

**Affected Programs:** BadgerCare Plus, Medicaid, SeniorCare

**To:** Blood Banks, Dispensing Physicians, Federally Qualified Health Centers, Pharmacies, Rural Health Clinics, HMOs and Other Managed Care Programs

## Changes to Prior Authorization for Pharmacy Services

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for pharmacy services, effective October 2008, with the implementation of the ForwardHealth interChange system. These changes include the following:

- Establishing deadlines for providers to respond to returned PA requests and PA amendment requests.
- Revising all PA forms. The revised PA forms will be available to download and print from the Web at [dhfs.wisconsin.gov/ForwardHealth/](http://dhfs.wisconsin.gov/ForwardHealth/).

Providers may also order copies from Provider Services.

The changes were made to do the following:

- Provide efficiencies for both providers and ForwardHealth.
- Accommodate changes required for full National Provider Identifier implementation.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

A separate *Update* will give providers a calendar of additional important dates related to implementation including when to begin submitting the revised PA forms.

Information in this *Update* applies to providers who provide services for BadgerCare Plus, Wisconsin Medicaid, and SeniorCare members.

### Changes to Prior Authorization with the Implementation of ForwardHealth interChange

In October 2008, the Department of Health and Family Services (DHFS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to PA forms and procedures that are detailed in this *Update*. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements).

The changes were made to:

- Provide efficiencies for both providers and ForwardHealth. Providers will be able to submit PA requests and receive decisions and requests for additional information via the ForwardHealth Portal.
- Accommodate changes required for full National Provider Identifier (NPI) implementation. Prior authorization forms were revised to include elements for providers to indicate NPI and taxonomy information.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

Specific implementation dates will be published in a separate *Update*.

*Note:* Use of information presented in this *Update* prior to implementation may result in returned PA requests.

Information in this *Update* applies to providers who provide services for BadgerCare Plus, Wisconsin Medicaid, and SeniorCare members.

### **Prior Authorization Numbers**

The PA number will no longer be pre-printed on the Prior Authorization Request Form (PA/RF), F-11018 (10/08). As a result, providers will be able to download and print the form from the Portal and no longer have to order pre-printed forms from ForwardHealth. Upon receipt of the form, ForwardHealth will assign a PA number to each PA request.

The PA number will consist of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request). Refer to Attachment 1 of this *Update* for information about interpreting PA numbers.

### **Drug Prior Authorizations No Longer Provider Specific**

Pharmacy providers will continue to submit drug PA requests for members. Once the PA request is approved, the member may go to any certified pharmacy provider to obtain the prior authorized drug. As a result, the member's PA does not need to be ended when the member changes pharmacies.

### **Changes to Prior Authorization Forms**

With the implementation of ForwardHealth interChange, pharmacy providers submitting a paper PA request will be required to use the revised PA/RF. Refer to Attachments 2 and 3 for completion instructions and a copy of the PA/RF for providers to photocopy. Attachment 4 is a sample PA/RF for pharmacy services.

*Note:* If ForwardHealth receives a PA request on a previous version of the PA/RF, a letter will be sent to the provider stating that the provider is required to submit a new PA request using the proper forms. This may result in a later grant date if the PA request is approved.

### **Revisions to the Prior Authorization Request Form and Instructions**

The following revisions have been made to the PA/RF:

- The PA number is eliminated from the form.
- The paper PA/RF is a one-part form (no longer a two-part, carbonless form) that can be downloaded and printed. The PA/RF is available in two formats on the Portal — Microsoft® Word and Portable Document Format (PDF).
- Checkboxes are added for HealthCheck “Other Services” and Wisconsin Chronic Disease Program (WCDP) (Element 1) to create efficiencies for providers who render services to members in Wisconsin Medicaid, BadgerCare Plus, and WCDP.
- When submitting a PA request for a 24-hour drug, providers can no longer indicate process type “137” (24-Hour Drug). Instead, providers must indicate process type “131” (drugs). ForwardHealth consolidated process type “131” (drugs) and process

type “137” (24-Hour Drug) into process type “131” (drugs).

- The term “rendering provider” replaces “performing provider” to align with HIPAA terminology.
- Billing and rendering provider taxonomy code fields are added (Elements 5b and 17) to accommodate NPI implementation.
- In the billing provider’s name and address fields, providers are now required to include the ZIP + 4 code (Element 4) to accommodate NPI implementation.

### **Prior Authorization Attachments**

With the implementation of ForwardHealth interChange, pharmacy services providers submitting a paper PA request will be required to use the following revised PA forms:

- Prior Authorization/Drug Attachment (PA/DGA), F-11049 (10/08). Refer to Attachments 8 and 9. Use this form for HealthCheck “Other Services” requests.
- Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083 (10/08). Refer to Attachments 10 and 11.
- Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs, F-11061 (10/08). Refer to Attachments 12 and 13.
- Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitors, F-11056 (10/08). Refer to Attachments 14 and 15.
- Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075 (10/08). Refer to Attachments 16 and 17.
- Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Including Cyclo-Oxygenase Inhibitors, F-11077 (10/08). Refer to Attachments 18 and 19.
- Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs, F-11078 (10/08). Refer to Attachments 20 and 21.
- Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs, F-11092 (10/08). Refer to Attachments 22 and 23.

- Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy, F-11179 (10/08). Refer to Attachments 24 and 25.
- Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents, F-11097 (10/08). Refer to Attachments 26 and 27.
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304 (10/08). Refer to Attachments 28 and 29.
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn’s Disease, F-11305 (10/08). Refer to Attachments 30 and 31.
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, F-11306 (10/08). Refer to Attachments 32 and 33.
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307 (10/08). Refer to Attachments 34 and 35.
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis, F-11308 (10/08). Refer to Attachments 36 and 37.

While the basic information requested on the forms have not changed, the format of the forms have changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests..

### **Revised STAT-PA System Instructions**

ForwardHealth has revised the STAT-PA System Instructions, F-11055 (10/08), to accommodate National Provider Identifier (NPI) requirements and the ForwardHealth interChange system capabilities. The revised STAT-PA System Instructions are included as Attachment 5.

Refer to the June 2008 *Update* (2008-42), titled “Changes to STAT-PA for Retail Pharmacy Drugs,” for complete information on changes to STAT-PA for pharmacy services.

### Obtaining Prior Authorization Request Forms and Attachments

Prior authorization forms are available in fillable PDF or fillable Microsoft® Word from the Forms page at [dhfs.wisconsin.gov/ForwardHealth/](http://dhfs.wisconsin.gov/ForwardHealth/) prior to implementation and will be available from the Portal after implementation.

The fillable PDF is accessible using Adobe Reader® and may be completed electronically. To use the fillable PDF, click on the dash-outlined boxes and enter the information. Press the “Tab” key to move from one box to the next.

To request a paper copy of a PA form for photocopying, call Provider Services at (800) 947-9627. Questions about the forms may also be directed to Provider Services.

In addition, a copy of any PA form and/or attachment is available by writing to ForwardHealth. Include a return address, the name of the form, and the number of the form (if applicable) and mail the request to the following address:

ForwardHealth  
 Form Reorder  
 6406 Bridge Rd  
 Madison WI 53784-0003

### Prior Authorization Decisions

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved as requested.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

### Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding 24-hour PA requests, such as PA requests for Brand Medically Necessary drugs, within 24 hours with the receipt of all the necessary information and telephone or fax the decision to the provider who submitted the PA request.

ForwardHealth will make a decision regarding a provider’s other PA requests within 20 working days from the receipt of all the necessary information. The new decision notice letter or returned provider review letter implemented with ForwardHealth interChange will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information.

Providers submitting PA requests via the Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), not to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

### ***Returned Provider Review Letter***

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the Portal.

The provider's paper documents submitted with the PA request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the PA request.

*Note:* When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

### ***Thirty Days to Respond to the Returned Provider Review Letter***

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the Portal. If the provider's response is received within 30 calendar days, ForwardHealth will still consider the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This will result in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through the WiCall Automated Voice Response system. Watch for future publications for more information regarding checking PA status via WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

## ***Listing Procedure Codes Approved as a Group on the Decision Notice Letter***

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

## **Methods for Requesting Prior Authorization**

Using the ForwardHealth Portal, providers will be able to submit PA requests for all services requiring PA. In addition to the Portal, providers may submit PA requests via any of the following:

- Fax at (608) 221-8616.
- Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) at (800) 947-1197.
- National Council for Prescription Drug Programs (NCPDP).
- Mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Watch for future publications for information on submitting PA requests via the Portal.

## ***NCPDP Transactions***

With the implementation of interChange, ForwardHealth will accept the following NCPDP Telecommunication Standard Format Version 5.1 PA transactions: P2 reversal, P3 inquiry, and the P4 request. These transactions will enable providers to reverse or

inactivate a PA, inquire about PA status, or submit a PA request.

Providers should work closely with their software vendors or information technology staff and software user guides to ensure that electronic PAs are submitted accurately according to the ForwardHealth Companion Document to HIPAA Implementation Guide: NCPDP V5.1. This document is available on the Medicaid Web site at [dhfs.wisconsin.gov/ForwardHealth/trading\\_partner/index.htm](http://dhfs.wisconsin.gov/ForwardHealth/trading_partner/index.htm).

The following are descriptions and/or requirements for each type of NCPDP PA transaction:

### *P2 Reversal*

To reverse (i.e., change the PA to an inactive status) a PA using the P2 transaction, the following must be true:

- The provider must be the provider who obtained PA and must have the provider number used to obtain the PA.
- The PA must be in one of the following statuses:
  - ✓ Approved — The PA request was approved as requested.
  - ✓ Returned — The PA request was returned to the provider for correction or for additional information.
  - ✓ Pending — The PA request is being reviewed by the Fiscal Agent.
  - ✓ Pending — The PA request is being reviewed by the State.
  - ✓ Suspend — The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
- None of the services on an approved PA have been used.

### *P3 Inquiry*

Providers may submit inquiries about PAs they have submitted and receive authorization information on PAs approved or approved with modifications from ForwardHealth using the P3 inquiry.

### *P4 Request*

Providers may submit a PA request using the P4 request transaction, however this will not result in real-time approval. The P4 request transaction does not allow providers to submit the appropriate PA attachment needed to adjudicate the PA request. When a P4 request is received, the request will be processed and placed in a “returned provider review” status. ForwardHealth will send the provider a returned provider review letter and the provider will have 30 calendar days from the date on the returned provider review letter to submit the remaining information or the PA request will be inactivated.

### **New Amendment Process**

Providers are required to use the Prior Authorization Amendment Request, F-11042 (10/08), to amend an approved or modified PA request. The Prior Authorization Amendment Request was revised to accommodate NPI information. Instructions for completion of the Prior Authorization Amendment Request are located in Attachment 6. Attachment 7 is a copy of the revised Prior Authorization Amendment Request for providers to photocopy.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

ForwardHealth will make a decision regarding a provider’s amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider’s file as his or her PA address (or to the physical address if there is no PA address on file), not to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

### ***Returned Amendment Provider Review Letter***

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the Portal.

ForwardHealth must receive the provider’s response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will

continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

*Note:* When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

### **Valid Diagnosis Codes Required**

Effective with implementation, the PA/RF will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific, diagnosis codes may have up to five digits.

Prior authorization requests sent by mail or fax with an invalid diagnosis code will be returned to the provider. Providers using the Portal will receive a message that the diagnosis code is invalid and will be allowed to correct the code and submit the PA request.

### **Local Drug Code No Longer Valid**

Wisconsin Medicaid local drug codes 88888-8888-88 and 00990-00-0000 will no longer be valid. Providers will be required to submit an appropriate National Drug Code on PA requests.

### **BadgerCare Plus Benchmark Plan**

Prior authorization is not available for drugs that are not included on the Benchmark Plan formulary. Prior authorization requests submitted for noncovered drugs

will be returned to the provider. Benchmark Plan members do not have appeal rights regarding returned PA requests for noncovered drugs.

### **Information Regarding Managed Care**

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. Pharmacy services for members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership are provided by the member's managed care organization. Managed care organizations must provide at least the same benefits as those provided under fee-for-service.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health and Family Services (DHFS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHFS.

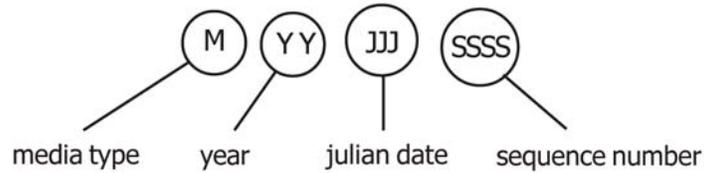
For questions, call Provider Services at (800) 947-9627 or visit our Web site at [dhfs.wisconsin.gov/forwardhealth/](http://dhfs.wisconsin.gov/forwardhealth/).

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# ATTACHMENT 1

## Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.



Type of Number and Description	Applicable Numbers and Description
<b>Media</b> — One digit indicates media type.	Digits are identified as follows: 1 = paper; 2 = fax; 3 = Specialized Transmission Approval Technology-Prior Authorization (STAT-PA); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = National Council for Prescription Drug Programs (NCPDP) transaction
<b>Year</b> — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
<b>Julian date</b> — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
<b>Sequence number</b> — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

# **ATTACHMENT 2**

## **Prior Authorization Request Form (PA/RF)**

### **Completion Instructions for Pharmacy Services**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with all applicable service-specific attachments, along with the Prior Authorization/Drug Attachment (PA/DGA), F-11049, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

#### **SECTION I — PROVIDER INFORMATION**

##### **Element 1 — HealthCheck “Other Services” and Wisconsin Chronic Disease Program (WCDP)**

Enter an “X” in the box next to HealthCheck “Other Services” if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck “Other Services.” Enter an “X” in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

##### **Element 2 — Process Type**

Enter the process type 131 — Drugs. The process type is a three-digit code used to identify a category of service requested.

##### **Element 3 — Telephone Number — Billing Provider**

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

##### **Element 4 — Name and Address — Billing Provider**

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and the four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

##### **Element 5a — Billing Provider Number**

Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

##### **Element 5b — Billing Provider Taxonomy Code**

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

#### **SECTION II — MEMBER INFORMATION**

##### **Element 6 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin’s Enrollment Verification System (EVS) to obtain the correct number.

##### **Element 7 — Date of Birth — Member**

Enter the member’s date of birth in MM/DD/CCYY format.

**Element 8 — Address — Member**

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

**Element 9 — Name — Member**

Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

**Element 10 — Gender — Member**

Enter an "X" in the appropriate box to specify male or female.

**SECTION III — DIAGNOSIS / TREATMENT INFORMATION****Element 11 — Diagnosis — Primary Code and Description**

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

**Element 12 — Start Date — SOI (not required)****Element 13 — First Date of Treatment — SOI (not required)****Element 14 — Diagnosis — Secondary Code and Description**

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

**Element 15 — Requested PA Start Date**

Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

**Element 16 — Rendering Provider Number**

Enter the prescribing provider's NPI.

**Element 17 — Rendering Provider Taxonomy Code**

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, *only* if this code is different from the taxonomy code listed for the billing provider in Element 5b.

**Element 18 — Procedure Code**

Enter the appropriate National Drug Code (NDC) for each service/procedure/item requested.

**Element 19 — Modifiers**

Enter the modifier(s) corresponding to the service code listed if a modifier is required.

**Element 20 — POS**

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

**Element 21 — Description of Service**

Enter a written description corresponding to the appropriate NDC code for each item requested.

**Element 22 — QR**

Enter the appropriate quantity (e.g., days' supply) requested for the procedure code listed.

**Element 23 — Charge**

Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

*Note:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

**Element 24 — Total Charges**

Enter the anticipated total charges for this request.

**Element 25 — Signature — Requesting Provider**

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

**Element 26 — Date Signed**

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

**ATTACHMENT 3**  
**Prior Authorization Request Form (PA/RF)**  
**(for photocopying)**

(A copy of the “Prior Authorization Request Form [PA/RF]” is located on the following page.)



# **ATTACHMENT 4**

## **Sample Prior Authorization Request Form (PA/RF) for Pharmacy Services**

(The “Sample Prior Authorization Request Form [PA/RF] for Pharmacy Services” is located on the following page.)



# **ATTACHMENT 5**

## **STAT-PA System Instructions**

(A copy of the “STAT-PA System Instructions” is located on the following pages.)

## FORWARDHEALTH STAT-PA SYSTEM INSTRUCTIONS

The ForwardHealth Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system is an automated voice response system that allows Medicaid-certified providers to receive PA via telephone rather than by mail or the Web. Providers answer a series of questions and receive an immediate response of an approved or returned PA.

Providers communicate with the STAT-PA system by entering requested information on a touch-tone telephone keypad or by calling Provider Services. Providers must have their provider number to access the STAT-PA system.

The STAT-PA system is available by calling one of the following telephone numbers:

- **Touch-Tone Telephone**  
(800) 947-1197  
Available 24 hours a day, seven days a week.
- **Provider Services**  
(800) 947-9627  
Available from 7:00 a.m. to 6:00 p.m., Monday through Friday, excluding state-observed holidays.

### REQUIRED INFORMATION

All providers using STAT-PA are required to provide the following information:

- Provider number.
- Practice Location ZIP+4 code.
- Member identification number.
- National Drug Code (NDC) or procedure code.
- *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code.*
- Patient location.
- First date of service (DOS).
- Days supply or total number requested.

*Note:* When requesting a drug, Prescribing Provider information is required. Additionally, if a National Provider Identifier (NPI) is entered, and the requesting provider is not a retail pharmacy, the Taxonomy Code is required.

### HOW TO USE WISCONSIN STAT-PA

1. Complete the appropriate PA attachment form.
2. Select mode of transmission (touch-tone telephone or Provider Services).

### TOUCH-TONE TELEPHONE REQUESTS

To use a touch-tone telephone to submit a PA request:

1. Call (800) 947-1197. This connects the provider directly with the STAT-PA system.
2. When the system answers, it will ask a series of questions that providers answer by entering the information on the telephone keypad. The service-specific PA attachments list the information needed in the order it is requested by the STAT-PA system.

*Note:* When using a touch-tone telephone to enter the NPI, member ID, NDC or procedure code, ICD-9-CM diagnosis code, patient location code, requested first DOS, and quantity, always press the pound (#) key to mark the end of the data just entered. The pound (#) key signals the system that the provider has finished entering the data requested and ensures the quickest response from the system.

Providers may be asked to enter alphabetic data, which can be entered by using the asterisk (\*) key. For example, a provider is asked to enter a procedure code such as L3216. The first character is an alpha character; therefore, the provider presses the single asterisk (\*) key followed by the two digits that indicate the letter. The first digit is the number on the keypad where the letter is located, and the second digit is the position of the letter on that key. For example: Procedure code L3216 should be entered as \*53 3 2 1 6.

Alphabet Key:

A = *21	G = *41	M = *61	S = *73	Y = *93
B = *22	H = *42	N = *62	T = *81	Z = *12
C = *23	I = *43	O = *63	U = *82	
D = *31	J = *51	P = *71	V = *83	
E = *32	K = *52	Q = *11	W = *91	
F = *33	L = *53	R = *72	X = *92	

3. Once all data have been entered completely, STAT-PA processes the information, indicates the status of the PA request, and gives providers the chance to finalize, cancel, or change their entered information. Once the PA request is finalized, STAT-PA indicates the PA number and, if approved, the effective dates and authorized number of services.

Once familiar with the STAT-PA system, providers may enter the PA information in the designated order immediately — there is no need to wait for the full voice prompt. Providers may key information at any time, even when the system is processing information. The system automatically proceeds to the next function.

### **PROVIDER SERVICES REQUESTS**

Providers who do not have a touch-tone telephone may call Provider Services at (800) 947-9627. The Provider Services correspondent will access STAT-PA and enter the required data requested from the provider.

Provider Services is available to all STAT-PA users. Providers who are experiencing difficulties with the system can select to be transferred to Provider Services for assistance.

### **DOCUMENTATION INFORMATION**

Providers must maintain all documentation that supports medical necessity, claim information, and delivery of the approved service(s) in their records for a period not less than five years. Regardless of what STAT-PA method is used, providers will receive a letter by mail indicating the assigned PA number and the STAT-PA decision. Providers with a secure ForwardHealth Portal account will also receive a copy of this letter in their portal mailbox. This letter should be maintained as a permanent record of the transaction.

#### *Helpful Hints*

- The provider is given three attempts at each field to correctly enter the requested data. If those attempts are unsuccessful, the provider can select to be transferred to Provider Services for assistance, or the call will be terminated.
- Providers are given two attempts to enter data within 10 seconds. If those attempts are unsuccessful, the provider can select to be transferred to Provider Services for assistance, or the call will be terminated.
- Providers are allowed 25 PA requests per connection for touch-tone telephone.
- Providers are allowed up to 25 minutes per connection for touch-tone telephone.
- The decimal point for diagnosis codes is not required when entering a STAT-PA request by touch-tone telephone; however, all digits of the codes must be entered.
- The first date of service entered by the provider may be up to 31 calendar days in the future or up to 14 days in the past.
- Providers who need to end date a PA request due to a change in prescription may do so through STAT-PA if the request was originally submitted through STAT-PA. If a provider needs assistance with the end date process, the provider may select to be transferred to Provider Services for assistance.

# **ATTACHMENT 6**

## **Prior Authorization Amendment Request Completion Instructions**

(A copy of the “Prior Authorization Amendment Request Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers are required to use the Prior Authorization Amendment Request, F-11042, to request an amendment to a PA. The use of this form is mandatory when requesting an amendment to a PA. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the PA Decision Notice of the PA to be amended along with physician's orders, if applicable, (within 90 days of the dated signature) and send it to ForwardHealth. Providers may submit the Prior Authorization Amendment Request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Original PA Number

Enter the unique PA number from the original PA to be amended.

#### Element 2 — Process Type

Enter the process type as indicated on the PA to be amended.

#### Element 3 — Member Identification Number

Enter the member ID as indicated on the PA to be amended.

#### Element 4 — Name — Member

Enter the name of the member as indicated on the PA to be amended.

### SECTION II — PROVIDER INFORMATION

#### Element 5 — Billing Provider Number

Enter the billing provider number as indicated on the PA to be amended.

#### Element 6 — Name — Billing Provider

Enter the name of the billing provider as indicated on the PA to be amended.

**SECTION III — AMENDMENT INFORMATION**

**Element 7 — Address — Billing Provider**

Enter the address of the billing provider (include street, city, state, and ZIP+4 code) as indicated on the PA to be amended.

**Element 8 — Requested Start Date**

Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

**Element 9 — Requested End Date (If Different from Expiration Date of Current PA)**

Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different than the current expiration date.

**Element 10 — Reasons for Amendment Request**

Enter an "X" in the box next to each reason for the amendment request. Check all that apply.

**Element 11 — Description and Justification for Requested Change**

Enter the specifics and supporting rationale of the amendment request related to each reason indicated in Element 10.

**Element 12 — Are Attachments Included?**

Enter an "X" in the appropriate box to indicate if attachments are or are not included with the amendment request. If Yes, specify all attachments that are included.

**Element 13 — Signature — Requesting Provider**

Enter the signature of the provider that requested the original PA.

**Element 14 — Date Signed — Requesting Provider**

Enter the date the amendment request was signed by the requesting provider in MM/DD/CCYY format.

**ATTACHMENT 7**  
**Prior Authorization Amendment Request**  
**(for photocopying)**

(A copy of the "Prior Authorization Amendment Request" is located on the following page.)

**FORWARDHEALTH  
PRIOR AUTHORIZATION AMENDMENT REQUEST**

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

**SECTION I — MEMBER INFORMATION**

1. Original PA Number	2. Process Type	3. Member Identification Number
4. Name — Member (Last, First, Middle Initial)		

**SECTION II — PROVIDER INFORMATION**

5. Billing Provider Number	7. Address — Billing Provider (Street, City, State, ZIP+4 Code)
6. Name — Billing Provider	

**SECTION III — AMENDMENT INFORMATION**

8. Requested Start Date	9. Requested End Date (If Different from Expiration Date of Current PA)
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10. Reasons for Amendment Request (Check All That Apply)

<input type="checkbox"/> Change Billing Provider Number	<input type="checkbox"/> Add Procedure Code / Modifier
<input type="checkbox"/> Change Procedure Code / Modifier	<input type="checkbox"/> Change Diagnosis Code
<input type="checkbox"/> Change Grant or Expiration Date	<input type="checkbox"/> Discontinue PA
<input type="checkbox"/> Change Quantity	<input type="checkbox"/> Other (Specify) _____

11. Description and Justification for Requested Change

12. Are Attachments Included?  Yes  No  
If Yes, specify attachments below.

13. <b>SIGNATURE</b> — Requesting Provider	14. Date Signed — Requesting Provider
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# **ATTACHMENT 8**

## **Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions**

(A copy of the “Prior Authorization/Drug Attachment [PA/DGA] Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting a PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/Drug Attachment (PA/DGA), F-11049, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

#### Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

### SECTION II — TYPE OF REQUEST

#### Element 4

Indicate the start date requested for PA or the date the prescription was filled.

#### Element 5

Check the appropriate box to indicate if this product has been requested previously.

### SECTION III — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

#### Element 6 — Drug Name

Enter the drug name.

**Element 7 — Strength**

Enter the strength of the drug listed in Element 6.

**Element 8 — Quantity Ordered**

Enter the quantity that was ordered.

**Element 9 — Date Order Issued**

Enter the date the order was issued.

**Element 10 — Directions for Use**

Enter the directions for use of the drug.

**Element 11 — Daily Dose**

Enter the daily dose.

**Element 12 — Refills**

Enter the amount of refills.

**Element 13 — Name — Prescriber**

Enter the name of the prescriber.

**Element 14 — National Provider Identifier**

Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

**Element 15**

Indicate if "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.

**SECTION IV — CLINICAL INFORMATION**

Include diagnostic, as well as clinical information, explaining the need for the product requested.

**Element 16**

List the member's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes and the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if more space is required.

**Element 17**

Indicate source of clinical information.

**Element 18**

Indicate use of the product requested.

**Element 19**

Indicate dosage of the product requested.

**Element 20 — Signature — Pharmacist or Dispensing Physician**

The pharmacist / dispenser must review this information and sign this form.

**Element 21 — Date Signed**

Enter the month, day, and year the PA/DGA was signed (in MM/DD/CCYY format).

# **ATTACHMENT 9**

## **Prior Authorization/Drug Attachment (PA/DGA)**

(A copy of the “Prior Authorization/Drug Treatment Attachment [PA/DGA]” is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / DRUG ATTACHMENT (PA/DGA)**

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions, F-11049A.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — TYPE OF REQUEST**

4. Indicate the Start Date Requested / Date Prescription Filled

5. Indicate if this drug has been previously requested.

This is an initial PA request for this drug, for this member, by this provider.

This is a request to renew or extend previously prior authorized therapy using this drug.

First PA Number \_\_\_\_\_

This is a request to change or add a new National Drug Code (NDC) number to a current valid PA.

First PA Number \_\_\_\_\_ NDC Number to add \_\_\_\_\_

**SECTION III — PRESCRIPTION INFORMATION**

6. Drug Name	7. Strength
8. Quantity Ordered	9. Date Order Issued
10. Directions for Use	
11. Daily Dose	12. Refills
13. Name — Prescriber	14. National Provider Identifier
15. "Brand Medically Necessary" is handwritten by the prescriber on the prescription order. <input type="checkbox"/> Yes <input type="checkbox"/> No	

*Continued*



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**SECTION IV — CLINICAL INFORMATION**

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16. List the member's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code for pharmaceutical care members. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

---

17. Source for Clinical Information (check one)

- This information was primarily obtained from the prescriber or prescription order.
- This information was primarily obtained from the member.
- This information was primarily obtained from some other source (specify). \_\_\_\_\_

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18. Use (check one)

- Compendial standards, such as the United States Pharmacopeia Drug Information (USP DI) or drug package insert, lists the intended use identified above as an accepted indication.
- Compendial standards, such as the USP DI, lists the intended use identified above as a [bracketed] accepted indication.
- Compendial standards, such as the USP DI or drug package insert, lists the intended use identified above as an unaccepted indication.
- The intended use above is not listed in compendial standards. Peer reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.)

---

19. Dose (check one)

- The daily dose and duration are within compendial standards general prescribing or dosing limits for the indicated use.
- The daily dose and duration are **not** within compendial standards general prescribing or dosing limits for the intended use. Attach or reference peer-reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)

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20. **SIGNATURE** — Pharmacist or Dispensing Physician

21. Date Signed

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# **ATTACHMENT 10**

## **Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA) Completion Instructions**

(A copy of the “Prior Authorization/Brand Medically Necessary Attachment [PA/BMNA] Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION / BRAND MEDICALLY NECESSARY ATTACHMENT (PA/BMNA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Prescribers are required to complete and sign the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083, and send it to the pharmacy provider where the prescription will be filled. Pharmacy providers are required to attach the completed PA/BMNA to a Prior Authorization Request Form (PA/RF), F-11018, and a copy of the prescription and send the forms to ForwardHealth. Prescribers and dispensing providers are required to retain a completed copy of the form.

Pharmacy providers may submit PA requests to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

#### Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

### SECTION II — PRESCRIPTION INFORMATION

#### Element 4 — Drug Name

Enter the drug name.

#### Element 5 — Strength(s)

Enter the strength(s) of the drug listed in Element 4.

#### Element 6 — National Drug Code

Enter the appropriate 11-digit National Drug Code.

**Element 7 — Date Prescription Written**

Enter the date the prescription was written.

**Element 8 — Directions for Use**

Enter the directions for use of the drug.

**Element 9 — Start Date Requested**

Enter the start date requested for PA.

**Element 10 — Name — Prescriber**

Enter the name of the prescriber.

**Element 11 — National Provider Identifier**

Enter the prescribing provider's National Provider Identifier for prescriptions for non-controlled substances.

**Element 12 — Address — Prescriber**

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

**Element 13 — Telephone Number — Prescriber**

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

**Element 14**

Indicate if "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.

**SECTION III — CLINICAL INFORMATION**

Include diagnostic and clinical information explaining the need for the product requested. Documentation must indicate how the brand name drug will prevent recurrence of an adverse or allergic reaction, or a therapeutic failure, with the generic drug. In Elements 16 through 21, check "yes" to all that apply.

**Element 15 — Diagnosis — Primary Code and/or Description**

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

**Element 16**

Check the appropriate box to indicate whether or not the member has experienced an adverse reaction to the generic equivalent drug. If yes, indicate the adverse drug reaction that can be directly attributable to the generic equivalent drug and the approximate dates the drug was taken.

**Element 17**

Check the appropriate box to indicate whether or not the member has experienced a treatment failure of the generic equivalent drug. If yes, indicate the treatment failure and the approximate dates the drug was taken.

**Element 18**

Check the appropriate box to indicate whether or not the member has experienced an allergic reaction to the generic equivalent drug and whether or not the provider anticipates that the brand name drug will not cause the same allergic reaction. If yes, indicate the allergic reaction and the approximate dates the drug was taken, if known.

**Element 19**

Explain how the brand medically necessary drug will prevent the recurrence of the adverse reaction, treatment failure, or allergic reaction described in responses to Elements 16, 17, and 18.

**Element 20**

Check the appropriate box to indicate whether or not the member has a medical condition that causes a contraindication to the use of the generic equivalent drug. If yes, indicate the medical condition and why or how the condition impacts the use of the generic equivalent drug.

**SECTION III — CLINICAL INFORMATION FOR NARROW THERAPEUTIC INDEX DRUGS**

**Element 21 — For The Following Drugs Only: Any Brand Name Anticonvulsant Drug Used to Treat a Seizure Disorder, Clozaril, Coumadin, Neoral, or Prograf**

Check the appropriate box to indicate whether or not the member's past medical history suggests an anticipated treatment failure with a generic equivalent drug. If yes, indicate the prescriber's documentation of the anticipated therapeutic failure and the past medical history that forms the basis of the anticipated therapeutic failure.

**Element 22 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 23 — Date Signed**

Enter the month, day, and year the PA/BMNA was signed.

**SECTION IV — ADDITIONAL INFORMATION**

**Element 24**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.

# **ATTACHMENT 11**

## **Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA)**

(A copy of the “Prior Authorization/Brand Medically Necessary Attachment [PA/BMNA]” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / BRAND MEDICALLY NECESSARY ATTACHMENT (PA/BMNA)**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA) Completion Instructions, F-11083A.

Prescribers are required to submit this completed form to the dispensing provider where the prescription will be filled.

Pharmacy providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength(s)
6. National Drug Code (NDC)	7. Date Prescription Written
8. Directions for Use	9. Start Date Requested
10. Name — Prescriber	11. National Provider Identifier
12. Address — Prescriber (Street, City, State, ZIP+4 Code)	

13. Telephone Number — Prescriber

14. Is "Brand Medically Necessary" handwritten by the prescriber on the prescription?  Yes  No

**SECTION III — CLINICAL INFORMATION**

15. Diagnosis — Primary Code and / or Description

16. Has the member experienced a clinically significant adverse reaction to the generic equivalent drug?  Yes  No

If yes, indicate the adverse reaction that can be directly attributed to the generic equivalent drug and the dose and approximate dates the drug was taken.

17. Has the member experienced a treatment failure with the generic equivalent drug?  Yes  No

If yes, indicate the treatment failure that can be directly attributed to the generic equivalent drug and the dose and approximate dates the drug was taken.

*Continued*



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**SECTION III — CLINICAL INFORMATION (Continued)**

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18. Has the member experienced an allergic reaction to the generic equivalent drug?  Yes  No
- Do you anticipate that the brand name drug will not cause the same allergic reaction?  Yes  No

If yes, indicate the allergic reaction that can be directly attributed to the generic equivalent drug and the dose and approximate dates the drug was taken, if known.

- 
19. Explain how the brand medically necessary drug will prevent the recurrence of the adverse reaction, treatment failure, or allergic reaction described in Elements 16, 17, and 18.

- 
20. Does the member have a medical condition that causes a contraindication to the use of the generic equivalent drug?  Yes  No

If yes, indicate the medical condition and why or how the condition impacts the use of the generic equivalent drug.

---

**SECTION IIIB — CLINICAL INFORMATION FOR NARROW THERAPEUTIC INDEX DRUGS**

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21. For the Following Drugs Only: Any Brand Name Anticonvulsant Drug Used to Treat a Seizure Disorder, Clozaril, Coumadin, Neoral, or Prograf

Does the member's past medical history suggest an anticipated treatment failure of the generic equivalent drug?  Yes  No

If yes, indicate the prescriber's documentation of the anticipated therapeutic failure\* and the past medical history that forms the basis of the anticipated therapeutic failure.

\* Therapeutic failure applies to treatment for seizure disorders.

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22. **SIGNATURE** — Prescriber

23. Date Signed

---

**SECTION IV — ADDITIONAL INFORMATION**

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24. Additional diagnostic and clinical information explaining the need for the drug required may be included below.
-

# **ATTACHMENT 12**

## **Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs Completion Instructions**

(A copy of the “Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR C-III AND C-IV STIMULANTS AND ANTI-OBESITY DRUGS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs form, F-11061. Pharmacy providers are required to use the Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs form to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a Prior Authorization Drug Attachment form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA Drug Attachment form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA Drug Attachment form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

#### Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters.

## SECTION II — PRESCRIPTION INFORMATION

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier

Enter prescribing provider's National Provider Identifier.

### Element 10 — Address and Telephone Number — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code, as well as the telephone number.

## SECTION III — CLINICAL INFORMATION FOR C-III AND C-IV STIMULANTS AND ANTI-OBESITY DRUGS

### Element 11 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 12

Enter the member's height in inches using a two-digit format. For example, if the member's height is 5' 10", enter "70."

### Element 13

Enter the member's weight in pounds using a three-digit format.

*Note:* For STAT-PA, the system will calculate the body mass index (BMI) using a formula after the information in this section is complete. If BMI is greater than 30, the PA will be approved for a maximum of 186 days. If BMI is less than 30, the provider will receive the following message: "Your prior authorization request requires additional information. Please submit your request on paper with complete clinical documentation."

### Element 14 — Signature — Prescriber

The prescriber is required to complete and sign this form.

### Element 15 — Date Signed

Enter the month, day, and year the form was signed in MM/DD/CCYY format.

## SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

### Element 16 — National Drug Code

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

### Element 17 — Days' Supply Requested

Enter the requested days' supply.

### Element 18 — National Provider Identifier

Enter the National Provider Identifier.

**Element 19 — Date of Service**

Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 20 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 21 — Assigned Prior Authorization Number**

Record the PA number assigned by the STAT-PA system.

**Element 22 — Grant Date**

Record the grant date of the PA as assigned by the STAT-PA system.

**Element 23 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 24 — Number of Days Approved**

Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 25**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

# **ATTACHMENT 13**

## **Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs**

(A copy of the “Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR C-III AND C-IV STIMULANTS**  
**AND ANTI-OBESITY DRUGS**

**Instructions:** Type or print clearly. Before completing this form, read Prior Authorization Drug Worksheet for C-III and C-IV Stimulants and Anti-Obesity Drugs Completion Instructions, F-11061A. Refer to the STAT-PA System Instructions, F-11055, for details regarding data entry through the STAT-PA system.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for C-III and C-IV Stimulants and Anti-Obesity Drugs form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier
10. Address and Telephone Number	

**SECTION III — CLINICAL INFORMATION FOR C-III AND C-IV STIMULANTS AND ANTI-OBESITY DRUGS**

11. Diagnosis — Primary Code and / or Description	
12. Member's Height (inches):	
13. Member's Weight (pounds):	
14. <b>SIGNATURE</b> — Prescriber	15. Date Signed

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

16. National Drug Code (11 Digits)	17. Days' Supply Requested (Up to 186 Days)
18. National Provider Identifier	19. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past)



20. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)		21. Assigned Prior Authorization Number	
22. Grant Date	23. Expiration Date	24. Number of Days Approved	

**SECTION V — ADDITIONAL INFORMATION**

25. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

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# **ATTACHMENT 14**

## **Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor Completion Instructions**

(A copy of the “Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ALPHA-1 PROTEINASE INHIBITOR COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor form, F-11056. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor form to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a Prior Authorization Drug Attachment form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate Prior Authorization Drug Attachment form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate Prior Authorization Drug Attachment form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

#### Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PRESCRIPTION INFORMATION

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written in MM/DD/CCYY format.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier (NPI)

Enter prescribing provider's NPI.

### Element 10 — Address and Telephone Number — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code, as well as the telephone number.

## SECTION III — CLINICAL INFORMATION FOR ALPHA-1 PROTEINASE INHIBITOR

### Element 11 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 12

Check the appropriate box to indicate whether or not the member has clinically significant panacinar emphysema due to congenital Alpha-1 Antitrypsin deficiency. If no, the PA request requires additional information. The provider should submit the PA request on paper with complete clinical documentation.

### Element 13 — Signature — Prescriber

The prescriber is required to complete and sign this form.

### Element 14 — Date Signed

Enter the month, day, and year the form was signed in MM/DD/CCYY format.

## SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

### Element 15 — National Drug Code

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

### Element 16 — Days' Supply Requested

Enter the requested days' supply.

### Element 17 — NPI

Enter the pharmacy provider's NPI.

### Element 18 — Date of Service

Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 19 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 20 — Assigned Prior Authorization Number**

Record the PA number assigned by the STAT-PA system.

**Element 21 — Grant Date**

Record the grant date of the PA as assigned by the STAT-PA system.

**Element 22 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 23 — Number of Days Approved**

Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 24**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

# **ATTACHMENT 15**

## **Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor**

(A copy of the “Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor”  
is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ALPHA-1 PROTEINASE INHIBITOR**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor Completion Instructions, F-11056A. Refer to the STAT-PA System Instructions, F-11055, for details regarding data entry through the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Alpha-1 Proteinase Inhibitor form signed by the prescriber before calling STAT-PA or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI)
10. Address and Telephone Number	

**SECTION III — CLINICAL INFORMATION FOR ALPHA-1 PROTEINASE INHIBITOR**

11. Diagnosis — Primary Code and / or Description	
12. Does the member have clinically significant panacinar emphysema due to congenital Alpha-1-Antitrypsin deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. SIGNATURE — Prescriber	14. Date Signed

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

15. National Drug Code (11 Digits)	16. Days' Supply Requested (Up to 186 Days)	
17. NPI	18. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)	
19. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)	20. Assigned Prior Authorization Number	
21. Grant Date	22. Expiration Date	23. Number of Days Approved



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**SECTION V — ADDITIONAL INFORMATION**

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24. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.
-

# **ATTACHMENT 16**

## **Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] Exemption Request Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, F-11075. Pharmacy providers are required to use the PA/PDL Exemption Request to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

#### Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier (NPI)

Enter the prescribing provider's NPI for prescriptions for non-controlled substances.

### Element 10 — Address and Telephone Number — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION

Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 15, check "yes" to all that apply.

### Element 11 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 12

Check the appropriate box to indicate whether or not the member has experienced treatment failure with the preferred drug(s). If "yes" is checked, indicate in the space provided the most recently failed preferred drug(s), the specific details of the treatment failure(s), and the approximate date(s) the preferred drug(s) was taken.

### Element 13

Check the appropriate box to indicate whether or not the member has a medical condition(s) that prevents the use of the preferred drug(s). If "yes" is checked, indicate in the space provided the member's medical condition(s) that prevent the use of the preferred drug(s).

### Element 14

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction between another medication the member is taking and the preferred drug(s). If "yes" is checked, indicate in the space provided the medication(s) and the drug interaction(s).

### Element 15

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction while taking the preferred drug(s). If "yes" is checked, indicate in the space provided the preferred drug(s) that caused the adverse drug reaction, specific details of the adverse reaction, and the approximate date(s) the preferred drug(s) was taken.

**Element 16**

Check the appropriate box to indicate whether or not the member has taken the requested non-preferred grandfathered drug in any of the following drug classes for more than 30 days outside ForwardHealth and had a measurable, therapeutic response. The drug classes include anti-Parkinson agents, selective serotonin reuptake inhibitor (SSRI) antidepressants, other antidepressants, anticonvulsants, and atypical antipsychotics.

**Element 17 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 18 — Date Signed**

Enter the month, day, and year the PA/PDL Exemption Request was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 19 — National Drug Code**

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

**Element 20 — Days' Supply Requested**

Enter the requested days' supply.

**Element 21 — NPI**

Enter the NPI.

**Element 22 — Date of Service**

Enter the requested first date of service (DOS) for the drug or biologic. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 23 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 24 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 25 — Grant Date**

Record the date the PA was approved by the STAT-PA system.

**Element 26 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 27 — Number of Days Approved**

Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 28**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

# **ATTACHMENT 17**

## **Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] Exemption Request” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions, F-11075A.

Pharmacy providers are required to have a completed PA/PDL Exemption Request form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI)
10. Address and Telephone Number — Prescriber (Street, City, State, ZIP+4 Code, and Telephone Number)	

**SECTION III — CLINICAL INFORMATION**

11. Diagnosis — Primary Code and / or Description

---

12. Has the member experienced treatment failure with the preferred drug(s)?  
If "yes," list the most recently failed preferred drug(s), specific details of the treatment failure(s), and the approximate date(s) the preferred drug(s) was taken.  Yes  No

---

13. Does the member have a medical condition(s) that prevents the use of the preferred drug(s)? If "yes," list the medical condition(s) in the space provided.  Yes  No

---

14. Is there a clinically significant drug interaction between another medication the member is taking and the preferred drug(s)? If "yes," list the medication(s) and interaction(s) in the space provided.  Yes  No

---

15. Has the member experienced a clinically significant adverse drug reaction while taking the preferred drug(s)? If "yes," list the preferred drug(s) that caused the adverse drug reaction, specific details of the adverse reaction, and the approximate date(s) the preferred drug(s) was taken.  Yes  No

---

16. For grandfathered classes, including, but not limited to, anti-Parkinson agents, selective serotonin reuptake inhibitor (SSRI) antidepressants, other antidepressants, anticonvulsants, and atypical antipsychotics, has the member taken the requested non-preferred medication for more than 30 days outside ForwardHealth and had a measurable, therapeutic response?  Yes  No

Continued



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**SECTION III— CLINICAL INFORMATION (Continued)**

17. SIGNATURE — Prescriber

18. Date Signed

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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

19. National Drug Code (11 Digits)

20. Days' Supply Requested (Up to 365 Days)

21. NPI

22. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

23. Patient Location (Use patient location code "0" [Not Specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)

24. Assigned PA Number

25. Grant Date

26. Expiration Date

27. Number of Days Approved

---

**SECTION V — ADDITIONAL INFORMATION**

28. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a member who was granted retroactive eligibility by ForwardHealth.

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# **ATTACHMENT 18**

## **Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDS), Including Cyclo-Oxygenase Inhibitors, Completion Instructions**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Non-Steroidal Anti-Inflammatory Drugs [NSAIDS], Including Cyclo-Oxygenase Inhibitors, Completion Instructions” is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING CYCLO-  
OXYGENASE INHIBITORS, COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and dispensing physicians are required to retain a completed copy of the form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, form, F-11077. Pharmacy providers are required to use the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, form to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier (NPI)

Enter the prescribing provider's NPI for prescriptions for non-controlled substances.

### Element 10 — Address and Telephone Number — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code, as well as the telephone number.

## SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED NSAIDs, INCLUDING CYCLO-OXYGENASE INHIBITORS

Include diagnostic and clinical information explaining the need for the product requested. In Elements 15 through 17, check "yes" to all that apply.

### Element 11 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or the description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 12

Check the appropriate box to indicate whether or not the member has tried two preferred, generic NSAIDs and experienced a treatment failure(s) or clinically significant adverse drug reaction(s). If "yes" is checked, circle the failed, preferred generic NSAIDs and indicate in the space provided the specific details of the treatment failure(s) or clinically significant adverse drug reaction(s) and the approximate date(s) the preferred, generic NSAIDs were taken.

### Element 13

Check the appropriate box to indicate whether or not the non-preferred NSAID is being prescribed to treat a chronic non-acute condition. If "yes" is checked, indicate in the space provided the condition the NSAID is prescribed to treat.

### Element 14

Check the appropriate box to indicate if the member has any of the following risk factors: he or she is over 65 years of age, is currently taking anti-coagulants, or has a history of gastrointestinal (GI) ulcers or bleeding.

### Element 15 — Signature — Prescriber

The prescriber is required to complete and sign this form.

### Element 16 — Date Signed

Enter the month, day, and year the PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, form was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 17 — National Drug Code**

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

**Element 18 — Days' Supply Requested**

Enter the requested days' supply.

**Element 19 — NPI**

Enter the NPI.

**Element 20 — Date of Service**

Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 21 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 22 — Assigned PA Number**

Indicate the PA number assigned by the STAT-PA system.

**Element 23 — Grant Date**

Indicate the date the PA was approved by the STAT-PA system.

**Element 24 — Expiration Date**

Indicate the date the PA expires as assigned by the STAT-PA system.

**Element 25 — Number of Days Approved**

Indicate the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 26**

Indicate any additional information in the space below. Submit additional information on a separate sheet if necessary.

**ATTACHMENT 19**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Non-Steroidal Anti-Inflammatory Drugs**  
**(NSAIDS), Including Cyclo-Oxygenase Inhibitors**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Non-Steroidal Anti-Inflammatory Drugs [NSAIDS], Including Cyclo-Oxygenase Inhibitors” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)**  
**FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS), INCLUDING CYCLO-OXYGENASE INHIBITORS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, Completion Instructions, F-11077A.

Pharmacy providers are required to have a completed PA/PDL for NSAIDs, Including Cyclo-oxygenase Inhibitors, form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI)
10. Address and Telephone Number — Prescriber (Street, City, State, ZIP+4 Code, and Telephone Number)	

**SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED NSAIDS, INCLUDING CYCLO-OXYGENASE INHIBITORS**

11. Diagnosis — Primary Code and / or Description

---

12. Has the member tried two preferred generic NSAIDs and experienced a treatment failure or had an adverse drug reaction? If yes, circle the two failed, preferred generic NSAIDs that were taken.  Yes  No

Preferred drugs:  
diclofenac etodolac flurbiprofen ibuprofen indomethacin ketoprofen ketorolac  
meclofenamate nabumetone naproxen piroxicam

List in the space provided the specific details of the treatment failure(s) or adverse drug reaction(s) and the approximate dates the preferred generic NSAIDs were taken.

*Continued*



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**SECTION III— CLINICAL INFORMATION FOR NON-PREFERRED NSAIDs, INCLUDING CYCLO-OXYGENASE INHIBITORS (Cont.)**

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13. Is the non-preferred NSAID being prescribed for a chronic, non-acute condition?  
If yes, what condition is the non-preferred NSAID being prescribed to treat?  Yes  No

---

14. Indicate whether or not the member has any of the following risk factors.

A. Is he or she over 65 years of age?  Yes  No

B. Is he or she currently taking anti-coagulants?  Yes  No

C. Does the member have a history of gastrointestinal (GI) ulcers or bleeding?  Yes  No

---

15. **SIGNATURE** — Prescriber

16. Date Signed

---

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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17. National Drug Code (11 Digits)

18. Days' Supply Requested (Up to 365 Days)

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19. NPI

---

20. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

---

21. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)

---

22. Assigned PA Number

---

23. Grant Date

24. Expiration Date

25. Number of Days Approved

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**SECTION V — ADDITIONAL INFORMATION**

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26. Include any additional information in the space below. Submit additional information on a separate sheet if necessary.

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# **ATTACHMENT 20**

## **Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs Completion Instructions**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Proton Pump Inhibitor [PPI] Drugs Completion Instructions” is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR PROTON PUMP INHIBITOR (PPI) DRUGS  
COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the Pharmacy page of the ForwardHealth Online Handbook for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a determination about the request.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs form, F-11078. Pharmacy providers are required to use the PA/PDL for PPI Drugs form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier (NPI)

Enter the prescribing provider's NPI for prescriptions for non-controlled substances.

### Element 10 — Address and Telephone Number — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED PROTON PUMP INHIBITOR DRUGS

Include diagnostic and clinical information explaining the need for the product requested. In Elements 12 through 14, check "yes" to all that apply.

*Note:* A member is required to try and fail both Prevacid<sup>®</sup> and Nexium<sup>®</sup> before trying omeprazole. The member is also required to try and fail omeprazole before another non-preferred PPI drug is prescribed.

### Element 11 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis code for PPIs must be one of the PPI-approved codes.

### Element 12

Check the appropriate box to indicate whether or not the member has experienced a clinically significant adverse drug reaction to Prevacid<sup>®</sup>, Nexium<sup>®</sup>, and Prilosec<sup>®</sup> OTC. If "yes" is checked, indicate in the space provided the specific details of the clinically significant adverse drug reaction(s) and the approximate dates Prevacid<sup>®</sup>, Nexium<sup>®</sup>, and Prilosec<sup>®</sup> OTC were taken.

### Element 13

Check the appropriate box to indicate whether or not the member has experienced a treatment failure on the maximum dose of Prevacid<sup>®</sup> (60 mg/day), Nexium<sup>®</sup> (40 mg/day), and Prilosec<sup>®</sup> OTC (40 mg/day)? If "yes" is checked, indicate in the space provided the approximate dates Prevacid<sup>®</sup>, Nexium<sup>®</sup>, and Prilosec<sup>®</sup> OTC were taken.

### Element 14

Check the appropriate box to indicate whether or not the member has experienced a treatment failure on the maximum dose of omeprazole (40 mg/day) or experienced a clinically significant adverse drug reaction to omeprazole (i.e., Prilosec<sup>®</sup>, Prilosec<sup>®</sup> OTC, or generic omeprazole). If "yes" is checked, indicate in the space provided the specific details of the treatment failure or clinically significant drug reaction and the approximate dates omeprazole was taken.

**Element 15 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 16 — Date Signed**

Enter the month, day, and year the PA/PDL for PPI Drugs form was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 17 — National Drug Code**

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

**Element 18 — Days' Supply Requested**

Enter the requested days' supply.

**Element 19 — NPI**

Enter the NPI.

**Element 20 — Date of Service**

Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 21 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 22 — Assigned PA Number**

Indicate the PA number assigned by the STAT-PA system.

**Element 23 — Grant Date**

Indicate the date the PA was approved by the STAT-PA system.

**Element 24 — Expiration Date**

Indicate the date the PA expires as assigned by the STAT-PA system.

**Element 25 — Number of Days Approved**

Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 26**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.

# **ATTACHMENT 21**

## **Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Proton Pump Inhibitor [PPI], Drugs” is located on the following pages.)

FORWARDHEALTH  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR PROTON PUMP INHIBITOR (PPI) DRUGS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Drugs Completion Instructions, F-11078A.

Pharmacy providers are required to have a completed PA/PDL for PPI Drugs signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI)
10. Address and Telephone Number — Prescriber (Street, City, State, ZIP+4 Code, and Telephone Number)	

**SECTION III — CLINICAL INFORMATION FOR NON-PREFERRED PROTON PUMP INHIBITOR DRUGS**

11. Diagnosis — Primary Code and / or Description

---

12. Has the member experienced a clinically significant adverse drug reaction to Prevacid<sup>®</sup>, Nexium<sup>®</sup>, and Prilosec<sup>®</sup> OTC? If “yes,” list the specific details of the clinically significant adverse drug reaction(s) and the approximate dates Prevacid<sup>®</sup>, Nexium<sup>®</sup>, and Prilosec<sup>®</sup> OTC were taken.  Yes  No

---

13. Has the member experienced a treatment failure on the maximum dose of Prevacid<sup>®</sup> (60 mg/day), Nexium<sup>®</sup> (40 mg/day), and Prilosec<sup>®</sup> OTC (40 mg/day)? If “yes,” indicate the approximate dates Prevacid<sup>®</sup>, Nexium<sup>®</sup>, and Prilosec<sup>®</sup> OTC were taken.  Yes  No

---

14. Has the member experienced a treatment failure on the maximum dose of omeprazole (40 mg/day) or experienced a clinically significant adverse drug reaction to omeprazole (i.e., Prilosec<sup>®</sup>, Prilosec<sup>®</sup> OTC, or generic omeprazole)? If “yes,” list the specific details of the treatment failure or clinically significant adverse drug reaction and the approximate dates omeprazole was taken.  Yes  No

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15. SIGNATURE — Prescriber	16. Date Signed
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Continued



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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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17. National Drug Code (11 Digits)		18. Days' Supply Requested (Up to 365 Days)
19. NPI		
20. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)		
21. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)		
22. Assigned PA Number		
23. Grant Date	24. Expiration Date	25. Number of Days Approved

---

**SECTION V — ADDITIONAL INFORMATION**

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26. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.

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**ATTACHMENT 22**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Growth Hormone Drugs Completion**  
**Instructions**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Growth Hormone Drugs Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, F-11092. Pharmacy providers are required to use the PA/PDL for Growth Hormone Drugs form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

#### Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

### SECTION II — PRESCRIPTION INFORMATION

#### Element 4 — Drug Name

Enter the drug name.

**Element 5 — Strength**

Enter the strength of the drug listed in Element 4.

**Element 6 — Date Prescription Written**

Enter the date the prescription was written.

**Element 7 — Directions for Use**

Enter the directions for use of the drug.

**Element 8 — Diagnosis — Primary Code and / or Description**

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

**Element 9 — Name — Prescriber**

Enter the name of the prescriber.

**Element 10 — National Provider Identifier (NPI)**

Enter the prescribing provider's NPI for prescriptions for non-controlled substances.

**Element 11 — Address — Prescriber**

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

**Element 12 — Telephone Number — Prescriber**

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

**Element 13 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 14 — Date Signed**

Enter the month, day, and year the PA/PDL for Growth Hormone Drugs form was signed (in MM/DD/CCYY format).

**SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS**

Include diagnostic and clinical information explaining the need for the drug requested. In Elements 15 through 21, check "yes" to all that apply.

**Element 15**

Check the box to indicate whether or not the member has tried and failed a preferred growth hormone drug. Preferred growth hormone drugs include Genotropin, Nutropin AQ, Saizen, and Tev-Tropin.

**Element 16**

Check the box to indicate whether or not the member's chronological age is under 20 years.

**Element 17**

Check the box to indicate whether or not the member's skeletal age is documented to be under 18 years.

**Element 18**

Check the box to indicate whether or not the prescription was written by an endocrinologist. The prescription must be written by an endocrinologist for the member to begin treatment with a growth hormone drug.

**Element 19**

Check the box to indicate whether or not the member has a diagnosis of growth deficiency. The member must have a diagnosis of growth deficiency to begin treatment with a growth hormone drug.

**Element 20**

Check the box to indicate whether or not the member has a diagnosis of Prader Willi or Turner's Syndrome. If the member has a diagnosis of Prader Willi or Turner's Syndrome, a stimulated growth hormone test is **not** required.

**Element 21**

Check the box to indicate whether or not the member had a recent stimulated growth hormone test that demonstrated a clear abnormality. Indicate the test result and normal range.

*Note:* When a STAT-PA request is returned because a member has not had a stimulated growth hormone test, additional information is required for PA review. If the member has a medical condition, such as hypopituitary disease, and a stimulated growth hormone test is *not* medically indicated, medical records supporting the growth hormone deficiency are required. The medical records should be included with a paper PA request, which includes a completed PA/RF, PA/PDL for Growth Hormone Drugs, and supporting documentation.

**SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA**

In Elements 22 through 25, prescribers should indicate “1” if the response to the question is yes. Indicate “2” if the response is no.

**Element 22 — Diagnosis**

The member must be at least 18 years of age and have a diagnosis of Human Immunodeficiency Virus (HIV) to begin treatment with a growth hormone drug.

**Element 23 — Member’s Current Medical Condition**

Indicate the member’s current medical condition by responding to the clinical information listed in this section.

**Element 24 — Evidence of Wasting Syndrome**

The member must have either an unintentional weight loss of at least 10 percent or a gastrointestinal (GI) obstruction or malabsorption to qualify for treatment with a growth hormone drug.

**Element 25**

All of the clinical information listed must be tried and failed before a member may begin a course of therapy with a growth hormone drug.

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 26 — National Drug Code**

Enter the appropriate 11-digit National Drug Code for each drug.

**Element 27 — Days’ Supply Requested**

Enter the requested days’ supply.

**Element 28 — NPI**

Enter the NPI.

**Element 29 — Date of Service**

Enter the requested first date of service (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 30 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 31 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 32 — Grant Date**

Record the date the PA was approved by the STAT-PA system.

**Element 33 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 34 — Number of Days Approved**

Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

**Element 35**

Check the box to indicate if additional information is necessary. Submit additional information on a separate sheet.

**ATTACHMENT 23**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Growth Hormone Drugs**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Growth Hormone Drugs” is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR GROWTH HORMONE DRUGS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions, F-11092A. If a growth hormone drug is prescribed for a member, prescribers are required to complete this form and submit it to the pharmacy where the prescription will be filled.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List for Growth Hormone Drugs form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Diagnosis — Primary Code and / or Description	
9. Name — Prescriber	10. National Provider Identifier (NPI)
11. Address — Prescriber (Street, City, State, ZIP+4 Code)	
12. Telephone Number — Prescriber	
13. SIGNATURE — Prescriber	14. Date Signed

**SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS**

15. Has the member tried and failed a preferred growth hormone drug? Preferred growth hormone drugs include Genotropin, Nutropin AQ, Saizen, and Tev-Tropin.  Yes  No
16. Is the member's chronological age under 20 years?  Yes  No
17. If the member's chronological age is 20 years or older, is the skeletal age of the member documented to be 18 years of age or younger?  Yes  No
18. Is the prescription for the growth hormone drug written by an endocrinologist?  Yes  No
19. Does the member have a diagnosis of growth deficiency?  Yes  No
20. Does the member have a diagnosis of Prader Willi or Turner's Syndrome?  Yes  No
21. Does the member have a recent stimulated response growth hormone test demonstrating a clear abnormality\*?  Yes  No

Indicate the test result. \_\_\_\_\_  
Indicate the normal range. \_\_\_\_\_

*Continued*



**SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA**

- 22. Diagnosis** **Response (Indicate "1" for yes or "2" for no.)**
- A) The member is 18 years of age or older. \_\_\_\_\_
  - B) The member has Human Immunodeficiency Virus (HIV) with serum antibodies to HIV. \_\_\_\_\_
  - C) The member is female and pregnant or lactating. \_\_\_\_\_

- 23. Member's Current Medical Condition**
- D) The member has signs or symptoms of Acquired Immune Deficiency Syndrome (AIDS) or associated illnesses. \_\_\_\_\_
  - E) The member has untreated or suspected serious systemic infection. \_\_\_\_\_
  - F) The member has an active malignancy other than Kaposi's sarcoma. \_\_\_\_\_
  - G) The member is on approved anti-retroviral therapy. \_\_\_\_\_
  - H) The member has documented hypogonadism and is taking gonadal steroids. \_\_\_\_\_

- 24. Evidence of Wasting Syndrome**
- I) The member has unintentional weight loss of at least 10 percent from baseline. \_\_\_\_\_
  - J) The member has a gastrointestinal (GI) obstruction or malabsorption to account for weight loss. \_\_\_\_\_

Indicate the member's height (in inches). \_\_\_\_\_  
 Indicate the member's usual weight (in pounds) prior to diagnosis of HIV. \_\_\_\_\_  
 Indicate the member's current weight (in pounds). \_\_\_\_\_

- 25. All of the following must be tried before beginning a course of therapy with a growth hormone drug.**
- K) The member is receiving at least 100 percent of estimated caloric requirement on current regimen. \_\_\_\_\_
  - L) The member has tried and failed a previous trial with megestrol acetate and / or dronabinal. \_\_\_\_\_
  - M) The member has completed a course of therapy of at least 24 weeks of protease inhibitors alone or with nucleosides. \_\_\_\_\_
  - N) The member has completed a course of therapy using dihydrotestosterone (when appropriate). \_\_\_\_\_

**NEED LEVEL**

Enter all 14 digits for this section in the following spaces. Do not include the measurements for the member's height, usual weight, or current weight.

_	_	_	_	_	_	_	_	_	_	_	_	_	_	_
A	B	C	D	E	F	G	H	I	J	K	L	M	N	

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

26. National Drug Code (11 Digits)	27. Days' Supply Requested*
------------------------------------	-----------------------------

28. NPI \_\_\_\_\_

29. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.) \_\_\_\_\_

30. Patient Location (Use patient location code "0" [Not Specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].) \_\_\_\_\_

31. Assigned PA Number \_\_\_\_\_

32. Grant Date	33. Expiration Date	34. Number of Days Approved
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35.  Check this box to indicate if any additional information is necessary. Submit additional information on a separate sheet.

\*Medical records supporting the growth hormone deficiency are required in cases when the STAT-PA is returned because a member has not had a stimulated growth hormone test due to a hypopituitary or other condition. The medical records should be included with the paper PA request, which includes a completed and signed PA/RF by the pharmacist and a signed and completed PA/PDL for Growth Hormone Drugs by the prescriber, and all other supporting documentation, including medical records. The prescriber should send the PA/PDL and supporting documentation, including medical records, to the pharmacy where the prescription will be filled. The pharmacy will send the PA/RF, the PA/PDL, and all supporting documentation to ForwardHealth.

**ATTACHMENT 24**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Hypoglycemics for Adjunct Therapy**  
**Completion Instructions**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Hypoglycemics for Adjunct Therapy Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

### INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy, F-11179. Pharmacy providers are required to use the PA/PDL for Hypoglycemics for Adjunct Therapy to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers may submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

#### Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier (NPI)

Enter the prescribing provider's NPI for prescriptions for non-controlled substances.

### Element 10 — Address and Telephone Number — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION IIIA — CLINICAL INFORMATION FOR BYETTA®

Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 20, check "yes" to all that apply.

### Element 11 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 12

Check the appropriate box to indicate whether or not the member has a diagnosis of Type II diabetes.

### Element 13

Check the appropriate box to indicate whether or not the member has failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonylurea or metformin. If "yes" is checked, indicate the member's current medication therapy and most current Hemoglobin A1c (HbA1c).

### Element 14

Check the appropriate box to indicate whether or not the member is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

## SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN®

### Element 15

Check the appropriate box to indicate whether or not the member has a diagnosis of Type I or Type II diabetes.

### Element 16

Check the appropriate box to indicate whether or not the member has failed to achieve adequate glycemic control despite optimal insulin management, including the use of meal time insulin. If "yes" is checked, indicate the member's current medication therapy, including insulin regimen.

### Element 17

Check the appropriate box to indicate whether or not the member has any of the following: an HbA1c greater than nine percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis. Indicate the member's most current HbA1c value. If the member has any of these conditions, the PA will be returned.

### Element 18

Check the appropriate box to indicate whether or not the member is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

**SECTION III C — CLINICAL INFORMATION FOR JANUVIA™ AND JANUMET™**

**Element 19**

Check the appropriate box to indicate whether or not the member has a diagnosis of Type II diabetes.

**Element 20**

Check the appropriate box to indicate whether or not the member has failed to achieve adequate glycemic control despite diabetic counseling, including diet and a supervised exercise program, and diabetic medication management, such as metformin or a thiazolidinedione? If “yes” is checked, indicate the member’s current medication therapy and most current HbA1c.

**Element 21**

Check the appropriate box to indicate whether or not Januvia™ or Janumet™ is being added to the member’s diabetic drug therapy regimen.

**Element 22 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 23 — Date Signed**

Enter the month, day, and year the PA/PDL for Hypoglycemics for Adjunct Therapy was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 24 — National Drug Code**

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

**Element 25 — Days’ Supply Requested**

Enter the requested days’ supply.

**Element 26 — Provider Number**

Enter the provider number.

**Element 27 — Date of Service**

Enter the requested first date of service (DOS) for the drug or biologic. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 28 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 29 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 30 — Grant Date**

Record the date the PA was approved by the STAT-PA system.

**Element 31 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 32 — Number of Days Approved**

Indicate the number of days for which the STAT-PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 33**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.

# **ATTACHMENT 25**

## **Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Hypoglycemics for Adjunct Therapy” is located on the following pages.)

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy Completion Instructions, F-11179A.

Pharmacy providers are required to have a completed PA/PDL for Hypoglycemics for Adjunct Therapy form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI)
10. Address and Telephone Number — Prescriber (Street, City, State, ZIP+4 Code, and Telephone Number)	

**SECTION IIIA — CLINICAL INFORMATION FOR BYETTA®**

11. Diagnosis — Primary Code and / or Description

12. Does the member have a diagnosis of Type II diabetes?  Yes  No

13. Has the member failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonylurea or metformin? If "yes," indicate the member's current medication therapy and most current HbA1c.  Yes  No

14. Is the member receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator?  Yes  No

**SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN®**

15. Does the member have a diagnosis of Type I or Type II diabetes?  Yes  No

16. Has the member failed to achieve adequate glycemic control despite optimal insulin management including the use of meal-time insulin? If "yes," indicate the member's current medication therapy, including insulin regimen.  Yes  No

Continued



DT-PA065-065

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**SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN® (CONTINUED)**

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17. Does the member have any of the following: an HbA1c greater than nine percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis? Indicate the most current HbA1c value.  Yes  No

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18. Is the member receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator?  Yes  No

---

**SECTION IIIC — CLINICAL INFORMATION FOR JANUVIA™ AND JANUMET™**

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19. Does the member have a diagnosis of Type II diabetes?  Yes  No

20. Has the member failed to achieve adequate glycemic control despite individualized diabetic counseling, including diet and a supervised exercise program, and diabetic medication management, such as metformin or a thiazolidinedione? If "yes," indicate the member's current medication therapy and most current HbA1c.  Yes  No

---

21. Is Januvia™ or Janumet™ being added to the member's diabetic drug therapy regimen?  Yes  No

22. **SIGNATURE** — Prescriber

23. Date Signed

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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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24. National Drug Code (11 Digits)

25. Days' Supply Requested (Up to 365 Days)

26. NPI

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27. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

---

28. Patient Location (Use patient location code "0" [Not Specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)

---

29. Assigned PA Number

---

30. Grant Date

31. Expiration Date

32. Number of Days Approved

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**SECTION V — ADDITIONAL INFORMATION**

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33. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a member who was granted retroactive eligibility by ForwardHealth.

**ATTACHMENT 26**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Stimulants and Related Agents Completion**  
**Instructions**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Stimulants and Related Agents Completion Instructions” is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR STIMULANTS AND RELATED AGENTS COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and dispensing physicians are required to retain a completed copy of the form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents form, F-11097. Pharmacy providers are required to use the PA/PDL for Stimulants and Related Agents to request PA by using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form by fax to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, followed by his or her first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to submit a copy of the prescription.

### Element 4 — Drug Name and Strength

Enter the drug name and strength.

### Element 5 — Date Prescription Written

Enter the date the prescription was written.

### Element 6 — Directions for Use

Enter the directions for use of the drug.

### Element 7 — Name — Prescriber

Enter the name of the prescriber.

### Element 8 — National Provider Identifier (NPI)

Enter the prescribing provider's NPI.

### Element 9 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

### Element 10 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

### Element 11 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or the description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis for stimulants must be one of the approved stimulant diagnosis codes.

### Element 12

Check the appropriate box to indicate if the member has taken a non-preferred drug for more than 30 days outside the ForwardHealth system and had a measurable, therapeutic response.

## SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

### Element 13

Check the appropriate box to indicate whether or not the member has a diagnosis of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) *and* Tourette's syndrome or a history of tics.

### Element 14

Check the appropriate box to indicate whether or not the member has a diagnosis of ADD or ADHD *and* obsessive compulsive disorder.

### Element 15

Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse. If yes, explain in the space provided.

### Element 16

Check the appropriate box to indicate whether or not the member has a serious risk of diversion. If yes, explain in the space provided.

**Element 17**

Check the appropriate box to indicate whether or not the member has experienced a treatment failure or a clinically significant adverse drug reaction to a preferred stimulant(s). If yes, indicate in the space provided the preferred stimulant(s), specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drug(s) was taken.

**SECTION IIIB — CLINICAL INFORMATION FOR PROVIGIL**

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check “yes” or “no” as it applies to each question. Include written documentation as indicated.

**Element 18**

Check the appropriate box to indicate whether or not the member has a diagnosis of narcolepsy, obstructive sleep apnea/hypopnea syndrome, or shift work sleep disorder.

**Element 19**

Check the appropriate box to indicate whether or not the member has a diagnosis of ADD or ADHD.

**Element 20**

Check the appropriate box to indicate whether or not the member has experienced a treatment failure or a clinically significant adverse drug reaction to *two* preferred stimulants. If yes, indicate in the space provided the preferred stimulants, specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drugs were taken.

**Element 21**

Check the appropriate box to indicate whether or not the prescriber has peer-reviewed medical literature to support the proven efficacy of the requested use of Provigil for ADD or ADHD. If yes, indicate in the space provided the medical literature references.

**SECTION IIIC — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS AND RELATED AGENTS**

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check “yes” or “no” as it applies to each question. Include written documentation as indicated.

**Element 22**

Check the appropriate box to indicate whether or not the member has a diagnosis of ADD or ADHD.

**Element 23**

Check the appropriate box to indicate whether or not the member has experienced a treatment failure or a clinically significant adverse drug reaction to a preferred stimulant(s). If yes, indicate in the space provided the preferred stimulant(s), specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drug(s) was taken.

**Element 24 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 25 — Date Signed**

Enter the month, day, and year the PA/PDL for Stimulants and Related Agents was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 26 — National Drug Code**

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

**Element 27 — Days’ Supply Requested**

Enter the requested days’ supply up to 365 days.

**Element 28 — NPI**

Enter the provider’s NPI.

**Element 29 — Date of Service**

Enter the requested first date of service (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 30 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

<b>Code</b>	<b>Description</b>
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 31 — Assigned PA Number**

Indicate the PA number assigned by the STAT-PA system.

**Element 32 — Grant Date**

Indicate the date the PA was approved by the STAT-PA system.

**Element 33 — Expiration Date**

Indicate the date the PA expires as assigned by the STAT-PA system.

**Element 34 — Number of Days Approved**

Indicate the number of days for which the PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 35**

Indicate any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

**ATTACHMENT 27**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Stimulants and Related Agents**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Stimulants and Related Agents” is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR STIMULANTS AND RELATED AGENTS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, F-11097A.

Pharmacy providers are required to have a completed PA/PDL for Stimulants and Related Agents form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

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**SECTION I — MEMBER INFORMATION**

- |  |                           |
|--|---------------------------|
| 1. Name — Member (Last, First, Middle Initial) | 2. Date of Birth — Member |
| 3. Member Identification Number                |                           |

---

**SECTION II — PRESCRIPTION INFORMATION**

- |   |                                       |
|---|---------------------------------------|
| 4. Drug Name and Strength                                 |                                       |
| 5. Date Prescription Written                              | 6. Directions for Use                 |
| 7. Name — Prescriber                                      | 8. National Provider Identifier (NPI) |
| 9. Address — Prescriber (Street, City, State, ZIP+4 Code) |                                       |
| 10. Telephone Number — Prescriber                         |                                       |

---

**SECTION III – CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS**

Providers are required to complete Section III *and* either Section IIIA, IIIB, or IIIC before signing this form.

11. Diagnosis — Primary Code and / or Description\*
- 
12. Has the member taken a non-preferred drug for more than 30 days outside the ForwardHealth system and had a measurable, therapeutic response?  Yes  No
- (“Yes” should be checked if the member is a new ForwardHealth member.)

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DT-PA041-041

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**SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA**

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13. Does the member have a diagnosis of attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD) *and* Tourette's syndrome or a history of tics?  Yes  No
14. Does the member have a diagnosis of ADD or ADHD *and* obsessive compulsive disorder?  Yes  No
15. Does the member have a medical history of substance abuse or misuse?  Yes  No

If yes, explain in the space below.

- 
16. Does the member have a serious risk of diversion?  Yes  No

If yes, explain in the space below.

- 
17. Has the member experienced a treatment failure or a clinically significant adverse drug reaction with the preferred stimulant(s)?  Yes  No

If yes, list the preferred stimulant drug(s), specific details about the treatment failure or adverse drug reaction, and the approximate dates the preferred drug(s) was taken in the space below.

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**SECTION IIIB — CLINICAL INFORMATION FOR PROVIGIL**

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For PA approval, providers must check "yes" for Element 20 or check "yes" for Elements 21, 22, and 23.

18. Does the member have a diagnosis of narcolepsy, obstructive sleep apnea / hypopnea syndrome (OSAHS), or shift work sleep disorder (SWSD)?  Yes  No

If yes, circle the diagnosis (i.e., narcolepsy, OSAHS, or SWSD).

19. Does the member have a diagnosis of ADD or ADHD?  Yes  No

20. Has the member experienced treatment failures or clinically significant adverse drug reactions with **two** preferred stimulants?  Yes  No

If yes, list the preferred stimulants, specific details about the treatment failures or adverse drug reactions, and the approximate dates the preferred drugs were taken.

- 
21. Does the prescriber have peer-reviewed medical literature to support the proven efficacy of Provigil for ADD or ADHD?  Yes  No

If yes, indicate the medical literature references in the space below.

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**SECTION IIIC — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS AND RELATED AGENTS**

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22. Does the member have a diagnosis of ADD or ADHD?  Yes  No

23. Has the member experienced a treatment failure or a clinically significant adverse drug reaction with the preferred stimulant(s)?  Yes  No

If yes, list the preferred stimulant drug(s), specific details about the treatment failure or adverse drug reaction, and the approximate date the preferred drug(s) was taken in the space below.

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24. **SIGNATURE** — Prescriber

25. Date Signed

*Continued*

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

26. National Drug Code (11 Digits)	27. Days' Supply Requested (Up to 365 Days)	
28. NPI		
29. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)		
30. Patient Location (Use patient location code "0" [Not Specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)		
31. Assigned PA Number		
32. Grant Date	33. Expiration Date	34. Number of Days Approved

**SECTION V — ADDITIONAL INFORMATION**

35. Include any additional diagnostic and clinical information explaining the need for the drug requested.

\* Diagnosis codes indicated must be one of the following approved diagnosis codes.

<b>Strattera (atomoxetine HCl)</b>	
<b>Cylert (pemoline)</b>	
<b>Desoxyn (methamphetamine)</b>	
31400	Attention deficit disorder without mention of hyperactivity
31401	Attention deficit disorder with hyperactivity
314-3140	Hyperkinetic syndrome of childhood — Attention deficit disorder

<b>Provigil (modafinil)</b>	
31400	Attention deficit disorder without mention of hyperactivity
31401	Attention deficit disorder with hyperactivity
314-3140	Hyperkinetic syndrome of childhood — Attention deficit disorder
34700	Narcolepsy without cataplexy
34701	Narcolepsy with cataplexy
78051	Insomnia with sleep apnea, unspecified
78053	Hypersomnia with sleep apnea, unspecified
78055	Disruption of 24 sleep wake cycle, unspecified
78057	Unspecified sleep apnea

**ATTACHMENT 28**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Ankylosing Spondylitis**  
**Completion Instructions**

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis Completion Instructions" is located on the following pages.)

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS  
COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier

Enter the prescribing provider's National Provider Identifier.

### Element 10 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

### Element 11 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

### Element 12 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 13

Check the appropriate box to indicate whether or not the member has a diagnosis of ankylosing spondylitis.

### Element 14

Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

### Element 15

Check the appropriate box to indicate whether or not the member has moderate to severe axial symptoms of ankylosing spondylitis.

### Element 16

Check the appropriate box to indicate whether or not the member has received one or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

**Element 17 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 18 — Date Signed**

Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 19 — National Drug Code**

Enter the appropriate 11-digit National Drug Code for each drug.

**Element 20 — Days' Supply Requested**

Enter the requested days' supply, up to 365 days.

**Element 21 — National Provider Identifier**

Enter the National Provider Identifier of the pharmacy provider.

**Element 22 — Date of Service**

Enter the requested first date of service (DOS) for the drug or biologic in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 23 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 24 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 25 — Grant Date**

Record the date the PA request was approved by the STAT-PA system.

**Element 26 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 27 — Number of Days Approved**

Record the number of days for which the PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 28**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

**ATTACHMENT 29**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Ankylosing Spondylitis**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Ankylosing Spondylitis” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions, F-11304A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier
10. Address — Prescriber (Street, City, State, ZIP+4 Code)	
11. Telephone Number — Prescriber	

**SECTION III — CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS**

12. Diagnosis — Primary Code and / or Description

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13. Does the member have a diagnosis of ankylosing spondylitis?  Yes  No

14. Is the prescription written by a rheumatologist or through a rheumatology consultation?  Yes  No

15. Does the member have moderate to severe axial symptoms of ankylosing spondylitis?  Yes  No

16. Has the member received one or more of the drugs listed below for at least **three** consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?  Yes  No

If yes, circle the drug(s) the member received. Indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate dates the drug(s) was taken in the space below.

corticosteroids      leflunomide      methotrexate      NSAID or COX-2      sulfasalazine

17. <b>SIGNATURE</b> — Prescriber	18. Date Signed
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*Continued*



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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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19. National Drug Code (11 digits)		20. Days' Supply Requested (Up to 365 Days)	
21. National Provider Identifier			
22. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)			
23. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)			
24. Assigned PA Number			
25. Grant Date		26. Expiration Date	27. Number of Days Approved

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**SECTION V — ADDITIONAL INFORMATION**

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28. Include any additional diagnostic and clinical information explaining the need for the drug requested.

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**ATTACHMENT 30**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Crohn's Disease Completion**  
**Instructions**

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease Completion Instructions" is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE COMPLETION  
INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease, F-11305. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier

Enter the prescribing provider's National Provider Identifier.

### Element 10 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

### Element 11 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

### Element 12 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 13

Check the appropriate box to indicate whether or not the member has a diagnosis of Crohn's disease.

### Element 14

Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of Crohn's disease.

### Element 15

Check the appropriate box to indicate whether or not the prescription was written by a gastroenterologist or through a gastroenterology consultation.

### Element 16

Check the appropriate box to indicate whether or not the member has received *two* or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

**Element 17 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 18 — Date Signed**

Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 19 — National Drug Code**

Enter the appropriate 11-digit National Drug Code for each drug.

**Element 20 — Days' Supply Requested**

Enter the requested days' supply.

**Element 21 — National Provider Identifier**

Enter the National Provider Identifier of the pharmacy provider.

**Element 22 — Date of Service**

Enter the requested first date of service (DOS) for the drug or biologic in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 23 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 24 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 25 — Grant Date**

Record the date the PA request was approved by the STAT-PA system.

**Element 26 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 27 — Number of Days Approved**

Record the number of days for which the PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 28**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

**ATTACHMENT 31**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Crohn's Disease**

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Crohn's Disease" is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease Instructions, F-11305A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Crohn's Disease form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier
10. Address — Prescriber (Street, City, State, ZIP+4 Code)	
11. Telephone Number — Prescriber	

**SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE**

12. Diagnosis — Primary Code and / or Description		
13. Does the member have a diagnosis of Crohn's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Does the member have moderate to severe symptoms of Crohn's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Has the member received <b>two</b> or more of the drugs listed below and taken each drug for at least <b>three</b> consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, circle the drugs the member received. Indicate the dose of the drugs, specific details about the treatment failures or adverse drug reactions, and the approximate dates the drugs were taken in the space below.

azathioprine      corticosteroids      methotrexate      sulfasalazine      5-aminosalicylic (5-ASA)      6-mercaptopurine (6MP)

17. <b>SIGNATURE</b> — Prescriber	18. Date Signed
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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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19. National Drug Code (11 digits)		20. Days' Supply Requested (Up to 365 Days)
21. National Provider Identifier		
22. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.		
23. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)		
24. Assigned PA Number		
25. Grant Date	26. Expiration Date	27. Number of Days Approved

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**SECTION V — ADDITIONAL INFORMATION**

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28. Include any additional diagnostic and clinical information explaining the need for the drug requested.

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**ATTACHMENT 32**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Plaque Psoriasis Completion**  
**Instructions**

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis Completion Instructions" is located on the following pages.)

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**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL**  
**ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS**  
**COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis, F-11306. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier

Enter the prescribing provider's National Provider Identifier.

### Element 10 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

### Element 11 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

### Element 12 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 13

Check the appropriate box to indicate whether or not the member has a diagnosis of plaque psoriasis.

### Element 14

Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area.

### Element 15

Check the appropriate box to indicate whether or not the member has a diagnosis of debilitating palmoplantar psoriasis.

### Element 16

Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or through a dermatology consultation.

### Element 17

Check the appropriate box to indicate whether or not the member has received one or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

**Element 18 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 19 — Date Signed**

Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 20 — National Drug Code**

Enter the appropriate 11-digit National Drug Code for each drug.

**Element 21 — Days' Supply Requested**

Enter the requested days' supply, up to 365 days.

**Element 22 — National Provider Identifier**

Enter the National Provider Identifier of the pharmacy provider.

**Element 23 — Date of Service**

Enter the requested first date of service (DOS) for the drug or biologic in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 24 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 25 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 26 — Grant Date**

Record the date the PA request was approved by the STAT-PA system.

**Element 27 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 28 — Number of Days Approved**

Record the number of days for which the PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 29**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

**ATTACHMENT 33**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Plaque Psoriasis**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Plaque Psoriasis” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PLAQUE PSORIASIS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Plaque Psoriasis Completion Instructions, F-11306A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Plaque Psoriasis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier
10. Address — Prescriber (Street, City, State, ZIP+4 Code)	
11. Telephone Number — Prescriber	

**SECTION III — CLINICAL INFORMATION FOR PLAQUE PSORIASIS**

12. Diagnosis — Primary Code and / or Description		
13. Does the member have a diagnosis of plaque psoriasis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Does the member have moderate to severe symptoms of plaque psoriasis involving greater than or equal to 10 percent of his or her body surface area?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Does the member have a diagnosis of palmoplantar psoriasis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Is the prescription written by a dermatologist or through a dermatology consultation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Has the member received one or more of the treatments listed below for at least <b>three</b> consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, circle the treatment(s) the member received. Indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate dates of the treatment(s) in the space below.

cyclosporine                      methotrexate                      phototherapy                      Soriatane

18. <b>SIGNATURE</b> — Prescriber	19. Date Signed
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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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20. National Drug Code (11 digits)		21. Days' Supply Requested (Up to 365 Days)
22. National Provider Identifier		
23. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)		
24. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)		
25. Assigned PA Number		
26. Grant Date	27. Expiration Date	28. Number of Days Approved

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29. Include any additional diagnostic and clinical information explaining the need for the drug requested.

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**ATTACHMENT 34**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Psoriatic Arthritis**  
**Completion Instructions**

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis Completion Instructions" is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS  
COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis, F-11307. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters.

## SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

### Element 4 — Drug Name

Enter the drug name.

### Element 5 — Strength

Enter the strength of the drug listed in Element 4.

### Element 6 — Date Prescription Written

Enter the date the prescription was written.

### Element 7 — Directions for Use

Enter the directions for use of the drug.

### Element 8 — Name — Prescriber

Enter the name of the prescriber.

### Element 9 — National Provider Identifier

Enter the prescribing provider's National Provider Identifier.

### Element 10 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

### Element 11 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

## SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

### Element 12 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

### Element 13

Check the appropriate box to indicate whether or not the member has a diagnosis of psoriatic arthritis.

### Element 14

Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of psoriatic arthritis.

### Element 15

Check the appropriate box to indicate whether or not the prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.

### Element 16

Check the appropriate box to indicate whether or not the member has moderate to severe axial symptoms of psoriatic arthritis.

### Element 17

Check the appropriate box to indicate whether or not the member has received *two* or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

**Element 18 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 19 — Date Signed**

Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 20 — National Drug Code**

Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

**Element 21 — Days' Supply Requested**

Enter the requested days' supply, up to 365 days.

**Element 22 — National Provider Identifier**

Enter the National Provider Identifier of the pharmacy provider.

**Element 23 — Date of Service**

Enter the requested first date of service (DOS) for the drug or biologic in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 24 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 25 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 26 — Grant Date**

Record the date the PA request was approved by the STAT-PA system.

**Element 27 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 28 — Number of Days Approved**

Record the number of days for which the PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 29**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

**ATTACHMENT 35**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Psoriatic Arthritis**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Psoriatic Arthritis” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIATIC ARTHRITIS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriatic Arthritis Completion Instructions, F-11307A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier
10. Address — Prescriber (Street, City, State, ZIP+4 Code)	
11. Telephone Number — Prescriber	

**SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS**

12. Diagnosis — Primary Code and / or Description

13. Does the member have a diagnosis of psoriatic arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Does the member have moderate to severe symptoms of psoriatic arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Is the prescription written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Does the member have moderate to severe axial symptoms of psoriatic arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Has the member received <b>two</b> or more of the drugs listed below and taken each drug for at least <b>three</b> consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, circle the drugs the member received. Indicate the dose of the drugs, specific details about the treatment failures or adverse drug reactions, and the approximate dates the drugs were taken in the space below.

azathioprine    corticosteroids    cyclosporine    hydroxychloroquine    leflunomide    methotrexate    NSAID or COX-2

18. <b>SIGNATURE</b> — Prescriber	19. Date Signed
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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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20. National Drug Code (11 digits)		21. Days' Supply Requested (Up to 365 Days)
22. National Provider Identifier		
23. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)		
24. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)		
25. Assigned PA Number		
26. Grant Date	27. Expiration Date	28. Number of Days Approved

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29. Include any additional diagnostic and clinical information explaining the need for the drug requested.

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**ATTACHMENT 36**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Rheumatoid Arthritis**  
**Completion Instructions**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis Completion Instructions” is located on the following pages.)

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**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS  
COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Prescribers and pharmacy providers are required to retain a completed copy of the form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis, F-11308. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

- 1) For STAT-PA requests, pharmacy providers should call (800) 947-1197.
- 2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, pharmacy providers should submit a PA/RF, the appropriate PA/PDL form, and supporting documentation to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters.

**SECTION II — PRESCRIPTION INFORMATION**

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

**Element 4 — Drug Name**

Enter the drug name.

**Element 5 — Strength**

Enter the strength of the drug listed in Element 4.

**Element 6 — Date Prescription Written**

Enter the date the prescription was written.

**Element 7 — Directions for Use**

Enter the directions for use of the drug.

**Element 8 — Name — Prescriber**

Enter the name of the prescriber.

**Element 9 — National Provider Identifier**

Enter the prescribing provider's National Provider Identifier.

**Element 10 — Address — Prescriber**

Enter the complete address of the prescriber's practice location, including the street, city, state, and ZIP+4 code.

**Element 11 — Telephone Number — Prescriber**

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

**SECTION III — CLINICAL INFORMATION FOR RHEUMATOID ARTHRITIS**

Include diagnostic and clinical information explaining the need for the product requested. Complete all elements in Section III. Check "yes" or "no" as it applies to each question. Include written documentation as indicated.

**Element 12 — Diagnosis — Primary Code and / or Description**

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

**Element 13**

Check the appropriate box to indicate whether or not the member has a diagnosis of polyarticular juvenile rheumatoid arthritis.

**Element 14**

Check the appropriate box to indicate whether or not the member has a diagnosis of rheumatoid arthritis.

**Element 15**

Check the appropriate box to indicate whether or not the member has moderate to severe symptoms of rheumatoid arthritis.

**Element 16**

Check the appropriate box to indicate whether or not the prescription is written by a rheumatologist or through a rheumatology consultation.

**Element 17**

Check the appropriate box to indicate whether or not the member has received *two* or more of the drugs listed on the PA/PDL form for at least *three* consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction. If "yes" is checked, circle the drug(s) received. In the space provided, indicate the dose of the drug(s), specific details about the treatment failure(s) or adverse drug reaction(s), and the approximate date(s) the drug(s) was taken.

**Element 18 — Signature — Prescriber**

The prescriber is required to complete and sign this form.

**Element 19 — Date Signed**

Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis was signed (in MM/DD/CCYY format).

**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 20 — National Drug Code**

Enter the appropriate 11-digit National Drug Code for each drug.

**Element 21 — Days' Supply Requested**

Enter the requested days' supply.

**Element 22 — National Provider Identifier**

Enter the National Provider Identifier of the pharmacy provider.

**Element 23 — Date of Service**

Enter the requested first date of service (DOS) for the drug or biologic in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 24 — Patient Location**

Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

**Element 25 — Assigned PA Number**

Record the PA number assigned by the STAT-PA system.

**Element 26 — Grant Date**

Record the date the PA request was approved by the STAT-PA system.

**Element 27 — Expiration Date**

Record the date the PA expires as assigned by the STAT-PA system.

**Element 28 — Number of Days Approved**

Record the number of days for which the PA request was approved by the STAT-PA system.

**SECTION V — ADDITIONAL INFORMATION**

**Element 29**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

**ATTACHMENT 37**  
**Prior Authorization/Preferred Drug List (PA/PDL)**  
**for Cytokine and Cell Adhesion Molecule (CAM)**  
**Antagonist Drugs for Rheumatoid Arthritis**

(A copy of the “Prior Authorization/Preferred Drug List [PA/PDL] for Cytokine and Cell Adhesion Molecule [CAM] Antagonist Drugs for Rheumatoid Arthritis” is located on the following pages.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL  
ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis Completion Instructions, F-11308A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs for Rheumatoid Arthritis form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier
10. Address — Prescriber (Street, City, State, ZIP+4 Code)	
11. Telephone Number — Prescriber	

**SECTION III — CLINICAL INFORMATION FOR RHEUMATOID ARTHRITIS**

12. Diagnosis — Primary Code and / or Description

13. Does the member have a diagnosis of polyarticular juvenile rheumatoid arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Does the member have a diagnosis of rheumatoid arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Does the member have moderate to severe symptoms of rheumatoid arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Is the prescription written by a rheumatologist or through a rheumatology consultation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Has the member received <b>two</b> or more of the drugs listed below and taken each drug for at least <b>three</b> consecutive months and failed to achieve an adequate response or a reduction in symptoms or experienced a clinically significant adverse drug reaction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, circle the drugs the member received. Indicate the dose of the drugs, specific details about the treatment failures or adverse drug reactions, and the approximate dates the drugs were taken in the space below.

azathioprine    corticosteroids    cyclosporine    gold sodium thiomalate    hydroxychloroquine    leflunomide  
methotrexate    NSAIDs or COX-2    penicillamine    sulfasalazine

18. <b>SIGNATURE</b> — Prescriber	19. Date Signed
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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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20. National Drug Code (11 digits)

21. Days' Supply Requested (Up to 365 Days)

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22. National Provider Identifier

---

23. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

---

24. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)

---

25. Assigned PA Number

---

26. Grant Date

27. Expiration Date

28. Number of Days Approved

---

---

29. Include any additional diagnostic and clinical information explaining the need for the drug requested.

---