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Division of Medical Services
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OFFICIAL NOTICE

DMS-2003-O-1 DMS-2003-II-1 DMS-2003-Q-1 DMS-2003-OO-1
DMS-2003-E-1 DMS-2003-KK-1 DMS-2003-R-1

TO: **Health Care Provider – Certified Nurse-Midwives, Dental, Federally Qualified Health Centers, Nurse Practitioners, Pharmacy, Physicians and Rural Health Clinics**

DATE:

SUBJECT: **Prescription Drug Program Requirement for Prescriber-Initiated Prior Authorization Transactions**

I. Prescription Drug Prior Authorization Process Effective February 1, 2003

Effective February 1, 2003, the prescriber will initiate prescription drug prior authorizations (PA's) by direct access of the Arkansas Medicaid Program Voice Response System (VRS) and Prescription Drug PA Help Desk. In light of growing concerns for patient confidentiality, this process eliminates the transfer of patient-specific information from the prescriber's office to the pharmacy provider.

The VRS allows prescribing providers to request PAs via telephone by responding to specific questions based on the current criteria for the type of request and the NDC number entered when needed. It will allow the prescriber to know within seconds whether the PA request is approved or denied. *The VRS is accessible twenty-four (24) hours per day, seven (7) days per week.* After the prescriber receives a PA approval message, the pharmacy provider can immediately process an electronic claim.

Providers need a touch-tone telephone to communicate the PA information to the system. Many electronics stores carry tone dialers for those providers who do not have a touch-tone telephone.

II. Before Calling the VRS

Prescribers must complete a Prior Authorization (PA) Request Form to process a drug prior authorization request or to add a benefit limit extension before calling the VRS. Revised PA Request Forms for the new process are enclosed with this notice.

Current Arkansas Medicaid PA Request Forms are available on the Arkansas Medicaid web site at *www.medicaid.state.ar.us*. Prescribers who do not have web access may call the Prescription Drug PA Help Desk to request a faxed or printed copy of the PA Request Form.

For processing the specific drug prior authorization request or the brand medically necessary drug request and using the VRS, you will use NDC numbers. An attached document provides NDC numbers for 1) specific drug PA and 2) Brand Medically Necessary PA transactions.

For completing the form for a benefit limit extension and using the VRS, the prescriber will list the patient's monthly maintenance medications. NDC numbers are not required when completing a prior authorization form for the benefit limit extension.

III. Initiating a PA Request

VRS PHONE NUMBER: 1-800-806-6181
Available 24 Hours Per Day / 7 Days Per Week / Three (3) Transactions Per Call

The prescriber will complete a PA Request Form. The prescriber will not mail or fax the completed request form to the pharmacy. Instead, the request form must remain as a record in the patient chart and will be subject to audit by the Division of Medical Services or its representative(s). After completing the PA Request form, dial the **VRS system (1-800-806-6181)** to process the request.

The VRS offers five options from the main menu:

A. To process a *prior authorization* drug request: Press 1. A list of *sample* NDC numbers is provided in an enclosed document for use when initiating a request for specific drug PAs.

B. To process a *brand medically necessary* drug request for Tegretol, Mysoline, Depakene or Coumadin: Press 2. Please note a separate list of specific NDC numbers is provided as required for Brand Medically Necessary PA transactions.

   All other requests for brand medically necessary PAs: Fax MedWatch documentation to the Arkansas Medicaid Prescription Drug Prior Authorization Help Desk at (501) 372-2971. See the August 30, 2002 Official Notice regarding MedWatch PA requirements.

C. To add a prescription *benefit limit extension*. Press 3. Non long-term care certified Medicaid recipients 21 years of age or older are limited to three (3) prescriptions per month.

The PA for extension of benefits enables the 3-prescription limit to be extended to 4, 5 or 6 prescriptions per month. The call flow through the VRS requires the prescriber to indicate if the patient needs an additional 4th, 5th or 6th prescription. An NDC number is not needed for this benefit. This extension is only available when the prescriber verifies that more than 3 monthly-maintenance medications for chronic illness are medically necessary for the patient. Controlled medications for pain, muscle relaxants, and sedatives are not regarded as maintenance medications. The physician must use discretion in completing an extension of prescription drug benefit prior authorization form for their patient.

D. To *inquire* about an existing prior authorization: Press 4. Within the inquiry mode of the VRS, the caller will be able to inquire as to whether the recipient has a specific type of PA (specific drug, brand medically necessary or benefit limit extension). For both the specific drug and brand medically necessary inquiries, VRS will prompt the caller to enter the NDC pertaining to the inquiry. The VRS will search the database and give the caller the start and end dates of the PA, if it exists, or will tell the caller the PA does not exist.

E. To request assistance or PA information from the *Prescription Drug PA Help Desk:* Press 0. At specified intervals during the VRS call, press zero to access the Prescription Drug PA Help Desk.

The inquiry and the PA Help Desk options described above will continue to be available to pharmacists as well as to prescribers. If one drug requires Prior Authorization for both coverage and for brand medically necessary, two transactions will be necessary. If the patient has a current PA for the requested drug, the VRS will notify the caller and direct the call to the Prescription Drug PA Help Desk. The number of transactions per call is limited to three, in order to serve as many callers as possible.

IV. Pharmacy Access to PA Information

Pharmacies will receive claim rejections on prescriptions requiring PAs unless the prescriber has completed the PA transaction process. Pharmacies can use the inquiry mode of the VRS to ascertain whether the prescriber has acquired authorization for pending prescriptions.

While the current PA process limits the prior authorized medication or service to a particular pharmacy and to the specific NDC on the PA record, the new process will allow the patient to obtain the authorized medication or service at any participating pharmacy. Also, although the prescriber enters a specific NDC to initiate the PA, the pharmacy will be able to process claims with the NDC of the specific product utilized in dispensing the prescription, even if the manufacturer or package size differs from the NDC on the PA record, as long as the drug and strength match the PA record.

V. Additional Assistance

Prescription Drug PA Help Desk Phone Number 1-800-707-3854

For your convenience, an attachment is included to explain the use of the VRS for initiating PAs. This document provides a list of the NDCs needed for VRS PA transactions and explains the use of Special Function Keys on the telephone keypad during VRS transactions. Providers may wish to post this page where it will be readily available when accessing the VRS.

A Prescription Drug PA Help Desk (1-800-707-3854) is provided for your assistance. The Prescription Drug PA Help Desk is available Monday through Friday from 8:00 AM to 5:00 PM, excluding holidays. Remember that VRS provides an option to inquire about Prescription Drug PAs 24 hours / day, 7 days / week.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 and 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this notice, please contact EDS at (501) 374-6609 ext. 500 or in-state WATS at 1-800-707-3854.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Assistant Director

Attachments

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: **www.medicaid.state.ar.us.**

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Regranex

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐ **Regranex** **Approved PA valid for 2 months**

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition of payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Diagnosis:

☐ Diabetic neuropathic ulcers of the lower extremity

AND

Failed therapy of all the following standard ulcer care practices:

☐ Initial sharp debridement ***and***

☐ Pressure relief

AND

☐ Ulceration extends into the subcutaneous tissue or beyond (full thickness ulceration)

AND

☐ No current infection present and no underlying osteomyelitis present

AND

☐ Prescription is written for one (1) – 15 gm tube and limited to one (1) – 15 gm tube refill. (When **properly** applied, one 15 gm tube will provide 4 to 8 weeks of treatment.)

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Bextra

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Bextra Strength/Frequency _____

* Approved PA valid for 6 months

** Covered only IF prescription is non-refillable and limited to therapy of 5 days or less, not to exceed 50 mg once daily

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

☐ Patient is 18 years of age or older

AND

☐ Patient will *not* be on concurrent non-Cox-2 inhibitor NSAID therapy (including, but not limited to, combination pain medications that contain an NSAID)

AND

Diagnosis:

☐ Osteoarthritis* (recommended dose 10 mg once daily), ***or*** ☐ Rheumatoid Arthritis* (recommended dose 10 mg once daily), ***or*** ☐ Primary dysmenorrhea**

AND

☐ Patient currently on warfarin (Monitor for changes in INR if a COX-II is added), ***or***

☐ Documented failure due to gastric ulcer or duodenal ulcer after a trial of one or more non-Cox-2 inhibitor NSAIDs (must specify NSAID tried) _____ , ***or***

☐ Documented history of GI hemorrhage or perforation, ***or***

☐ Documented history of gastric ulcer or duodenal ulcer resistant to H. pylori treatment, ***or***

☐ Documented active gastric ulcer or active duodenal ulcer, ***or***

☐ Gastric outlet obstruction documented by endoscopy or x-ray

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: _____ _____
Start

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Celebrex

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Celebrex Strength/Frequency _____

* Approved PA valid for 6 months
** Covered only IF prescription is non-refillable and limited to therapy of 5 days or less

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

☐ Patient is 18 years of age or older

AND

☐ Patient will *not* be on concurrent non-Cox-2 inhibitor NSAID therapy (including, but not limited to, combination pain medications that contain an NSAID)

AND

Diagnosis:

☐ Osteoarthritis*, ***or*** ☐ Rheumatoid Arthritis*, ***or*** ☐ Familial Adenomatous Polyposis (FAP)*, ***or***
☐ Primary dysmenorrhea**, ***or*** ☐ Acute pain**

AND

☐ Patient currently on warfarin (Monitor for changes in INR if a COX-II is added), ***or***
☐ Documented failure due to gastric ulcer or duodenal ulcer after a trial of one or more non-Cox-2 inhibitor NSAIDs (must specify NSAID tried) _____ , ***or***
☐ Documented history of GI hemorrhage or perforation, ***or***
☐ Documented history of gastric ulcer or duodenal ulcer resistant to H. pylori treatment, ***or***
☐ Documented active gastric ulcer or active duodenal ulcer, ***or***
☐ Gastric outlet obstruction documented by endoscopy or x-ray

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS - TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: _____ _____
Start

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Enbrel

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: Enbrel Strength/Frequency _____

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Diagnosis: Approved PA valid for 3 months

- ☐ Moderately to severely active Rheumatoid Arthritis (recommended dose 25 mg SQ twice weekly), ***or***
- ☐ Active Arthritis in patients with Psoriatic Arthritis (recommended dose 25 mg SQ twice weekly), ***or***
- ☐ Moderately to severely active Juvenile Rheumatoid Arthritis (recommended dose 0.4 mg/kg SQ twice weekly up to 25 mg per dose)

AND

Failed trial of at least six (6) months on one of the following treatments:

- ☐ Hydroxychloroquine, ***or***
- ☐ Gold, ***or***
- ☐ Methotrexate, ***or***
- ☐ Azathioprine, ***or***
- ☐ D-penicillamine, ***or***
- ☐ Sulfasalazine

AND

- ☐ Drug is prescribed by a rheumatologist or in consultation with a rheumatologist

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS - TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Extension of Benefits

Pharmacy benefit limit of 3 Rx per month may be extended to 4, 5 or 6 Rx per month if medical necessity is established. The 3 Rx per month limit does not apply to recipients under 21 years of age or to those who are long term care-certified.

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Request for extension of pharmacy benefits from 3 Rx per month to 4, 5 or 6 Rx per month

Note to prescribing physician: Failure to provide a list of *all* maintenance prescriptions the patient is taking may result in the denial of this request. This request, when approved, extends the prescriptions benefits, but does not authorize provision of any restricted medications. A specific and separate request is necessary for any medications restricted to Prior Authorization. Please contact the Pharmacy Help Desk (1-800-707-3854) for instructions, if needed.

Approved PA valid for 6 months

Prescription medication currently required to allow appropriate care for this patient:	**Diagnosis:**
1.	
2.	
3.	
4.	
5.	
6.	

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: _____ _____
Start

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Impotence Medication

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form, please dial the Pharmacy PA Help Desk to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐ **Caverject** or ☐ **Edex** or ☐ **Muse** Strength/Frequency _____

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Diagnosis: Approved PA valid for 6 months

- ☐ Diabetes with peripheral vascular disease ***or***
- ☐ Spinal cord injury-induced impotence unresponsive to other therapy ***or***
- ☐ Prostate cancer-induced impotency ***or***
- ☐ Hypertension with peripheral vascular disease

AND

- ☐ Diagnosis and PA request made by urologist.

AND

- ☐ Erectile dysfunction for at least 6 months.

AND

- ☐ Prescription for 6 or fewer dosage units cumulative for this entire category.

AND

- ☐ Patient gender is male.

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Kineret

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: Kineret Strength/Frequency _____

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

☐ Patient is 18 years of age or older Approved PA valid for 6 months

AND

Diagnosis:

☐ Moderately to severely active Rheumatoid Arthritis (recommended dose 100 mg SQ once daily)

AND

Failed trial of at least six (6) months on one of the following treatments:

☐ Hydroxychloroquine, ***or***
☐ Gold, ***or***
☐ Methotrexate, ***or***
☐ Azathioprine, ***or***
☐ D-penicillamine, ***or***
☐ Sulfasalazine

AND

☐ Drug is prescribed by a rheumatologist or in consultation with a rheumatologist

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Nitroglycerin Patches

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: Nitroglycerin Patches _____ Strength/Frequency _____
Specify
brand, if any

Initial or check specific criteria boxes below:
Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Approved PA valid for 6 months

☐ Failed therapy or intolerance of nitroglycerin paste or ointment

OR

☐ Inability of patient to appropriately apply nitroglycerin paste or ointment (not applicable to nursing home residents – nursing personnel may apply the medication.)

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program

Prior Authorization (PA) Request for Non-steroidal Anti-inflammatories (NSAIDs)

(Arthrotec, Lodine/ etodolac 500mg, Lodine/ etodolac XL, Mobic,
Naprelan SA, Oruvail/ ketoprofen ER, Ponstel, Voltaren XR/ diclofenac Na SA)

Please use form DMS0685-15, DMS0685-7 or DMS0685-6 for Bextra, Celebrex, or Vioxx requests.

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐ Arthrotec, ☐ Lodine/ etodolac 500mg, ☐ Lodine/ etodolac XL, ☐ Mobic, Naprelan SA, ☐ Oruvail/ ketoprofen ER, ☐ Ponstel, or ☐ Voltaren XR/ diclofenac Na SA
Strength/Frequency _____ Approved PA valid for 6 months
Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Initial or check specific criteria boxes below:

☐ Failed trial of four multi-source (generic) NSAIDs (e.g., ASA, diclofenac, diflunisal, etodolac 200mg or 400mg, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, meclofenamate, nabumetone, naproxen (EC), naproxen sodium, oxaprozin, piroxicam, salicylsalicylic acid, sulindac, tolmetin). Specify NSAIDs tried:

_____, _____, _____, _____

OR

☐ Medical contraindication to use of multi-source NSAIDs (listed above) in this patient. Specify contraindicated NSAIDs:

_____, _____, _____, _____

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Non-sedating Antihistamine

(Allegra, Allegra D; Clarinex; Claritin, Claritin-D, Claritin-D24H, Claritin Reditabs, Claritin Syrup; Semprex-D; Tavist/ clemastine syrup; Zyrtec, Zyrtec-D)

PA is not required for non-sedating antihistamines for patients under 21 years old. An exception to this is Claritin Reditab which requires PA regardless of patient age.

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐ Allegra, ☐ Allegra D, ☐ Clarinex, ☐ Claritin, Claritin-D, Claritin-D24H, Claritin Syrup, ☐ Claritin Reditabs, ☐ Semprex-D, ☐ Tavist/ clemastine Syrup, ☐ Zyrtec, Zyrtec-D

Strength/Frequency _____ Approved PA valid for 3 months

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Initial or check specific criteria boxes below:

☐ Failed trial on at least two (2) multi-source (generic) antihistamines (e.g., brompheniramine, chlorpheniramine, clemastine, cyproheptadine, dexchlorpheniramine, diphenhydramine, hydroxyzine, promethazine, or triprolidine). (Must specify below antihistamines tried.)
_____, _____

OR

☐ Covered multi-source (generic) antihistamines are medically contraindicated in this patient. (Must explain medical contraindication.)
_____

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Remicade

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Remicade Strength/Frequency _____

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Diagnosis:

☐ Fistulizing Crohn's Disease, Approved PA valid for 2 months

OR

☐ Moderately to severely active Crohn's Disease, ***or***
☐ Regional Enteritis
AND Failed therapy on one of the following conventional therapies:
☐ Corticosteroids and 5-ASA, ***or***
☐ Azathioprine, ***or*** Approved PA valid for 1 month
☐ Mercaptopurine (1 treatment cycle only)

OR

☐ Moderately severe to severe Rheumatoid Arthritis,
AND ☐ Methotrexate therapy is being prescribed in conjunction with Remicade.
Approved PA valid for 6 months

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Synagis or RespiGam

ATTN: Pharmacy PA Center
FAX: (501) 372-2971

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: Please fax the completed form to the Pharmacy PA Center for evaluation/processing.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Synagis ☐RespiGam Strength/Frequency _____

Note: Either Medication must be given every 30 days during the RSV season. The RSV season is October to March. Synagis (palivizumab is generally preferred due to easier administration, safety, effectiveness, and lack of interference with routine immunization schedules. However, RespiGam (RSV-IVIG) may provide additional benefit lowering the risk of other respiratory illnesses and otitis media and may be preferred in patients with severe chronic lung disease or severe immunodeficiency who can tolerate the additional fluid required.

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid

Approved PA is valid for the current designated RSV season.

Select ONE of the following criteria that the patient currently meets:

- ❑ 1. CLD (chronic lung disease) **AND** patient is less than 2 years of age **AND** currently requires medical therapy for their CLD (e.g. diuretics, systemic steroids or oxygen).
- ❑ 2. CLD (chronic lung disease) **AND** less than 2 years of age **AND** has required medical therapy for their CLD within the past 6 months (e.g. diuretics, systemic steroids, or oxygen).
- ❑ 3. Former premature (≤ 28 weeks EGA) **AND** less than 12 months of age at the start of RSV season.
- ❑ 4. Former premature (≤ 32 weeks EGA) **AND CURRENTLY** less than or equal to 6 months of age.
- ❑ 5. Former premature (≤ 32 weeks EGA) **AND CURRENTLY** 6 to 12 months of age **WITH** 2 or more additional risk factors (circle all that apply):
  a) history of frequent hospitalization for lower respiratory disease b) parental smoking
  c) prior hospitalization for RSV d) daycare
- ❑ 6. Former premature (32 to 35 weeks EGA) **AND CURRENTLY** less than 6 months of age **WITH** 2 or more additional risk factors (circle all that apply):
  a) history of frequent hospitalization for lower respiratory disease b) parental smoking
  c) prior hospitalization for RSV d) daycare
- ❑ 7. Severe immunodeficiency (e.g. SCID or severe acquired immunodeficiency syndrome) **AND** patient is less than 2 years of age. ***Note:*** if receiving monthly IVIG infusion, RespiGam (NOT SYNAGIS) may be substituted in the RSV season.

Physician Signature: _____ Date: _____
(by signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

If none of the above criteria are met, exceptions must be submitted in the form of a letter by the physician, identifying the patient and documenting the conditions for which the exception is being requested. These letters may be faxed to the DMS Pharmacy Unit at 1-501-683-4124.

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Vioxx

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐**Vioxx** Strength/Frequency _____

* Approved PA valid for 6 months; recommended dose 12.5 mg once daily to a maximum dose of 25mg once daily

** Covered only IF prescription is non-refillable and limited to therapy of 5 days or less, not to exceed 50 mg once daily

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

☐ Patient is 18 years of age or older

AND

☐ Patient will *not* be on concurrent non-Cox-2 inhibitor NSAID therapy (including, but not limited to, combination pain medications that contain an NSAID)

AND

Diagnosis

☐ Osteoarthritis*, ***or*** ☐ Rheumatoid Arthritis* ***or***

☐ Primary dysmenorrhea**, ***or*** ☐ Acute pain**

AND

☐ Patient currently on warfarin (Monitor for changes in INR if a COX-II is added), ***or***

☐ Documented failure due to gastric ulcer or duodenal ulcer after a trial of one or more non-Cox-2 inhibitor NSAIDs (must specify NSAID tried) _____ , ***or***

☐ Documented history of GI hemorrhage or perforation, ***or***

☐ Documented history of gastric ulcer or duodenal ulcer resistant to H. pylori treatment, ***or***

☐ Documented active gastric ulcer or active duodenal ulcer, ***or***

☐ Gastric outlet obstruction documented by endoscopy or x-ray

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for Xenical

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: Xenical Strength/Frequency _____

Initial or check specific criteria boxes below.
Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Diagnosis: Approved PA valid for 6 months

- ☐ Hyperlipidemia

AND each of the following qualifications (documentation of each value required):

- ☐ BMI of 27 kg/m^2 or greater, BMI Value: _____
- ☐ Failed therapy with niacin ***and*** statins, Failed therapy on _____, *and* _____
- ☐ Total cholesterol greater than 250 mg/dl Total cholesterol: _____
- ☐ LDL greater than 130 mg/dl LDL: _____
- ☐ HDL less than 35 mg/dl HDL: _____
- ☐ Prescription limited to 360 mg/day Rx: _____ mg/day

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for
Proton Pump Inhibitors with Complicated Diagnoses

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Aciphex, ☐Nexium, ☐Prevacid, ☐Prilosec, ☐Protonix Strength/Frequency_____
*Approved PA valid for 6 months, **Approved PA valid for 3 months, ***Approved PA valid for 2 months

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Complicated Diagnoses

- ☐ Pathological hypersecretory condition, such as Zollinger-Ellison Syndrome,*

OR

- ☐ Barrett's Esophagitis as diagnosed by esophageal biopsy,*

OR

- ☐ Complicated GERD diagnosed by endoscopy **and** meet **ONE** of the following conditions:
  - ☐ Mucosal erosive esophagitis, Grade 4 (massive ulceration with stricture)*
  - ☐ Mucosal erosive esophagitis, Grade 3 (massive ulceration)*
  - ☐ Mucosal esophagitis, Grade 2**
  - ☐ Mucosal esophagitis, Grade 1**

OR

Patient diagnosed within the last two months by endoscopy or radiographic studies with:

- ☐ Complicated Duodenal Ulcer (H. pylori status unknown) **OR** Complicated Gastric Ulcer, (H. pylori status unknown) **and** one or more of the complications listed below:
  - ☐ Active GI Bleeding***, ***or***
  - ☐ Gastric Outlet Obstruction***, ***or***
  - ☐ Ulcer penetration or perforation***, ***or***
  - ☐ Ulcer size >= 1 cm***

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for
Histamine H2 Antagonists without Generic Availability

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Pepcid RPD Tablet/Suspension, ☐Zantac Efferdose Tablet/Syrup
Zantac Syrup does not require PA for recipients less than 5 years of age
Initial or check specific criteria boxes below: Approved PA valid for two months
Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

☐ Patient failed a trial of at least 12 weeks of an FDA approved acute dose of at least one multisource (generic) Histamine H2 antagonist **(see generic drugs listed below).**
Specify most recent failed therapy below:

Drug: _____

***AND* Select One of the following treatment options below:**

☐ This is the patient's first treatment with this drug; **and** the patient has been re-evaluated within 30 days prior to the date on this form
(fill in date of last physician visit _____),

OR

☐ Patient is experiencing a continuation of symptoms while on this drug; **and** the patient has been re-evaluated within 30 days prior to the date on this form
(fill in date of last physician visit _____)

(cimetidine, famotidine tablets, nizatidine and ranitidine capsules/tablets do NOT require Prior Authorization)

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for
Proton Pump Inhibitors for *Active* H. pylori Diagnosis

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Prevpac Approved PA valid for one month

Initial or check specific criteria boxes below:

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Diagnosis

- ☐ Documented ***active*** H. pylori

AND

Select one or more of the following method(s) used to determine and document *active* H. pylori:

- ☐ Urea Breath Test
- ☐ Biopsy Urease Test
- ☐ Histologic identification of H. pylori from biopsy

Note: cimetidine liquid/tablets, famotidine tablets, and ranitidine capsules/tablets do NOT require Prior Authorization

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

Arkansas Medicaid Prescription Drug Program
Prior Authorization (PA) Request for
Proton Pump Inhibitors with Non-Complicated Diagnoses

Voice Response System (automated PA processing)
Toll free: 1-800-806-6181

Prescription Drug PA Help Desk
Toll free: 1-800-707-3854

Prescribing physician: After completing the request form please dial the Arkansas Medicaid Pharmacy PA Voice Response System to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: ☐Aciphex, ☐Nexium, ☐Prevacid, ☐Prilosec, ☐Protonix

Strength/Frequency_____

Prevacid and Prilosec do not require PA for recipients less than 2 years of age

*Approved PA valid for 2 months, **Approved PA valid for 3 months

Initial or check specific criteria boxes below:
Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

Non-Complicated Diagnoses

- ☐ Non-Complicated Duodenal Ulcer*, ***or*** (Recommended dose is once daily)
- ☐ Non-Complicated Gastric Ulcer*, ***or*** (Recommended dose is once daily)
- ☐ Non-Complicated GERD** (gastroesophageal reflux disease) (Recommended dose is once daily)

AND

- ☐ Patient completed at least an 8-week trial of a scheduled acute dose of a Histamine H2 antagonist

(cimetidine, famotidine tablets, nizatidine and ranitidine capsules/tablets do NOT require Prior Authorization)

***AND* Select One of the following treatment options below:**

- ☐ This is the patient's first treatment with a PPI; **and** the patient has been re-evaluated for this diagnosis within 30 days prior to the date on this form
  (fill in date of last physician visit _____),

OR

- ☐ Patient is experiencing a continuation of symptoms while on a PPI; **and** the patient has been re-evaluated for this diagnosis within 30 days prior to the date on this form
  (fill in date of last physician visit _____)

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS -- TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.