Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: October 9, 2015

GENERIC MEMANTINE IR

Effective October 14, 2015, the generic form of Namenda (immediate release), ***memantine***, will be preferred by Wyoming Medicaid. Please call the GHS Pharmacy Help Desk at 877-209-1264 with any questions.

METHYLPHENIDATE TABLETS DOSAGE LIMIT

Effective October 7, 2015, the maximum allowable daily dose for all methylin, methylphenidate, and methylphenidate ER tablets will be ***90 mg***. Clients currently taking a dose that exceeds 90 mgs daily will be allowed to continue on their current dose. Please call the GHS Pharmacy Help Desk at 877-209-1264 with any questions.

TEST CLAIM POLICY

Pharmacies are not allowed to test claims to determine reimbursement rates, eligibility, and/or coverage. In addition, pharmacies should not reverse paid claims at a later date and resubmit those claims to determine if the reimbursement is higher. Wyoming Medicaid ***will not*** override any claims that have been rebilled for this purpose. Pharmacies that are transmitting test claims could be subject to recovery and further audit proceedings. To determine client eligibility and medication coverage, please call the GHS Pharmacy Help Desk at 877-209-1264.

IMMUNOMODULATOR DOSING

Effective October 21, 2015, Enbrel and Humira claims will be limited to the following quantities:

- Enbrel dosing will be limited to:
  - 50 mg syringes and auto injectors – limit to 5 syringes/auto injectors per month
    25 mg syringes or multiple use vials – limit to 10 syringes/vials per month
- Humira maintenance will be limited to:
  - 40 mg syringes or pens – limit to 5 syringes/pens per month
  - 20 mg syringes – limit to 10 syringes per month
  - 10 mg syringes will remain non-preferred

SYNAGIS

Please see the attached prior authorization form for Synagis for the 2015-2016 RSV season. The form can also be found at www.wymedicaid.org. No criteria changes have been made from the previous year. Please note that US Bioservices ***WILL NOT*** be contracted with Wyoming Medicaid after October 31, 2015, so providers will need to find a different pharmacy to dispense Synagis. Please call the GHS Pharmacy Help Desk for further assistance.

FAX completed form to
Goold Health Systems, an Emdeon Company
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. If the client has tested positive for RSV, further requests for Synagis will not be approved. 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), continues to require medical intervention (chronic corticosteroid or diuretic therapy) or required supplemental oxygen for at least 28 days after birth.

☐ **CONGENITAL HEART DISEASE:** Client is ≤**12 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®	**ANTICIPATED ADMINISTRATION DATE**	**PREVIOUS DOSE ADMINISTRATION DATE**	**CLIENT'S WEIGHT**	**POSITIVE RSV TEST IN 2015-2016 RSV SEASON?**	**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