Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: November 15, 2012

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*** dose, the client's weight, the anticipated administration date, the previous dose administration date, and the date of submission of the prior authorization must be included. The prescriber (or prescriber's agent) must also initial the form for each dose. Authorizations for subsequent doses will not be approved without the previously mentioned information being updated for each dose. Additionally, requests will only be allowed at a dosing interval of not less than 28 days between injections. Claims submitted for a day supply less than 28 days may be subject to recovery.

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 the state, 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 doses (5) of Synagis, there is **no guarantee that 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

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

SYNAGIS®

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. Claims submitted for a day supply less than 28 days may be subject to recovery.

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**
1st Dose				**Lbs** **oz.**	
2nd Dose				**Lbs** **oz.**	
3rd Dose				**Lbs** **oz.**	
4th Dose				**Lbs** **oz.**	
5th Dose				**Lbs** **oz.**	

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

American Academy of Pediatrics-Website: *http://aapredbook.aappublications.org/cgi/content/full/2009/1/3.110*

PREFERRED BRANDS SWITCHING TO GENERIC

- **Geodon/ziprasidone** – Effective November 7, 2012, the brand name Geodon will be considered non-preferred and the ***generic ziprasidone will be preferred***.

- **Lexapro/escitalopram** – Effective November 7, 2012, ***generic escitalopram will be preferred over brand name Lexapro***. However, please note that the generic escitalopram will still be considered a non-preferred antidepressant and will require trial and failure of two (2) preferred antidepressants prior to approval.

- **Valtrex/valacyclovir**– Effective November 7, 2012, the brand name Valtrex will be considered non-preferred and the ***generic valacyclovir will be preferred***.

MISCELLANEOUS

- **Omeclamox** – Effective December 5, 2012, this will be considered a non-preferred agent and Wyoming Medicaid will require the use of the separate ingredients.

- **Prevpac** – Effective December 5, 2012, this will be considered a non-preferred agent and Wyoming Medicaid will require the use of the separate ingredients.

- **Cyclobenzaprine** – Effective December 5, 2012, prior authorization will be required for any client that is receiving a tricyclic antidepressant in combination with cyclobenzaprine.

- **Qnasl** – Is a non-preferred nasal steroid and will require two (2) trials of the preferred nasal steroids greater than or equal to thirty (30) days prior to approval.

- **Zetonna** – Is a non-preferred nasal steroid and will require two (2) trials of the preferred nasal steroids greater than or equal to thirty (30) days prior to approval.

INSULIN CLAIMS

Effective December 5, 2012, all insulin claims that exceed 80ml in a thirty (30) day time period will reject at the pharmacy. To resolve this rejection, ***the pharmacy will need to call the GHS pharmacy help desk*** at 877-209-1264 to allow for review of the claim to make sure the directions for use match the day supply and quantities submitted. Once that information has been confirmed, an override will be put in place to allow for the claim to process.

PEDIATRIC MULTIVITAMIN DAY SUPPLY

Pediatric vitamin claims will now be allowed to process through the Point-of-Sale for up to a one hundred (100) day supply without an override from the GHS Pharmacy Help Desk. Please note that Wyoming Medicaid will still require that the prescription's day supply ***must*** equal the quantity of the drug dispensed divided by the daily dose prescribed. Failure to bill claim(s) with the correct day supply (according to the prescription quantity and directions), may lead to formal recovery, possible future audit proceedings or suspension of payment.

STATE MAXIMUM ALLOWABLE COSTS

Wyoming Medicaid in the near future will be implementing State Maximum Allowable Cost (SMAC) prices on the following medications outlined in the table below. The SMAC is the maximum allowable cost the State of Wyoming will pay for medications. For more information regarding these medications and the implemented SMAC pricing, please refer to www.wyequalitycare.org.

DRUG NAME	DRUG NAME
TOBI NEBULIZER SOLUTION	SANDOSTATIN INJECTION
CANCIDAS IV INJECTION	ACTHAR HP INJECTION
ISENTRESS TABLET	SENSIPAR TABLET
REYATAZ CAPSULE	BUPHENYL POWDER
PREZISTA TABLET	REVATIO TABLET
LEXIVA TABLET	LETAIRIS TABLET
VIRACEPT TABLET	PULMOZYME SOLUTION
NORVIR SOLUTION	SUCRAID SOLUTION
SUSTIVA TABLET	REMICADE INJECTION
TRUVADA TABLET	ELMIRON CAPSULE
KALETRA TABLET	CYMBALTA CAPSULE
TRIZIVIR TABLET	FANAPT TABLET
ATRIPLA TABLET	INVEGA TABLET
VALCYTE SOLUTION	INVEGA SUSTENNA
PEGASYS	RISPERDAL INJECTION
PEG-INTRON	SEROQUEL XR TABLET
INCIVEK TAB 375MG	SAPHRIS SUBLINGUAL TABLET
CAYSTON INHALATION SOLUTION	ABILIFY TABLET
XIFAXAN TABLET	ABILIFY SOLUTION
ZYVOX TABLET	ABILITY ORALLY DISINTEGRATING TABLET
ZYVOX SUSPENSION	LATUDA TABLET
RHOPHYLAC INJECTION	ORAP TABLET
RHOGAM PLUS INJECTION	NAMENDA TABLET
TEMODAR CAPSULE	XENAZINE TABLET
XELODA TABLET	COPAXONE INJECTION
LUPRON INJECTION	REBIF INJECTION
ZELBORAF TABLET	AVONEX INJECTION
NEXAVAR TABLET	TYSABRI INJECTION
TARCEVA TABLET	AMPYRA TABLET
GLEEVEC TABLET	CAMPRAL TABLET
TASIGNA CAPSULE	SYMBYAX CAPSULE
INTRON-A INJECTION	HUMIRA INJECTION
PROLIA INJECTION	ENBREL INJECTION
XGEVA INJECTION	SABRIL POWDER
SUPPRELIN LA	LYRICA CAPSULE
LUPRON PEDIATRIC INJECTION	PROCRIT INJECTION
NUTROPIN AQ INJECTION	NEUPOGEN INJECTION
NORDITROPIN INJECTION	NEULASTA INJECTION
OMNITROPE INJECTION	STELARA INJECTION
GENOTROPIN INJECTION	SYPRINE CAPSULE
TEV-TROPIN INJECTION	CUPRID CAPSULE
HUMATROPE INJECTION	REVLIMID CAPSULE
INCRELEX INJECTION	