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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

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

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 __________

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

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

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
   - ☐ History of gastric ulcer and current NSAID therapy
   - ☐ Benign gastric ulcer
   - ☐ Recurrent gastroesophageal reflux disease
   - ☐ Erosive esophagitis
   - ☐ 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 30 days of the denial date of the original PA request.

Instructions to submit: (Choose One) Send to: ACS State Healthcare, Prescription Benefits Management
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

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
 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 30 days of the appeal denial date of the original PA request.

Instructions to submit: (Choose One)
Send to: Wyoming Pharmacy Program
To Fax or Mail: Appeal Request Unit
1. Form maybe completed electronically or handwritten. 2. Fax or mail to ACS State Healthcare.

2424 Pioneer Ave
Suite 100
Cheyenne, WY 82002
Fax: (307) 777-8623

June 2003