This Update has been revised since its original publication. The revised information appears in red text on pages 46-47.

DECEMBER 2024 | NO. 2024-52

ForwardHealth UPDATE

Wisconsin serving you

Your First Source of ForwardHealth Policy and Program Information

JANUARY 2025 PREFERRED DRUG LIST CHANGES AND OTHER PHARMACY POLICY CHANGES

On November 6, 2024, the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee met to review existing therapeutic drug classes on the Preferred Drug List (PDL).

This ForwardHealth Update announces changes to the PDL and certain PDL drug classes from the November 2024 PDL review, certain PA form changes, and other pharmacy policy changes.

All policy and form changes are effective January 1, 2025, unless otherwise noted.

Providers may refer to the ForwardHealth Online Handbook Standard Pharmacy Policy for Covered and Noncovered Drugs topic #22337 for general ForwardHealth policy for drugs that require PA approval. Providers may also refer to this topic about what may **not** be considered criteria to support the need for a drug.

AFFECTED PROGRAMS

BadgerCare Plus, Medicaid, SeniorCare

TO

Blood Banks, Community Health Centers, Dentists, Hospital Providers, Nurse Practitioners, Nursing Homes, Pharmacies, Pharmacists, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, Tribal Federally Qualified Health Centers, HMOs and Other Managed Care Programs

CONTACT INFORMATION

Provider Services and the Drug Authorization and Policy Override (DAPO) Center, 800-947-9627

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

WISCONSIN DEPARTMENT of HEALTH SERVICES

Providers are responsible for being up to date with current ForwardHealth policy and procedures and billing information in the Online Handbook.

Refer to the following sections for more information about:

- Drug status changes on the PDL.
- Changes to pharmacy-related PA forms and instructions.
- A brief overview of the PDL.
- Changes to legacy exemptions for Alzheimer's agents.
- Changes to legacy exemptions for antipsychotic drugs.
- Changes to legacy exemptions for pancreatic enzymes.
- Changes to legacy exemptions for stimulant drugs.
- Changes to Alzheimer's agents drug class.
- Changes to analgesics, opioids short-acting drug class.
- Changes to cytokine and cell adhesion molecule (CAM) antagonists drug class.
- Changes to epinephrine self-injected drug class.
- Changes to H2 antagonists drug class.
- Changes to immunomodulators, asthma drug class.
- Changes to immunomodulators, atopic dermatitis drug class.
- Changes to immunomodulators, atopic dermatitis—topical drug class.
- Changes to intranasal rhinitis agents drug class.
- Changes to stimulants drug class.
- Other pharmacy policy changes.

Drug Status Changes on the Preferred Drug List

Attachment A to this Update lists the drugs that have changed their preferred or non-preferred status as a result of the November 2024 PDL review. The Preferred Drug List Quick Reference data table contains a complete list of preferred and non-preferred drugs.

For drugs that were previously preferred and will become non-preferred, pharmacy providers should work with prescribers to transition members to a preferred drug or complete the appropriate PA request forms for non-preferred drugs.

As a reminder, new drugs are usually added to existing drug classes on the PDL as non-preferred drugs until the next scheduled drug class review by the Wisconsin Medicaid Pharmacy PA Advisory Committee. This means that some drugs listed in the table have not previously been reviewed and were added to

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

the PDL with an interim status of non-preferred. These drugs have now been reviewed, and their PDL status is included in Attachment A.

Changes to Pharmacy-Related PA Forms and Instructions

Attachment B lists the PA forms and instructions that have been revised, revised and renamed, or discontinued as a result of the November 2024 PDL review or as a result of other pharmacy policy changes. The Forms page of the ForwardHealth Portal (the Portal) contains current copies of all PA forms and instructions.

More information regarding changes to clinical criteria or PA request submission options is noted in the applicable drug class or Other Pharmacy Policy Changes sections of this Update.

Archive Page for Pharmacy-Related Forms and Instructions

The Pharmacy-Related Forms and Instructions link under the Archives Quick Links box on the Pharmacy Resources page of the Portal contains previous versions of pharmacy-related forms and instructions for reference purposes.

A Brief Overview of the Preferred Drug List

ForwardHealth makes recommendations to the Wisconsin Medicaid Pharmacy PA Advisory Committee about whether certain PDL drugs should be preferred or non-preferred. These recommendations are based primarily on objective evaluations of a drug's relative safety, effectiveness, clinical outcomes, and relative cost (to Wisconsin Medicaid) in comparison with other therapeutically interchangeable, alternative agents in the same drug class.

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Wisconsin Medicaid Pharmacy PA Advisory Committee.

The PDL is not a drug formulary and is not a comprehensive list of covered drugs.

Most drugs and drug classes included on the PDL are covered fee for service by BadgerCare Plus, Wisconsin Medicaid, and SeniorCare, but certain drugs may have restrictions (for example, diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Non-preferred drugs may be covered with an approved

DID YOU KNOW?

Prescribers and pharmacy providers can find specific pharmacy-related PA forms on the Forms page by entering the form number into the Keyword or Form Number field of the Search Criteria and clicking Search.

PA request. Most preferred drugs do not require PA, except in designated classes identified on the Preferred Drug List Quick Reference data table.

IMPORTANT REMINDERS OF CURRENT PA POLICY FOR PREFERRED DRUG LIST DRUGS

For prescribers' responsibilities for PA for PDL drugs, refer to Online Handbook A Prescriber's Responsibilities for Prior Authorization for Preferred Drug List Drugs topic #1987.

For pharmacy providers' responsibilities for PA for PDL drugs, refer to Online Handbook A Pharmacy Provider's Responsibilities for Prior Authorization for Preferred Drug List Drugs topic #10937.

Changes to Legacy Exemptions for Alzheimer's Agents

BadgerCare Plus, Medicaid, and SeniorCare members who were eligible for the legacy exemption for galantamine tablets or galantamine ER for dates of service (DOS) on and after January 1, 2012, and remained eligible throughout 2024 will no longer be allowed to receive the legacy exemption for galantamine tablets or galantamine ER for DOS on and after January 1, 2025, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have had no claim activity for galantamine tablets or galantamine ER for DOS in the last six months of 2024.
- Members with other primary insurance on file with ForwardHealth have had no claim activity for galantamine tablets or galantamine ER for DOS in calendar year 2024.

PA is required for galantamine tablets and galantamine ER for members who do not have a legacy exemption for either one of the drugs.

Changes to Legacy Exemptions for Antipsychotic Drugs

BadgerCare Plus, Medicaid, and SeniorCare members who were granted a legacy exemption for thioridazine for DOS on and after October 1, 2010, and remained eligible throughout 2024 will no longer be allowed to receive the legacy exemption for thioridazine for DOS on and after January 1, 2025, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have had no claim activity for thioridazine for DOS in the last six months of 2024.

QUICK LINKS

- Overview of Drug Legacy Exemptions topic #3509
- Legacy Exemptions for Alzheimer's Agents topic #12897
- Legacy Exemptions for Antipsychotic Drugs topic #10659
- Legacy Exemptions for Pancreatic Enzymes topic #10661
- Legacy Exemptions for Stimulant Drugs topic #10662

Note: Topics #12897, #10659, #10661, and #10662 will be updated on January 2, 2025.

- Members with other primary insurance on file with ForwardHealth have had no claim activity for thioridazine for DOS in calendar year 2024.

PA is required for thioridazine for members who do not have a legacy exemption for the drug.

Changes to Legacy Exemptions for Pancreatic Enzymes

Creon

BadgerCare Plus, Medicaid, and SeniorCare members who were granted a legacy exemption for Creon for DOS on and after October 1, 2010, and remained eligible throughout 2024 will no longer be allowed to receive the legacy exemption for Creon for DOS on and after January 1, 2025, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have had no claim activity for Creon for DOS in the last six months of 2024.
- Members with other primary insurance on file with ForwardHealth have had no claim activity for Creon for DOS in calendar year 2024.

PA is required for Creon for members who do not have a legacy exemption for the drug.

Changes to Legacy Exemptions for Stimulant Drugs

BadgerCare Plus, Medicaid, and SeniorCare members who were granted a legacy exemption for designated amphetamine drugs for DOS on and after January 1, 2018, and remained eligible throughout 2024 will no longer be allowed to receive the legacy exemption for amphetamine drugs for DOS on and after January 1, 2025, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have had no claim activity for amphetamine drugs for DOS in the last six months of 2024.
- Members with other primary insurance on file with ForwardHealth have had no claim activity for amphetamine drugs for DOS in calendar year 2024.

PA is required for designated amphetamine drugs for members who do not have a legacy exemption for the drug. Refer to Attachment C for the table that lists the allowed legacy exemptions for amphetamine drugs and their applicable legacy exemption details.

Changes to Alzheimer's Agents Drug Class

Memantine Products Policy Exceptions

BadgerCare Plus, Medicaid, and SeniorCare members who were 44 years of age or younger and were taking memantine (as identified from drug paid claims history) prior to February 15, 2013, were allowed to continue receiving memantine or memantine XR products without PA. Those members who remained eligible in 2024 to receive memantine products without PA will no longer be eligible to continue receiving memantine products without PA for DOS on and after January 1, 2025, if **one** of the following is true:

- Members do not have other primary insurance on file with ForwardHealth and have had no claim activity for any memantine products for DOS in the last six months of 2024.
- Members have other primary insurance on file with ForwardHealth and have had no claim activity for any memantine products for any DOS in 2024.

The remaining previously identified BadgerCare Plus, Medicaid, and SeniorCare members with active claim activity will be allowed to continue receiving memantine products without PA until further notice.

Changes to Analgesics, Opioids Short-Acting Drug Class

Effective January 1, 2025, non-preferred drugs fentanyl citrate oral transmucosal lozenges and Fentora in the analgesics, opioids short-acting—fentanyl mucosal agents drug class will move to the analgesics, opioids short-acting drug class.

The analgesics, opioids short-acting—fentanyl mucosal agents drug class will be discontinued from the PDL on January 1, 2025.

Discontinued Prior Authorization/Preferred Drug List for Fentanyl Mucosal Agents Form

ForwardHealth has discontinued the Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents form, F-00281 (07/2013).

Effective January 1, 2025, pharmacy providers must submit PA requests for non-preferred fentanyl mucosal agents with the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form, F-11075 (07/2023). ForwardHealth will return PA requests that are not submitted with the PA/PDL Exemption Request form.

QUICK LINKS

Alzheimer's Agents topic #15037

Note: This topic will be updated on January 2, 2025.

QUICK LINKS

- Fentanyl Mucosal Agents topic #9877
- Non-Preferred Drugs That Use the Prior Authorization/Preferred Drug List Exemption Request Form topic #22218
- Forms page

Note: Topic #9877 will be removed from the Online Handbook on January 2, 2025. Topic #22218 will be updated on January 2, 2025.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

ForwardHealth will honor PA requests for non-preferred fentanyl mucosal agents approved before January 1, 2025, until they expire or until the approved days' supply is used up.

Changes to Cytokine and Cell Adhesion Molecule Antagonists Drug Class

Cimzia, Cyltezo, Simponi subQ, and Tyenne subQ will become preferred drugs in the cytokine and CAM antagonists drug class. Preferred drugs do not require PA.

New Indications for Bimzelx, Kevzara, Tremfya SubQ, and Zymfentra

Bimzelx, Kevzara, Tremfya subQ, and Zymfentra are non-preferred drugs in the cytokine and CAM antagonist drug class.

Bimzelx will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat these clinical conditions:

- Ankylosing spondylitis
- Hidradenitis suppurativa
- Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
- Psoriatic arthritis

Zymfentra will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat these clinical conditions:

- Crohn's disease
- Ulcerative colitis

Kevzara will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat juvenile idiopathic arthritis (JIA). Tremfya subQ will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis.

Revised PA Forms for Cytokine and Cell Adhesion Molecule Antagonist Drugs

ForwardHealth has revised the following PA forms for non-preferred cytokine and CAM antagonist drugs:

- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis form, F-11304 (01/2025)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form, F-01950 (01/2025)

QUICK LINKS

Cytokine and Cell Adhesion Molecule Antagonist Drugs topic #16217

Note: This topic will be updated on January 2, 2025.

- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa form, F-03174 (01/2025)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis form, F-11306 (01/2025)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis form, F-01951 (01/2025)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis form, F-03224 (01/2025)

ForwardHealth has also revised and renamed the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Deficiency of Interleukin-1 Receptor Antagonist (DIRA), Giant Cell Arteritis, Neonatal Onset Multisystem Inflammatory Disease (NOMID), and Non-Radiographic Axial Spondyloarthritis (nr-axSpA) form, F-01952 (01/2022). The form has been renamed the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Giant Cell Arteritis and Non-Radiographic Axial Spondyloarthritis (nr-axSpA) form, F-01952 (01/2025).

Effective January 1, 2025, pharmacy providers must submit PA requests for non-preferred cytokine and CAM antagonist drugs on the revised or revised and renamed PA forms (dated 01/2025). ForwardHealth will return PA requests that are not submitted with these revised forms.

ForwardHealth will honor PA requests for non-preferred cytokine and CAM antagonist drugs approved before January 1, 2025, until they expire or until the approved days' supply is used up.

Cytokine and Cell Adhesion Molecule Antagonist Biosimilar Drugs

All cytokine and CAM antagonist biosimilar drugs will be added to the cytokine and CAM antagonist drug class as non-preferred drugs (unless specifically identified or noted) until the next scheduled drug class review by the Wisconsin Medicaid Pharmacy PA Committee. The cytokine and CAM antagonists drug class is typically reviewed at the November PDL review each year.

ForwardHealth will use a blanket "xxxx" placeholder after the biosimilar generic name when referring to non-preferred biosimilar drug products in the

QUICK LINKS

Forms page

clinical PA criteria for the appropriate clinical condition. The Preferred Drug List Quick Reference data table will list the brand names with the complete generic names of the biosimilar drug products in the cytokine and CAM antagonists drug class.

Revised Clinical Criteria for Non-Preferred Cytokine and Cell Adhesion Molecule Antagonist Drugs Used to Treat Ankylosing Spondylitis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis.

Cimzia, Cyltezo, Enbrel, Humira, Simponi subQ, and Xeljanz are preferred drugs used to treat ankylosing spondylitis. Preferred drugs do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, Rinvoq, Taltz, and Xeljanz XR are non-preferred drugs used to treat ankylosing spondylitis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis are **all** of the following:

- The member has ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. (Note: ForwardHealth will only consider use of Cyltezo or Humira as one of the preferred cytokine and CAM antagonist drugs.)
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

Xeljanz XR

The prescriber must submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should not submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form and a completed Prior Authorization Request Form (PA/RF), F-11018 (05/2013), to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis may be submitted on the Portal, by fax, or by mail (but **not** using the Specialized Transmission Approval Technology-Prior Authorization [STAT-PA] system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease.

Cimzia, Cyltezo, and Humira are preferred drugs used to treat Crohn's disease. Preferred drugs do not require PA.

Adalimumab-xxxx, Entyvio subQ, Rinvoq, Skyrizi subQ, Stelara subQ, and Zymfentra are non-preferred drugs used to treat Crohn's disease.

Note: Skyrizi and Stelara will require an IV induction prior to initiating treatment with the subQ. A PA request for the IV induction must be approved before ForwardHealth will consider PA for the subQ. PA for the IV induction may be obtained through the physician-administered drug PA process.

QUICK LINKS

Forms page

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. (Note: ForwardHealth will only consider use of Cyltezo or Humira as one of the preferred cytokine and CAM antagonist drugs.)
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form and a completed PA/RF to ForwardHealth.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Deficiency of Interleukin-1 Receptor Antagonist

Kineret is a non-preferred drug used to treat DIRA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat DIRA are **both** of the following:

- The member has DIRA.
- The prescription is written by or through consultation with a DIRA specialist (for example, an immunologist or a rheumatologist).

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of DIRA and outline the member's current treatment plan for DIRA.

Using Section VI of the Prior Authorization/Drug Attachment Form for Non-Preferred Cytokine and CAM Antagonist Drugs for Deficiency of Interleukin-1 Receptor Antagonist

Effective January 1, 2025, PA requests for non-preferred cytokine and CAM antagonist drugs for DIRA must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the Prior Authorization/Drug Attachment (PA/DGA) form, F-11049 (01/2024). ForwardHealth will return PA requests that are not completed with Section VI of the PA/DGA form.

ForwardHealth will honor PA requests approved for non-preferred cytokine and CAM antagonist drugs for DIRA that used the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for DIRA, Giant Cell Arteritis, NOMID, and nr-axSpA form (dated 01/2022) before January 1, 2025, until they expire or until the approved days' supply is used up.

QUICK LINKS

Prior Authorization/Drug Attachment topic #15937

Note: This topic will be updated on January 2, 2025.

When initially accessing Online Handbook topic links available throughout this Update, providers need to click the "I Accept" button at the bottom of the licensure agreement page of the Online Handbook. After 30 minutes of inactivity, providers will need to click "I Accept" again before going to their intended topic.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Deficiency of Interleukin-1 Receptor Antagonist

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat DIRA must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat DIRA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Giant Cell Arteritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs for giant cell arteritis.

Tyenne subQ is a preferred drug used to treat giant cell arteritis. Preferred drugs do not require PA.

Actemra subQ is a non-preferred drug used to treat giant cell arteritis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat giant cell arteritis are **all** of the following:

- The member has giant cell arteritis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken Tyenne subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Giant Cell Arteritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat giant cell arteritis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and nr-axSpA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and nr-axSpA form (dated 01/2025) and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat giant cell arteritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Hidradenitis Suppurativa

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs for hidradenitis suppurativa.

Cyltezo and Humira are preferred drugs used to treat hidradenitis suppurativa. Preferred drugs do not require PA.

Adalimumab-xxxx, Bimzelx, and Cosentyx subQ are non-preferred drugs used to treat hidradenitis suppurativa.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat hidradenitis suppurativa are **all** of the following:

- The member has hidradenitis suppurativa.
- The prescription is written by a dermatologist or through a dermatology consultation.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Hidradenitis Suppurativa

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat hidradenitis suppurativa must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Hidradenitis Suppurativa form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Hidradenitis Suppurativa form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat hidradenitis suppurativa may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Neonatal Onset Multisystem Inflammatory Disease

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat NOMID.

QUICK LINKS

Forms page

Kineret is a non-preferred drug used to treat NOMID.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat NOMID are **both** of the following:

- The member has NOMID.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of NOMID and outline the member's current treatment plan for NOMID.

Using Section VI of the Prior Authorization/Drug Attachment Form for Non-Preferred Cytokine and CAM Antagonist Drugs for Neonatal Onset Multisystem Inflammatory Disease

Effective January 1, 2025, PA requests for non-preferred cytokine and CAM antagonist drugs for NOMID must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. ForwardHealth will return PA requests that are not completed with Section VI of the PA/DGA form.

ForwardHealth will honor PA requests approved for non-preferred cytokine and CAM antagonist drugs for NOMID before January 1, 2025, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Neonatal Onset Multisystem Inflammatory Disease

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat NOMID must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat NOMID may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Non-Radiographic Axial Spondyloarthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA.

Cimzia is a preferred drug used to treat nr-axSpA. Preferred drugs do not require PA.

Bimzelx, Cosentyx subQ, Rinvoq, and Taltz are non-preferred drugs used to treat nr-axSpA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA are **all** of the following:

- The member has nr-axSpA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken Cimzia **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Non-Radiographic Axial Spondyloarthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and nr-axSpA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and nr-axSpA form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA may be submitted on the Portal, by fax, or by mail **(but** not using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis.

Cimzia, Cyltezo, Enbrel, Humira, and Otezla are preferred drugs used to treat psoriasis. Preferred drugs do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, Siliq, Skyrizi subQ, Sotyktu, Stelara subQ, Taltz, and Tremfya subQ are non-preferred drugs used to treat psoriasis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis are **all** of the following:

- The member has psoriasis.
- The prescription is written by a dermatologist or through a dermatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. (Note: ForwardHealth will only consider use of Cyltezo or Humira as one of the preferred cytokine and CAM antagonist drugs.)
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis.

Cimzia, Cyltezo, Enbrel, Humira, Orencia subQ, Otezla, Simponi subQ, and Xeljanz are preferred drugs used to treat psoriatic arthritis. Preferred drugs do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, Rinvoq, Rinvoq LQ, Skyrizi subQ, Stelara subQ, Taltz, Tremfya subQ, and Xeljanz XR are non-preferred drugs used to treat psoriatic arthritis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis are **all** of the following:

- The member has psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. (Note: ForwardHealth will only consider use of Cyltezo or Humira as one of the preferred cytokine and CAM antagonist drugs.)
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

Xeljanz XR

The prescriber must submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz.

Submitting PA Requests Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and a completed PA/RF to ForwardHealth.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat RA.

Cimzia, Cyltezo, Enbrel, Humira, Orencia subQ, Simponi subQ, Tyenne subQ, and Xeljanz are preferred drugs used to treat RA. Preferred drugs do not require PA.

Actemra subQ, adalimumab-xxxx, Kevzara, Kineret, Olumiant, Rinvoq, and Xeljanz XR are non-preferred drugs used to treat RA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat RA are **all** of the following:

- The member has RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. (Note: ForwardHealth will only consider use of Cyltezo or Humira as one of the preferred cytokine and CAM antagonist drugs.)
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

Xeljanz XR

The prescriber must submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Juvenile Idiopathic Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat JIA.

Cimzia, Cyltezo, Enbrel, Humira, Orencia subQ, Tyenne subQ, and Xeljanz are preferred drugs used to treat JIA. Preferred drugs do not require PA.

Actemra subQ, adalimumab-xxxx, Kevzara, Rinvoq, Rinvoq LQ, and Xeljanz Oral Solution are non-preferred drugs used to treat JIA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat JIA are **all** of the following:

- The member has JIA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. (Note: ForwardHealth will only consider use of Cyltezo or Humira as one of the preferred cytokine and CAM antagonist drugs.)
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

Xeljanz Oral Solution

The prescriber must submit detailed clinical justification for prescribing Xeljanz Oral Solution instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz Oral Solution instead of Xeljanz.

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Systemic Juvenile Idiopathic Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat systemic JIA.

Tyenne subQ is a preferred drug used to treat systemic JIA. Preferred drugs do not require PA.

Actemra subQ is a non-preferred drug used to treat systemic JIA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat systemic JIA are **all** of the following:

- The member has systemic JIA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken Tyenne subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Juvenile Idiopathic Arthritis and Systemic Juvenile Idiopathic Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat JIA and systemic JIA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat JIA and systemic JIA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis.

Cyltezo, Humira, Simponi subQ, and Xeljanz are preferred drugs used to treat ulcerative colitis. Preferred drugs do not require PA.

Adalimumab-xxxx, Entyvio subQ, Omvoh subQ, Rinvoq, Skyrizi subQ, Stelara subQ, Tremfya subQ, Xeljanz XR, and Zymfentra are non-preferred drugs used to treat ulcerative colitis.

Note: Omvoh, Skyrizi, and Stelara will require an IV induction prior to initiating treatment with the subQ. A PA request for the IV induction must be approved before ForwardHealth will consider PA for the subQ. PA for the IV induction may be obtained through the physician-administered drug PA process.

QUICK LINKS

Forms page

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. (Note: ForwardHealth will only consider use of Cyltezo or Humira as one of the preferred cytokine and CAM antagonist drugs.)
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

Xeljanz XR

The prescriber must submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Uveitis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat uveitis.

Cyltezo and Humira are preferred drugs used to treat uveitis. Preferred drugs do not require PA.

Adalimumab-xxxx is a non-preferred drug used to treat uveitis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat uveitis are **all** of the following:

- The member has uveitis.
- The prescription is written by an ophthalmologist or through an ophthalmology consultation.
- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. The clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Uveitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat uveitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Uveitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Uveitis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat uveitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

QUICK LINKS

Forms page

Omvoh IV for Ulcerative Colitis

Omvoh IV is a physician-administered drug that will require clinical PA.

All PA requests for Omvoh IV must be submitted with a Healthcare Common Procedure Coding System code J2267 (Injection, mirikizumab-mrkz, 1 mg).

Note: Modifier JA (Administered intravenously) may be needed for billing.

Conditions for Which PA Requests for Use of Omvoh IV Will Be Considered for Review

ForwardHealth will only consider PA requests for Omvoh IV to treat ulcerative colitis.

New Clinical Criteria for Omvoh IV for Ulcerative Colitis

ForwardHealth has established the clinical PA criteria for Omvoh IV for ulcerative colitis.

Clinical criteria that must be documented for approval of a PA request for Omvoh IV for members with ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.

QUICK LINKS

Prior Authorization/Physician-Administered Drug Attachment topic #22580

Note: This topic will be updated on January 2, 2025.

- The member has been diagnosed by a gastroenterologist.
- The member has taken Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member has taken Xeljanz for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Omvoh IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Omvoh IV. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Omvoh IV are met, PA requests will only be approved for the three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Omvoh subQ. PA for Omvoh subQ must be obtained through the pharmacy PA process.

Submitting PA Requests for Omvoh IV for Members With Ulcerative Colitis

PA requests for Omvoh IV must be completed, signed, and dated by the prescriber. PA requests for Omvoh IV must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) on the Prior Authorization/Physician-Administered Drug Attachment (PA/PAD) form, F-11034 (07/2022). Clinical documentation supporting the use of Omvoh IV must be submitted with the PA request.

Prescribers are required to submit the completed PA/PAD form and a completed PA/RF to ForwardHealth. PA requests for Omvoh IV may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Changes to Epinephrine Self-Injected Drug Class

Neffy became a non-preferred drug in the epinephrine self-injected drug class December 1, 2024. Neffy will have an interim status of non-preferred and will be reviewed at the November 2025 PDL review.

QUICK LINKS

Forms page

PA requests for Neffy must be submitted with the PA/PDL Exemption Request form.

Effective January 1, 2025, the epinephrine self-injected drug class on the PDL will be renamed epinephrine self-administered.

Changes to H2 Antagonists Drug Class

Famotidine suspension will become a preferred drug in the H2 antagonists drug class. Preferred drugs do not require PA.

Changes to Immunomodulators, Asthma Drug Class

Nucala and Tezspire require clinical PA.

Conditions for Which PA Requests for Use of Nucala Will Be Considered for Review

PA requests for Nucala will only be approved for use to treat the following identified clinical conditions:

- Asthma with an eosinophilic phenotype
- Chronic rhinosinusitis with nasal polyposis (CRSwNP)
- Eosinophilic granulomatosis with polyangiitis (EGPA)
- Hypereosinophilic syndrome (HES)

Note: If a member has more than one clinical condition for which ForwardHealth will approve a non-preferred immunomodulators, asthma drug and the provider would like to bypass the required trial of a ForwardHealth preferred biologic drug, the provider must submit complete medical records for the clinical conditions. Additionally, the provider must clearly identify on the PA/DGA form that the member has more than one clinical condition for which the non-preferred drug is approved, and they must provide justification for bypassing the required ForwardHealth-preferred biologic drug. ForwardHealth will use the member's complete clinical picture to evaluate the PA request.

Revised Clinical Criteria for Nucala for Members With Eosinophilic Granulomatosis With Polyangiitis

ForwardHealth has revised the clinical criteria for Nucala for members with EGPA.

QUICK LINKS

- H2 Antagonists topic #15517
- Immunomodulators, Asthma topic #22357

Note: Topic #15517 will be removed from the Online Handbook on January 2, 2025. Topic #22357 will be updated on January 2, 2025.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Clinical criteria that must be documented for approval of a PA request for Nucala for members with EGPA are **all** of the following:

- The member's age must be consistent with Food and Drug Administration (FDA)-approved product labeling for Nucala.
- The member has EGPA.
- The prescription is written by or through consultation with an EGPA specialist.
- The member has taken Fasenra for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The member will not use Nucala in combination with any biologic immunomodulator.

Supporting clinical information and a copy of the member's current medical records must be submitted with the PA request to support the member's condition of EGPA and outline the member's current treatment plan for EGPA.

If the clinical criteria for Nucala are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Nucala may be approved for up to 365 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Other Clinical Criteria for Nucala and Tezspire

The clinical criteria have not changed for Nucala for members with:

- Asthma with an eosinophilic phenotype.
- CRSwNP.
- HES.

The clinical criteria for Tezspire also have not changed.

Submitting PA Requests for Nucala and Tezspire

PA requests for Nucala or Tezspire must be completed, signed, and dated by the prescriber. PA requests for Nucala or Tezspire must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of Nucala or Tezspire must be submitted with the PA request.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Nucala or Tezspire may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Changes to Immunomodulators, Atopic Dermatitis Drug Class

Ebglyss and Nemluvio will become non-preferred drugs in the immunomodulators, atopic dermatitis drug class. Ebglyss and Nemluvio will have an interim status of non-preferred and will be reviewed at the November 2025 PDL review.

Clinical PA is required for non-preferred immunomodulators, atopic dermatitis drugs.

PA requests for non-preferred immunomodulators, atopic dermatitis drugs will only be approved for use to treat the following identified clinical conditions:

- Atopic dermatitis
- Chronic obstructive pulmonary disease (COPD)
- CRSwNP
- Eosinophilic esophagitis (EoE)
- Eosinophilic asthma
- Oral corticosteroid dependent asthma
- Prurigo nodularis

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for non-preferred immunomodulators, atopic dermatitis drugs. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

QUICK LINKS

Immunomodulators, Atopic Dermatitis topic #8857

Note: This topic will be updated on January 2, 2025.

Note: If a member has more than one clinical condition for which ForwardHealth will approve a non-preferred immunomodulators, atopic dermatitis drug and the provider would like to bypass the required trial of a ForwardHealth preferred biologic drug, the provider must submit complete medical records for the clinical conditions. Additionally, the provider must clearly identify on the PA/DGA form that the member has more than one clinical condition for which the non-preferred drug is approved, and they must provide justification for bypassing the required ForwardHealth-preferred biologic drug. ForwardHealth will use the member's complete clinical picture to evaluate the PA request.

New Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Chronic Obstructive Pulmonary Disease

ForwardHealth has established the clinical PA criteria for non-preferred immunomodulators, atopic dermatitis drugs used to treat COPD.

Dupixent is a non-preferred drug used to treat COPD.

Clinical criteria that must be documented for the approval of non-preferred immunomodulators, atopic dermatitis drugs used to treat COPD are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has COPD with an eosinophilic phenotype. A baseline blood eosinophil count of greater than 300 cells/mcL within the previous three months must be documented.
- The prescription is written by or through consultation with an asthma specialist (for example, an allergist, an immunologist, or a pulmonologist).
- The member has a history of two or more COPD exacerbations that required treatment with systemic corticosteroids and/or antibiotics, or an emergency department visit or hospitalization for the treatment of asthma in the past year. Documentation should include the approximate dates and what interventions took place for each exacerbation.
- The member's baseline forced expiratory volume in one second (FEV1) is 30–70% predicted. A baseline FEV1 percent predicted from the previous three months must be documented.
- The member has been adherent to and maintained on a maximized COPD treatment regimen, including triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled

corticosteroid (ICS) for **at least three** months prior to requesting Dupixent. Documentation should include the LAMA, LABA, and ICS names, doses, and start dates.
- Exacerbating factors that may contribute to the member's COPD, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.
- The member will not use the requested drug in combination with any biologic immunomodulator.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have COPD must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a decrease in the number of COPD exacerbations or an increase in FEV1 percent predicted. Members must also continue to take their maximized asthma treatment regimen, including a LAMA, LABA, and ICS.

All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Revised Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Atopic Dermatitis

ForwardHealth has revised the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs used to treat atopic dermatitis.

Adbry is a preferred drug used to treat atopic dermatitis. Preferred drugs do not require PA.

Cibinqo, Dupixent, Ebglyss, and Rinvoq are non-preferred drugs used to treat atopic dermatitis.

Clinical criteria that must be documented for approval of a PA request for a non-preferred drug used to treat atopic dermatitis are **all** of the following:
- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has moderate to severe atopic dermatitis. Documentation must include the approximate body surface area involved and the area(s) affected.

- The prescription is written by or through consultation with a dermatologist, an allergist, or an immunologist.
- Exacerbating factors that may contribute to the member's atopic dermatitis, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar dermatologic conditions, have been ruled out.
- The member will not use the requested drug in combination with any biologic immunomodulator.
- **At least one** of the following is true:
  - The member has a recent history (within a year of the clinical visit when the requested drug was first prescribed) of use of at least a medium-potency topical corticosteroid for **at least two** months and experienced an unsatisfactory therapeutic response.
  - The member has used at least a medium-potency corticosteroid and experienced a clinically significant adverse drug reaction.
- **At least one** of the following is true:
  - The member is 6 months–11 years old (Dupixent PA requests only).
  - The member is 12 years of age or older and has taken Adbry for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have atopic dermatitis must include supporting clinical information and copies of the member's current medical records demonstrating that the member has had a significant reduction in the area(s) affected and/or the severity of atopic dermatitis.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Chronic Rhinosinusitis With Nasal Polyposis

ForwardHealth has revised the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs used to treat CRSwNP.

Dupixent is a non-preferred drug used to treat CRSwNP.

Clinical criteria that must be documented for approval of a non-preferred drug used to treat CRSwNP are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has CRSwNP.
- The prescription is written by or through consultation with an allergist or an ear, nose, and throat specialist.
- The member has been adherent to and maintained on a maximized CRSwNP treatment regimen, including an intranasal corticosteroid (INCS) for **at least three** months prior to requesting Dupixent. Documentation should include the CRSwNP drug treatment names, doses, and start dates.
- **At least one** of the following is true:
  - The member is 12–17 years old.
  - The member is 18 years of age or older and has taken Xolair for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member is 18 years of age or older and has a serum immunoglobulin E (IgE) level less than 30 IU/mL. A current serum IgE level completed within the past 90 days must be submitted.
- The member will not use the requested drug in combination with any biologic immunomodulator.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have CRSwNP must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant reduction in CRSwNP symptoms. Members must also continue to take their maximized CRSwNP treatment regimen, including the INCS.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Revised Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Eosinophilic Asthma

ForwardHealth has revised the clinical criteria for immunomodulators, atopic dermatitis drugs used to treat eosinophilic asthma.

Dupixent is a non-preferred drug used to treat eosinophilic asthma.

Clinical criteria that must be documented for approval of a non-preferred drug used to treat eosinophilic asthma are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has eosinophilic asthma. A baseline blood eosinophil count of greater than 150 cells/mcL within the previous three months must be documented.
- The prescription is written by or through consultation with an asthma specialist (for example, an allergist, an immunologist, or a pulmonologist).
- **At least one** of the following is true:
    - The member has a history of two or more asthma exacerbations that required treatment with systemic corticosteroids or an emergency department visit or hospitalization for the treatment of asthma in the past year. Documentation should include the approximate dates and what interventions took place for each exacerbation.
    - The member's baseline FEV1 is less than 80% predicted. A baseline FEV1 percent predicted from the previous three months must be documented.
- The member has been adherent to and maintained on a maximized asthma treatment regimen, including a high-dose ICS in combination with a LABA for **at least three** months prior to requesting Dupixent. Documentation should include the ICS and LABA names, doses, and start dates.
- The member has taken Fasenra for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- Exacerbating factors that may contribute to the member's asthma, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.
- The member will not use the requested drug in combination with any biologic immunomodulator.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have eosinophilic asthma must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a decrease in the number of asthma exacerbations or an increase in FEV1 percent predicted. Members must also continue to take their maximized asthma treatment regimen, including an ICS and a LABA.

All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Revised Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Eosinophilic Esophagitis

ForwardHealth has revised the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs used to treat EoE.

Dupixent is a non-preferred drug used to treat EoE.

Clinical criteria that must be documented for approval of a non-preferred drug used to treat EoE are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has EoE. A baseline intraepithelial eosinophils per high-powered field of greater than or equal to 15 must be documented.
- The prescription is written by or through consultation with an allergist or a gastroenterologist.
- Exacerbating factors that may contribute to the member's EoE, such as member non-compliance with therapy, environmental allergies, food allergies, acid reflux, and other allergic/immune conditions of the esophagus, have been ruled out.
- **At least one** of the following is true:
    - The member has a recent history (within a year of the clinical visit when the requested drug was first prescribed) of proton pump inhibitor (PPI) use for **at least two** months and experienced an unsatisfactory therapeutic response.
    - The member has used a PPI and experienced a clinically significant adverse drug reaction.

- The member will not use the requested drug in combination with any biologic immunomodulator.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have EoE must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant reduction in eosinophils per high-powered field or EoE symptoms (abdominal pain, chest pain, dysphagia, difficulty feeding, impaction, regurgitation, vomiting).

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Oral Corticosteroid Dependent Asthma

ForwardHealth has revised the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs used to treat oral corticosteroid dependent asthma.

Dupixent is a non-preferred drug used to treat oral corticosteroid dependent asthma.

Clinical criteria that must be documented for approval of a non-preferred drug used to treat oral corticosteroid dependent asthma are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has oral corticosteroid dependent asthma.
- The prescription is written by or through consultation with an asthma specialist (for example, an allergist, an immunologist, or a pulmonologist).
- The member has been adherent and maintained on a maximized asthma treatment regimen, including a high-dose ICS in combination with a LABA for **at least three** months prior to requesting Dupixent. Documentation should include the ICS and LABA names, doses, and start dates.
- The member has required daily oral corticosteroid treatment for **at least three** months prior to requesting Dupixent. Documentation should include the oral corticosteroid name, daily dose, and start date.

- Exacerbating factors that may contribute to the member's asthma, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.
- The member will not use the requested drug in combination with any biologic immunomodulator.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have oral corticosteroid dependent asthma must include supporting clinical information and copies of the member's current medical records demonstrating that the member's daily oral corticosteroid dose has decreased while maintaining asthma control. Members must also continue to take their maximized asthma treatment regimen, including an ICS and a LABA.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Prurigo Nodularis

ForwardHealth has revised the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs used to treat prurigo nodularis.

Dupixent and Nemluvio are non-preferred drugs used to treat prurigo nodularis.

Clinical criteria that must be documented for approval of a non-preferred drug used to treat prurigo nodularis are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has moderate to severe prurigo nodularis.
- The prescription is written by or through consultation with a dermatologist.
- Exacerbating factors that may contribute to the member's prurigo nodularis, such as member non-compliance with therapy and other similar dermatologic conditions, have been ruled out.
- **At least one** of the following is true:
    - The member has a recent history (within a year of the clinical visit when the requested drug was first prescribed) of a topical treatment(s)

to reduce itching and inflammation for **at least two** months and experienced an unsatisfactory therapeutic response.
    - The member has used a topical treatment(s) to reduce itching and inflammation and experienced a clinically significant adverse drug reaction.
- The member will not use the requested drug in combination with any biologic immunomodulator.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have prurigo nodularis must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant reduction in prurigo nodularis symptoms.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Using Section VI of the Prior Authorization/Drug Attachment Form for Ebglyss and Nemluvio

Effective January 1, 2025, PA requests for Ebglyss for members with atopic dermatitis and Nemluvio for members with prurigo nodularis must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. ForwardHealth will return PA requests that are not completed with Section VI of the PA/DGA form.

ForwardHealth will honor PA requests approved for Ebglyss and Nemluvio that used Section VII (Clinical Information for Other Drug Requests) of the PA/DGA form before January 1, 2025, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Non-Preferred Immunomodulators, Atopic Dermatitis Drugs

PA requests for non-preferred immunomodulators, atopic dermatitis drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred immunomodulators, atopic dermatitis drugs must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical

QUICK LINKS

Forms page

documentation supporting the use of the requested drug must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

PA requests will not be considered for subcutaneous dosage forms of immunomodulators, atopic dermatitis drugs that will be administered in a medical office or medical facility.

Changes to Immunomodulators, Atopic Dermatitis—Topical Drug Class

Eucrisa will become a preferred drug in the immunomodulators, atopic dermatitis—topical drug class. Preferred drugs do not require PA.

Revised Clinical Criteria for Non-Preferred Immunomodulators, Atopic Dermatitis—Topical Drugs

ForwardHealth has revised the clinical criteria for non-preferred immunomodulators, atopic dermatitis—topical drugs.

Clinical criteria that must be documented for approval of a PA request for non-preferred immunomodulators, atopic dermatitis—topical drugs are **all** of the following:

- The member has atopic dermatitis.
- At least **one** of the following is true:
  - The member used Eucrisa for **at least two** consecutive months and experienced an unsatisfactory therapeutic response.
  - The member used Eucrisa and experienced a clinically significant adverse drug reaction.

QUICK LINKS

Immunomodulators, Atopic Dermatitis—Topical Drugs #23497

Note: This topic will be updated on January 2, 2025.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- At least **one** of the following is true:
  - The member used a topical calcineurin inhibitor for **at least two** consecutive months and experienced an unsatisfactory therapeutic response.
  - The member used a topical calcineurin inhibitor and experienced a clinically significant adverse drug reaction.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis—topical drugs are met, initial PA requests may be approved for up to 365 days.

Revised Prior Authorization/Preferred Drug List for Immunomodulators, Atopic Dermatitis—Topical Form

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Immunomodulators, Atopic Dermatitis—Topical form, F-02572 (01/2025).

Effective January 1, 2025, pharmacy providers must use the revised PA/PDL for Immunomodulators, Atopic Dermatitis—Topical form to submit PA requests for non-preferred immunomodulators, atopic dermatitis—topical drugs.

ForwardHealth will return PA requests that are not submitted with the revised form.

ForwardHealth will honor PA requests for non-preferred immunomodulators, atopic dermatitis—topical drugs approved before January 1, 2025, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Non-Preferred Immunomodulators, Atopic Dermatitis—Topical Drugs

PA requests for non-preferred immunomodulators, atopic dermatitis—topical drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred immunomodulators, atopic dermatitis—topical drugs must be submitted using the PA/PDL for Immunomodulators Atopic Dermatitis—Topical form. Clinical documentation supporting the use of non-preferred immunomodulators, atopic dermatitis—topical drugs must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The

QUICK LINKS

Forms page

pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/PDL for Immunomodulators, Atopic Dermatitis—Topical form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred immunomodulators, atopic dermatitis—topical drugs may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

Changes to Intranasal Rhinitis Agents Drug Class

The over-the-counter mometasone furoate spray will be added to the PDL and become a preferred drug in the intranasal rhinitis agents drug class. Preferred drugs do not require PA. Mometasone furoate spray (legend) will remain non-preferred. Non-preferred drugs require PA.

Changes to Stimulants Drug Class

Effective January 1, 2025, the generic copay for Adderall XR will no longer apply.

Refer to Attachment C for the revised table of legacy stimulant drugs.

Mydayis ER will become a brand medically necessary (BMN) drug effective January 1, 2025, and will be subject to BMN policy. Mydayis ER will require both BMN PA and the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Preferred Stimulants form, F-01672 (01/2017).

Other Pharmacy Policy Changes

Duvyzat

Duvyzat will require clinical PA.

New Clinical Criteria for Duvyzat

ForwardHealth has established the clinical PA criteria for Duvyzat.

Clinical criteria for approval of a PA request for Duvyzat are **all** of the following:

- The member has a diagnosis of Duchenne muscular dystrophy.
- The member is able to ambulate.

QUICK LINKS

- Brand Medically Necessary Drugs: A Pharmacy Provider's Responsibilities topic #2017
- Brand Medically Necessary Drugs: A Prescriber's Responsibilities topic #2016
- Intranasal Rhinitis Agents topic #10660
- Stimulants topic #16357
- Forms page

Note: Topic #10660 will be removed from the Online Handbook on January 2, 2025. Topic #16357 will be updated on January 2, 2025.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- The member's age must be consistent with FDA-approved product labeling for Duvyzat.
- The prescription is written by or through consultation with a neurologist.
- The provider will obtain and evaluate the member's platelet count and triglyceride levels prior to and during treatment with Duvyzat.
- The member's baseline four-stair climb results are documented.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Duvyzat. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Duvyzat are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Duvyzat may be approved for up to 365 days. Renewal PA requests must include supporting clinical information and copies of the member's current medical records.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Duvyzat

PA requests for Duvyzat must be completed, signed, and dated by the prescriber. PA requests for Duvyzat must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Duvyzat may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Rezdiffra

Rezdiffra requires clinical PA.

Revised Clinical Criteria for Rezdiffra

ForwardHealth has revised the clinical criteria for Rezdiffra.

Clinical criteria that must be documented for approval of a PA request for Rezdiffra are **all** of the following:

- Rezdiffra must be prescribed in a dose and manner consistent with FDA-approved product labeling.
- The member has been diagnosed with noncirrhotic nonalcoholic steatohepatitis with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) by a biopsy or noninvasive tests (such as FibroScan or magnetic resonance enterography [MRE] + MRI-proton density fat fraction [PDFF]).
- The member will use the medication in conjunction with diet and exercise.
- The prescriber has documented that the member has not had significant alcohol consumption within the past year.
- The prescription is written by a liver specialist physician such as a gastroenterologist or hepatologist.
- The member does not have decompensated cirrhosis.
- The prescriber will monitor for elevations in liver tests and development of liver-related adverse reactions.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Rezdiffra. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Rezdiffra are met, initial PA requests may be approved for up to 183 days.

Initial Renewal PA Request

Initial renewal PA requests require documentation to support that the member is responding adequately to treatment (as documented in laboratory tests). A copy of the member's current medical records must be included with the PA

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

request. Initial renewal PA requests for Rezdiffra may be approved for up to 183 days.

Subsequent Renewal PA Requests

Subsequent renewal PA requests require documentation to support that the member is responding adequately to treatment (as documented in laboratory tests and a biopsy or noninvasive tests [such as FibroScan or MRE + MRI-PDFF]) and has a resolution of steatohepatitis without worsening of fibrosis or at least one stage improvement in fibrosis without worsening of steatohepatitis. A copy of the member's current medical records must be included with the PA request. Subsequent renewal PA requests for Rezdiffra may be approved for up to 365 days.

Submitting PA Requests for Rezdiffra

For PA requests for Rezdiffra, the prescriber is required to complete, sign, and date the PA/DGA form. PA requests for Rezdiffra must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. The prescriber should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Rezdiffra may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Pharmacy-Provided COVID-19 Vaccines for Children ~~Reminder~~

~~The following information was published in the September 2024 ForwardHealth Update 2024-31, "COVID-19 Unwinding: ForwardHealth Ends COVID-19 Public Health Emergency Policy Changes."~~

Most vaccines provided to members 18 years of age or younger are available through the Vaccines for Children (VFC) Program at no extra charge to the provider.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Note: If a vaccine is available for a member under 18 through the federal VFC Program, **providers must use the vaccine from the VFC supply**.

A federal provision that was in place through December 31, 2024, has been extended to December 31, 2029, which will allow members 18 years of age or younger to continue to receive the COVID-19 vaccine from a pharmacy provider who does not participate in the federal VFC Program. In this event, ForwardHealth can reimburse for both the vaccine product and the vaccine administration.

~~Beginning January 1, 2025, ForwardHealth:~~

- ~~Will no longer reimburse the COVID-19 vaccine product for members 18 years of age or younger because the vaccine is available through the VFC Program.~~
- ~~Will continue to reimburse for COVID-19 vaccine administration.~~

Quantity Limit Changes

Quantity Limit Reduction for Short-Acting Opioids

Effective for DOS on and after March 1, 2025, the quantity limits for short-acting opioids will be reduced from 360 units to 240. Drugs impacted by the quantity-limit reduction are listed on the Quantity Limit Drugs and Diabetic Supplies pharmacy data table on the Pharmacy Resources page of the Portal.

All short-acting opioids will have a cumulative quantity limit of 240 units per month. Members will be limited to 240 units per month. When a claim is submitted with a quantity that exceeds the monthly limit, the claim will be denied.

A transition period will be allowed for this upcoming quantity-limit reduction for short-acting opioids. During this period, pharmacy providers should work with prescribers to consolidate, adjust, or change members' short-acting and long-acting opioid medication(s) and dosage(s) as appropriate. Pharmacy providers and prescribers are encouraged to use the most cost-effective strength and quantity of the medication(s).

Transition Period for One-Time Quantity Limit Override for Short-Acting Opioids

ForwardHealth will allow a one-time quantity limit override request for short-acting opioids during the transition period from March 1, 2025, through March

QUICK LINKS

Quantity Limits topic #3444

Note: This topic will be updated on January 2, 2025.

31, 2025. To request an override of the quantity limit, providers may call the DAPO Center.

Providers should not contact the DAPO Center to request the one-time short-acting opioids drug quantity limit override before March 1, 2025.

Effective April 1, 2025, if a member does not qualify for a short-acting opioid quantity limit override through the DAPO Center and the submitted claim exceeds the allowed quantity limit, the claim will be denied.

Revised Quantity Limits Policy

ForwardHealth has revised the quantity limits policy. Effective January 1, 2025, the revised policy will apply to all applicable drugs with a quantity limit.

Generally, ForwardHealth follows FDA-labeled dose and administration guidelines to establish quantity limits. The quantity limit allowed for a specific drug and drug strength is established to encourage prescribing and dispensing of the most cost-effective strength and quantity of a drug.

The Quantity Limit Drugs and Diabetic Supplies data table contains the most current quantity limits.

When a claim is submitted with a quantity that exceeds the monthly limit, the claim will be denied.

Quantity Limit Overrides

Prior to requesting a quantity limit override, the pharmacy provider should contact the prescriber to determine whether it is medically appropriate for a member to exceed the quantity limit. If it is medically appropriate for a member to exceed a quantity limit, pharmacy providers may request an override by calling the DAPO Center. Pharmacy providers may request a quantity limit override for members enrolled in BadgerCare Plus, Wisconsin Medicaid, and SeniorCare.

Note: The pharmacy provider should have clinical information to support a quantity limit override when calling the DAPO Center.

A one-time quantity limit override may be considered for approval in certain situations, including:

- Lost or stolen medication
- Vacation supply
- A medication and/or dosage change ordered by the prescriber

HOURS OF OPERATION

Hours of operation for the DAPO Center are from 8 a.m. to 5:30 p.m., Monday through Friday. After business hours and on weekends, providers may leave a voicemail message for DAPO Center staff to return the next business day.

In limited instances, other one-time or longer-term overrides may be considered for approval. The pharmacy provider should have clinical information from the prescriber when calling the DAPO Center.

Examples of when other one-time or longer-term overrides may be considered include:

- The prescriber has identified a specific medical need or clinical condition that requires a larger quantity of the medication.
- The prescriber is reducing, consolidating, or tapering the dose over an extended period.

Drugs Dispensed up to a 96-Hour Supply

Pharmacy providers may dispense up to a 96-hour supply of a drug to a member when the DAPO Center is closed and a policy override to exceed a quantity limit must be obtained.

If the claim for a 96-hour supply is submitted on paper, the pharmacy provider must complete and submit the Pharmacy Special Handling Request form, F-13074 (04/2014).

If the DAPO Center grants the override request to exceed a quantity limit, the override will be retroactive. The pharmacy provider may submit a claim for the drug using the real-time Point-of-Sale system or on paper. A paper claim must be submitted with the Pharmacy Special Handling Request form.

If the DAPO Center denies the override request, the quantity exceeding the drug's established quantity limit will not be covered. ForwardHealth will only reimburse the provider for the 96-hour supply. Members do not have appeal rights for noncovered drugs or services.

Changes for Certain Select High Cost, Orphan, and Accelerated Approval Drugs

Effective January 1, 2025, the established clinical PA criteria for Casgevy and Lyfgenia will move to new topics in the Online Handbook.

Casgevy and Lyfgenia will remain on the Select High Cost, Orphan, and Accelerated Approval Drugs data table on the Pharmacy Resources page of the Portal.

For specific questions about the billing or coverage of high cost, orphan, and accelerated approval drugs, providers may contact Provider Services at 800-947-9627 or email dhsorphandrugs@dhs.wisconsin.gov.

Casgevy

Clinical PA is required for Casgevy.

If a PA request for Casgevy is approved, Casgevy will be covered under the pharmacy benefit. To bill ForwardHealth for Casgevy, pharmacy providers should submit a pharmacy noncompound drug claim.

Additional Requirements for Casgevy

Casgevy will be reimbursed separately from physician and clinical services associated with the administration of Casgevy. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered Casgevy is delivered directly to the prescriber or an agent of the prescriber.

Pharmacy providers may only submit a claim to ForwardHealth for Casgevy that has been administered to a member. If Casgevy has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Casgevy that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Conditions for Which PA Requests for Casgevy Will Be Considered for Review

ForwardHealth will only consider PA requests for Casgevy for the following clinical conditions:

- β-thalassemia
- Sickle cell disease (SCD)

Clinical Criteria for Casgevy for β-Thalassemia

The clinical criteria that must be documented for approval of a PA request for Casgevy for β-thalassemia are **all** of the following:

- Casgevy must be prescribed and administered by a physician and treatment center with expertise in treating β-thalassemia with Casgevy.
- Casgevy must be prescribed at a minimum recommended dose of 3.0×10^6 CD34+ cells/kg of body weight.
- The member has β-thalassemia, which requires regular red blood cell (RBC) transfusions. The member has a history of transfusions for the past two

years of at least 100 mL/kg/year of packed RBCs or with eight or more transfusions of packed RBCs per year.

- The member's age is consistent with the FDA-approved product labeling for Casgevy.
- The member will undergo hematopoietic stem cell (HSC) mobilization, apheresis, and myeloablative conditioning. The prescriber must confirm the member has been evaluated for renal and hepatic impairment and that HSC transplantation is appropriate for the member.
- The member must have full myeloablative conditioning administered before infusion of Casgevy. Full myeloablative conditioning must be administered between 48 hours and seven days before infusion of Casgevy.
- The prescriber will provide documentation of completed negative screening for infectious diseases including hepatitis B virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV) 1 and 2 (HIV-1/HIV-2), and Human T-lymphotropic virus (HTLV) 1 and 2 (HTLV-1/HTLV-2), in accordance with clinical guidelines before collection of cells for manufacturing.
- Standard procedures for patient management after HSC transplantation should be followed after Casgevy infusion.
- The prescriber must manage other concomitant medications (as applicable) consistent with FDA product labeling.
- The member must not take disease-modifying therapies (for example, crizanlizumab, hydroxyurea, L-glutamine, voxelotor) for at least eight weeks prior to mobilization.
- The member must not take iron chelation therapy at least seven days prior to myeloablative conditioning. The member must not take non-myelosuppressive iron chelators for at least three months and myelosuppressive iron chelators for at least six months after Casgevy infusion.

Clinical Criteria for Casgevy for Sickle Cell Disease

The clinical criteria that must be documented for approval of a PA request for Casgevy for SCD are **all** of the following:

- Casgevy must be prescribed and administered by a physician and treatment center with expertise in treating SCD with Casgevy.
- Casgevy must be prescribed at a minimum recommended dose of 3×10^6 CD34+ cells/kg of body weight.

NEVER MISS A MESSAGE

Stay current on policies and procedures by signing up for Portal text messages or email alerts! These alerts let providers know when there is a new secure Portal message. Go to the **Message Center** on the secure Portal and click **Notification Preferences**. Section 12.4 of the ForwardHealth Provider Portal Account User Guide has detailed instructions.

- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response with hydroxyurea.
  - The member has experienced a clinically significant adverse drug reaction with hydroxyurea.
  - There is a clinically significant drug interaction between another drug(s) the member is taking and hydroxyurea.
  - The member has a medical condition(s) that prevents the use of hydroxyurea.
- The member has SCD with a history of severe vaso-occlusive events (VOEs). The member must have had at least four severe VOEs within the previous two years. The severe VOEs must include one or more of the following:
  - The member has experienced an acute pain event requiring a visit to a medical facility and administration of pain medications (opioids or IV non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions.
  - The member has experienced an acute chest syndrome.
  - The member has experienced a priapism lasting more than two hours and requiring a visit to a medical facility.
  - The member has experienced a splenic sequestration.
- The member's age must be consistent with the FDA-approved product labeling for Casgevy.
- The member will undergo HSC mobilization, apheresis, and myeloablative conditioning. The prescriber must confirm the member has been evaluated for renal and hepatic impairment and that HSC transplantation is appropriate for the member.
- The member must have full myeloablative conditioning administered before infusion of Casgevy. Full myeloablative conditioning must be administered between 48 hours and seven days before infusion of Casgevy.
- The prescriber will provide documentation of completed negative screening for infectious diseases including HBV, HCV, HIV 1 and 2 (HIV-1/HIV-2), and HTLV 1 and 2 (HTLV-1/HTLV-2) in accordance with clinical guidelines before collection of cells for manufacturing.
- Standard procedures for patient management after HSC transplantation should be followed after Casgevy infusion.
- The prescriber must manage other concomitant medications (as applicable) consistent with FDA product labeling.

- Granulocyte-Colony Stimulating Factor (G-CSF) must not be used prior to or with mobilization and conditioning.
- The member must not take disease-modifying therapies for SCD (for example, crizanlizumab, hydroxyurea, L-glutamine, voxelotor) for at least eight weeks prior to mobilization.
- The member must not take iron chelation therapy at least seven days prior to myeloablative conditioning. The member must not take non-myelosuppressive iron chelators for at least three months and myelosuppressive iron chelators for at least six months after Casgevy infusion.

Conditions Not Approved for PA Requests for Casgevy

PA requests for Casgevy for β-thalassemia or SCD **will not** be approved if the member has any of the following conditions:

- Advanced liver disease (for example, alanine transaminases greater than three times the upper limit of normal, direct bilirubin value greater than 2.5 times the upper limit of normal, baseline prothrombin time [INR] greater than 1.5 times the upper limit of normal, cirrhosis, bridging fibrosis, or active hepatitis)
- A history of untreated Moyamoya disease or the presence of Moyamoya disease that, in the opinion of the prescriber, puts the member at risk of bleeding
- Prior or current malignancy, myeloproliferative disorder, or significant immunodeficiency disorder
- Prior allogenic or autologous HSC transplant

Using Section VI of the Prior Authorization/Drug Attachment Form for Casgevy

Effective January 1, 2025, PA requests for Casgevy must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. ForwardHealth will return PA requests that are not completed with Section VI of the PA/DGA form.

ForwardHealth will honor PA requests approved for Casgevy that used Section VII (Clinical Information for Other Drug Requests) of the PA/DGA form before January 1, 2025, until they expire or until the approved days' supply is used up.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Submitting PA Requests for Casgevy

PA requests for Casgevy must be completed, signed, and dated by the prescriber. PA requests for Casgevy must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of Casgevy must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Casgevy may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Lyfgenia

Clinical PA is required for Lyfgenia. If a PA request for Lyfgenia is approved, Lyfgenia will be covered under the pharmacy benefit. To bill ForwardHealth for Lyfgenia, pharmacy providers should submit a pharmacy noncompound drug claim.

Additional Requirements for Lyfgenia

Lyfgenia will be reimbursed separately from physician and clinical services associated with the administration of Lyfgenia. The pharmacy provider is required to establish a delivery process with the prescriber to ensure that the physician-administered Lyfgenia is delivered directly to the prescriber or an agent of the prescriber.

Pharmacy providers may only submit a claim to ForwardHealth for Lyfgenia that has been administered to a member. If Lyfgenia has been dispensed for a member but the dose is not administered to the member, the prescriber is responsible for notifying the dispensing pharmacy. If ForwardHealth has paid the dispensing pharmacy for any portion of the dispensing of Lyfgenia that is not administered to the member, the dispensing pharmacy is responsible for reversing any claims submitted to ForwardHealth.

Clinical Criteria for Lyfgenia

Clinical criteria that must be documented for approval of a PA request for Lyfgenia are **all** of the following:

- Lyfgenia must be prescribed at a minimum recommended dose of 3×10^6 CD34+ cells/kg of body weight.
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response with hydroxyurea.
  - The member has experienced a clinically significant adverse drug reaction with hydroxyurea.
  - There is a clinically significant drug interaction between another drug(s) the member is taking and hydroxyurea.
  - The member has a medical condition(s) that prevents the use of hydroxyurea.
- The member has SCD with a history of severe VOEs. The member must have had at least four severe VOEs within the previous two years. The severe VOEs must include one or more of the following:
  - The member has experienced an acute pain event requiring a visit to a medical facility and administration of pain medications (opioids or IV NSAIDs) or RBC transfusions.
  - The member has experienced an acute chest syndrome.
  - The member has experienced a priapism lasting more than two hours and requiring a visit to a medical facility.
  - The member has experienced a splenic sequestration.
- The member's age must be consistent with the FDA-approved product labeling for Lyfgenia.
- The member will undergo HSC mobilization, apheresis, and myeloablative conditioning. The prescriber must confirm the member has been evaluated for renal and hepatic impairment and that HSC transplantation is appropriate for the member.
- The member must have full myeloablative conditioning administered before infusion of Lyfgenia. Full myeloablative conditioning must be administered a minimum of 48 hours before infusion of Lyfgenia.
- The prescriber will provide documentation of completed negative screening for infectious diseases including HBV, HCV, HIV 1 and 2 (HIV-1/HIV-2) and HTLV 1 and 2 (HTLV-1/HTLV-2) in accordance with clinical guidelines before collection of cells for manufacturing.

- Standard procedures for patient management after HSC transplantation should be followed after Lyfgenia infusion.
- The prescriber must manage other concomitant medications (as applicable) consistent with FDA product labeling.
- G-CSF must not be used prior to or with mobilization and conditioning. G-CSF is not recommended for at least 21 days after Lyfgenia infusion.
- The member must not take prophylactic HIV anti-retroviral medications for at least one month prior to mobilization and until all cycles of apheresis are completed. Adjust time appropriately for long-acting anti-retroviral medications.
- The member must not take hydroxyurea at least two months prior to mobilization and two days prior to conditioning and will not resume until all cycles of apheresis are completed.
- The member must not take disease-modifying therapies for SCD (for example, crizanlizumab, L-glutamine, voxelotor) for at least two months prior to mobilization.
- The member must not take erythropoietin for at least two months prior to mobilization.
- The member must not take iron chelation therapy at least seven days prior to mobilization and conditioning. If the member takes iron chelation after apheresis, the member must discontinue iron chelation at least seven days prior to myeloablative conditioning. Myelosuppressive iron chelators are not recommended for six months after Lyfgenia infusion.

PA requests for Lyfgenia **will not** be approved if the member has any of the following conditions:

- Advanced liver disease (for example, alanine transaminases greater than three times the upper limit of normal, direct bilirubin value greater than 2.5 times the upper limit of normal, baseline prothrombin time [INR] greater than 1.5 times the upper limit of normal, cirrhosis, bridging fibrosis, or active hepatitis)
- A history of untreated Moyamoya disease or the presence of Moyamoya disease that, in the opinion of the prescriber, puts the member at risk of bleeding
- Prior or current malignancy, myeloproliferative disorder, or significant immunodeficiency disorder
- Prior allogenic or autologous HSC transplant
- More than two alpha-globin gene deletions

IN THE KNOW

Stay current by signing up for ForwardHealth's email subscription service. Select from a list of service areas to receive policy, training, and benefit information specific to those areas.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Using Section VI of the Prior Authorization/Drug Attachment Form for Lyfgenia

Effective January 1, 2025, PA requests for Lyfgenia must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. ForwardHealth will return PA requests that are not completed with Section VI of the PA/DGA form.

ForwardHealth will honor PA requests approved for Lyfgenia that used Section VII (Clinical Information for Other Drug Requests) of the PA/DGA form before January 1, 2025, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Lyfgenia

PA requests for Lyfgenia must be completed, signed, and dated by the prescriber. PA requests for Lyfgenia must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of Lyfgenia must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Lyfgenia may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Hemgenix, Roctavian, and Zynteglo

ForwardHealth has revised the clinical criteria for Hemgenix, Roctavian, and Zynteglo to include certain clinical conditions where PA requests will not be approved.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

PA requests for Hemgenix **will not** be approved if the member has any of the following conditions:

- Prior or current malignancy or myeloproliferative disorder or significant immunodeficiency disorder
- Prior allogenic or autologous HSC transplant

PA requests for Roctavian **will not** be approved if the member has any of the following conditions:

- Prior or current malignancy or myeloproliferative disorder or significant immunodeficiency disorder
- Prior allogenic or autologous HSC transplant

PA requests for Zynteglo **will not** be approved if the member has any of the following conditions:

- Advanced liver disease (for example, alanine transaminases greater than three times the upper limit of normal, direct bilirubin value greater than 2.5 times the upper limit of normal, baseline prothrombin time [INR] greater than 1.5 times the upper limit of normal, cirrhosis, bridging fibrosis, or active hepatitis)
- Prior or current malignancy or myeloproliferative disorder or significant immunodeficiency disorder
- Prior allogenic or autologous HSC transplant

The remaining clinical criteria and PA submission options for Hemgenix, Roctavian, and Zynteglo have not changed.

QUICK LINKS

- Hemgenix topic #22820
- Roctavian topic #23117
- Zynteglo topic #23357

Note: These topics will be updated on January 2, 2025.

Copay for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copay to a brand name drug when a drug that previously required BMN PA becomes a preferred drug on the PDL, and the available generic equivalents are non-preferred drugs.

This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and not yet cost-effective when compared to brand pricing.

For drugs included in this policy, ForwardHealth will automatically apply the generic copay when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate a National Council for Prescription Drug Program Dispense as Written/Product Selection code on claims to ensure the generic copay deduction.

QUICK LINKS

Amounts topic #1927

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Refer to Attachment D for the Copay for Brand Name Drugs Preferred Over Generic Drugs table for the most current list of drugs for which this copay policy applies. This information is also available on the Preferred Drug List Quick Reference data table.

Expedited Emergency Supply Request Drugs Data Table

As a result of the changes made during the November 2024 PDL review, the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page will be updated effective January 1, 2025.

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § DHS 106.02(9). Providers are required to produce or submit documentation, or both, to the Wisconsin Department of Health Services (DHS) upon request. Per Wis. Stat. § 49.45(3)(f), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

Information Regarding Managed Care Organizations

This Update applies to Family Care, Family Care Partnership, BadgerCare Plus, and SSI Medicaid managed care program members because pharmacy services for members of these programs are provided on a fee-for-service basis. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) are provided by the member's managed care organization.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

This Update was issued on 12/13/2024 and information contained in this Update was incorporated into the Online Handbook on 01/02/2025.

ATTACHMENT A
Changes to Preferred or Non-Preferred Status of Drugs on the Preferred Drug List

The following table lists the drugs that changed their preferred or non-preferred status as a result of the November 2024 Preferred Drug List (PDL) review. Unless otherwise noted, the updated statuses are effective January 1, 2025. Drugs that have not been previously reviewed by the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee are marked with the footnote ([1]). Refer to the current Preferred Drug List Quick Reference data table on the Pharmacy Resources page of the ForwardHealth Portal.

DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JANUARY 1, 2025, UNLESS OTHERWISE NOTED
Anticonvulsants	oxcarbazepine ER tablets (Gen-Oxtellar XR)[1]	Non-Preferred
	Libervant film[1]	Non-Preferred
	Motpoly XR[1]	Non-Preferred
	Vigafyde[1]	Non-Preferred
Antidepressants, Other	vilazodone tablet (Gen-Viibryd)	Preferred
	Nardil	Non-Preferred
	Zurzuvae capsule[1]	Non-Preferred
Antiparkinson's Agents	Crexont ER capsule[1]	Non-Preferred
Antipsychotics	paliperidone ER tablets	Preferred
	Saphris	Non-Preferred
Antipsychotics, Injectable	risperidone ER (Gen-Risperdal Consta)[1]	Non-Preferred
Bile Salts	Iqirvo tablet[1]	Non-Preferred
	Livdelzi capsule[1]	Non-Preferred
COPD Agents	Ohtuvayre[1]	Non-Preferred

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JANUARY 1, 2025, UNLESS OTHERWISE NOTED
Cytokine and CAM Antagonists	adalimumab-aacf (Idacio)[1]	Non-Preferred
	adalimumab-aaty (Yuflyma)[1]	Non-Preferred
	adalimumab-adbm (Cyltezo)[1]	Non-Preferred
	adalimumab-ryfk (Simlandi subQ)[1]	Non-Preferred
	Abrilada[1]	Non-Preferred
	Amjevita (adalimumab-atto)[1]	Non-Preferred
	Bimzelx[1]	Non-Preferred
	Cimzia	Preferred
	Cyltezo	Preferred
	Entyvio subQ[1]	Non-Preferred
	Omvoh subQ[1]	Non-Preferred
	Rinvoq LQ solution[1]	Non-Preferred
	Simlandi subQ[1]	Non-Preferred
	Simponi subQ	Preferred
	Spevigo subQ[1]	Non-Preferred
	Tyenne subQ[1]	Preferred
	Zymfentra[1]	Non-Preferred
Erythropoiesis Stimulating Proteins	Jesduvroq[1]	Non-Preferred
	Vafseo tablet[1]	Non-Preferred
Glucocorticoids, Inhaled	Asmanex HFA	Preferred
	Qvar Redihaler	Preferred
Glucocorticoids, Oral	deflazacort suspension (Gen-Emflaza suspension)[1]	Non-Preferred
	deflazacort tab (Gen-Emflaza tab)[1]	Non-Preferred
	Agamree[1]	Non-Preferred
	Eohilia[1]	Non-Preferred
H2 Antagonists	cimetidine solution	Non-Preferred
	famotidine RX suspension	Preferred
Immunomodulators, Atopic Dermatitis—Topical	Eucrisa	Preferred
	Zoryve 0.15% cream[1]	Non-Preferred
Immunomodulators, Topical	podofilox gel[1]	Non-Preferred

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JANUARY 1, 2025, UNLESS OTHERWISE NOTED
Intranasal Rhinitis Agents	mometasone furoate spray OTC[1]	Preferred
	Qnasl 80	Preferred
Methotrexate	Jylamvo[1]	Non-Preferred
Movement Disorders	Ingrezza sprinkles[1]	Preferred
Neuropathic Pain	gabapentin ER (Gen-Gralise)[1]	Non-Preferred
NSAIDS	indomethacin supension[1]	Non-Preferred
Ophthalmics, Allergic Conjunctivitis	azelastine	Preferred
	loteprednol etabonate (Gen-Alrex)[1]	Non-Preferred
Ophthalmics, Anti-Inflammatories	bromfenac 0.075% (Gen-Bromsite)[1]	Non-Preferred
	bromfenac 0.07% (Gen-Prolensa)[1]	Non-Preferred
Ophthalmics, Anti-Inflammatory/ Immunomodulator	Vevye[1]	Non-Preferred
Ophthalmics, Glaucoma—Other	brimonidine tartrate 0.1% (Gen-Alphagan P 0.1%)[1]	Non-Preferred
	Alphagan P 0.1%	Preferred
Sedative Hypnotics	Rozerem	Non-Preferred
Sickle Cell Anemia	l-glutamine (Gen-Endari)[1]	Non-Preferred
Steroids, Topical High	fluocinonide cream	Preferred
	fluocinonide ointment	Preferred
	fluocinonide solution	Preferred
Stimulants	dextroamphetamine-amphetamine ER (Gen-Mydayis ER)[1]	Non-Preferred
Stimulants, Related Agents	Onyda XR suspension[1]	Non-Preferred
Ulcerative Colitis	Velsipity[1]	Non-Preferred

[1] The drug was not previously reviewed by the Wisconsin Medicaid Pharmacy PA Advisory Committee. For more information, providers should refer to the Drug Status Changes on the Preferred Drug List section of this ForwardHealth Update.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

ATTACHMENT B
Changes to Pharmacy-Related Prior Authorization Forms and Instructions

The table below lists the pharmacy-related prior authorization (PA) forms and instructions that have been revised, revised and renamed, or discontinued as a result of the November 2024 Preferred Drug List review or as a result of other pharmacy policy changes. Providers should refer to the Forms page of the ForwardHealth Portal for current copies of these forms and instructions. Effective January 1, 2025, the previous versions of these forms and instructions will be moved to the Pharmacy-Related Forms and Instructions archive page. For more information regarding clinical criteria or PA request submission options, refer to the applicable drug class section in this ForwardHealth Update.

FORM NAME	FORM NUMBER	REVISED, REVISED AND RENAMED, OR DISCONTINUED	EFFECTIVE DATE
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis	F-11304	Revised	01/2025
Instructions	F-11304A	Revised	01/2025
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis	F-01950	Revised	01/2025
Instructions	F-01950A	Revised	01/2025
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Deficiency of Interleukin-1 Receptor Antagonist (DIRA), Giant Cell Arteritis, Neonatal Onset Multisystem Inflammatory Disease (NOMID), and Non-Radiographic Axial Spondyloarthritis (nr-axSpA)	F-01952	**Revised and Renamed:** Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Giant Cell Arteritis and Non-Radiographic Axial Spondyloarthritis (nr-axSpA)	01/2025
Instructions	F-01952	Revised and Renamed	01/2025

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

FORM NAME	FORM NUMBER	REVISED, REVISED AND RENAMED, OR DISCONTINUED	EFFECTIVE DATE
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa	F-03174	Revised	01/2025
Instructions	F-03174A	Revised	01/2025
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis	F-11306	Revised	01/2025
Instructions	F-11306A	Revised	01/2025
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis	F-01951	Revised	01/2025
Instructions	F-01951A	Revised	01/2025
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis	F-03224	Revised	01/2025
Instructions	F-03224A	Revised	01/2025
Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents	F-00281	Discontinued	01/2025
Instructions	F-00281A	Discontinued	01/2025
Prior Authorization/Preferred Drug List (PA/PDL) for Immunomodulators, Atopic Dermatitis—Topical	F-02572	Revised	01/2025
Instructions	F-02572A	Revised	01/2025

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

ATTACHMENT C
Legacy Exemptions for Stimulants—Amphetamine Drugs

The following table lists all of the designated amphetamine drugs with a legacy exemption in the stimulants drug class and their applicable legacy exemption details.

LEGACY EXEMPTION DRUGS—AMPHETAMINE	LEGACY EXEMPTION DETAILS
dextroamphetamine **dextroamphetamine ER**	Eligible members identified to be taking any of these two drugs **are allowed to receive any of the following as a legacy exemption drug**: • Generic dextroamphetamine • Generic dextroamphetamine ER Note: An approved prior authorization (PA) request is not required for any child 6 years of age or younger for generic dextroamphetamine.
Adderall **Adderall XR** **dextroamphetamine-amphetamine** **dextroamphetamine-amphetamine ER**	Eligible members identified to be taking any of these four drugs **are allowed to receive any of the following as a legacy exemption drug**: • Brand name Adderall • Brand name Adderall XR • Generic dextroamphetamine-amphetamine • Generic dextroamphetamine-amphetamine ER Note: An approved PA request is not required for any child 6 years of age or younger for brand name Adderall or generic dextroamphetamine-amphetamine.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

ATTACHMENT D
Copay for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copay to a brand name drug when a drug that previously required brand medically necessary prior authorization becomes a preferred drug on the Preferred Drug List and the available generic equivalents are non-preferred drugs. The following table lists the drugs with generic copay. The Preferred Drug List Quick Reference data table, which also includes the current Brand Name Drugs With Generic Copay table, is available on the Pharmacy Resources page of the ForwardHealth Portal.

DRUG CLASS	DRUG NAME	EFFECTIVE DATE
Acne Agents, Topical	Retin-A (not micro)	07/01/2016
Anticonvulsants	Carbatrol ER	01/01/2021
	Depakote sprinkle	01/01/2021
	Tegretol suspension	01/01/2016
	Tegretol tablet	01/01/2016
	Tegretol XR	01/01/2021
Antiemetics/Antivertigo	Transderm-Scop	07/01/2022
Bronchodilators, Beta Agonists	Ventolin HFA	01/01/2023
HIV/AIDS	Intelence	07/01/2023
	Selzentry solution, tablet	07/01/2023
	Symfi	07/01/2023
	Symfi Lo	07/01/2023
Hypoglycemics, Insulins	Humalog Jr Kwikpen	05/01/2020
	Humalog Mix	05/01/2020
	Humalog U-100 Kwikpen/Vial	07/01/2019
	Novolog Mix	01/01/2020
	Novolog U-100 Pen/Vial	01/01/2020
Ophthalmics, Antibiotic-Steroid Combinations	Tobradex suspension	01/01/2012
Ophthalmics, Glaucoma-Other	Alphagan P 0.15%	01/01/2012
Ophthalmics, Glaucoma-Prostaglandins	Xalatan	01/01/2023

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

DRUG CLASS	DRUG NAME	EFFECTIVE DATE
Opioid Dependency Agents—Buprenorphine	Suboxone film	07/01/2020
Stimulants	Concerta	01/01/2018
	Vyvanse capsule	01/01/2024

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.