wisconsin Medicaid update and BadgerCare

March 2007 ● No. 2007-28

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

# Spring 2007 Preferred Drug List Review

This *Wisconsin Medicaid and BadgerCare Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List effective for dates of service on and after April 2, 2007.

## Preferred Drug List Changes

Wisconsin Medicaid has reviewed the following Preferred Drug List (PDL) classes and made changes to previously reviewed PDL classes. Changes to the PDL are effective for dates of service (DOS) on and after April 2, 2007. These changes apply to Wisconsin Medicaid and BadgerCare fee-for-service and Wisconsin SeniorCare. As a reminder, prior authorization (PA) is always required for non-preferred drugs, and all other policies still apply. Providers may begin submitting PA requests for non-preferred drugs in the classes listed below on March 16, 2007. Current, approved PA requests will be honored until their expiration date or until services have been exhausted.

### *Wisconsin Medicaid and SeniorCare Preferred Drug Lists Available on ePocrates*

Wisconsin Medicaid and SeniorCare providers may access the PDL using their personal digital assistants (PDAs) or personal computers through ePocrates. ePocrates' products provide clinical reference information specifically for health care providers to use at the point of care.

Prescribers and pharmacy providers who use PDAs may also subscribe and download the PDL by accessing the ePocrates Web site at *www.epocrates.com/*.

The tables on the following pages contain the preferred drugs in each class.

| ACE Inhibitors/Calcium Channel Blocker Combinations |
|---|
| Lotrel |
| Tarka |

| Acne Agents, Topical |
|---|
| Akne-mycin |
| Azelex |
| benzoyl peroxide |
| clindamycin |
| erythromycin |
| Retin-A Micro |
| Tazorac |
| tretinoin |

| Agents for Benign Prostatic Hyperplasia (BPH) |
|---|
| Avodart |
| doxazosin |
| finasteride |
| Flomax |
| terazosin |
| Uroxatral |

| Analgesics, Narcotics, Long Acting |
|---|
| fentanyl transdermal patches |
| Kadian |
| methadone |
| morphine ER |
| oxycodone ER |

| Analgesics, Narcotics, Short Acting |
|---|
| acetaminophen/codeine |
| aspirin/codeine |
| butalbital/apap/codeine/caffeine |
| codeine |
| hydrocodone/apap |
| hydrocodone/ibuprofen |
| hydromorphone |
| levorphanol |
| oxycodone |
| oxycodone/apap, aspirin |
| propoxyphene HCL, apap |
| tramadol |

| Angiotensin Receptor Blockers |
|---|
| Avapro, Avalide |
| Benicar, HCT |
| Cozaar, Hyzaar |
| Diovan, HCT |
| Micardis, HCT |

| Anticoagulants, Injectables |
|---|
| Arixtra |
| Fragmin |
| Lovenox |

| Anticonvulsants |
|---|
| carbamazepine |
| Carbatrol |
| Celontin |
| clonazepam |
| Depakote, ER, sprinkle |
| Diastat |
| Equetro |
| ethosuximide |
| Felbatol |
| gabapentin |
| Gabitril |
| Keppra |
| Lamictal |
| Lyrica |
| mephobarbital |
| Peganone |
| phenobarbital |
| phenytoin |
| primidone |
| Topamax |
| Trileptal |
| valproic acid |
| zonisamide |

| Antidepressants, Other |
|---|
| bupropion, SR |
| Effexor XR |
| mirtazapine |
| trazodone |
| venlafaxine |

| Antihistamines, Nonsedating |
|---|
| loratadine tablet, syrup, loratadine-D |

| Antimigraine, Triptans |
|---|
| Amerge |
| Axert |
| Imitrex (oral, nasal, and subcutaneous) |
| Maxalt, MLT |

| Beta Blockers (Alpha/Beta Adrenergic Blocking Agents, Beta-Adrenergic Blocking Agents) |
|---|
| acebutolol |
| atenolol |
| betaxolol |
| bisoprolol |
| Coreg |
| labetalol |
| metoprolol |
| nadolol |
| pindolol |
| propranolol, LA |
| sotalol |
| timolol |
| Toprol XL |

| Bladder Relaxant Preparations (Urinary Tract Antispasmodic/Anti-incontinence Agents) |
|---|
| Enablex |
| oxybutynin, ER |
| Oxytrol |
| Sanctura |
| VesiCare |

| Calcium Channel Blocking Agents |
|---|
| Cardizem LA |
| diltiazem, ER |
| felodipine ER |
| nicardipine |
| nifedipine, ER |
| Norvasc |
| Sular |
| verapamil, SR |
| Verelan PM |

| Erythropoiesis Stimulating Proteins |
|---|
| Aranesp |
| Procrit |

| Growth Hormone Drugs |
|---|
| Genotropin† |
| Nutropin AQ† |
| Saizen† |
| Tev-Tropin† |
| †Preferred agents that require clinical PA. |

| Hepatitis C Agents |
|---|
| Pegasys |
| Peg-Intron, Redipen |
| ribavirin |

| Hypoglycemics, Meglitinides |
|---|
| Starlix |

| Hypoglycemics, Thiazolidinediones |
|---|
| Actos |
| Avandamet |
| Avandaryl |
| Avandia |

| Lipotropics, Bile Acid Sequestrants |
|---|
| cholestyramine |
| colestipol |

| Lipotropics, Fibric Acids |
|---|
| fenofibrate |
| gemfibrozil |
| Tricor |

| Lipotropics, Other |
|---|
| Niaspan |
| Vytorin |

| Lipotropics, Statins |
|---|
| Advicor |
| Lescol, XL |
| Lipitor |
| lovastatin |
| simvastatin |

| Multiple Sclerosis Agents |
|---|
| Avonex |
| Betaseron |
| Copaxone |
| Rebif |

| Otics, Antibiotics |
|---|
| Ciprodex |
| Floxin |

| Phosphate Binders and Related Agents |
|---|
| Fosrenol |
| Phoslo |
| Renagel |

| Proton Pump Inhibitors |
|---|
| Nexium |
| Prevacid (caps, SoluTab, suspension) |

| Sedative Hypnotics |
|---|
| Ambien, CR |
| chloral hydrate |
| estazolam |
| flurazepam |
| Lunesta |
| Rozerem |
| temazepam |
| triazolam |

| Ulcerative Colitis |
|---|
| Asacol |
| Canasa |
| mesalamine |
| sulfasalazine |

## Grandfathering

Effective for DOS on and after April 2, 2007, Oxycontin® will be removed from the list of brand medically necessary drugs. Oxycontin® will be added as non-preferred drug on the PDL. Providers are required to complete the PA/PDL Exemption Request to obtain PA for Oxycontin®.

Wisconsin Medicaid will grandfather recipients currently taking Oxycontin®. Oxycodone ER will remain as a preferred drug as long as the drug is available in the marketplace.

Recipients currently taking oxycodone ER may continue filling prescriptions for Oxycontin® and oxycodone ER for six months without PA. Grandfathering of Oxycontin® and oxycodone ER for six months is being allowed to ease the transition for recipients who are in need of Oxycontin®.

## New Prior Authorization/Preferred Drug List Form

Effective for DOS on and after April 2, 2007, Exubera will be a non-preferred drug with specific PA criteria. Providers are required to complete the Prior Authorization/Preferred Drug List (PA/PDL) for Exubera, HCF 11294 (03/07), if the drug is dispensed on and after April 2, 2007. Refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for copies of the form and completion instructions.

### *Prior Authorization Criteria for Prescribing Exubera*

Specific PA criteria for prescribing Exubera are:

- The recipient is eighteen years or older.
- The recipient has been a non-smoker for six months or more.
- The recipient does not have a diagnosis of asthma or chronic obstructive pulmonary disease (COPD).
- The recipient has had a pulmonary function test prior to taking Exubera *and* FEV1 or DLCO results are 70 percent or greater of predicted values. (*Note:* Pulmonary function tests are recommended prior to initiating Exubera use, after the first six months of therapy, and annually thereafter. If there is a greater than or equal to 20 percent decline from baseline FEV1, Exubera should be discontinued.)
- The recipient has failed to achieve adequate glycemic control with PDL diabetic drugs despite individualized diabetic medication management and a clinician-supervised diet and exercise program.
- The recipient has experienced difficulty with insulin injections or needs to reduce the number of daily insulin injections.

Recipients who have Diabetes Type 1 must use a long-acting insulin and add Exubera as their pre-meal insulin. Exubera must be added as a pre-meal insulin to the recipient's current diabetic regimen for recipients who have Diabetes Type 2.

## Prior Authorization Request Information for Growth Hormone Drugs

Effective for DOS on and after April 2, 2007, Exubera will be a non-preferred drug with specific PA criteria.

When a Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) request is returned because a recipient has not had a stimulated growth hormone test, additional information is required for PA review. If the recipient has a medical condition, such as hypopituitary disease, and a stimulated growth hormone test is *not* medically indicated, medical records supporting the growth hormone deficiency are required. The medical records should be included with a *paper* PA request, which includes a completed Prior Authorization Request Form (PA/RF), HCF 10118 (Rev. 10/03), PA/PDL for Growth Hormone Drugs, HCF 11092 (03/07), and all supporting documentation.

The prescriber should complete, sign, and submit the PA/PDL for Growth Hormone Drugs and the supporting documentation to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete, sign, and submit the PA/RF, along with the PA/PDL for Growth Hormone Drugs and supporting documentation, to Wisconsin Medicaid. Refer to Attachments 3 and 4 for copies of the PA/PDL for Growth Hormone Drugs form and completion instructions.

## Reminders

The following are reminders for providers about Wisconsin Medicaid and SeniorCare policies.

### *Diagnosis-Restricted Drugs*

Drugs that are diagnosis restricted continue to be diagnosis restricted even if they are preferred drugs on the PDL. The following are diagnosis-restricted drug classes:

- Erythropoiesis stimulating proteins.
- Hepatitis C agents.
- Multiple sclerosis agents.
- Proton pump inhibitor drugs. (Omeprazole may be approved after a recipient has tried and failed or experienced an adverse reaction to Prevacid® and Nexium®.)
- Stimulants and related agents. (Wisconsin Medicaid has added Daytrana™ as a non-preferred stimulant drug on the PA/PDL for Stimulants and Related Agents, HCF 11097 [Rev. 06/06].)

Pharmacy providers should continue to submit diagnosis codes on claims for preferred drugs that are also diagnosis-restricted.

Pharmacy providers should continue to submit diagnosis codes on claims for preferred drugs that are also diagnosis restricted. If a drug is diagnosis restricted *and* non-preferred, pharmacy providers are required to indicate the appropriate diagnosis code on the PA request regardless of whether it is submitted through the STAT-PA system or on paper. Refer to the Pharmacy Data Tables on the Pharmacy page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/* for a list of diagnosis codes for diagnosis-restricted drugs.

### *Quantity Limits*

Quantities of antimigraine triptan drugs are limited to the following:

- Eighteen tablets every month, regardless of the drug dispensed.
- Eight syringes (four boxes) every month, regardless of the drug dispensed.
- Six nasal sprays (one box) every month, regardless of the drug dispensed.

Quantities for Januvia™ are limited to 34 tablets every month.

Refer to the June 2006 *Update* (2006-53), titled "Quantity Limits Apply to Triptans and Pharmaceutical Care Code Expansion," for additional information.

### *Emergency Medication Dispensing*

An emergency medication supply may be dispensed in situations where the pharmacy provider or prescriber deem it is medically necessary. Medications dispensed in emergency situations do not require PA.

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim, HCF 13072 (Rev. 06/03), with a Pharmacy Special Handling Request, HCF 13074 (Rev. 06/06), indicating the nature of the emergency. Providers should mail completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request form. Providers may also fax these forms to Wisconsin Medicaid at (608) 221-8616.

Providers may refer to the February 2007 *Update* (2007-14), titled "Emergency Medication Dispensing," for additional information.

## For More Information

Providers should refer to the PDL page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/pdl/index.htm* for the most current PDL. Both preferred and non-

preferred drugs are included on the 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 call Provider Services at (800) 947-9627 or (608) 221-9883 for information about Wisconsin Medicaid, BadgerCare, and SeniorCare drug coverage.

## 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 Exubera Completion Instructions

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

(This page was intentionally left blank.)

## WISCONSIN MEDICAID
# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR EXUBERA 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.

**INSTRUCTIONS**
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Exubera, HCF 11294 (03/07). Pharmacy providers are required to use the PA/PDL for Exubera 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 (Rev. 10/03), 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/CCYY 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 prescribed.

**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 EXUBERA**
Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 17, answer the questions according to the recipient's clinical status.

**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 match the ICD-9-CM description.

**Element 12**
Check the appropriate box to indicate whether or not the recipient is 18 years of age or older.

**Element 13**
Check the appropriate box to indicate whether or not the recipient has been a non-smoker for six months or more.

**Element 14**
Check the appropriate box to indicate whether or not the recipient has a diagnosis of chronic obstructive pulmonary disease (COPD) or asthma.

**Element 15**
Check the appropriate box to indicate whether or not the recipient had a recent pulmonary function test and the FEV1 or DLCO results were 70 percent or greater of predicted values. If yes, indicate the results of the recipient's most current pulmonary function test.

**Element 16**
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control with preferred drug list diabetic agents, despite individualized diabetic medication management, along with a clinician-supervised diet and exercise program. If yes, indicate the recipient's current diabetic therapy regimen and most recent HbA1c.

**Element 17**
Check the appropriate box to indicate whether or not the recipient has difficulty with insulin injections or if the recipient needs to reduce the number of daily insulin injections.

**SECTION IIIA — CLINICAL INFORMATION FOR RECIPIENTS WITH DIABETES TYPE 1**
If the recipient does not have a diagnosis of Diabetes Type 1, proceed to Section IIIB.

**Element 18**
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Diabetes Type 1.

**Element 19**
Check the appropriate box to indicate whether or not Exubera is being added as a pre-meal insulin to the recipient's current diabetic treatment regimen.

**Element 20**
Check the appropriate box to indicate whether or not the recipient is using a long-acting insulin concurrently with Exubera.

## SECTION IIIB — CLINICAL INFORMATION FOR RECIPIENTS WITH DIABETES TYPE 2

**Element 21**
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Diabetes Type 2.

**Element 22**
Check the appropriate box to indicate whether or not Exubera is being added as a pre-meal insulin to the recipient's current diabetic treatment regimen.

**Element 23 — Signature — Prescriber**
The prescriber is required to complete and sign this form.

**Element 24 — Date Signed**
Enter the month, day, and year the PA/PDL for Exubera was signed (in MM/DD/CCYY format).

## SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

**Element 25 — National Drug Code**
Enter the appropriate 11-digit National Drug Code for each drug.

**Element 26 — Days' Supply Requested**
Enter the requested days' supply.

**Element 27 — Wisconsin Medicaid Provider Number**
Enter the provider's eight-digit Wisconsin Medicaid provider number.

**Element 28 — 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 29 — 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 30 — Assigned Prior Authorization Number**
Record the seven-digit PA number assigned by the STAT-PA system.

**Element 31 — Grant Date**
Record the date the PA was approved by the STAT-PA system.

**Element 32 — Expiration Date**
Record the date the PA expires as assigned by the STAT-PA system.

**Element 33 — 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 34**
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 Exubera

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

**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11294 (03/07)

## WISCONSIN MEDICAID
# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR EXUBERA

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Exubera Completion Instructions, HCF 11294A.

Pharmacy providers are required to have a completed PA/PDL for Exubera 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 EXUBERA** (Must be completed for all recipients.)

11. Diagnosis — Primary Code and / or Description

12. Is the recipient 18 years of age or older? ❑ Yes ❑ No

13. Has the recipient been a non-smoker for six months or more? ❑ Yes ❑ No

14. Does the recipient have a diagnosis of chronic obstructive pulmonary disease (COPD) or asthma? ❑ Yes ❑ No

15. Did the recipient have a recent pulmonary function test and the FEV1 or DLCO results were 70 percent or greater of predicted values? If “yes,” indicate the results of the recipient’s most current pulmonary function test.* ❑ Yes ❑ No

16. Has the recipient failed to achieve adequate glycemic control with preferred drug list diabetic agents, despite individualized diabetic medication management, along with a clinician-supervised diet and exercise program? If “yes,” indicate the recipient’s current diabetic therapy regimen and most current HbA1c. ❑ Yes ❑ No

17. Does the recipient have difficulty with insulin injections or does the recipient need to reduce the number of daily insulin injections? ❑ Yes ❑ No

*Continued*

**SECTION IIIA — CLINICAL INFORMATION FOR RECIPIENTS WITH DIABETES TYPE 1** (If the recipient does not have a diagnosis of Diabetes Type 1, proceed to Section IIIB.)

18. Does the recipient have a diagnosis of Diabetes Type 1? ❑ Yes ❑ No

19. Is Exubera being added as a pre-meal insulin to the recipient's current diabetic treatment regimen? ❑ Yes ❑ No

20. Is the recipient using long-acting insulin concurrently? ❑ Yes ❑ No

**SECTION IIIB — CLINICAL INFORMATION FOR RECIPIENTS WITH DIABETES TYPE 2**

21. Does the recipient have a diagnosis of Diabetes Type 2? ❑ Yes ❑ No

22. Is Exubera being added as a pre-meal insulin to the recipient's current diabetic treatment regimen? ❑ Yes ❑ No

| 23. **SIGNATURE —** Prescriber | 24. Date Signed |
|---|---|

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

| 25. National Drug Code (11 Digits) | 26. Days' Supply Requested (Up to 365 Days) |
|---|---|

27. Wisconsin Medicaid Provider Number (Eight Digits)

28. Date of Service (MM/DD/CCYY) (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.)

29. 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].)

30. Assigned Prior Authorization Number (Seven Digits)

| 31. Grant Date | 32. Expiration Date | 33. Number of Days Approved |
|---|---|---|

**SECTION V — ADDITIONAL INFORMATION**

34. 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.

*Pulmonary function tests are recommended prior to initiating Exubera use, after the first six months of therapy, and annually thereafter. If there is a greater than or equal to 20 percent decline from baseline FEV1, Exubera should be discontinued.

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

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

(This page was intentionally left blank.)

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

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

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

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

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

**INSTRUCTIONS**
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, HCF 11092 (03/07). Pharmacy providers are required to use the PA/PDL for Growth Hormone 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 (Rev. 10/03), 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/CCYY format (e.g., September 8, 1996, would be 09/08/1996).

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

**SECTION II — PRESCRIPTION INFORMATION**

**Element 4 — Drug Name**
Enter the drug name.

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

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

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

**Element 8 — Diagnosis — Primary Code and / or Description**
Enter the appropriate *International Classification of Diseases, Ninth 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 9 — Name — Prescriber**
Enter the name of the prescriber.

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

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

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

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

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

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

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

**SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS**
Include diagnostic and clinical information explaining the need for the drug requested. In Elements 15 through 21, check "yes" to all that apply.

**Element 15**
Check the box to indicate whether or not the recipient has tried and failed a preferred growth hormone drug. Preferred growth hormone drugs include Genotropin, Nutropin AQ, Saizen, and Tev-Tropin.

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

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

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

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

**Element 20**
Check the box to indicate whether or not the recipient has a diagnosis of Prader Willi or Turner's Syndrome. If the recipient has a diagnosis of Prader Willi or Turner's Syndrome, a stimulated growth hormone test is **not** required.

**Element 21**
Check the box to indicate whether or not the recipient had a recent stimulated growth hormone test that demonstrated a clear abnormality. Indicate the test result and normal range.

> *Note:* When a STAT-PA request is returned because a recipient has not had a stimulated growth hormone test, additional information is required for PA review. If the recipient has a medical condition, such as hypopituitary disease, and a stimulated growth hormone test is *not* medically indicated, medical records supporting the growth hormone deficiency are required. The medical records should be included with a paper PA request, which includes a completed PA/RF, PA/PDL for Growth Hormone Drugs, and supporting documentation.

**SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA**
In Elements 22 through 25, prescribers should indicate "1" if the response to the question is yes. Indicate "2" if the response is no.

**Element 22 — Diagnosis**
The recipient must be at least 18 years of age and have a diagnosis of Human Immunodeficiency Virus (HIV) to begin treatment with a growth hormone drug.

**Element 23 — Recipient's Current Medical Condition**
Indicate the recipient's current medical condition by responding to the clinical information listed in this section.

**Element 24 — Evidence of Wasting Syndrome**
The recipient must have either an unintentional weight loss of at least 10 percent or a gastrointestinal (GI) obstruction or malabsorption to qualify for treatment with a growth hormone drug.

**Element 25**
All of the clinical information listed must be tried and failed before a recipient may begin a course of therapy with a growth hormone drug.

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 26 — National Drug Code**
Enter the appropriate 11-digit National Drug Code 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 in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 30 — 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 31 — Assigned Prior Authorization 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 STAT-PA request was approved by the STAT-PA system.

**Element 35**
Check the box to indicate if additional information is necessary. Submit additional information on a separate sheet.

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

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

(This page was intentionally left blank.)

**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11092 (03/07)

**WISCONSIN MEDICAID**

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

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

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

## SECTION I — RECIPIENT INFORMATION

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

## SECTION II — PRESCRIPTION INFORMATION

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

## SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS

| | | |
|---|---|---|
| 15. Has the recipient tried and failed a preferred growth hormone drug? Preferred growth hormone drugs include Genotropin, Nutropin AQ, Saizen, and Tev-Tropin. | ❑ Yes | ❑ No |
| 16. Is the recipient's chronological age under 20 years? | ❑ Yes | ❑ No |
| 17. If the recipient's chronological age is 20 years or older, is the skeletal age of the recipient documented to be 18 years of age or younger? | ❑ Yes | ❑ No |
| 18. Is the prescription for the growth hormone drug written by an endocrinologist? | ❑ Yes | ❑ No |
| 19. Does the recipient have a diagnosis of growth deficiency? | ❑ Yes | ❑ No |
| 20. Does the recipient have a diagnosis of Prader Willi or Turner's Syndrome? | ❑ Yes | ❑ No |
| 21. Does the recipient have a recent stimulated response growth hormone test demonstrating a clear abnormality*? | ❑ Yes | ❑ No |

Indicate the test result. _____
Indicate the normal range. _____

*Continued*

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

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

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

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

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

24. **Evidence of Wasting Syndrome**

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

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

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

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

**NEED LEVEL**

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

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

## SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

| 26. National Drug Code (11 Digits) | 27. Days' Supply Requested* |
|---|---|

28. Wisconsin Medicaid Provider Number (Eight Digits)

29. Date of Service (MM/DD/CCYY) (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 Prior Authorization Number (Seven Digits)

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

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

*Medical records supporting the growth hormone deficiency are required in cases when the STAT-PA is returned because a recipient has not had a stimulated growth hormone test due to a hypopituitary or other condition. The medical records should be included with the paper PA request, which includes a completed and signed PA/RF by the pharmacist and a signed and completed PA/PDL for Growth Hormone Drugs by the prescriber, and all other supporting documentation, including medical records. The prescriber should send the PA/PDL and supporting documentation, including medical records, to the pharmacy where the prescription will be filled. The pharmacy will send the PA/RF, the PA/PDL, and all supporting documentation to Wisconsin Medicaid.