Wyoming
Department
of Health

Division of Healthcare Financing

# Medicaid Pharmacy News

Dear Providers: September 3, 2014

## CONTRACEPTIVE DEVICES/IMPLANTS

Effective September 2, 2014, contraceptive devices/implants (Nexplanon, Implanon, Mirena, Skyla, and Paragard) will no longer be covered through the point-of-sale system on the pharmacy side. These claims must now be billed to the medical side. Please contact Xerox at 1-800-251-1269.

## AGE LIMITS ON ANTIPSYCHOTICS, ANTIDEPRESSANTS AND BENZODIAZEPINES

Effective October 1, 2014, Wyoming Medicaid will require prior authorization on the following drugs if the client is 5 years of age or younger. Please note that prior authorization requests received for these medications for this age group may be sent for review by Seattle Children's Hospital as deemed appropriate by the state. The affected medications are:

**Antipsychotics:**

Abilify, clozapine, Equetro, Fanapt, Fazaclo, Invega, Latuda, loxapine, olanzapine, quetiapine, risperidone, Saphris, and ziprasidone.

**Antidepressants:**

Amitriptyline, amoxapine, Aplenzin, Brintellix, bupropion IR/SR/XL, citalopram, clomipramine, desipramine, doxepine , duloxetine, escitalopram, Fetzima , fluoxetine, fluvoxamine, Forfivo XL, imipramine, mirtazapine, nefazodone, nortriptyline, paroxetine IR/CR, Pristiq, protriptyline, sertraline, trazodone, trimipramine, venlafaxine IR/ER and Viibryd.

**Benzodiazepines:**

Alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, and triazolam.

# HEPATITIS C PRIOR AUTHORIZATION FORM

The new prior authorization form specific for Hepatitis C treatment is now available and will need to be used to request Hepatitis C medications such as Sovaldi and Olysio. It can be found at www.wymedicaid.org under the "Prior Authorization (PA) Forms & Related Info" tab or can be requested by calling the GHS Pharmacy Help Desk at 1-877-207-1126. The form has also been included at the end of this newsletter. Please note that if the incorrect form is submitted it will be denied and the correct form will be requested.

# PHARMACY RE-ENROLLMENT

The Affordable Care Act of 2011 (ACA) requires all Medicaid providers to be screened and to re-enroll with Wyoming Medicaid at a minimum of every five (5) years. The federal regulations specific to provider screening and re-enrollment can be viewed at: http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf. Pharmacy re-enrollment began on **May 15, 2014** and all pharmacies must submit re-enrollment packets no later than **October 31, 2014**. *All pharmacies must re-enroll.* **Pharmacies that fail to submit their re-enrollment by October 31, 2014 will be disenrolled as a Wyoming Medicaid Pharmacy Provider**. Enrollment packets may be obtained by calling the GHS Pharmacy Help Desk at 877-205-8083 ext. 1051, by emailing the GHS Pharmacy Help Desk at wyprovider@ghsinc.com, or by obtaining the packet at www.wymedicaid.org.

**FAX** completed form to
**Goold Health Systems, an Emdeon company**
**1-866-964-3472**

Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM

# Hepatitis C Treatment

**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: _____

| **Drug Name** (Only 1 Drug per Form) | **Strength** | **Dosage Instructions** | **Days Supply** | **Quantity** | **Refills** |
|---|---|---|---|---|---|

1. **Has the client engaged in substance abuse within the last six months? ☐ Yes ☐No**

2. **Has the client had a drug screening performed within the last month? ☐ Yes ☐No**
   If yes, please include screening results with the completed prior authorization form. If no, prior authorization will be deferred until a screening is completed and the results have been submitted to GHS. ***If the drug screen is positive for illicit drugs the prior authorization will be denied.***

3. **Has the client completed the PREP-C (Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment) survey? ☐ Yes ☐No**
   If yes, please include results with the completed prior authorization form. If no, prior authorization will be deferred until the survey is completed and the results have been submitted to GHS. The PREP-C survey can be obtained at https://prepc.org.

4. **Client's Hepatitis C Genotype**_____

5. **Please list any other Hepatitis C medications that will be given concurrently with the requested medication above as well as anticipated length of treatment.**

| | Medication | Anticipated Length of Use |
|---|---|---|
| A. | _____ | _____ |
| B. | _____ | _____ |

6. **Is this client Hepatitis C treatment naïve? ☐ Yes ☐No**
   If no, please list previous treatments below:

| | Medication | Dates of use | Reason for Discontinuing |
|---|---|---|---|
| A. | _____ | _____ | _____ |
| B. | _____ | _____ | _____ |
| C. | _____ | _____ | _____ |
| D. | _____ | _____ | _____ |

***All clients that are approved for treatment of Hepatitis C will be referred to Xerox CQS (Care and Quality Solutions) nurses for case management. Wyoming Medicaid will only cover one course of treatment per client.*

**Prescriber Signature:** _____ **Date(s) of Submission:** _____
**MUST MATCH PRESCRIBER LISTED ABOVE*