wisconsin Medicaid update
and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
- Community Support Programs
- Dispensing Physicians
- Federally Qualified Health Centers
- Inpatient Hospital Providers
- Mental Health/ Substance Abuse Clinics
- Nurse Practitioners
- Nursing Homes
- Outpatient Hospital Providers
- Pharmacies
- Physician Assistants
- Physician Clinics
- Physicians
- Rural Health Clinics
- HMOs and Other Managed Care Programs

Atypical Antipsychotic Drug Class Added to Preferred Drug List and Prior Authorization/ Preferred Drug List Forms Revised

This *Wisconsin Medicaid and BadgerCare Update* provides information for prescribers and pharmacy providers about the atypical antipsychotic drug class that will be added to the Preferred Drug List beginning July 5, 2006. The revised Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, HCF 11075 (Rev. 06/06), and the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents, HCF 11097 (Rev. 06/06), are also included in this *Update.*

Preferred Drug List Changes

Effective for dates of service (DOS) and after July 5, 2006, Wisconsin Medicaid will add the atypical antipsychotic drug class to the Preferred Drug List (PDL). Wisconsin Medicaid has reviewed this drug class and will add the following preferred drugs to the PDL.

Atypical Antipsychotics
clozapine
Geodon
Seroquel
Risperdal

Grandfathered Prescriptions

Effective for DOS on and after July 5, 2006, Wisconsin Medicaid will grandfather prescriptions for recipients who are currently taking non-preferred atypical antipsychotic drugs. Recipients currently taking these drugs may remain on the drug indefinitely without prior authorization (PA) with the appropriate prescription. The following are non-preferred drugs that will be grandfathered:

- Abilify.
- Fazaclo.
- Symbyax.
- Zyprexa.

Prior authorization is required only for a recipient who is newly started on an atypical antipsychotic drug. Prior authorization is required for non-preferred drugs and future refills of new non-preferred atypical antipsychotic drugs. If it is medically necessary for a prescriber to switch a recipient to another non-preferred drug in the atypical antipsychotic drug class, PA is required. Beginning June 16, 2006, Wisconsin Medicaid will accept PA requests for non-preferred atypical antipsychotic drugs for recipients who are not grandfathered on these medications.

Note: Prescriber and pharmacy provider responsibilities for the PDL *remain unchanged*.

Modification to Prior Authorization/ Preferred Drug List Forms

The following Prior Authorization/Preferred Drug List (PA/PDL) forms have been revised:

- The Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, HCF 11075 (Rev. 06/06).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents, HCF 11097 (Rev. 06/06).

Providers may complete these forms for DOS on and after July 5, 2006.

Wisconsin Medicaid has added the following question to the PA/PDL Exemption Request and the PA/PDL for Stimulants and Related Agents:

> Has the recipient taken a non-preferred drug for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response?

Prior Authorization/Preferred Drug List Exemption Request

Providers are required to answer the previously indicated question only for drug classes where grandfathering exists. Grandfathering is allowed in the following drug classes:

- Anti-Parkinson agents.
- Antidepressants, other.
- Anticonvulsants.
- Atypical antipsychotics.
- Glaucoma agents.

The PA/PDL Exemption Request form and completion instructions are located in Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for photocopying and may also be downloaded and printed from the Medicaid Web site.

Prior Authorization/Preferred Drug List for Stimulants and Related Agents

In addition to the question that has been added to the PA/PDL for Stimulants and Related Agents form, Wisconsin Medicaid has added Provigil® approval criteria to this form.

Prescriber and pharmacy provider responsibilities for the PDL *remain unchanged.*

The following approval criteria questions for Provigil® have been added to the form:

- Does the recipient have a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)?
- Has the recipient tried and failed or had an adverse reaction to **two** preferred stimulants?
- Does the prescriber have peer-reviewed medical literature to support the proven efficacy of the requested use of the drug for ADD or ADHD?

Prescribers must be aware of the Food and Drug Administration's review of the use of Provigil® for ADHD and the identified safety concerns.

If prescribers answer "yes" to all of the previous questions, a PA request for Provigil® may be approved through the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system.

The PA/PDL for Stimulants and Related Agents form and completion instructions are located in Attachments 3 and 4 for photocopying and may also be downloaded and printed from the Medicaid Web site.

Emergency Medication Dispensing Reminder

An emergency medication supply may be dispensed in situations where the pharmacy provider or prescriber deem it is medically 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. 06/06), indicating the nature of the emergency. Providers should mail the completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request form. Medications dispensed in emergency situations do not require PA.

Changes have been made to the Pharmacy Special Handling Request form. The revised Pharmacy Special Handling Request and completion instructions are located in Attachments 5 and 6 for photocopying and may also be downloaded and printed from the Medicaid Web site.

For More Information

Providers may refer to the March 2006 *Update* (2006-32), titled "Spring 2006 Preferred Drug List Review," and to the PDL page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/pdl/index.htm* for the most current PDL.

The PDL may be revised as changes occur. Changes to the PDL are posted on the Pharmacy page of the Medicaid Web site.

Providers may also refer to the Epocrates Web site at *www.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/*.

PHC 1250

ATTACHMENT 1
Prior Authorization/Preferred Drug List Exemption Request Completion Instructions

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

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 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.

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, HCF 11075. Pharmacy providers must 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.

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 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 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 and Strength
Enter the drug name and strength.

Element 5 — Date Prescription Written
Enter the date the prescription was written.

Element 6 — Directions for Use
Enter the directions for use of the drug.

Element 7 — Name — Prescriber
Enter the name of the prescriber.

Element 8 — 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 9 — 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 10 — 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 match the ICD-9-CM description.

Element 11
Check the appropriate box to indicate whether or not the recipient has experienced treatment failure with the preferred product(s). If "yes" is checked, indicate in the space provided the failed drug(s) and the dates the drug(s) was taken.

Element 12
Check the appropriate box to indicate whether or not the recipient has a condition(s) preventing the use of the preferred product(s). If "yes" is checked, indicate in the space provided the condition(s) the recipient experienced that prevents the use of the preferred product(s).

Element 13
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 product(s). If "yes" is checked, indicate in the space provided the medication interaction experienced.

Element 14
Check the appropriate box to indicate whether or not the recipient has experienced clinically significant side effects while on the preferred product(s). If "yes" is checked, indicate in the space provided the side effects the recipient experienced.

Element 15
Check the appropriate box to indicate whether or not the recipient has taken a non-preferred grandfathered drug in any of the following classes for more than 30 days and had a measurable, therapeutic response: anti-Parkinson agents; antidepressants, other; anticonvulsants; atypical antipsychotics; or glaucoma agents.

Element 16 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 17 — 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 18 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 19 — Days' Supply Requested
Enter the requested days' supply.

Element 20 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 21 — 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 four days in the past.

Element 22 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs (NCPDP) 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 23 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 24 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 25 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 26 — 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 27
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.

ATTACHMENT 2
Prior Authorization/Preferred Drug List Exemption Request

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11075 (Rev. 06/06)

STATE OF WISCONSIN

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 and Strength

5. Date Prescription Written	6. Directions for Use
7. Name — Prescriber	8. Drug Enforcement Agency Number

9. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, Telephone Number)

SECTION III — CLINICAL INFORMATION

10. Diagnosis — Primary Code and/or Description

11. Has the recipient experienced treatment failure with the preferred product(s)? If yes, list in the space provided the most recent preferred drug that failed and the approximate dates the drug was taken. ❑ Yes ❑ No

12. Does the recipient have a condition(s) preventing the use of the preferred product(s)? If yes, list the condition(s) in the space provided. ❑ Yes ❑ No

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

14. Has the recipient experienced clinically significant side effects while taking the preferred product(s)? If yes, list the side effects in the space provided. ❑ Yes ❑ No

15. For grandfathered classes, including anti-Parkinson agents; antidepressants, other; anticonvulsants; atypical antipsychotics; and glaucoma agents, 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

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

Continued

SECTION IV — FOR DISPENSING PROVIDERS USING STAT-PA

18. National Drug Code (11 digits)	19. Days' Supply Requested (up to 365 days)

20. Wisconsin Medicaid Provider Number (Eight digits)

21. 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 four days in the past.)

22. 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].)

23. Assigned PA Number (Seven digits)

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

SECTION V — ADDITIONAL INFORMATION

27. 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, BadgerCare, or SeniorCare.

ATTACHMENT 3
Prior Authorization/Preferred Drug List for Stimulants and Related Agents Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List for Stimulants and Related Agents Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS 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 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 Stimulants and Related Agents form, HCF 11097. Pharmacy providers are required to use the PA/PDL for Stimulants and Related Agents 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 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 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 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 submit a copy of the prescription.

Element 4 — Drug Name and Strength
Enter the drug name and strength.

Element 5 — Date Prescription Written
Enter the date the prescription was written.

Element 6 — Directions for Use
Enter the directions for use of the drug.

Element 7 — 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 requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis for stimulants must be one of the approved stimulant diagnosis codes.

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

Element 10 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 11 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 12 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 13 — Date Signed
Enter the month, day, and year the PA/PDL for Stimulants and Related Agents was signed (in MM/DD/YYYY format).

Element 14
Check the appropriate box to indicate if the recipient has taken a non-preferred stimulant and related agent for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response.

SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA

Include clinical information explaining the need for the drug requested. In Elements 15 through 19, check "yes" to all that apply.

Element 15
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) *and* Tourette's Syndrome or a history of tics.

Element 16
Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD *and* obsessive compulsive disorder.

Element 17
Check the appropriate box to indicate whether or not the recipient has a medical history of substance abuse or misuse. If yes, explain in the space provided.

Element 18
Check the appropriate box to indicate whether or not the recipient has a serious risk of diversion. If yes, explain in the space provided.

Element 19
Check the appropriate box to indicate whether or not the recipient has tried and failed or had an adverse drug reaction to a preferred stimulant. If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced.

SECTION IIIB — CLINICAL INFORMATION FOR PROVIGIL

Include diagnostic and clinical information explaining the need for the drug requested. In Elements 20 through 23, check "yes" to all that apply. For PA approval, providers must check "yes" for Element 20 **or** check "yes" for Elements 21, 22, and 23.

Element 20
Check the appropriate box to indicate whether or not the recipient has a diagnosis of narcolepsy or idiopathic hypersomnolence, obstructive sleep apnea/hypopnea syndrome (OSAHS), or shift work sleep disorder (SWSD). Indicate the diagnosis in the space provided.

Element 21
Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD.

Element 22
Check the appropriate box to indicate whether or not the recipient has tried and failed or had an adverse drug reaction to **two** preferred stimulants. If yes, indicate in the space provided the failed drugs or the adverse reaction experienced.

Element 23
Check the appropriate box to indicate whether or not the prescriber has peer-reviewed medical literature to support the proven efficacy of the requested use of the drug for ADD or ADHD. If yes, indicate in the space provided the medical literature references.

SECTION IIIC — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS AND RELATED AGENTS

Include diagnostic and clinical information explaining the need for the drug requested. In Elements 24 and 25, check "yes" where applicable.

Element 24
Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD.

Element 25
Check the appropriate box to indicate whether or not the recipient has tried and failed or had an adverse reaction to a preferred stimulant. If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 26 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 27 — Days' Supply Requested
Enter the requested days' supply.

Element 28 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 29 — 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 30 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs (NCPDP) 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 31 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 32 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 33 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 34 — Number of Days Approved
Record the number of days for which the PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 35
Indicate any additional information in the space below. Submit additional information on a separate sheet if necessary.

ATTACHMENT 4
Prior Authorization/Preferred Drug List for Stimulants and Related Agents

(A copy of the "Prior Authorization/Preferred Drug List for Stimulants and Related Agents" is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11097 (Rev. 06/06)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, HCF 11097A.

Pharmacy providers are required to have a completed PA/PDL for Stimulants and Related Agents 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 and Strength
5. Date Prescription Written
6. Directions for Use
7. Diagnosis — Primary Code and / or Description (The diagnosis code must be one of the stimulant-approved diagnosis codes.*)
8. Name — Prescriber
9. Drug Enforcement Agency Number
10. Address — Prescriber (Street, City, State, Zip Code)
11. Telephone Number — Prescriber
12. **SIGNATURE** — Prescriber
13. Date Signed
14. Has the recipient taken a non-preferred drug for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response? ❑ Yes ❑ No

SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA

15. Does the recipient have a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD) **and** Tourette's Syndrome or a history of tics? ❑ Yes ❑ No
16. Does the recipient have a diagnosis of ADD or ADHD **and** obsessive compulsive disorder? ❑ Yes ❑ No
17. Does the recipient have a medical history of substance abuse or misuse? ❑ Yes ❑ No
    If yes, explain in the space provided.
18. Does the recipient have a serious risk of diversion? ❑ Yes ❑ No
    If yes, explain in the space provided.
19. Has the recipient tried and failed or had an adverse reaction to a preferred stimulant? ❑ Yes ❑ No
    If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced.

Continued

SECTION IIIB — CLINICAL INFORMATION FOR PROVIGIL

For PA approval, providers must check "yes" for Element 20 **or** check "yes" for Elements 21, 22, and 23.

20. Does the recipient have a diagnosis of narcolepsy or idiopathic hypersomnolence, obstructive sleep apnea / hypopnea syndrome (OSAHS), or shift work sleep disorder (SWSD)?**?** If yes, circle the diagnosis listed. ❑ Yes ❑ No

21. Does the recipient have a diagnosis of ADD or ADHD? ❑ Yes ❑ No

22. Has the recipient tried and failed or had an adverse reaction to **two** preferred stimulants? If yes, indicate in the space provided the failed drugs or the adverse reaction experienced. ❑ Yes ❑ No

23. Does the prescriber have peer-reviewed medical literature to support the proven efficacy of the requested use of the drug for ADD or ADHD? If yes, indicate in the space provided the medical literature references. ❑ Yes ❑ No

SECTION IIIC — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS AND RELATED AGENTS

24. Does the recipient have a diagnosis of ADD or ADHD? ❑ Yes ❑ No

25. Has the recipient tried and failed or had an adverse reaction to a preferred stimulant? If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced. ❑ Yes ❑ No

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

26. National Drug Code (11 digits)	27. Days' Supply Requested (up to 365 days)

28. Wisconsin Medicaid Provider Number (Eight digits)

29. 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.)

30. 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].)

31. Assigned PA Number (Seven digits)

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

Continued

SECTION V — ADDITIONAL INFORMATION

35. Indicate any additional information in the space below. Submit additional information on a separate sheet if necessary.

*The following are stimulant-approved diagnosis codes for the drugs listed.

Strattera (atomoxetine HCl) Cylert (pemoline) Desoxyn (methamphetamine)	
31400	Attention Deficit Disorder without mention of hyperactivity
31401	Attention Deficit Disorder with hyperactivity
314-3140	Hyperkinetic syndrome of childhood — Attention Deficit Disorder

Provigil (modafinil)	
31400	Attention Deficit Disorder without mention of hyperactivity
31401	Attention Deficit Disorder with hyperactivity
314-3140	Hyperkinetic syndrome of childhood — Attention Deficit Disorder
34700	Narcolepsy, without cataplexy
34701	Narcolepsy, with cataplexy
78057	Other and unspecified sleep apnea

ATTACHMENT 5
Pharmacy Special Handling Request Completion Instructions

(A copy of the "Pharmacy Special Handling Request Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PHARMACY SPECIAL HANDLING 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 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 dispensing physicians are required to retain a completed copy of the form.

Pharmacy providers are required to complete and sign the Pharmacy Special Handling Request when appropriate. Pharmacy providers submitting paper claims that require the Pharmacy Special Handling Request may submit the paper claim form with the Pharmacy Special Handling Request to the following address:

Wisconsin Medicaid
Pharmacy Special Handling Unit
Suite 20
6406 Bridge Rd
Madison WI 53784-0020

SECTION I — PROVIDER INFORMATION

Element 1 —Wisconsin Medicaid Provider Identification Number
Enter the provider's eight-digit Wisconsin Medicaid provider identification number.

Element 2 —Telephone Number — Pharmacy Provider
Enter the telephone number, including the area code, of the pharmacy provider.

SECTION II — REASON FOR REQUEST (Choose one.)

Element 3 — Emergency Supply Dispensed
Check the box to indicate that the pharmacy dispensed an emergency supply of up to 14 days per fill.

Element 4 — Original Claim Denied
Check the box to indicate that the original claim was denied and that the pharmacy provider is resubmitting the claim for reconsideration. Include the following information:

- Date of denial.
- Authorization / Internal Control Number.
- Explanation of Benefits (EOB) Number and / or National Council for Prescription Drug Program (NCPDP) Reject Code.
- Description of issue for reconsideration.

Element 5 — National Drug Code (NDC) not on Medicaid file
Check the box to indicate that the NDC submitted on the claim is not on the Medicaid drug file. Include the following information:

- National Drug Code.
- Description of NDC.

Element 6 — Pharmacy Consultant Review
Check the box to indicate that a pharmacy consultant review is being requested. Also check a box to indicate that the pharmacy provider is requesting a review for quantity limits exceeded or "other" reason. Include the following information when requesting an "other" review:

- Explanation of review needed.
- Supporting documentation such as Remittance and Status Report or manufacturer-reviewed and/or peer-reviewed medical literature.

When requesting a review for quantity limits exceeded for triptans, include the following information:

- Complete directions for use. ("As needed" or "PRN" are not sufficient.)
- The maximum triptan dose the prescriber has established by day, week, or month.
- The migraine prophylactic medication the recipient is taking. Specify the drug name, strength, directions for use and compliance.
- Indicate other abortive analgesic headache medications the recipient is taking. Specify the drug name, strength, quantity, directions for use and how frequently the medication is being filled.
- Indicate clinical information from the prescriber regarding the frequency of headaches and either why prophylactic treatment is not being used or why prophylactic treatment has been unsuccessful in reducing the headache frequency.

SECTION III — CERTIFICATION

Element 7 — Signature — Pharmacist or Dispensing Physician
The pharmacy provider or dispensing physician is required to complete and sign this form.

Element 8 — Date Signed
Enter the month, day, and year the Pharmacy Special Handling Request was signed (in MM/DD/YYYY format).

ATTACHMENT 6
Pharmacy Special Handling Request

(A copy of the “Pharmacy Special Handling Request” is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13074 (Rev. 06/06)

WISCONSIN MEDICAID
PHARMACY SPECIAL HANDLING REQUEST

Instructions: Providers may submit the Pharmacy Special Handling Request and paper drug claim to: Wisconsin Medicaid, Pharmacy Special Handling Unit, Suite 20, 6406 Bridge Road, Madison, WI 53784-0020. Type or print clearly.

SECTION I — PROVIDER INFORMATION

1. Wisconsin Medicaid Provider Number	2. Telephone Number — Pharmacy Provider

SECTION II — REASON FOR REQUEST (Choose one.)

❑ 3. Emergency Supply Dispensed

❑ 4. Original Claim Denied

Date of Denial _____

Authorization / Internal Control Number _____

Explanation of Benefits (EOB) Number and / or National Council for Prescription Drug Program (NCPDP) Reject Code

_____

Description of issue for reconsideration _____

_____

❑ 5. National Drug Code (NDC) Not on Medicaid File

NDC _____

Description _____

❑ 6. Pharmacy Consultant Review

❑ Other: Explanation of review needed. (Provide the explanation in the space below.)

❑ Quantity limits exceeded. (Provide the required documentation in the space below.)

_____

_____

Provide supporting documentation when available (e.g., Remittance and Status Report or manufacturer-reviewed and / or peer-reviewed literature).

_____

_____

_____

_____

SECTION III — CERTIFICATION

7. SIGNATURE — Pharmacist or Dispensing Physician	8. Date Signed