Wyoming Medicaid
Prior Authorization Program

Provider Training Manual

Effective October 1, 2002
Last Update 6/18/2003

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PRIOR AUTHORIZATION PROGRAM FOR WYOMING MEDICAID

General Information

The physician or the dispensing pharmacy may request prior authorization (PA). Requestor may submit a PA on the standard "Request for Prior Authorization" form for the requested drug via fax, mail, e-mail or by phone call to the ACS PA Program at the below location. Proton pump inhibitors (PPI - exceeding 60 days full or maintenance dose therapy per year) and all cyclooxygenase-2 inhibitors (COX-2) will require prior authorization. Sample PPI and COX-2 "Request for Prior Authorization" forms are included in this training manual for reference.

Contact Information for Prior Authorization Submissions

Address for Submitting PA Requests: ACS State Healthcare
Prescription Benefits Management
Prior Authorization Dept.
365 Northridge Road, Suite 400
Atlanta, GA 30350

Phone: 866-556-9320
Facsimile: 866-879-0104
E-mail: WyomingMedicaid.PA@acs-inc.com

Clinical staff will review the request and communicate the determination to the requesting physician during the initial contact in most cases. It will not be necessary for providers to enter a PA number on the claim. However, if prior authorization was not granted, the POS will return Edit 75 with the following message: PA REQUIRED – PLEASE CONTACT ACS AT 866-556-9320 FOR PA REQUEST. The dispensing pharmacy may contact ACS at 866-556-9320 to verify the status of a physician initiated PA.

Emergency Supply

In the event of an emergency and the ACS Clinical Call Desk is closed, the pharmacy is authorized to dispense up to a 72-hour emergency supply to the recipient by entering a med cert code 8 in the PA medical certification field, the first position of NCPDP field number 416. A med cert code 8 can only be used twice for each drug per month. A dispensing fee will not apply.

Quick Reference Phone Numbers

INQUIRY TYPE	CONTACT	NUMBER
Prior Authorization Request	ACS Clinical Call Center	(866) 556-9320
Claims Processing Questions	ACS Atlanta Call Center	(800) 365-4944
Provider Relations Unit	ACS Cheyenne Office	(307) 772-8401, Cheyenne (800) 251-1268, outside Cheyenne (307) 772-8405, fax
Client Eligibility Automated Voice Response (AVR)	ACS Cheyenne Office	(307) 772-8420, Cheyenne (800) 251-1270, outside Cheyenne (307) 772-8405, fax
Client Eligibility (Provider Relations Unit)	ACS Cheyenne Office	(307) 772-8401, Cheyenne (800) 251-1268, outside Cheyenne (307) 772-8405, fax

Prior Authorization Process

ACS Clinical Call Center in Atlanta, Georgia, reviews requests for prior authorization.

1. Requesting physician or dispensing pharmacy must contact ACS Clinical Call Center directly for PA request by phone, fax, e-mail, or mail submission.

2. Requestor should use the "Request for Prior Authorization" forms customized for each drug or drug class.

3. If PA is approved, ACS will enter the approval in the system immediately.
   Pharmacy can now process claim for recipient.
   Most PA requests are completed within 24 hours. Turnaround is contingent upon the accuracy of information obtained from the PA request.

4. If PA is not approved or not obtained, the claim will deny.

5. ACS will notify the requesting physician and the recipient of a PA denial.

6. Emergency or 72-Hour Supply. Should a pharmacy need to dispense an emergency supply for medication on prior authorization to a recipient and the ACS Clinical Call Center is closed, the pharmacist can dispense a 72-hour supply by entering a med cert code 8 in the PA medical certification field, the first position of NCPDP field number 416. A med cert code 8 can only be used twice for each drug per month. A dispensing fee will not apply.

Appeals Process

1. If a PA is denied, only the physician may submit an appeal. All appeals must in writing on the standard "Request for Patient Exemption from Prior Authorization Criteria" form within 30 days of the date the original PA request was denied.

2. A clinical supervisor (and escalation to a ACS clinical pharmacist) reviews the appeal and determines if exception is warranted.

3. If an appeal is approved, ACS will enter an approval into the POS claims system.
   Pharmacy can now process claim for recipient

4. If an appeal is denied, ACS will notify the requesting physician and recipient.
   Physician may submit a second appeal directly to the Medicaid Pharmacy Program. All 2nd appeals must be in writing on the standard "**2nd** Request for Patient Exemption from Prior Authorization Criteria" form submitted by fax or mail to the following address:

   Medicaid Pharmacy Program
   Att: Appeals Request Unit
   2424 Pioneer Ave.
   Suite 100
   Cheyenne, WY 82002
   Fax: (307) 777-8623

5. When directed by Wyoming Medicaid, ACS will enter an approval for the denied appeal for a 30 day supply until a final decision is made by the State and the Drug Utilization Board on the 2nd request. Pharmacy can process claim for recipient without an approved PA for one month.

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 ☐ Celebrex ☐ Vioxx ☐ Dosage/Strength: _____

Quantity: _____ Length of Therapy on Prescription: _____ Frequency of Dosing: _____

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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

Signature of Prescriber: _____Date: _____

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: _____

September 2002

Prior Authorization Criteria for COX-2 Inhibitors

June 2003

Vioxx, Celebrex, Bextra

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

1. Patient has a diagnosis of familial adenomatous polyposis

    Or

2. 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

WYOMING MEDICAID
PPI 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 _____

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*Drug: Aciphex ☐ Nexium ☐ Prevacid ☐ Prilosec ☐ Protonix ☐ *Dosage/Strength: _____

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

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1. Does the patient meet *one* of the following diagnoses?

☐ Barrett's esophagus

☐ Zollinger-Ellison Syndrome

☐ Pathological hypersecretory condition

OR

2. Does the patient meet *one* of the following diagnoses after the initial treatment period:

☐ Duodenal ulcer maintenance

☐ Benign gastric ulcer

☐ Erosive esophagitis

☐ History of gastric ulcer and current NSAID therapy

☐ Recurrent gastroesophageal reflux disease

OR

3. Does the patient meet *both* of the following qualifications:

☐ Diagnosis of *H.pylori* and

☐ Concurrent antibiotic prescription with the PPI prescription

*Signature of Provider: _____ *Date: _____

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: _____

October 2002

Prior Authorization Criteria for Proton Pump Inhibitors

June 2003

Aciphex, Nexium, Prilosec, Protonix, Prevacid

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)

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

WYOMING MEDICAID

Oxycontin Prior Authorization Request Form

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

PLEASE NOTE: ***Prior authorization for Oxycontin is only required for requests exceeding 2 tablets per day and 3 different strengths per month. Medicaid allows 2 tablets of Oxycontin per day and maximum of 3 different strengths per month without PA. Do not submit a PA if request does not exceed plan limits.***

*****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 _____

Drug: Oxycontin *****Dosage/Strength: _____
*****Quantity: _____ *****Length of Therapy on Prescription: _____ *****Frequency of Dosing: _____

1. Does the quantity exceed 2 tablets per day? If yes, answer question 3. If no, do not request PA.
2. Does request exceed maximum of 3 strengths per month? If yes, answer question 3. If no, do not request PA.
3. Does the patient *currently* have a diagnosis of cancer?
Yes No

*****Signature of Provider: _____ *****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: _____

October 2002

Wyoming Medicaid

Request for Patient Exemption from Prior Authorization Criteria

Request Date_____

Patient Name (full name) _____ Patient DOB _____/____/_____

Patient Address_____

City _____ State_____ Zip Code_____

Patient Medicaid ID#_____

Drug Name & Strength _____

Dosage_____

Prescriber Name (full name)_____ Prescriber DEA#_____

Prescriber Address_____

City _____ State _____ Zip Code _____

Prescriber Telephone # _____ Fax # _____

Please provide justification below of the medical necessity of the above-named medication for this patient.

Diagnosis:

Date of Diagnosis:

Past Treatment History: (Extenuating circumstances: i.e., drug allergies, medical conditions, etc)

Signature of Prescriber:_____ Date:_____

Important: Completed form must be received by ACS within 30days of the denial date of the original PA request.

Instructions to submit: (Choose One)

To Fax or Mail:

1. Form maybe completed electronically or handwritten.
2. Fax or mail to ACS State Healthcare.

To E-Mail

3. Save the form using a different filename.
4. Complete electronically
5. 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:_____

June 2003

Wyoming Medicaid

2nd Request for Patient Exemption from Prior Authorization Criteria

Request Date_____

Patient Name (full name) _____ Patient DOB _____/____/_____

Patient Medicaid ID#_____

Drug Name & Strength _____

Dosage_____

Prescriber Name (full name)_____ Prescriber DEA#_____

Prescriber Address_____

City _____ State _____ Zip Code _____

Prescriber Telephone # _____ Fax # _____

Please provide justification below of the medical necessity of the above-named medication for this patient.

Diagnosis:

Date of Diagnosis:

Past Treatment History: (Extenuating circumstances: i.e., drug allergies, medical conditions, etc)

Signature of Prescriber:_____ Date:_____

Important: Completed form must be received by Wyoming Pharmacy Program, Appeal Request Unit within 30days of the appeal denial date of the original PA request.

Instructions to submit: (Choose One)
To Fax or Mail:
1. Form maybe completed electronically or handwritten.
2. Fax or mail to ACS State Healthcare.

Send to:
Wyoming Pharmacy Program
Appeal Request Unit
2424 Pioneer Ave
Suite 100
Cheyenne, WY 82002
Fax: (307) 777-8623

June 2003