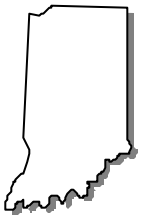

P R O V I D E R B U L L E T I N

B T 2 0 0 2 1 0 — M A R C H 1 , 2 0 0 2

To: All Indiana Medicaid Prescribers and Pharmacy Providers

Subject: Indiana Rational Drug Program Phase II

> *Note: The information in this bulletin about prior authorization payment methodology does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.*

Overview

The Prior Authorization (PA) Department of Health Care Excel (HCE) will initiate the addition of six drugs to the Indiana Rational Drug Program effective April 15, 2002. The Drug Utilization Review Board, after careful review, approved the addition of these drugs. Prior authorization services will be provided for six additional drugs: Synagis®, Respigam®, lactulose, Zithromax®, tretinoin (Retin-A®), and Oxycontin® (oxycodone controlled-release). This program is designed for fee-for-service, Primary Care Case Management (PCCM), and Package C members. The intent of the program is to promote quality of care and control costs.

The Indiana Rational Drug Program is carried out in compliance with all applicable provisions of both state and federal law. Prescribing practitioners will be responsible for initiating and obtaining prior authorization (PA) for all prescriptions they issue that require prior authorization.

Attached to this bulletin are the required forms for prior authorization of the six new drugs.

Current rules and procedures will remain in effect for appeals of denied PA requests. The prescriber may request an administrative review by submitting a written request to the following address.

Health Care Excel
Prior Authorization Department
Attn: Hearing and Appeals
2629 Waterfront Parkway East Drive, Suite 200

Indianapolis, IN 46214

Direct questions about this bulletin to the HCE Medical Policy Department at (317) 347-4500.

Prior Authorization Process

Prior authorization will be given to drug categories related to the prior authorization program and not by national drug codes (NDCs). Prescribers and authorized office personnel can submit requests via telephone, fax, or mail to the following HCE office site.

Health Care Excel
Prior Authorization Department
Attn: Indiana Rational Drug Program
2629 Waterfront Parkway East Drive, Suite 200
Indianapolis, IN 46214
Telephone: (317) 347-4511
Toll Free Telephone: (800) 457-4518, option 5
Fax: (317) 347-4537

Each request will be entered into Indiana*AIM* and given a unique PA number. There will be a 24-hour response by telephone, fax, or mail for all pharmacy requests. Telephone authorizations are given for one month only, and then a written PA request must be completed and faxed or mailed to the HCE PA Department. The 24-hour response by mail will begin on the date and time the mail has been received by HCE. When the PA office is closed, provisions will be made within Indiana*AIM* to authorize a minimum 72-hour supply of medications. Business hours for the PA Department are 7:30 a.m. – 6:00 p.m. Indianapolis time, Monday through Friday. A recorded message on the telephone line will instruct those who call after hours, weekends, or holidays that when the office is closed, the pharmacist can issue a supply of drugs that will cover a minimum of 72 hours. During long holiday weekends, larger quantities will be available.

New and Revised Forms for the Indiana Rational Drug Program

Attached to this bulletin are the new PA forms for Phase II and the revised forms for Phase I. Please use only the forms included with this bulletin when requesting PA from the Indiana Rational Drug Program.

Criteria for Synagis â , RespigamÒ, lactulose, Zithromax â , tretinoin (Retin-A â), and OxycontinÒ (oxycodone controlled-release)

Criteria for the Indiana Rational Drug Program are based on national standards and have been approved for use by the IHCP.

Tretinoin (Retin-AÒ) Criteria

- Tretinoin topical products for patients under the age of 21 years do not require PA.
- PA is required for patients being treated for acne that are over the age of 21 years.
- These products will not be approved for other diagnoses.

> *Note: A PA form is **required** and must be filled out completely for processing PA requests. You can obtain these forms from this bulletin or on the IHCP Web site at www.indianamedicaid.com. Copies of bulletins can also be obtained by calling EDS Customer Assistance at 1-800-577-1278 or (317) 655-3240.*

ZithromaxÒ Criteria

- Prior authorization is not required for a standard five-day therapy of Zithromax.
- Prescription is not eligible for refill within 10 days of the date the original prescription was filled. The exceptions would be culture and sensitivity and a specific disease state indicating this as the drug of choice.
- Seven days of oral therapy will be approved as follow-up to intravenous (IV) Zithromax® used in the hospital for community-acquired pneumonia.
- Prophylaxis in patients with immune deficiency secondary to Human Immunodeficiency Virus (HIV) is permitted, but requires PA with reauthorization on an annual basis.
- Decisions about dosage approval will be based on utilization recommendations found in the Sanford Guide to Antibiotic therapy.

> *Note: A PA form is **required** and must be filled out completely for processing PA requests. You can obtain these forms from this bulletin or on the IHCP Web site at www.indianamedicaid.com. Copies of bulletins can also be obtained by calling EDS Customer Assistance at 1-800-577-1278 or (317) 655-3240.*

Lactulose Criteria

- Providers are encouraged to use a less expensive alternative, such as Sorbitol® that has very similar efficacy.
- Monitoring of diabetic patients may be required due to changes in blood sugar during the transition to Sorbitol® usage.
- Lactulose will be approved for patients with documented Hepatic Encephalopathy, but will require PA.

> *Note: A PA form is **required** and must be filled out completely for processing PA requests. You can obtain these forms from this bulletin or on the IHCP Web site at www.indianamedicaid.com. Copies of bulletins can also be obtained by calling EDS Customer Assistance at 1-800-577-1278 or (317) 655-3240.*

Synagis â and RespigamÒ Criteria

- Respigam®

  The following medication administration site criteria will need to be met before Respigam® will be approved. Home administration is not permitted by the Indiana Rational Drug Program. Administration can be performed in a clinic, physician's office, or a hospital.

- Synagis®

  Synagis® can be administered in any setting where intra-muscular (IM) injections are appropriate.

- At least one of the following criteria must be met before the patient is considered "at risk" for Respiratory Syncytial Virus (RSV).
  - Patient is less than 24 months of age at start of therapy and has chronic lung disease, especially if on oxygen chronically or if only off oxygen less than 3-6 months.
  - Patient is less than 1 year of age at start of therapy with a gestational age of less than 28 weeks or less than 1 year and has a history of concomitant medical problems (e.g., caffeine administration for respiratory stimulation within the last year).
  - Patient is less than 6 months of age at start of therapy with a gestational age of 28-32 weeks.
  - Patient is less than 3 months of age at the start of therapy with gestational age of 32-36 weeks and concomitant medical problems.
  - Patient cannot be approved if he or she is currently receiving Immunoglobulin infusions. Immunity should be acquired through those infusions.
- Treatment can only be approved for the RSV season. Therefore, the approval period will be October 15 through April 30 of the next year, for a maximum of six doses.

Note:	*A PA form is **required** and must be filled out completely for processing PA requests. You can obtain these forms from this bulletin or on the IHCP Web site at www.indianamedicaid.com. Copies of bulletins can also be obtained by calling EDS Customer Assistance at 1-800-577-1278 or (317) 655-3240.*

INDIANA RATIONAL DRUG PROGRAM AUTHORIZATION REQUEST

(# REQUIRED IF MEDICAID PROVIDER)
Requesting Provider # _____ Phone _____
FAX _____
Name _____
Address _____
City/State/Zip _____

Rendering Provider # _____ Phone _____
FAX _____
Name _____
Address _____
City/State/Zip _____

Patient Information
RID No. _____
DOB _____
Name _____
Address _____
City/State/Zip _____

MEDICAL DIAGNOSIS:
Primary _____
Secondary _____
Has medication been previously provided? Yes ____ Date _____ No ____
WARNING: AUTHORIZATION IS VALID ONLY IF THE MEMBER IS ELIGIBLE ON THE DATE THAT SERVICE WAS PROVIDED.

REQUESTED DRUG	STRENGTH	QUANTITY	DOSAGE REGIMEN

Please add a brief summary that would help document the need for the above listed medications.
Clinical Summary: A current plan of treatment and progress notes may be requested for documentation.

Signature of Requesting Provider _____ **Date** _____
(original signature required)

The above sections must be completed or the request will be rejected.

FORWARD TO:
HCE Prior Authorization Department
Indiana Rational Drug Program
2629 Waterfront Parkway East Drive, Suite 200
Indianapolis, IN 46214
Or fax to (317) 347-3593

Date of Submission _____

Reason for Denial of Request or Specific Notes:

Authorization/Denial Status	Prior Authorization Number	Date of Request	Therapeutic Class/Generic Code

CONFIDENTIAL INFORMATION
Confidentiality Notice: The documents that accompany this telecopy contain legally confidential information belonging to the sender. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copy distribution or actions taken in reliance on the content of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of the documents.

NOTE: This form has been revised since publication in Bulletin 200148. Please use this version of the form for all prior authorization requests for drugs.

Indiana Health Coverage Programs
Indiana Rational Drug Program

Health Care Excel
2629 Waterfront Parkway, East Drive, Suite 200
Indianapolis, IN 46214
Telephone: 1-317-347-4511 Fax: 1-317-347-3593
Toll Free: 1-800-457-4518 (Please choose call option 5)

OXYCONTINÒ (OXYCODONE CONTROLLED-RELEASE)

Objective: To achieve effective pain relief at the dosing interval of every 12 hours and the use of the most appropriate dosage strengths.

Prior approval is required for the following situations:

1. Oxycontin® (oxycodone controlled-release) is to be used only for the management of chronic, intractable pain.

2. Prior authorization is required when the quantity of Oxycontin® (oxycodone controlled-release) exceeds 120 tablets for any given 30-day period.

3. Prior approval will be necessary for greater than 100 doses per month of oxycodone immediate-release, when used in conjunction with Oxycontin® (oxycodone controlled-release), for breakthrough pain management.

Prior approval requirements for doses not meeting the above guidelines:

1. The prescribing physician is required to make the prior approval requests for dosing not meeting the stated requirements. Requests from other health care personnel will not be accepted.

2. Diagnosis and cause of chronic, intractable pain must be stated.

3. Since Oxycontin® (oxycodone controlled-release) is a second-line drug of choice for chronic pain, a list of previously prescribed opioids must be presented.

4. The provider should keep a signed copy of the Patient and Physician Pain Management Agreement on file.

Indiana Health Coverage Programs
Indiana Rational Drug Program

Health Care Excel
2629 Waterfront Parkway, East Drive, Suite 200
Indianapolis, IN 46214
Telephone: 1-317-347-4511 Fax: 1-317-347-3593
***Toll Free: 1-800-457-4518* (Please choose call option 5)**

OXYCONTINÒ (OXYCODONE CONTROLLED-RELEASE) PRIOR AUTHORIZATION REQUEST FORM

Patient Name _____ **Medicaid ID #** _____

Prescriber's Name (Print) _____ **Provider #** _____

The criteria for use of Oxycontin® (oxycodone controlled-release) within the Indiana Rational Drug Program allows for 120 tables per 30 days of Oxycontin® (oxycodone controlled-release) without prior authorization (PA).

All other prescriptions for Oxycontin® (oxycodone controlled-release) require prior authorization initiated by the prescribing physician. Prior authorization must be renewed every six (6) months or when dosage changes.

Prior approval criteria require the following information.

- The use of Oxycontin® (oxycodone controlled-release) is limited to the treatment of intractable pain only. Short term or acute use of Oxycontin® (oxycodone controlled-release) will not be approved. Documentation must be provided as to the specific type and cause of the pain, along with the statement that the patient is in intractable pain.

  I hereby certify that the intractable pain is caused by or is a result of _____
  _____

- The completion of a pain management agreement between the prescriber and the patient is recommended and should be kept on file by the provider. Copies of a suggested pain management agreement are included with this bulletin and may be obtained from the IHCP Web site at www.indianamedicaid.com.

- Because Oxycontin® (oxycodone controlled-release) is not indicated for the first-line treatment of opiate naïve patients, documentation of previously used shorter acting opioids must accompany the request for prior approval.

This patient has received the following short acting opioids in the management of intractable pain.

Date	Medication	Dose	Frequency	Date	Medication	Dose	Frequency

I hereby request the Indiana Rational Drug Program approve the following dose(s) of Oxycontin® (oxycodone controlled-release) to accommodate this patient's intractable pain.

Controlled-Release Dose Frequency _____ _____

Controlled-Release Dose Frequency _____ _____

Other concurrent narcotic medications_____

Physician Signature_____ **Date**_____ **Fax # (____)**_____

For Indiana Rational Drug Program Use Only		
Reason for Denial of Request or Specific Notes		
Approval/Denial Status	**Prior Authorization Number**	**Date of Request**

Confidentiality Notice: The documents that accompany this telecopy contain legally confidential information belonging to the sender. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified

that any disclosure, copy, distribution, or actions taken in reliance on the content of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of the documents.

IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL (317) 347-4511.

Indiana Rational Drug Program
COX-2 INHIBITOR (COX-1 SPARING) AND BRAND NAME NSAID AUTHORIZATION FORM

1. Patient Name (Last) (First) (MI)	2. IN Medicaid ID #:	3. Date of Birth
Medication Name:	Dose	Directions
Indicating Diagnosis:	If applicable, Anticoagulant being utilized:	
Physician Name:	Provider Number:	
Physician Signature		

IHCP Criteria of Use (Must meet #1 and at least one of #2-6)

1. If the patient meets the below criteria then authorization for medication is granted.
   A. Celecoxib – diagnosis of osteoarthritis or rheumatoid arthritis. Not authorized for acute, occasional, or PRN dosing.
   B. Rofecoxib – diagnosis of osteoarthritis or 5-day acute pain situation after completion of the GI Risk rating scale below. Not authorized for rheumatoid arthritis.
2. Authorization for medication is granted for any patient requiring a full dose NSAID and > 70 years of age.
3. Authorization for medication is granted for any patient requiring a full dose NSAID with a history of **serious** NSAID induced gastrointestinal complications. (e.g., GI Bleed requiring hospitalization).
   Please Document:
   Type of Complication_____Date of Complication_____
4. Authorization for medication is granted for patients failing two, two-week trials of generically available NSAIDs.
5. Authorization for medication is granted for any patient requiring a full dose NSAID and concurrently on anticoagulant therapy.
6. Authorization for medication is granted for any patient requiring a full dose NSAID and NOT falling into the above categories. Patient must have a total point score of 13 points or more from the chart below:

IHCP GI Risk Rating Scale

Patient's Risk Criteria			Patient's Points
Current Health Status (Select only one Category)			
No restrictions of ability to perform normal activities		= 0 points	
Moderate restriction, but with an ability to perform most activities of daily living and occupation		= 1 point	
Marked restrictions, with an inability to perform most activities of daily living and occupation		= 2 points	
Incapacitation with confinement to bed or wheelchair		= 3 points	
How frequent has the patient experienced NSAID induced GI Side Effects?	Never Occasional Frequent	= 0 points = 4 points = 5 points	
How is the patient currently using their NSAIDs?	OTC or PRN RX/Constant Use	= 0 points = 1 point	
Is the patient taking concurrent Oral Steroids?	No = 0 Points Yes = 4 Points		

Patient's Age	Points	Patient's Age	Points	Patient's Age	Points	
<25 years	= 0 points	41-45 years	= 4 points	61-65 years	= 8 points	
25-30 years	= 1 point	46-50 years	= 5 points	65-70 years	= 9 points	
31-35 years	= 2 points	51-55 years	= 6 points	> 70 years	authorized	
36-40 years	= 3 points	56-60 years	= 7 points			
					SUM OF POINTS	

FORWARD TO:
HCE Prior Authorization Department
Indiana Rational Drug Program
2629 Waterfront Parkway East Drive, Suite 200
Indianapolis, IN 46214
Or fax to (317) 347-3593

Reason for Denial of Request or Specific Notes:			
Authorization/Denial Status	Authorization ID#	Date of Request	Therapeutic Class/Generic Code

NOTE: This form has been revised since publication in Bulletin 200148. Please use this version of the form for all prior authorization requests for drugs.

Indiana Rational Drug Program
Tramadol Prior Authorization Form

1. Patient Name (Last) (First) (MI)	2. IN Medicaid ID #:	3. Date of Birth
Medication Name:	Dose	Directions
Specific Chronic Pain Diagnosis:	If applicable, Anticoagulant being utilized:	
Physician Name:	Provider #:	
Physician Signature:		

Indiana Rational Drug Program Criteria for Tramadol

1. Authorization of medication authorized for any chronic pain patient >/= 70 years of age. (300 mg/day maximum dose)
2. Diagnosis of chronic pain syndrome of moderate or moderately severe intensity and which has failed a full therapeutic treatment of NSAIDs. Maximum authorized dose is 400 mg per day.
3. Authorization for any patient failing a recent trial of an NSAID for the same condition in the past sixty days.
   Please document:

Date and Length of Trial:	Name of NSAID and Dosage Failed:	Type of Failure and/or Complication:

4. Authorization for any patient concurrently on drugs or with disease states having documented interactions with NSAID use. (Examples: anticoagulants (e.g. warfarin), cyclosporine, lithium, ACE Inhibitors and/or beta-blockers being used in congestive heart failure, renal disease)
5. Authorization for any patient considered at risk for GI bleed. To be considered at risk, the patient must have a total point score of 13 or more from the chart below:

Indiana Health Coverage Program						
Patient's Risk Criteria						**Patient's Points**
Current Health Status (Select only one Category) No restrictions of ability to perform normal activities = 0 points Moderate restriction, but with an ability to perform most activities of daily living and occupation = 1 points Marked restrictions, with an inability to perform most activities of daily living and occupation = 2 points Incapacitation with confinement to bed or wheelchair = 3 points						
How frequent has the patient experienced NSAID induced GI Side Effects?				Occasional = 4 points Frequent = 5 points		
How is the patient currently using their NSAIDs?				OTC or PRN = 0 points RX/Constant Use = 1 point		
Is the patient taking concurrent Oral Steroids?				No = 0 points Yes = 4 points		
Patient's Age	Points	Patient's Age	Points	Patient's Age	Points	
<25 years	= 0 points	41-45 years	= 4 points	61-65 years	= 8 points	
25-30 years	= 1 point	46-50 years	= 5 points	65-70 years	= 9 points	
31-35 years	= 2 points	51-55 years	= 6 points	> 70 years	authorized	
36-40 years	= 3 points	56-60 years	= 7 points			
					SUM OF POINTS	

Authorization will not occur for: short term pain management therapy beyond 24 tablets in any thirty-day period, patients with previous or suspected substance abuse or with seizure disorders unless benefits outweigh the risks (documentation required), treatment with concomitant opiate use, or patients with a recent failure of a stronger opiate for the same condition.

FORWARD TO:
HCE Prior Authorization Department
Indiana Rational Drug Program
2629 Waterfront Parkway East Drive, Suite 200
Indianapolis, IN 46214
Or fax to (317) 347-3593

Reason for Denial of Request or Specific Notes:			
Authorization/Denial Status	Authorization ID#	Date of Request	Therapeutic Class/Generic Code

NOTE: This form has been revised since publication in Bulletin 200148. Please use this version of the form for all prior authorization requests for drugs.

Physician/Institution
Letterhead or Logo Here

MEDICATION MANAGEMENT AGREEMENT

This Agreement between _____, ("Patient") and _____ _____("Provider") is for the purpose of establishing agreement between Provider and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Provider for the Patient. Provider and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed or provided by the Provider for the Patient:

I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

I realize that all of the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell, or trade my medication for money, goods or services.

I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Provider. I understand it is against the law to do so. If my referring physician is willing to prescribe my medications, the Provider will have to approve the arrangements to make sure there is no duplication. **I will discontinue all previously used pain medications, unless told to continue them**.

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

I agree to use _____ Pharmacy, located at _____, telephone number _____, for all my pain medication. If I change pharmacy for any reason, I agree to notify the Provider at the time I receive a prescription, and advise my new pharmacy of my prior pharmacy's address and telephone number.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the Provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Indiana Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the Provider to provide a copy of this Agreement to my pharmacy.

I agree that I will submit to a blood or urine test if requested by my Provider to determine my compliance with this agreement and my regimen of pain control medication.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time, **and could possibly cause my death**.

I understand that this medication regimen will be continued for a period of four months. My case will be reviewed at the end of that period. If there is no evidence that I am improving or that no progress is being made to improve my function or my quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.

Provider and Patient agree that this Agreement is essential to the Provider's ability to treat the Patient's pain effectively and provide medical services. Failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Provider and the termination of the Provider/Patient relationship.

This agreement is entered into on this _____ day of _____, 20_____.

_____ _____
Patient Provider

_____
Witness