



Medicaid Pharmacy News

Dear Providers:

November 10, 2011

SYNAGIS® PRIOR AUTHORIZATION PROCEDURE

Prior authorization is required for **ALL** Synagis® claims. There is a **separate authorization request** form that is required and it is available in this newsletter, as well as at <http://wyequalitycare.org/pa>. The **prescriber must sign** the prior authorization request form and the client's gestational age must be provided for the first dose. For each subsequent dose, the client's weight, the anticipated administration date, the previous dose administration date, and the date submission of the prior authorization must be updated and the prescriber or prescriber's agent (which does not include any pharmacy staff personnel) must initial the form. Authorizations for subsequent doses **will not be approved** without that updated information.

The Wyoming Department of Health will **only approve five (5) doses** of therapy with Synagis per client per season. Therefore, if the RSV season has not begun in the client's area of residence, consideration should be given to delaying the start of administration of Synagis to avoid exceeding the Wyoming Medicaid dosing limits. If the medication is needed later in the season and the patient has already received their five (5) doses of Synagis, there is **no guarantee an additional dose will be approved**. Keep in mind that last year RSV was not detected in CO, WY, MT, SD and ND until December and cleared in April. Please be cognizant of what is occurring in your area.

Wyoming Medicaid will approve Synagis® prior authorization requests that meet the criteria below. If a client does not meet the criteria, please provide as much information as possible, and those requests will be reviewed by the state on a case by case basis:

- **CHRONIC LUNG DISEASE:** Client is ≤ 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, diuretic, or chronic corticosteroid therapy) or oxygen within 6 months of the start of RSV season.
- **CONGENITAL HEART DISEASE:** Client is ≤ 24 months of age at start of therapy and has hemodynamically significant congenital heart disease and one or more of the following:
 - Is receiving medication to control congestive heart failure
 - Has a diagnosis of moderate to severe pulmonary hypertension
 - Has a diagnosis of cyanotic heart disease
- **PREMATURITY:**
 - Client is ≤ 12 months of age at the start of RSV season and born at ≤ 28 weeks, 6 days gestational age.
 - Client is ≤ 12 months of age at the start of RSV season and born at 34 weeks, 6 days or less gestational age and has either severe neuromuscular disease or congenital abnormalities, either of which compromise handling of respiratory secretions.
 - Client is ≤ 6 months of age at the start of RSV season and born between 29 weeks, 0 days and 35 weeks, 6 days gestational age.

FAX completed form to
Goold Health Systems (GHS)
 1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program
MULTIPLE USE**
 PRIOR AUTHORIZATION REQUEST FORM
SYNAGIS®

PHONE:
 (For questions or inquiries ONLY)
 1-877-207-1126

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

Client ID #: _____

Client's Full Name: _____ DOB: _____

Prescriber NPI: _____

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: _____

Pharmacy Name: _____ Phone: _____

Wyoming Medicaid will approve Synagis® PA requests for clients that meet the guidelines below. Requests will only be approved for a maximum of 5 doses at a dosing interval of not less than 28 days between injections.

CLIENT'S GESTATIONAL AGE: _____

MEDICAL NECESSITY DOCUMENTATION (Please check all that apply):

- CHRONIC LUNG DISEASE:** Client is ≤ 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, diuretic, or chronic corticosteroid therapy) or oxygen within 6 months of the start of RSV season.
- CONGENITAL HEART DISEASE:** Client is ≤24 months of age at start of therapy and has hemodynamically significant congenital heart disease and one or more of the following: (Please check all that apply)
 - Is receiving medication to control congestive heart failure
 - Has a diagnosis of moderate to severe pulmonary hypertension
 - Has a diagnosis of cyanotic heart disease.
- PREMATURITY:**
 - Client is ≤12 months of age at start of RSV season and born at ≤28 weeks, 6 days gestational age.
 - Client is ≤12 months of age at start of RSV season and born at 34 weeks, 6 days or less gestational age and has either severe neuromuscular disease or congenital abnormalities, either of which compromise handling of respiratory secretions.
 - Client is ≤ 6 months of age at start of RSV season and born between 29 weeks, 0 days and 35 weeks, 6 days gestational age.
- OTHER** (Please include any applicable information including gestational age if client was born premature and does not meet the above criteria):

Please indicate if the client has received Synagis® in an inpatient setting. If yes, provide the date(s) of administration and dose:

No Yes Administration Date(s): _____ Dose: _____

**** Please submit (by fax) the same PA form per client per season ****

SYNAGIS®	STRENGTH	ANTICIPATED ADMINISTRATION DATE	PREVIOUS DOSE ADMINISTRATION DATE	CLIENT'S WEIGHT	PRESCRIBER'S INITIALS
1 st Dose				Lbs oz.	
2 nd Dose				Lbs oz.	
3 rd Dose				Lbs oz.	
4 th Dose				Lbs oz.	
5 th Dose				Lbs oz.	

Prescriber Signature: _____ **Date(s) of Submission:** _____
 *MUST MATCH PRESCRIBER LISTED ABOVE 1ST DOSE 2ND 3RD 4TH 5TH

STATE MAXIMUM ALLOWABLE COST – PRENATAL VITAMINS

Effective December 1, 2011, Wyoming Medicaid will implement State Maximum Allowable Cost (SMAC) prices on the prenatal vitamins outlined in the table below. The State Maximum Allowable Cost is the maximum allowable cost the State of Wyoming will pay for medications.

PRODUCT DESCRIPTION	SMAC
*Prenatal Vit w/ Iron Carbonyl-FA Tab 29-1 MG***	0.16000
*Prenatal Vit w/ Fe Fumarate-FA Tab 27-1 MG***	0.07600
*Prenatal Vit w/ Fe Fumarate-FA Tab 27-1 MG***	0.08000
*Prenatal Vit w/ Fe Fumarate-FA Tab 27-1 MG***	0.07000
*Prenatal Vit w/ Fe Fumarate-FA Tab 27-1 MG***	0.04550
*Prenatal Vit w/ Fe Fumarate-FA Tab 28-1 MG***	0.16000
*Prenatal Vit w/ Fe Fumarate-FA Tab 29-1 MG***	0.15870
*Prenatal Vit w/ Fe Fumarate-FA Tab 60-1 MG***	0.20000
*Prenatal Vit w/ Fe Fumarate-FA Tab 65-1 MG***	0.06290
*Prenatal Vit w/ Fe Fumarate-FA Chew Tab 29-1 MG***	0.29950
*Prenatal Vit w/ Fe Fumarate-FA Chew Tab 29-1 MG***	0.20000
*Prenatal w/o A Vit w/ Fe Fumarate-FA Cap 106.5-1 MG***	0.20000
*Prenatal w/o A Vit w/ Fe Fumarate-FA Tab DR 30-1 MG***	0.18190
*Prenatal without A w/ Fe Carbonyl-Docusate-FA Tab 90-1MG***	0.35649
*Prenatal Vit w/ DSS-Iron Carbonyl-FA Tab 90-1 MG***	0.19350
*Prenatal Vit w/ DSS-Iron Carbonyl-FA Tab 90-1 MG***	0.16250
*Prenatal Vit w/ DSS-Iron Carbonyl-FA Tab 90-1 MG***	0.18000
*Prenatal Vit w/ DSS-Fe Fumarate-FA Tab 29-1 MG***	0.20000
*Prenat-Fe Bis-Fe Prot Succ-FA-Ca Tab & Omega 3 Cap 400 Pk**	0.51440
Prenat-Fe Bis-Fe Prot Succ-FA-Ca Tab & Omega Cap DR 430 Pk	0.57027

MISCELLANEOUS CHANGES (TENTATIVE EFFECTIVE DATE NOVEMBER 30, 2011)

- **Injectable** haloperidol will require a prior authorization prior to approval.
- Long-acting blood pressure medications will be limited to their labeled dosing frequency.
- Prior authorization will be required for use of less than 100mg of Seroquel **without** a diagnosis of mood disorder or major depressive disorder. For titration doses, please call the GHS pharmacy help desk for an override at 800-209-1264.
- Zytiga will only be approved for castration-resistant prostate cancer in those clients who have received prior chemotherapy containing docetaxel.
- Xarelto will only be approved for prophylaxis of deep vein thrombosis which can lead to pulmonary embolism in clients undergoing hip or knee replacement.
- Viibryd will be considered a non-preferred antidepressant and will require a six (6) week trial and failure each of two (2) preferred antidepressants prior to approval.
- Brilinta will only be approved for reducing thrombotic cardiovascular events in clients with acute coronary syndrome.
- Horizant will be considered a non-preferred agent for Restless Leg Syndrome and will require a sixty (60) day trial of gabapentin and a sixty (60) day trial of a dopamine agonist prior to approval.
- Gabapentin will now be approved for the diagnosis of Restless Leg Syndrome.
- Nutropin 5mg, NDC 50242-0072-03, will no longer be covered (currently in effect).

SHORT DAY SUPPLY PRESCRIPTION FILLS

Wyoming Medicaid requires pharmacies that fill medications for facilities to fill at least a fourteen (14) day supply with each fill. A pharmacy should not fill less than a fourteen (14) day supply for a facility unless the prescription has been written specifically for less than fourteen (14) days or the shorter day supply has been approved through the prior authorization process. Recovery is possible if this requirement is not followed.