Attention Pharmacists and Physicians!!!

The Wyoming Medicaid Pharmacy Program will be implementing a preferred drug list January 1, 2004 with the Proton Pump Inhibitors. Additional therapeutic classes will be added to the list periodically. The medication(s) selected as the preferred drug in each class will be available without prior authorization. All other medications within the therapeutic class will be subject to the prior authorization process.

Effective January 1, 2004, Prilosec OTC will be the preferred proton pump inhibitor and will not require prior authorization. Prior authorization will continue to be required for all other proton pump inhibitors.

Proton Pump Inhibitors effective 1/1/04

<table>
<thead>
<tr>
<th>Drug Name*</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC Prilosec (omeprazole)</td>
<td>Yes</td>
</tr>
<tr>
<td>Protonix (pantoprazole)</td>
<td>PA Required</td>
</tr>
<tr>
<td>Prevacid (lansoprazole)</td>
<td>PA Required</td>
</tr>
<tr>
<td>Aciphex (rabeprazole)</td>
<td>PA Required</td>
</tr>
<tr>
<td>Nexium (esomeprazole)</td>
<td>PA Required</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>PA Required</td>
</tr>
<tr>
<td>Prilosec (omeprazole)</td>
<td>PA Required</td>
</tr>
</tbody>
</table>

*Drugs are listed in order of increasing cost.

ATTENTION

Starting January 1, 2004, Xolair (omalizumab), will require prior authorization. Enclosed, please find the Prior Authorization Criteria and Appeal Request form for Xolair.

Also enclosed, are new PA Criteria for the Proton Pump Inhibitors and Cox-2 medications, as well as Appeal Request forms for both classes of drugs. Please replace the June 2003 forms with the new November 2003 forms.
Prior Authorization Criteria for Xolair (omalizumab)

November 2003

Patient must be using one of the following long-acting bronchodilators:
  a. Serevent Diskus (salmeterol)
  b. Foradil (formoterol)
  c. Volmax (albuterol)
  d. Sustained release theophylline

OR

Leukotriene antagonist:
  a. Singulair (montelukast)
  b. Accolate (zafirlukast)

PLUS

Medium dose inhaled steroid with the following daily dosages:
  a. Vanceril (beclomethasone) > 12 puffs
  b. Pulmicort (budesonide) > 2 puffs
  c. Aerobid (flunisolide) > 4 puffs
  d. Flovent (fluticasone) > 2 puffs ≥ 110 mcg
  e. Azmacort (triamcinolone) > 10 puffs
WYOMING MEDICAID
Xolair Prior Authorization Request Form

PLEASE PRINT LEGIBLY. ALL * FIELDS ARE MANDATORY AND MUST BE COMPLETED IN FULL.

*Request Date _____________________________ *Return Fax Number ____________________________

*Recipient’s Medicaid ID # _________________________________ *Date of Birth ______/_______/____________

*Recipient’s Full Name__________________________ *Prescriber Full Name ____________________________

*Provider DEA # (if prescriber) or NABP # (if pharmacy) _________________________________________________

*Prescriber Telephone # ____________________________ *Fax # ____________________________ E-mail Address ____________________________

Prescriber Address ____________________________ City ____________________________ State _______ Zip _______

*Quantity: ___________ *Length of Therapy on Prescription: ___________ *Frequency of Dosing: ___________

1. Which of the following medications is the patient receiving?
   □ Serevent or Serevent Diskus
   □ Foradil
   □ Volmax
   □ Sustained release theophylline
   OR

2. Which of the following medications is the patient receiving?
   □ Singulair
   □ Accolate
   □ None of the above
   PLUS

3. Which of the following medications is the patient also receiving?
   □ Vanceril Daily Dose: ____________
   □ Flovent Daily Dose: ____________
   □ Pulmicort Daily Dose: ____________
   □ Azmacort Daily Dose: ____________
   □ Aerobid Daily Dose: ____________

*Signature of Provider: _____________________________________________________ *Date: __________________

Instructions to submit: (Choose one)
Send to: ACS State Healthcare, Prescription Benefits Management
Prior Authorization Dept.
Northridge Center One, Suite 400
365 Northridge Road
Atlanta, GA 30350
Fax: (866) 879-0104
Phone: (866) 556-9320; M-F 7am-11pm, EST; S-S 7am-6pm, EST
E-mail: WyomingMedicaid.PA@acs-inc.com

FOR AFFILIATED COMPUTER SERVICES (ACS) USE ONLY

Date: ____________________________ Notified: ____________________________
Approved: ____________________________ Denied: ____________________________
Reason: ____________________________
Prior Authorization Criteria for COX-2 Inhibitors

November 2003

Vioxx (rofecoxib), Celebrex (celecoxib), Bextra (valdecoxib)

1. Patient must be 18 years of age or older to receive prior authorization for a COX-2 and one of the following criteria required for approval

2. Patient has a diagnosis of familial adenomatous polyposis

Or

3. Patient has one of the following diagnoses:
   a. Osteoarthritis
   b. Rheumatoid arthritis
   c. Primary dysmenorrhea (covered for primary dysmenorrhea only if prescription is limited to therapy of 7 days or less)
   d. Acute pain (covered for acute pain only if prescription is non-refillable and limited to therapy of 5 days or less)

   and one of the following qualifications:
   a. Medical necessity for the concomitant use of low dose aspirin, warfarin or methotrexate
   b. Concomitant use of a non-COX-2 NSAID and an H-2 antagonist or proton pump inhibitor for the past three months
   c. History of peptic ulcer disease or GI bleeding
   d. Failure with or intolerance of a trial (as defined by provider) of any three specified multi-source NSAIDS
   e. Is not currently taking a proton pump inhibitor
WYOMING MEDICAID
COX-2 Prior Authorization Request Form

Request Date _________________________________
Recipient’s Medicaid ID#_______________________________________________ Date of Birth ________/________/____________________
Recipient’s Full Name___________________________________________________________________________________________________
Prescriber Full Name_____________________________________________________Prescriber DEA #_________________________________
Prescriber Address (mandatory)____________________________________________________________________________________________
City________________________________________________State______________________Zip______________________________________
Prescriber Telephone #____________________________Fax #_______________________________E-mail Address________________________
________________________________________________________________________________________________________________________________________
Drug:     Bextra (valdecoxib) □ Celebrex (celecoxib) □ Vioxx (rofecoxib) □ Dosage/ Strength________________________
Quantity:____________ Length of Therapy on Prescription:________________________________Frequency of Dosing:_____________________

1. Is the patient 18 years of age or older?         YES □ NO □

2. Does the patient have one of the following diagnoses:
   □ Osteoarthritis
   □ Rheumatoid arthritis
   □ Primary dysmenorrhea
   □ Acute pain
   a. Is there a refill on this prescription?         YES □ NO □
   b. Is the therapy for 5 days or less?              YES □ NO □

3. Does the patient have one of the following qualifications:
   □ Medical necessity for the concomitant use of low dose aspirin, warfarin, or methotrexate
   □ Concomitant use of a non-COX-2 NSAID and an H-2 antagonist or proton pump inhibitor for the past 3 months
   □ History of peptic ulcer disease or GI bleeding
   □ Failure with or intolerance of a trial as designated by the provider of any three multi-source NSAIDS
   □ Is not currently taking a proton pump inhibitor

Signature of Prescriber:_________________________________________________________________________________________

Instructions to submit: (Choose one)
To Fax or Mail:  
Form may be completed electronically or handwritten.
Fax or mail to ACS State Healthcare.
To E-Mail:  
Save the form using a different filename.
Complete electronically.
E-mail as an attachment to ACS State Healthcare.

Send to:  
ACS State Healthcare Prescription Benefits Management
Prior Authorization Dept.
Northridge Center One, Suite 400
365 Northridge Road
Atlanta, GA 30350
Fax: (866) 879-0104
Phone: (866) 556-9320; M-F 7am-11pm, EST,  S-S 7am-6pm, EST
E-mail: WyomingMedicaid.PA@acs-inc.com

FOR AFFILIATED COMPUTER SERVICES (ACS) USE ONLY

Date:__________________________________ Notified:_________________________ _________________
Approved:______________________________ Denied:___________________________________________
Reason:_____________________________________________________________________________________________________________

November 2003
Prior Authorization Criteria for Proton Pump Inhibitors

Prilosec OTC is the preferred drug and does not require prior authorization

Aciphex (rabeprazole), Nexium (esomeprazole), Prilosec (omeprazole), Protonix (pantoprazole), Prevacid (lansoprazole)

Acute dosing for up to 60 days in each 12 month period does not require prior authorization. Additional therapy beyond 60 days requires the following:

1. One of the following diagnoses (approval will be granted for a lifetime):
   a. Barret’s esophagitis
   b. Zollinger-Ellison Syndrome
   c. Pathological hypersecretory condition

   Or

2. One of the following diagnoses after initial treatment period:
   a. Duodenal ulcer maintenance (approval granted for one 12 month period)
   b. Benign gastric ulcer (approval granted for one 12 month period)
   c. Erosive esophagitis (approval granted for one 12 month period)
   d. History of gastric ulcer and current NSAID therapy (approval granted for one 12 week period)
   e. Recurrent gastroesophageal reflux disease (approval granted for one 8 week period)
   f. Pregnancy (approval granted for 12 month period)

   Or

3. Both of the following qualifications (approval granted for one 12 month period):
   a. Diagnosis of H. pylori
   b. Concurrent antibiotic prescription with the PPI prescription

November 2003
WYOMING MEDICAID
PPI Prior Authorization Request Form  November 2003

Recipient’s Medicaid ID# __________________________ Request Date _______________________

Recipient’s Full Name_________________________________ Date of Birth____/_____/____

Prescriber Full Name _____________________________ Prescriber DEA # ______________________________

Prescriber Address

City __________________ State ____________ Zip ______________

Prescriber Telephone # ______________ Fax #__________________ E-mail Address________________________

Drug:         Aciphex (rabeprazole)       Nexium (esomeprazole)        Prevacid (lansoprazole)          Prilosec  (omeprazole)

Protonix (pantoprazole)                  *Dosage/ Strength___________________________________________

Quantity: ___________ Length of Therapy on Prescription: ______________ Frequency of Dosing ____________

PRILOSEC OTC IS THE PREFERRED DRUG AND DOES NOT REQUIRE PRIOR AUTHORIZATION------------

1.  Does the patient meet one of the following diagnoses?
    □ Barrett’s esophagus
    □ Zollinger-Ellison Syndrome
    □ Pathological hypersecretory condition

2.  Does the patient meet one of the following diagnoses after the initial treatment period:
    □ Duodenal ulcer maintenance
    □ History of gastric ulcer and current NSAID therapy
    □ Benign gastric ulcer
    □ Recurrent gastroesophageal reflux disease
    □ Erosive esophagitis
    □ Pregnancy

3.  Does the patient meet both of the following qualifications:
    □ Diagnosis of H. pylori and
    □ Concurrent antibiotic prescription with the PPI prescription

Signature of Prescriber:_____________________________________________________ Date: _______________

Instructions to submit: (Choose one)

To Fax or Mail:
1. Form may be completed electronically or handwritten.
2. Fax or mail to ACS State Healthcare.

To E-mail:
1. Save the form using a different filename.
2. Complete electronically.
3. E-mail as an attachment to ACS State Healthcare.

Send to: ACS State Healthcare, Prescription Benefits Management
        Prior Authorization Dept.
        Northridge Center One, Suite 400
        365 Northridge Road
        Atlanta, GA  30350
        Fax: (866) 879-0104
        Phone: (866) 556-9320, M-F 7am-11pm, EST, S-S 7am-6pm, EST
        E-mail: WyomingMedicaid.PA@acs-inc.com

FOR AFFILIATED COMPUTER SERVICES (ACS) USE ONLY

Date: ___________________________ Notified: ___________________________

Approved: _____________ Denied: ________________ Reason: ___________________________
Important Changes!  Please read!

ACS, Inc.
P.O. Box 667
Cheyenne, WY 82003-0667

PHONE:
(800) 251-1269

IN CHEYENNE:
(307) 772-8401

FAX:
(307) 772-8405

We’re on the Web!
http://wyqualitycare.acs-inc.com

Wyoming Department of Health – Public Health Insurance Plans