A. COVERED DRUGS - LEGEND DRUGS

Wisconsin Medicaid uses an Open Formulary for legend drugs with few restrictions. Restrictions include: Drugs Which Require Prior Authorization (refer to Sections C and D below), Noncovered Manufacturer Drugs (refer to Section A of Appendix 4 of this handbook), Less-Than-Effective Drugs (refer to Section B of Appendix 4 of this handbook) and Negative Formulary Drugs (refer to Section C of Appendix 4 of this handbook).

B. COVERED DRUGS - OVER-THE-COUNTER DRUGS

The general categories are:

ANALGESICS-ORAL/RECTAL[1] ANTACIDS ANTIBIOTIC OINTMENTS ANTIFUNGALS-TOPICAL ANTIFUNGALS-VAGINAL BISMUTH SUBSALICYLATE CAPSAICIN CONTRACEPTIVE SUPPLIES	COUGH SYRUPS[2] DIPHENHYDRAMINE FERROUS GLUCONATE/ SULFATE FOR PREGNANT WOMEN (AND FOR A 60-DAY PERIOD BEYOND THE END OF THE PREGNANCY)	HYDROCORTISONE PRODUCTS-TOPICAL INSULIN LICE CONTROL PRODUCTS AND PINWORM TREATMENT PRODUCTS	MECLIZINE OPHTHALMIC LUBRICANTS PSEUDOEPHEDRINE PYRIDOXINE TABLETS THERAPEUTIC ORAL ELECTROLYTE REPLACEMENT SOLUTIONS

(Note: Coverage is limited to generic drugs for most covered OTC drugs [excluding the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies]. Some products in these categories are *not* covered because the manufacturer did not sign a rebate agreement. Examples of noncovered brand name products include Mylanta, Rolaids, Clear Tears, Lyteers, Neo Tears, Maalox, Titralac, Ecotrin, Robitussin, Tylenol, Ascriptin, Riopan and Advil.)

B. COVERED DRUGS - OVER-THE-COUNTER DRUGS (HealthCheck "Other Services")

Effective with dates of service beginning January 1, 1994, the following drug categories are covered through HealthCheck "Other Services" without prior authorization but with a written prescription, as well as verification that a comprehensive HealthCheck screen occurred within the last year. Pharmacies are required to maintain this documentation. HealthCheck is a preventive health care program for children under the age of 21. Refer to Appendix 25 of the pharmacy handbook for more specific information on covered categories.

ANTI-DIARRHEALS IRON SUPPLEMENTS	LACTASE PRODUCTS LAXATIVES	MULTIVITAMINS	TOPICAL PROTECTANTS

[1] Limited to single entity aspirin, acetaminophen, ibuprofen products only. These analgesics remain in the daily rate for nursing home recipients.

[2] Covered "cough syrups" are limited to products for treatment of coughs only. Covered products include those containing a single component (terpin hydrate or guaifenesin), a single cough suppressant (codeine or dextromethorphan), or a combination of an expectorant and cough suppressant. Multiple ingredient cough/cold combination products are noncovered.

C. COVERED NON REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

These drugs require prior authorization because the manufacturer did not sign a rebate agreement. Prescribers are requested to provide a statement regarding the nature of the medical need for these specific brand drugs, as well as a statement which asserts that failure to cover the drug will result in costs to Wisconsin Medicaid which exceed the cost of the drug. This list may change if the manufacturer signs a rebate agreement.
Generic equivalents of these drugs are not included in this requirement and may be billed without prior authorization if the generic manufacturer has signed a rebate agreement.

DALMANE LIBRITABS	LIBRIUM MELANEX	MENRIUM QUARZAN	RIMSO 50 VALIUM

D. COVERED REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

1. Paper Submission
These drugs are produced by manufacturers which have signed rebate agreements but require prior authorization to determine medical necessity. Diagnosis and information regarding the medical requirements for these drugs must be provided on the prior authorization request.

ALGLUCERASE (11/1/92) Ceredase* ALPHA-1-PROTEINASE INHIBITOR Prolastin*	CS III & IV STIMULANTS (Excludes Mazindol) Benzphetamine, Diethylpropion, Fenfluramine, Phendimetrazine, Phentermine	ENTERAL NUTRITIONALS Ensure, Pediasure Meritine, Enrich, MCT Sustacal, Pregestimil, etc. EPOETIN ALFA Epogen,* Procrit*	FERTILITY ENHANCEMENT DRUGS (when used to treat conditions other than infertility) Chorionic Gonadotropin, Menotropins, Clomiphene, Urofollitropin, Gonadorelin
HUMAN GROWTH HORMONE Humatrope,* Protropin* Serostim™ HYPERALIMENTATION Total Parenteral Nutrition Peripheral Parenteral Nutrition	IMPOTENCE TREATMENT DRUGS (When used for a condition other than impotence) Alprostadil Systemic (Prostin VR Pediatric, Vasoprost), Phentolamine, Systemic (Regitine), Phentolamine Oral (Vasomax), Sildenafil (Viagra)	INTERFERONS Alferon N,* Intron-A,* Infergen, Roferon-A,* Betaseron* (10/01/93) Avonex (07/01/96)	MUPIROCIN (02/01/94) Bactroban* MUROMONAB-CD3 Orthoclone OKT3*
	UNLISTED/ INVESTIGATIONAL DRUGS Biopterin (tetrahydrobiopterin), Somogard (deslorelin)	WEIGHT LOSS AGENTS Meridia (2/1/98)	

D. COVERED REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED			
2. Specialized Transmission Approval Technology (STAT) PA.			
ORAL ULCER TREATMENT DRUGS (07/01/94) Axid, Carafate, Cytotec, Pepcid, Prilosec, Tagamet, Zantac Prevacid (10/01/95), Tritec (8/26/96), Arthrotec (1/1/98), Prevpac (1/20/98)	SMOKING CESSATION PRODUCTS (07/01/94) Habitrol, ProStep, Zyban (6/23/97) (OTC products not covered.)	COLONY STIMULATING FACTORS (07/01/94) Neupogen, Leukine, Prokine	

* Providers will receive a response within 24 hours from Wisconsin Medicaid for these drug products produced by manufacturers who have signed rebate agreements. Providers must have properly submitted the prior authorization requests.