

Wisconsin Medicaid update and BadgerCare

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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 Prior Authorization/Preferred Drug List for Hypoglycemics for Adjunct Therapy Form

Effective immediately, providers are required to use the revised Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy form, HCF 11179 (06/07), when submitting prior authorization (PA) requests for preferred hypoglycemic drugs for adjunct hypoglycemic therapy.

Wisconsin Medicaid has revised section IIIC (Clinical Information for Januvia™ and Janumet™) of the PA/PDL for Hypoglycemics for Adjunct Therapy form to include Janumet™. Recipients must meet specific PA criteria to receive Janumet™.

Refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for the revised completion instructions and form.

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 determination about the request. 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:

- XX555555 — Prescriber's DEA number cannot be obtained.
- XX999999 — 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.

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 — 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 Hypoglycemics for Adjunct Therapy was signed (in MM/DD/YYYY format).

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA®

Include diagnostic and clinical information explaining the need for the product requested. In Elements 14 through 23, check "yes" to all that apply.

Element 14

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

Element 15

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," indicate the recipient's current medication therapy and most current Hemoglobin A1c (HbA1c).

Element 16

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 17

Check the appropriate box to indicate whether or not the recipient has a diagnosis of Diabetes Type 1 or Type 2.

Element 18

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," indicate the recipient's current medication therapy, including insulin regimen.

Element 19

Check the appropriate box to indicate whether or not the recipient has any of the following: an HbA1c greater than 9 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 20

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™ AND JANUMET™

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 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 23

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

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.)

**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) | |
| 11. Diagnosis — Primary Code and / or Description | |
| 12. SIGNATURE — Prescriber | 13. Date Signed |

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA®

14. Does the recipient have a diagnosis of Diabetes Type 2? Yes No
15. 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
16. 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®

17. Does the recipient have a diagnosis of Diabetes Type 1 or Type 2? Yes No

Continued

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN® (CONTINUED)

18. 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

19. Does the recipient have any of the following: an HbA1c greater than 9 percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis? Indicate the most current HbA1c value. Yes No

20. 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™ AND JANUMET™

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

22. 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

23. Is Januvia™ or Janumet™ being added to the recipient’s diabetic drug therapy regimen? Yes No

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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