# EqualityCare Pharmacy News

Dear Providers: October 1, 2010

Please see below for the following changes to Wyoming EqualityCare:

## COMPOUND CLAIMS

Wyoming EqualityCare has noticed issues with compound claims. To better understand the issues, pharmacies may be contacted to help identify and resolve potential issues with the way pharmacies bill compound claims. We appreciate your assistance.

## SYNAGIS® PRIOR AUTHORIZATION PROCEDURE

Wyoming EqualityCare requires a prior authorization for **ALL** Synagis® claims. Requests will be accepted starting November 1, 2010 for a medication start date of November 15, 2010. Requests will be approved for a **max of 5 doses at a dosing interval of not less than 28 days between injections.** There is a **separate authorization request** form below; it will also be available on http://wyequalitycare.org/. The provider must sign the request form for the first dose. For each subsequent dose, the client's weight, the medication administration date, and the date of submission must be updated and the provider (or provider's agent) must initial the form. Authorizations for subsequent doses **will not be approved** without that updated information. Wyoming EqualityCare 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 EqualityCare will approve Synagis® PA requests for clients that meet the guidelines below. Requests will be approved for a max of 5 doses at a dosing interval not less than 28 days between injections. Requests will be accepted November 1st for the start date of 11/15/10.***

## 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 indicate if the client has received a previous Synagis® dose in an inpatient setting. If yes, please provide the date(s) of administration:***

☐ ***No*** ☐ ***Yes*** ***Administration Date(s):_____***

****Please submit (by fax) the same PA form per client per season. After the initial PA has been approved, additional doses require ONLY the strength, date and weight to be filled in below.**

| SYNAGIS® | STRENGTH | DAYS SUPPLY | ADMINISTRATION DATE | CLIENT'S WEIGHT | | PROVIDER'S INITIALS |
|---|---|---|---|---|---|---|
| 1st Dose | | 28 | | Lbs | oz. | |
| 2nd Dose | | 28 | | Lbs | oz. | |
| 3rd Dose | | 28 | | Lbs | oz. | |
| 4th Dose | | 28 | | Lbs | oz. | |
| 5th Dose | | 28 | | Lbs | oz. | |

**Provider Signature:_____ Date(s) of Submission:** _____ _____ _____ _____ _____

**MUST MATCH PROVIDER 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 DRUG LIST UPDATES

Please refer to http://wyequalitycare.org/ for entire preferred drug list

| PRODUCT NAME | NEW CRITERIA |
|---|---|
| **LOVAZA** | Will be **non-preferred**. Requires a 90 day trial and failure of a preferred agent. |
| **ZYCLARA** | Will be **non-preferred**. Requires a 30 day trial and failure of the preferred agent. |
| **JALYN** | Will be **non-preferred**. Requires the use of the preferred separate agents. |
| **DULERA** | Will be **non-preferred**. Requires a 30 day trial and failure of a preferred agent. |
| **RYBIX ODT** | Will be **non-preferred**. Requires a 14 day trial and failure of the preferred agent. |
| **LIVALO** | Will be **non-preferred**. Requires a 90 day trial and failure of a preferred agent. |
| **ZYMAXID** | Will be **non-preferred**. Requires a 5 day trial and failure of a preferred agent. |
| **EXALGO** | Will be **non-preferred**. Requires a 6 day trial and failure of 3 of the preferred agents. |

# MISCELLANEOUS

| PRODUCT NAME | NEW CRITERIA |
|---|---|
| **ONDANSETRON** | Clients ≤ 11 will be allowed a one (1) day supply every 34 days unless there is a diagnosis of cancer. |
| **ORBIVAN** | Will be **non-preferred**. Requires a trial and failure of **ALL** butalbital containing agents, the max dose of acetaminophen, ***and*** the max dose of a preferred NSAID. For the treatment of migraine headache, **ALL** preferred migraine agents must also be tried in addition to the butalbital, APAP, and NSAID trials. |
| **ORAVIG** | Will be **non-preferred**. Requires the diagnosis of oral candidiasis **AND** diagnosis of head and neck cancer or HIV. |
| **ULESFIA** | Will be **non-preferred**. Requires a trial and failure of lindane **AND** permethrin. |
| **XEOMIN** | Will be **non-preferred**. Requires a diagnosis of cervical dystonia **OR** the diagnosis of blepharospasm **and** a 30 day trial and failure of Botox. |
| **VELTIN and ZIANA** | Will be **non-preferred**. Requires the use of the separate agents. |
| **TEKAMLO** | Will be **non-preferred**. Requires the use of the separate agents. |
| **TRIBENZOR** | Will be **non-preferred**. Requires the use of separate agents/criteria still applies. |
| **XERESE** | Will be **non-preferred**. Requires the use of the separate agents. |
| **AQUORAL** | ***Will not be covered*** at the pharmacy level. |
| **PODOCON** | ***Will not be covered*** at the pharmacy level. |