

**May 28, 2009 EqualityCare
Pharmacy Provider Manual**



**Wyoming
Department
of Health**

Commit to your health.



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SECTION 1. PROVIDER RELATIONS CONTACT INFORMATION

GHS Wyoming POS Help Desk/Provider Relations Department :

Phone: 877-209-1264

Times: Monday – Friday 8:00 AM – 5:00 PM MT

GHS Wyoming Prior Authorization (PA) /Pharmacy Appeals/Clinical Call Center:

Phone: 877-207-1126

Times: Monday – Friday 8:00 AM – 5:00 PM MT

RightFAX: 866-964-3472 (Fax PA System available 24/7)

GHS Wyoming Mailing Address

PO Box 21719

Cheyenne, WY 82003

Provider inquiries regarding client inquiries:

ACS Provider Relations Unit Inside Cheyenne: (307) 772-8402

Outside Cheyenne: (800) 251-1269

Fax: (307) 772-8405

Provider Inquiries regarding health care policy:

ACS Provider Relations Unit Inside Cheyenne: (307) 772-8401

Outside Cheyenne: (800) 251-1268

Fax: (307) 772-8405

SECTION 2. PRESCRIPTION SERVICES

- Prescription services may be provided by and reimbursed to a licensed enrolled retail pharmacy upon the order of a licensed practitioner.
- A licensed pharmacist or pharmacy intern(s) under the direct supervision of a licensed pharmacist must provide prescription services.

LEGEND DRUGS

LEGEND DRUGS MAY BE COVERED ONLY IF (ALL PLANS)

- Ordered by a licensed prescribing provider;
- Prescriptions for schedule II-V drugs must be ordered from a prescriber with a valid DEA number;
- The manufacturer has signed the rebate agreement with the Centers for Medicare and Medicaid Services (CMS);
- The product has been assigned a NDC number;
- The manufacturer has submitted all product data to Medispan; and
- The drug is not a Drug Efficacy Study Implementation (DESI) drug.

LEGEND DRUG EXCLUSIONS (ALL PLANS)

- Anorexiant products.
- Androgenic or Anabolic steroids used for weight gain.
- Agents used to promote fertility.
- Cosmetic agents.
- Agents used for the stimulation of hair growth.
- Erectile Dysfunction medications.
- DESI (Drug Efficacy Study Implementation), as well as similar, related or identical drugs considered to be less effective by the Food and Drug Administration (FDA)
- Compound prescriptions, which include a DESI drug, will deny. (Refer to Compound Drugs section of this manual for instructions on billing non-DESI ingredients.)
- Promethazine for children 2 years and younger.

DRUG EFFICACY STUDY IMPLEMENTATION (DESI) DRUGS

DESI drugs, (class 5) as well as similar, related or identical drugs considered being less than effective by the Food and Drug Administration (FDA) and compound prescriptions, which include a DESI drug, are not covered. Claims submitted via the Point-of-Sale (POS) system for a DESI drug will immediately deny. If you hand bill claims and are unsure whether or not a drug is a DESI drug you can call the Goold Health Systems POS Help Desk at (877) 209-1264.

OVER-THE-COUNTER (OTC) DRUGS

OTC DRUGS MAY BE COVERED ONLY IF (ALL PLANS)

- Ordered by a licensed prescribing practitioner;
- Furnished to a client who is NOT residing in a nursing facility;
- The product has been assigned a NDC number; and
- The manufacturer has signed the rebate agreement with the Centers for Medicare and Medicaid Services (CMS);
- The manufacturer has submitted all product data to Medispan.

COVERED OTCS (EXCLUDES PLANS 191 & 291)

- Analgesic/NSAIDS medications (oral)
- Antacids/Heartburn Medications
- Antidiarrheal medications
- Allergy medications
- Artificial tears
- Cough and cold products
- Insulin
- Laxatives
- Pediatric and Prenatal Vitamins
- Sodium Chloride for nebulizer
- Smoking Cessation Products
- Supplements (calcium, calcium + Vitamin D, and iron only)
- Topical Agents (topical antibiotics, antifungals, antiparasitics, and steroids)
- Vaginal Anti-infectives

ADDITIONAL OTC COVERAGE

Additional OTC drugs may be covered, if they are medically necessary, and if their use will reduce the cost of therapy when compared to a prescription drug therapy. A physician or a pharmacist on behalf of a physician may submit a request for coverage in writing to:

WY Office of Pharmacy Services
6101 Yellowstone Ave., Suite 259B
Cheyenne, WY 82002

The Office of Pharmacy Services will determine if the OTC is medically necessary and will benefit several clients. If approved, GHS will add the product to the OTC formulary. Prescribers and pharmacies will be notified in writing.

INFANT FORMULA (ALL PLANS)

EqualityCare does not normally cover infant formulas for infants 3 years and under because they are provided through the Women, Infants & Children (WIC) program. Eligible EqualityCare clients who are also eligible for the WIC program should obtain formula through the WIC program. Any formula not provided by the WIC program or for units prescribed that exceed program benefits may obtain formula through the EqualityCare Program.

MEDICAL SUPPLIES (DME)

DME MAY BE COVERED ONLY IF (EXCLUDES PLANS 191, 192, AND 291)

- Ordered by a licensed prescribing practitioner.
- Furnished to a client NOT residing in a nursing facility.
- The manufacturer has submitted all product data to Medispan.

COVERED DME PRODUCTS

The following DME products are reimbursable through the pharmacy program:

- Allergy Syringes – maximum days supply = 100
- Asthma spacers, nebulizers, spirometers – maximum quantity = 1 per year
- Diabetic Supplies
 - Test strips, control solution, alcohol swabs, lancets, insulin syringes – maximum days supply = 100
 - Monitor, lancet devices – maximum quantity = 1 per year
- Enteral liquid nutrition products – maximum days supply = 34
- Food Thickeners – maximum days supply = 34
- Gloves (latex, surgical) – not cotton – maximum days supply = 100
- Incontinence products (with the exception of diaper and catheters) – maximum days supply = 100
 - Diapers: Maximum of 13 per day and a maximum of 34 day supply at one time, for 3 years of age and older.
 - Catheters: Maximum of 10 per day, and a maximum of 34 day supply at one time.
- Irrigation supply – maximum days supply = 34
- IV Equipment – maximum quantity = 1 per year
- Ostomy and urologic supplies – maximum days supply = 100
- Sharp containers – maximum quantity = 1 per year

ADDITIONAL DME COVERAGE

Additional DME products may be covered under the EqualityCare Medical Supplies Program. Contact ACS, Inc. at 1-800-251-1268 for information on enrolling as a Medical Supplies Provider.

NOTE: All medical supplies used by clients residing in a nursing facility are included in the nursing facility's per diem rate and will not be reimbursed separately.

PRESCRIPTION LIMITS

NUMBER OF PRESCRIPTIONS ANNUALLY

With the exception of the Prescription Drug Assistance Program (PDAP), there are no limits on the number of prescriptions an EqualityCare client can receive. All prescriptions must be medically necessary.

Prescription Drug Assistance Program (PDAP) clients may receive a maximum of 3 prescriptions a month.

TIMEFRAME TO FILL PRESCRIPTIONS

Schedule 2-5 prescriptions must be filled within 6 months of the date the prescription was written. All other prescriptions are only valid for one year from the date written, including OTCs. Prescriptions must be renewed annually.

DISPENSING LIMITATIONS

Days supply: A prescription's days supply must equal the quantity of drug dispensed divided by the daily dose prescribed. A prescription claim will be subject to subsequent recovery if:

- (i) The days supply submitted is not supported by the dosing direction as prescribed.
- (ii) The dosing directions are given as "take as directed" and the pharmacist has not taken appropriate action to obtain and document on the prescription the actual dosing directions given by the practitioner.
- (iii) Extra Doses. The Department does not pre-emptively pay for extra doses in the anticipation of lost or wasted medication.

PLEASE NOTE:

- All prescriptions written with PRN dosing must be verified with prescribing entity in order to obtain an actual dosing regimen for days supply calculation.
- This days supply calculation must equal the number of doses given divided by the dosing regimen- example: 90 tablets given 3 times a day must be billed as a 30 days supply.
- Equality Care must not be billed for extra tablets for an institutional fill to account for missed or lost doses.

Exceptions to these rules include prescriptions where it is clinically appropriate to be variable in the dosing schedule. Examples may include but are not limited to blood thinners, food products, diapers and incontinence products. EqualityCare reserves the right to make the final determination of the appropriateness of following this exception.

DISPENSING QUANTITIES

Within specific plan limitations, prescriptions should be dispensed in the maximum quantity that the physician order allows. For non-maintenance medications, the maximum day supply allowed is 34 days.

If plan limitations allow, prescriptions for oral contraceptives and maintenance drugs should be dispensed in a ninety-day (90) day supply, if the physician order allows. A few exceptions to the 90 day maximum maintenance supply include:

- Eye drops – maximum days supply = 100
- Fluoride – maximum days supply = 100

MAINTENANCE MEDICATIONS

A “maintenance medication” is a medication used to treat a chronic condition over months or years. When a client has been stabilized on a dosage of a maintenance medication, the physician may choose to prescribe the medication for a ninety-day supply. When all other criteria and conditions have been met, EqualityCare will reimburse for a maintenance supply for the following medications:

- ADHD (once the patient has been maintained on the strength and dose for 3 months or 90 days)
- Antiarrhythmic medications
- Antiasthmatic medications
- Anticonvulsant medications
- Antidiabetic medications
- Diuretic medications
- Hormonal medications (estrogenic, progestational, thyroid)
- Hypotensive medications
- Lipotropic/antihyperlipidemic medications
- Oral contraceptives
- Proton Pump Inhibitors

TAMPER RESISTANT PRESCRIPTION PAD REQUIREMENT

On May 25, 2007 Section 7002(b) of the U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law. The Center for Medicare and Medicaid Services (CMS) released guidance providing baseline requirements to States to define and implement tamper resistant prescription pads as required by this law. The law requires that **ALL** written, non-electronic prescriptions for Medicaid outpatient drugs must be executed on tamper resistant pads in order for them to be reimbursable by the federal government.

In addition to all current Wyoming Board of Pharmacy requirements for Tamper Resistant Prescription forms; all prescriptions, paid for by Wyoming EqualityCare must meet the following requirements to help insure against tampering:

Written prescriptions:

As of October 1, 2008, prescriptions must contain all three of the following characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all written prescriptions must contain:
 - Some type of “void” or “illegal” pantograph that appears if the prescription is copied.
 - May also contain any of the features listed within category one or that meets the standards set forth in this category.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. **THIS REQUIREMENT APPLIES ONLY TO PRESCRIPTIONS WRITTEN FOR CONTROLLED SUBSTANCES.** In order to meet this requirement all written prescriptions must contain:

- Quantity check-off boxes PLUS numeric form of quantity values OR alpha and numeric forms of quantity value.
 - Refill Indicator (circle or check number of refills or “NR”) PLUS numeric form of refill values OR alpha AND numeric forms of refill values.
 - May also contain any of the features listed within category one or that meets the standards set forth in this category.
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all written prescriptions must contain:
- Security features and descriptions listed on the FRONT of the prescription blank.
 - May also contain any of the features listed within category one or that meets the standards set forth in this category.

Computer Printed Prescriptions:

As of October 1, 2008, prescriptions must contain all three of the following characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form. In order to meet this requirement all computer printed (rather than written) prescriptions must contain:
 - Same as above for this category.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. In order to meet this requirement all computer printed prescriptions must contain:
 - Same as above for this category
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms. In order to meet this requirement all computer printed prescriptions must contain:
 - Security features and descriptions listed on the FRONT or BACK of the prescription blank.
 - May also contain any of the features listed within category one or that meets the standards set forth in this category.

In addition to the guidance outlined above, the tamper resistant requirement does not apply when a prescription is communicated by the prescriber to the pharmacy electronically, verbally, or by fax; when a managed care entity pays for the prescription; or in most situations when drugs are provided in designated institutional and clinical settings. The guidance also allows emergency fills with a non-compliant written prescription as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours.

Audits of pharmacies will be performed in the future by the Wyoming Department of Health, Program Integrity Unit to ensure that the above requirement is being followed.

MANDATORY GENERIC PROGRAM

Effective May 28, 2009, if covered brand name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brands and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. EqualityCare does not make

determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA.

Brand medication requests for drugs with multi-source generics must be submitted on a Brand Name (PA) request form. Prescriptions will require “brand medically necessary” to be written on the prescription. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH. A copy of the MEDWATCH report must be included with the PA request.

Completed information should be faxed to the Goold Health Services’ PA Department at 866-964-3472.

If the request for the brand medication is approved, a prior authorization will be given within 72 hours of receipt of the request. Both the prescriber and the pharmacy will be notified of the approval and the pharmacy will then be able to process the claim. If the request is denied, both the prescriber and the pharmacy will be notified by fax or phone of the denial and the reasons for the denial.

MANDATORY GENERIC PROGRAM EXCEPTIONS

The following medications are exempt from the mandatory generic requirements and require a ‘preferred brand’ co-payment:

- Coumadin
- Depakene
- Dilantin
- Lanoxin (including Lanoxicaps)
- Levothroid
- Levoxyl
- Mysoline
- Synthroid
- Tegretol (not including XR)

Continued use of a brand name anticonvulsant following introduction of a generic version will be allowed if the client has an epilepsy diagnosis and has been on the brand name in the previous year. If the client has not been on the brand name within the previous year, the generic mandatory policy will be enforced (requiring efficacy trial of generic or documentation of adverse effect from generic formulation.)

The EqualityCare Preferred Drug List (PDL) may require the use of a brand medication over a generic medication if the cost of brand medication is less costly to the EqualityCare program. In general, branded generics are considered to be generics by the EqualityCare program.

More information and Brand Name Drug Request Forms may be found on the Wyoming Department of Health’s Office of Pharmacy Services webpage at: <http://www.health.wyo.gov/healthcarefin/pharmacy/index.html>

DISPENSE AS WRITTEN (DAW)

Due to the Mandatory Generic Program, Preferred Drug List (PDL) and Prior Authorization (PA) process, DAW CODES are no longer necessary on prescription CLAIMS. DAW codes included in claims will be ignored by the POS system.

However, if the claim is for a medication where the brand is preferred over the generic (denoted by an asterisk on the PDL, e.g. Duragesic) and a DAW code is necessary for the pharmacy software system to process a brand name medication, then a 5 is recommended in the DAW field.

A handwritten notification of “brand name medically necessary” in the prescriber’s handwriting on or attached to the prescription is still required. Documentation for a positive “brand name medically necessary” on telephone prescriptions must be on file within thirty (30) days of prescription origination.

Documentation for a positive “DAW” for nursing facility client prescription claims must consist of a letter on file in the pharmacy, signed by the physician, for each prescription where a “brand name medically necessary” was affixed to the claim.

EMERGENCY SUPPLY

In the event of an emergency the pharmacy is authorized to dispense up to a 72 hour emergency supply. An emergency supply may only be used twice for each drug per month. A dispensing fee will not apply. Please refer to the payer sheet for instructions for PA code type and PA number field.

SIGNATURE LOG

Wyoming EqualityCare Pharmacy Program requires that each pharmacy keep a dated log that maintains a record of when a patient or a patient’s representative picks up, or takes delivery of, every prescription paid for by the Department. All signatures must be original at the time each prescription is dispensed; electronic or other methods of reproducing past signatures are not acceptable. The signature log can be either manual or electronic and should comply with all HIPAA (Health Insurance Portability and Accountability Act) and State and Federal regulations.

Prescriptions that are mailed to clients shall be recorded in a dated log that must contain the prescription number, date of fill, client’s name and address that the prescription is mailed to as well as the name of the person mailing or delivering the mail to the mail carrier. If a single prescription to be mailed has a dollar amount paid by EqualityCare exceeding \$500.00, a receipt that indicates that the prescription was mailed must be obtained and attached to the log.

The above requirements also apply to clients living in nursing and/or institutional facilities.

MEDICATION RETURNED TO STOCK

If a client has not picked up a medication within 10 days of the date it was filled, Wyoming EqualityCare Pharmacy Program requires that the claim be reversed and the medication be put back into stock.

RETURNING MEDICATIONS FROM NURSING FACILITIES

According to the Deficit Reduction Act (DRA) of 2005, States are to insure that when redistribution is permitted, any facility utilizing unit dosed prescriptions must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuation of the prescription. Therefore, the Wyoming EqualityCare Pharmacy program requires nursing facilities to return any unused medications to the pharmacy that dispensed the medication as long as the requirements under Chapter 2, Section 15 of the State of Wyoming Pharmacy Act Rules

and Regulations are met. Where it is appropriate to restock and resell these medications, recovery actions will apply if the medications are not properly credited to Wyoming EqualityCare. In those circumstances that Wyoming State Pharmacy law does not allow for restocking and reselling of medications (example, in a closed door pharmacy that has no retail outlet) the medications do not need to be credited to Wyoming EqualityCare, but should be donated to a Medication Donation outlet whenever possible, in the unopened unit dose packaging in which they were dispensed. Otherwise, the medications should be properly destroyed.

In either situation, a record of medications donated or destroyed must be kept containing, at a minimum, the date of donation or destruction; the prescription number; the number of tablets destroyed or donated; the name of the donation outlet or the location where the medications were destroyed. Recovery is possible if this information is not recorded.



SECTION 3. DRUG UTILIZATION REVIEW (DUR)

Under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), each state is required to establish a drug use review program for covered outpatient drugs for Medicaid clients. This is to assure that prescriptions are appropriate, medically necessary and are not likely to result in adverse effects.

PROSPECTIVE DUR

PATIENT COUNSELING REQUIREMENTS

The Wyoming State Board of Pharmacy details specific patient counseling regulations in the Board of Pharmacy Administration Rule, Section IX. Information covered during counseling should be determined by the pharmacist's professional judgment.

New prescriptions are covered by the counseling provision. Mail order prescription outlets must offer counseling and provide a toll free telephone number.

POINT-OF-SALE (POS) DUR

Prescriptions will be screened for drug therapy problems before they are filled or at the point of sale. Pharmacists or their designee must offer to counsel patients (unless counseling is refused) on the following items:

- Name and description of the medication
- Dosage form, dosage, route of administration and duration of therapy
- Special directions, precautions for preparation, administration and use of the medication
- Common severe side effects, adverse effects or interactions and therapeutic contraindications
- Proper storage, refill information
- Actions in case of a missed dose

Pharmacists must also make a reasonable effort to maintain patient profiles.

REFILL TOO SOON (RTS)

- Scheduled drugs II through V, Ultram/tramadol and Soma/carisoprodol require 90% of the days supply to be used and no more than 7 days accumulation over a 180 day look back period before a refill or new claim for the same medication will be allowed.
- All other medications require 80% of the days supply be used and no more than 15 days of accumulated medication over a 180 day look back period before a refill or a claim for the same medication will be allowed.

Pharmacies with denied claims for Refill Too Soon (edit 79) must call the GHS POS Help Desk 877-209-1264 to obtain an override. If the following criteria are met for a dosage change or lost prescription, the PA Call Center will enter the override via a PA system. GHS will inform the pharmacy if the override is allowed and the override has been entered. The pharmacy can then resubmit the denied claim. PA requests for vacations will be denied. A maximum of 1 Refill Too Soon override is allowed per patient per year.

Note: Trying to obtain overrides for reasons other than dosage change or lost prescription will result in claims adjudication in which the reimbursement of the claim(s) may be reversed by and the associated funds will be returned to the State.

DRUG QUANTITY LIMITS

Medications with quantity limits are limited to a specified number of units per month. Please note there is no grace period for day supply with these edits.

Amerge:

- Amerge 1mg limited to 25 tablets in 34 days.
- Amerge 2.5mg limited to 10 tablets in 34 days.

Axert:

- Axert 6.25mg limited to 27 tablets maximum per 34 days.
- Axert 12.5mg limited to 27 tablets maximum per 34 days.

Frova:

- Frova 2.5mg limited to 20 tablets maximum in 34 days.

Imitrex:

- Imitrex kit 6mg/0.5ml limited to a maximum of 3 kits in 34 days.
- Imitrex vial 6mg/0.5ml limited to a maximum of 2 vials in 34 days.
- Imitrex 20mg nasal spray limited to 6 bottles maximum in 34 days.
- Imitrex 25mg tablets limited to 41 tablets maximum in 34 days.
- Imitrex 50mg tablets limited to 20 tablets maximum in 34 days.
- Imitrex 100mg tablets limited to 10 tablets maximum in 34 days.

Maxalt:

- Maxalt 5mg and Maxalt MLT 5mg limited to 27 tablets in 34 days.
- Maxalt 10mg and Maxalt MLT 10mg limited to 14 tablets in 34 days.

Oxandrin:

- Oxandrin 2.5mg limited to 272 tablets maximum per 34 days.
- Oxandrin 10 mg limited to 68 tablets maximum per 34 days.

Relpax:

- Relpax 20mg limited to 20 tablets maximum per 34 days.
- Relpax 40mg limited to 14 tablets maximum per 34 days.

Stadol:

- Stadol Nasal Spray 10mg/ml limited to a maximum of 1 bottle in 34 days.

Toradol:

- Toradol 30mg syringe limited to a maximum of 5-day duration of therapy.
- Toradol 15mg syringe limited to a maximum of 5-day duration of therapy.
- Toradol 10mg tablet limited to maximum of 5-day duration of therapy.

Zomig:

- Zomig 2.5mg and Zomig ZMT 2.5mg limited to 20 tablets in 34 days.
- Zomig 5mg limited to 10 tablets in 34 days.

Note: Certain narcotic medications require maximum days supply within the PA process.

MEDICAL SUPPLY QUANTITY LIMITS

- Allergy Syringes – maximum days supply = 100
- Asthma spacers, nebulizers, spirometers – maximum quantity = 1 per year
- Diabetic Supplies
 - Test strips, control solution, alcohol swabs, lancets, insulin syringes- maximum days supply = 100
 - Monitor, lancet devices – maximum quantity = 1 per year
- Enteral nutrition products – maximum days supply = 34
- Food Thickeners – maximum days supply = 34
- Gloves (latex, surgical) – not cotton – maximum days supply = 100
- Incontinence products (with the exception of diaper and catheters) – maximum days supply = 100
 - Diapers: Maximum of 13 per day and a maximum of 34 day supply at one time, for clients 3 years of age and older.
 - Catheters: Maximum of 10 per day, and a maximum of 34 day supply at one time.
- Irrigation supply – maximum days supply = 34
- IV Equipment – maximum quantity = 1 per year
- Ostomy and urologic supplies – maximum days supply = 100
- Sharp containers – maximum quantity = 1 per year

PREFERRED DRUG LIST (PDL)

The Wyoming EqualityCare Pharmacy Program implemented a preferred drug list on January 1, 2004. The preferred drug(s) are chosen following a systematic process that begins with the Preferred Drug List Advisory Committee (PDLAC).

The PDLAC begins the process by reviewing evidence-based prescription drug effectiveness reviews completed by the Center for Evidence-Based Practice. The committee makes a recommendation indicating whether the evidence shows that all medications in a class are clinically equivalent or not. The Wyoming Office of Pharmacy Services takes this recommendation, reviews cost information and chooses the preferred drug(s) based on the committee's decision. Once the preferred drug(s) are chosen, the Drug Utilization Review (DUR) Board determines prior authorization criteria for all non-preferred drugs.

The following classes of drugs are currently managed on the preferred drug list (PDL):

- Allergy
- Analgesics, Narcotics
- Angiotensin Modulators
- Antidepressants
- Antivirals
- Cholesterol Agents
- Gastrointestinal
- Growth Hormones
- Insomnia Agents
- Migraine Treatments
- NSAIDS
- Overactive Bladder Agents
- Prostate Agents
- Skeletal Muscle Relaxants
- Smoking Cessation products
- Topical Agents

Additional classes will be added as the evidence is reviewed by the PDLAC. For more information regarding the preferred drug list, including preferred drugs and additional classes, see Appendix or website at <http://uwacadweb.uwyo.edu/dur/>

PRIOR AUTHORIZATION

PRIOR AUTHORIZATION (PA) PROCESS

The Prior Authorization (PA) process assures that the approved service is medically necessary and considered to be a benefit of the EqualityCare program. All claims, including those for PA, must meet claim submission requirements before payment can be made (i.e., client eligibility, approval, timely filing, etc.).

Following introduction to the market, new drugs and new formulations of existing drugs, and new indications that are covered through the pharmacy services program will require prior authorization until published literature is available through standard literature review processes. The drug will be included in the next review of that drug class, and its coverage status will be reviewed at that time. Exceptions to this rule will be handled on a case by case basis.

The prior authorization process is done electronically through the POS system. As a pharmacy claim is processed, the POS system checks the claim against clinical rules based on prescription, diagnostic, and therapeutic histories. If the clinical rules are met, the claim will pay. If the clinical rules are not met, the claim will deny. POS PAs reduce the number of paper prior authorization requests due to the system's ability to check both prescription and medical claims information.

PA Questions may be addressed to:

Goold Health Systems
Prior Authorization Department
PO BOX 21719
Cheyenne, WY 82003-7032

Phone: 877-207-1126

RightFax: 866-964-3472

Note: High cost prescription claims may require PA approval prior to dispensing.

EMERGENCY SUPPLY

In the event of an emergency the pharmacy is authorized to dispense up to a 72 hour emergency supply. An emergency supply may only be used twice for each drug per month. A dispensing fee will not apply. Please refer to the payer sheet for instructions for PA code type and PA number field.

PA APPEALS PROCESS

If a PA is denied, clients or the prescriber may submit a request for consideration of the decision to deny the PA within twenty (20) days of the receipt of the notice of denial. The request for reconsideration should include additional supporting documentation along with the denial letter. Please send the submission to:

Goold Health Systems
Prior Authorization Department
PO BOX 21719
Cheyenne, WY 82003-7032

RightFax: 866-964-3472

Once the department issues its redetermination, you may contest the decision in writing. An appeal for a hearing may be requested according to Chapter One of the Wyoming Medicaid Rules. According to Wyoming Medicaid Rules, Chapter Three, Section 14(g), the failure to request reconsideration in a timely manner prevents appeal. Fax or mail the letter to:

WY Office of Pharmacy Services
6101 Yellowstone Ave., Suite 259 B
Cheyenne, WY 82002

FAX: 307-777-8623

BACKDATED PA REQUESTS

Requests for backdating PAs will not be approved by GHS. These requests should be forwarded directly to:

WY Office of Pharmacy Services
6101 Yellowstone Ave., Suite 259B
Cheyenne, WY 82002

FAX: 307-777-8623

MEDICAID LOCK-IN PROGRAM

The EqualityCare pharmacy lock-in program limits clients to the use of one designated pharmacy provider to receive prescription services. The program criteria are as follows:

- Any client who receives controlled substances prescriptions from 2 or more physicians; and
- Utilizes 2 or more pharmacies for filling controlled substances (excluding diagnosis of cancer).

Attempts to bill EqualityCare for pharmacy claims through any other pharmacy other than the lock-in pharmacy will be denied.

EMERGENCY PRESCRIPTIONS

1. If the dispensing pharmacist feels that in his/her professional judgment a prescription should be filled and they are not the lock-in provider, they may submit a hand-billed claim to GHS for review.
2. Overrides will be approved for true emergencies (auto accidents, sudden illness, and medication unavailable at lock-in pharmacy).

Goold Health Systems
Provider Relations Unit
PO BOX 21719
Cheyenne, WY 82003-7032

HOSPICE LOCK-IN PROGRAM

Medication for clients in the Hospice Lock-In program should be billed directly to the hospice provider. The hospice provider will directly reimburse the pharmacy for prescriptions that are deemed 'related to the hospice condition' by the hospice provider.

Medications that are deemed 'not related to the hospice condition' by the hospice provider should be billed to the Wyoming EqualityCare program. The pharmacy should complete a PA fax form and fax to the GHS Prior Authorization (PA) line at 866-964-3472 to request an electronic PA override. The PA request must include the hospice form provided by the hospice provider that states that the medications are not related to the client's terminal illness and will not be covered by the hospice provider.

Once the override PA is in the claims system, the pharmacy provider will be notified by GHS and the pharmacy provider should bill the hospice claim as any other Medicaid pharmacy claim. All Medicaid rules, edits and limitations will apply. No co-payments apply to hospice claims.

RETROSPECTIVE DUR

Drug claims data will be reviewed periodically, using predetermined standards, to monitor for therapeutic appropriateness. Retrospective DUR also includes educational programs, conducted through State DUR boards, and interventions to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

Screening of claims will occur bimonthly. Screening will be based on predetermination criteria and involve monitoring the following:

- Therapeutic appropriateness, over and under utilization, appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect dosage or duration of therapy and clinical abuse or misuse

The predetermination standards must be consistent with the peer reviewed medical literature, as well as:

- *AMA Drug Evaluations*
- *USP Drug Information*
- *American Hospital Formulary Service Drug Information*
- *DrugDEX Information System*

SECTION 4. REIMBURSEMENT & CO-PAYMENTS

TIMELY FILING FOR CLAIMS SUBMISSION

Timely filing for pharmacy claims must occur within one (1) year from the date the medication was dispensed or services rendered. The Office of Pharmacy Services must approve any requests to file claims beyond the one year limit.

MEDISPAN PRODUCT INFORMATION

Please note that even though a product may be listed as covered by EqualityCare (such as diapers or catheters), a particular manufacturer's product may not be covered if the manufacturer has not submitted all product information to Medispan. It is the manufacturer's responsibility to submit their product information to Medispan.

If a pharmacy is aware of a product that you believe should be covered by EqualityCare, but is not accepted by the system because the product information is not listed in Medispan, please contact the manufacturer of the product to forward necessary information to Medispan. Sometimes the manufacturer is unwilling to give all the necessary information (usually pricing information) to Medispan; therefore their product will not be covered.

CLIENT CO-PAYMENT RESPONSIBILITIES

Payment for pharmaceutical services should be arranged for at the time services are given. Wyoming EqualityCare clients may be denied services by pharmacies if they regularly refuse to pay their co-payments. Co-payment amounts are specific to each plan (see Plan information in this manual).

CO-PAYMENT EXEMPTIONS (ALL PLANS EXCEPT PLAN 192)

- Clients under age 21
- Nursing Facility Residents
- Pregnant Women*
- Family planning services
- Emergency services
- Hospice services

* The pregnancy co-payment exemption ends on the day of delivery. For pregnant women, place a "2" in the PA Type Code and a "4" in the PA number submitted to denote "Exemption from Copay" when you are submitting a prescription via Point of Sale or on the UCF. Indicating a "4" in the upper right section of the Universal Claim Form will also be accepted. An audit will be conducted on a regular basis to verify the accurate use of the co-payment override codes for pregnancy.

FEDERAL UPPER LIMIT (FUL) PRICING

The Federal Upper Limit (FUL) pertains to multi-source generic drug products. FUL pricing is also referred to as Federal Maximum Allowable Costs (FMACs). This is the maximum allowable cost per unit that will be reimbursed

for federally funded Medicaid and Medicare programs. FUL prices are determined by the Centers for Medicaid & Medicare (CMS). http://www.cms.hhs.gov/Reimbursement/05_FederalUpperLimits.asp#TopOfPage

STATE MAXIMUM ALLOWABLE COST (SMAC) DRUGS

The State Maximum Allowable Cost (SMAC) pertains to both multi-source generic and single source drug products. A SMAC price is the maximum allowable cost per unit that will be reimbursed for Wyoming EqualityCare prescriptions. SMAC prices are determined by the Office of Pharmacy Services.

If a SMAC price is found to be less than a provider's actual purchase price, the provider should contact Goold Health Systems 877-206-4714. A copy of the provider's invoice is needed to initiate the research on the appropriateness of the SMAC price.

Drugs with a State Maximum Allowable Cost can be found on the Office of Pharmacy Services website at: <http://www.health.wyo.gov/healthcarefin/pharmacy/index.html>

BRANDED GENERIC DRUGS

With a few exceptions, branded generic medications pay the same as generic claims and collect generic co-payment. If pharmacies observe otherwise, they should contact the GHS provider help desk at 877-209-1264.

Pharmacies are required to send a fax or email with the NDC detail and the reason for the request. GHS will verify that the NDC is a branded generic and will request a change in the POS if warranted. Once complete, GHS Help Desk staff will notify the pharmacy and let them know they can reverse and resubmit the claim to obtain the appropriate co-payment. GHS does not have the ability to alter specific claim co-payments.

PCN, BIN

Processor Control Number: WYOPOP (Effective 05/28/2009)

BIN Number: 014293 (Effective 05/28/2009)

NCPDP Version: 5.1

CLAIMS REIMBURSEMENT RATES

EqualityCare reimbursement for covered services is based on a variety of payment methodologies depending on the service provided:

- AWP (Average Wholesale Price)
- FMAC (Federal Maximum Allowable Cost)/FUL (Federal Upper Limit)
- SMAC (State Maximum Allowable Cost)
- Negotiated Rates (Submitted Ingredient Cost)
- Usual & Customary Rate
- Gross amount due

Questions regarding reimbursements should be directed to the GHS POS Help Desk at:

Goold Health Systems
Provider Relations Unit
PO BOX 21719
Cheyenne, WY 82003-7032

877-209-1264

REIMBURSEMENT ALGORITHM

The following reimbursement algorithm applies to all legend drugs, diabetic supplies, medical supplies and OTC medications for all WY Plans:

Providers will be reimbursed the lesser of SMAC, FUL, AWP-11% or Submitted Ingredient Cost + \$5.00 dispensing fee, Usual and Customary, or Gross Amount Due, whichever is less.

POINT-OF-SALE BILLING

The Point-of-Sale (POS) drug claims system allows pharmacists to send claims to EqualityCare via telecommunications networks as they are filling prescriptions for EqualityCare clients, and to have those claims adjudicated on-line or in real time. The following on-line processing functions are performed:

- Verify client eligibility
- Verify claim data validity
- Perform on-line duplicate services detection and drug capitations
- Verify coverage of the drug due to formulary restrictions, DESI status, obsolete dates and rebate closures
- Price the claim, determine co-payment amounts, and pharmacy reimbursement amounts
- Provide Prospective DUR, the detection of conflicts prior to filling the prescriptions
- Completes Prior Authorizations
- Allows Pharmacy Overrides

When a prescription is filled, the pharmacy enters the prescription data into the internal system through a personal computer, a terminal, or some other point of sale device. The pharmacy system then formats and sends the EqualityCare claim to the POS drug claims system for adjudication. EqualityCare uses the National NCPDP 5.1 claim format.

The POS drug claims system interfaces with individual pharmacies through switch vendors who provide telecommunications. The switch vendors route POS claims from the pharmacies to claim processors. The response is sent back to the pharmacy via the switch vendor. With the exception of limited maintenance periods, the POS claims system is available twenty-four hours a day, seven days a week.

The signed POS business agreement must be on file with Goold Health Systems, Inc. before you will be allowed to submit claims by POS. Pharmacies are responsible for their own telecommunications “switch” costs through their regular POS vendor.

GHS POS HELP DESK CALL CENTER – 877-209-1264

NPI & DEA REQUIREMENTS

All Wyoming EqualityCare pharmacy claims require the pharmacy provider's NPI number and the prescriber's NPI number. Pharmacy claims will not be reimbursed by Wyoming EqualityCare if both NPI numbers are not on the pharmacy claim.

Invalid Prescriber NPIs may not be substituted with the submitting pharmacy's NPI. These claims will reject with "Invalid Prescriber NPI" or equivalent code. The use of the EqualityCare approved dummy NPI number is allowed for one claim submission. The correct NPI number must be obtained before the next claim submission or funds could be returned to the State.

The EqualityCare approved dummy NPI number is: 9995555999.

Schedule 2-5 prescriptions also require a prescriber DEA number be on the Prescriber's file. Pharmacies should submit a prescriber's NPI number and the POS will verify the prescriber's DEA on file. Pharmacies cannot submit provider DEA numbers via the POS.

To assist pharmacies in obtaining a prescriber's NPI number, the Centers for Medicare and Medicaid Services (CMS) provides a website that is accessible to both pharmacies and providers. There is not a charge to use the NPI registry. NPI searches can be conducted by entering the prescriber's name. The website is:

<https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind>

COMPOUND DRUGS CLAIMS

Compound prescriptions are covered if the main active ingredient or ingredients are drugs covered by EqualityCare.

Due to NCPDP 5.1 Standards, each NDC number in a compound can be billed by a pharmacy up to 40 lines. All ingredients of the compound will go through PDL, PA and DUR edits. If the NDC number is not covered, the claim will deny. A pharmacy can resubmit the claim with a submission clarification code of 8, and only the approved ingredients covered will pay.

Reimbursement is based on the lesser of pricing logic of each drug and a single \$5.00 dispensing fee. There is no additional compensation for compounding. Co-payments for compounds are \$3.00.

If you need to bill a paper claim, see guidelines below.

PAPER CLAIMS

EqualityCare requires all pharmacy claims to be submitted electronically through the Point of Sale (POS) system. EqualityCare will **only** accept a claim submitted on paper when:

1. A client becomes eligible for EqualityCare after receiving services (retroactive EqualityCare) **AND**
2. The provider's software system cannot support a claim with a previous date of service, **OR**
3. The claim is a pharmacy lock-in client who has gone to another pharmacy for an emergency (see Lock-In section of this manual.)

If submitting on paper, use the Universal Claim Form when requesting payment for drugs and pharmaceutical products authorized under the EqualityCare program. If the Universal Claim Form is not used, the claim will be returned. Examples of the claim form are depicted in this section as Exhibits 1. Step-by-step instructions for completing the form follow in this module.

BASIC RULES FOR PAPER CLAIMS SUBMISSIONS

- Always use the Universal Claim Form.
- Use one claim for each client.
- Be sure the information on the form is legible.

BEFORE YOU BEGIN

- Is the client eligible for EqualityCare on the date of service? (Refer to the EqualityCare website at: <http://www.health.wyo.gov/healthcarefin/medicaid/eligibility.html>)
- Do you have a copy of the client's proof of eligibility?
- Does EqualityCare cover the service?
- Have you checked to make sure the client does not have other insurance?

BILLING ADDRESS

Wyoming Medicaid pharmacies should send paper claims to the following address:

Goold Health Systems
Provider Relations Unit
PO BOX 21719
Cheyenne, WY 82003-7032

If the response to all of the above questions is favorable, you can begin to fill out the claim form following the instructions in this module.

EXHIBIT 1 – UNIVERSAL CLAIM FORM

MEMBER ID. 2 GROUP I.D. 1

NAME _____ PLAN NAME _____
 PATIENT NAME 3 OTHER COVERAGE CODE (1) 5 PERSON CODE (2) _____
 PATIENT DATE OF BIRTH _____ PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____
 PHARMACY NAME 6

ADDRESS 7 SERVICE PROVIDER I.D. 9 QUAL (5) _____
 CITY _____ PHONE NO. () _____
 STATE & ZIP CODE 8 FAX NO. () _____

WORKERS COMP. INFORMATION
 EMPLOYER NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 CARRIER ID. (6) _____ EMPLOYER PHONE NO. _____
 DATE OF INJURY _____ CLAIM (7) REFERENCE I.D. _____

I have hereby read the Certification Statement on the reverse side, I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.
 PATIENT / AUTHORIZED REPRESENTATIVE 10 11

FOR OFFICE USE ONLY	

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE
--

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)
DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)	
OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE		

<u>21</u>	INGREDIENT COST SUBMITTED
<u>22</u>	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
<u>23</u>	GROSS AMOUNT DUE SUBMITTED
<u>24</u>	PATIENT PAID AMOUNT
<u>25</u>	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY
PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)
DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)	
OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE		

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

HOW TO COMPLETE A UNIVERSAL CLAIM FORM

Claim Item	Title	Req'd	Action
1	Group ID		No longer required (effective 6/1/09)
2	Cardholder ID	X	Enter the 10-digit EqualityCare client ID number for the specific client whom the prescription is written.
3	Patient Name	X	Using last name, first name and middle initial format, enter the name of the actual client receiving the service as recorded on the EqualityCare client ID Card for the month that service is being provided.
4	Submit Claim To Field (in upper right corner) OR submit in the PA TYPE field.	X	Enter the "4" for pregnancy (exempt from co-payment) Choose upper right of claim form or actual PA Type field located after Prior Auth # Submitted field.
5	Other Coverage Code (1)	X	If you are billing via POS, EqualityCare will deny pharmacy claims for EqualityCare clients with insurance pharmacy coverage if the prescriptions can be submitted electronically to the other insurance company. EqualityCare will continue to pay claims up front for all other EqualityCare clients with insurance that cannot be billed electronically to the insurance company by the pharmacy. If you are billing by hand and the client's other health insurance has already paid, and you are billing EqualityCare for the unpaid balance, enter a 2 in this box. Enter the amount paid by other insurance in box #25.
6	Pharmacy Name	X	Enter the name of the pharmacy dispensing the prescription(s).
7	Address	X	Enter the pharmacy's street address.
8	City, State & Zip	X	Enter the pharmacy's city, state & zip code information.
9	Service Provider ID	X	Enter the pharmacy's NPI number.

Claim Item	Title	Req'd	Action
10	Patient Information Auth.		Not required.
11	Authorized Pharmacy Representative	X	The authorized pharmacy representative must sign the form here or enter "Signature on File" which means the pharmacy has signed the patient signature log.
12	Date Written	X	In numeric format, enter the month, day and year the prescription(s) were written. For example, 05/12/1993 for May 12, 1993. The claim form can be used to bill two prescriptions filled by the pharmacy for the same client.
13	Date of Service	X	In numeric format enter the month, day and year the prescription(s) is filled. For example, 05/12/1993 for May 12, 1993.
14	Rx/Service Ref. #	X	Enter the number assigned by the pharmacy for the prescription(s).
15	Fill #	X	The code indicating whether the prescription is an original or a refill. 0 = original dispensing 1 to 99 = refill number
16	Qty. Dispensed	X	Enter the number of tablets or capsules dispensed, the number of grams of ointments or powders or the number of "cc's" or "ml's" dispensed. Use whole units only.
17	Days Supply	X	Enter the number of days of medicine this prescription will supply.
18	Product/Service ID	X	Enter the 11-digit NDC number assigned to the product.
19	Prescriber ID	X	Enter the prescriber's NPI number.
20	DAW Code	X	Effective 6/1/09, DAW codes are no longer needed.

Claim Item	Title	Req'd	Action
21	Ingredient Cost	X	Submitted product component cost of the dispensed prescription. This amount is included in the Gross Amount Due.
22	Dispensing Fee		Dispensing Fee submitted by the pharmacy. This amount is included in the Gross Amount Due.
23	Gross Amount Due	X	Legend Drugs – Enter the total charge for this prescription or product. The total charge should be the provider’s usual and customary charge to the public. OTC Drugs or Medical Supplies – Enter the total charge for this prescription/product. The total charge should be the usual and customary charge to the public.
24	Patient Paid Amount	X	Amount the pharmacy received from the patient for the prescription dispensed.
25	Other Payer Amount Paid	X	Amount of any payment known by the pharmacy from other sources . Support by Other Coverage Code = 2 in Instruction #5.

TPL BILLING INSTRUCTIONS

When payment is received from insurance, enter the insurance payment in the “Other Payer Amount Paid ” field and submit the claim to EqualityCare. EqualityCare will subtract the insurance payment and any required co-payment for the allowed fee in pricing the claim. You should continue to collect the EqualityCare co-payment from the client.

If a claim is denied by EqualityCare because the client has other insurance that may be billed by the pharmacy and the client cannot supply a card with the insurance information, contact Goold Health Systems’ Provider Help Desk at 877-209-1264.

If the insurance company denies the claim because it is a non-covered service or deductible, use the corresponding NCPDP code to process the claim though POS, then enter:

00 = other coverage information is not specified by the client

01 = no other coverage information is available

02 = other coverage exists (must have paid amount in other payer amount paid field)

03 = other coverage was billed but claim was not paid because the service is not covered by other insurance

04 = other coverage was billed, but no payment was received (ex: 100% deductible)

An audit will be conducted on a regular basis to verify the accurate use of the above override codes.

If a claim is for a medication where the brand is preferred over the generic (denoted by an asterisk on the PDL, e.g. Duragesic) and the primary insurance only covers the generic then the generic may be dispensed and the remainder of the cost billed to Medicaid. The Pharmacy will have to contact the GHS PA Helpdesk at 877-207-1126 for an override prior to billing Medicaid.

SECTION 5. PLAN INFORMATION

PLAN 190– REGULAR MEDICAID CLIENTS

Plan 190	Overrides/Exceptions/Comments	
Co-payments		
<ul style="list-style-type: none"> Generics 	\$1.00	Standard co-payment exemptions, Compounds \$3.00 co-payment for both Brand and Generic drugs
<ul style="list-style-type: none"> Preferred Brands 	\$2.00	
<ul style="list-style-type: none"> Non-Preferred Brands 	\$3.00	
Reimbursement Rates	Standard	Lesser of logic
Maximum Day Supply Limits		
<ul style="list-style-type: none"> Non-maintenance 	34	Non-maintenance drugs are covered up to a 34 day supply
<ul style="list-style-type: none"> Maintenance (90 days supply) 	Yes	Limited classes of Maintenance drugs are covered for up to a 90 day supply. Exceptions for 100 day supply allowed on certain medications.
DUR Edits		
<ul style="list-style-type: none"> PAs 	Yes	Standard
<ul style="list-style-type: none"> PDL 	Yes	Standard
<ul style="list-style-type: none"> Quantity Edits 	Yes	Standard
Covered Services		
<ul style="list-style-type: none"> Legend drugs 	Yes	Standard
<ul style="list-style-type: none"> OTC drugs 	Yes	Limited OTC coverage
<ul style="list-style-type: none"> DME 	Yes	Limited DME covered through POS.

PLAN 191 – WYOMING MEDICAID NURSING HOME CLIENTS

Plan 191	Overrides/Exceptions/Comments	
Co-payments		
<ul style="list-style-type: none"> • Generics • Preferred Brands • Non-Preferred Brands 	\$0 \$0 \$0	Compounds \$0.00 co-payment
Reimbursement Rates	Standard	Lesser of Logic
Maximum Day Supply Limits		
<ul style="list-style-type: none"> • Non-maintenance • Maintenance (90 days supply) 	34 Yes	Limited classes of Maintenance drugs are covered for up to a 90 day supply. Exceptions for 100 day supply allowed on certain medications.
DUR Edits		
<ul style="list-style-type: none"> • PAs • PDL • Quantity Edits 	Yes Yes Yes	Standard Standard Standard
Covered Services		
<ul style="list-style-type: none"> • Legend drugs • OTC drugs • DME 	Yes No No	Standard 190

PLAN 192 – PRESCRIPTION DRUG ASSISTANCE PROGRAM (PDAP) – STATE ONLY PLAN

Plan 192	Overrides/Exceptions/Comments	
Co-payments		Clients are limited to <u>3 prescriptions per month</u> including legend, compounds, and OTCs
<ul style="list-style-type: none"> • Generics • Preferred Brands • Non-Preferred Brands 	\$10 or less \$25 or less \$25 or less	Compounds containing only generic ingredients have a \$10 co-payment Compounds containing one or more brand ingredients have a \$25 co-payment
Reimbursement Rates	Standard	Lesser of logic
Maximum Day Supply Limits		
<ul style="list-style-type: none"> • Non-maintenance • Maintenance (90 days supply) 	30 No	
DUR Edits		
<ul style="list-style-type: none"> • PAs • PDL • Quantity Edits 	Yes Yes Yes	Standard Standard Standard
Covered Services		
<ul style="list-style-type: none"> • Legend drugs • OTC drugs • DME 	Yes Yes No	Standard (190) Standard (190)

PLAN 193 – LONG TERM CARE WAIVER CLIENTS

Plan 193	Overrides/Exceptions/Comments	
Co-payments		
• Generics	\$1	Compounds \$3.00 co-payment for both Brand and Generic drugs
• Preferred Brands	\$2	
• Non-Preferred Brands	\$3	
Reimbursement Rates	Standard	Lesser of logic
Maximum Day Supply Limits		
• Non-maintenance	34	
• Maintenance (90 days supply)	Yes	Standard 190
DUR Edits		
• PAs	Yes	
• PDL	Yes	
• Quantity Edits	Yes	
Formulary		
• Legend drugs	Yes	Standard 190
• OTC drugs	Yes	Standard 190
• DME	Yes	Standard 190

PLAN 194 – IMMRX CLIENTS

Plan 194	Overrides/Exceptions/Comments	
Co-payments		
<ul style="list-style-type: none"> • Generics • Preferred Brands • Non-Preferred Brands 	<p>\$2</p> <p>\$2</p> <p>\$2</p>	<p>Compounds \$2.00 co-payment for both Brand and Generic drugs</p>
Reimbursement Rates	Standard	Lesser of logic
Maximum Day Supply Limits		
<ul style="list-style-type: none"> • Non-maintenance • Maintenance (90 days supply) 	<p>30</p> <p>NO</p>	
DUR Edits		
<ul style="list-style-type: none"> • PAs • PDL • Quantity Edits 	<p>NO</p> <p>NO</p> <p>NO</p>	
Formulary		
<ul style="list-style-type: none"> • Legend drugs • OTC drugs • DME 	<p>Yes</p> <p>Specific IMMRX formulary</p> <p>Specific IMMRX formulary</p>	<p>Specific IMMRX specific formulary</p>

PLAN 195 – CHILDREN’S SPECIAL HEALTH (CSH) (STATE PLAN)

Plan 195	Overrides/Exceptions/Comments	
Co-payments	Clients are eligible based on their illness or disease. State determines eligibility.	
<ul style="list-style-type: none"> • Generics • Preferred Brands • Non-Preferred Brands 	<ul style="list-style-type: none"> \$0 \$0 \$0 	Compounds \$0.00 co-payment for both Brand and Generic drugs
Reimbursement Rates	Standard	Lesser of logic
Maximum Day Supply Limits		
<ul style="list-style-type: none"> • Non-maintenance • Maintenance (90 days supply) 	<ul style="list-style-type: none"> 30 NO 	
DUR Edits		
<ul style="list-style-type: none"> • PAs • PDL • Quantity Edits 	<ul style="list-style-type: none"> NO NO NO 	
Covered Services		
<ul style="list-style-type: none"> • Legend drugs • OTC drugs • DME 	<ul style="list-style-type: none"> Yes Specific CSH formulary Specific CSH formulary 	Specific CHS formulary

PLAN 197 - AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Plan 197	Overrides/Exceptions/Comments	
Co-payments	ADAP specific Formulary. State determines eligibility.	
<ul style="list-style-type: none"> • Generics • Preferred Brands • Non-Preferred Brands 	\$0	Compounds \$0.00 co-payment
	\$0	
	\$0	
Reimbursement Rates	Standard	Lesser of logic
Maximum Day Supply Limits		
<ul style="list-style-type: none"> • Non-maintenance 	34	
<ul style="list-style-type: none"> • Maintenance (90 days supply) 	No	
DUR Edits		
<ul style="list-style-type: none"> • PAs 	NO	
<ul style="list-style-type: none"> • PDL 	NO	
<ul style="list-style-type: none"> • Quantity Edits 	NO	
Covered Services		
<ul style="list-style-type: none"> • Legend drugs 	Yes	Specific ADAP Formulary
<ul style="list-style-type: none"> • OTC drugs 	Specific ADAP formulary	
<ul style="list-style-type: none"> • DME 	Specific ADAP formulary	

PLAN 198: FAMILY PLANNING

Plan 198	Overrides/Exceptions/Comments	
<p>Co-payments/eligibility</p> <ul style="list-style-type: none"> • Generics • Preferred Brands • Non-Preferred Brands 	<p>\$0 \$0 \$0</p>	<p>Eligibility limited to women ages 19 to 45 years of age Compounds \$0.00 co-payment</p>
<p>Reimbursement Rates</p>	<p>Standard</p>	<p>Lesser of logic</p>
<p>Maximum Day Supply Limits</p> <ul style="list-style-type: none"> • Non-maintenance • Maintenance (90 days supply) 	<p>See above See above</p>	<p>Prescriptions are limited to a 90 day supply, with the exception of implants and intramuscular injections, which are limited to 1 service per 90 days supply.</p>
<p>DUR Edits</p> <ul style="list-style-type: none"> • PAs • PDL • Quantity Edits 	<p>Yes Yes Yes</p>	<p>Standard Standard Standard</p>
<p>Covered Services</p> <ul style="list-style-type: none"> • Legend drugs • OTC drugs • DME 	<p>Yes Specific family planning formulary Specific family planning formulary</p>	<p>Limited to family planning (birth control) products</p>

WYOMING MEDICAID DUAL ELIGIBLE PLANS

If a client has coverage under one of the plans listed below then they are dual-eligible. There are only three plans that a dual-eligible client would have coverage under. Drug coverage for current plans will remain the same.

- **Plan 290:** Regular dual eligibles (clients eligible for Medicaid and Medicare D drug coverage)
- **Plan 291:** Nursing home dual eligibles (clients eligible for Medicaid nursing home benefits and Medicare)
- **Plan 293:** LTC Waiver dual eligibles (clients eligible for Medicaid LTC Waiver benefits and Medicare)

MEDICARE/MEDICAID DUAL ELIGIBLE CLIENT LIMITATIONS

The EqualityCare Office of Pharmacy Services covers only those drugs that are exempt from coverage by Medicare Part D prescription drug plans. These drugs include benzodiazepines, barbiturates, and Over-the-Counter (OTC) products currently covered by Wyoming Medicaid. Medicaid will not cover drugs that are excluded from a prescription drug plan's formulary.

Pharmacies should bill Medicare eligible clients for benzodiazepines, barbiturates, and OTC products currently covered by Wyoming EqualityCare in the same way they bill for non-dual EqualityCare clients; through POS with the clients EqualityCare identification number. Copays will still apply.

Nursing Home patients eligible for Medicare services may receive coverage of benzodiazepines and barbiturates through EqualityCare. OTC medications are not covered for dual eligible nursing home patients because OTC medications are included in nursing home per diem rates. EqualityCare will not cover drugs that are excluded from a prescription drug plan's formulary, so any issues concerning a nursing home patient's drug coverage need to be directed to the client's Medicare prescription drug plan.

PLAN 290: REGULAR DUAL ELIGIBLE CLIENTS

Plan 290	Overrides/Exceptions/Comments	
Co-payments/Eligibility	Clients eligible for Medicaid and Medicare D drug coverage	
<ul style="list-style-type: none"> • Generics 	\$1	Compounds \$3.00 co-payment for both Brand and Generic copay
<ul style="list-style-type: none"> • Preferred Brands 	\$2	
<ul style="list-style-type: none"> • Non-Preferred Brands 	\$3	
Reimbursement Rates	Standard	Lesser of Logic
Day Supply Limits		
<ul style="list-style-type: none"> • Non-maintenance 	34	
<ul style="list-style-type: none"> • Maintenance (90 days supply) 	NO	
DUR Edits		
<ul style="list-style-type: none"> • PAs 	Yes	Standard
<ul style="list-style-type: none"> • PDL 	Yes	Standard
<ul style="list-style-type: none"> • Quantity Edits 	Yes	Standard
Covered Services		
<ul style="list-style-type: none"> • Legend drugs 	Limited	Limited to benzodiazepines and barbiturates
<ul style="list-style-type: none"> • OTC drugs 	Yes	Standard 190
<ul style="list-style-type: none"> • DME 	Limited	Limited to Syringes, Diapers/Guards/Liners/Liner Pads for Incontinence, and Enteral Nutrition products

PLAN 291: NURSING HOME DUAL ELIGIBLE CLIENTS

Plan 291	Overrides/Exceptions/Comments	
Co-payments/Eligibility <ul style="list-style-type: none"> • Generics • Preferred Brands • Non-Preferred Brands 	\$0 \$0 \$0	Nursing home clients eligible for Medicaid nursing home benefits and Medicare benefits Compounds \$0.00 co-payment
Reimbursement Rates	Standard	Lesser of Logic
Day Supply Limits <ul style="list-style-type: none"> • Non-maintenance • Maintenance (90 days supply) 	34 No	
DUR Edits <ul style="list-style-type: none"> • PAs • PDL • Quantity Edits 	Yes Yes Yes	Standard Standard Standard
Covered Services <ul style="list-style-type: none"> • Legend drugs • OTC drugs • DME 	Limited NO NO	Limited to benzodiazepines and barbiturates

PLAN 293: LTC WAIVER DUAL ELIGIBLE CLIENTS

Plan 293	Overrides/Exceptions/Comments	
Co-payments/Eligibility		Clients eligible for Medicaid and LTC Waiver benefits
<ul style="list-style-type: none"> Generics 	\$1	Compounds \$3.00 co-payment for both Brand and Generic drugs
<ul style="list-style-type: none"> Preferred Brands 	\$2	
<ul style="list-style-type: none"> Non-Preferred Brands 	\$3	
Reimbursement Rates	Standard	Lesser of Logic
Day Supply Limits		
<ul style="list-style-type: none"> Non-maintenance 	34	
<ul style="list-style-type: none"> Maintenance (90 days supply) 	No	
DUR Edits		
<ul style="list-style-type: none"> PAs 	Yes	Standard 190
<ul style="list-style-type: none"> PDL 	Yes	Standard 190
<ul style="list-style-type: none"> Quantity Edits 	Yes	Standard 190
Covered Services		
<ul style="list-style-type: none"> Legend drugs 	Limited	Limited to benzodiazepines and barbiturates
<ul style="list-style-type: none"> OTC drugs 	Yes	Same as 190
<ul style="list-style-type: none"> DME 	Limited	Limited to Syringes, Diapers/Guards/Liners/Liner Pads for Incontinence, and Enteral Nutrition products

APPENDIX

PRIOR AUTHORIZATION (PA) FORMS

Wyoming Medicaid – Pharmacy Services Program

BRAND NAME DRUG REQUEST FORM

PHONE: 1-877-207-1126

MAIL: Goold Health Systems

FAX: 1-866-964-3472

P.O. Box 21719

Cheyenne, WY 82003

Provider must fill all information below. It must be legible, correct and complete or form will be returned.

Recipient ID #: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Recipient's Full Name: _____ DOB: _____

Prescriber NPI: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Pharmacy Name: _____ Phone: _____

ONE Drug Per Form ONLY

Dosage

<u>Drug Name</u>	<u>Strength</u>	<u>Instructions</u>	<u>Quantity</u>	<u>Days Supply</u>	<u>Refills</u>
_____	_____	_____	_____	_____	1 2 3 4 5

Has member tried a generic?

- No
- Yes
 - Adverse reaction
 - Inadequate response
 - Other _____

Details of adverse reaction, inadequate response, or other: (please provide chart notes.)

Is the side effect experienced also listed in the Brand Drug Side Effect Profile? If no please explain.

What other therapeutic alternatives other than the name brand version were tried first?

MEDICAL JUSTIFICATION (Please indicate why the individual's medical condition cannot be adequately treated with generic forms of the drug. ***If the patient had an adverse reaction to the generic form of the drug, have you submitted a MedWatch form to the FDA? If yes, please include a copy with this form. **IF NO, ONE MUST BE INCLUDED WITH THIS REQUEST.** A MedWatch form may be obtained at: <http://www.fda.gov/medwatch/report.htm>.)

Provider Signature: _____ **Date of Submission:** _____

*MUST MATCH PROVIDER LISTED ABOVE

PREFERRED DRUG LIST (PDL)**Effective 05/28/2009**

Drugs listed on the PDL are preferred or do not require prior authorization. For more information on drugs with preferred status, please visit our website at <http://uwyo.edu/PDL>.

MEDWATCH ADVERSE EVENT REPORTING FORM

MEDWATCH

For VOLUNTARY reporting of
adverse events, product problems and
product use errors

The FDA Safety Information and
Adverse Event Reporting Program

[General Instructions](#)

Page of

FDA USE ONLY	
Triage unit sequence #	<input type="text"/>

A. PATIENT INFORMATION Section A - Help

1. Patient Identifier <small>In confidence</small>	2. Age at Time of Event, or Date of Birth:	3. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	4. Weight lb or kg
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B. ADVERSE EVENT, PRODUCT PROBLEM OR ERROR Section B - Help

Check all that apply:

1. Adverse Event Product Problem (e.g., defects/malfunctions)
 Product Use Error Problem with Different Manufacturer of Same Medicine

2. Outcomes Attributed to Adverse Event (Check all that apply)

Death: _____ (mm/dd/yyyy) Disability or Permanent Damage
 Life-threatening Congenital Anomaly/Birth Defect
 Hospitalization - initial or prolonged Other Serious (Important Medical Events)
 Required Intervention to Prevent Permanent Impairment/Damage (Devices)

3. Date of Event (mm/dd/yyyy) 4. Date of this Report (mm/dd/yyyy)
 _____ 04/23/2009

5. Describe Event, Problem or Product Use Error

(Continue on page 2)

6. Relevant Tests/Laboratory Data, including Dates

(Continue on page 2)

7. Other Relevant History, including Preexisting Medical Conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hereditary problems, etc.)

(Continue on page 2)

C. PRODUCT AVAILABILITY Section C - Help

Product Available for Evaluation? (Do not send product to FDA)

Yes No Returned to Manufacturer on: _____ (mm/dd/yyyy)

D. SUSPECT PRODUCT(S) Section D - Help

1. Name, Strength, Manufacturer (from product label)

#1 _____
#2 _____

2. Dose or Amount	Frequency	Route
#1 _____	_____	_____
#2 _____	_____	_____

3. Dates of Use (if unknown, give duration) from/to (or best estimate)

#1 _____
#2 _____

4. Diagnosis or Reason for Use (indication)

#1 _____
#2 _____

5. Event Abated After Use Stopped or Dose Reduced?
 #1 Yes No Doesn't Apply
 #2 Yes No Doesn't Apply

6. Lot # 7. Expiration Date

#1 _____ #1 _____
#2 _____ #2 _____

8. Event Reappeared After Reintroduction?
 #1 Yes No Doesn't Apply
 #2 Yes No Doesn't Apply

9. NDC # or Unique ID

E. SUSPECT MEDICAL DEVICE Section E - Help

1. Brand Name

2. Common Device Name

3. Manufacturer Name, City and State

4. Model #	Lot #	5. Operator of Device <input type="checkbox"/> Health Professional <input type="checkbox"/> Lay User/Patient <input type="checkbox"/> Other: _____
Catalog #	Expiration Date (mm/dd/yyyy)	
Serial #	Other #	
6. If Implanted, Give Date (mm/dd/yyyy)		

7. If Implanted, Give Date (mm/dd/yyyy)

8. Is this a Single-use Device that was Reprocessed and Reused on a Patient?
 Yes No

9. If Yes to Item No. 8, Enter Name and Address of Reprocessor

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS Section F - Help

Product names and therapy dates (exclude treatment of event)

(Continue on page 2)

G. REPORTER Section G - Help

1. Name and Address

Phone # _____ E-mail _____

2. Health Professional? Yes No 3. Occupation _____

4. Also Reported to:
 Manufacturer
 User Facility
 Distributor/Importer

5. If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box:

PLEASE TYPE OR USE BLACK INK