wisconsin Medicaid update
and BadgerCare
December 2006 ● No. 2006-100
Wisconsin Medicaid and BadgerCare Information for Providers

To:
Blood Banks
Dentists
Dispensing Physicians
Federally Qualified Health Centers
Inpatient Hospital Providers
Nurse Practitioners
Nursing Homes
Outpatient Hospital Providers
Pharmacies
Physician Assistants
Physician Clinics
Physicians
Podiatrists
Rural Health Clinics
HMOs and Other Managed Care Programs

Revised Criteria and Forms for the Prior Authorization/Preferred Drug List

Wisconsin Medicaid has revised certain Prior Authorization/Preferred Drug List (PA/PDL) prior authorization criteria, forms, and completion instructions and has discontinued using one PA/PDL form. This *Wisconsin Medicaid and BadgerCare Update* includes the revised criteria, forms, and instructions.

Wisconsin Medicaid has revised certain Prior Authorization/Preferred Drug List (PA/PDL) prior authorization (PA) criteria, forms, and completion instructions and has discontinued using one PA/PDL form. This *Wisconsin Medicaid and BadgerCare Update* includes the revised PA criteria, forms, and instructions. Providers are required to use these revised forms for PA request submissions to Wisconsin Medicaid on and after December 21, 2006.

Wisconsin Medicaid has made the following changes:

- Revised criteria and PA/PDL forms for the following drug classes:
  - ✓ Hypoglycemics for adjunct therapy.
  - ✓ Proton pump inhibitor (PPI) drugs.
  - ✓ Non-steroidal anti-inflammatory drugs (NSAIDs).
- Revised the PA/PDL Exemption Request, HCF 11075 (12/06).
- Discontinued the PA/PDL for Nonsedating Antihistamine Drugs.

Providers may find the following revised forms in Attachments 1 through 8 of this *Update*:

- The Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy, HCF 11179 (12/06).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs, HCF 11078 (12/06).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, HCF 11077 (12/06).
- The PA/PDL Exemption Request.

These revised forms are effective for PA requests received on and after December 21, 2006.

If a pharmacy provider submits a paper PA request to Wisconsin Medicaid on an incorrect PA/PDL form on and after December 21, 2006, the request will be returned to the provider. If the provider submits a PA request using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system with an incorrect form on and after December 21, 2006, the provider will not hear the questions that correspond with the form.

Current, approved PA requests for drugs in these classes will be honored until their expiration date.

Prior Authorization/Preferred Drug List for Hypoglycemics for Adjunct Therapy

Januvia™ will be added to the PDL as a preferred drug on December 21, 2006; however, specific PA criteria are required. The PA criteria for Januvia™ include all of the following:

- The recipient has a diagnosis of Type II diabetes.
- The recipient has failed to achieve adequate glycemic control despite individualized diabetic counseling, including diet and a supervised exercise program, and diabetic medication management, such as metformin or a thiazolidinedione.
- Januvia™ is being added to the recipient's diabetic drug therapy regimen.

Quantity Limit

Recipients are limited to a maximum quantity of 34 tablets of Januvia™ every month, regardless of the strength dispensed.

When a claim is submitted with a quantity that exceeds the limit, providers will receive the following:

- Explanation of Benefits (EOB) code 485: "Quantity limits exceeded."
- National Council for Prescription Drug Programs (NCPDP) reject code 76: "Plan limitations exceeded." (Providers will receive this reject code only on real-time claim submissions.)

The pharmacy provider should contact the prescriber to determine that it is medically necessary for a recipient to exceed the quantity limit. If it is necessary, the pharmacy provider is required to complete the Noncompound Drug Claim form, HCF 13072 (Rev. 06/03), and a Pharmacy Special Handling Request form, HCF 13074 (Rev. 06/06), explaining the medical necessity to exceed the set quantity limit.

Prior Authorization/Preferred Drug List for Proton Pump Inhibitor Drugs

Proton Pump Inhibitor drugs have specific PA approval criteria. Wisconsin Medicaid may approve a PA request for a non-preferred PPI drug if the recipient has experienced a clinically significant adverse drug reaction to Nexium® and Prevacid® *or* if the recipient has experienced a treatment failure on the maximum dose of Nexium® (40 mg/day) and Prevacid® (60 mg/day).

The pharmacy provider should contact the prescriber to determine that it is medically necessary for a recipient to exceed the quantity limit.

In addition to experiencing a clinically significant adverse drug reaction to Nexium® and Prevacid® or a treatment failure on the maximum dose of Nexium® and Prevacid®, the recipient is required to experience a treatment failure on the maximum dose of omeprazole (40 mg/day) or have experienced a clinically significant adverse drug reaction to omeprazole (i.e., Prilosec®, Prilosec® OTC, or generic omeprazole). The recipient is required to try and fail *both* Nexium® and Prevacid® before trying omeprazole. The recipient is also required to try and fail omeprazole before another non-preferred PPI drug is prescribed.

Providers are still required to indicate a diagnosis code on claims for PPI drugs. For diagnosis codes, providers may refer to the Pharmacy page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/*.

Prior Authorization/Preferred Drug List for Non-Steroidal Anti-Inflammatory Drugs, Including Cyclo-oxygenase Inhibitors

Non-steroidal anti-inflammatory Drugs, including cyclo-oxygenase (COX-2) inhibitors,

have specific PA approval criteria. Wisconsin Medicaid may approve a PA request for a non-preferred NSAID if at least one of the following applies:

- The recipient has tried two preferred generic NSAIDs and experienced a treatment failure(s) or clinically significant adverse drug reaction(s).
- The non-preferred NSAID is being prescribed to treat a chronic, nonacute condition.
- The recipient has any of the following risk factors:
  - ✓ Is over 65 years of age.
  - ✓ Is currently taking anti-coagulants.
  - ✓ Has a history of gastrointestinal (GI) ulcers or bleeding.

Prior Authorization/Preferred Drug List Exemption Request

The PA/PDL Exemption Request contains a revision to the question in Element 15.

Prior Authorization/Preferred Drug List for Nonsedating Antihistamine Drugs

Effective for dates of service on and after December 21, 2006, providers are required to complete the PA/PDL Exemption Request for non-preferred nonsedating antihistamine drugs. Providers are required to *discontinue* using the PA/PDL for Nonsedating Antihistamine Drugs on and after December 21, 2006.

Effective December 21, 2006, PA is no longer required for Zyrtec® syrup for recipients two years of age and under. Zyrtec® syrup will remain as a non-preferred nonsedating antihistamine drug for recipients over two years of age. Providers are reminded that PA is not required for preferred nonsedating antihistamine drugs; however, PA is required for non-preferred nonsedating antihistamine 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/*.

PHC 1250

ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy Completion Instructions

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

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY 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 of 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 dispensing physicians 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 Hypoglycemics for Adjunct Therapy, HCF 11179. Pharmacy providers are required to use the PA/PDL for Hypoglycemics for Adjunct Therapy to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form 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 may submit a Prior Authorization Request Form (PA/RF), HCF 11018, and the appropriate PA/PDL form to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate 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 Medicaid 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
If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

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 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — 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 10 — Address and Telephone Number — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA®
Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 20, check "yes" to all that apply.

Element 11 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 12
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type II diabetes.

Element 13
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonyurea or metformin. If "yes" is checked, indicate the recipient's current medication therapy and most current Hemoglobin A1c (HbA1c).

Element 14
Check the appropriate box to indicate whether or not the recipient is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN®

Element 15
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type I or Type II diabetes.

Element 16
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control despite optimal insulin management, including the use of meal time insulin. If "yes" is checked, indicate the recipient's current medication therapy, including insulin regimen.

Element 17
Check the appropriate box to indicate whether or not the recipient has any of the following: an HbA1c greater than nine percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis. Indicate the recipient's most current HbA1c value. If the recipient has any of these conditions, the PA will be returned.

Element 18
Check the appropriate box to indicate whether or not the recipient is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

SECTION IIIC — CLINICAL INFORMATION FOR JANUVIA™

Element 19
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type II diabetes.

Element 20
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control despite diabetic counseling, including diet and a supervised exercise program, and diabetic medication management, such as metformin or a thiazolidinedione? If "yes" is checked, indicate the recipient's current medication therapy and most current HbA1c.

Element 21
Check the appropriate box to indicate whether or not Januvia™ is being added to the recipient's diabetic drug therapy regimen.

Element 22 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 23 — Date Signed
Enter the month, day, and year the PA/PDL for Hypoglycemics for Adjunct Therapy was signed (in MM/DD/YYYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 24 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 25 — Days' Supply Requested
Enter the requested days' supply.

Element 26 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 27 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 28 — 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 29 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 30 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 31 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 32 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 33
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Hypoglycemics for Adjunct Therapy" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11179 (12/06)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy Completion Instructions, HCF 11179A.

Pharmacy providers are required to have a completed PA/PDL for Hypoglycemics for Adjunct Therapy signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number)	

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA®

11. Diagnosis — Primary Code and / or Description

12. Does the recipient have a diagnosis of Type II diabetes?	❑ Yes	❑ No
13. Has the recipient failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonyurea or metformin? If "yes," indicate the recipient's current medication therapy and most current HbA1c.	❑ Yes	❑ No
14. Is the recipient receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator?	❑ Yes	❑ No

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN®

15. Does the recipient have a diagnosis of Type I or Type II diabetes?	❑ Yes	❑ No
16. Has the recipient failed to achieve adequate glycemic control despite optimal insulin management including the use of meal-time insulin? If "yes," indicate the recipient's current medication therapy, including insulin regimen.	❑ Yes	❑ No

Continued

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN® (CONTINUED)

17. Does the recipient have any of the following: an HbA1c greater than nine percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis? Indicate the most current HbA1c value. ❑ Yes ❑ No

18. Is the recipient receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator? ❑ Yes ❑ No

SECTION IIIC — CLINICAL INFORMATION FOR JANUVIA™

19. Does the recipient have a diagnosis of Type II diabetes? ❑ Yes ❑ No

20. Has the recipient failed to achieve adequate glycemic control despite individualized diabetic counseling, including diet and a supervised exercise program, and diabetic medication management, such as metformin or a thiazolidinedione? If "yes," indicate the recipient's current medication therapy and most current HbA1c. ❑ Yes ❑ No

21. Is Januvia™ being added to the recipient's diabetic drug therapy regimen? ❑ Yes ❑ No

22. **SIGNATURE —** Prescriber	23. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

24. National Drug Code (11 Digits)	25. Days' Supply Requested (Up to 365 Days)

26. Wisconsin Medicaid Provider Number (Eight Digits)

27. 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.)

28. 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].)

29. Assigned PA Number (Seven Digits)

30. Grant Date	31. Expiration Date	32. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

33. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid or SeniorCare.

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs Completion Instructions

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

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) 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 of 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.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs form, HCF 11078. Pharmacy providers are required to use the PA/PDL for PPI Drugs form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form 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), HCF 11018, and the appropriate PA/PDL form to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate 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 Medicaid 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

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

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 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — 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 10 — Address and Telephone Number — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED PROTON PUMP INHIBITOR DRUGS

Include diagnostic and clinical information explaining the need for the product requested. In Elements 12 through 14, check "yes" to all that apply.

Note: A recipient is required to try and fail both Prevacid® and Nexium® before trying omeprazole. The recipient is also required to try and fail omeprazole before another non-preferred PPI drug is prescribed.

Element 11 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis code for PPIs must be one of the PPI-approved codes.

Element 12
Check the appropriate box to indicate whether or not the recipient has experienced a clinically significant adverse drug reaction to Prevacid® and Nexium®. If "yes" is checked, indicate in the space provided the specific details of the clinically significant adverse drug reaction(s) and the approximate dates Prevacid® and Nexium® were taken.

Element 13
Check the appropriate box to indicate whether or not the recipient has experienced a treatment failure on the maximum dose of Prevacid® (60 mg/day) *and* Nexium® (40 mg/day)? If "yes" is checked, indicate in the space provided the approximate dates Prevacid® and Nexium® were taken.

Element 14
Check the appropriate box to indicate whether or not the recipient has experienced a treatment failure on the maximum dose of omeprazole (40 mg/day) or experienced a clinically significant adverse drug reaction to omeprazole (i.e., Prilosec®, Prilosec® OTC, or generic omeprazole). If "yes" is checked, indicate in the space provided the specific details of the treatment failure or clinically significant drug reaction and the approximate dates omeprazole was taken.

Element 15 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 16 — Date Signed
Enter the month, day, and year the PA/PDL for PPI Drugs form was signed (in MM/DD/YYYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 17 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 18 — Days' Supply Requested
Enter the requested days' supply.

Element 19 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 20 — Date of Service
Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 21 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be dispensed.

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

Element 22 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 23 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 24 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 25 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 26
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 4
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Proton Pump Inhibitor [PPI] Drugs" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11078 (12/06)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) DRUGS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs Completion Instructions, HCF 11078A.

Pharmacy providers are required to have a completed PA/PDL for PPI Drugs signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number)	

SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED PROTON PUMP INHIBITOR DRUGS

11. Diagnosis — Primary Code and / or Description*

12. Has the recipient experienced a clinically significant adverse drug reaction to Prevacid® *and* Nexium®? If "yes," list the specific details of the clinically significant adverse drug reaction(s) and the approximate dates Prevacid® and Nexium® were taken. ❑ Yes ❑ No

13. Has the recipient experienced a treatment failure on the maximum dose of Prevacid® (60 mg/day) *and* Nexium® (40 mg/day)? If "yes," indicate the approximate dates Prevacid® and Nexium® were taken. ❑ Yes ❑ No

14. Has the recipient experienced a treatment failure on the maximum dose of omeprazole (40 mg/day) or experienced a clinically significant adverse drug reaction to omeprazole (i.e., Prilosec®, Prilosec® OTC, or generic omeprazole)? If "yes," list the specific details of the treatment failure or clinically significant adverse drug reaction and the approximate dates omeprazole was taken. ❑ Yes ❑ No

15. **SIGNATURE** — Prescriber	16. Date Signed

Continued

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

17. National Drug Code (11 Digits)	18. Days' Supply Requested (Up to 365 Days)

19. Wisconsin Medicaid Provider Number (Eight Digits)

20. 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.)

21. 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].)

22. Assigned PA Number (Seven Digits)

23. Grant Date	24. Expiration Date	25. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

26. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid or SeniorCare.

ATTACHMENT 5
Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Non-Steroidal Anti-Inflammatory Drugs [NSAIDs], Including Cyclo-oxygenase Inhibitors, Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING CYCLO-OXYGENASE INHIBITORS, 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 of 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 dispensing physicians 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 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, form, HCF 11077. Pharmacy providers are required to use the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, form to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form 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), HCF 11018, and the appropriate PA/PDL form to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate 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 Medicaid 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

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

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 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — 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 10 — Address and Telephone Number — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code, as well as the telephone number.

SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED NSAIDs

Include diagnostic and clinical information explaining the need for the product requested. In Elements 15 through 17, check "yes" to all that apply.

Element 11 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or the description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 12
Check the appropriate box to indicate whether or not the recipient has tried two preferred, generic NSAIDs and experienced a treatment failure(s) or clinically significant adverse drug reaction(s). If "yes" is checked, circle the failed, preferred generic NSAIDs and indicate in the space provided the specific details of the treatment failure(s) or clinically significant adverse drug reaction(s) and the approximate date(s) the preferred, generic NSAIDs were taken.

Element 13
Check the appropriate box to indicate whether or not the non-preferred NSAID is being prescribed to treat a chronic non-acute condition. If "yes" is checked, indicate in the space provided the condition the NSAID is prescribed to treat.

Element 14
Check the appropriate box to indicate if the recipient has any of the following risk factors: he or she is over 65 years of age, is currently taking anti-coagulants, or has a history of gastrointestinal (GI) ulcers or bleeding.

Element 15 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 16 — Date Signed
Enter the month, day, and year the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, form was signed (in MM/DD/YYYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 17 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 18 — Days' Supply Requested
Enter the requested days' supply.

Element 19 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 20 — Date of Service
Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 21 — 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 22 — Assigned PA Number
Indicate the seven-digit PA number assigned by the STAT-PA system.

Element 23 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 24 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 25 — Number of Days Approved
Indicate the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 26
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 6
Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Non-Steroidal Anti-Inflammatory Drugs [NSAIDs], Including Cyclo-oxygenase Inhibitors" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11077 (12/06)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING CYCLO-OXYGENASE INHIBITORS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, Completion Instructions, HCF 11077A.

Pharmacy providers are required to have a completed PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number)	

SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED NSAIDs

11. Diagnosis — Primary Code and / or Description

12. Has the recipient tried two preferred generic NSAIDs and experienced a treatment failure or had an adverse drug reaction? If yes, circle the two failed, preferred generic NSAIDs that were taken. ❑ Yes ❑ No

Preferred drugs:
diclofenac etodolac flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate nabumetone naproxen oxaprozin piroxicam sulindac

List in the space provided the specific details of the treatment failure(s) or adverse drug reaction(s) and the approximate dates the preferred generic NSAIDs were taken.

Continued

SECTION III— CLINICAL INFORMATION FOR NON-PREFERRED NSAIDs (Continued)

13. Is the non-preferred NSAID being prescribed for a chronic, non-acute condition?
    If yes, what condition is the non-preferred NSAID being prescribed to treat? ❑ Yes ❑ No

14. Indicate whether or not the recipient has any of the following risk factors.
    A. Is he or she over 65 years of age? ❑ Yes ❑ No
    B. Is he or she currently taking anti-coagulants? ❑ Yes ❑ No
    C. Does the recipient have a history of gastrointestinal (GI) ulcers or bleeding? ❑ Yes ❑ No

15. **SIGNATURE** — Prescriber	16. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

17. National Drug Code (11 Digits)	18. Days' Supply Requested (Up to 365 Days)

19. Wisconsin Medicaid Provider Number (Eight Digits)

20. 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.)

21. 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].)

22. Assigned PA Number (Seven Digits)

23. Grant Date	24. Expiration Date	25. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

26. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid or SeniorCare.

ATTACHMENT 7
Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions

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

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST 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 of 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 dispensing physicians 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) Exemption Request, HCF 11075. Pharmacy providers are required to use the PA/PDL Exemption Request to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form 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), HCF 11018, and the appropriate PA/PDL form to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate 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 Medicaid 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

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

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 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — 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 10 — Address and Telephone Number — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION

Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 15, check "yes" to all that apply.

Element 11 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 12
Check the appropriate box to indicate whether or not the recipient has experienced treatment failure with the preferred drug(s). If "yes" is checked, indicate in the space provided the most recently failed preferred drug(s), the specific details of the treatment failure(s), and the approximate date(s) the preferred drug(s) was taken.

Element 13
Check the appropriate box to indicate whether or not the recipient has a medical condition(s) that prevents the use of the preferred drug(s). If "yes" is checked, indicate in the space provided the recipient's medical condition(s) that prevent the use of the preferred drug(s).

Element 14
Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the recipient is taking and the preferred drug(s). If "yes" is checked, indicate in the space provided the medication(s) and the drug interaction(s).

Element 15
Check the appropriate box to indicate whether or not the recipient has experienced a clinically significant adverse drug reaction while taking the preferred drug(s). If "yes" is checked, indicate in the space provided the preferred drug(s) that caused the adverse drug reaction, specific details of the adverse reaction, and the approximate date(s) the preferred drug(s) was taken.

Element 16
Check the appropriate box to indicate whether or not the recipient has taken a non-preferred grandfathered drug in any of the following drug classes for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response. The drug classes include anti-Parkinson agents, selective serotonin reuptake inhibitor (SSRI) antidepressants, other antidepressants, anticonvulsants, and atypical antipsychotics.

Element 17 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 18 — Date Signed
Enter the month, day, and year the PA/PDL Exemption Request was signed (in MM/DD/YYYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 19 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 20 — Days' Supply Requested
Enter the requested days' supply.

Element 21 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 22 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 23 — 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 24 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 25 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 26 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 27 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 28
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 8
Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] Exemption Request" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11075 (12/06)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions, HCF 11075A.

Pharmacy providers are required to have a completed PA/PDL Exemption Request signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number)	

SECTION III — CLINICAL INFORMATION

11. Diagnosis — Primary Code and / or Description

12. Has the recipient experienced treatment failure with the preferred drug(s)? If "yes," list the most recently failed preferred drug(s), specific details of the treatment failure(s), and the approximate date(s) the preferred drug(s) was taken. ❑ Yes ❑ No

13. Does the recipient have a medical condition(s) that prevents the use of the preferred drug(s)? If "yes," list the medical condition(s) in the space provided. ❑ Yes ❑ No

14. Is there a clinically significant drug interaction between another medication the recipient is taking and the preferred drug(s)? If "yes," list the medication(s) and interaction(s) in the space provided. ❑ Yes ❑ No

15. Has the recipient experienced a clinically significant adverse drug reaction while taking the preferred drug(s)? If "yes," list the preferred drug(s) that caused the adverse drug reaction, specific details of the adverse reaction, and the approximate date(s) the preferred drug(s) was taken. ❑ Yes ❑ No

16. For grandfathered classes, including, but not limited to, anti-Parkinson agents, selective serotonin reuptake inhibitor (SSRI) antidepressants, other antidepressants, anticonvulsants, and atypical antipsychotics, has the recipient taken a non-preferred medication for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response? ❑ Yes ❑ No

Continued

SECTION III— CLINICAL INFORMATION (Continued)

17. **SIGNATURE —** Prescriber	18. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

19. National Drug Code (11 Digits)	20. Days' Supply Requested (Up to 365 Days)

21. Wisconsin Medicaid Provider Number (Eight Digits)

22. 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.)

23. 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].)

24. Assigned PA Number (Seven Digits)

25. Grant Date	26. Expiration Date	27. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

28. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid or SeniorCare.