physician Clinics

Physicians

Podiatrists

Rural Health Clinics

HMOs and Other Managed Care Programs

Expanded Preferred Drug List Information for Prescribers

The Preferred Drug List will be expanded for Wisconsin Medicaid and BadgerCare fee-for-service and Wisconsin SeniorCare on July 1, 2005.

New Drug Classes

The Preferred Drug List (PDL) will be expanded for Wisconsin Medicaid and BadgerCare fee-for-service and Wisconsin SeniorCare on July 1, 2005. Refer to the following tables for the preferred drugs in the new therapeutic classes that will be added to the PDL on July 1, 2005.

Alzheimer's Agents
Aricept
Exelon
Namenda
Reminyl/Razadyne, ER

Anticoagulants, Injectables
Lovenox

Antiparkinson's Agents
Benztropine
Carbidopa/Levodopa
Comtan
Mirapex
Pergolide
Selegiline
Stalevo
Trihexyphenidyl

Erythropoiesis Stimulating Proteins
Procrit

Growth Hormones
Nutropin
Nutropin AQ
Saizen

Hepatitis C Agents
Copegus
Pegasys
Peg-Intron
Peg-Intron Redipen
Rebetol
Ribavirin

Sedative Hypnotics
Ambien
Chloral hydrate
Estazolam
Flurazepam
Temazepam
Triazolam

Prescriber Requirements for the Preferred Drug List

Prescribers should review the Wisconsin Medicaid Preferred Drug List Quick Reference in Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a complete list of preferred and non-preferred drugs. If medically appropriate for a recipient, prescribers are encouraged to try more than one preferred drug before a non-preferred drug is prescribed. Providers should note that most preferred drugs do not require prior authorization (PA), although they may have other restrictions (e.g., age, diagnosis).

Non-preferred Drugs

If a non-preferred drug is medically necessary for a recipient, the prescriber is required to complete the appropriate Prior Authorization/ Preferred Drug List (PA/PDL) form and submit it to a pharmacy provider. The prescriber is required to attest on the form that the recipient meets the clinical criteria for PA approval. Prescribers *and* pharmacy providers are required to retain a completed copy of the PA/PDL form. Refer to the "Available Prior Authorization/Preferred Drug List Forms" section of this *Update* for a list of PA/PDL forms.

Diagnosis-Restricted Drug Classes

The following new PDL drug classes are diagnosis restricted:

- Erythropoiesis stimulating proteins.
- Hepatitis C agents.

Because pharmacy providers are required to indicate a diagnosis code on a PA request for a non-preferred drug, prescribers should indicate a valid and approved diagnosis code on the appropriate PA/PDL form. Refer to Attachment 2 for a list of diagnosis codes for non-preferred drugs in the erythropoiesis stimulating protein and hepatitis C agent classes.

Recipients Taking Antiparkinson's Agents

Wisconsin Medicaid will allow eligible recipients who are taking a non-preferred antiparkinson's agent to remain on that agent without PA. Recipients are required to have *filled* a prescription with a date of service on and after April 1, 2005, to remain on the agent. If it is medically necessary to change the recipient to another non-preferred antiparkinson's agent, PA is required.

If medically appropriate for a recipient, prescribers are encouraged to try more than one preferred drug before a non-preferred drug is prescribed.

Prior Authorization Required for Growth Hormone Drugs

Currently, all growth hormone drugs require PA.

Prescribers are required to provide clinical documentation on the Prior Authorization/ Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, HCF 11092 (Dated 06/05), so that pharmacy providers can submit PA requests to Wisconsin Medicaid for growth hormone drugs.

Refer to Attachments 3 and 4 for a copy of the PA/PDL for Growth Hormone Drugs form, completion instructions, and the clinical criteria requirements for PA approval.

Current, approved PA requests for growth hormone drugs will be honored until their expiration date or until the approved days' supply has been exhausted.

Submitting Prior Authorization/Preferred Drug List Forms

Prescribers should *not* submit PA/PDL forms to Wisconsin Medicaid. Instead, prescribers should send signed and completed PA/PDL forms to the pharmacy where the prescription will be filled. These forms may be faxed or mailed to the pharmacy or the recipient may carry the form, along with the prescription, to the pharmacy.

Prescribers should *not* submit PA/PDL forms to Wisconsin Medicaid. Instead, prescribers should send signed and completed PA/PDL forms to the pharmacy where the prescription will be filled.

Prescribers may submit the appropriate PA/PDL form to pharmacy providers for non-preferred drugs in the new therapeutic classes listed in this *Update* and preferred *and* non-preferred growth hormone drugs beginning June 16, 2005.

Available Prior Authorization/Preferred Drug List Forms

The PA/PDL forms and completion instructions are available on the Forms page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

The following PA/PDL forms are available for drugs that do not require step therapy:

- The Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form, HCF 11075 (Dated 09/04).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Nonsedating Antihistamine Drugs, HCF 11082 (Dated 03/05).
- The PA/PDL for Growth Hormone Drugs.

The following PA/PDL forms are available for drugs that require step therapy:

- The Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), HCF 11077 (Dated 12/04).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs, HCF 11078 (Rev. 05/05).

Emergency Medication Dispensing

An emergency medication supply may be dispensed in situations where the pharmacy provider deems it is necessary.
When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim form, HCF 13072 (Rev. 06/03), with a Pharmacy Special Handling Request form, HCF 13074 (Rev. 06/03), indicating the nature of the emergency. Mail completed Noncompound Drug Claim forms and Pharmacy Special Handling Requests to the address indicated on the Pharmacy Special Handling Request form. Medications dispensed in an emergency do not require PA.

SeniorCare

Providers are reminded that Wisconsin SeniorCare does not cover over-the-counter drugs. Also, SeniorCare does not cover drugs that do not have a signed rebate agreement between the manufacturer and Wisconsin SeniorCare for SeniorCare participants in levels 2b and 3. Refer to the drug search tool on the SeniorCare Web site at *dhfs.wisconsin.gov/seniorcare/* for a complete list of covered drugs. The drug search tool is located on the "Information for Providers" page of the SeniorCare Web site.

For More Information

Changes to the PDL and the PDL implementation schedule are posted to the Pharmacy page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/*.

Refer to the following *Updates* for additional information:

- The September 2004 *Update* (2004-77), titled "Prescriber Information on the Wisconsin Medicaid Preferred Drug List."
- The December 2004 *Update* (2004-92), titled "Preferred Drug List Information for Prescribers."
- The March 2005 *Update* (2005-18), titled "New Preferred Drug List Information for Prescribers."

Providers can also refer to the ePocrates Web site at *www2.epocrates.com/* to access and download the Wisconsin Medicaid and SeniorCare PDLs to their personal digital assistants (PDAs). Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 for information about Wisconsin Medicaid, BadgerCare, and SeniorCare coverage of drugs.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants also.

Wisconsin Medicaid, BadgerCare, and SeniorCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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ATTACHMENT 1
Preferred Drug List Quick Reference

The following table includes the current and new therapeutic classes, effective July 1, 2005, on the Wisconsin Medicaid Preferred Drug List. Preferred drugs are indicated with a "P." Non-preferred drugs require prior authorization (PA) and are indicated with a "PA." Drugs with an "*" are diagnosis restricted by Wisconsin Medicaid.

Providers are reminded that Wisconsin SeniorCare does not cover over-the-counter drugs. Wisconsin SeniorCare also does not cover drugs that do not have a signed rebate agreement between the manufacturer and Wisconsin SeniorCare for SeniorCare participants in levels 2b and 3. Refer to the SeniorCare drug search tool at *dhfs.wisconsin.gov/seniorcare/* for a complete list of covered drugs.

Alzheimer's Agents	
Aricept	P
Exelon	P
Namenda	P
Reminyl/Razadyne, ER	P
Cognex	PA

Analgesics, Narcotics	
APAP/Codeine	P
Aspirin/Codeine	P
Butalbital/APAP/Codeine	P
Butalbital/APAP/Codeine/ Caffeine	P
Codeine	P
Fentanyl Transdermal	P
Hydrocodone/APAP	P
Hydrocodone/Ibuprofen	P
Hydromorphone	P
Kadian	P
Levorphanol	P
Methadone	P
Morphine Sulfate	P
Oxycodone	P
Oxycodone/APAP	P
Oxycodone/Aspirin	P
Pentazocine/APAP	P
Pentazocine/Naloxone	P
Propoxyphene	P
Propoxyphene HCl/APAP	P
Tramadol	P
Tramadol/Acetaminophen	P
Actiq	PA
Avinza	PA
Darvon-N	PA
Meperidine	PA
Oxycodone ER	PA
Oxycontin	PA
Palladone	PA
Panlor DC/SS	PA
Synalgos-DC	PA

Angiotensin Converting Enzyme (ACE) Inhibitor/ Calcium Channel Blocker Drugs	
Lexxel	P
Lotrel	P
Tarka	P

Angiotensin Receptor Blockers	
Cozaar	P
Diovan	P
Hyzaar	P
Micardis	P
Atacand	PA
Avalide	PA
Avapro	PA
Benicar	PA
Teveten	PA

Anticoagulants, Injectables	
Lovenox	P
Arixtra	PA
Fragmin	PA
Innohep	PA

Antiemetics, Oral	
Anzemet	P
Emend	P
Zofran, ODT	P
Kytril	PA

Antifungals, Oral	
Clotrimazole	P
Fluconazole	P
Grifulvin V Suspension	P
Griseofulvin	P
Itraconazole	P
Ketoconazole	P
Lamisil	P
Nystatin	P
Ancobon	PA
Mycostatin	PA
Sporanox (liquid)	PA
Vfend	PA

Antifungals, Topical	
Ciclopirox	P
Clotrimazole	P
Clotrimazole/Betamethasone	P
Econazole Nitrate	P
Exelderm	P
Ketoconazole	P
Loprox	P
Loprox Shampoo	P
Naftin	P
Nystatin	P
Nystatin/Triamcinolone	P
Ertaczo	PA
Mentax	PA
Oxistat	PA
Penlac	PA

Antihistamines, Nonsedating	
Loratadine	P
Loratadine-D	P
Loratadine Syrup	P
Allegra	PA
Allegra-D	PA
Clarinex	PA
Clarinex Syrup	PA
Zyrtec tablet	PA
Zyrtec-D	PA
Zyrtec Syrup	PA

Antimigraine, Triptans	
Amerge	P
Axert	P
Imitrex (oral, nasal, subcutaneous)	P
Frova	PA
Maxalt, MLT	PA
Relpax	PA
Zomig (nasal, ZMT)	PA

Antiparkinson's Agents	
Benztropine	P
Carbidopa/Levodopa	P
Comtan	P
Mirapex	P
Pergolide	P
Selegiline	P
Stalevo	P
Trihexyphenidyl	P
Kemadrin	PA
Parcopa	PA
Requip	PA
Tasmar	PA

Antivirals, Influenza	
Amantadine	P
Rimantadine	P
Tamiflu	P
Relenza	PA

Antivirals, Other	
Acyclovir	P
Valcyte	P
Valtrex	P
Famvir	PA
Ganciclovir (Cytovene)	PA

Agents for Benign Prostatic Hyperplasia (BPH)	
Avodart	P
Doxazosin	P
Flomax	P
Terazosin	P
Uroxatral	P
Proscar	PA

Beta Blockers (Alpha/Beta Adrenergic Blocking Agents, Beta-Adrenergic Blocking Agents)	
Acebutolol	P
Atenolol	P
Betaxolol	P
Bisoprolol	P
Coreg	P
Labetalol	P
Metoprolol	P
Nadolol	P
Pindolol	P
Propranolol	P
Sotalol	P
Timolol	P
Toprol XL	P
Cartrol	PA
Inderal LA	PA
Innopran XL	PA
Levatol	PA

Bladder Relaxant Preparations (Urinary Tract Antispasmodic/ Anti-incontinence Agents)	
Detrol, LA	P
Enablex	P
Oxybutynin	P
Oxytrol	P
Sanctura	P
Ditropan XL	PA
Vesicare	PA

Bone Resorption Suppression and Related Agents	
Actonel	P
Fosamax	P
Miacalcin	P
Boniva	PA
Didronel	PA
Evista	PA

Bronchodilators, Anticholinergic	
Atrovent, HFA	P
Combivent	P
Ipratropium	P
Spiriva	P
Duoneb	PA

Bronchodilators, Beta Agonists	
Albuterol	P
Metaproterenol	P
Serevent	P
Terbutaline	P
Accuneb	PA
Alupent	PA
Foradil	PA
Maxair	PA
Vospire ER	PA
Xopenex	PA

Calcium Channel Blocking Agents	
Cardizem LA	P
Diltiazem, ER, SR	P
Dynacirc, CR	P
Felodipine ER	P
Nicardipine	P
Nifedipine, ER	P
Norvasc	P
Sular	P
Verapamil, SR	P
Cardene SR	PA
Covera-HS	PA
Nimotop	PA
Verelan PM	PA

Cephalosporins and Related Agents (Cephalosporins, Second and Third Generation, Penicillins)	
Amox TR-Clavulanate Potassium 600	P
Amoxicillin/Clavulanate	P
Augmentin XR	P
Cefaclor	P
Cefadroxil	P
Cefpodoxime	P
Cefuroxime	P
Cephalexin	P
Omnicef	P
Spectracef	P
Cedax	PA
Cefzil	PA
Lorabid	PA
Panixine	PA
Raniclor	PA
Suprax	PA

Erythropoiesis Stimulating Proteins*	
Procrit	P
Aranesp	PA
Epogen	PA

Fluoroquinolones	
Avelox	P
Ciprofloxacin	P
Cipro XR	P
Levaquin	P
Noroxin	P
Tequin	P
Factive	PA
Maxaquin	PA
Ofloxacin (Floxin)	PA

Glucocorticoids, Inhaled	
Advair Diskus	P
Aerobid, Aerobid-M	P
Azmacort	P
Flovent	P
Pulmicort Respules	P
Qvar	P
Pulmicort Turbuhaler	PA

Growth Hormones	
Nutropin†	P
Nutropin AQ†	P
Saizen†	P
Genotropin	PA
Humatrope	PA
Norditropin	PA
Serostim	PA
Tev-Tropin	PA
† Preferred drugs that require clinical PA.	

Hepatitis C Agents*	
Copegus	P
Pegasys	P
Peg-Intron	P
Peg-Intron Redipen	P
Rebetol	P
Ribavirin	P
Infergen	PA

Hypoglycemics, Insulins	
Humalog	P
Humalog Mix	P
Humulin	P
Lantus	P
Novolin	PA
Novolog	PA
Novolog Mix	PA

Hypoglycemics, Thiazolidinediones	
Actos	P
Avandia	P

Intranasal Rhinitis Agents	
Flonase	P
Flunisolide	P
Ipratropium	P
Nasarel	P
Nasonex	P
Astelin	PA
Beconase AQ	PA
Nasacort AQ	PA
Rhinocort Aqua	PA

Leukotriene Modifiers	
Accolate	P
Singulair	P

Lipotropics, Other	
Advicor	P
Cholestyramine	P
Colestid	P
Gemfibrozil	P
Lofibra	P
Niacin	P
Niaspan	P
Zetia	P
Antara	PA
Tricor	PA
Welchol	PA

Lipotropics, Statins	
Altoprev	P
Caduet	P
Crestor	P
Lescol, XL	P
Lipitor	P
Lovastatin	P
Vytorin	P
Zocor	P
Pravachol	PA
Pravigard PAC	PA

Macrolides/Ketolides	
Clarithromycin	P
Erythromycin	P
Zithromax	P
Biaxin XL	PA
Ketek	PA

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (This class requires step therapy.)	
Diclofenac Potassium	P
Diclofenac Sodium, XL	P
Etodolac, XL	P
Fenoprofen	P
Flurbiprofen	P
Ibuprofen	P
Indomethacin, SR	P
Ketoprofen	P
Ketorolac	P
Meclofenamate	P
Nabumetone	P
Naproxen	P
Naproxen Sodium, DS	P
Oxaprozin	P
Piroxicam	P
Sulindac	P
Tolmetin, DS	P
Arthrotec	PA
Celebrex	PA
Mobic	PA
Ponstel	PA
Prevacid NapraPAC	PA

Ophthalmics, Allergic Conjunctivitis	
Acular	P
Alrex	P
Cromolyn	P
Elestat	P
Patanol	P
Zaditor	P
Alamast	PA
Alocril	PA
Alomide	PA
Emadine	PA
Optivar	PA

Ophthalmics, Antibiotics	
Bacitracin	P
Ciprofloxacin Solution	P
Erythromycin	P
Gentamicin	P
Ofloxacin	P
Tobramycin	P
Vigamox	P
Zymar	P
Ciloxan Ointment	PA
Quixin	PA

Ophthalmics, Glaucoma Agents	
Alphagan P	P
Azopt	P
Betaxolol	P
Betimol	P
Betoptic S	P
Brimonidine	P
Carteolol	P
Cosopt	P
Dipivefrin	P
Levobunolol	P
Lumigan	P
Metipranolol	P
Pilocarpine	P
Timolol	P
Travatan	P
Trusopt	P
Xalatan	P
Istalol	PA

Otics, Antibiotics (Ear Preparations; Otic Preparations, Anti-Inflammatory Antibiotics)	
Ciprodex	P
Coly-mycin S	P
Floxin	P
Neomycin/Polymixin/ Hydrocortisone	P
Cipro HC	PA
Cortisporin-TC	PA

Phosphate Binders and Related Agents	
Phoslo	P
Renagel	P
Fosrenol	PA
Magnebind 400 RX	PA

Proton Pump Inhibitor (PPI) Drugs* (This class requires step therapy.)	
Prilosec OTC	P
Aciphex	PA
Nexium	PA
Omeprazole (Prilosec)	PA
Prevacid	PA
Prilosec	PA
Protonix	PA
Zegerid	PA

Sedative Hypnotics	
Ambien	P
Chloral hydrate	P
Estazolam	P
Flurazepam	P
Temazepam	P
Triazolam	P
Doral	PA
Lunesta	PA
Restoril 7.5mg	PA
Sonata	PA

Topical Immunomodulators (Dermatitis)	
Elidel	P
Protopic	P

Ulcerative Colitis	
Asacol	P
Canasa	P
Dipentum	P
Mesalamine	P
Pentasa	P
Sulfasalazine	P
Colazal	PA

ATTACHMENT 2
Diagnosis-Restricted Drugs in Erythropoiesis Stimulating Protein and Hepatitis C Drug Classes

The following table contains Wisconsin Medicaid's valid and approved diagnosis codes for non-preferred drugs in the erythropoiesis stimulating protein and hepatitis C treatment drug classes. Refer to the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for a complete list of diagnosis restricted drugs.

Drugs in the following classes are diagnosis restricted by Wisconsin Medicaid. A diagnosis code must be indicated by a pharmacy provider on a prior authorization request for drugs in these classes. Information on this table is effective July 1, 2005.

Drug Class	Brand Name	Diagnosis Code	Disease Description
Erythropoiesis Stimulating Proteins	Aranesp	042	Anemia from Acquired Immune Deficiency Syndrome (AIDS)
		07953	Human Immunodeficiency Virus (HIV), type two [HIV-Two]
		585	Chronic renal failure
		140-20491, 230-2386, 2388-2399, 2733	Non-myeloid malignancies or multiple myeloma
		2387	Myelodysplastic syndrome
		2849	Aplastic anemia
		2850	Sideroblastic anemia
		20610	Chronic myelomonocytic leukemia
		28521	Anemia in end stage renal disease
		28522	Anemia in neoplastic disease
	Epogen	042, 07953	Anemia from AIDS
		585	Chronic renal failure
		140-20491, 230-2386, 2388-2399, 2733	Non-myeloid malignancies or multiple myeloma
		2837, 2849, 2850	Myelodysplastic syndrome
		20610	Chronic myelomonocytic leukemia
		28521	Anemia in end stage renal disease
Hepatitis C Agents	Infergen	07054	Chronic hepatitis C without mention of hepatic coma

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Growth Hormone Drugs Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Instructions
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, HCF 11092. Pharmacy providers (e.g., pharmacies, dispensing physicians, federally qualified health centers, blood banks) are required to use the PA/PDL form for Growth Hormone Drugs to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA/PDL forms in one of the following ways:

1) For STAT-PA requests, pharmacy providers should call (800) 947-1197 or (608) 221-2096.

2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF) and the PA/PDL form by fax to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the PA/PDL form to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Enter the drug name.

Element 5 — Strength
Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written
Enter the date the prescription was written.

Element 7 — Directions for Use
Enter the directions for use of the drug.

Element 8 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 11 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 13 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 14 — Date Signed
Enter the month, day, and year the PA/PDL for Growth Hormone Drugs form was signed (in MM/DD/YYYY format).

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS
Include diagnostic and clinical information explaining the need for the drug requested. In Elements 15 through 22, check "yes" to all that apply.

Element 15
Has the recipient tried and failed a preferred growth hormone drug? Preferred growth hormone drugs include Nutropin, Nutropin AQ, and Saizen.

Element 16
Check the box to indicate whether or not the recipient's chronological age is under 20 years.

Element 17
Check the box to indicate whether or not the recipient's skeletal age is documented to be under 18 years.

Element 18
Check the box to indicate whether or not the prescription was written by an endocrinologist. The prescription must be written by an endocrinologist for the recipient to begin treatment with a growth hormone drug.

Element 19
Check the box to indicate whether or not the recipient has a diagnosis of growth deficiency. The recipient must have a diagnosis of growth deficiency to begin treatment with a growth hormone drug.

Element 20
Check the box to indicate whether or not the recipient has a diagnosis of Prader Willi or Turner's Syndrome.

Element 21
Check the box to indicate whether or not the recipient's fasting blood growth hormone level is less than 12 nanograms/ml. The recipient's blood growth hormone level must be less than 12 nanograms/ml to begin treatment with a growth hormone drug.

Element 22
Check the box to indicate whether or not the recipient had a recent stimulated growth hormone test that demonstrated a clear abnormality. Indicate the test result and normal range.

SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA
In Elements 23 through 26, prescribers should indicate "1" if the response to the question is yes. Indicate "2" if the response is no.

Element 23 — Diagnosis
The recipient must be at least 18 years of age and have a diagnosis of Human Immunodeficiency Virus (HIV) to begin treatment with a growth hormone drug.

Element 24 — Recipient's Current Medical Condition
Indicate the recipient's current medical condition by responding to the clinical information listed in this section.

Element 25 — Evidence of Wasting Syndrome
The recipient must have either an unintentional weight loss of at least 10 percent or a gastrointestinal (GI) obstruction or malabsorption to qualify for treatment with a growth hormone drug.

Element 26
All of the clinical information listed must be tried and failed before a recipient may begin a course of therapy with a growth hormone drug.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 27 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 28 — Days' Supply Requested
Enter the requested days' supply.

Element 29 — Wisconsin Medicaid Provider Identification Number
Enter the provider's eight-digit Wisconsin Medicaid provider identification number.

Element 30 — Date of Service
Enter the requested first date of service (DOS) for the drug in MM/DD/YYYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 31 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
00	Not Specified
01	Home
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 32 — Assigned Prior Authorization Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 33 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 34 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 35 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

Element 36
Check the box to indicate if additional information is necessary. Submit additional information on a separate sheet.

ATTACHMENT 4
Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Growth Hormone Drugs" form is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11092 (06/05)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions, HCF 11092A. If a growth hormone drug is prescribed for a Wisconsin Medicaid recipient, prescribers are required to complete this form and submit it to the pharmacy where the prescription will be filled.

Pharmacy providers are required to have a completed PA/PDL for Growth Hormone Drugs form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a paper PA request.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Diagnosis — Primary Code and / or Description	
9. Name — Prescriber	10. Drug Enforcement Agency Number
11. Address — Prescriber (Street, City, State, Zip Code)	
12. Telephone Number — Prescriber	
13. **SIGNATURE** — Prescriber	14. Date Signed

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS

15. Has the recipient tried and failed a preferred growth hormone drug? Preferred growth hormone drugs include Nutropin, Nutropin AQ, and Saizen. ❑ Yes ❑ No

16. Is the recipient's chronological age under 20 years? ❑ Yes ❑ No

17. If the recipient's chronological age is 20 years or older, is the skeletal age of the recipient documented to be 18 years of age or younger? ❑ Yes ❑ No

18. Is the prescription for the growth hormone drug written by an endocrinologist? ❑ Yes ❑ No

19. Does the recipient have a diagnosis of growth deficiency? ❑ Yes ❑ No

20. Does the recipient have a diagnosis of Prader Willi or Turner's Syndrome? ❑ Yes ❑ No

21. Is the recipient's fasting blood growth hormone level less than 12 nanograms/ml? ❑ Yes ❑ No

22. Does the recipient have a recent stimulated response growth hormone test demonstrating a clear abnormality? ❑ Yes ❑ No

Indicate the test result _____
Indicate the normal range _____

Continued

SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA

23. **Diagnosis** **Response (Indicate "1" for yes or "2" for no.)**

A) The recipient is 18 years of age or older. _____
B) The recipient has Human Immunodeficiency Virus (HIV) with serum antibodies to HIV. _____
C) The recipient is female and pregnant or lactating. _____

24. **Recipient's Current Medical Condition**

D) The recipient has signs or symptoms of Acquired Immune Deficiency Syndrome (AIDS) or associated illnesses. _____
E) The recipient has untreated or suspected serious systemic infection. _____
F) The recipient has an active malignancy other than Kaposi's sarcoma. _____
G) The recipient is on approved antiretroviral therapy. _____
H) The recipient has documented hypogonadism and is taking gonadal steroids. _____

25. **Evidence of Wasting Syndrome**

I) The recipient has unintentional weight loss of at least 10 percent from baseline. _____
J) The recipient has a gastrointestinal (GI) obstruction or malabsorption to account for weight loss. _____

Indicate the recipient's height (in inches) _____
Indicate the recipient's usual weight (in pounds) prior to diagnosis of HIV _____
Indicate the recipient's current weight (in pounds) _____

26. **All of the following must be tried before beginning a course of therapy with a growth hormone drug.**

K) The recipient is receiving at least 100 percent of estimated caloric requirement on current regimen. _____
L) The recipient has tried and failed a previous trial with megesterol acetate and / or dronabinal. _____
M) The recipient has completed a course of therapy of at least 24 weeks of protease inhibitors alone or with nucleosides. _____
N) The recipient has completed a course of therapy using dihydrotestosterone (when appropriate). _____

NEED LEVEL

Enter all 14 digits for this section in the following spaces. Do not include the measurements for the recipient's height, usual weight, or current weight.

___ ___ ___—___ ___ ___ ___ ___—___ ___—___ ___ ___ ___
A B C D E F G H I J K L M N

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

27. National Drug Code (11 digits)	28. Days' Supply Requested*

29. Wisconsin Medicaid Provider Identification Number (Eight digits)

30. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

31. Place of Service (Patient Location) (Use patient location code "00" [Not Specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient])

32. Assigned Prior Authorization Number (Seven digits)

33. Grant Date	34. Expiration Date	35. Number of Days Approved

36. ❑ Check this box to indicate if additional information is necessary. Submit additional information on a separate sheet.