wisconsin Medicaid update
and BadgerCare November 2007 • No. 2007-77
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

Winter 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. Changes are effective for dates of service on and after January 3, 2008.

Preferred Drug List Changes

Effective for dates of service (DOS) on and after January 3, 2008, changes will be made to certain Preferred Drug List (PDL) drug classes. Changes will be made to the following drug classes:

- Anti-Parkinson's agents.
- Bone resorption suppression and related agents.
- Intranasal rhinitis agents.
- Ophthalmics for allergic conjunctivitis.

To request prior authorization (PA) for non-preferred drugs in these classes, providers are required to complete the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, HCF 11075 (12/06). Providers may submit PA requests for drugs in these classes using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system beginning December 18, 2007.

Anti-Parkinson's Agents

Effective for DOS on and after January 3, 2008, Comtan® and Mirapex® will be non-preferred drugs. Prior authorization is required for these drugs for DOS on and after January 3, 2008, or recipients may be switched to a preferred agent. Providers are required to indicate an allowable diagnosis code on PA requests for Mirapex®.

Wisconsin Medicaid will grandfather recipients taking Mirapex® to treat Parkinson's disease when an allowable diagnosis code for Parkinson's disease was indicated on claims submitted between October 1, 2007, and January 3, 2008.

For a new prescription for Mirapex® or for a current prescription where Mirapex® is used to treat restless leg syndrome (RLS), the provider is required to change the

recipient to a preferred drug or request PA for the non-preferred drug.

Recipients currently taking Comtan® will be grandfathered.

The following are preferred anti-Parkinson's agents.

Anti-Parkinson's Agents
benztropine
carbidopa/levodopa
Kemadrin
Requip
selegiline
Stalevo
trihexyphenidyl

Bone Resorption Suppression and Related Agents

Effective for DOS on and after January 3, 2008, Actonel® will be a non-preferred drug. Prior authorization is required for Actonel® for DOS on and after January 3, 2008. Providers are required to change recipients' prescriptions to a preferred bone resorption suppression and related agent or submit a PA request to Wisconsin Medicaid for Actonel®. Providers received a letter in November 2007 explaining the change to this drug class. (Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a copy of the letter.) The following are preferred bone resorption suppression and related agents.

Bone Resorption Suppression and Related Agents
Fosamax, Plus D
Miacalcin

Intranasal Rhinitis Agents

Effective for DOS on and after January 3, 2008, Nasonex® will be a non-preferred drug. Prior authorization is required for Nasonex® for DOS on and after January 3, 2008. Providers are required to change recipients' prescriptions to a preferred intranasal rhinitis agent or submit a PA request to Wisconsin Medicaid for Nasonex®. Providers received a letter in November 2007 explaining the change to this drug class. (Refer to Attachment 1 for a copy of the letter.) The following are preferred intranasal rhinitis agents.

Intranasal Rhinitis Agents
Astelin
Flonase
flunisolide
ipratropium
Nasacort AQ

Ophthalmics, Allergic Conjunctivitis

Effective for DOS on and after January 3, 2008, the following are preferred ophthalmic drugs for allergic conjunctivitis.

Ophthalmics, Allergic Conjunctivitis
Alaway
cromolyn sodium
Zaditor OTC

All other drugs in this class are non-preferred and require trial and failure of a preferred drug before a PA request may be submitted to Wisconsin Medicaid.

For Wisconsin SeniorCare participants, cromolyn sodium is the only preferred drug in this class. Alaway™ and Zaditor® OTC are available over-the-counter and are not covered by SeniorCare.

Prior Authorization Request Submissions

Providers may submit PA requests using the STAT-PA system or on paper.

STAT-PA

Pharmacy providers should submit PA requests using the STAT-PA system, if possible. Prescribers are required to complete and sign the appropriate PA/PDL form and submit it to the pharmacy where the prescription will be filled. The pharmacy provider may submit the PA request using the STAT-PA system.

Paper

Prescribers are required to complete and sign the appropriate PA/PDL form and submit it to the pharmacy where the prescription will be filled. The pharmacy provider is required to complete and sign a Prior Authorization Request Form (PA/RF), HCF 11018 (10/03), and submit it with the PA/PDL form and any supporting documentation to Wisconsin Medicaid.

New Prior Authorization/Preferred Drug List Forms

The following disease-specific PA/PDL forms will be required for use on and after January 16, 2008:

- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, HCF 11304 (11/07)
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, HCF 11305 (11/07).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, HCF 11306 (11/07).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, HCF 11307 (11/07).
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis, HCF 11308 (11/07).

These forms will replace the PA/PDL for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs, HCF 11094 (10/05).

Prescribers are required to complete the forms listed above for PA requests on and after January 16, 2008. For PA requests submitted on or before January 15, 2008, prescribers are required to complete the existing PA/PDL for Cytokine and CAM Antagonist Drugs form.

Refer to Attachments 2 through 11 for copies of the new forms and completion instructions.

Note: Amevive™, Remicade®, and Orencia® will be removed from the cytokine and CAM drug class on January 16, 2008. These drugs will be noncovered pharmacy services under Wisconsin Medicaid; however, they are covered services under Wisconsin Medicaid's medical benefit. Claims for these drugs may be submitted to Wisconsin Medicaid using "J" codes.

Clinical Criteria for Approval

Prescribers are required to provide clinical documentation on the new PA/PDL for Cytokine and CAM Antagonist Drugs forms so pharmacy providers can submit PA requests to Wisconsin Medicaid. The following explains the clinical criteria requirements.

Ankylosing Spondylitis

Enbrel® and Humira® are approved to treat ankylosing spondylitis. For approval of a PA request for these drugs, prescribers are required to indicate "yes" for questions 13, 14, and 15 or 13, 14, and 16 on the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form.

Clinical criteria for ankylosing spondylitis include the following:

- The recipient has a diagnosis of ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The recipient has moderate to severe axial symptoms of ankylosing spondylitis.
- The recipient has received one or more of the following drugs for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction:
  - ✓ Corticosteroids.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ A nonsteroidal anti-inflammatory drug (NSAID) or cyclo-oxygenase (COX-2) inhibitor drug.
  - ✓ Sulfasalazine.

Crohn's Disease

Humira® is approved to treat Crohn's disease. For approval of a PA request for Humira, prescribers are required to indicate "yes" to all clinical criteria questions on the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease form.

Clinical criteria for Crohn's disease include the following:

- The recipient has a diagnosis of Crohn's disease.
- The recipient has moderate to severe symptoms of Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The recipient has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Corticosteroids.
  - ✓ Methotrexate.
  - ✓ Sulfasalazine.
  - ✓ 5-aminosalicylic (5-ASA).
  - ✓ 6-mercaptopurine (6MP).

Plaque Psoriasis

Enbrel® and Raptiva® are approved to treat plaque psoriasis. For approval of a PA request for these drugs, prescribers are required to indicate "yes" for questions 13, 14, 16, and 17, *or* questions 13, 15, 16, and 17 on the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis form.

Clinical criteria for plaque psoriasis include the following:

- The recipient has a diagnosis of plaque psoriasis.
- The recipient has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent or more of his or her body surface area.
- The recipient has a diagnosis of debilitating palmoplantar psoriasis.
- The prescription was written by a dermatologist through a dermatology consultation.
- The recipient has received one or more of the following drugs for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction:
  - ✓ Cyclosporine.
  - ✓ Methotrexate.
  - ✓ Phototherapy.
  - ✓ Soriatane.

Psoriatic Arthritis

Enbrel® and Humira® are approved to treat psoriatic arthritis. For approval of a PA request for these drugs, prescribers are required to indicate "yes" for questions 13, 14, 15, and 16, *or* questions 13, 14, 15, and 17 on the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis form.

Clinical criteria for psoriatic arthritis include the following:

- The recipient has a diagnosis of psoriatic arthritis.
- The recipient has moderate to severe symptoms of psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- The recipient has moderate to severe axial symptoms of psoriatic arthritis.
- The recipient has failed to achieve an adequate response or reduction in symptoms with treatment with **two** or more of the following drugs for at least **three** consecutive months or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Corticosteroids.
  - ✓ Cyclosporine.
  - ✓ Hydroxychloroquine.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ An NSAID or COX-2 inhibitor drug.

Rheumatoid Arthritis

Enbrel®, Humira®, and Kineret® are approved to treat rheumatoid arthritis. Enbrel® is approved to treat polyarticular juvenile rheumatoid arthritis. For approval of a PA request for these drugs, prescribers are required to indicate "yes" for questions 13, 16, and 17 on the PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis form. If "no" is indicated in question 13, prescribers are required to indicate "yes" in questions 14, 15, 16, and 17.

Clinical criteria for rheumatoid arthritis include the following:

- The recipient has a diagnosis of polyarticular juvenile rheumatoid arthritis.

- The recipient has a diagnosis of rheumatoid arthritis.
- The recipient has moderate to severe symptoms of rheumatoid arthritis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The recipient has received **two** or more of the following drugs and taken each drug for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction:
  - ✓ Azathioprine.
  - ✓ Corticosteroids.
  - ✓ Cyclosporine.
  - ✓ Gold sodium thiomalate.
  - ✓ Hydroxychloroquine.
  - ✓ Leflunomide.
  - ✓ Methotrexate.
  - ✓ An NSAID or COX-2 inhibitor drug.
  - ✓ Penicillamine.
  - ✓ Sulfasalazine.

Revised Prior Authorization/Preferred Drug List Form

The PA/PDL for Stimulants and Related Agents, HCF 11097 (11/07), will be revised effective for DOS on and after January 16, 2008. Providers may refer to Attachments 12 and 13 for copies of the revised completion instructions and form.

Prescribers are required to complete the revised PA/PDL for Stimulants and Related Agents form for PA requests on and after January 16, 2008. For PA requests submitted on or before January 15, 2008, prescribers are required to complete the existing PA/PDL for Stimulants and Related Agents form.

The wording for the approval criteria for non-preferred stimulants and related agents has been modified to include the following:

- The recipient has a diagnosis of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).
- The recipient experienced a treatment failure or a clinically significant adverse drug reaction with the preferred stimulant(s).

The approval criteria for Provigil® have been revised to include if the recipient has a diagnosis of narcolepsy, obstructive sleep apnea/hypopnea syndrome, or shift work sleep disorder.
The rest of the form remains the same.

Discontinued Prior Authorization/Preferred Drug List Forms

Wisconsin Medicaid is discontinuing the following PA/PDL forms for DOS on and after January 3, 2008:

- The PA/PDL for Exubera, HCF 11294 (03/07). (Exubera is no longer available in the marketplace.)
- The PA/PDL for Lamisil, HCF 11180 (09/06). (Terbinafine is a preferred drug on the PDL and requires an appropriate diagnosis code.)

Wisconsin Medicaid will no longer accept these forms after January 3, 2008.

Emergency Medication Dispensing Reminder

Wisconsin Medicaid encourages pharmacy providers to dispense a 14-day emergency supply of a medication when they determine it is medically necessary or an emergency. An emergency medication supply may be dispensed if a recipient receives a prescription for a drug with any type of restriction and the physician cannot be reached to obtain a new prescription or the appropriate documentation to override the restriction. The emergency medication dispensing policy overrides drug restriction policies and all PA polices including the PDL, brand medically necessary, and diagnosis-restriction policies; however, other policies, such as recipient eligibility and noncovered services still apply. Medications dispensed in an emergency do not require PA.

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

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

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 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/*.

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 at *dhfs.wisconsin.gov/medicaid/pharmacy/index.htm.*

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 also.

Wisconsin Medicaid and BadgerCare 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
Medicaid Provider Letter

(A copy of the Medicaid provider letter is located on the following pages.)

Jim Doyle
Governor

Kevin R. Hayden
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 888-692-1402
dhfs.wisconsin.gov

October 29, 2007

Dear Prescriber:

Wisconsin Medicaid has been successful in reducing prescription drug costs through our preferred drug list and other measures. Annualized savings are well over $100 million. We greatly appreciate the cooperation and assistance of prescribers, pharmacists and consumers in making this possible.

In October 2007, changes to the Wisconsin Medicaid Preferred Drug List (PDL) were implemented. Two therapeutic classes reviewed in this phase of the PDL were Bone Resorption/Suppression Agents and Intranasal Rhinitis Agents. The Wisconsin Medicaid Pharmacy Prior Authorization Advisory Committee recommended, and the Secretary of the Department of Health and Family Services (DHFS) approved, the recommendation making Actonel and Nasonex non-preferred products.

You are receiving this letter because you have patients who are currently being prescribed Actonel and/or Nasonex. The intent of this letter is to inform you of the change in status of these drugs and what this will mean to you as a prescriber. For your convenience, enclosed is a listing that contains the names of patients for whom you recently prescribed Actonel and/or Nasonex.

Effective January 1, 2008, Actonel and Nasonex will be non-preferred and will require a prior authorization (PA). This will allow you time to review your patients' medications, and, if it is medically appropriate, please switch your patients to one of the preferred drugs in each therapeutic class.

If it is medically necessary for a patient to remain on a non-preferred product, you will need to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form and submit it to the pharmacy where the prescription will be filled. *Please do not send these completed forms to Wisconsin Medicaid.* The clinical criteria for PA approval of a non-preferred drug are the following:

- Treatment failure with a preferred product(s).
- Condition(s) preventing the use of a preferred product(s).
- Clinically significant drug interaction with a medication and a preferred product(s).
- Intolerable side effects experienced on the preferred product(s).

A copy of the PA/PDL Exemption Request form is enclosed. Other information pertaining to the Wisconsin Medicaid Preferred Drug List is available on the physician web site at www.dhfs.wisconsin.gov/medicaid/physician. Providers may also contact Provider Services at (800)-947-9627 or (608) 221-9883 to request copies of the PDL updates and forms or with any additional questions.

Thank you for your attention to this matter. Wisconsin Medicaid appreciates your efforts to preserve state resources by adhering to the PDL.

Sincerely,

Jason A. Helgerson
Medicaid Director

Enclosures
HP10020

Preferred Drugs in these Classes

Bone Resorption/Suppression Agents
Fosamax
Fosamax Plus D
Miacalcin

Intranasal Rhinitis Agents
flunisolide
ipratropium
Astelin
Flonase
Nasacort AQ

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS 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 pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, HCF 11304. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis 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 to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 listed in Element 4.

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

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

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

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

Element 10 — Address — 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.

SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the recipient has a diagnosis of ankylosing spondylitis.

Element 14
Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

Element 15
Check the appropriate box to indicate whether or not the recipient has moderate to severe axial symptoms of ankylosing spondylitis.

Element 16
Check the appropriate box to indicate whether or not the recipient has received one or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

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

Element 18 — Date Signed
Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

Element 20 — Days' Supply Requested
Enter the requested days' supply, up to 365 days.

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

Element 22 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 23 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

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

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

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

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

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

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions, HCF 11304A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) 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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address — Prescriber (Street, City, State, ZIP Code)	
11. Telephone Number — Prescriber	

SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

12. Diagnosis — Primary Code and / or Description

13. Does the recipient have a diagnosis of ankylosing spondylitis?	❑ Yes	❑ No
14. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No
15. Does the recipient have moderate to severe axial symptoms of ankylosing spondylitis?	❑ Yes	❑ No
16. Has the recipient received one or more of the drugs listed below for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	❑ Yes	❑ No

If yes, circle the drug(s) the recipient received. Indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate dates the drug(s) was taken in the space below.

corticosteroids leflunomide methotrexate NSAID or COX-2 sulfasalazine

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

Continued

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

21. Wisconsin Medicaid Provider Number (Eight Digits)

22. Date of Service (MM/DD/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.)

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

24. Assigned Prior Authorization Number (Seven Digits)

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

SECTION V — ADDITIONAL INFORMATION

28. Include any additional diagnostic and clinical information explaining the need for the drug requested.

ATTACHMENT 4
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE 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 pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, HCF 11305. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease 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 to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 listed in Element 4.

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

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

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

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

Element 10 — Address — 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.

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Crohn's disease.

Element 14
Check the appropriate box to indicate whether or not the recipient has moderate to severe symptoms of Crohn's disease.

Element 15
Check the appropriate box to indicate whether or not the prescription was written by a gastroenterologist or through a gastroenterology consultation.

Element 16
Check the appropriate box to indicate whether or not the recipient has received *two* or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

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

Element 18 — Date Signed
Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

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

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

Element 22 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 23 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

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

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

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

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

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

SECTION V — ADDITIONAL INFORMATION

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

ATTACHMENT 5
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease Instructions, HCF 11305A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) 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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address — Prescriber (Street, City, State, ZIP Code)	
11. Telephone Number — Prescriber	

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE

12. Diagnosis — Primary Code and / or Description

13. Does the recipient have a diagnosis of Crohn's disease?	❑ Yes	❑ No
14. Does the recipient have moderate to severe symptoms of Crohn's disease?	❑ Yes	❑ No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	❑ Yes	❑ No
16. Has the recipient received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	❑ Yes	❑ No

If yes, circle the drugs the recipient received. Indicate the dose of the drugs, specific details about the treatment failures or adverse drug reactions, and the approximate dates the drugs were taken in the space below.

azathioprine corticosteroids methotrexate sulfasalazine 5-aminosalicylic (5-ASA) 6-mercaptopurine (6MP)

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

Continued

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

21. Wisconsin Medicaid Provider Number (Eight Digits)

22. Date of Service (MM/DD/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.

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

24. Assigned Prior Authorization Number (Seven Digits)

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

SECTION V — ADDITIONAL INFORMATION

28. Include any additional diagnostic and clinical information explaining the need for the drug requested.

ATTACHMENT 6
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS 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 pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, HCF 11306. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis 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 to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 listed in Element 4.

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

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

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

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

Element 10 — Address — 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.

SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the recipient has a diagnosis of plaque psoriasis.

Element 14
Check the appropriate box to indicate whether or not the recipient has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area.

Element 15
Check the appropriate box to indicate whether or not the recipient has a diagnosis of debilitating palmoplantar psoriasis.

Element 16
Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or through a dermatology consultation.

Element 17
Check the appropriate box to indicate whether or not the recipient has received one or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — Date Signed
Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply, up to 365 days.

Element 22 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 24 — 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 25 — Assigned Prior Authorization Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Record the date the PA request was approved by the STAT-PA system.

Element 27 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 28 — 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 29
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 7
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions, HCF 11306A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) 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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address — Prescriber (Street, City, State, ZIP Code)	
11. Telephone Number — Prescriber	

SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS

12. Diagnosis — Primary Code and / or Description		
13. Does the recipient have a diagnosis of plaque psoriasis?	❑ Yes	❑ No
14. Does the recipient have moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area?	❑? Yes	❑? No
15. Does the recipient have a diagnosis of palmoplantar psoriasis?	❑ Yes	❑ No
16. Is the prescription written by a dermatologist or through a dermatology consultation?	❑ Yes	❑ No
17. Has the recipient received one or more of the treatments listed below for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	❑ Yes	❑ No

If yes, circle the treatment(s) the recipient received. Indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate dates of the treatment(s) in the space below.

cyclosporine methotrexate phototherapy Soriatane

18. **SIGNATURE** — Prescriber	19. Date Signed

Continued

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 digits)	21. Days' Supply Requested (Up to 365 Days)

22. Wisconsin Medicaid Provider Number (Eight Digits)

23. 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.)

24. 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].)

25. Assigned Prior Authorization Number (Seven Digits)

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

29. Include any additional diagnostic and clinical information explaining the need for the drug requested.

ATTACHMENT 8
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS 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 pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, HCF 11307. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis 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 to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 listed in Element 4.

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

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

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

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

Element 10 — Address — 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.

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the recipient has a diagnosis of psoriatic arthritis.

Element 14
Check the appropriate box to indicate whether or not the recipient has moderate to severe symptoms of psoriatic arthritis.

Element 15
Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.

Element 16
Check the appropriate box to indicate whether or not the recipient has moderate to severe axial symptoms of psoriatic arthritis.

Element 17
Check the appropriate box to indicate whether or not the recipient has received *two* or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — Date Signed
Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply, up to 365 days.

Element 22 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 24 — 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 25 — Assigned Prior Authorization Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Record the date the PA request was approved by the STAT-PA system.

Element 27 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 28 — 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 29
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 9
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis Completion Instructions, HCF 11307A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) 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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address — Prescriber (Street, City, State, ZIP Code)	
11. Telephone Number — Prescriber	

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS

12. Diagnosis — Primary Code and / or Description

13. Does the recipient have a diagnosis of psoriatic arthritis?	❑ Yes	❑ No
14. Does the recipient have moderate to severe symptoms of psoriatic arthritis?	❑ Yes	❑ No
15. Is the prescription written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation?	❑ Yes	❑ No
16. Does the recipient have moderate to severe axial symptoms of psoriatic arthritis?	❑ Yes	❑ No
17. Has the recipient received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	❑ Yes	❑ No

If yes, circle the drugs the recipient received. Indicate the dose of the drugs, specific details about the treatment failures or adverse drug reactions, and the approximate dates the drugs were taken in the space below.

azathioprine corticosteroids cyclosporine hydroxychloroquine leflunomide methotrexate NSAID or COX-2

18. **SIGNATURE** — Prescriber	19. Date Signed

Continued

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 digits)	21. Days' Supply Requested (Up to 365 Days)

22. Wisconsin Medicaid Provider Number (Eight Digits)

23. 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.)

24. 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].)

25. Assigned Prior Authorization Number (Seven digits)

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

29. Include any additional diagnostic and clinical information explaining the need for the drug requested.

ATTACHMENT 10
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS 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 pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis, HCF 11308. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis 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 to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation 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 listed in Element 4.

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

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

Element 8 — Name — Prescriber
Enter the name of the prescriber.

Element 9 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

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

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

Element 10 — Address — 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.

SECTION III — CLINICAL INFORMATION FOR RHEUMATOID ARTHRITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 12 — 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 13
Check the appropriate box to indicate whether or not the recipient has a diagnosis of polyarticular juvenile rheumatoid arthritis.

Element 14
Check the appropriate box to indicate whether or not the recipient has a diagnosis of rheumatoid arthritis.

Element 15
Check the appropriate box to indicate whether or not the recipient has moderate to severe symptoms of rheumatoid arthritis.

Element 16
Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

Element 17
Check the appropriate box to indicate whether or not the recipient has received *two* or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — Date Signed
Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis was signed (in MM/DD/CCYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply.

Element 22 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic 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 24 — 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 25 — Assigned Prior Authorization Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Record the date the PA request was approved by the STAT-PA system.

Element 27 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 28 — 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 29
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 11
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis Completion Instructions, HCF 11308A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) 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. Name — Prescriber	9. Drug Enforcement Agency Number
10. Address — Prescriber (Street, City, State, ZIP Code)	
11. Telephone Number — Prescriber	

SECTION III — CLINICAL INFORMATION FOR RHEUMATOID ARTHRITIS

12. Diagnosis — Primary Code and / or Description

13. Does the recipient have a diagnosis of polyarticular juvenile rheumatoid arthritis?	❑ Yes	❑ No
14. Does the recipient have a diagnosis of rheumatoid arthritis?	❑ Yes	❑ No
15. Does the recipient have moderate to severe symptoms of rheumatoid arthritis?	❑ Yes	❑ No
16. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No
17. Has the recipient received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	❑ Yes	❑ No

If yes, circle the drugs the recipient received. Indicate the dose of the drugs, specific details about the treatment failures or adverse drug reactions, and the approximate dates the drugs were taken in the space below.

azathioprine corticosteroids cyclosporine gold sodium thiomalate hydroxychloroquine leflunomide
methotrexate NSAIDs or COX-2 penicillamine sulfasalazine

18. **SIGNATURE** — Prescriber	19. Date Signed

Continued

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 digits)	21. Days' Supply Requested (Up to 365 Days)

22. Wisconsin Medicaid Provider Number (Eight Digits)

23. 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.)

24. 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].)

25. Assigned Prior Authorization Number (Seven digits)

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

29. Include any additional diagnostic and clinical information explaining the need for the drug requested.

ATTACHMENT 12
Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions

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

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

Element 10 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 11 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or the description most relevant to the drug 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 12
Check the appropriate box to indicate if the recipient has taken a non-preferred drug for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response.

SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 13
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 14
Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD *and* obsessive compulsive disorder.

Element 15
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 16
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 17
Check the appropriate box to indicate whether or not the recipient has experienced a treatment failure or a clinically significant adverse drug reaction to a preferred stimulant(s). If yes, indicate in the space provided the preferred stimulant(s), specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drug(s) was taken.

SECTION IIIB — CLINICAL INFORMATION FOR PROVIGIL
Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 18
Check the appropriate box to indicate whether or not the recipient has a diagnosis of narcolepsy, obstructive sleep apnea/hypopnea syndrome, or shift work sleep disorder.

Element 19
Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD.

Element 20
Check the appropriate box to indicate whether or not the recipient has experienced a treatment failure or a clinically significant adverse drug reaction to *two* preferred stimulants. If yes, indicate in the space provided the preferred stimulants, specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drugs were taken.

Element 21
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 Provigil 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 product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

Element 22
Check the appropriate box to indicate whether or not the recipient has a diagnosis of ADD or ADHD.

Element 23
Check the appropriate box to indicate whether or not the recipient has experienced a treatment failure or a clinically significant adverse drug reaction to a preferred stimulant(s). If yes, indicate in the space provided the preferred stimulant(s), specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drug(s) was taken.

Element 24 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 25 — Date Signed
Enter the month, day, and year the PA/PDL for Stimulants and Related Agents was signed (in MM/DD/CCYY format).

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 up to 365 days.

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 request 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. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 13
Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents

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

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. Name — Prescriber	8. Drug Enforcement Agency Number

9. Address — Prescriber (Street, City, State, ZIP Code)

10. Telephone Number — Prescriber

SECTION III – CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS

Providers are required to complete Section III *and* either Section IIIA, IIIB, or IIIC before signing this form.

11. Diagnosis — Primary Code and / or Description*

12. 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

("Yes" should be checked if the recipient is a new Wisconsin Medicaid recipient.)

Continued

SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA

13. 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

14. Does the recipient have a diagnosis of ADD or ADHD *and* obsessive compulsive disorder? ❑ Yes ❑ No

15. Does the recipient have a medical history of substance abuse or misuse? ❑ Yes ❑ No

    If yes, explain in the space below.

16. Does the recipient have a serious risk of diversion? ❑ Yes ❑ No

    If yes, explain in the space below.

17. Has the recipient experienced a treatment failure or a clinically significant adverse drug reaction with the preferred stimulant(s)? ❑ Yes ❑ No

    If yes, list the preferred stimulant drug(s), specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drug(s) was taken in the space below.

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.

18. Does the recipient have a diagnosis of narcolepsy, obstructive sleep apnea / hypopnea syndrome (OSAHS), or shift work sleep disorder (SWSD)? ❑ Yes ❑ No

    If yes, circle the diagnosis (i.e., narcolepsy, OSAHS, or SWSD).

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

20. Has the recipient experienced treatment failures or clinically significant adverse drug reactions with **two** preferred stimulants? ❑ Yes ❑ No

    If yes, list the preferred stimulants, specific details about the treatment failures or adverse drug reactions, and the approximate dates the preferred drugs were taken.

21. Does the prescriber have peer-reviewed medical literature to support the proven efficacy of Provigil for ADD or ADHD? ❑ Yes ❑ No

    If yes, indicate the medical literature references in the space below.

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

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

23. Has the recipient experienced a treatment failure or a clinically significant adverse drug reaction with the preferred stimulant(s)? ❑ Yes ❑ No

    If yes, list the preferred stimulant drug(s), specific details about the treatment failure or adverse drug reaction, and the approximate date the preferred drug(s) was taken in the space below.

24. **SIGNATURE** — Prescriber	25. Date Signed

Continued

SECTION V — 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/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

SECTION VI — ADDITIONAL INFORMATION

35. Include any additional diagnostic and clinical information explaining the need for the drug requested.

* Diagnosis codes indicated must be one of the following approved diagnosis codes.

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
78051	Insomnia with sleep apnea, unspecified
78053	Hypersomnia with sleep apnea, unspecified
78055	Disruption of 24 sleep wake cycle, unspecified
78057	Unspecified sleep apnea